Quality and Productivity Commission

34th Annual Productivity and Quality Awards Program

"Leading with Excellence"

2021 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12-point font):

NAME OF PROJECT: READY, SET, HIKE! HUDDLE UP TO PROTECT PATIENTS

DATE OF IMPLEMENTATION/ADOPTION: **MAY 2019**

(Must have been **fully** implemented **for a minimum of** at least one year - on or before July 1, 2020)

☐ **CHECK HERE IF THIS PROJECT IS BEING SUBMITTED FOR THE *COVID-19 IMPACT AWARD* ONLY**. (Projects must be implemented on or before December 31, 2020. **Note**: Projects implemented less than one year ago will not be eligible for any other PQA awards. In addition, once a project is submitted, you cannot submit the same project for awards consideration in subsequent years).

PROJECT STATUS: x Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes x No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

First, do no harm. This is a guiding principle for medical professionals and serves as a reminder that we must not cause injury or ill while treating the patients in our care. Healthcare-associated harm events (like infections caused by medical procedures) are unintended, and almost always preventable, outcomes that occur while patients receive medical care. These events result in significant patient harm, prolongation of hospital stay by several days, and higher costs for both the patient and the hospital.

To reduce the incidence of harm events at LAC+USC, we implemented daily, multi-disciplinary safety huddles on our medical-surgical (medsurg) units. Piloted on a single medsurg unit, the huddles have now been spread to all medsurg units and have led to a 50% reduction in the rates of hospital acquired harm events on the medsurg wards over the last 2 years. Though these benefits are hard to quantify, national data suggests that each harm event can lead to 3 to 7 more days in the hospital and cost the hospital up to $48,000 per event. Thus, these huddles allowed LAC+USC staff to be better stewards of our patients lives and LA County's resources.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$576,000	**$**	**$**	**$576,000**	XX☐

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS LAC+USC Medical Center 2015 Marengo St, Los Angeles, 90033		**TELEPHONE NUMBER** 323-409-2800
PROGRAM MANAGER'S NAME David Chung, MD, MBA Allison Luu, MD dchung@dhs.lacounty.gov/aluu2@dhs.lacounty.gov	**EMAIL**	**TELEPHONE NUMBER** 323-409-2815
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Laura Sarff, DNP, RN	**DATE** 6-11-21	**TELEPHONE NUMBER** 323-409-2815 **EMAIL** lsarff@dhs.lacounty.gov
DEPARTMENT HEAD'S NAME AND SIGNATURE Christina R. Ghaly, M.D. - *Signature on file*	**DATE**	**TELEPHONE NUMBER**

****ELECTRONIC, WET, OR SCANNED SIGNATURES ARE ACCEPTABLE****

We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12-point font):
NAME OF PROJECT: READY, SET, HIKE! HUDDLE UP TO PROTECT PATIENTS

1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project **to the County**. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success **and specify assessment time frame**. Use Arial 12 point font.

In the final quarter of 2018, LAC+USC Medical Center's rates of hospital acquired harm events were above the national average. Investigation of institutional practices revealed significant variety in the identification and prevention of harm events across the hospital. Additionally, we found that nearly all of the hospital's initiatives around the reduction of harm events were dependent on frontline nurses, even when some of the interventions involved other members of the healthcare team.

To standardize the hospital's efforts to reduce patient harm events, we created a daily unit huddle that was first piloted on a single medical-surgical (medsurg) unit in May 2019. Over the next year, the unit safety huddles (USHs) were spread to all eight medsurg units and several other specialty wards. Specifically, the huddles focused on preventing four patient harm events – catheter associated urinary tract infections (CAUTIs), central line associated blood stream infections (CLABSIs), healthcare acquired pressure injuries (HAPIs), and falls.

The huddles use a facilitator script to ensure that core patient safety concerns are highlighted, are led by frontline nursing staff, use standardized magnets on a visual management board, and have clear expectations of daily attendance by the multidisciplinary team. Huddles are attended by the frontline nurses, the charge nurse, the unit nurse manager, a member of the patient safety team, a physician champion, and hospital administration. The patient safety office shares evidence-based practices to reduce harm events and routinely provides unit specific harm event data. The physician champion interfaces directly with clinical teams when patient harm risks are identified and expedites interventions. Hospital administration provides key operational updates, confirms that the units have everything they need to take care of patients (e.g. supplies, IT issues, clinical equipment, facilities, EVS, security, etc), and encourages frontline staff to speak up and raise any concerns or logistical issues. White boards on each unit are used as visual management tools and clearly show each patient's risk for the four main harm events. For example, when a patient has a central line, a red magnet is placed next to the patient's room number on the white board, which helps staff quickly recognize the patient's risk for a CLABSI. Once the huddles were spread to the other units, the core patient harm events were uniformly identified using the same colored magnets.

The primary goal of the USHs is to reduce the incidence of patient harm events. Prior to the implementation of the unit safety huddle, the hospital had a reactive approach to patient harm events. A root cause analysis was done, and corrective action plans were rolled out, but only after a patient was harmed. With the USHs, the hospital moved from reactive to proactive, and focused on eliminating or

mitigating the risk of harm events before they happened. This included the timely removal of unnecessary intravenous lines and urinary catheters, and the quick identification of patients who were at risk for falls. After the huddles were started in May 2019, there was a steady reduction in harm events, specifically CAUTIs and CLABSIs, on the medical surgical units, averaging 2 events per month with some months having as many as 6 events. By March 2020, we averaged 1 per month, with 3 months between March 2020 and April 2021 have 0 events. This improvement was sustained through the majority of the COVID pandemic. Using national financial estimates, reducing our numbers from 2 per month to 1 per month results in a cost avoidance of $576,000.

Beyond the successful reduction of patient harm events, the USHs have led to many other positive changes as well. Most notably, there has been an improvement in the culture of communication and psychological safety of our staff. One large contributing factor to this psychological safety is the frequent presence of hospital leadership and the patient safety office at the huddles. The leadership is very active, asking open ended questions, offering assistance, and empowering hospital staff to speak up and voice their concerns. Additionally, leaders use closed loop communication and regularly follow up with the frontline staff. These sentiments were captured in surveys to the units with one nurse stating that the huddle '[gave] a feeling of being a medical care TEAM'. Members of the patient safety team also make themselves available to the frontline staff to offer an empathetic ear and provide second victim syndrome support through our Helping Healers Heal (H3) program. These H3 sessions were vital during the COVID pandemic and helped our staff feel supported and valued.

Another benefit of the USHs that was observed during the COVID pandemic was the communication infrastructure that was fortuitously instituted with the huddles. This structure allowed leadership to regularly provide timely and critical hospital information to our frontline staff. The COVID pandemic, and every surge of patients and cases, caused so much fear, anxiety, and uncertainty. It was in this unsettling crisis that the daily USHs became a place where our nurses, medical assistants, physicians, social workers, etc. received daily updates on the number of COVID patients in the hospital, the bed situation, personal protective equipment supply status, surge plans, visitation policies, and so much more. This communication construct continues to be utilized to this day and serves as an effective way to reach our staff.

From its inception in May 2019, the USHs have been adaptive and innovative. They have had to evolve as several large changes were made to the medsurg wards. In May 2020, the physician medicine teams who care for patients were geographically

cohorted to six medsurg wards, with two teams cohorted to each ward. The goal of geographic cohorting was to admit the majority of a medicine team's patients to the same geographic area, or ward. This provided an opportunity to include the cohorted physicians at the huddles and have greater collaboration across disciplines in preventing patient safety harm events. To facilitate more interdisciplinary communication around patient plans on these cohorted units, while maintaining the core focus on patient safety, the unit safety huddles were modified to become multidisciplinary safety huddles (MDSHs) in July 2020. As the clinicians discussed care plans and disposition plans with the frontline nurses and social workers at these retooled huddles, the clinicians were gently probed on the necessity of various medical devices, reminded of the ways to reduce hospital acquired harm events, and encouraged to raise other safety concerns.

The most recent change to the medsurg wards was the introduction of unit medical directors (UMDs) – physician champions who formed a dyad with unit nurse managers with the goal of improving the clinical care that patients receive. The UMDs started at the beginning of 2021 and have quickly become extensions of the patient safety team. These clinicians have made sure to always remind staff of patient safety issues during the huddles and help address other physician specific issues. We are actively working to get UMDs on every ward by the end of 2021.

With every change that is made to the USHs the guiding principle remains the same – first, do no harm. Patients come to the hospital to heal and entrust us with their lives. Therefore, it is vital that we prevent our patients from being harmed when they are under our care. This charge does not fall squarely on any one medical profession. Instead, it is the responsibility of the entire multidisciplinary team. The USHs have provided the structure to have a shared mission around proactive reduction of patient harm and has grown a culture of communication, collaboration, and camaraderie that now extends to many other aspects of patient care. We are pleased with the changes that the USHs have brought and are excited to continue moving towards eliminating harm events all together!

Title of Project (Limited to 50 characters, including spaces, using Arial 12-point font):
NAME OF PROJECT: READY, SET, HIKE! HUDDLE UP TO PROTECT PATIENTS

Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12-point font.

Goal 1 Make Investments that transform Lives; Strategy I.1. Increase our focus on prevention initiatives

The project focuses on prevention of harm. The unit safety huddles changed the way that the hospital approached patient harm events. The paradigm around harm events shifted away from responding to injuries and infections, to daily reviewing the various ways we can prevent them from happening in the first place.

Quality and Productivity Commission

34th Annual Productivity and Quality Awards Program

"Leading with Excellence"

2021 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12-point font):

NAME OF PROJECT: READY, SET, HIKE! HUDDLE UP TO PROTECT PATIENTS

COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12-point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) TOTAL **ANNUAL** ACTUAL/ESTIMATED	SERVICE ENHANCEMENT PROJECT
$576,000	**$**	**$**	**$576,000**	XX☐

ANNUAL= 12 MONTHS ONLY

Cost calculations:

1 harm event = $48,000 cost to hospital. Costs estimated, but include additional days as inpatient, medications to treat the harm event, possibly higher level of care based on harm event. National estimates put this number at ~ $48,000 per event.

Baseline identified average of 2 harm events per month @$48,000 per event = $1,152,000 per annum. Reducing to 1 harm event/month= $576,000 cost avoidance per annum.