MHA: Strategic Quality
What’s Up Wednesday|Lunch and Learn
Your clinical quality, process improvement resource

Alison Williams, Vice President of Clinical Quality Improvement
May 3, 2017
May 2017

• Vizient™ Patient Safety Organization Update
• Quality Initiatives Updates
• Resources and Upcoming Events
Featured Presentation

Jessica Schoenthal, RN, MSN, CPPS
PSO Collaborative Advisor
Vizient™ Patient Safety Organization
Vizient Patient Safety Organization

Jessica Schoenthal, RN, MSN, CPPS
Collaborative Advisor
Vizient PSO

May 3, 2017
Disclosures

I have no financial disclosures
Objectives

- Overview of PSO team, offerings and events
- Review of PSO data
- Submitting data to the PSO
- PSO project updates
- Additional PSO resources
Vizient PSO: Your patient safety partners

Ellen Flynn, RN, MBA, JD, CPPS
Associate VP Safety Programs
(312) 775-4294
Ellen.Flynn@vizientinc.com

Jessica Schoenthal, RN, MSN, CPPS
PSO Collaborative Advisor
T (312) 775-4380
Jessica.Schoenthal@vizientinc.com

Tammy Williams, RN, MSN, CPPS
PSO Collaborative Advisor
(312) 775-4380
Tammy.Williams@vizientinc.com

Jessie Blackwell
Member Support Specialist
(312) 775-4234
Jessie.Blackwell@vizientinc.com

Joyce Kloth
Administrative Specialist
(312) 775-4418
Joyce.Kloth@vizientinc.com
# Vizient PSO participants

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Number of states with participating organizations</td>
<td>29</td>
</tr>
<tr>
<td>Number of organizations participating</td>
<td>234</td>
</tr>
<tr>
<td>Number of participating health systems</td>
<td>18</td>
</tr>
<tr>
<td>Number of health system providers</td>
<td>137</td>
</tr>
<tr>
<td>• General, specialty, or critical access hospital</td>
<td>179</td>
</tr>
<tr>
<td>• Community health center, group practice, clinic, surgical center, etc.</td>
<td>27</td>
</tr>
<tr>
<td>• Other: ambulance, emergency medical technician, paramedics, etc.</td>
<td>13</td>
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<tr>
<td>• Academic medical centers</td>
<td>33</td>
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<tr>
<td>• Rehabilitation hospitals</td>
<td>5</td>
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<tr>
<td>• Behavioral health</td>
<td>12</td>
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</table>
## Vizient PSO - offering details

### Participation in the Vizient PSO provides:

<table>
<thead>
<tr>
<th>Educational opportunities</th>
<th>Collaboration opportunities</th>
<th>Other</th>
<th>Additional services (incremental fee)</th>
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</thead>
<tbody>
<tr>
<td>Safety alerts, checklists and white papers</td>
<td>Safe Table participation (minimum of six per year)</td>
<td>Privilege and confidentiality protection for PSWP</td>
<td>PSES documentation support</td>
</tr>
<tr>
<td>Evidence based and expert consensus recommendations</td>
<td>Leading practice development projects</td>
<td>Multidimensional Analytic Tool access</td>
<td>NPSD reporting</td>
</tr>
<tr>
<td>Patient Safety Evaluation System (PSES) documentation calls</td>
<td>2 in-person PSO conferences</td>
<td>Annual Evidence Based Feedback Report with comparative data</td>
<td>Quarterly Feedback Report</td>
</tr>
<tr>
<td>PSO operations orientation and Patient safety officer education</td>
<td>Quarterly virtual PSO user group</td>
<td>Access to Vizient Performance Management Resources</td>
<td></td>
</tr>
<tr>
<td>Case law updates</td>
<td>PSO listserv participation</td>
<td>PSO manager consultation and coaching via telephone and email</td>
<td></td>
</tr>
</tbody>
</table>

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Additional services (incremental fee):

- PSES documentation support
- NPSD reporting
- Quarterly Feedback Report
## 2017 Vizient PSO calendar (MHA)

<table>
<thead>
<tr>
<th>Month</th>
<th>PSO Officer Training*</th>
<th>Safe Tables</th>
<th>PSO Operations</th>
<th>Safety Web Conference*</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td></td>
<td></td>
<td>JANUARY 10: Documenting PSES</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>JANUARY 25: PSO User Group</td>
<td></td>
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<tr>
<td>February</td>
<td>FEBRUARY 17: Daily huddle and PRN Containment</td>
<td>FEBRUARY 23: Medication Safety</td>
<td>FEBRUARY 7: PSO Orientation</td>
<td>FEBRUARY 1: Achieving Insulin Safety ...</td>
</tr>
<tr>
<td>March</td>
<td></td>
<td></td>
<td>MARCH 7: Documenting PSES</td>
<td>MARCH 1: Ambulatory Safety Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MARCH 21: PSO User Group</td>
<td>MARCH 22: Glycemic Management</td>
</tr>
<tr>
<td>April</td>
<td></td>
<td>APRIL 19: Patient Falls</td>
<td>APRIL 4: PSO Orientation</td>
<td>APRIL 25: PSO Semi-Annual Meeting and Networking Dinner (Chicago)</td>
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<tr>
<td>May</td>
<td>MAY 11: Measurement and Transparency</td>
<td></td>
<td>MAY 2: Documenting PSES</td>
<td>MAY 25: Observation Unit Management</td>
</tr>
<tr>
<td>June</td>
<td></td>
<td>JUNE 28: Care Coordination</td>
<td>JUNE 6: PSO Orientation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>JUNE 21: PSO User Group</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>JULY 18: Teamwork and Deference to Experts</td>
<td></td>
<td>JULY 13: Making Sense of the PSO Privilege-Post HHS Guidance (Columbia, MO)</td>
<td>JULY 27: Patient Engagement and Activation</td>
</tr>
<tr>
<td>August</td>
<td>AUGUST 17: Identifying and preventing &quot;Unacceptable Harm&quot;</td>
<td></td>
<td>AUGUST 8: PSO Orientation</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td></td>
<td>SEPTEMBER 26: Electronic Communication (Excellence in Clinical Care Series, Lake Ozark, MO)</td>
<td>SEPTEMBER 26: PSO User Group Meeting (Excellence in Clinical Care Series, Lake Ozark, MO)</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>OCTOBER 19: Crew Resource Management</td>
<td></td>
<td>OCTOBER 3: Documenting PSES</td>
<td>OCTOBER 25: Opioid Safety</td>
</tr>
<tr>
<td>November</td>
<td></td>
<td></td>
<td>NOVEMBER 7: PSO Orientation</td>
<td>NOVEMBER 30: Preventing Diagnostic Errors</td>
</tr>
</tbody>
</table>

All web conferences begin at 1 p.m. CST.
(All events listed are web conferences unless location stated)
*CE's offered for Nursing, Pharmacist, Physicians

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Making sense of the PSO privilege after the HHS guidance
July 13, 2017 (Columbia, MO)

Ellen Flynn RN, MBA, JD, CPPS
AVP Vizient Inc., Safety Programs

Jane Drummond, J.D.
General Counsel and Vice President of Legal Affairs

- Missouri state law peer review protections
- Missouri mandatory state reporting and other external record keeping obligations
- HHS Guidance regarding PSWP and providers extremal obligations - what are the benefits of working with a PSO?

HHS = Department of Health and Human Services
Excellence in clinical care series on Patient Safety Day

Tuesday September 26
Camden on the Lake, Lake Ozark, MO

• Case law update, Wes Butler Esq.
• Breaking silos - PSO safety huddle pilot
• Sustaining patient centered fall reduction program
• Multidisciplinary direct oral anticoagulation project update
• PSO data and 2018 project prioritization feedback
• PSO Safe Table: Reliable communication in a complex electronic environment
PSO list server

• Must request a login and password from Vizient website to be added to the list server
• Notify Joyce Kloth if you need to be added to the list server or want us to add others
• Check your junk email if you have been added to the list server and are not receiving emails
• Note: The new email address for our PSO list server for MHA is VIZIENT-PSO-MHA@DISCUSS.VIZIENTINC.COM
• Remove the old address
Patient event data
Reporting trend

Total event reports from 2014 – Feb. 2017 = 168,080
Most common patient event types and unsafe conditions (2014 – Feb. 2017)

- Laboratory test
- Medication related
- Care Coordination/Communication
- Fall
- Other/Miscellaneous
- Skin Integrity
- Complications of care (unanticipated, non-surgical)
- Behavioral Event
- Event related to surgery or invasive procedure
- Equipment/Devices

Number of Events = 168,080
Most common patient event categories and unsafe conditions (2014 – Feb. 2017)

Number of Events = 168,080
Harmful (6-9) event categories (2014 – Feb. 2017)

- Fall: 12%
- Pressure ulcer: 11%
- IV site complication: 5%
- Other other/miscellaneous event: 4%
- Self-harm or injury: 3%
- Other behavioral event: 3%
- Contrast extravasation: 2%
- Assault: 2%
- Other skin integrity event: 2%
- Skin tear: 2%

Number of Events = 6,945
Harm Score 6 - 9

- Death: 0.1%
- Severe permanent harm: 0.3%
- Permanent harm: 0.2%
- Temporary harm: 3.6%
- Additional treatment: 13.9%
- Emotional distress or inconvenience: 20.6%
- No harm evident, physical or otherwise: 15.2%
- Near miss: 12.0%
- Unsafe condition: 34.1%

Number of Events = 167,644
Submitting data to Vizient PSO
PSO Member Feedback Report

Each organization or health system receives an individualized report identifying organization-specific opportunities for improvement based on findings in their data.

Comparison data can drive further analysis of the details of events to uncover specific safety issues.

- Mislabeled specimens and specimen quality
- Patient identification
- Care coordination
- Sterilization issues
Vizient™ PSO SFTP file transfer details

Vizient utilize industry standard protocol (SSH v2) for secure file transfer. Organizations are expected to deploy and retain full control of the SSH server and all aspects of its security. They will have the choice of using any SSH v2 compatible client software which can be commercial or open source (openSSH).

Vizient supports SFTP with the Private/public key approach. We are flexible and if you prefer another method, we are willing to discuss. Please have your IT contact reach out to Lane Adamson at Lane.Adamson@vizientinc.com or (312) 775-4102.

Private/Public Key: Configuring an SSH user for public key authentication requires both a public SSH key and a private SSH key.

Our recommendation is that the members create their own SSH2 key pair and then send the public key to the Vizient administrator while keeping the secret private key for their SFTP client. The public key is the only file the Vizient administrator needs and that file’s contents do not need to be kept secret. The public key file can be sent unencrypted from the members to the Vizient administrator.

SFTP = secure file transfer protocol
SSH = secure shell
Vizient web conferences on data transfer

Invite your information technology (IT) staff to one of the following web conferences on data transfer facilitated by Vizient IT staff.

Click the link below to register for the session your team can attend.

**Wednesday, May 3rd 1100-1200 CST**

**Thursday, May 25th 1100-1200 CST**
Are you entering data manually on the Spreadsheet?

<table>
<thead>
<tr>
<th>DE1</th>
<th>DE4</th>
<th>DE2</th>
<th>DE30</th>
<th>DE3</th>
<th>DE9</th>
<th>DI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider ID</td>
<td>PSO OID</td>
<td>Event ID</td>
<td>Initial report date</td>
<td>Report type</td>
<td>Event discovery date/time</td>
<td>Dunn</td>
</tr>
</tbody>
</table>

- **A3** = Incident: A patient safety event that reached the patient, whether or not the patient was harmed.

Email **Jessica** if you would like her to send the updated spreadsheet.
Vendors that can send data per Vizient PSO file specifications

1. Clarity Group
2. CRG Medical, Inc.
3. Datix
4. MarshClearSight
5. MidasPlus, Inc., A Xerox Company
6. NextPlane Solutions
7. Quantros
8. Risk Connect
9. RL Solutions
10. Verge

Notes:
- We are having discussions with other vendors and this request will be updated as additional information comes in.
- Ability to send data will be dependent on data elements collected and may require mapping.
PSO project updates

- Anticoagulants
- Falls
- Safety huddles
Multidisciplinary direct oral anticoagulation project
Anticoagulation project

- Convened a group of medication safety experts
- Reviewed events of harm related to medication
- Determined scope of project and deliverables
- Hosted a safe table discussion
- Data analysis from PSO events
- Literature review
- Gathered leading practices and policies from experts
- Creating toolkit for members
Medication Safety Advisory Team Members

- Elena Meeker, Medication Safety Pharmacist, University of Washington
- Timothy Lesar, Director of Clinical Pharmacy Services, Patient care Services Director, Albany Medical Center
- Michelle Then, Pharmacy Manager, Medication Safety, Quality & Regulatory, Pharm D, MBA, Denver Health
- Melissa W. King, Medication Safety Manager, BS Pharm, Duke Hospital
- Adeline Saliba, Pharm D, MBA, CPPS, CPHQ, Continuous Quality Improvement Lead, Seha Emirates Hospital
- Rachel Hensley, Pharm D, MBA, Director of Pharmacy, SSM Health
- Christi Quarles Smith, Pharm D, Assistant director of Pharmacy for medication safety, University of Arkansas
- Vanessa B. Bibbs, Accreditation Nurse Specialist, BSN, Vidant Health
- Cheryl Edwards, BS Pharm, Pharm D, MBA, Medication Safety Manager, PHD, MBA, Parkland Health and Hospital
- Luba Burman, Pharm D, BCPS, CDE, Rush University
- Steven B. Meisel, PharmD., CPPS, Director of Patient Safety, Fairview Health Services
- Joe Melucci, MBA, RPH, Medication Safety Officer, the Ohio State University Wexner Medical Center
- Ketan Patell, Pharm D, DHS-Pharmacy Affairs, LA County
- Scott Murray PharmD, Senior Pharmacist, Medication Safety and Pharmacy Transitions Coordinator, Emergency Department Pharmacy Manager, Upstate University Hospital
- Dr. Dhawale, University Washington, hematology resident
- Dr. Cromwell, University Iowa
- Dr. Robert Dean, Vizient Inc
- Jim Lichauer, Pharm D, Project Manager Vizient Inc.
- Tammy Williams RN, MSN, CPPS, Collaborative Advisor, Vizient PSO
- Jessica Schoenthal, RN, MSN, CPPS, Collaborative Advisor, Vizient PSO
- Ellen Flynn, RN, MBA, JD, CPPS, AVP Safety Program
Experts in medication safety concerns

**What keeps them up at night?**

Direct Oral Anticoagulants (DOAC)

- Dabigatran
- Apixaban
- Eliquis
- Rivaroxaban
- Lixiana
- XARELTO
- Pradaxa
- Savaysa
- Edoxaban
Medication advisory group deliverables

- Safety alerts:
  - Share safety concerns for each category
  - Leading practice recommendations
  - ISMP self assessment

- Toolkit:
  - Quick reference guide
  - Aggregation of all Safety Alerts
  - Leading practices
  - Data Summary
  - Staff and patient education
  - Checklist for discharge

- Webinar:
  - Case scenarios
  - Present leading practices
  - Provide toolkit
  - Q&A Session
DOAC event report data

• A retrospective review of three years of PSO data entered from 2014 - 2016
• Text search for generic and brand names for the following drugs:
  – Rivaroxaban (Xarelto)
  – Apixaban (Eliquis)
  – Dabigatran (Pradaxa, Prazaxa)
  – Edoxaban (Savaysa, Lixiana)
• Description of events were reviewed and identified factors and issues involved
Drugs involved in events

DOAC involved

Vizient PSO data 2014 - 2016
Total number of events = 147

Other drug involved

Therapeutic duplication
Known drug interactions
Med reconciliation
Incorrect transition between drugs
Event type/category

- Wrong dose/frequency (over, under, extra, missed)
- Other medication event
- Known drug interaction
- Care Coordination/Communication
- Event before surgery (delayed, cancelled, wrong prep)
- Prescription/refill delayed
- Wrong drug
- Wrong duration
- Wrong timing
- Adverse drug reaction

Vizient PSO data 2014 - 2016
Total number of events = 147
Factors and issues described in events

- Therapeutic duplication
- Medication reconciliation issue
- Poor care coordination
- Procedure-related errors (hold/resume)
- DOAC-related bleed
- Incorrect transition between drugs
- Wrong dose or frequency
- Drug - Disease contraindication
- Conflicting orders between physicians
- Delays due drug availability
- Cost/insurance coverage issues
- Patient non-compliance/adherence

Vizient PSO data 2014 - 2016
Total number of events = 147
More than 1 factor could be selected in 1 event
AHRQ Common Format Harm Score assigned to events

Vizient PSO data 2014 - 2016
Total number of events = 147
Patient-centered DOAC care coordination

- Initiation of therapy
- Admission to acute care
- Discharge from acute care
- Peri-procedural care
- Ambulatory care

Patient
Safety alert

Vizient P&O Safety Message

March 2017

The new DOAC medications are high risk, high volume, and prone to dosing errors. DOACs are the preferred anticoagulant agents among all categories of patients. DOACs are associated with a decrease in bleeding complications compared to warfarin. DOACs require patient education and monitoring to ensure proper dosing and dosing adjustments. DOACs are associated with a decrease in bleeding complications compared to warfarin. DOACs require patient education and monitoring to ensure proper dosing and dosing adjustments.

Assessment: The Vizient Patient Safety Organization conducted a retrospective review of safety events involving DOACs that occurred from 2014 to 2016 and determined that the DOACs are high volume, high risk, and prone to error. Patients involved in adverse events on DOACs from 2014-2016. ISMP describes this strategy for “one of the highest risk outpatient drug therapies” (Institute for Safe Medication Practices, 2015). Furthermore, in 2016, FDA published a draft guideline for drugs with “Severe” or “Moderate” effects as a result of DOACs.

Background: Over 30% of hospitalized patients are on some type of antiplatelet, including 54% of patients greater than 65 years old. These rate drugs have added complexity to anticoagulation management. In a study, providers had multiple anticoagulants to use, the patient population is growing, and the state is struggling. These states can easily recognize these high-risk drugs as anticoagulants. Studies also suggest that these drugs are not interchangeable, as several different have been shown to interact with certain drugs.

Recommendations: The Vizient P&O, with a team of experts in medicines safety, is creating a comprehensive DOAC Toolkit for P&O partners. Below are five recommendations on how you can begin to identify your DOAC safety needs and take action on them.

1. Review the guidelines of the DOACs (Rivera-Tabah, 2017). Diagnostic, national, and international guidelines for all DOACs are available. These guidelines are updated regularly and should be included in your organization’s education program.

2. Implement a dose checklist or form used for patients prescribed DOAC therapy. This should include the following information:
   - The patient’s name and identifying number
   - The patient’s dose and frequency
   - The patient’s weight
   - The patient’s laboratory results
   - The patient’s body mass index
   - The patient’s renal function
   - The patient’s bleeding history
   - The patient’s anticoagulation history
   - The patient’s current medications

3. Conduct a risk assessment tool similar to the one available at the American College of Chest Physicians (ACCP).

4. Implement a blood test program for patients prescribed DOAC therapy. This should include the following information:
   - The patient’s name and identifying number
   - The patient’s dose and frequency
   - The patient’s weight
   - The patient’s laboratory results
   - The patient’s body mass index
   - The patient’s renal function
   - The patient’s bleeding history
   - The patient’s anticoagulation history
   - The patient’s current medications

5. Implement a training program for all staff involved in the management of patients prescribed DOAC therapy. This should include the following information:
   - The patient’s name and identifying number
   - The patient’s dose and frequency
   - The patient’s weight
   - The patient’s laboratory results
   - The patient’s body mass index
   - The patient’s renal function
   - The patient’s bleeding history
   - The patient’s anticoagulation history
   - The patient’s current medications

Resources:
Management of Patients on Non-Vitamin K Antagonist Oral Anticoagulants in the Acute Care and Perioperative Setting: A Scientific Statement from the American Heart Association available at http://circ.ahajournals.org/content/130/20/S1
Guidance for the practice management of direct oral anticoagulants (DOACs) in VTE treatment available at https://www.cirrhosis.org/newsroom/docs/2015/12/14/PJ_Kennedy.pdf

The ISMP anticoagulation self-assessment tool is available at http://www.ismp.org/QuarterlyWatch/2016/Q2.pdf
ISMP self assessment of high risk medication

• ISMP states there is a way for the PSO members to participate in the ISMP risk assessment for high alert medications, which includes anticoagulants.
• It is a self-assessment that would allow organizations to identify areas to focus improvement efforts.
• Allow organizations to complete a re-self assessment to evaluate effectiveness of improvement strategies and prioritize next steps for improvement work.
• Creating Vizient ID’s for members of PSO to DEidentify assessments and share with PSO to assist us to determine PSO safety projects.

ISMP = Institute for Safe Medication Practices
Sustaining results of a patient centered fall reduction program
Experts in falls advisory group

- Convened a group of fall prevention experts
- Reviewed events of harm from preventable falls
- Determined scope of project and deliverables
- Hosted a safe table discussion
- Data analysis from PSO events
- Literature review
- Gathered leading practices and policies from experts
- Creating virtual binder of resources
Expert fall advisory group members

- Patricia C. Dykes PhD, RN, FAAN, FACMI, Sr. Nurse Scientist, Program Director, Center for Patient Safety Research and Practice
  Program Director, Center for Nursing Excellence, Brigham & Women's Hospital
- Amy L. Hester, PhD, RN, BC, Director of Nursing Research and Innovation, UAMS Medical Center
- Dorri Bierley, RN, MSN, CNRN Nursing Professional Development Specialist, UAB Hospital
- Eric Weiskoph, Continuing Education with focus upon ergonomics, Mercy Springfield within MHM Support division
- Adam Meier BSN, MSN, Nurse Manager, University of Kansas Hospital
- Kristine Harper, MSN, Manager Safe Patient Handling Program, Medical University of South Carolina
- Linda Stevens, DNP, RC-BC, CPHQ, CSPHP, Director Nursing Quality and Safety, UW Health
- Eileen Costantinou, MSN RN-BC, Practice Specialist, Senior Coordinator, Barnes-Jewish Hospital
- Donna Guillaume PHD, RN, Regulatory and Public Reporting Project Manager, UMASS Memorial Medical Center
- Lauri Wolf, PhD in Human Factors Engineering and Ergonomics, Barnes-Jewish Hospital
- Patricia Lavin, Director of Quality and Outcome, NYU Hospital
# Expert Fall Advisory Team Charter

1) **Problem Statement:**
   
   Hospitals continue to struggle with sustaining a decrease in preventable patient falls with moderate to severe injury through reliability of fall risk assessments and implementation of patient centered fall prevention interventions.

2) **PSO Expert Fall Advisory Team Goal:**
   
   The goal of the PSO Expert Fall Advisory Team is to engage experienced patient safety leaders from across the nation in collaboration with Vizient PSO to provide insights to and strategies to address member opportunities to improve their performance related to reducing falls with moderate to severe injury.

3) **Deliverables:**
   
   a. Virtual Binder
   
   b. ______________________
   
   c. ______________________
   
   d. ______________________

4) **Strategies:**
   
   a. Discuss member barriers in sustaining a decrease in unassisted falls with moderate to severe injury at April PSO Safe Tables.
   
   b. Aggregate/Analyze PSO unassisted patient fall with moderate to severe injury data.
   
   c. Identify and create solutions through expert advisory team leading practices and literature review.
   
   d. Share solutions with members, possibly through Virtual Binder, webinars, etc. (TBD)

5) **Focus areas:**
   
   a. Patient engagement in fall prevention plan
   
   b. Inter relator reliability of fall risk assessment
   
   c. Sustaining results in fall prevention program
   
   d. ______________________
Expert falls advisory team timeline

- **March 30**
  - Meeting 1
- **April 18 - 19**
  - Safe Tables
- **April 20**
  - Meeting 2
- **May**
  - Sub groups to meet and create “chapters” of virtual binder
- **June 7th**
  - Meeting 3
- **TBD**
  - Share deliverables

- Define problem and deliverables
- Identify solutions
- Contribute and review deliverables
Type of fall

- Unknown
- Assisted
- Unassisted
Was the patient in restraints at time of fall?

- 2014: 100%
- 2015: 100%
- 2016: 100%
Was the fall observed?

- **2014**
  - Unknown: 10%
  - No: 60%
  - Yes: 30%

- **2015**
  - Unknown: 11%
  - No: 60%
  - Yes: 29%

- **2016**
  - Unknown: 12%
  - No: 60%
  - Yes: 28%
Identify any contributing factors at the time of the fall

<table>
<thead>
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<th>Factor</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormalities of gait or balance</td>
<td>1806</td>
<td>1744</td>
<td>1371</td>
</tr>
<tr>
<td>Altered elimination (urgency, frequency, incontinence bowel or bladder)</td>
<td>505</td>
<td>435</td>
<td>433</td>
</tr>
<tr>
<td>Altered mental status/cognitive impairment</td>
<td>1119</td>
<td>1011</td>
<td>888</td>
</tr>
<tr>
<td>Behavioral/mental health issue</td>
<td>650</td>
<td>631</td>
<td>605</td>
</tr>
<tr>
<td>Depression</td>
<td>132</td>
<td>156</td>
<td>98</td>
</tr>
<tr>
<td>Dizziness/vertigo</td>
<td>395</td>
<td>423</td>
<td>339</td>
</tr>
<tr>
<td>Low glucose/sodium levels</td>
<td>28</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td>98</td>
<td>122</td>
<td>73</td>
</tr>
<tr>
<td>Patient did not call for help</td>
<td>1989</td>
<td>1995</td>
<td>1666</td>
</tr>
<tr>
<td>Side effects of medication</td>
<td>310</td>
<td>285</td>
<td>243</td>
</tr>
<tr>
<td>Unable to rise or ambulate without assistance</td>
<td>888</td>
<td>781</td>
<td>656</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>108</td>
<td>102</td>
<td>105</td>
</tr>
<tr>
<td>Grab bar or hand rail placement</td>
<td>26</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Side rails found down</td>
<td>71</td>
<td>63</td>
<td>57</td>
</tr>
<tr>
<td>Items not within reach (e.g., call light, personal items, food/water)</td>
<td>87</td>
<td>78</td>
<td>59</td>
</tr>
<tr>
<td>Lighting</td>
<td>50</td>
<td>53</td>
<td>31</td>
</tr>
<tr>
<td>Lock for movable transfer equipment not set</td>
<td>29</td>
<td>43</td>
<td>24</td>
</tr>
<tr>
<td>Tripped/slipped</td>
<td>740</td>
<td>733</td>
<td>597</td>
</tr>
</tbody>
</table>
At the time of the fall, was the patient on medication known to increase the risk for a fall?
Prior to the fall, what was the patient doing or trying to do?

<table>
<thead>
<tr>
<th>Activity</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulating WITHOUT assistance and without an assistive device or medical equipment</td>
<td>956</td>
<td>953</td>
<td>908</td>
</tr>
<tr>
<td>Ambulating WITH assistance and/or with an assistive device (e.g., walker, cane, wheelchair)</td>
<td>355</td>
<td>388</td>
<td>315</td>
</tr>
<tr>
<td>Ambulating WITH assistance and/or with medical equipment (e.g., IV pole)</td>
<td>62</td>
<td>73</td>
<td>71</td>
</tr>
<tr>
<td>Changing position (e.g., rolling over in bed)</td>
<td>134</td>
<td>164</td>
<td>130</td>
</tr>
<tr>
<td>Climbing out of crib</td>
<td>3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Climbing over/around bedrails</td>
<td>143</td>
<td>139</td>
<td>148</td>
</tr>
<tr>
<td>Dressing or undressing</td>
<td>96</td>
<td>88</td>
<td>80</td>
</tr>
<tr>
<td>Reaching for an item</td>
<td>201</td>
<td>193</td>
<td>161</td>
</tr>
<tr>
<td>Showering or bathing</td>
<td>114</td>
<td>99</td>
<td>87</td>
</tr>
<tr>
<td>Threw self to the floor</td>
<td>51</td>
<td>43</td>
<td>36</td>
</tr>
<tr>
<td><strong>Toileting-related activities</strong></td>
<td>964</td>
<td>935</td>
<td>763</td>
</tr>
<tr>
<td>Transferring to or from bed, chair, etc.</td>
<td>322</td>
<td>369</td>
<td>229</td>
</tr>
<tr>
<td>Undergoing a diagnostic or therapeutic procedure</td>
<td>31</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Unknown and/or found on floor</td>
<td>638</td>
<td>621</td>
<td>483</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>739</td>
<td>748</td>
<td>581</td>
</tr>
</tbody>
</table>
Did the patient have any prior incidents of falling since admission to this care area?
Was a fall risk assessment performed prior to the fall?

- 2014: 95% Yes, 5% Unknown
- 2015: 90% Yes, 10% Unknown
Were fall protocols and prevention strategies in place prior to the fall?
Fall with injury reduction strategies

- Fall risk assessment
- Equipment and technology
- Prioritizing hourly rounding
- Patient specific fall prevention interventions; family involvement
- Physical environment
- Visual ques
- Care companions
- Daily huddles
- Multi-disciplinary team: pharmacy, physical therapy
- Standardized handoff
Leadership methods to sustain results

• Fair and Just Culture
• Leader rounding
• Reward and recognition
• Socialization of key fall prevention behaviors
Breaking down silos through PSO safety huddles
Safety huddle pilot
Critical Access Hospitals and General Acute Care < 100 beds

**Situation:** The Vizient PSO is initiating a pilot of weekly huddle calls for MHA members of Vizient PSO specifically targeted for critical access hospitals and general acute care hospitals with less than 100 beds.

**Background:** Many organizations have implemented a daily huddle or briefing to improve communication and collaboration among teams. After implementing daily huddles, the organizations report success in rapid safety process improvements and awareness of safety issues within their organization. The Children’s PSO has implemented a weekly huddle for the children’s hospitals to discuss de-identified safety concerns and lessons learned. This has increased communication on product safety recalls and learnings from process improvement work.

**Assessment:** To improve learnings across a specialized subset of PSO members, the pilot will include MHA member critical access hospitals and general acute care hospitals who participate in Vizient PSO.

**Recommendation:** If you accept this invitation to participate in the pilot, there will be a 2-3 hour time commitment to assist in developing and evaluating the safety huddles over the next 90 days. As a pilot member you will help identify key members from the organizations who should participate in the safety huddle call and determine content to be discussed during the safety huddle calls.
Vizient PSO -

Your patient safety partners
2017 Resources

**PSES Policy**

**AHRQ resources**

- Patient Safety and Quality Improvement Act of 2005
- Patient Safety Rule (November 2008)
- Video: [Working With a PSO: One Approach](#)
- Diagram: [Working With a PSO: One Approach](#)
- [Guide for determining parent organizations and affiliated providers](#)
- [HHS Guidance Regarding Patient Safety Work Product and Providers’ External Obligations](#)
- [AHRQ PSO website](#)

**Annual report**
Vizient PSO: Aggregate analyses and leading safety practices

Safety insights from Vizient PSO‘s aggregate analyses, collaborative meetings, and member success stories are available in Vizient™ Patient Safety Organization: Aggregate analyses and leading safety practices. This document provides a summary of our latest quality and patient safety projects and links to resources including toolkits, publications, and web conferences to help your organization shape your improvement efforts.

If you are having problems accessing any of the documents or web conferences in the above document, please contact Joyce Kloth for assistance. For questions about our analyses and leading practice documents, please contact Tammy Williams.
Questions?
2017 Key Strategies and Initiatives Update
MHA Safe Culture Accelerator
AHRQ Culture of Safety Survey
MHA Safe Culture Accelerator

- MHA is providing this complimentary opportunity for all HIIN hospitals to access and utilize the AHRQ Culture of Safety Survey.
- The project to begin early June 2017.
Why Survey?

- Properly measuring hospital safety culture is a crucial step for creating a safe environment for patients and health care staff.
- A strong safety culture serves to develop organizational-wide strategies to prevent patient harms.
MHA Safe Culture Accelerator

- Partnering with Beterra Health, Inc.
Beterra Health, Inc.

• Strong hospital portal access and analytics package allowing hospital access to results post-survey within five days.

• Electronic survey

• Data analytics portal per organization that will allow the organization not only see aggregate results, but also to drill down through results to see specific departments, units, etc. within the organization. These can be exported and shared within the organization.
Full Participation

- Survey Administration
- Analytics Portal
- Best Practice
- Benchmarking

Benchmarking

- Analytics Portal
- Best Practice
- Benchmarking
Full Program

- **FREE** Safety Culture Measurement — HSOPS Administration
- **FREE** Access to survey results and analysis within days of survey close
- **FREE** Explore how to compare data against peers
- **FREE** Ongoing support, quarterly webinars and collaboration
## Timeline

<table>
<thead>
<tr>
<th>Event</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1 ('18)</th>
<th>Q2 ('18)</th>
<th>Q3 ('18)</th>
<th>Q4 ('18)</th>
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<tr>
<td>Intro Webinar</td>
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<td>Cohort 1 Kickoff</td>
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<td>Cohort 1 Survey Period</td>
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<tr>
<td>Analytics Portal Deployed</td>
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<td>Cohort 1 Webinar and Report</td>
<td></td>
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<tr>
<td>Cohort 2 Planning</td>
<td></td>
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<tr>
<td>Cohort 2 Kickoff</td>
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<tr>
<td>Cohort 2 Survey Period</td>
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<tr>
<td>Cohort 2 Webinar and Report</td>
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</tbody>
</table>
Next Step

Click [here](#) to register for the informational webinar.

10 a.m. Tuesday, May 9
MHA/ MSC Immersion Projects Update
Immersion Projects

- Antibiotic Stewardship Program — in month seven of the project
- Readmissions Reduction/Care Transitions
  - Registration open June 12 – July 14
  - Project launches Aug. 15, 2017 – Sept. 7, 2018
- Sepsis
  - Registration open Oct. 2 – Oct. 31
  - Project launches Nov. 29, 2017 – Sept. 2018
- HIIN participating hospitals receive complimentary fee coverage
- Non-HIIN participating hospitals will be charged the project fee based on MSC fee schedule
#HandHygiene #AntibioticResistance

FIGHT ANTIBIOTIC RESISTANCE
IT'S IN YOUR HANDS

HEALTH WORKERS:
Clean YOUR HANDS at the right times and STOP the spread of ANTIBIOTIC RESISTANCE

SAVE LIVES
CLEAN YOUR HANDS
World Hand Hygiene Day

• MHA is preparing to celebrate World Hand Hygiene Day on Friday, May 5. We are collecting pictures of hand hygiene compliance and will compile them into a collage to represent Missouri hospitals’ collective efforts and commitment to practicing hand hygiene, reducing infections and improving patient care. Participation details on next slide.

• MHA is partnering with Qualaris Healthcare Solutions to launch the hand hygiene audit tool application!
  ➢ Informational email to come this Friday!
  ➢ MHA’s Hospital Improvement Innovation Network website
World Hand Hygiene Day

- **Who:** Anyone!
- **What:** Take a picture of yourself and co-workers practicing good hand hygiene, for example, pictures of hand washing or signage around your facility. Please, be creative!
- **When:** We will collect pictures during the month of May and include those pictures in our webinars, newsletter, conferences and social media campaigns.
- **Why:** To celebrate the importance of hand hygiene.
- **How:** Take a picture of yourself practicing good hand hygiene. Email the picture to twilde@mhanet.com with the following information:
  - name and title
  - name of organization
  - sentence about why good hand hygiene is important to you/your facility
Qualaris Audit Tool Projects

New MHA Collaborative Learning
To complement members’ improvement project work, MHA is partnering with Qualaris Healthcare Solutions to offer members access to 4 Evidence-Based Practice audit tools: Sepsis, Hand Hygiene, Culture of Safety (COS) Rounding, and Readmissions/Care Transitions.

Improve outcomes
These tools support rapid process improvement by simplifying ERP observational data collection and providing real-time information to identify gaps and focus on areas for improvement.

Simplify & save time
Replace paper-based work with secure, web-based digital collection on any workstation or mobile device and easily share real-time data & reports.

Share best practices
MHA will automatically provide collaborative benchmarking and best practice sharing reports for all participants.

Intent to Participate
Monthly Newsletter

Quality News

May 2017

Join the Conversation
Find us on LinkedIn.

Upcoming Events
Hospital Case Management Boot Camp: Advanced May 2017

In This Issue
MHA Initiatives and Programming Update
Announcements
Resources
Quality Reporting News
Quality and Population Health News

Spotlight

This year’s MHA Annual Conference is scheduled for June 6-7 at the

Click here for past issues
Latest Issue Briefs

- May 1, 2017 — CMS Seeks Comments on Possible SNF and Nursing Home Revisions to Case-Mix
- May 1, 2017 — CMS Proposes Skilled Nursing Facility FY 2018 Update
- April 28, 2017 — CMS Proposes Inpatient Rehabilitation Facility FY 2018 PPS Update
- April 28, 2017 — CMS Issues Proposed FY 2018 Hospice Wage Index, Payment Rate and Quality Reporting Requirements Update
- April 17, 2017 — CMS Releases Proposed FY 2018 Medicare IPPS and LTCH Update
- April 14, 2017 — CMS Issues Final Rule Regarding the ACA; Market Stabilization
The Opioid Crisis | Interactive Toolkit

Understanding the Issue

- **Background**
- **Research**

Strategies to Reduce Opioid Misuse

- **Prevention**
  - Missouri Prevention Resources
  - Prescribing Guidelines: Emergency Department
  - Managing Pain

- **Assessment & Treatment**
  - Assessment
  - Treatment

- **Patient Education**
  - Addiction
  - Pain Management
  - Understanding Use and Disposal of Narcotics

- **Policy Changes**
  - Prescription Drug Monitoring Database
  - Payers
  - Access to Treatment

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Upcoming Events

- **Hospital Case Management Boot Camp: Advanced**
  - Tan-Tar-A Resort, Osage Beach, Mo.
  - May 9-10

- **Missouri HIIN: Innovate. Exnovate. Improve. Inspire**
  - Courtyard by Marriott, Columbia, Mo.
  - June 6-7

- **Charge Nurse Leadership Development**
  - Courtyard by Marriott, Columbia, Mo.
  - June 7-8
Save the Date

H1N HAI Regional Bootcamps

- Cape Girardeau
  - July 18
  - Ray’s Banquet Center
  - Register [here](#)

- Chesterfield
  - July 19
  - Hampton Inn & Suites
  - Register [here](#)

- Springfield
  - August 24
  - Oasis Hotel Convention Center
  - Register [here](#)

- Independence
  - August 25
  - Hilton Garden Inn
  - Register [here](#)
Upcoming Virtual Events

- **FLEX — Essential Steps of Developing a Community Health Needs Assessment and Implementation Plan**
  - 10 a.m. Thursday, May 4
- **Provision of Care: Treatment and Services**
  - 10 a.m. Tuesday, May 9
- **MHA Safe Culture Accelerator Informational Webinar**
  - 10 a.m. Tuesday, May 9
- **PSO Measurement and Transparency** (PSO members only)
  - 1 p.m. Thursday, May 11
- **Medication Management**
  - 10 a.m. Friday, May 12
- **Standing Orders**
  - 9 a.m. Monday, May 15
Upcoming Virtual Events

- **Bridging the Generation Gap**
  - Noon Tuesday, May 16

- **HIIN Huddle Webinar**
  - 1 p.m. Tuesday, May 23

- **Strategies of Success for Department Heads**
  - 10 a.m. Wednesday, May 24

- **PSO Observation Unit Management** (PSO members only)
  - 1 p.m. Thursday, May 25

- **Documenting Provider Competency**
  - 10 a.m. Wednesday, May 31

- **CMS Radiology & Nuclear Medicine Hospital CoPs**
  - 9 a.m. Monday, June 5

- **Creating a Positive Work Environment: Strategies to Maximize Staff Motivation and Performance**
  - 9 a.m. Tuesday, June 6
Save the Date

• Excellence in Clinical Care Series
  ➢ Lake Ozark, Mo.
  ➢ September 26-29

• 2017 Annual Emergency Preparedness & Safety Conference
  ➢ Lake Ozark, Mo.
  ➢ October 11-13
Thank You for Joining Us!

• See you at 12 noon Wednesday, June 14
  ➢ Antibiotic Stewardship Programming — presented by Alison Williams
Contact Information

Alison Williams, MBA-HCM, BSN, R.N., CPHQ
Vice President of Clinical Quality Improvement
Missouri Hospital Association
awilliams@mhanet.com
573/893-3700, ext. 1326