Southern California Patient Safety Collaborative

The Southern California Patient Safety Collaborative (SCPSC) - founded by the Hospital Association of Southern California (HASC) and the National Health Foundation (NHF) - began in November 2007 with funding from UniHealth Foundation and Blue Shield Foundation of California to help hospitals improve quality and patient safety by adopting evidence-based standards and protocols and by sharing successful implementation strategies in a peer-to peer collaborative learning environment. The SCPSC initially addressed hospital-acquired infections by focusing clinical programming and networking through SCIP, VAP, CLBSI, sepsis and medication safety. HASC engaged another partner in this collaborative effort in 2008 when the Health Services Advisory Group (HSAG) was given the contract from CMS as the QIO for California. HSAG contributed to the funding of the SCPSC and provided clinical expertise for SCIP and the topics of addressing MRSA and Pressure Ulcers were added. When the initial foundation funding ended in 2009, HASC and HSAG continued the SCPSC and began a search for continued funding.

Results for this initial work were good with 680 saved lives in sepsis between January 2007 and September 2009. For the five SCIP infection measures, 87 hospitals participating from Q1 2009 to Q2 2010 improved from 87.9% to 99.6%. For the two VTE measures in the same period, the compliance for these hospitals improved from 87% to 92%.

In 2010, through a partnership of the three California Regional Hospital Associations and NHF, funding was received from Anthem Blue Cross, to join in a three-year, $6 million effort to improve the quality and consistency of care for California patients. This new effort, called *Patient Safety First… a California Partnership for Health* was formulated to build upon established peer-to-peer learning networks like BEACON (The Bay Area Patient Safety Collaborative) and SCPSC. The three initial areas of focus elected by the collaborative are:

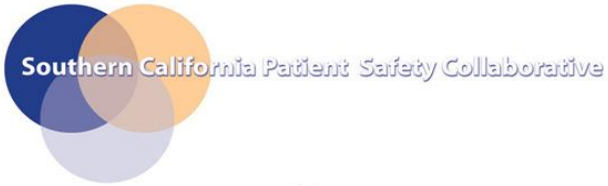
Perinatal Care:	Reduction of elective deliveries prior to thirty-nine weeks
Sepsis:	Reduction of incidence and morbidity
Hospital Acquired Infections in the ICU Setting:	Reduction of incidence of VAP and CLBSI

The addition of a focus on perinatal care compliments the work of the March of Dimes, particularly in the area of early elective deliveries, prematurity of the neonate, and teaching women why the last weeks of pregnancy can be critical to the health of the mother and baby.

This new funding source allowed the SCPSC to continue its partnership with HSAG and expand into three tracks of work, each involving managers and clinicians from different areas of the hospital. The SCPSC provides in-person meetings and webinars for each of the following Tracks:

Track I:	Hospital-acquired infections, sepsis, and SCIP
Track II:	Facility-acquired pressure ulcers (a partnership with hospitals, nursing homes, and long-term care), readmissions, and transitions of Care
Track III:	Perinatal Safety: focusing on birth trauma and non-medically necessary deliveries prior to 39 weeks gestation

In 2011 hospital participation in SCPSC has increased to 100, exceeding the original goal of 80. In 2010, the SCPSC held ten meetings and nine webinars with 1,757 attendees. Fourth quarter efforts have focused on encouraging hospitals to enter data on the SCPSC measures.



At the core of SCPSC is the collaborative learning model. This focuses on a technical area and seeks to spread existing knowledge or best practices related to that topic to multiple settings through systematic improvement efforts of teams. It is time-limited and emphasizes the exchange of insights and support among a set of providers. Hospitals involved in *Patient Safety First* and the SCPSC are engaged in regional quarterly in-person meetings, webinars and conference calls where they are exposed to experts in the field and peers that share strategies and methods for improvement. Hospitals are encouraged to "steal shamelessly" and work in teams within their institutions to implement improvement efforts.

Evaluation is a cornerstone of SCPSC and *Patient Safety First.* The collaborative has a dedicated web-based data collection and reporting system. All participating hospitals agree to enter data quarterly. Benchmarks have been established to enable the success of the program in monitoring and reporting on lives saved, quality outcomes and cost reductions from of the work of the partnership.

After its first year, *Patient Safety First* demonstrated positive outcomes in reducing rates of hospital acquired infections and sepsis mortality.

Within the Southern California region, numerous hospitals have reported one or more quarters of zero rates of VAP and CAUTI. Some strides in sepsis have also been made as the average rate of mortality has been reduced from 24% to 18% in Southern California.

Southern California Patient Safety Collaborative (2007-2010)	100	• **2007** - 181 lives saved • VAP – 305 fewer infections • CL/BSI – 328 fewer infections • **2008** – 1st quarter – 17 lives saved • VAP – 38 fewer infections • CL/BSI – 11 fewer infections • 50% of hospitals implementing medication reconciliation improvement practices • 70% of hospitals implementing best practices related to high-risk medications • All hospitals - <1 MRSA blood stream case per 1000 patient days	• In-person meetings with an average of 60 hospitals in attendance • Web-conferences with an average of 30 hospitals in attendance • Web-based data collection system provided by the National Health Foundation • Site visits to hospitals to provide consultation to catalyze improvement and assist hospitals in integrating safety interventions within their system • Practical Skills of Quality Improvement classes offered to hospitals

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