Minnesota Hospital Association Hospital Engagement Network

Partnership for Patients 2013 Annual Report
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Overview

Minnesota is a nationally recognized leader in patient safety and quality. Its hospitals have demonstrated commitment to the development of a strong infrastructure to promote implementation of evidence-based strategies to reduce health care-acquired conditions.

The Minnesota Hospital Association (MHA) Hospital Engagement Network (HEN) is one of 26 HENs across the U.S. working to reduce 10 hospital-acquired conditions (HACs) by 40 percent and readmissions by 20 percent by the end of 2014 as part of the federal Partnership for Patients contract. The MHA HEN includes 113 hospitals (see page 24) out of the 138 (non-behavioral health) hospitals and health systems MHA represents across the state of Minnesota. The hospitals include large metropolitan hospitals, mid-size hospitals in suburban and rural locations and critical access hospitals in rural areas of the state.

One of the strengths of the MHA HEN is its ability to build on the Call to Action framework that has been helping member hospitals prevent adverse events since 2006. This framework provides an innovative approach to prevent patient harm and provides a road map of clinical best practices as well as the infrastructure necessary to help hospitals achieve quality measurement goals and embed sustainable best practices. This systemic approach also ensures consistency among organizations and across the state.

At the foundation of all hospital safety and quality work is an effective organizational safety culture. The MHA HEN has partnered with the Minnesota Alliance for Patient Safety (MAPS) in the development of the Culture Road Map, a compendium of best practices that makes it possible for all organizations to access tools that lead to a culture of safety.

The MHA HEN recognizes that patient-centered care has a positive impact on patient satisfaction, length of stay and cost per case. Across Minnesota, hospitals are engaging patients and their families as essential partners in efforts to continually improve the quality and safety of care in our hospitals. The MHA HEN has formed a Patient and Family Advisory Council to help promote a better understanding of the principles of patient and family-centered care among patients and hospitals. The advisors meet quarterly to offer input and advocate for patient and family needs from a broad perspective. Moving forward, the MHA HEN will continue to create an environment where patients, families, clinicians and hospital staff work together as partners to improve the quality and safety of hospital care.

MHA HEN by the numbers

113 Hospitals participating in Partnership for Patients through the MHA HEN
69 Critical access hospitals participating in Partnership for Patients through the MHA HEN
58 Hospitals have reduced at least three hospital-acquired conditions by 40 percent
6,211 Readmissions prevented statewide
682 Pressure ulcers been prevented in Minnesota hospitals
512 Falls prevented
300 Early elective deliveries avoided
Bright spots

Minnesota hospitals have made tremendous strides toward the Partnership’s goals. Even more, there is a growing emphasis on reduction of harm across the board as opposed to individual HACs. To date, 58 hospitals (51 percent) have reduced three or more HACs by 40 percent and/or preventable readmissions by 20 percent. One hospital, Saint Elizabeth’s Medical Center in Wabasha has achieved this 40/20 reduction on six of the 10 HACs and readmissions.

Leading the way on pressure ulcer prevention

Minnesota hospitals are national leaders in efforts to reduce pressure ulcers. As of first quarter 2013, there has been an 83 percent reduction in the number of pressure ulcers statewide. The state’s efforts earned recognition from the Centers for Medicare and Medicaid Services (CMS) as being far below the national average.

Eliminating early elective deliveries

To help newborns get a strong start, hospitals across the state have committed to ending elective deliveries before 39 weeks gestation. Nearly all Minnesota birthing hospitals have implemented a hard stop policy restricting inductions before 39 weeks, accounting for 99.81 percent of all births in the state. The efforts are paying off in a big way: hospitals have reduced early elective deliveries by almost 90 percent. Since 2010, 300 early elective deliveries have been prevented.
Collaborative effort helps reduce readmissions

Through a unique partnership with the Institute for Clinical Systems Improvement (ICSI), Stratis Health (Minnesota’s quality improvement organization) and MHA, hospitals have prevented 6,211 readmissions, reducing inpatient costs by more than $40 million. The Reducing Avoidable Readmissions Effectively (RARE) Campaign involves 83 hospitals and 93 community partners across Minnesota and is one of the largest coordinated improvement initiatives undertaken by the Minnesota health care community.

Leadership engagement and culture

Improving the culture of safety within health care is an essential component of preventing or reducing harm to patients and improving overall health care quality. A culture of safety acknowledges the high-risk nature of an organization’s activities and the determination to consistently achieve safe operations.

The MHA HEN partners with Stratis Health and the Minnesota Alliance for Patient Safety (MAPS) to address a culture of safety in a collaborative way that enables the best practices to become a community standard across health care settings. Stratis Health coordinates participation in the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture Survey. The survey provides a baseline to assess the current status of patient safety culture within the hospital. Hospitals are then able to use the results of the AHRQ survey to identify areas for improvement and develop strategies to enhance their culture of safety.
to prioritize their work on the MAPS Culture Road Map. Using MHA’s Call to Action framework, the road map of best practices focuses on five domains of culture:

- Communication
- Justice
- Teamwork
- Learning
- Patient and Family Engagement

Early indications show a positive shift in attitudes about safety culture over the past three years. In nearly all areas of the AHRQ survey, Minnesota hospitals are performing at or above the national benchmark.

Leadership support is crucial to moving the needle on patient safety and quality across the organization. The MHA HEN enjoys strong support from the MHA Board of Directors, which has exercised bold action to commit to patient safety. Since 2000, MHA’s strategic plan has included patient safety and quality improvement as a top priority. The MHA HEN is committed to helping hospitals engage leadership and staff at all levels, including trustees and physician leaders. Hospitals have made great strides in this area, and 77 percent of MHA HEN hospitals have implemented at least three out of four best practices for engaging leadership (see box for criteria).
### 77% of hospitals have implemented 3 or more leadership best practices

L1 Hospital has regular quality review aligned with the Partnership for Patients goals.

L2 Hospital has a public commitment to safety improvement with transparency in sharing more than CORE measurement data with the public.

L3 Hospital staff, all or nearly all, have a role or perceived goal in patient safety (e.g., can be explicit in HR goals or a group bonus based on a patient safety target).

L4 Hospital board of trustees has a quality committee established with regular review of patient safety data, including review and analysis of risk events.

### Transforming Care at the Bedside

The MHA HEN is leading its third cohort of Transforming Care at the Bedside (TCAB). TCAB aims to increase the time nurses spend in direct patient care, improve reliability and safety of patient care, create patient-centered care, and to improve nurse retention by improving workforce vitality. By achieving these goals, hospitals hope to reduce errors and adverse events. Results from the second cohort of TCAB, which involved 24 hospital teams representing seven critical access hospitals and 11 larger hospitals, include:

- One team had zero falls for 306 consecutive days; seven other teams reported going 60 to 100 days without a patient fall.
- Half of the teams had an increase in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, a measure of patient perspective of hospital care.
- The teams enacted more than 1,300 innovations, including simple acts that helped nurses save time by reducing the number of steps taken to gather supplies.
- The cohort experienced an 8 percent increase in team vitality over the 18 months of the initiative. Some teams had as much as a 34 percent increase in team vitality.
- 59 hospital teams have completed or are currently participating in TCAB.

TCAB has been widely successful throughout Minnesota. In fact, the historical success of TCAB led Sanford Bemidji Medical Center to join the MHA HEN in order to participate in TCAB. The MHA HEN will initiate a fourth cohort in May 2014.
Patient and family engagement

For hospitals, providing high quality, safe, patient-centered care is paramount. According to the Centers for Medicare and Medicaid Services (CMS), studies show that providing patient-centered care has a positive impact on patient satisfaction, length of stay and cost per case. Across Minnesota, hospitals are engaging patients and their families as essential partners in efforts to continually improve the quality and safety of care in our hospitals. Nearly half (46 percent) of MHA HEN hospitals have implemented three or more best practices for a comprehensive patient and family engagement (PFE) program (see box below).

In an effort to help Minnesota hospitals further engage patients and families, MHA formed a Patient and Family Advisory (PFA) committee in June 2013. The PFA committee is comprised of patients, patient advisors and a consumer-oriented representative from the public relations firm Weber Shandwick. The committee’s purpose is to provide recommendations and help to oversee the PFE work on a statewide level.

- MHA has contracted with a patient and family engagement representative. The PFE representative will act as co-chair of the PFA committee.
- The PFE representative will contact several HEN hospitals to identify learnings, successes and best practices related to patient and family engagement with the goal to spread the knowledge statewide. Additionally, strategies to overcome identified barriers will be developed and spread.

46% of hospitals have implemented 3 or more patient and family engagement best practices

P1 Prior to admission, hospital staff provides and discusses with every patient that has a scheduled admission, allowing questions or comments from the patient or family, a planning checklist that is similar to CMS’s Discharge Planning Checklist.

P2 Hospital conducts shift change huddles and does bedside reporting with patients and family members in all feasible cases.

P3 Hospital has a dedicated person or functional area that is proactively responsible for patient and family engagement and systematically evaluates patient and family engagement activities.

P4 Hospital has an active Patient and Family Engagement Committee OR at least one former patient that serves on a patient safety or quality improvement committee or team.

P5 Hospital has at least one or more patient(s) who serve on a governing or leadership board and serves as a patient representative.

“My opinions count. It is clear that patients and family members are being included in care and when changes need to be made they are done for the better of all.”
— Sue, patient partner, Essentia Health
Redwood Area Hospital is a 25-bed city owned critical access hospital in southwest Minnesota. When challenged with the work of the hospital engagement network, the hospital seized the opportunity to evaluate its current processes and implement new processes to reduce adverse events. Even as a small hospital with limited resources, the hospital is engaged on all 10 HEN focus areas and making exceptional progress. Realizing frontline staff is critical to safety improvement efforts, the hospital uses the principles of Transforming Care at the Bedside to reduce harm across the board. In practice, this means staff is involved in designing the systems that support the initiatives and move the work forward. Since they are at the bedside, staff is able to identify small tweaks that can make the hospital’s processes better.

“TCAB principles serve as the foundation of our implementation,” said Dawn Allen, chief clinical officer. “We’ve brought the work to the direct line staff for involvement in design, testing and implementation. This has required strong support from leadership as well as the quality risk manager.”

By bringing the safety improvement work to the bedside, Redwood Area Hospital fosters a collaborative team that involves departments outside of the specific unit. For example, lab x-ray, physical therapy and housekeeping have all been involved in one or more initiative.

The hospital has learned it is important to have clear expectations for staff and to provide them necessary support to move the work forward.

“We’ve had success showing staff how the work improves care to the patient and positively impacts their work flow,” said Allen.

**Outcomes:**

Redwood Area Hospital fall with injury rates are consistently below average and currently the hospital’s fall with injury rate is zero. The hospital also has zero early elective deliveries in Q3 2013 and has a hard stop policy in place prohibiting deliveries before 39 weeks.
Pressure ulcers

Focus on pressure ulcer prevention has paid off with the rate of pressure ulcers in Minnesota hospitals far below the national average. Yet when pressure ulcers do occur, the injuries to skin and underlying tissue are painful and increase the risk for infection and other complications. Since 2007, hospitals have been participating in the SAFE SKIN road map that provides hospitals with best clinical practices to prevent pressure ulcers. The MHA HEN sought to drive down the incidence of pressure ulcers even further through the development of SAFE SKIN 2.0, which provides best practice recommendations for the operating room and preventing device-related pressure ulcers. In addition, a focused SAFE SKIN in the ICU campaign provides guidance to hospitals to prevent pressure ulcers in complex and critically ill patients.

MHA HEN is also partnering with the University of Minnesota School of Nursing to use immersive learning simulation technology for pressure ulcer prevention. The simulation targets head-to-toe skin inspection and risk assessment as well as targeting interventions.

In 2012, Bethesda Hospital in St. Paul identified an upward trend in its hospital-acquired pressure ulcer rate. The hospital’s pressure ulcer prevention and management practices were inconsistent, which led to eight reportable pressure ulcer events under Minnesota’s Adverse Health Event reporting law. The hospital set a goal to reduce its hospital-acquired pressure ulcer incidence rates below 4.88% for 2013 and to not have any pressure ulcers progress to stage III or greater, which is the trigger for becoming a reportable event under the Adverse Health Event law. In addition, the hospital set a goal for concurrent pressure ulcer tracking (reporting them as they happen) and for handovers between direct patient care providers to always include an update on pressure ulcers and skin integrity.

Interventions applied:

- Increased risk assessment from two times per week to every day.
- Implemented “four eyes” – two nurses complete skin inspection upon admission.
- Performed skin inspection around devices at every shift.
- Target RED
  - Reposition the patient or medical device to remove pressure and report findings to the patient’s nurse or provider.

83% reduction in stage II – unstageable pressure ulcers

682 fewer patients developed a pressure ulcer for a cost savings of more than $1.5 million

85% of HEN hospitals participating in pressure ulcer prevention

Hospital success story: Bethesda Hospital reduces pressure ulcers
• **Encourage and endorse interventions to protect the patient’s skin:** repositioning of the patient or medical device; recommend alternative pressure redistribution device; loosen equipment.

• **Document that the patient’s nurse has been notified of redness/abnormal inspection and interventions that were implemented.** Nurse completes an orange sticker to communicate this change to provider.

• Held a three-day performance improvement intensive event.

• Charge nurses round on patients every two hours.

• The charge nurse for each unit leads hospital huddles and reports status of hospital-acquired pressures ulcers and who is high risk.

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**HealthEast Bethesda Hospital**

**Pressure Ulcer: Incidence Study Data**

- Start monthly P&I, daily huddles, concurrent tracking of HAPUs
- Device work
- 3 day event

**Rate of Pressure Ulcers in Minnesota for 70 (64%) hospitals reporting an 83% decrease (concurrent reporting) (Q4 2010 - Q2 2013)**

- Pressure Ulcer Rate
- 40% Reduction
Fall prevention

According to the National Center for Injury Prevention and Control, falls are the most common adverse event in hospitals. Using the SAFE from FALLS road map which provides hospitals with resources and best clinical practices to prevent patient falls, Minnesota hospitals have reduced falls by 27 percent. Even more, hospitals have experienced four consecutive years of steady or decreasing numbers of serious falls.

Key strategies include:

• Falls and fall injury risk screening, assessment, documentation, communication and consistent application of risk reduction interventions.

• Shifting from a reliance on fall screening tools to identifying individual patient risk factors and customizing an intervention plan to mitigate those risk factors.

• Collaborating with the University of Minnesota School of Nursing to use immersion learning simulation technology that addresses key scenarios staff may encounter. For example, effective interaction with the patient during rounding, assessing the patient for high risk injury, and interacting with the patient to “stay within arm’s reach” during toileting.

Problem statement:

In reviewing its data on falls, Fairview Southdale Hospital discovered that 50 percent of falls were happening while the patient was using the bathroom.

Interventions applied:

• The hospital’s Fall Prevention Committee got approval from senior leadership to implement a policy that staff stay “within arm’s reach” of a patient when assisting with toileting.

• To garner staff support, the hospital shared fall rates, stories about real patients with falls, stories from nurses who had falls occur on their watch, and received strong support by management.

• Provided education and scripting for staff to explain to patients why it was important they stay nearby.

Lessons learned:

• There are many reasons patients are considered a fall risk, but staff must be consistent in applying the within arms reach approach to all fall risk patients, regardless of the patients’ assurance they will ask for assistance before getting up from a chair or toilet.
Outcomes:

- After implementing within arm’s reach, Fairview Southdale Hospital immediately saw a reduction in falls, from 50 percent in Q3 2010 to 23 percent in Q4.
- Fairview Southdale Hospital had its first year without a reportable fall in 2011.
- Fall rates are up because staff are not afraid to report incidents such as “patient was lowered to the floor;” however, the hospital’s fall rate with injury is significantly decreased.
- Through Q3 2013, 20 percent of falls occurred while toileting with no injuries.
- Overall, 17 percent of falls with minor injuries, three percent moderate and zero percent major injury to the patient.
Obstetrical adverse events

According to the U.S. Department of Health and Human Services, obstetrical adverse events occur in approximately 9 percent of all deliveries in the U.S. These adverse events include perineal tears, hemorrhaging or even death for the mother and injuries to the skeleton or spinal cord of the infant, as well as some neonatal intensive care unit admissions. And while research shows that important development takes place in a baby’s brain and lungs during the last few weeks of pregnancy, early elective deliveries (those not medically necessary) are still happening in some hospitals across the nation.

Minnesota hospitals have placed a strong focus on eliminating early elective deliveries and have reduced the number of elective deliveries prior to 39 weeks gestation by 87 percent, from 127 in fourth quarter 2010 to 26 in first quarter 2013. Of the 113 hospitals in the MHA HEN, 86 provide obstetrical services with approximately 46,000 deliveries per year. Nearly all (85 of 86) birthing hospitals have adopted a hard stop policy, as required by law, restricting inductions prior to 39 weeks unless medically necessary. These 85 hospitals account for 99.81 percent of deliveries in Minnesota. MHA continues to work one-on-one with the remaining hospitals to implement the policy. Other strategies include:

- A Perinatal Advisory Team made up of physicians and perinatal leadership staff.
- Development of a Perinatal Safety road map that includes patient education/nurse training on key areas to prevent adverse perinatal events, including the standardization of the management of oxytocin and use of vacuum extractors for operative vaginal deliveries.

While hospitals have made tremendous strides in reducing early elective deliveries, the MHA HEN continues to strive for zero early elective deliveries in Minnesota.
Percentage of early elective deliveries (EED) not meeting the Joint Commission’s criteria over the number of deliveries for 64 of 86 (74%) birthing hospitals showing 87% improvement (Q4 2010 - Q1 2013)

<table>
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<tr>
<th>Quarter</th>
<th>%EED/Deliveries</th>
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<tbody>
<tr>
<td>Q4 2010 (n=46)</td>
<td>2.82</td>
</tr>
<tr>
<td>Q1 2011 (n=47)</td>
<td>2.92</td>
</tr>
<tr>
<td>Q2 2011 (n=47)</td>
<td>2.36</td>
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<td>Q3 2011 (n=47)</td>
<td>2.39</td>
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<tr>
<td>Q4 2011 (n=47)</td>
<td>2.95</td>
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<td>Q1 2012 (n=51)</td>
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<td>Q3 2012 (n=0)</td>
<td>0.38</td>
</tr>
<tr>
<td>Q4 2012 (n=41)</td>
<td>0.00</td>
</tr>
<tr>
<td>Q1 2013 (n=64)</td>
<td>0.00</td>
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</table>

Number of HEN birthing hospitals in MN, of the 86 applicable, who have had an EED policy approved by DHS and have implemented the hard stop process 2012-2013

<table>
<thead>
<tr>
<th>Year</th>
<th># of Hospitals signed EED policy</th>
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<tbody>
<tr>
<td>2012</td>
<td>50</td>
</tr>
<tr>
<td>2013</td>
<td>75</td>
</tr>
<tr>
<td>2014</td>
<td>81</td>
</tr>
<tr>
<td>2015</td>
<td>85</td>
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Allina Health delivers more than 14,000 infants annually. While only a small percentage of these births result in complications, Allina Health recognized that in cases of shoulder dystocia (when an infant’s shoulders get stuck behind the mother’s pubic bone) the hospital was seeing a greater need for infant resuscitation and long-term care of the infant, as well as injuries to the mother. Shoulder dystocia can lead to fractures, brachial plexus injury (injury to the network of nerves that sends signals from the spine to the shoulder, arm and hand), or the need to resuscitate due to lack of oxygen. The hospital set a goal to improve on three measures:

- Decrease the length of time from identification of shoulder dystocia to delivery of the infant
- Improve infant APGAR scores
- Improve the cord gas pH to >7 at 5 minutes of age (an indicator of the well-being of the infant)

“By improving on these three measures, we were able to greatly reduce the incidence of infant resuscitation in our hospitals,” said Alice Timm, RNC, patient care supervisor at Unity Hospital, part of Allina Health. In fact, across Allina Health’s 10 hospitals that perform births, newborn complications were cut in half, from 13.5 percent in 2007 to 6.7 percent as of September 2013.

To achieve its improvement goals, Allina Health focused on nurse and provider education. Beginning in 2008, Allina provided education and simulated scenarios to providers and labor and delivery nurses. The evidence-based education focused on identification of shoulder dystocia, initial interventions that needed to be done, invasive maneuvers that providers needed to perform, and the evaluation of the mother and infant following delivery as well as the proper documentation of that evaluation. The simulated training focused on different shoulder dystocia scenarios that could occur during delivery.
In one Allina Health hospital, the length of time between identification of shoulder dystocia and delivery was previously three to five minutes. After the education sessions and simulation, it is down to one minute.

“One of the keys to our success was teamwork and communication among the caregivers. It was something we emphasized throughout our training,” said Timm. “As a result, providers feel that nurses know exactly what is needed and are ready for the interventions before it’s even asked. This helps the team work together more seamlessly and helps the delivery go more smoothly,” she added.

To ensure nurses and providers are current on the techniques and information, Allina offers refresher education and simulation every two years in addition to new nurse education that occurs quarterly. New physicians also attend this training or it is provided one-to-one at individual hospital sites.
Readmissions

Each year in the U.S., unplanned readmissions cost Medicare $17.5 billion. In Minnesota, nearly one in five Medicare patients is readmitted within 30 days. To meet the Partnership for Patients goal of reducing preventable readmissions by 20 percent by the end of 2014, MHA partnered with the Institute for Clinical Systems Improvement and Stratis Health to form the RARE Campaign — Reducing Avoidable Readmissions Effectively. The RARE Campaign focuses on five key areas that, if not managed well, are known to be main contributors to avoidable hospital readmissions:

1. Comprehensive discharge planning
2. Medication management
3. Patient and family engagement
4. Transition care support
5. Transition communications

For MHA HEN hospitals, RARE work centers around the SAFE Transitions of Care road map, which seeks to improve patient safety by standardizing and improving communication during transitions between hospitals and across all settings of care, including other hospitals, skilled nursing facilities, long-term care, assisted living, home health and primary care. The SAFE Transitions strategies help patients experience fewer incidents of delayed care or redundant tests, fewer medication events or missed doses, and reduced readmissions to the hospital.

*Hospital success story: Windom Area Hospital achieves notable reduction in readmissions*

Windom Area Hospital has worked methodically to provide the highest quality care to its patients as it endeavors to reduce avoidable readmissions. In fact, hospital staff are so committed to improving care coordination that they include readmissions metrics on their organization-wide scorecard. Windom Area Hospital staffers worked together as a care team to refine discharge instructions, and have capitalized on their community assets to build and foster working relationships with local home health agencies and nursing homes. Thus far, Windom Area Hospital has reduced their avoidable readmissions rate from 0.85 in 2009 to multiple quarters in 2012 at or near zero.
The staff is committed to continuing the challenging and complex work of preventing avoidable readmission, and plans to continue working on teach back techniques and enhancing the use of their electronic medical record to further advance their readmissions work.
Health care-associated infections

Health care-associated infections are infections that patients acquire during the course of receiving health care treatment for other conditions. They are one of the most common complications of hospital care. To develop a consistent statewide approach, MHA joined forces with Stratis Health, the Minnesota Department of Health (MDH) and the Minnesota Association for Professionals in Infection Control (MN-APIC) to create the Collaborative Healthcare Associated Infections Network (CHAIN). CHAIN developed a road map of best clinical practices to help organizations prevent catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), surgical site infections (SSI) and ventilator-associated events (VAE).

Interventions are focused on:
- Hand hygiene
- Transmission precautions
- Injection practices
- Antimicrobial stewardship
- Environmental cleaning

A gap analysis was developed for each focus area to provide a comprehensive set of evidence-based best practices that hospitals can use in the evaluation of preventive capabilities for each area of harm and form an action plan to guide improvement activities.

Problem statement:
The hospital sought to implement a nurse-driven protocol to remove catheters when no longer necessary and engage staff to ensure they were removed in a timely manner.

Interventions applied:
- Used evidence-based best practices to identify where catheters were appropriate as well as under what circumstances nurses should continue the use of a catheter.
- Garnered physician support and approval of policy.
- Changes were made to the electronic medical record to provide a hard stop requiring an approved reason to order a catheter.
- Built in a daily reminder to nurses asking whether it was necessary to continue catheter.

CAUTI results
23% reduction in CAUTI among MHA HEN hospitals
36 hospitals participating in CAUTI gap analysis

CLABSI results
28% reduction in CLABSI among MHA HEN hospitals
13 central line-associated blood stream infections have been avoided from 2012-2013 for a cost savings of $595,582
42 hospitals participating in CLABSI gap analysis

Hospital success story:
FirstLight Health System, Mora
• Nurses document if catheter should continue. If patient does not meet criteria, nurse gets order to discontinue.
• Conduct coordination of care meetings every morning and discuss patients with foley catheters and whether it’s necessary to continue.

Lessons learned:
It is important to balance the capacity of staff to engage in new improvement efforts. The infection prevention team at FirstLight was already well established, allowing this work to be a natural extension of their efforts.

Outcomes:
• FirstLight Health System has had only one CAUTI in each of the last two years.
• Excellent implementation of best practice process measures:
  • HAI road map = 91.9%
  • CAUTI gap analysis = 93%
  • CLABSI gap analysis = 89%
  • SSI gap analysis = 100%

SSI results
12% reduction in SSI related to abdominal hysterectomy
6.5% reduction in SSI related to colon surgery
37 HEN hospitals participating in SSI gap analysis

VAE results
72 MHA HEN hospitals that treat patients with ventilators are working to reduce ventilator-associated pneumonia in their intensive care units
98% average hospital compliance with the VAP bundle
Adverse drug events

In an effort to reduce the nearly 50 percent of all adverse drug events in hospitals each year that are preventable, Minnesota hospitals have implemented the Road Map to a Medication Safety program. This road map of best practices focuses specifically on anticoagulants, hypoglycemic agents and opioids. Adverse drug events involving these medication classes account for up to two-thirds of emergency hospitals admissions for older Americans. Focus was also put on these drug classes because they most often intersect with other hospital-acquired conditions, most notably readmissions, falls and venous thromboembolisms.

Organizations across the country have asked to adapt the road map developed by Minnesota hospitals for their own use. In addition, MHA staff presented Minnesota’s work on multiple occasions to the national Partnership for Patients audiences.

Venous thromboembolism

Each year, there are more than 30 million surgeries performed in the U.S. and venous thromboembolisms (blood clots) are one of the most common postoperative complications. While postoperative venous thromboembolisms (VTE) are considered a hospital-acquired condition, they can often be prevented by following a few evidence-based guidelines.

In consultation with some of the leading experts on preventing VTE, the MHA HEN incorporated into the Adverse Drug Events road map evidence-based best practices to increase the number of surgical patients who receive appropriate VTE prophylaxis within 24 hours prior to surgery to 24 hours after surgery. The MHA HEN also developed a VTE prevention strategies gap analysis that guides hospitals through key elements of VTE prevention, including:

- Patient and family engagement strategies
- Assessment and prevention strategies
- Implementation of defined therapeutic strategies
- Mitigation strategies
- Critical thinking and knowledge strategies
Partnerships and networking

Some of the best quality improvement work has been accomplished by capitalizing on the power of partnerships and collaboration. The MHA HEN is leveraging expertise from a variety of state and community partners that provide access to the latest research and best practices in patient safety and allow us to capitalize on the collaborative spirit that is strong in Minnesota. Key partners include:

- Association for Professionals in Infection Control and Epidemiology (APIC)
- Institute for Clinical Systems Improvement (ICSI)
- March of Dimes
- Minnesota Alliance for Patient Safety (MAPS)
- Minnesota Department of Health (MDH)
- Minnesota Department of Human Services (DHS)
- Minnesota Medical Association (MMA)
- Stratis Health (the state’s quality improvement organization)
- University of Minnesota School of Nursing
- VHA Upper Midwest

This strong spirit of collaboration has created a desire among hospitals to share experiences and learn from best practices. By learning from their colleagues, hospitals are able to more quickly spread improvement and ensure patients across the state receive the highest level of care.

The MHA HEN provides hospitals with a variety of training and education opportunities throughout the year including webinars, workshops and learning events. In particular, hospitals have appreciated one-one-one consultation to review data and help them prioritize their efforts and resources allotted to each focus area.

Lessons Learned

The MHA HEN has pushed its participating hospitals to focus on all-cause harm reduction. This push to focus on all topic areas prompted questions about whether hospitals may not be able to achieve meaningful reduction if they cannot focus and prioritize their efforts. To help hospitals prioritize their efforts and resources assigned to each focus area, MHA has offered one-on-one consultation to help them identify priority focus areas, including culture and leadership. To date, MHA has completed one-on-one consultation with 61 hospitals. In addition, MHA developed a harm across the board road map, SAFE CARE, to help streamline and focus all HACs and readmissions best practices and activities. MHA has found this road map to be a valuable tool in helping hospitals expand their focus on all topic areas.
MHA HEN in the future

Through the Hospital Engagement Network, Minnesota hospitals have built a foundation of evidence-based strategies to reduce hospital-acquired conditions. Through consistent implementation of the road maps of best practices, hospitals have been able to embed these processes into their workflow to ensure sustainability after the Partnership for Patients contract is complete.

MHA HEN will continue to focus on reducing harm in all areas of patient care and will continue to make it a priority to engage patients and families in their care. Hospitals have made great strides in obtaining leadership support for the work and MHA will work with hospitals to further develop a strong culture of safety. MHA HEN has a targeted approach for improvement in each HAC by identifying and sharing key insights learned throughout Minnesota and the national network of HENs and hospitals. MHA is expanding one-to-one consulting with hospitals to identify strengths and areas needed for improvement on a given HAC, based on benchmark data.

MHA HEN selected for national role

In addition, the MHA HEN is one of six hospital engagement networks across the country to be selected for the Partnership for Patients Leading Edge Advanced Practice Topics (LEAPT). The LEAPT funding will allow Minnesota hospitals to further expand patient safety and quality efforts by creating tested strategies to measure and improve outcomes for patients. Specifically, hospitals will develop and share with hospitals nationally significant advances in the following areas:

- Severe sepsis, a rapid onset of organ dysfunction caused by an overwhelming immune response to infection and septic shock, a form of severe sepsis accompanied by a life-threatening decrease in blood pressure.
- Clostridium difficile (C. diff), a bacterial infection that can be acquired during hospitalization and after treatment of an unrelated infection with antibiotics. C. diff infection leads to a wide range of symptoms from diarrhea to life-threatening colon inflammation, and primarily occurs in older adults in hospitals.
- Iatrogenic delirium, a rapid decline in cognitive function, which results in temporary, but severe confusion and disorientation as a result of medical treatment.
- Creating a hospital culture of safety that fully integrates patient and worker safety.
- Expanding the reduction of hospital acquired conditions and readmissions across the health care community, including: collaborating with long-term care, clinics, the community and others to prevent falls and falls with injury across all settings;
improving transitions of care through comprehensive medication therapy management; engaging medical school residents in meaningful quality improvement and patient safety efforts; and engaging patients as partners in the prevention of harm.

The MHA HEN submitted a proposal to extend its contract with CMS for an additional year, extending the work of the HEN through December 2014. With this option year one funding, Minnesota hospitals will be able to continue the advances to reduce hospital acquired conditions by 40 percent and readmissions by 20 percent. Hospitals will continue to focus on reducing all-cause harm, with specific focus on the 10 hospital-acquired conditions. MHA HEN will work to engage the remaining seven Minnesota acute care hospitals in the work, and will further refine improvement efforts across all focus areas.
### MHA HEN participating hospitals

<table>
<thead>
<tr>
<th>Hospital Name</th>
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<tr>
<td>Abbott Northwestern Hospital</td>
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Lake View Memorial Hospital ............................... Two Harbors
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Mayo Clinic Health System in Red Wing .................. Red Wing
Meeker Memorial Hospital .................................... Litchfield
Mercy Hospital ................................................. Coon Rapids
Mercy Hospital ................................................ Moose Lake
Mille Lacs Health System ...................................... Onamia
Minnesota Valley Health Center ........................... Le Sueur
Murray County Medical Center ............................. Slayton
New Ulm Medical Center ...................................... New Ulm
North Memorial Medical Center ......................... Robbinsdale
North Valley Health Center .................................. Warren
Northfield Hospital ........................................... Northfield
Olmsted Medical Center ....................................... Rochester
Ortonville Area Health Services ........................... Ortonville
Owatonna Hospital ............................................. Owatonna
Park Nicollet Methodist Hospital ......................... Saint Louis Park
Paynesville Area Health Care System .................. Paynesville
Perham Health ................................................ Perham
Phillips Eye Institute .......................................... Minneapolis
Pipestone County Medical Center ....................... Pipestone
Rainy Lake Medical Center ................................. International Falls
Range Regional Health Center ............................. Hibbing
RC Hospital & Clinics ......................................... Olivia
Redwood Area Hospital ...................................... Redwood Falls
Regina Medical Center ....................................... Hastings
Rice Memorial Hospital ....................................... Willmar
Ridgeview Medical Center .................................. Waconia
River Falls Area Hospital - Allina Health ............. River Falls
River's Edge Hospital & Clinic .............................. Saint Peter
RiverView Health ............................................... Crookston
Riverwood Healthcare Center .............................. Aitkin
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