MHA
Michigan Health & Hospital Association

Leading Healthcare

MTQIP Quarterly Meeting

Brittany Bogan
Vice President, Patient Safety and Quality
MHA Keystone Center

February 14, 2017

MHA Keystone Center

Vision

Healthcare that is safe, effective, efficient, patient centric, timely and equitable.

Mission

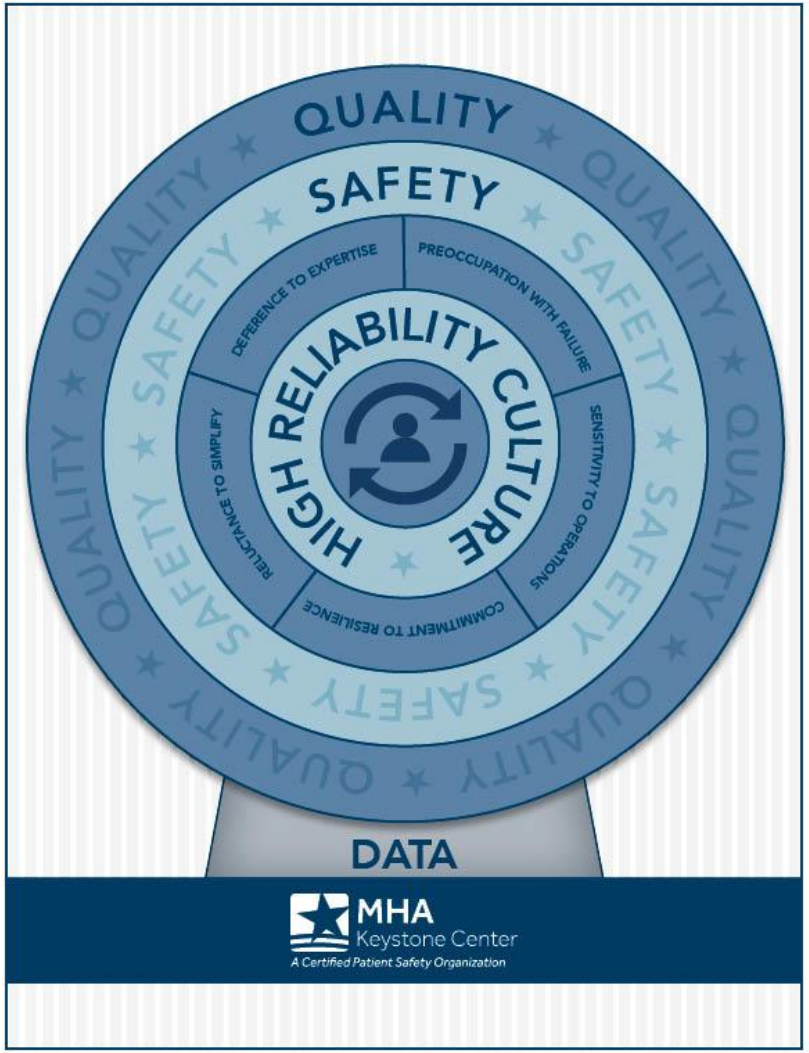
To lead the nation in quality and patient safety through the diffusion of change using patient-centered, evidence-based interventions supported by cultural improvement.

Values

Excellence ● Innovation ● Compassion ● Teamwork

Our Model

- **Why:** Person at the Center – Patients and Healthcare Workers
- **What:** High Reliability Culture is core to work
- **How:** Safety, Quality and Data



Quality Improvement

- MHA-member hospitals have avoided over $100 million in healthcare costs over the past few years due to quality improvement work funded by BCBSM and CMS
- The 12-month “HEN 2.0” initiative included 215 hospitals from Michigan and Illinois that among other accomplishments, achieved:
    - 45.1% reduction in catheter-associated urinary tract infections
    - 28.2% reduction in adverse drug events due to IV opioids
    - 20.2% reduction in early elective deliveries prior to 39 weeks gestation
    - 29.7% reduction in MRSA
- Lessons from MHA Keystone collaboratives have shaped future QI work

Hospital Improvement Innovation Network

- CMS Hospital Improvement Innovation Network (HIIN) contract awarded to the MHA on September 28, 2016
- Two-year federal contract with an optional third year based on performance
- Expanded work to include both Illinois and Wisconsin hospitals in partnership with respective state hospital associations (315 hospitals in total) = *Great Lakes Partners for Patients HIIN*
- New model for improvement will use data to identify hospitals with opportunities for improvement and then provide direct support or Improvement Action Networks (IANs)
- Short-term, focused effort versus historical large-scale collaborative model

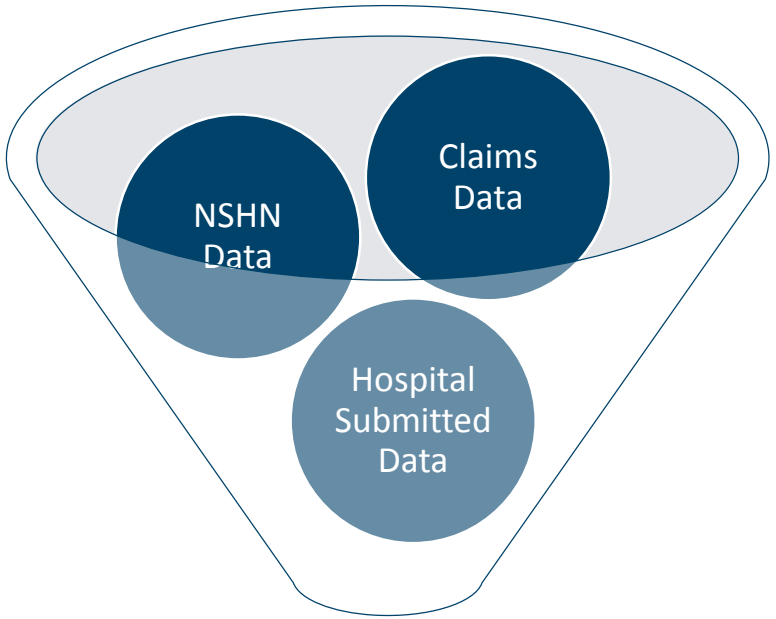
GREAT LAKES
PARTNERS FOR PATIENTS

Illinois | Michigan | Wisconsin
Powered by the MHA Keystone Center

Accelerating Improvement at the Point of Care

Keystone Data System (KDS)

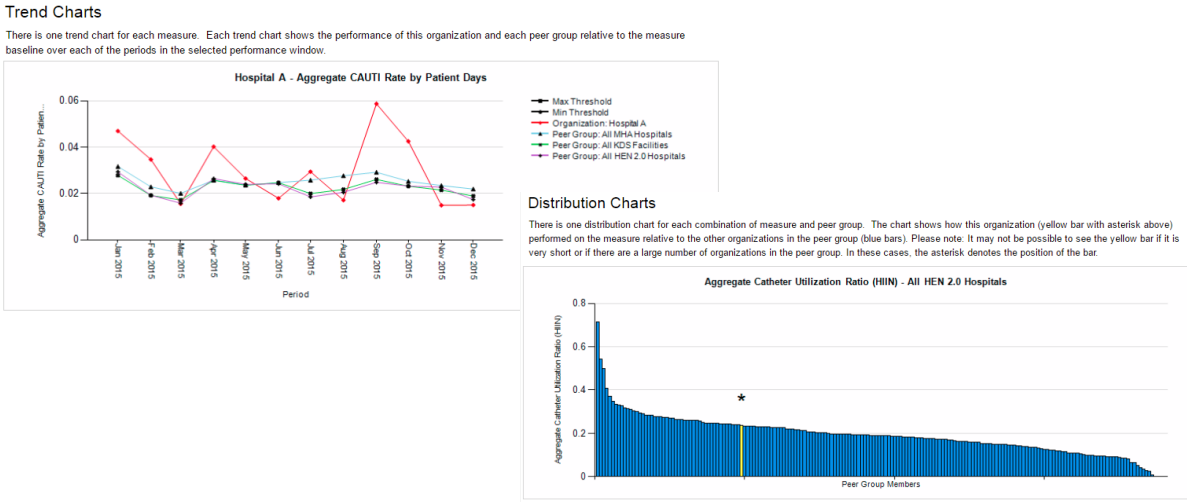
One-stop data repository



MHA Keystone Center
A Certified Patient Safety Organization
Keystone Data System

Performance Reports

Trends & Distribution Graphs
Comparisons to Peer Groups and participating facilities



Data Exports

Raw Data & Aggregate Totals
Allows users to do internal analysis

Safety

- The MHA Keystone Center has been listed as a certified Patient Safety Organization by the Agency for Healthcare Research and Quality since 2009.
- Michigan hospitals voluntarily report patient safety events for analysis and translation into actionable cultural and safety improvements.
- As a PSO, the MHA Keystone Center offers opportunities for hospital peers to learn about serious event trends, exchange patient safety experiences, discuss best practices, and learn in an open, uninhibited and legally protected environment.

Root Cause Analysis and Action (RCA^2)

- Across 2017, training on the National Patient Safety Foundation's RCA^2 process will be provided to MHA Keystone PSO members
  - Train-the-trainer sessions
  - Expert root-cause analysis review and feedback
  - Root cause analysis domain in adverse event portal

Safe & Reliable Healthcare's SCORE

A biennial integrated culture and employee engagement survey administration, the SCORE survey integrates safety culture, local leadership, learning systems, resilience/burnout and work-life balance.

- Survey offered to PSO member organizations twice per year, every other year
- 29 hospitals have committed to administering the SCORE in the Spring 2017 administration
- Starting with the Fall 2017 administration, hospitals will have the option of using the SCORE survey or the AHRQ Hospital Survey on Patient Safety (HSOPS)

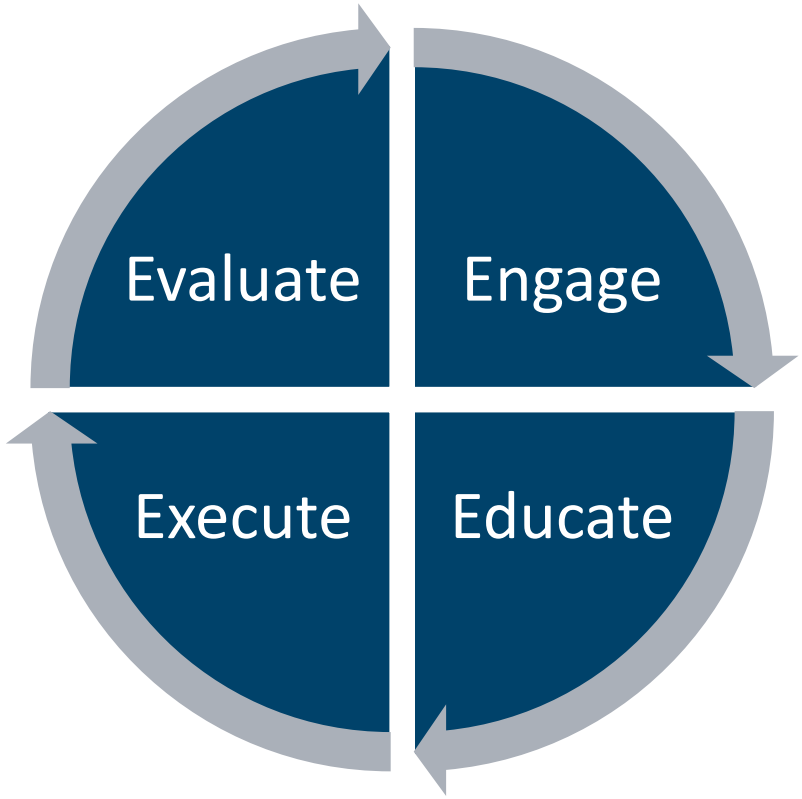
Speak Up! Award

- Quarterly award presented to staff from PSO-member organizations
- Engage staff, recognize and reward patient safety efforts
- Annual award winner to be recognized at 2017 MHA Patient Safety & Quality Symposium

High Reliability Culture

Principles of High Reliability Organizations (HROs):

- Deference to expertise
- Preoccupation with failure
- Sensitivity to operations
- Reluctance to simplify
- Commitment to resilience



Chassin & Loeb. The Milbank Quarterly, Vol. 91, No. 3, 2013 (pp. 459–490).

Pronovost, P., Berenholtz, S., Goeschel, C., Needham, D., Sexton, J.B., Thompson, D., . . . Hunt, E. Creating High *Reliability in Health Care Organizations. Health Serv Res. 2006 August; 41(4 Pt 2):* 15991617.

High Reliability Model

Joint Commission Center for Transforming Healthcare

Leadership Commitment

- Board
- CEO/Management
- Physicians
- Quality Strategy
- Quality Measures
- Safe Adoption of IT

Adoption of Safety Culture

- Trust
- Accountability
- Identifying Unsafe Conditions
- Strengthening Systems
- Assessment

Performance Improvement

- Methods
- Training
- Spread

Stages of Maturity: Beginning → Developing → Advancing → Approaching

High Reliability - Tier 1

- Partnered with The Joint Commission Center for Transforming Healthcare
- All MHA-member hospitals invited to participate
- Focus on education and sharing of principles and practices to move from low to high reliability
- Executive leadership (CEO) buy-in is critical to success
- Step 1: Administer baseline Oro 2.0 assessment
  - 90 percent of Michigan hospitals have completed this step
  - Across 2017, focus on assisting hospitals in the execution of HRO action plans

High Reliability Assessment

Baseline Oro 2.0

- The executive team, leadership, board members (suggested)
  - CEO
  - CMO, CNO, CQO
  - VPs/Directors of Quality, PI, Risk Manager, Patient Safety Office
  - Others to consider or for specific topics: Board member, COO, CFO
- Provides information about strengths, opportunities, and potential investment strategies for achieving performance
- Self-Assessment (49 questions with Branching Logic)
  - Followed by a consensus meeting, where senior leaders meet and take assessment as a group – alignment is critical

ORO™ 2.0
High Reliability Organizational Assessment and Resources

High Reliability

Tier 1

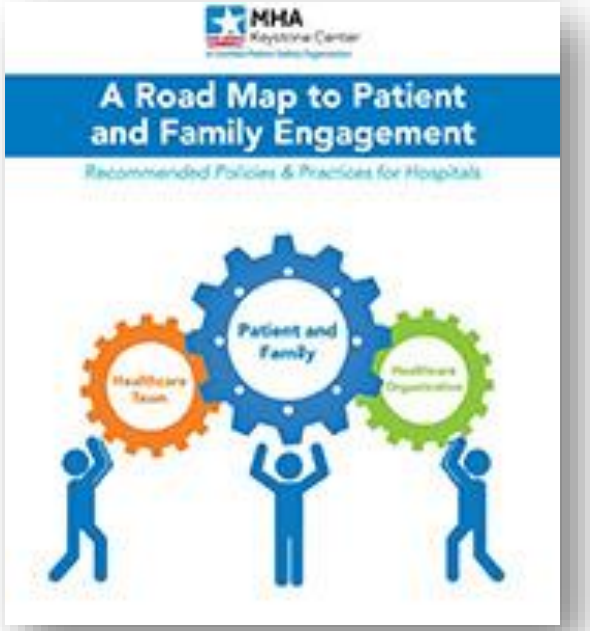
- Linked to HIIN and BCBSM P4P Initiatives – all MHA-member hospitals
- Focus on education and sharing of principles and practices to move from Low to High Reliability
- Oro 2.0 assessment process
  - Assessment
  - Consensus
  - Action Planning
- Educational Webinars with the experts
- Coaching Webinars began in June 2016, across three topic areas:
  - Safety culture
  - Leadership
  - Performance improvement
- In-person Workshop to be held May 24
- Repeat Oro 2.0 reassessment in 18 - 24 months

Tier 2

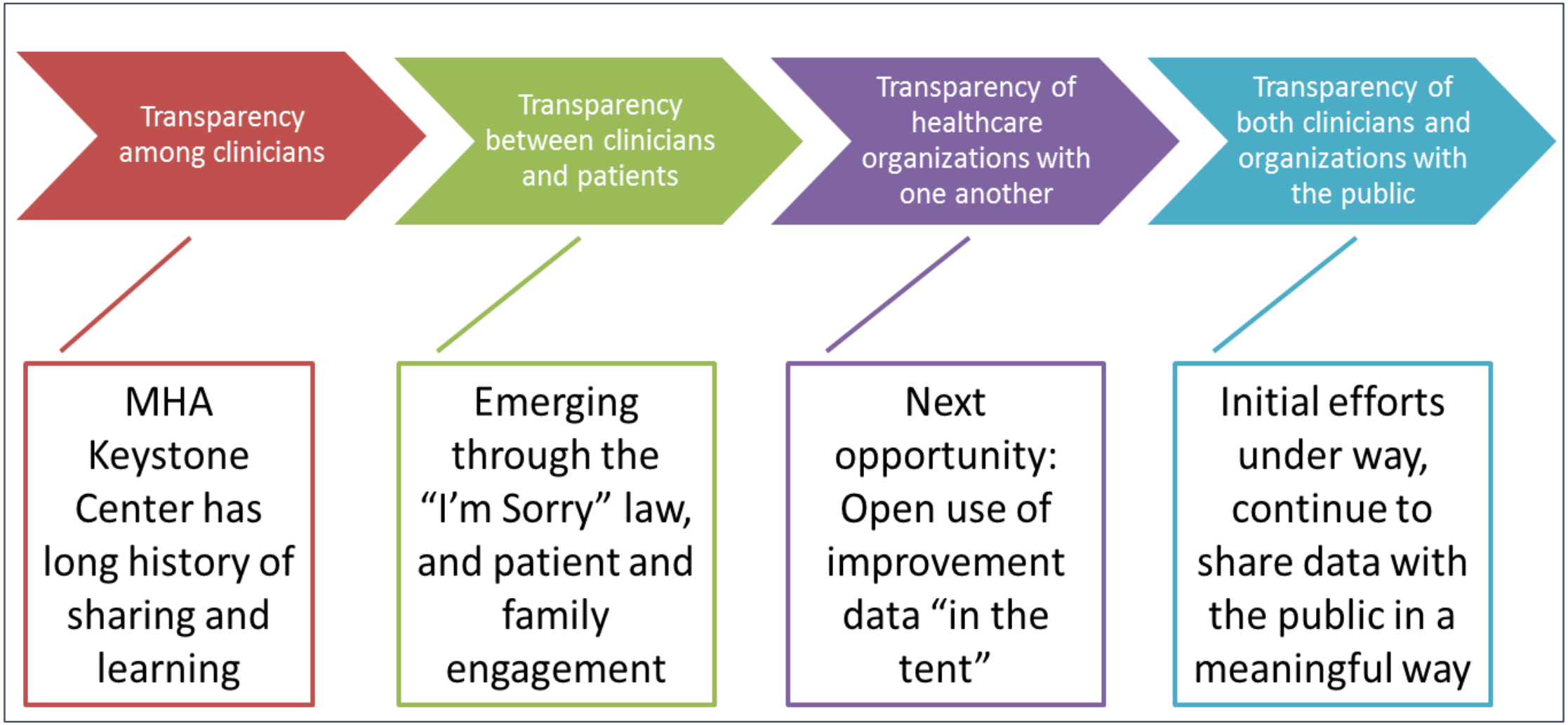
- Three year process with the goal of long term aim to Zero Harm – 9 Michigan hospitals
- Executive (CEO) committed to making change and holding themselves accountable – no delegating
- Executive leaders develop and commit to executing their own high reliability action plan
- Measures
  - Clinical outcomes
  - Financial performance
  - Safety Culture Data - From 2014 or 2015
- Onsite facilitated, in-depth high reliability assessment
- Annual Workshops – in person, off-site
- Two onsite visits per year
- Topic specific workgroup with an initial focus on transparency

Person & Family Engagement

- MHA Keystone Patient & Family Advisory Council
- Recommended practices and policies to increase patient engagement within the hospital
- 2017 Goal: All Michigan hospitals have a local patient and family advisory council or include patient advisors on existing quality improvement committees
    - 50 Michigan hospitals currently reporting fully implemented PFACs



Data & Transparency



MHA Keystone Center

A Certified Patient Safety Organization

Leading Healthcare

2112 University Park Drive | Okemos, MI 48864

(517) 323-3443 | www.mha.org

Brittany Bogan

bbogan@mha.org

(517)348-2238