Quality & Patient Safety Overview

For Leaders Transitioning from Ascension

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ASPIRUS™
Passion for excellence.
Compassion for people.

Aspirus Quality Transformation

Metrics and Reporting

Where We Have Been

- Centers for Medicare & Medicaid Services measures only
- Process focus
- 3 – 4-month lag
- Quarterly monitoring and reporting
- Reactive response
- Decentralized and mal-aligned resources

Transition

- Established internal "proxy" measures
- Outcome focus
- Near real time
- Monthly monitoring and reporting
- Proactive response
- "System" quality alignment

Transition

- Broader quality performance domains
- Outcome/process focus "lag/lead"
- Near real time electronic health record leverage
- Monthly, weekly, daily reporting
- Visual management
- Goal-metric cascade

Quality Measures

Why are Quality Measures Important?

- Outpatient Measure: "Advance Care Planning"
- Inpatient Measure: "Decrease house wide readmissions"
- Post Acute Care Measure: "Hospice Visits in the Last Days of Life"

Diligently Managing Our Business

Process Improvement

We must use Process Improvement throughout this model to stabilize, hardwire and achieve success

ADVANCE!

Fix and Hardwire

Identify true root cause(s), create highly reliable solutions

Monitor Performance

Track performance and closely monitor early warning signs

Set Goals

Set measurable goals linked to our most important work

Clinical Risk Management & Patient Safety

A Culture of High Reliability

High Reliability Definition:

"We do no harm to our patients by consistently adhering to the highest quality practices."

Vision:

We will advance the culture of high reliability by creating an environment that:

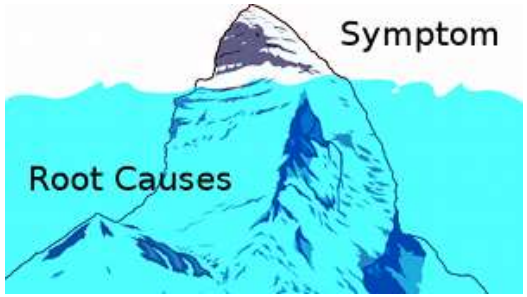
- encourages reporting of safety concerns & good catches
- is based in learning; safety concerns & good catches are rigorously reviewed for opportunities to improve
- acts to continuously improve processes that support patient care & experience
- enhances communication with our teams to share actions taken to improve safety

Promoting Reporting & Review of Events

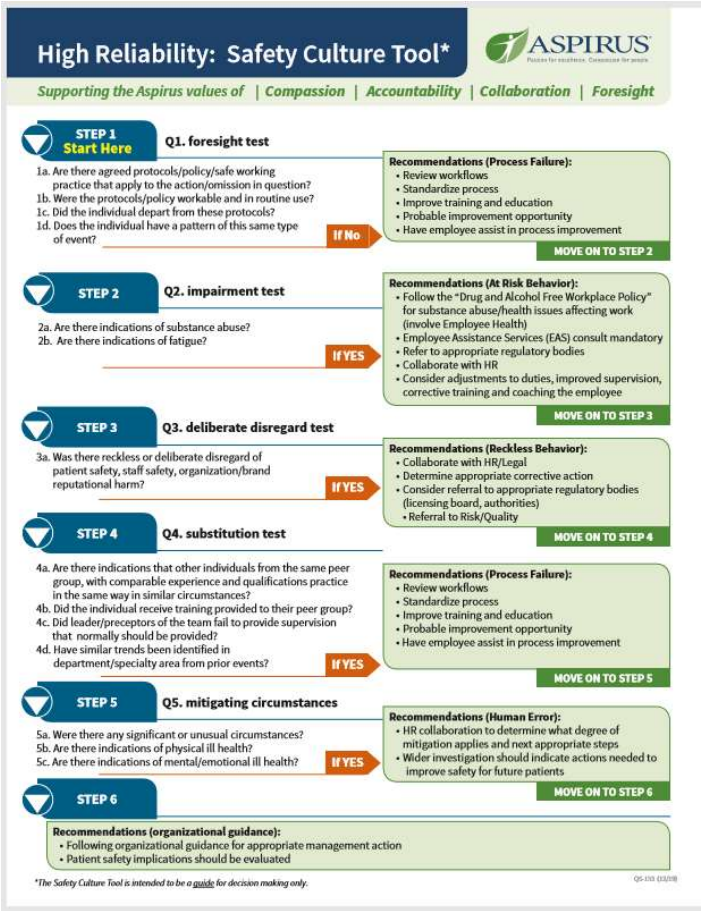
- High Reliability means:
  - Promoting reporting of Good Catches/Near Misses and unexpected adverse events into SafetyZone
    - Leaders will receive SafetyZone training to learn how to enter events into SafetyZone; review events, follow-up on events and close events
  - Improving and Learning from unexpected events by:
    - Applying the Safety Culture Tool algorithm
    - Collaborating with key stakeholders in review of events
    - Conducting thorough and credible investigations for serious patient safety events
    - Sharing learning with others, and
    - Spreading improvements to improve patient safety and quality of care

Promoting Improvement & Learning

- Highly reliable processes include:
  - Involving staff in improving clinical outcomes and patient safety through:
    - Root cause analysis (RCA2)
    - Critical incident review (CIR)
    - Failure Mode & Effect Analysis (FMEA)
    - A3
    - Organize & Execute (O & E)
    - Other Continuous Process Improvement (CPI) tools



High Reliability: Safety Culture Tool



High Reliability: Safety Culture Tool*

ASPIRUS

Supporting the Aspirus values of | Compassion | Accountability | Collaboration | Foresight

STEP 1 Start Here — **Q1. foresight test**

1a. Are there agreed protocols/policy/safe working practice that apply to the action/omission in question?
1b. Were the protocols/policy workable and in routine use?
1c. Did the individual depart from these protocols?
1d. Does the individual have a pattern of this same type of event?

If No

Recommendations (Process Failure):
- Review workflows
- Standardize process
- Improve training and education
- Probable improvement opportunity
- Have employee assist in process improvement

MOVE ON TO STEP 2

STEP 2 — **Q2. impairment test**

2a. Are there indications of substance abuse?
2b. Are there indications of fatigue?

If YES

Recommendations (At Risk Behavior):
- Follow the "Drug and Alcohol Free Workplace Policy" for substance abuse/health issues affecting work (involve Employee Health)
- Employee Assistance Services (EAS) consult mandatory
- Refer to appropriate regulatory bodies
- Collaborate with HR
- Consider adjustments to duties, improved supervision, corrective training and coaching the employee

MOVE ON TO STEP 3

STEP 3 — **Q3. deliberate disregard test**

3a. Was there reckless or deliberate disregard of patient safety, staff safety, organization/brand reputational harm?

If YES

Recommendations (Reckless Behavior):
- Collaborate with HR/Legal
- Determine appropriate corrective action
- Consider referral to appropriate regulatory bodies (licensing board, authorities)
- Referral to Risk/Quality

MOVE ON TO STEP 4

STEP 4 — **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications practice in the same way in similar circumstances?
4b. Did the individual receive training provided to their peer group?
4c. Did leader/preceptors of the team fail to provide supervision that normally should be provided?
4d. Have similar trends been identified in department/specialty area from prior events?

If YES

Recommendations (Process Failure):
- Review workflows
- Standardize process
- Improve training and education
- Probable improvement opportunity
- Have employee assist in process improvement

MOVE ON TO STEP 5

STEP 5 — **Q5. mitigating circumstances**

5a. Were there any significant or unusual circumstances?
5b. Are there indications of physical ill health?
5c. Are there indications of mental/emotional ill health?

If YES

Recommendations (Human Error):
- HR collaboration to determine what degree of mitigation applies and next appropriate steps
- Wider investigation should indicate actions needed to improve safety for future patients

MOVE ON TO STEP 6

STEP 6

Recommendations (organizational guidance):
- Following organizational guidance for appropriate management action
- Patient safety implications should be evaluated

**The Safety Culture Tool is intended to be a guide for decision making only.*

Frequently Asked Questions

Question: Can a scenario fit more than one box?

- Possibly yes. For example, you may have a situation where you have an employee who identifies he/she is fatigued, but also a process is broken. In this case, make sure you both support the employee to get the help he/she needs, but also work on improving the process.
- The goal with this algorithm is not to punish, but to help leaders identify process leaders as well as organization or safety risks that need to be escalated or evaluated with additional resources (i.e. Risk, Quality, Compliance, Legal)

Question: How do I work through a situation I've never come across before? Who are my resources/partners?

- It's okay to identify others you see as 'mentors' who may have experience. Some of the best use of this tool has come with a small group discussion to ensure all perspectives are evaluated.
- This tool is intended to be a guide to help evaluate those situations that may not be clear cut or have a direct answer.

Scenarios
Applying the Algorithm

1. During patient rounds, you find one of your patient's crying. When you ask what is wrong, the patient identifies the CNA who came into do her bath that morning yelled at her and said she was 'fat and lazy' because she was moving slowly and in pain. When you speak with the CNA, she confirms she said this and that she is 'sick and tired of taking care of people who won't follow directions".

   Using the **High Reliability: Safety Culture** Tool, which recommendations will you follow?

   a. What additional information would you like to know, if any?

   b. How would additional information impact your evaluation of the situation?

2. An employee (Lisa) is scheduled to work the Monday after the Big Game! Lisa grumbles throughout the week to her colleagues that she can't believe she has to work Monday at 7am. Her request for PTO was denied because she has already exhausted all her PTO due to multiple excused and unexcused absences. If taking Monday off was that important to her, her colleagues encouraged her to find a replacement. She was not successful in finding a replacement.
   Lisa seemed to have a great time at the game. She posted all over social media her experiences. Monday morning, Lisa called in sick to work. One of her colleagues reports to the manager what had occurred the prior week and shared the social media posts.

   Using the **High Reliability: Safety Culture** Tool, which recommendations will you follow?

   a. What additional information would you like to know, if any?

   b. How would additional information impact your evaluation of the situation?

Participation in a Patient Safety Organization (PSO)

- Under a provision of the Affordable Care Act (ACA), PPS hospitals are required to attest annually to their participation in a PSO or a federal or state quality improvement program
- Effective April 1, 2021, Aspirus acute care, clinics, and post-acute care started participating in the Vizient PSO
- Purpose

"To improve patient safety and reduce
medical errors by creating a ''culture of safety''
to share and learn from information
related to patient safety events"
with the confidence of confidentiality

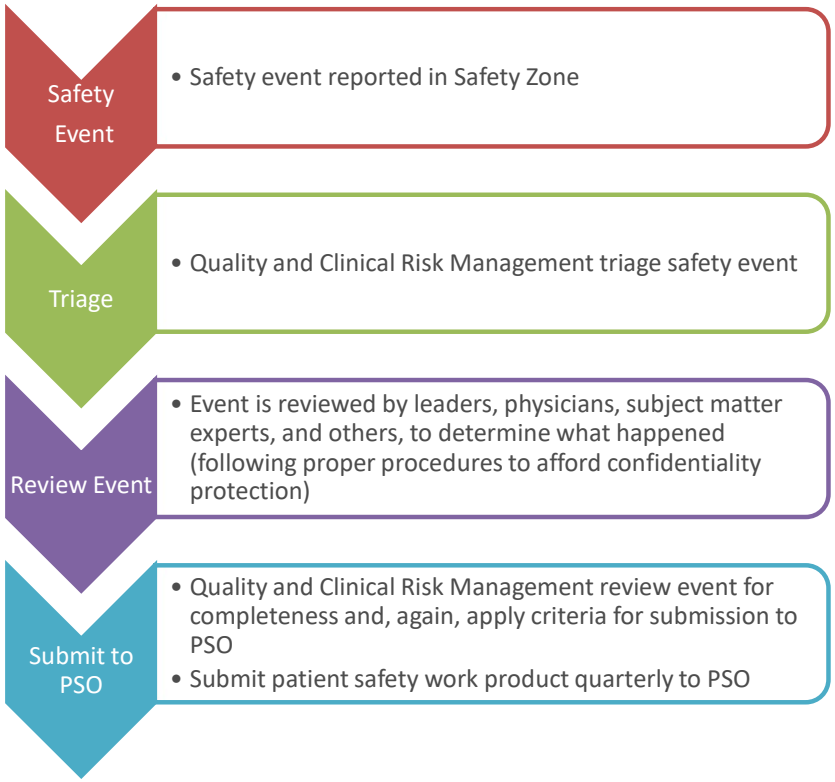
Benefits with the Vizient PSO

Increases member awareness of patterns and trends of common safety issues and rare high harm events and their contributing factors

Serves as an improvement community, accelerates the pace of improvement, including offering evidence-based practices

Provides education and consultative support in Just Culture, high reliability, health system management, lean methodology, transformational change, and communication and resolution certification

Aspirus PSO Process



- Triage Criteria:
  - Patient safety and quality information that could improve safety, quality, or outcomes of health care; and
  - Assembled or developed solely for reporting to PSO (not for other purposes)

Aspirus System Plans

Site Approval

System Performance Improvement (PI), Risk Management, and Patient Safety Plan

Primary goals of the Plan:

- Continuously and systematically improve performance.
- Encourage a culture of patient safety and high reliability of the Aspirus system related to clinical outcomes; care coordination, delivery and service.
- Reduce/prevent the risk of patient harm.

Utilization Review (UR) Plan

The UR Committee is established to:

- Assess and ensure, regardless of payment source, efficient and cost-effective care.
- Delineate the methods for conducting reviews of appropriateness and medical necessity of admission, continued stay, supportive services, and discharge planning.
  - Analyze profiles and patterns of care.
  - Assist in the promotion and maintenance of high-quality care by review of current patterns of utilization, medical necessity of admissions, and prolonged length of stays (outliers).
- Assure continuity of patient care, address over/under utilization and scheduling of resources and provide recommendations for corrective action.

QUESTIONS