Achieving High Reliability Through Comprehensive Event Reporting

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Q&A

- Submit questions anytime via the Q&A box
- Questions answered verbally during Q&A at the end

Speakers

Morgan Beschle
Director, Product Management
Quantros

Lynn Schuster
Senior Director, Risk Management
Ascension Care Management

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About Quantros

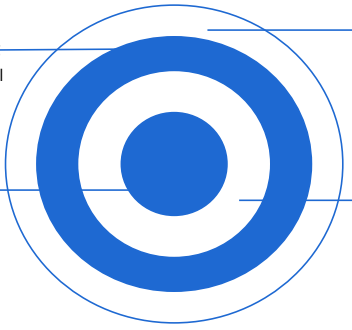
Comprehensive Approach to Improving Outcomes

Best-in Class Benchmarking

- Hospital and physician level
- Financial and clinical variables
- Internal and external comparisons

Comprehensive Data

- National databases
- State databases
- Hospital claims and real-time data



Intelligent Analytics

- Executive scorecards
- Interactive dashboards
- Physician- and DRG-level analysis

Multi-dimensional models

- Peer-reviewed risk adjustment methodology
- Composite quality scoring
- Advanced statistical significant testing

Our Unique Experience

20+ years in healthcare	**Over 800 Hospital and Health System clients**	**24M+ annual discharges represented**	**Average client length 7+ years**

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About Quantros

Supporting Healthcare to Deliver the Best Care

SAFETY AND RISK

Our robust Safety Risk Management System provides a holistic view of safety performance, patient satisfaction and staff engagement. The solution includes:

- Comprehensive safety incident reporting, tracking and management
- Robust peer review process support
- All-inclusive capture and management of patient complaints/grievances
- Complete picture of claims and pending lawsuits
- Ability to capture and assess disruptive employee behavior
- Secure management and reporting of PSO requirements

QUALITY AND OUTCOMES

Our best-in-class outcomes solution saves time and enhances the effectiveness of staff around identifying and solving cost and quality variances. The solution includes:

- Comparison of quality and cost performance to other peer physicians and other comparable hospitals
- Identification of areas of most profitable, high quality, low cost care
- Isolation of outsized cost and low quality drivers at hospital, physician and DRG level
- Measurement of physician utilization performance across all care settings

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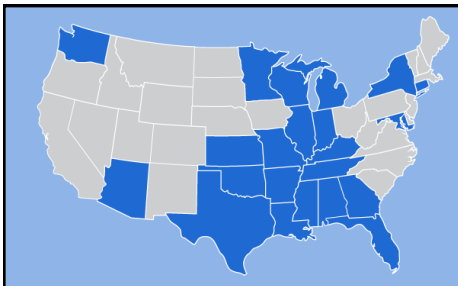

Ascension is the largest Catholic healthcare organization in the country, with over 165,000 associates and 34,000 aligned providers working as one to connect care and deliver solutions to individuals and communities in 22 states and the District of Columbia.

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About Ascension

Ascension is a faith-based healthcare organization that delivers personalized, compassionate care to all, especially to those who are poor and vulnerable.

- In FY17, Ascension provided over $1.8 billion for care of persons living in poverty and community benefit.
- Our Mission-driven work is carried out through a number of subsidiaries dedicated to providing healthcare services, delivery and solutions to support personalized care.

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About Ascension

The core of all we do

Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable.

Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities.

We are advocates for a compassionate and just society through our actions and our words.

Vision

We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare.

We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle.

We will expand the role of the laity, in both leadership and sponsorship, to ensure a Catholic health ministry of the future.

Values

Service of the Poor
Generosity of spirit, especially for persons most in need

Reverence
Respect and compassion for the dignity and diversity of life

Integrity
Inspiring trust through personal leadership

Wisdom
Integrating excellence and stewardship

Creativity
Courageous innovation

Dedication
Affirming the hope and joy of our ministry

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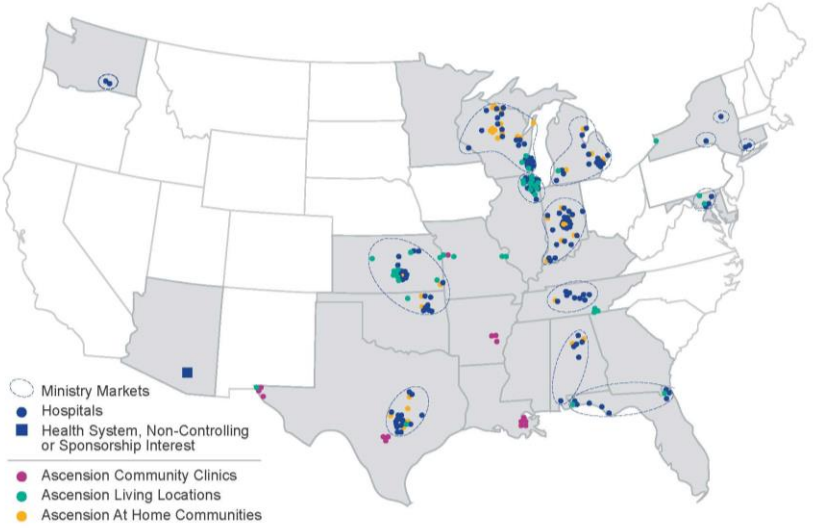
About Ascension

Care delivery map



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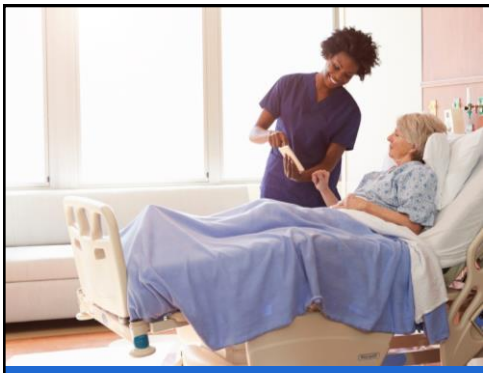

Together we enable all associates and care providers to report near misses, serious safety events, and patient compliments and complaints in a consistent manner. Regular and consistent event reporting along with learning from every event encourages the development of a just culture and permits vital progress on the high-reliability journey.

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Objectives

- Examine the Principles of a High Reliability Organization
- Describe how the Event Reporting System supports a culture of safety
- Improve clinical process reliability and maintain a Just Culture

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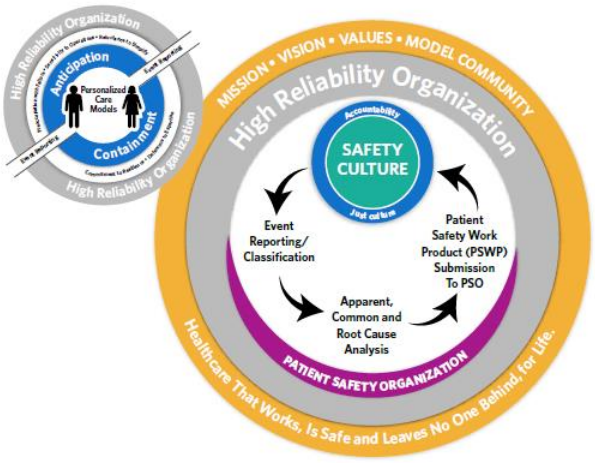
Learn From Every Event

The Ascension Way: Learning from Every Event



ERS – Everyone is Responsible for Safety

- Aggregate and share data for immediate opportunity
- Foster a Just Culture and support a High Reliability Organization
- Identify error-prone processes at the unit/department level
- Be accessible to users across the continuum of care

Journey to High Reliability

Deployment History

Feb 2015

Go Live with Pilot

2,623

To Date: Total Number of Facilities Deployed

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- Pilot: 3 hospital systems in 3 states
- 152 physical locations: inpatient, outpatient, long-term care, physician offices
- 6 deployment waves 2015-2017
- Today:
  - 28 local health systems deployed
  - 139 acute care facilities
  - 27 behavioral health facilities
  - 74 long-term care facilities
  - 1459 physician offices

Five Principles of High Reliability

The three principles of anticipation **Continuously anticipating where an error can occur and creating processes and building barriers to prevent errors from occurring**	
1. Preoccupation with failure	Be alert to what could go wrong. To avoid failure, we must openly recognize, report and track weak signals of failure or near misses. We must consider these situations as opportunities to learn and prevent harm.
2. Reluctance to simplify	Avoid oversimplifying. Simplified processes are desired, NOT a simplified understanding of processes. We must have awareness that our environment is complex and acknowledge that we should consider the full range of opportunities to prevent errors.
3. Sensitivity to operations	Be attuned to the front-line work and mindful of the complexity of the systems in which providers and associates work. Recognize that we work in complex environments with frequent change; therefore, situational awareness is critical to provide safe and reliable care.
The two principles of containment **The ability of an organization to react rapidly to an error, to minimize the impact of that error and to return to normal operations in the shortest possible time**	
4. Commitment to resilience	Resilience is the capability to maintain structure and function after an unexpected event has occurred. In other words, contain and bounce back from errors.
5. Deference to expertise	Highly reliable organizations de-emphasize hierarchy to allow the individual(s) with the appropriate knowledge relevant to an issue or concern to be included in the decision-making process. This includes deferring to the individuals doing the actual work because they have the expertise.

Principle 1 Preoccupation with Failure

Reporting all safety events and near misses demonstrates the first principle of a High Reliability Organization

Ascension National Risk Management Goal: Improve near miss reporting by 5%

- ✓ Measure monthly progress toward the goal
- ✓ Emphasize importance of reporting near miss events
- ✓ Consider these situations as opportunities to learn and prevent harm

Preoccupation with Failure

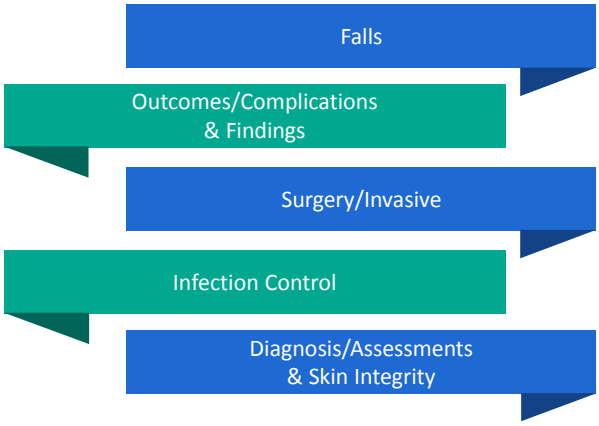
Improving Near Miss Reporting

FY19 SYSTEM RISK MANAGEMENT GOALS:

- Increase near miss reporting by 5%
- Create system-wide near miss education program
- Utilize the ERS to incentivize near miss reporting

One System's Story

Most Reported Events



Continuing Our Journey:

Using the ERS to Learn from Every Event

Unexpected Finding

Emergency Department in one hospital was the department with highest number of falls with injury.

Next Steps

Review all fall events in Emergency Department during time frame. Evaluate fall risk assessment in the Emergency Department and implement a post-fall huddle in the Emergency Department.

Not Actual Data – Used for Illustration Purposes Only

Click to go to:
- ▶ Top 5 Events
- ▶ Top 5 Events Detail
- ▶ Fall Information
- ▶ Medication Information
- ▶ Skin Integrity Information

Health Ministry: All
Facility Type: All
Facility: All
Department: All

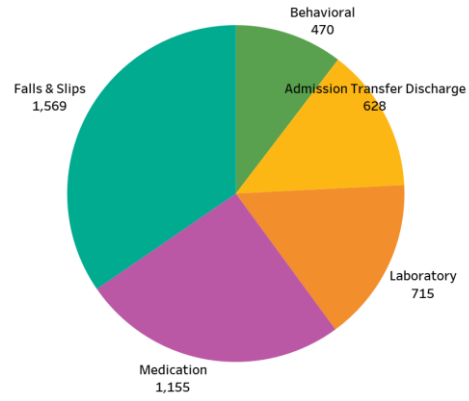
Final Severity
- [ ] -
- [x] A - No Harm
- [x] B - No Harm
- [x] C - No Harm
- [x] D - No Harm
- [x] E - Mild
- [x] F - Moderate
- [x] G - Severe
- [x] I - Death
- [ ] Not Applicable
- [ ] Unknown
- [x] X - Death

Top 5 Event Types
(Reported in the last 12 months)

---Data pulled as of 7/1/2018 for the period of 5/1/2018 through 6/30/2018---

*Not Actual Data

Multiple Health Ministries
Multiple Facilities
Multiple Departments



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Details of Top 5 Event Types
(Reported in the last 12 months)

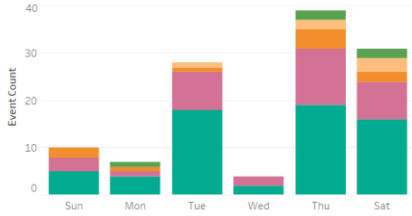
---Data pulled as of 7/1/2018 for the period of 5/1/2018 through 6/30/2018---

*Not Actual Data

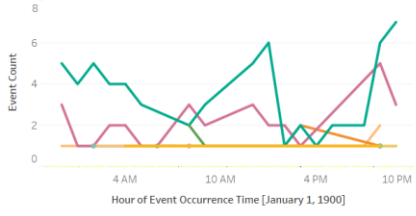
Multiple Health Ministries
Multiple Facilities
Multiple Departments

Falls & Slips	Outcomes, Complications & Findings	Skin Integrity	Surgery & Invasive Procedures	Behavioral
64	34	10	6	5

Count of Events by Day of the Week



Count of Events by Time of Day



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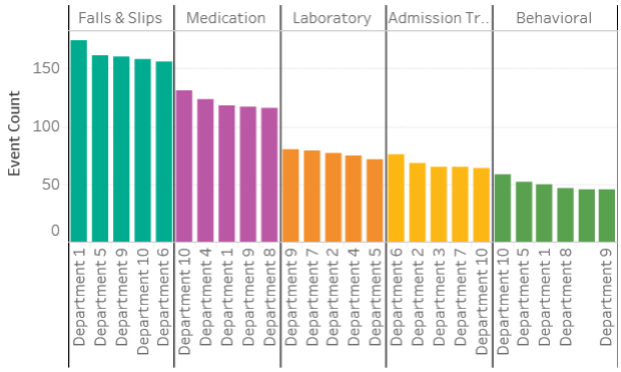
Top 5 Departments



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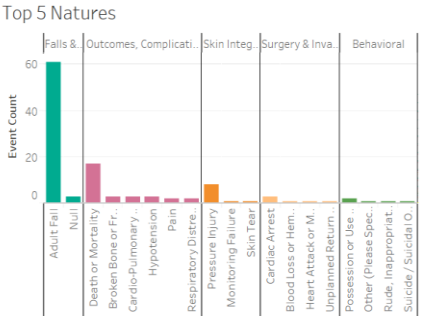
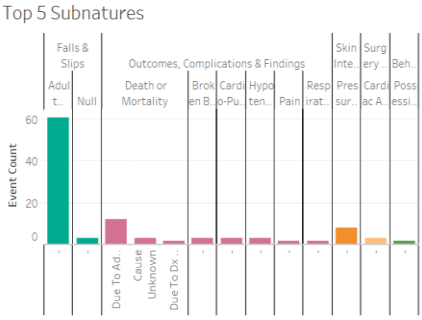
Top 5 Natures



Top 5 Subnatures



Principle 4 Commitment to Resilience

Identify Issues and Innovate Solutions within a Dynamic Environment

Scaling Product Safety Issue Identification

System-wide process for escalation

Identify issues and innovate solutions within dynamic environment

System-wide Response

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Scaling Product Safety Issue Identification

How Did We Address "Patient Safety Issues Team"

1. 7 a.m. huddle twice per week to address any new product safety alerts/recalls and recommended consistent national response
2. National Risk, Care Excellence, Supply Chain, Pharmacy, Infection Prevention, Communications and PSO Members
3. High Reliability in response to recall, communication to patients

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> I know that I responded appropriately to prevent further harm in my facility, but the immediate response I received from the System Office and how my call may have prevented harm to patients across the country is the most rewarding feeling. One person really can make a difference.

Quote from
Director Risk Management

Principle 1	**Preoccupation with Failure**
Principle 2	**Reluctance to Simplify**
Principle 5	**Deference to Expertise**

Obstetrical Hemorrhage

Problem	Action Taken
Increase in obstetrical hemorrhage	• ERS data reviewed • Task force created • Recommendations to improve clinical process reliability

Principle 1	**Preoccupation with Failure**
Principle 2	**Reluctance to Simplify**
Principle 5	**Deference to Expertise**

Task Force Finding and Recommendation for Reporting Events

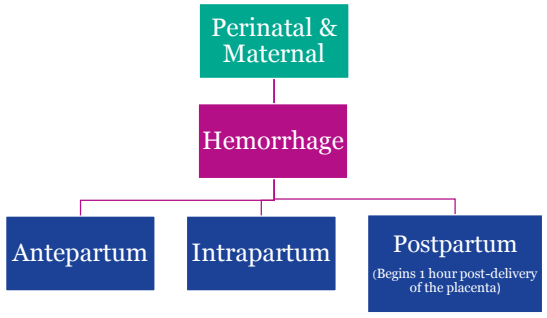
Obstetrical hemorrhage events found within multiple event types

- Perinatal/Maternal
- Surgical Complications
- Outcomes, Complications & Findings

Standardized process for reporting obstetrical hemorrhage events

Recommendation: Event reporting in ERS

1. Cumulative blood Loss greater than or equal to 500mL for vaginal birth or greater than or equal to 1000mL for Cesarean birth
2. If cumulative blood loss does not exceed the above thresholds, yet intervention (medical or surgical) is required to prevent hemorrhage, it should be reported in ERS



Continuing Our Journey:

Using the ERS to Learn from Every Event

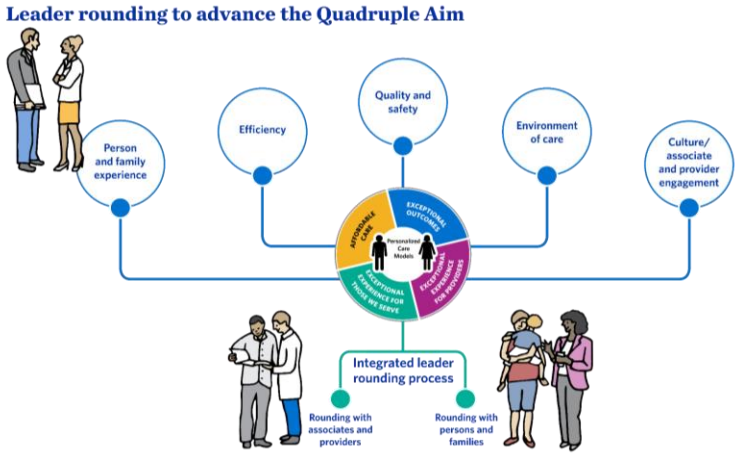
[Risk Management Monthly Educational Calls]

Obstetrical Hemorrhage Taskforce Recommendations presented at RM monthly education call

Encouraged risk leaders to bring forward issues/concerns that can be reviewed on a national level

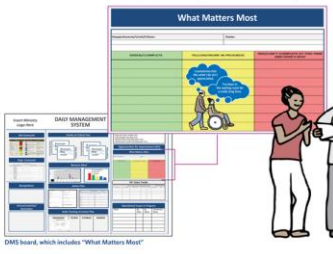
Supports a Just Culture and High Reliability

Address Learnings in Leader Rounding

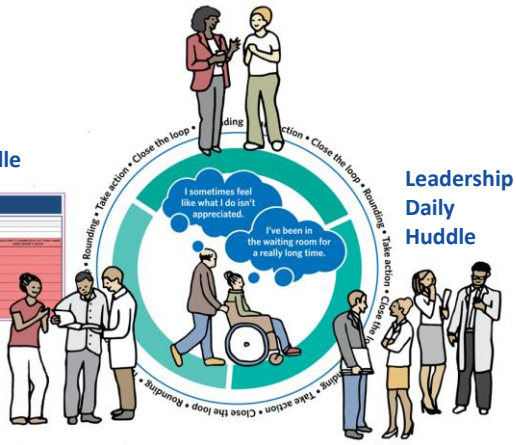


Taking Action on What Matters Most

Departmental Daily Huddle



Leadership Daily Huddle



Principle 1 **Preoccupation with Failure**

Principle 2 **Reluctance to Simplify**

Learn from Every Event

Serious Safety Event Review Team (SERT)

- Standardized process for reviewing serious safety events
- Standard interdisciplinary membership – risk, quality, physician and nursing leaders
- Determination of final severity
- Weekly meeting cadence
- Determines if the event is preventable and if a deviation from generally-accepted practices or processes occurred
- Ensures that a root cause analysis (RCA) is completed

Establishing Standard Processes for Reviewing Serious Safety Events

Leadership Safety Notifications

1. Daily Harm Report
   - Contains a listing of all patient events reported the previous day with chosen event severity (Recommend G, H & I events)
   - Automatically generated and emailed by the Event Reporting System (ERS) to individuals subscribed to receive the report

2. Monthly Serious Safety Event Report
   - Report is compiled monthly by the Ascension Healthcare Patient Safety Organization (AHPSO) for its Affiliated Providers
   - Severe harm and death event findings and recommendations provided by the Chief Quality Officers
   - Finalized report is emailed to each Affiliated Provider's PSO Liaison

Formation of Ascension National ERS Steering Committee

Jan 2018-Deployment to Data Mining to Partnership Maturity

Purpose

Oversee development and monitoring of all standard processes and enhancements to ERS

Objectives

- Develop and implement new governance structure for management of ERS
- Members: Risk, Care Excellence, PSO, Ascension Technologies, Patient Experience, Project Management, Data Analytics
- Collaborate with ERS vendor Quantros on system enhancements and updates. Steering Committee reviews all user enhancement requests prior to submission to Quantros.
- Identify and govern dissemination of data contained within ERS.
- Identify data mining improvements
- Collaborate with Ascension Technologies on technical support needs impacting functionality and system contents

Partnership: Defining Road Map for Shared Future Success

Changes Requested:

- Restructuring of Smart Classification Taxonomy to optimize Event Categorization for Outcomes, Complications and Findings
- Ministry Risk and Quality ERS super users participated in development
- Very positive feedback from super users regarding Ascension and Quantros recognition of their expertise

High Reliability Principle #3 "Sensitivity to Operations"

- Front line best positioned to recognize failure and identify improvement opportunities

Principle 2 Reluctance to Simplify

Next Steps in Our Journey

"Accept and Embrace Complexity and Conduct Root Cause Analysis and Reject Simple Diagnoses"

Development of a new standardized root cause analysis tool

↓

Tracks and trends common root causes & tracks action plans related to SSEs

↓

Commitment from Quantros to enhance the RCA Module in ERS to support data mining on causes and contributory factors and print and monitor action plans

↓

This wealth of RCA data can be used for improvement in all care settings

Next Steps in Our Journey and Our Partnership with Quantros

Clinical Process Reliability Improvement will:

- Improve healthcare quality
- Improve clinical outcomes
- Improve patient safety

Pivotal activities include:

- Continued use of ERS to identify trends & common cause
- Ongoing Quantros taxonomy updates based on industry and clinical standards, as well as user feedback
- Continued input from super users through sessions with Quantros

Next Steps in Our Journey and Our Partnership

Just Culture

- Without Just Culture, data is just data
- Garner input from associates to improve culture in support of those who make and report errors
- In partnership with Quantros, we continually improve upon our ability to mine data
- We have a responsibility to continually foster data-drive culture to reduce serious safety events and improve patient care

Next Steps in Our Journey and Our Partnership

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Quantros in Brief

SAFETY AND RISK

- ✓ **Safety Event Manager** – Report, track, monitor and manage safety events and near misses
- ✓ **Feedback Manager** – Gather and process compliments, complaints and grievances
- ✓ **Disruptive Event Manager** – Manage employee behavioral issues
- ✓ **Claims Manager** – Manage potentially compensable events, realized claims and pending lawsuits
- ✓ **Patient Safety Organization Manager** – Aggregate, segregate and report data to a designated Patient Safety Organization (PSO)

QUALITY AND OUTCOMES

- ✓ **Outcomes Analytics** – Comparison to external norms and benchmarks allowing the identification of both performance improvement opportunities and areas of competitive advantage
- ✓ **CareTracks** – Incorporate hospital claim data to not only allow for more real-time comparison and opportunity identification. Isolate additional drivers of variance at DRG and case level
- ✓ **CareChex**– Nationally recognized hospital annual quality awards across 38 clinical categories of medical and surgical services

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Thank You!
Questions?