Reducing Risk Adjusted Mortality

**FY19 Focus Area:** Sepsis, Early Recognition and Emergency Response

**Improvement Activities:**

1. Development and enculturation of all system high reliability sepsis governance infrastructure
2. Evaluation of current and new innovations: Inpatient RN BPA, admin instruction within order sets/panels, sepsis lactate confirmation within all sepsis orders, RT sepsis screen
3. Tableau data development for performance improvement and compliance tracking; TOP, Peds, and CDI dashboards under development
4. System collaboration: ED/Inpt Sepsis Fallout Improvement Project, PSI-13 Improvement Project, Oncology Sepsis Mortality, UCOP Sepsis Simulation
5. External collaborations: Vizient, CHPSO
6. Defining of “code sepsis” opportunities throughout the continuum – Code Sepsis Pilot at SMH go-live May, 2019
7. Mandatory 2 hour education for clinical care partners
8. Development of 3-5 year vision for RRMC Emergency Response teams; current state assessment complete, action planning phase initiated
9. American Heart Association (AHA) Get with the Guidelines: Resuscitation Registry - building Tableau dataset to share with clinicians and focus QI projects
11. Development of education plan – simulation, mock codes and AHA RQI programming
12. Mortality Review Workgroup: 7ICU, SPCU/PTCU and CDI teams validating potential coding opportunities for all mortalities based on Vizient data

**Advance Care Planning**

1. Continued support and growth of Palliative Nurse Practitioner in Oncology. Exploration of potential new contract with Blue Shield as well as expansion opportunities across the outpatient setting.
2. Development of embedded Social Worker on Cardiac Myopathy and scope increase to educational efforts with cardiologists.
3. ACP education in the primary care setting spreading throughout the health system.
4. Development and formation of the Advance Care Planning Strategic Plan.
5. Death database ownership, in coordination with hospice quality efforts.
6. ACP CareConnect Module has been rolled out as of October 2018, with efforts to disseminate into primary care practices and continued trainings throughout the system.
7. All 2.7 PRIME measures were funded last year, currently actively working on achieving them for this year.

**Palliative Care**

2. General Inpatient Hospice Patient (GIP) admissions grew 294% since the program started in 2014 to 126 admits in 2018. Created new process of streamlining admissions consults currently implemented for NeuroICU, Neurology, Solid Oncology, and Geriatrics.
3. Three Wishes program with Dr. Thanh Neville (MICU) and Dr. Peter Phung (Palliative Care) has expanded to Santa Monica Hospital and fulfilled over 494 Wishes across Ronald Reagan and Santa Monica.

Improving Process and Outcome Measures

**FY19 Focus Areas:** Value Based Purchasing Ranking

**Improvement Activities:**

1. Business Owner of each of the VBP Domain presented current state and areas of opportunity
2. Business Owners monitor ranking per Domain using the VBP calculator in Tableau.
3. Committee members granted access to the Press Ganey VBP calculator, given tutorial to monitor performance per domain using PG VBP calculator.

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**Safety**

1. CDI: Clostridium difficile Infection
2. CAUTI: Catheter-Associated Urinary Tract Infection
3. CLABSI: Central Line-Associated Bloodstream Infection
4. MRSA: Methicillin-Resistant Staphylococcus aureus Bacteremia
5. SSI: Surgical Site Infection Colon, Surgery & Abdominal/Hysterecnotomy
6. PC-01: Elective Deltawh: Prior to 30 Completed Weeks/Osation

**Efficiency and Cost Reduction**

1. MSPB: Medicare Spending Per Beneficiary

**Domain Weights**

- **Clinical Care**
  1. MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
  2. MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
  3. MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
  4. THA/TKA: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

- **Person and Community Engagement**
  1. Communication with Nurses
  2. Communication with Doctors
  3. Responsiveness of Hospital Staff
  4. Communication about Medicines
  5. Cleanliness and Quietness of Hospital Environment
  6. Discharge Information
  7. Care Transition
  8. Overall Rating of Hospital

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**Contact:**

Kim Ternavan; Jennie Kung (ACP/Palliative)

Sherry Watson-Lawler
## Implementing Value Care Design

**FY19 Focus Areas:** ValU projects aligned to Health System PI Infrastructure

**Improvement Activities:**

1. Adult Epilepsy Care Redesign
2. Pediatric Epilepsy Care Redesign
3. Optimizing Ancillary Services Project
4. ICU LOS Reduction Initiative
5. Joint Replacement Care Redesign
6. Kidney Transplant Care Redesign

Contact: Christine Ahn

## Enhancing the Patient Experience

**FY19 Focus Areas:** Discharge, Nurse Communication, MD-RN rounding, Pain Management

**Improvement Activities:**

1. **Discharge Improvement:**
   - (1) Pharmacy Collaboration: Medication Reconciliation, Discharge Medication Report
   - (2) Optimization of Patient Progression Board across the system.
   - (3) Critical Care Transport: internal referrals of ICU to transfer patients to outpatient facility
   - (4) Staff education around Care Coordination to promote discharge efficacy.

2. **Nurse Communication:**
   - (1) Redesign of nurse to patient communication framework through My Care folder and My Bedside initiatives.
   - (2) Structural Empowerment Magnet council will develop new My Care folder implementation plan.
   - (3) New Knowledge Magnet Council will simultaneously work on educating nurses and patients on My Bedside to increase utilization.

3. **MD-RN rounding:**
   - (1) MD-RN rounding interdisciplinary workgroup and Transformational Leadership Magnet Council are working to improve MD-RN rounding.
   - (2) Current focus is to increase the occurrence of MD-RN rounding by involving unit secretaries in facilitating the rounding and helping doctors find nurses prior to rounding.
   - (3) We are also partnering with chief residents to educate incoming residents on the importance of MD-RN rounding.

4. **Pain Management:**
   - (1) Pain Management Steering Committee (PMSC) formed
   - (2) Taskforces: develop a Tableau dashboard for the 7 metrics identified
   - (3) IV/Phlebotomy Initiatives: Implement EMLA cream.
   - (4) Continue offering training for Urban Zen (UZ) Integrative Therapy, create a CareConnect consult for UZ.

Contact: Namgyal Kyulo
Reducing Preventable Readmissions

**FY19 Focus Area:** Reduce 30-Day Unplanned Readmission by 12%

**Improvement Activities:**

1. Better Outcomes by Optimizing Safe Transition (BOOST) tool in Care Connect is the Safe Transition Report. It is an automated tool that calculates the LACE+ score and identify the 8Ps in BOOST.
2. Safe Transition Report to be in Patient Story in CC by March 2019
3. Safe Transition Report Pilot
   a) What: Use of Safe Transition Report with LACE+ in Care Connect
   b) Where: Pilot Units: RR-7E & 8N SMH-5NW & 4MN
   c) Who: All disciplines caring for patients in the pilot units (MD, RN, CM/SW, Pharm, PT)
   d) When: April 2019
   e) Why:
      - To test the build of BOOST in CC (Safe Transition Report) to ensure risk conditions are captured on patients 100%
      - To determine how the use of the Safe Transition Report can be incorporated into the usual workflow of all disciplines
      - Standardize interventions to each of the risk condition to prevent readmission
      - Standardize documentation of interventions
4. Focus Area #1: Outpatient Optimization
   i. Priorities: (A) Implementation / tracking of referrals to Extensivist Clinic (B) Evaluation of post DC visit use at Suite 420 to Thousand Oaks (C) Planning with Focus group 2 on <48 hours LOS
5. Focus Area #2: Patient Readiness for Discharge
   i. Priorities: (A) palliative Care – appropriate intervention identified for when risk condition identified in the BOOST tool (B) Pharmacy- current state (c) Improve workflow processes- RN/MD Rounding, IDR Rounds
6. Focus Area #3: Transition of Care
   i. Priorities: (A) Work with F2 in achieving seamless transition from UCLA to PAC (B) Explore a process to enable preferred Skilled Nursing Facilities to work with Enhanced Home Health Agencies (EHH) to enhance patient experience (C) Standardize the on-site visit (warm hand-off) for EHH (D) Provide continuing education to post-acute providers on best practices

**FY19 Focus Areas: AHRQ Patient Safety Indicators (PSI-90), HAPU, fall w/ Injury, CAUTI, CLABSI**

**Improvement Activities:**

1. Fully transitioned to 3M 360 Encompass - a software that is interfaced with Care Connect that can identify quality indicators resulting from ICD-CODES (working or final) concurrently, flags cases that need further review/action regarding patient care. Mainly used by Quality Dept. for HACs and PSIs.
2. Working closely with the CDI specialists in concurrently monitoring physician documentations on POAs & suspected conditions, clarifying documentations with MD champions for possible HAC or PSI case reversal.
3. Working closely with Coding Dept. to ensure cases are coded correctly.
4. HAC/PSI cases with care management issues are for referral for Peer Review.
5. Coding Dept. providing physician education on appropriate documentation.
6. HAC/PSI case reporting to Medical services and other appropriate committees for trending, education and resolution planning.
7. HAC/PSI monthly update and discussion with CMOs
8. Quality & Coding Depts are working with specific medical services on reducing their HAC/PSI cases
9. CLABSI:
   (1) System wide focus on CLABSI bundle, including hand hygiene, appropriate insertion practices, dressing change standardization, optimal site selection, and daily review of line necessity.
   (2) System wide Nursing/Infection Prevention CLABSI event review performed to identify deviations in practice. Infection Prevention recommendations and education conducted concurrently.
   (3) Multidisciplinary CLABSI Task Force (SMH) established in May 2017 to evaluate CLABSI trends. Action plans created to address challenges identified. To date, interventions have led to significant CLABSI reductions. CLABSI Task Force (RR and MCH) established in January 2018 with improvement in practice noted.
   (4) Protective insertion dressing disk with CHG (Biopatch) approved in August 2018. Implementation and education commenced in September 2018.
10. CAUTI:
    (1) Multidisciplinary CAUTI workgroup targeting Active Daily Management and nurse-driven protocol optimization.
    (2) Continued participation in a best practice program offered by Bard to further reduce CAUTI events across the system.