AHA/HRET HEN 2.0 DATA WEBINAR
FOCUS ON IMPROVEMENT: TIPS AND STRATEGIES FOR MOVING BEYOND DATA COLLECTION

May 5, 2016
11:00 a.m. – 12:30 p.m. CT
WELCOME AND INTRODUCTIONS

Senior Program Manager, HRET | 11:00 – 11:05
# AGENDA FOR TODAY

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Description</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00-11:05 AM</td>
<td>Welcome and Introductions</td>
<td>Open and housekeeping information, including review of relevant HRET HEN resources, change packages and Listserv®.</td>
<td>Natalie Erb, MPH, Senior Program Manager, HRET</td>
</tr>
<tr>
<td>11:05-11:15 AM</td>
<td>HEN Data Progress Report</td>
<td>Review of percent reduction and percent reporting across HEN topics.</td>
<td>Julia Heitzer, MS, Data Analyst, HRET</td>
</tr>
<tr>
<td>11:25-11:50 AM</td>
<td>Excel for Quality</td>
<td>Review of basic data features that are useful for quality improvement. Tips on how to use Excel to capture, understand and utilize your data to drive improvement and understand if your changes are improvements.</td>
<td>Annette Urganus, MPH, Paul Cholod, MS, Data Analysts, HRET</td>
</tr>
<tr>
<td>11:50 AM-12:15 PM</td>
<td>Hospital Story – Saint Francis Healthcare System</td>
<td>Hear how a hospital uses data to drive quality improvement in their facility.</td>
<td>Stephanie A. La Pierre, MBA, BSN, RN, CSSBB (ASQ), CPHQ, Leigh-Ann White, MSN, RN, CPHQ, CSSBB (ASQ), Chief Performance Improvement Officer, Lead Performance Improvement Specialist, Saint Francis Healthcare System, Cape Girardeau, MO</td>
</tr>
<tr>
<td>12:15-12:25 PM</td>
<td>Q &amp; A</td>
<td></td>
<td>HRET Data Team</td>
</tr>
<tr>
<td>12:25-12:30 PM</td>
<td>Bring it Home</td>
<td></td>
<td>Natalie Erb, MPH, Senior Program Manager, HRET</td>
</tr>
</tbody>
</table>
ENCYCLOPEDIA OF MEASURES (EOM)

• Catalogued measure information available on the HRET HEN website
  – HEN Core Topics – (evaluation measures)
  – HEN Core Process Measures
  – HEN Additional Topics
SIGN UP TODAY: DATA ANALYTICS LISTSERV®

- Data Analytics Listserv® is available for:
  - Sharing of:
    - HRET Resources
    - Publically Available Resources
    - Best Practices
    - Learnings from Subject Matter Experts
  - Troubleshooting for Data Reporting and Analysis

Sign Up Here
CAUTI Rate per 1,000 Urinary Catheter Days – Data submitted to AHA/HRET as of: 3/30/2016

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

CLABSI Rate per 1,000 Central Line Days- Data submitted to AHA/HRET as of: 3/30/2016

<table>
<thead>
<tr>
<th>CLABSI Rate (per 1,000 central line days) – All inpatient locations</th>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.99</td>
<td>1.05</td>
<td>0.99</td>
<td>0.96</td>
<td>0.81</td>
<td>0.82</td>
<td>-12%</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>990 (95%)</td>
<td>954 (91%)</td>
<td>951 (91%)</td>
<td>934 (89%)</td>
<td>774 (74%)</td>
<td>568 (54%)</td>
<td>--</td>
</tr>
<tr>
<td>CLABSI Rate (per 1,000 central line days) – ICUs</td>
<td>1.12</td>
<td>1.15</td>
<td>1.00</td>
<td>1.00</td>
<td>0.80</td>
<td>0.96</td>
<td>-18%</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>786 (93%)</td>
<td>743 (88%)</td>
<td>740 (88%)</td>
<td>729 (86%)</td>
<td>586 (70%)</td>
<td>428 (51%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Early Elective Deliveries: Data submitted to AHA/HRET as of: 3/30/2016

Many hospitals abstract their EED data as part of the core measures process, which can take 30-45 days after the end of a month to complete. This issue likely explains lower data submission for the most recent month.

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early elective deliveries</td>
<td>3.73</td>
<td>3.39</td>
<td>3.67</td>
<td>3.78</td>
<td>3.78</td>
<td>4.63</td>
<td>5%</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>696 (90%)</td>
<td>623 (81%)</td>
<td>609 (79%)</td>
<td>557 (72%)</td>
<td>388 (50%)</td>
<td>229 (30%)</td>
<td>--</td>
</tr>
</tbody>
</table>
HEN DATA UPDATE

OB Harm: Data submitted to AHA/HRET as of: 3/30/2016

These measures are AHRQ Patient Safety Indicators (PSIs), which are claims-based measures. Two factors affect timely data submission:

1. Claims often take longer than 30 days to finalize, therefore, reports will not be available by the end of the subsequent month.

2. Hospitals or states reliant on the AHRQ software are unable to generate results, since the AHRQ software has not yet incorporated ICD-10 codes which took effect October 1, 2015.

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

OB Hemorrhage - Massive Blood Transfusions: Data submitted to AHA/HRET as of: 3/30/2016

Lower than expected data submission may be influenced by the proportion of CAH and/or rural hospitals that provide OB services. Twenty percent of OB hospitals are CAH, and 32% are in rural areas.

These rural and/or critical access hospitals are likely referring high-risk pregnancies to other hospitals that are able to provide an advanced level of care. The relatively few patients actually treated at rural hospitals and/or CAHs means lower case volumes and that a single adverse event can cause significant rate changes.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB Hemorrhage – Massive Blood Transfusions (per 1,000 patients)</td>
<td>2.24</td>
<td>2.45</td>
<td>2.63</td>
<td>2.79</td>
<td>2.87</td>
<td>2.45</td>
</tr>
<tr>
<td>Number (% of hospitals reporting)</td>
<td>404 (52%)</td>
<td>391 (51%)</td>
<td>378 (49%)</td>
<td>359 (46%)</td>
<td>288 (37%)</td>
<td>175 (23%)</td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Pre-Eclampsia - ICU Admissions: Data submitted to AHA/HRET as of 3/30/2016

Lower than expected data submission may be influenced by the proportion of CAH and/or rural hospitals that provide OB services. Twenty percent of OB hospitals are CAH, and 32% are in rural areas.

These rural and/or critical access hospitals are likely referring high-risk pregnancies to other hospitals that are able to provide an advanced level of care. The relatively few patients actually treated at rural hospitals and/or CAHs means lower case volumes and that a single adverse event can cause significant rate changes.

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Falls w/Injury: Data submitted to AHA/HRET as of: 3/30/2016

<table>
<thead>
<tr>
<th>All Documented Patient Falls with an Injury Level of Minor or Greater (per 1,000 patient days)</th>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>1179 (91%)</td>
<td>1095 (84%)</td>
<td>1075 (83%)</td>
<td>1039 (80%)</td>
<td>775 (60%)</td>
<td>513 (40%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Pressure Ulcer Rate and Prevalence: Data submitted to AHA/HRET as of: 3/30/2016

The pressure ulcer rate measure is an AHRQ Patient Safety Indicators (PSIs), which is a claims-based measure. Two factors affect timely data submission:
1 - Claims often taken longer than 30 days to finalize, therefore, reports will not be available by the end of the subsequent month
2 - Hospitals or states reliant on the AHRQ software are unable to generate results, since the AHRQ software has not yet incorporated ICD-10 codes which took effect October 1 2015.

Many hospitals do quarterly pressure ulcer prevalence studies; all hospitals are encouraged to perform prevalence monthly.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer Rate, Stages 3+ (per 1,000 patients)</td>
<td>0.99</td>
<td>0.55</td>
<td>0.64</td>
<td>0.67</td>
<td>0.98</td>
<td>1.44</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>1090 (84%)</td>
<td>733 (56%)</td>
<td>700 (54%)</td>
<td>672 (52%)</td>
<td>524 (40%)</td>
<td>351 (27%)</td>
</tr>
<tr>
<td>Pressure Ulcer Prevalence, Hospital-Acquired-Stage 2+</td>
<td>0.28</td>
<td>0.19</td>
<td>0.18</td>
<td>0.23</td>
<td>0.19</td>
<td>0.40</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>1024 (79%)</td>
<td>728 (56%)</td>
<td>726 (56%)</td>
<td>783 (60%)</td>
<td>578 (45%)</td>
<td>422 (33%)</td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Surgical Site Infection Rates, Colon Surgeries and Abdominal Hysterectomies: Data submitted to AHA/HRET as of: 3/30/2016


<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Rate - Colon surgeries</td>
<td>5.11</td>
<td>5.29</td>
<td>5.79</td>
<td>4.74</td>
<td>4.69</td>
<td>3.08</td>
<td>-12%</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>898 (89%)</td>
<td>668 (66%)</td>
<td>652 (65%)</td>
<td>628 (62%)</td>
<td>432 (43%)</td>
<td>242 (24%)</td>
<td>--</td>
</tr>
<tr>
<td>SSI Rate - Abdominal hysterectomies</td>
<td>1.57</td>
<td>1.64</td>
<td>1.30</td>
<td>1.58</td>
<td>1.13</td>
<td>0.75</td>
<td>-15%</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>684 (93%)</td>
<td>510 (69%)</td>
<td>500 (68%)</td>
<td>488 (66%)</td>
<td>307 (42%)</td>
<td>182 (25%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Surgical Site Infection Rates, Hip and Knee Surgeries: Data submitted to AHA/HRET as of: 3/30/2016

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Rate - Total knee replacements</td>
<td>0.76</td>
<td>0.59</td>
<td>0.53</td>
<td>0.43</td>
<td>0.52</td>
<td>0.40</td>
<td><strong>-41%</strong></td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>620 (62%)</td>
<td>484 (48%)</td>
<td>474 (47%)</td>
<td>444 (44%)</td>
<td>301 (30%)</td>
<td>180 (18%)</td>
<td></td>
</tr>
<tr>
<td>SSI Rate - Total hip replacements</td>
<td>1.18</td>
<td>1.07</td>
<td>1.08</td>
<td>1.07</td>
<td>0.57</td>
<td>0.44</td>
<td><strong>-32%</strong></td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>610 (61%)</td>
<td>469 (47%)</td>
<td>459 (46%)</td>
<td>442 (44%)</td>
<td>288 (29%)</td>
<td>177 (18%)</td>
<td></td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.

To date, there is no current reporting mandate for total hip replacements and total knee replacements.

Relative reduction from baseline:

- **Total knee replacements**: -41%
- **Total hip replacements**: -32%

Graph showing SSI rates from 2015-10 to 2016-06 for total knee and total hip replacements.
HEN DATA UPDATE

Ventilator Associated Events: Data submitted to AHA/HRET as of: 3/30/2016

Many hospitals provide data via an AHA/HRET or state NHSN group. NHSN submission deadlines are 45 days after the close of a month. Some, but not all, hospitals will submit data to NHSN prior to formal NHSN or CMS deadlines.

<table>
<thead>
<tr>
<th>Ventilator Associated Condition (VAC) (per 1,000 ventilator days)</th>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.66</td>
<td>4.67</td>
<td>4.46</td>
<td>4.54</td>
<td>3.83</td>
<td>3.34</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>755 (87%)</td>
<td>673 (78%)</td>
<td>668 (77%)</td>
<td>658 (76%)</td>
<td>536 (62%)</td>
<td>388 (45%)</td>
<td>--</td>
</tr>
<tr>
<td>Infection-Related Ventilator-Associated Complication (IVAC) (per 1,000 ventilator days)</td>
<td>1.40</td>
<td>1.64</td>
<td>1.26</td>
<td>1.39</td>
<td>1.13</td>
<td>1.16</td>
<td>-11%</td>
</tr>
<tr>
<td>Number (%) of hospitals reporting</td>
<td>762 (88%)</td>
<td>680 (78%)</td>
<td>674 (78%)</td>
<td>666 (77%)</td>
<td>542 (62%)</td>
<td>384 (44%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

Post-Operative VTE or DVT: Data submitted to AHA/HRET as of: 3/30/2016

This measure is an AHRQ Patient Safety Indicator (PSI), which is a claims-based measure. Two factors affect timely data submission:
1 - Claims often taken longer than 30 days to finalize, therefore, reports will not be available by the end of the subsequent month
2 - Hospitals or states reliant on the AHRQ software are unable to generate results, since the AHRQ software has not yet incorporated ICD-10 codes which took effect October 1 2015.

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
HEN DATA UPDATE

ADE Composite - All Harms Reported: Data submitted to AHA/HRET as of: 3/30/2016

This measure represents aggregate adverse drug events for all events reported by a facility, for the three areas:

1 - Excessive anticoagulation;
2 - Hypoglycemia; and
3 - Opioid events.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2015-10</th>
<th>2015-11</th>
<th>2015-12</th>
<th>2016-01</th>
<th>2016-02</th>
<th>Relative reduction from baseline, most recent quarter (Dec 2015, Jan &amp; Feb 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE Composite rate - All areas reported</td>
<td>1.67</td>
<td>1.57</td>
<td>1.60</td>
<td>1.66</td>
<td>1.69</td>
<td>1.55</td>
</tr>
</tbody>
</table>

**Data submission varies by area**
HEN DATA UPDATE

All-Cause 30 Day Readmissions: Data submitted to AHA/HRET as of: 3/30/2016

This measure requires monitoring for 30 days post-discharge, therefore, February 2016 data is not complete nor expected at the end of March 2016.

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.
NHSN Troubleshooting

Rich Rodriguez, Data Analyst, HRET | 11:15–11:25
NHSN DATA NOT VISIBLE IN CDS - WHY?

- NHSN alerts must be cleared
- Monthly reporting plans must be complete and up-to-date
NHSN ALERTS

• Help ensure accurate and complete NHSN data entry

• Appear on NHSN home page

• For in-plan data (please make sure all of your reporting plans are complete and up to date!)

• Temporarily limited to 2015 onward
NHSN ALERTS

NHSN Patient Safety Component Home Page

Use the Navigation bar on the left to access the features of the application.

Action items

You must complete these items.

- A survey is required for 2015

Alerts

- You have 9 missing events
- You have 5 incomplete summary items
- You have 10 missing summary items
- You have 5 missing procedures
INCOMPLETE EVENTS ALERT

- This alert will list in-plan events from any module with required data elements missing.
- Facility should report these data per the NHSN protocols. Click the link in the 6th column (titled “Event #”) in order to resolve the incomplete event.
MISSING EVENTS ALERT

• This alert lists months in which events from the device-associated or MDRO/CDI modules were included in the monthly reporting plan and summary data have been reported to NHSN, but no events have been reported.
• Facility should 1) add events Or 2) check ‘Report No Events’.

<table>
<thead>
<tr>
<th>Location</th>
<th>CDC Location</th>
<th>Month/Year</th>
<th>Alert Type</th>
<th>Event Type/Pathogen</th>
<th>Summary Data Form Type</th>
<th>Report No Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACWIDEIN</td>
<td></td>
<td>02/2013</td>
<td>Summary but no events</td>
<td>LabID (All) - CDIF</td>
<td>MDRO</td>
<td></td>
</tr>
</tbody>
</table>
INCOMPLETE SUMMARY DATA

• This alert will list in-plan months of summary data for the device-associated or MDRO/CDI modules in which a required field is missing.
• Facility should enter the missing data. Click on the link under summary ID to submit missing elements.
MISSING SUMMARY DATA

• This alert will list in-plan months in which no summary data for the device-associated or MDRO/CDI modules have been entered.
• Facility should add summary data – click ‘Add summary’ link.
INCOMPLETE PROCEDURES

- This alert will list those in-plan procedure records that have been imported with incomplete data.
- Facility should submit the missing data per the NHSN protocols. Click the link in the 6th column (titled “Event #”) in order to resolve the incomplete procedure.

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Event #</th>
<th>Event Type</th>
<th>Date Admitted to Facility</th>
<th>Procedure Date</th>
<th>NHSN Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRO_932B_10</td>
<td>M</td>
<td>11/24/1955</td>
<td>44607</td>
<td>PROC</td>
<td>08/04/2014</td>
<td>HPRO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MISSING PROCEDURES

- This alert will list those months in which NHSN operative procedure categories were listed in your monthly reporting plan and no procedures have been reported to NHSN. Note that procedures will be listed by category and setting.
- Facility should 1) enter procedures OR 2) if no procedures performed check the ‘No Procedures Performed’ box.

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Procedures</th>
<th>Setting</th>
<th>No Procedures Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/2015</td>
<td>HYST - Abdominal hysterectomy</td>
<td>IN - Inpatient</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
MISSING PROCEDURE-ASSOCIATED EVENTS

• This alert will list those months in which NHSN operative procedures were reported in-plan and no in-plan procedure-associated events (i.e., SSIs) have been reported to NHSN, for procedures performed during that month/year.

• Facility should 1) enter SSIs Or 2) if the facility does not have any SSIs then check the ‘Report No Events’ box.
Excel for Quality
Annette Urganu MPH, Paul Cholod MS, Data Analysts | 11:25 – 11:50
DISCLAIMER

- The AHA/HRET are not endorsing any particular spreadsheet software brands.
EXCEL

• Microsoft Excel
  – Spreadsheet program used to collect, sort and analyze data
  – Advanced options – data collection tool, dashboards, graphing capabilities

• Excel basics (Live Demo)

• Using NHSN unit level data in Excel
POLLING QUESTION – HOW OFTEN DO YOU USE EXCEL IN YOUR WORK?

- Daily
- Once a week
- Once a month
- A few times a year
- Never
POLLING QUESTION – HOW COMFORTABLE ARE YOU USING EXCEL IN YOUR WORK?

- Very comfortable
- Somewhat comfortable
- Excel scares me!
LIVE EXCEL DEMO
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell location</td>
<td>Just like a map. Use the coordinates along the top and left side. Letters denotes columns; numbers denote rows. This cell is B2: column B, row 2.</td>
</tr>
<tr>
<td>Rename worksheet</td>
<td>Right click on worksheet tab. You will see rename as an option, select it with your left mouse key and type the new name of your worksheet. Double click on worksheet name (e.g., Sheet1), then type new name.</td>
</tr>
<tr>
<td>Insert Column</td>
<td>Right click on the letter of the column, and choose insert (left click). Select entire column by left clicking on the letter of the column. Use 'Insert' drop down menu (under Home Ribbon-Cells).</td>
</tr>
<tr>
<td>Insert Row</td>
<td>Right click on the number of the row, and choose insert (left click). Select entire row by left clicking on the number of the row. Use 'Insert' drop down menu (under Home Ribbon-Cells).</td>
</tr>
<tr>
<td>Drag and copy</td>
<td>Select the cell(s) you wish to copy. Move your mouse to the bottom right-hand corner of the cell, until you see a &quot;skinny cross,&quot; then left click and drag the information over (or down).</td>
</tr>
</tbody>
</table>
## EXCEL

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copy and paste</td>
<td>Right click on the cell(s) you wish to copy. Select copy. Select cell where you'd like to paste the information. Right click and select paste. Select the cell(s) you wish to copy. Left click Home-ClipBoard-Copy. Select cell where you'd like to paste the information. Left click Home-ClipBoard-Paste. Select the cell(s) you wish to copy. Hit Ctrl+C. Select cell where you'd like to paste the information. Hit Ctrl+V.</td>
</tr>
<tr>
<td>Add a worksheet</td>
<td>Left click the far most right tab (*). Select Home-Cells-Insert (drop down; choose worksheet).</td>
</tr>
<tr>
<td>Add formulas</td>
<td>All formulas start with an =. The basic formula construct is: =WHAT(cell location:cell location).</td>
</tr>
<tr>
<td>SUM</td>
<td>=SUM(beginning cell:ending cell), e.g., =SUM(A2:A6)</td>
</tr>
<tr>
<td>TOPIC</td>
<td>NOTES</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Average</td>
<td>=AVERAGE(beginning cell:ending cell), e.g., =AVERAGE(B2:B6)</td>
</tr>
<tr>
<td>Count if</td>
<td>=COUNTIF(beginning cell: ending cell,&quot;criteria&quot;), e.g., =COUNTIF(C2:C6,&quot;&lt;2&quot;)</td>
</tr>
<tr>
<td>Percentage</td>
<td>There is no function for percent. The formula is: =numerator/denominator, e.g., D2/D3.</td>
</tr>
<tr>
<td>Using Function wizard</td>
<td>Select the cell where you want the answer returned. Click the 'fx' button in front of the formula bar. Using the drop down category menu, select all. Scroll down until you reach the function you want. Enter all arguments required. Select function under Formulas (using categories). Under formulas, click insert function.</td>
</tr>
<tr>
<td>TOPIC</td>
<td>NOTES</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
</tr>
</tbody>
</table>
| Create Data Collection Sheet | - Use Row 1 as a header row (variable names). The data will be entered in rows.  
- The first column(s) should be demographic data (try to include unique identifier).  
- Keep the headers and unique identifiers visible while entering data by using View-Freeze Panes drop down menu. |
<p>| Add data | Enter data into a cell then hit the 'tab' button. Continue (left to right) until you reach the last data point for that row. Then hit enter. |
| Auto filter | Used to view only a portion of your data. Grab your data by selecting (left-click) all rows of your data. Under Home Ribbon-Editing-Sort &amp; Filter, select filter. To turn off auto-filter, repeat process: under Home Ribbon-Editing-Sort &amp; Filter, deselect (left-click) filter. |</p>
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sort</td>
<td>Grab your data by selecting (left-click) all rows of your data. Home Ribbon-Editing-Sort &amp; Filter, select sort. Selecting A to Z sorts data alphabetically by first column of selected data. Z to A sorts reverse alphabetically. Selecting Custom sort opens a dialogue box. Choose (using drop downs) which column to use in sorting the data. Select ascending or descending sort. Add level to add a second layer of sorting. Check the box, if your data has header rows.</td>
</tr>
<tr>
<td>Insert graph</td>
<td>Grab your data. Using the 'Insert' Ribbon, select desired chart type.</td>
</tr>
<tr>
<td>Format graph to your style</td>
<td>When you are in your chart (left click), Go to Chart Tools. Design: Can change chart type, e.g. column. Can change source data color and location here. Layout: Here you format title, axes, gridlines, legend, data labels, data table. Format: Here is where you format borders/color fill.</td>
</tr>
</tbody>
</table>
EXCEL RESOURCES

• Excel training

• 10 Essential Microsoft Excel 2010 Tips for Beginners
  – http://www.pcmag.com/article2/0,2817,2386988,00.asp
Hospital Story: Saint Francis Medical Center

Stephanie La Pierre, Chief Performance Improvement Officer and Leigh-Ann White, Lead Performance Improvement Specialist

| 11:50 – 12:15 |
DAILY PERFORMANCE MANAGEMENT

Stephanie La Pierre, MBA, BSN, RN, CPHQ, CSSBB (ASQ)
Chief Performance Improvement Officer

Leigh-Ann White, MSN, RN, CPHQ, CSSBB (ASQ)
Lead Performance Improvement Specialist

Saint Francis Medical Center, Cape Girardeau, Missouri
ABOUT US

Saint Francis Medical Center is a 284-bed facility serving more than 713,000 people throughout Missouri, Illinois, Kentucky, Tennessee and Arkansas. Guided by its mission to provide a ministry of healing and wellness inspired by its Christian philosophy and values, the Medical Center has become a progressive, innovative regional tertiary care referral center. Saint Francis’ major service lines, which have received national recognition, include the Neurosciences Institute; Orthopedic Institute; Family BirthPlace, featuring the region’s first Level III Neonatal Intensive Care Unit; Heart Hospital; Emergency and Level III Trauma Center; Cancer Institute; and Fitness Plus.
BARRIERS AND HOW WE RESOLVED

• Pre-improvement culture
  – Data published every 6 months pushed to service lines
  – Performance data reported by quarter
  – Score cards, no observed performance over time (statistical process control)
  – Front-line colleague anecdotally familiar with performance

• Identified opportunity to share data effectively
  – Data needed real-time
  – Transition from retrospective to concurrent
  – Where can we make a difference in patient outcomes?

• Looked to manufacturing industry for improvement tool
  – Daily Performance Management
MEASURES – WHAT

• Deployed Daily Performance Management (DPM)
  – Patient-centered tool shifting retrospective performance activities to concurrent using leading measures at the “sharp end” of care delivery
    • Sharp end: person actually doing task
    • Leading measure: activities that prevent poor outcomes
      – Examples: Device insertion bundle compliance, timely VTE prophylaxis, LACE scoring, Falls risk assessment, line necessity reassessment, “Foleys at five”, q 2 hour turns documented
    • Lag measure: outcomes
      – Examples: CLABSI, VTE, Readmission, Falls, CAUTI, Pressure Ulcers, etc.

The WIN – instead of conducting an apparent cause analysis (ACA), we are addressing measures to prevent harms!
MEASURES – HOW

• How did Saint Francis Medical Center measure the improvement?
  – Identified DPM measures
    • Aligned with Strategic Quality & Patient Safety Plan
    • Validated leading v. lagging
    • Integrated (Baldrige criteria)
  – Piloted project on an inpatient department
    • Low-cost method to test effectiveness
  – Developed boards
    • Placed in patient care areas, visible to patients and guests

The WIN – transition from “management audits” to front-line colleagues empowered to prevent harms.
# DPM “HUDDLE BOARD”

## Daily Performance Management

**THE ROAD TO HIGHLY RELIABLE CARE**

**LAST UPDATE** 5/4/16 10:30

### Measures of Excellence

<table>
<thead>
<tr>
<th>Metric</th>
<th>Last 24 Hours</th>
<th>Patients to Monitor</th>
<th>Days Since Event</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Prevention</td>
<td>5/3</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>VTE Compliance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>CAUTI Compliance</td>
<td>100%</td>
<td>Patients with VTE</td>
<td>Critical 2-90</td>
<td></td>
</tr>
<tr>
<td>CLABSI Compliance</td>
<td>100%</td>
<td>Patients with CLABSI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Diff Compliance</td>
<td>100%</td>
<td>Patients with C. Diff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Protocols</td>
<td>100%</td>
<td>Percent positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia Protocols</td>
<td>100%</td>
<td>Percent positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-Person Skin</td>
<td>100%</td>
<td>Percent positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turn Schedule</td>
<td>100%</td>
<td>Percent involved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAP Compliance</td>
<td>100%</td>
<td>Percent involved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient-Centered Goals for Safety

**1 Bedside Report**

**2 Weeks on All Admits**

**3 Follow-Hours Protocol**

**Team Goal (Current shift)**

**Signs of Distress**

**Signs of Improved Outcomes**

---

### DPM Compliance Data

**C. Diff**

- Complete ALL diarrhea screening on admission and daily after three days of hospitalization.
- If positive screen:
  1. Start isolation protocol
  2.�新生 Pfizer with antibiotic
  3. Place isolation kit, approved signage, etc., at entrance of room
  4. Collect first available stool specimen
  5. Educate/document patient/family (1) C. Diff.
  6. Ensure ALL colleagues and guests entering the room are wearing appropriate PPE

**Falls**

- Complete the following fall prevention measures:
  1. Foul bed alarm
  2. Place fall risk pressure
  3. Cell light within reach
  4. Room clear of environmental hazards
  5. Falls precautions in place: signage, non-skid footwear, and gait belt
  6. Consider turnover bed and telemonitor as needed

**VAP**

- Complete the following VAP prevention measures:
  1. HOB 90 degrees
  2. Daily oral care with CHG
  3. VTE ppx
  4. SRT: meditation
  5. Risk screening

**Clabsi**

- Complete the following clabsi prevention measures:
  1. HOB 90 degrees
  2. Daily oral care with CHG
  3. VTE ppx
  4. SRT: meditation

**Skin**

- Complete the following skin care measures:
  1. HOB 90 degrees
  2. Daily oral care with CHG
  3. VTE ppx
  4. SRT: meditation

**Cauti**

- Complete the following cauti prevention measures:
  1. HOB 90 degrees
  2. Daily oral care with CHG
  3. VTE ppx
  4. SRT: meditation

---

### Pressure Ulcer Prevention

- Evaluate on admission and each shift:
  1. Two-person skin assessment on admission and transfers
  2. Burden score completed on admission and every other day
  3. Special orthopedic mattresses ordered if criteria met
  4. Nutrition screening completed on admission

- Evaluate each shift:
  1. Two-person skin assessment on admission and transfers
  2. Burden score completed on admission and every other day
  3. Special orthopedic mattresses ordered if criteria met

- Evaluate on admission and each shift:
  1. Two-person skin assessment on admission and transfers
  2. Burden score completed on admission and every other day
  3. Special orthopedic mattresses ordered if criteria met

---

**Note:**

- Use of gfts
- Use of non-sterile gloves
- Use of chlorhexidine
- Use of alcohol
- Use of sterile gloves
- Use of chlorhexidine
- Use of alcohol
- Use of sterile gloves
- Use of chlorhexidine
- Use of alcohol
- Use of sterile gloves
DPM “HUDDLE BOARD”

• Where did we find the data?
  – Front-line colleagues (i.e., nurse, pharmacist, respiratory therapist)
    • Evidenced-based activities that they are already doing

• How did we share data following the improvement?
  – Front-line colleagues shared it with each other each shift (interdisciplinary)
  – Front-line colleagues briefed managers daily and prn
  – Managers reported fallouts (prn) at daily “Operations Huddle”
    • Daily leadership meeting to discuss quality, patient safety and value across the organization
QUALITATIVE DATA

• Transparency
  – “I don’t want my patients and their families to see that we had a fall yesterday and think we don’t take good care of our patients.”
    ~ Sarah, Charge Nurse

• Improved Communication & Accountability
  – “The colleagues feel that they are adequately informed about the selected leading measures. I noticed that they have a vested interest in keeping the numbers stable and within ranges, which all staff can be proud of.” ~ Jamie, Nurse Manager

• Colleague Engagement
  – “It gives nurses a sense of ownership and motivation to deliver patient-centered care.” ~ Heather, Clinical Excellence Specialist
ADVICE FOR OTHERS

• Department managers must support the process and demonstrate the importance of DPM
• Front-line colleagues must own the “DPM huddle” process every shift
  – Charge nurse, nurse, administrative assistant or physician
• Pilot in one department first, then employ a “front-line leader” to assist in spread
  – Peer-to-peer coaching was a success in the spread of DPM
• Outcomes data must be communicated back to the front-line colleagues
  – How did this approach (DPM) reduce harms?
• Celebrate the wins!
  – No matter how small (e.g., days since last fall, decreasing SCD refusal, HOUDINI compliance)
  – Saint Francis modeled recognition after Memorial Hermann’s program
NEXT STEPS

• What is Saint Francis Healthcare System planning next?
  
  – Complete the spread of DPM to:
    • Ancillary departments
    • Non-clinical departments
    • Ambulatory care
  
  – Leverage current EHR to create electronic “huddle boards”
    • Streamline electronic documentation to complete DPM measures
QUESTIONS

• What questions do you have about Daily Performance Management (DPM)?

• In what ways can DPM help your organization?

• How can the Saint Francis Medical Center improvement journey benefit your patients?

• What other questions might you have?
CONTACTS

• Stephanie La Pierre, MBA, BSN, RN, CPHQ, CSSBB (ASQ)  
  Chief Performance Improvement Officer  
  slapierre@sfmc.net

• Leigh-Ann White, MSN, RN, CPHQ, CSSBB (ASQ)  
  Lead Performance Improvement Specialist  
  lwhite@sfmc.net
THANK YOU!

Find more information on our website: www.hret-hen.org

Questions/Comments: hen@aha.org