

OHIO HOSPITALS

*Achieving Excellence
in Patient Safety
and Quality*



Ohio Hospitals

Achieving Excellence in Patient Safety and Quality

STRATEGIC INITIATIVE

Ohio hospitals share a common vision. Quality and safety are integrated into the culture of every Ohio hospital.

The Ohio Hospital Association (OHA) has been the leading force over the past 12 years in efforts to improve health care quality, patient safety and satisfaction in Ohio and aims to lead the nation in this important arena. Prior even to Centers for Medicare and Medicaid Services (CMS) efforts to organize and impact quality, OHA was engaged in efforts to reduce cardiac care mortality rates through its Dayton-based hospital collaborative. Hospital leaders in the state have long recognized the critical importance of improved patient safety and quality of care as life-saving, money-saving imperatives that each health care provider must integrate into their organization's culture.

OHA's quality efforts are overseen by its **Quality Institute of the Research and Educational Foundation**, an actualization of the vision statement. The Quality Institute's mission is to drive transformational change in areas of quality and safety in Ohio hospitals and affiliated providers.

IMPORTANT OHIO HOSPITAL "FIRSTS"

- First state to lead a campaign in prevention of wrong-site surgery
- First multi-organizational Codman Award
- First statewide children's collaborative
- First initiative in Central Ohio for hospitals and the business community
- First collaborative to take on surgical care
- First and largest C-diff prevention collaborative
- First Patient Safety Organization in the state of Ohio

The Future...Pursuit of Perfection

It seems, in most situations, almost counterintuitive to set goals at zero, unless you're referring to eliminating adverse events in health care. Stated goals of the Quality Institute include:

Zero hospital-acquired infections

- Reduce blood stream infections in Ohio hospitals – participate in a national quality project.
- Reduce incidences of methicillin-resistant staphylococcus aureus (MRSA).
- Reduce incidences of Clostridium difficile (C-diff) – in collaboration with the OSU epicenter and Centers for Disease Control (CDC) in developing a statewide standardized identification process for health care acquired cases of C-diff and define levels of appropriate precautions.

Achieve top 10th percentile in patient satisfaction scores in Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey

- Collect and compare HCAHPS survey results.
- Engage clinical leadership to develop an implementation plan.
- Share best practices.

Ensure all medical and surgical care is consistent with universally-accepted evidence-based standards

- Increase care bundle scores – assuring patients receive all of the appropriate treatment and services to maximize improvement of their condition.
- Examine data, evaluate and recommend processes for improvement beyond stated goals.
- Partner with national and state organizations to establish evidence-based standards.
- Disseminate effective practices statewide.

Zero preventable deaths

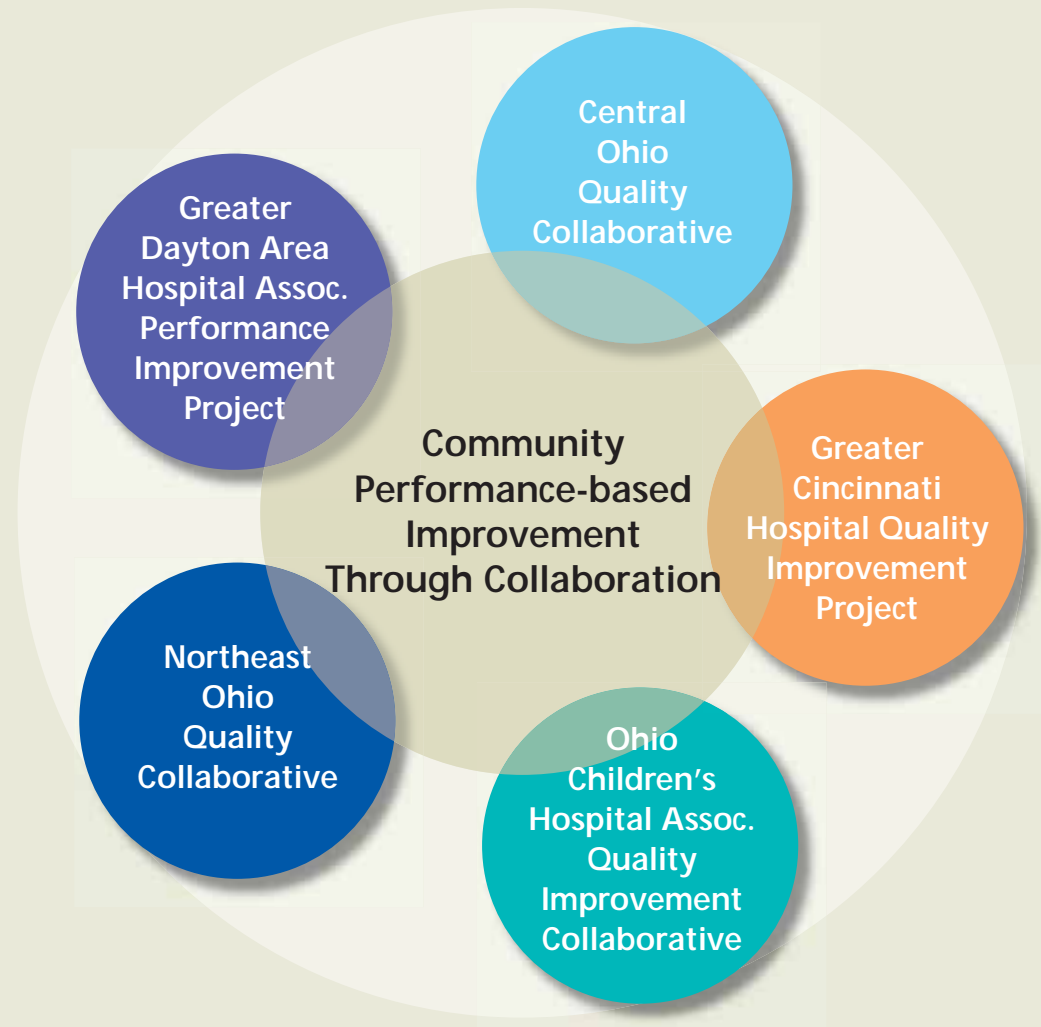
- Obtain designation as a statewide Patient Safety Organization.
- Seek opportunities to develop strategies and initiatives to improve identified patient safety opportunities.



Community Performance-Based Improvement Through Collaboration

What is Quality?

Quality of hospital care can mean different things. It could mean that there is a successful outcome (for example: a patient survived a heart attack or is cured of pneumonia) or it may mean that patients were satisfied with their hospital stay and thought they were treated well. Process measures are another way to measure quality of care. A process measure determines if a patient was given the right medicine, treatment or test at the right time. The three most common hospitalized medical conditions are heart attacks, heart failure and pneumonia; therefore, these are the most frequently studied conditions.



Quality Improvement Collaboratives

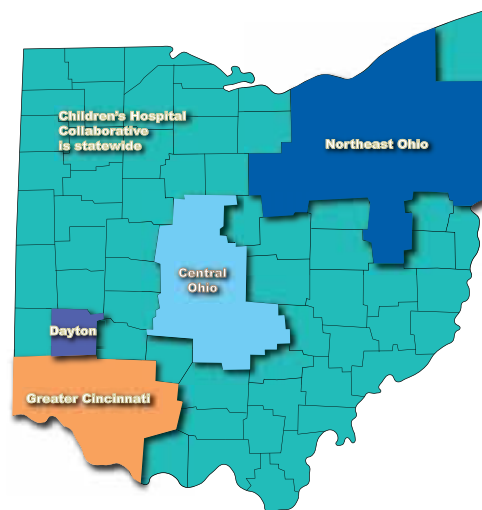
Hospitals Working Together to Increase Patient Safety and Improve Quality of Care

The Quality Institute serves as home to all of OHA's current quality initiatives, including the regional and statewide hospital collaboratives.

Around Ohio, groups of general hospitals have formed collaborative relationships designed to improve the quality of care delivered in their regions of the state. In addition, a statewide network of Ohio's children's hospitals has formed to improve pediatric hospital care.

Each region is unique, with specific cultural differences and health care disparities which the collaboratives work to address. In addition to improving safety and quality in each region, collaboratives which demonstrate success in addressing an issue of concern share their best practices with other regions. This "cross-collaboration" demonstrates the true power of these groups to bring the tools and knowledge of proven, successful improvements in quality and safety to patients around the state. The program design for "members helping members" ensures that every quality and safety success model is maximized to the entire state's fullest benefit.

Quality improvement collaboratives managed by the Ohio Hospital Association include Greater Dayton Area, Central Ohio, Greater Cincinnati area, Ohio Children's Hospital Association and Northeast Ohio.

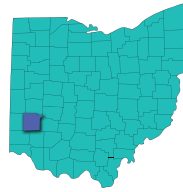


In early 2005, the Greater Cincinnati Hospital Quality Improvement Project (HQIP), identified congestive heart failure (CHF) care as a particular area of concern for patients in their geographical region. Seeking improvement and best practices from other collaboratives in the state, the group engaged in an educational program for providers, held the first quarter of 2006.

The trend in improvement for the Cincinnati collaborative was nearly three times that of another collaborative used for comparison. The rate of change was significant, clearly demonstrating the power of the collaboratives to improve care even beyond their own boundaries.



The Joint Commission's prestigious Ernest A. Codman Award is presented to health care organizations for achievement in the use of process and outcome measures to improve organizational performance and ultimately the quality and safety of care provided to the public.



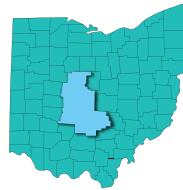
Dayton

Greater Dayton Area Hospital Association Performance Improvement Project (GDAHA)

The Dayton-based collaborative was the first of its kind in Ohio, established in 1999. The six participating hospitals received the first multi-organizational Codman Award in 2002 for **reducing heart attack mortality by 36 percent over a three-year period, saving 52 lives per year.**

In addition the collaborative has demonstrated excellence in care by working on better processes to treat pneumonia and deep vein thrombosis (DVT). Hospitals in this collaborative **improved their pneumonia care processes from 66.5 percent in the first quarter of 2005 to 88 percent by the third quarter of 2006, and have maintained scores above 85 percent since then.**

For more information about GDAHA, visit: www.gdaha.org



Central Ohio

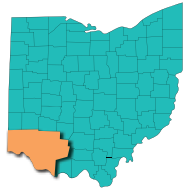
Central Ohio Quality Collaborative

Like the Dayton collaborative, the Central Ohio effort represents the collective commitment of area hospitals to develop and share practices and engage in new efforts to improve the quality of care in the community. The group of 17 hospitals was established in 2003. Early accomplishments included reduced heart attack mortality. In cross-collaboration between the Dayton and Central Ohio collaborative, Central Ohio achieved **even more dramatic heart attack mortality reduction (42%), saving 150 lives per year** in central Ohio in half the time as the original project in Dayton.

Additional projects demonstrated improvements in heart failure and data collection in Intensive Care Units (ICU) which has led to the current Solutions for Patient Safety projects as follows:

- reduce central line catheter-associated blood borne infections by June 2010, and
- reduce health care-associated MRSA infections by June 2010.

For more information, visit: www.centralohiohospitals.org



Cincinnati Greater Cincinnati Hospital Quality Improvement Project (HQIP)

This collaborative of 18 hospitals in southwest Ohio and southeast Indiana works together to provide performance measures and tools for hospitals to use to improve their quality of care in heart attack, heart failure and pneumonia.

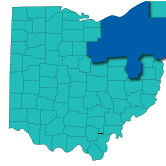
Greater Cincinnati has **improved their overall heart attack performance** – the measure which indicates how many patients get all of the care appropriate for their condition – from **78 percent in first quarter 2005 to 93 percent in the fourth quarter of 2008**.

Between 2005 and 2008, the Cincinnati area dramatically **improved heart failure process of care scores from 53.2 percent to 90.7 percent** as a result of best practices shared with them by Central Ohio area hospitals.

HQIP was the first collaborative to take on surgical care. As a result of this initiative they have developed a community-wide, standardized patient history and physical exam process to ensure consistent evaluation of patients' risks prior to surgery. In addition, the collaborative developed a community-wide beta blockade assessment tool.

For more information, visit: www.gchhospitalquality.org





Northeast Ohio *Northeast Ohio Quality Collaborative*

The newest OHA-based 35-hospital collaborative, the Northeast Ohio Quality Collaborative, established in 2007, began working on data processing, risk adjustment models, data reports and the collaborative structure.

To date, this group of hospitals has demonstrated a nearly **20 percent improvement in performance for pneumonia care**. Prior to the establishment of the collaborative (fourth quarter, 2006) Northeast Ohio's participating hospitals were providing all of the recommended pneumonia treatment to 62 percent of the areas patients. By the third quarter of 2008, nearly 82 percent of patients were receiving all of the appropriate care and treatment.

Currently, this collaborative is evaluating opportunities to **reduce 30-day readmission rates for heart failure patients**, which is a common and costly occurrence for hospitals.

Ohio Children's Hospital Association Quality Improvement Collaborative

The Ohio Children's Hospital Association (OCHA) Quality Improvement Collaborative was formed in 2007 as a statewide process improvement project drawing on the collective expertise of the six participating pediatric hospitals.

In its first initiative, the collaborative focused on reducing preventable codes, or cardiac and pulmonary arrest, occurring outside of the neonatal and pediatric intensive care units. By identifying and deploying a Medical Response Teams approach to preventable codes they were able to **reduce incidences of preventable codes, by 46 percent in the first two years** of the project.

Joining the six OCHA hospitals, St. Vincent Mercy Children's Hospital and the Cleveland Clinic Children's Hospital are participating in the Solutions for Patient Safety Initiative (described fully on page 15). The collaborative of eight children's hospitals is currently working to:

- Reduce surgical site infections in designated cardiac, neurosurgery and orthopedic procedures by June 2010, and
- Eliminate severe hardship or death to any child due to medication errors by March 2010, while also working to eliminate any harm or injury from preventable adverse drug events.

For more information, visit: www.ohiochildrenshospitals.org



“ I am proud that Ohio's children's hospitals are taking this courageous step to join forces to improve quality. I believe this Collaborative can be an important factor in improving the quality of care in our state while also helping to curb the rising cost of health care. ”

Ohio Governor Ted Strickland

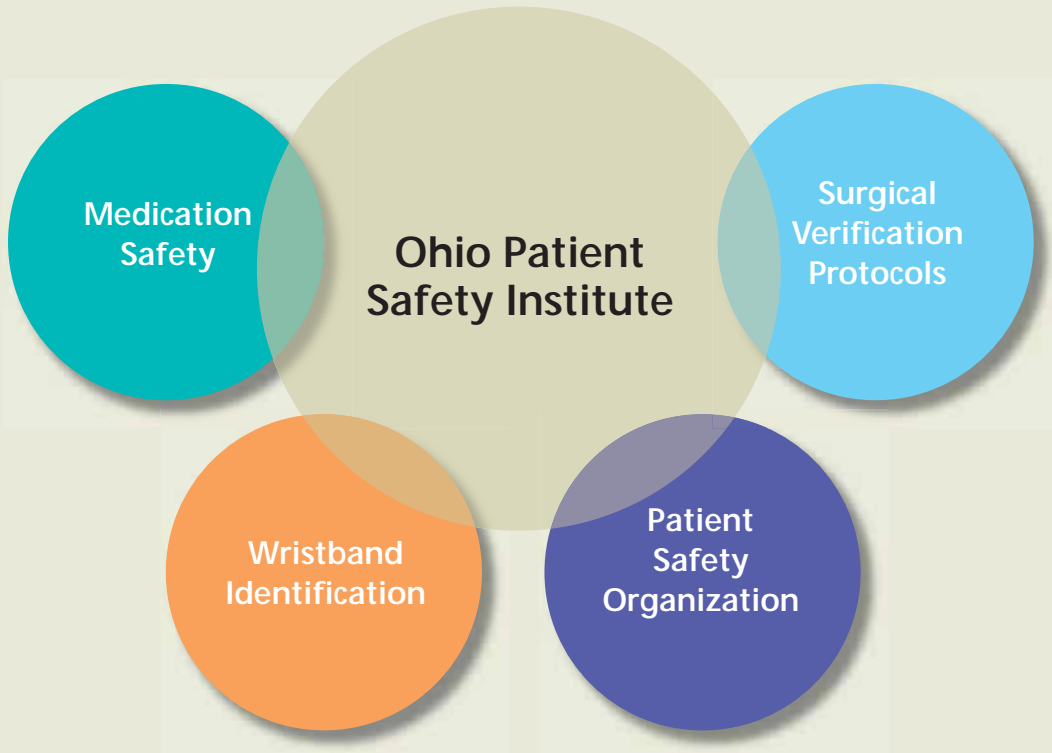
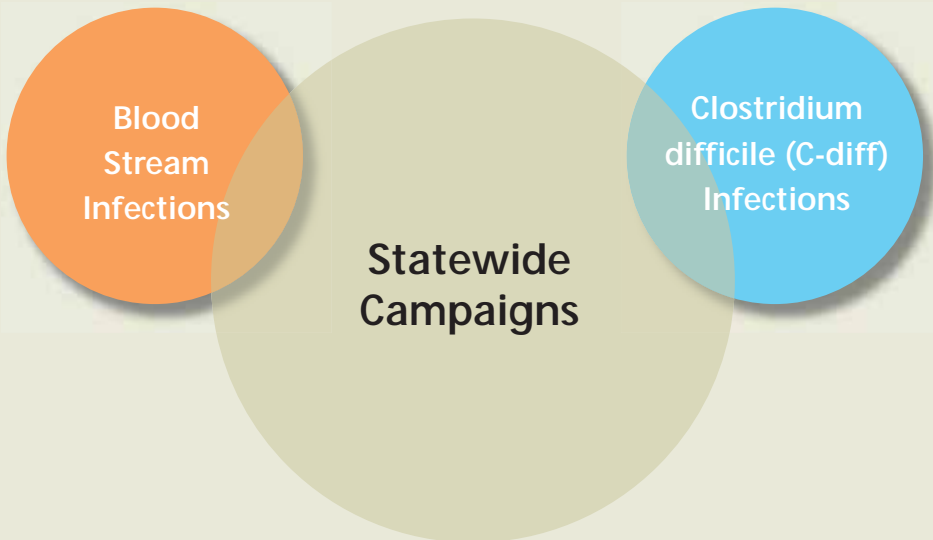
“ Ohio is blessed to have some of the country’s finest children’s hospitals in geographically diverse sections of our great state. The Ohio Children’s Hospital Association Quality Improvement Collaborative is a shining example of how working together can make a difference and save children’s lives while identifying best practices that will reduce unnecessary illness and injury. ”

Ohio Senate President Bill Harris



A Life Saved

Chance was born in February 2008 and just a week later exhibited signs of a cold. Following visits to his doctor, he was admitted to Nationwide Children’s Hospital in Columbus, Ohio, with a diagnosis of respiratory syncytial virus (RSV). Alarmed at blood test results, pulse drops, congestion and breathing difficulties, Chance’s nurse at Children’s called in the ACT Team, which is the rapid response team at the hospital. As a result, Chance was moved to the neonatal intensive care unit (NICU) and was placed on a ventilator to aid his breathing. This quick action prevented Chance’s condition from deteriorating further and provided the intensive intervention that he needed. A happy, healthy Chance was discharged from the hospital on March 17, 2008.



What is Patient Safety?

Patient safety is a relatively recent initiative in health care, emphasizing the reporting, analysis and prevention of medical error and adverse health care events. Patient safety efforts are developed to transform health care into a reliable system for the safe, consistent delivery of care.



Ohio Patient Safety Institute

Since 2000, the Ohio Patient Safety Institute (OPSI) has been dedicated to improving patient safety in Ohio. The Institute is a subsidiary of the Ohio Health Council, which was founded by the Ohio Hospital Association, the Ohio State Medical Association and the Ohio Osteopathic Association. OPSI has the ability to work with more than 180 hospitals and 9,000 physicians.

In February 2009, the Agency for Healthcare Research and Quality (AHRQ) designated the Ohio Patient Safety Institute as a Patient Safety Organization. OPSI is the first organization in Ohio to receive the designation.

The mission of *The Ohio Patient Safety Institute* is to be the **leader** and **catalyst** in transforming health care into a reliable safe delivery system.

Designation as a Patient Safety Organization allows OPSI the legal authority to collect medical error data from Ohio hospitals without subjecting individual data to unintended use as evidence in medial malpractice lawsuits.

Simple Solutions

OPSI's focus is and will continue to be the patient. Because few patient resources were available to improve medication safety, OPSI:

- Developed a low literacy medication brochure for patients.
- Conducted a multi-agency campaign to reduce dangerous abbreviations.
- Held brown bag sessions – public service events where individuals bring all their medications – prescriptions, over-the-counter and herbal – to be reviewed by a pharmacist for potential medication safety issues such as duplication of medication, medication interactions, etc., and subsequently developed the Brown Bag toolkit.



Recent accomplishments, program initiatives:

OPSI was selected by the Agency for Healthcare Research and Quality (AHRQ) as the Ohio organization (where Ohio is one of 10 states) to participate in a national initiative to reduce central line-associated blood stream infections. Funding has been secured, with the assistance of U.S. Senator Sherrod Brown, to offset the cost of participating in this initiative.

Goals of this two-year project include:

- Reducing the mean infection rate within Ohio to less than one per 1,000 catheter days in participating hospitals.
- Improving the safety culture by 50 percent in participating hospitals.
- Creating educational modules to teach the prescribed Comprehensive Unit-based Safety Program (CUSP) – which delivers information and training to those health professionals who are providing direct patient care.
- Developing a statewide model for implementing and disseminating patient safety initiatives throughout the state.

OPSI also conducted a collaborative project with VHA, Inc., to reduce life-threatening complications sometimes associated with blood thinners, which many patients take to prevent blood clots following a stroke, heart attack or vascular surgery.

During the six-month program, which began in May 2008, participating hospitals created or upgraded their individual safety protocols on anticoagulants to appropriately start patients on these drugs when they are in the hospital and then continue to monitor the patients long after they return home.

The projects helped the hospital meet the Joint Commission's National Patient Safety Goal to "reduce the likelihood of patient harm associated with the use of anticoagulant therapy," which required accredited hospitals to have standardized practices on anticoagulants in place by January 1, 2009.



The Ohio Patient Safety Institute has worked to reduce “wrong site surgeries” in Ohio, as reported in *The Columbus Dispatch*, May 4, 2004:

“Rare, but sometimes catastrophic, so called wrong-site surgeries are the latest target of efforts to reduce medical errors.

Pointing to prominent cases, including an incident in which a Tampa surgeon cut off the wrong foot of a diabetic man, doctors are working harder to make sure they perform the right procedure in the right place on the right patient.

By July, all U.S. hospitals must adhere to new national guidelines, and in Ohio, the Patient Safety Institute has gone a step further. Over the past five months, it has developed more-stringent safeguards to be adopted here.”



The Basics:

- When a patient arrives, nurses and doctors verify who the patient is, who the surgeon is, what kind of procedure is to be done and where.
- Before the patient enters the operating room, the surgeon (or someone he or she designates) initials the incision site with a pen.
- Immediately before the incision, the surgical team calls a timeout and double checks all their information.

Most hospitals already take some precautions, but many “were not marking the sites or they weren’t doing another piece of it,” said Rosalie Weakland, director of quality improvement for the Ohio Hospital Association.”

“ CDC and its partners are working together to prevent infections caused by *Clostridium difficile* (CDI) in Ohio hospitals and nursing homes. In concert with CDC, the Ohio Hospital Association, the Ohio Department of Health, and the Ohio Prevention Epicenter are implementing a set of tiered interventions to reduce CDI rates by using NHSN definitions for reporting. This is the first and largest CDI prevention collaboratives to date, and demonstrates the preventability of CDI among a large cohort of hospitals while helping to define the most effective strategies for prevention.”

Richard E. Besser, M.D.
Acting Director
Centers for Disease Control and Prevention
Congressional Committee
Testimony

Control of Clostridium difficile (C-diff) Infections in Acute Care Hospitals: A Statewide Collaborative

The Ohio Hospital Association, in partnership with The Ohio State University Medical Center's Division of Infectious Diseases and its CDC-funded Prevention Epicenter and the Centers for Disease Control and Prevention (CDC), are embarking on a statewide pilot program to utilize a two-pronged effort to address the surveillance and control of Clostridium difficile, (commonly referred to as C-diff) infections in acute care facilities within the state of Ohio.

Infections with Clostridium difficile lead to a significant impact on hospitalized patients and our community. In a recent study, a case of C-diff led to a 41 percent increase in costs over non-C-diff admissions. In addition, the incidence and severity of C-diff has increased. In acute care facilities in Ohio in 2006, there were 454 cases of C-diff per month. Prevention and control of C-diff has taken on increasing importance because of its associated morbidity, mortality, costs, and lengths of stay.

The intended outcomes of this statewide pilot are two-fold:

- 1) Quantify C-diff rates in Ohio using 2008 CDC/NHSN surveillance definitions; and,
- 2) Engage in a performance improvement project (PIP) for single unit or whole facility to adopt a tiered, evidence-based strategy to decrease C-diff.

Solutions for Patient Safety

Solutions for Patient Safety is a unique collaboration among health care providers and the business community with a shared aspiration of making Ohio the safest place in the nation for health care. This group is an outgrowth of the hospital collaboratives program, but functions as a stand-alone, complementary statewide effort.

While Solutions for Patient Safety is a new effort, the partnership is building on an established body of work in patient safety and quality improvement in health care. Initially funded by a \$1.5 million investment from Cardinal Health Foundation, the group welcomes involvement from organizations representing providers, patients, policy-makers, businesses and other constituents interested in making a difference in the quality of health care in Ohio.

By joining forces to implement new patient safety efforts, The Cardinal Health Foundation, the Ohio Business Roundtable, the Central Ohio Hospital Council, the Ohio Hospital Association and the Ohio Children's Hospital Association will improve health care quality and reduce the overall cost of health care in Ohio.

Initial program goals for participating Central Ohio adult hospitals:

- Reduce central line catheter-associated blood borne infections by June 2010.
- Reduce health care-associated methicillin-resistant staphylococcus aureus (MRSA) infections by June 2010.

Initial program goals for Ohio children's hospitals:

- Reduce surgical site infections in designated cardiac, neurosurgery and orthopedic procedures by June 2010.
- Eliminate severe harm or death to any child due to medication errors by March 2010, while also working to eliminate any harm or injury from preventable adverse drug events.

References for hospital patient safety and quality improvement

Centers for Disease Control and Prevention: www.cdc.gov
Centers for Medicare and Medicaid Services: www.cms.hhs.gov
Central Ohio Hospital Council: www.centralohiohospitals.org
Consumers Guide to Healthcare in Ohio: www.ohiohealthcareguide.org
Greater Cincinnati Hospital Quality Improvement Project: www.gchchospitalquality.org
Greater Dayton Area Hospital Association Performance Improvement Project: www.gdaha.org
HCAHPS (Hospital Consumer Assessment of Health Care Providers and Systems): www.hcahpsonline.org
HealthGrades: www.healthgrades.com
Hospital Compare: www.hospitalcompare.hhs.gov
Joint Commission: www.jointcommission.org
National Quality Forum: www.qualityforum.org
Ohio Children's Hospital Association: www.ohiochildrenshospitals.org
Ohio Hospital Association: www.ohanet.org
Ohio Patient Safety Institute: www.ohiopatientsafety.org
Solutions for Patient Safety: www.solutionsforpatientsafety.org
The Leapfrog Group: www.leapfroggroup.org
Thomson Healthcare: www.thomsonreuters.com
U.S. News & World Report: www.usnews.com

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