Institute *for* Healthcare Improvement

May, 2017
Doha, Qatar

Patient Safety and the Triple Aim

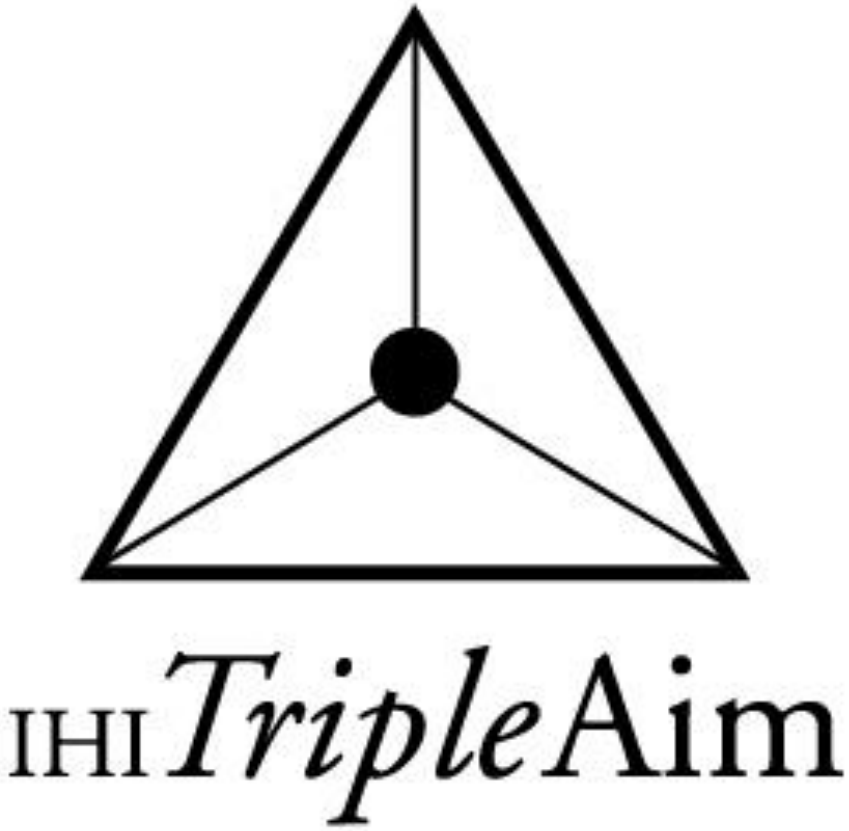
Middle East Forum on Quality and Safety in Healthcare

Derek Feeley
President and CEO

We’ll Cover

- Where are we on patient safety?
- Next phase of safety?
- From safe care to Triple Aim results?
- How will we do that?

Definition



A System design that is one aim with three dimensions:

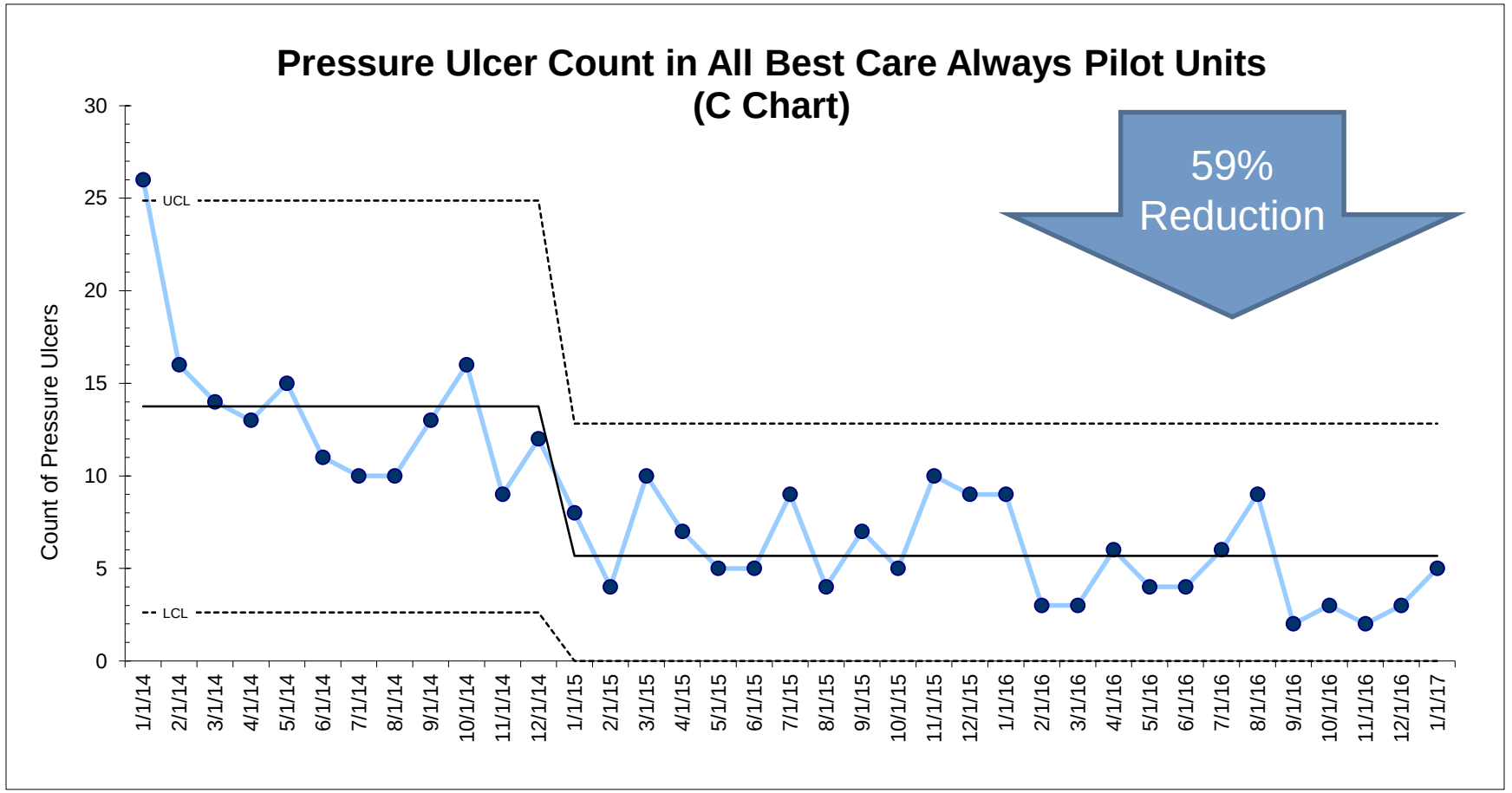
- Improving the health of the populations
- Improving the patient experience of care
- Reducing the per capita cost of health care

The Best Care Always (BCA) Campaign

- HMC-wide patient safety initiative to reduce adverse events and patient harm in general wards, critical care units and operating theaters
- 58 teams from 8 HMC hospitals participating

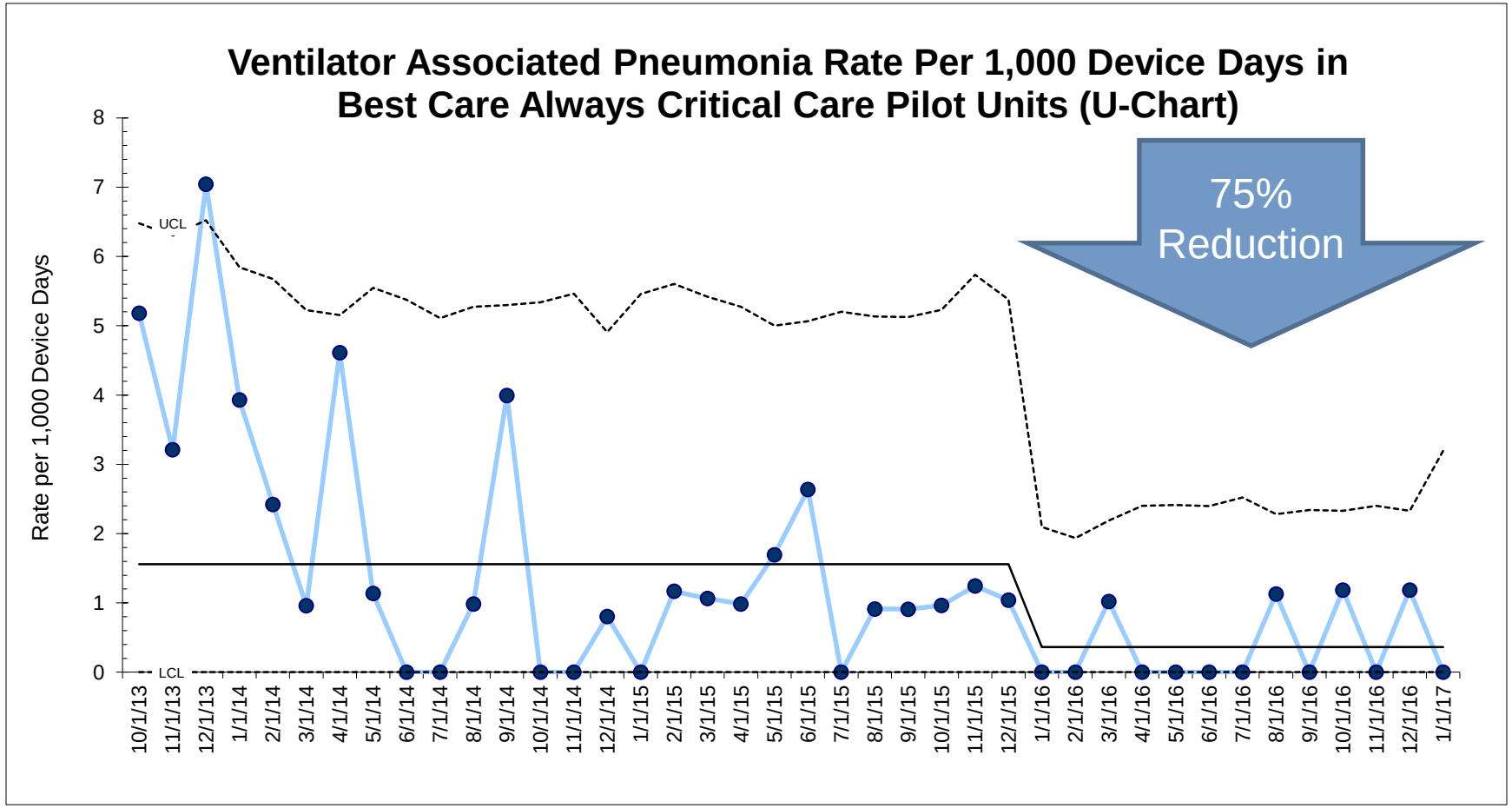
- Campaign Goals:
  - Improve performance to zero incidence of VAP, CLABSI, CAUTI, Pressure ulcers, and SSIs in pilot units
  - Develop a sustainable and reusable infrastructure for health and health care improvement within HMC with increased capability and capacity to improve

Pressure Ulcer Count Reduction



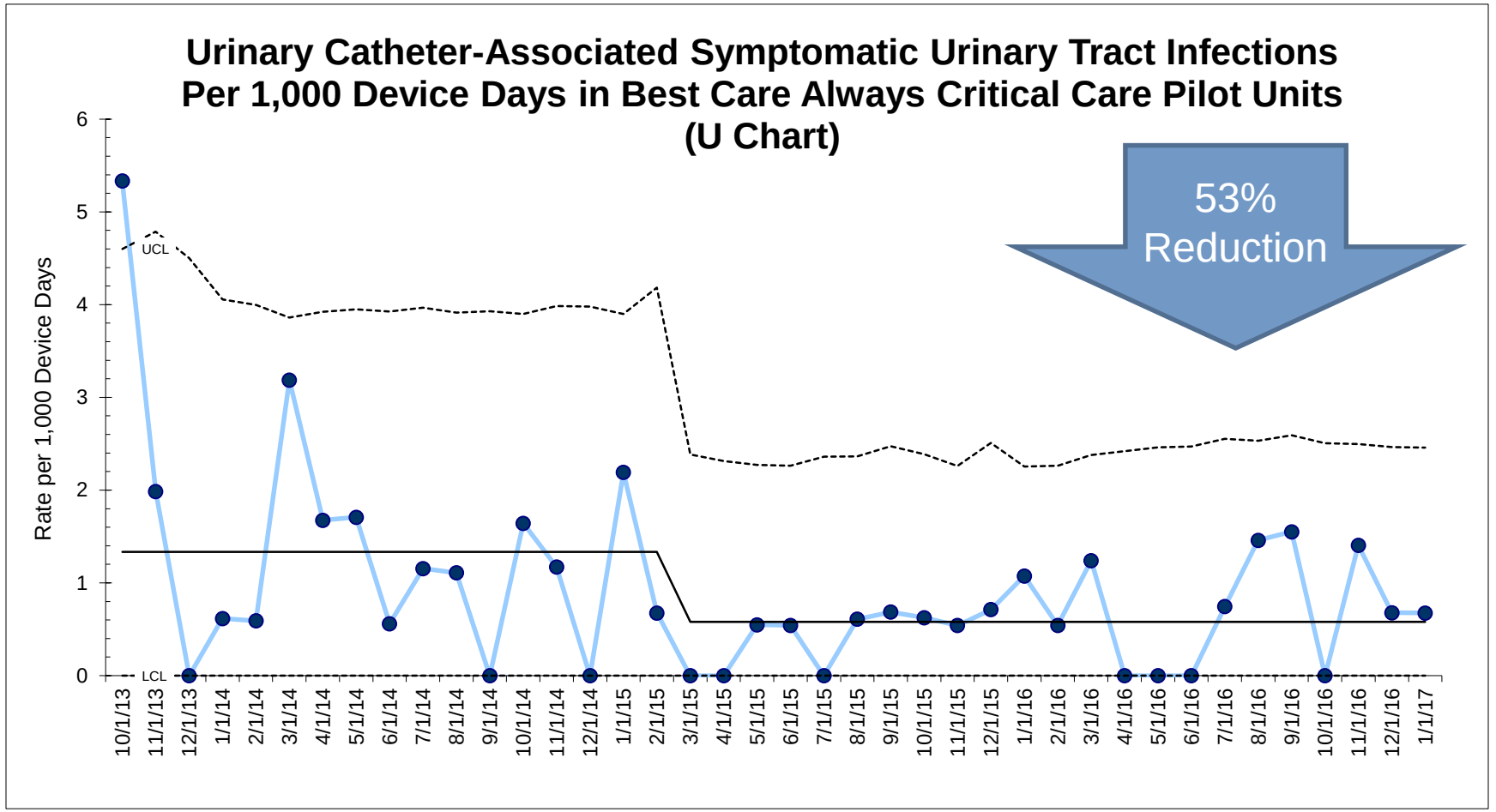
Participating Hospital Units: Al Khor ICU, Al Wakra MICU, Al Wakra SICU, Cuban ICU, HGH MICU, HGH SICU, HGH TICU, Heart Hospital CICU, Heart Hospital CTICU, Al Khor Medical Wards, Al Wakra 6 North Medical World, Rumailah Ennaya, Cuban Hospital General Ward, HGH 5 South 1 Surgical Ward, HGH 5 North 1 Medical Ward, HGH Pediatric Unit 2 South 1, Heart Hospital General Ward, NCCCR Ward II Hematology Unit, Rumailah Long-Term Care Units, Rumailah Female Plastic Surgery Ward

Ventilator Associated Pneumonia Rate Reduction



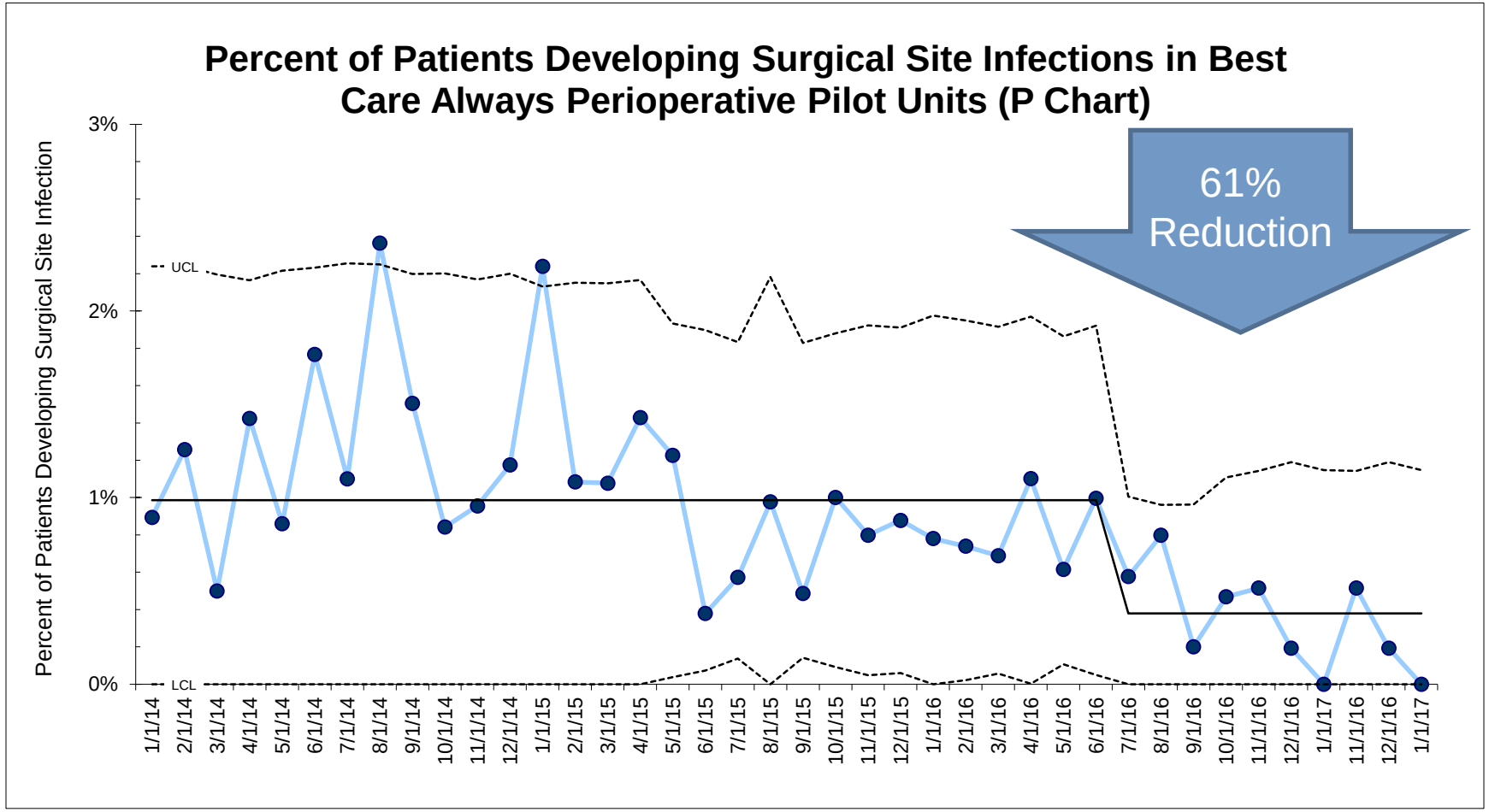
Participating Hospital Units: Al Khor ICU, Al Wakra MICU, Al Wakra NICU, Al Wakra SICU, Cuban ICU, HGH Pediatric Unit 2 South 1, HGH TICU, Heart Hospital CTICU, Heart Hospital CICU, Women's ICU

Urinary Tract Infection Rate Reduction



Participating Hospital Units: Al Khor ICU, Al Wakra MICU, Al Wakra SICU, Cuban ICU, HGH 6 North 1 MICU, HGH MICU, HGH SICU, HGH TICU, Heart Hospital CTICU, Heat Hospital CICU

Surgical Site Infection Reduction



Participating Hospital Units: Al Khor Operating Theater, Al Wakra Operating Theater, Cuban Surgical Wards/Operating Theater, HGH General Surgery ORIF Theater, Heart Hospital CABG Cases, Rumailah Plastic Surgery, Women's Hospital C-Section Theaters

Next Steps for the Campaign

- Continue the pursuit of zero adverse events and zero patient harm
- Focus on sustainability, scale-up, and spread
- Developing “Safety Champions” at each hospital
- Continue building skills in improvement tools and methods for all staff

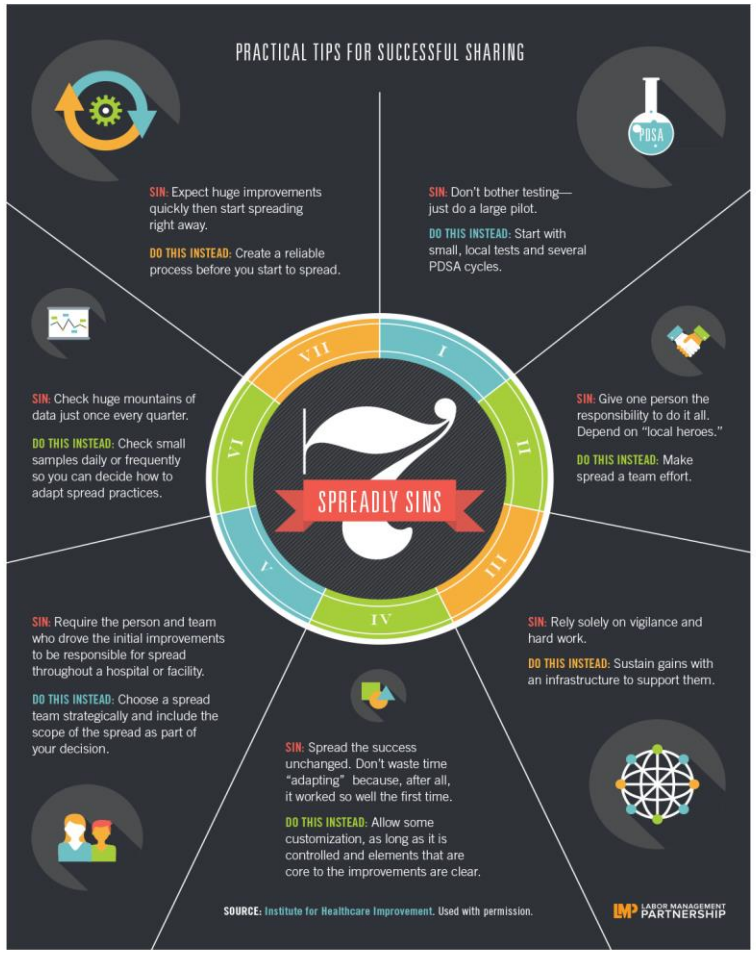
2 Big Challenges

1. Spreading the existing program to all units – every patient, every time.
2. Getting to safety as a system property – not only a project or a program

“Up to 70% of improvement projects never spread.”

Eccles R, Miller Perkins K, Serafeim G. How to Become a Sustainable Company. MIT Sloan Management Review 2012; 53(4): 43-50.

The Seven *Spreadly* Sins



If you do these things, Spread efforts will fail!

1. Start with large pilots
2. Find one person willing to do it all
3. Expect vigilance and hard work to solve the problem
4. If a pilot works, then spread the pilot unchanged
5. Require the person who drove the pilot to be responsible for system-wide spread
6. Look at process and outcome measures on a quarterly basis
7. Early on expect marked improvement in outcomes without attention to process reliability

“Strong evidence for an innovation is necessary but not sufficient to result in its adoption.”

Mark Freeman

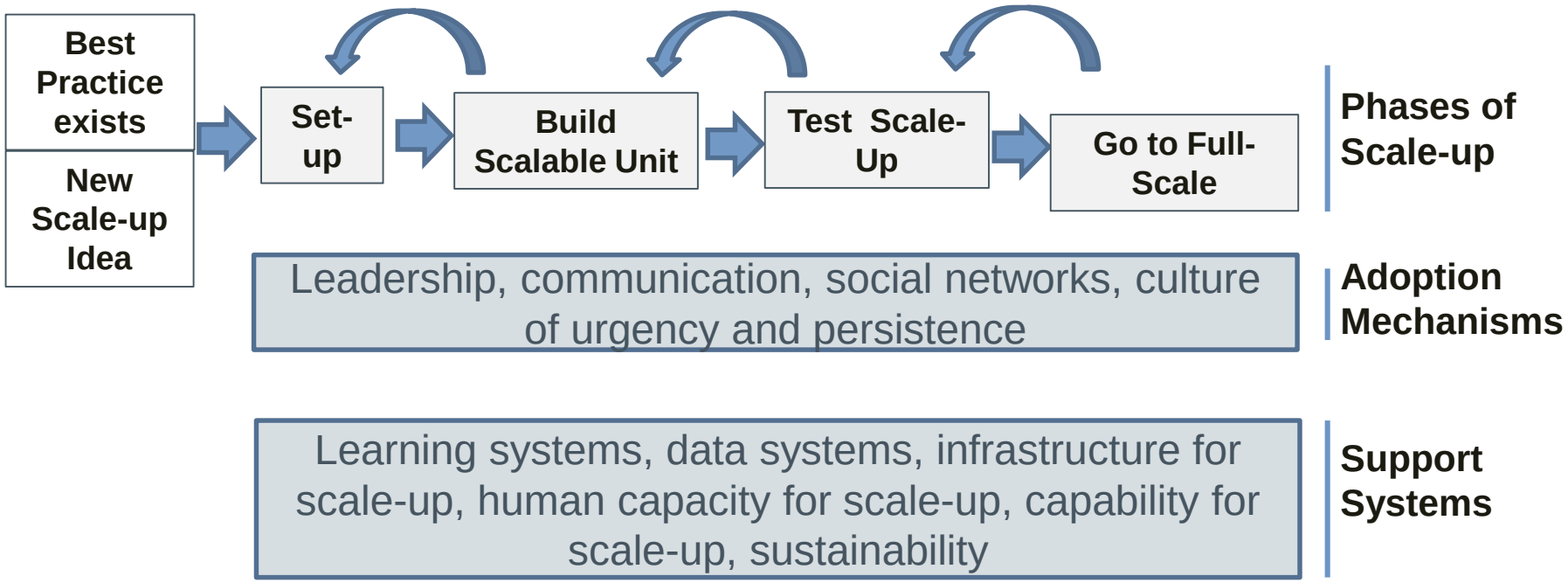
The International Journal of Management Education, 2012

Making Policy (as a metaphor for spread)

policy[1] *n pl* **-cies1.** (Government, Politics & Diplomacy) a plan of action adopted or pursued by an individual, government, party, business, etc

UK National School for Government, 2006

A Learning System for Getting to Full Scale

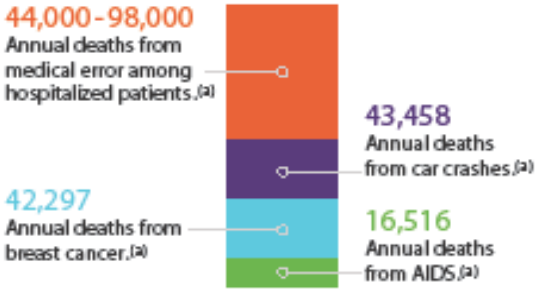


FREE FROM HARM:

ACCELERATING PATIENT SAFETY IMPROVEMENT FIFTEEN YEARS AFTER *TO ERR IS HUMAN*

Report of an expert panel convened by the National Patient Safety Foundation argues for looking at morbidity as well as mortality caused by medical errors and going beyond hospitals to improve safety across the continuum of care.

TO ERR IS HUMAN FRAMED PATIENT SAFETY AS A SERIOUS PUBLIC HEALTH ISSUE (1999 ESTIMATES)



BY SOME MEASURES, HEALTH CARE HAS GOTTEN SAFER SINCE TO ERR IS HUMAN

1.3 Million

Estimated reduction in hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative.[b]

TO UNDERSTAND THE FULL IMPACT OF PATIENT SAFETY PROBLEMS, WE MUST LOOK AT BOTH MORTALITY AND MORBIDITY

1in10

patients develops a health care acquired condition (such as infection, pressure ulcer, fall, adverse drug event) during hospitalization.[b]

BUT WE MUST LOOK BEYOND HOSPITALS TO THE FULL CARE CONTINUUM

Roughly **1 billion** ambulatory visits occur in the US each year.[c]

About **35 million** hospital admissions occur annually.[c]

ADVANCEMENT IN PATIENT SAFETY REQUIRES AN OVERARCHING SHIFT FROM REACTIVE, PIECEMEAL INTERVENTIONS TO A TOTAL SYSTEMS APPROACH TO SAFETY[d]

1. Ensure that leaders establish and sustain a safety culture.
2. Create centralized and coordinated oversight of patient safety.
3. Create a common set of safety metrics that reflect meaningful outcomes.
4. Increase funding for research in patient safety and implementation science.
5. Address safety across the entire care continuum.
6. Support the health care workforce.
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.

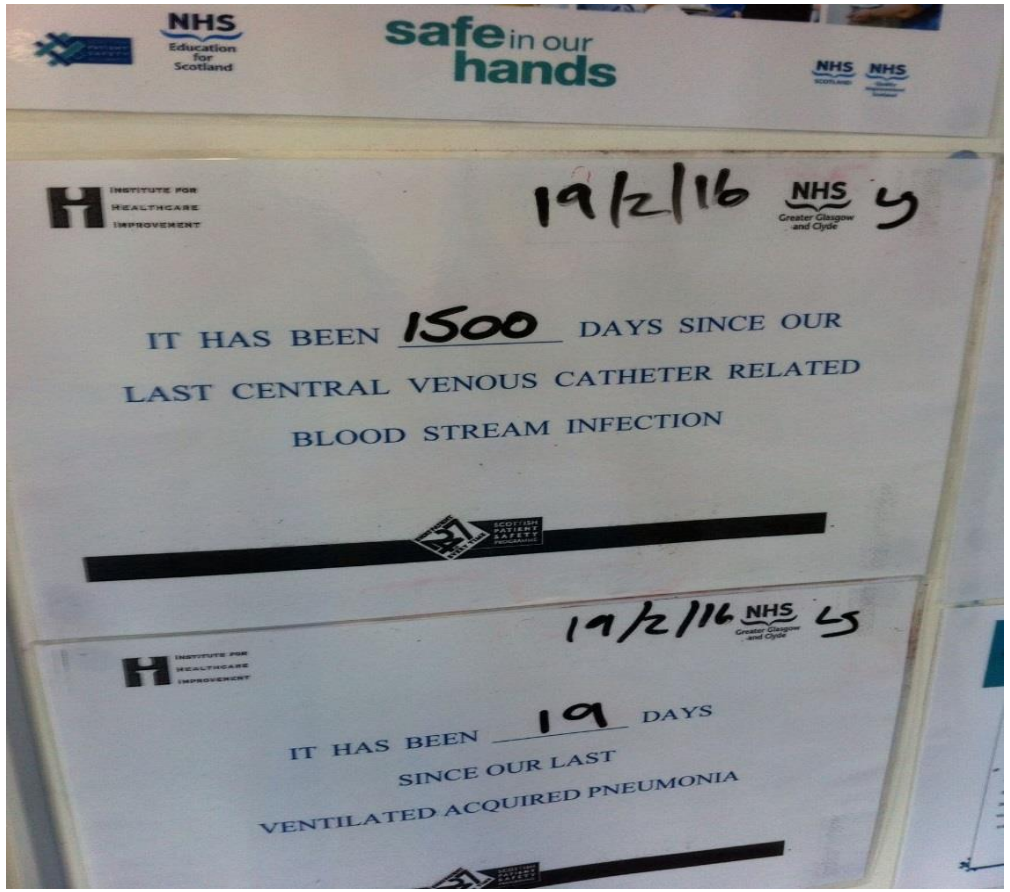
NPSF National Patient Safety Foundation

To read the full report and detailed set of recommendations, visit **www.npsf.org/free-from-harm**

AIG

This project was made possible in part through a generous grant from AIG in support of the advancement of the patient safety mission. AIG had no influence whatsoever on report direction or its content. The views and opinions expressed herein are those of the author(s) and do not necessarily reflect those of American International Group, Inc. (AIG) or its subsidiaries, business units or affiliates. Sources: (a) Institute of Medicine. To Err Is Human: Building a Safer Health System. Washington, DC: The National Academies Press, 2000. (b) 2012 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2012. Rockville, MD: Agency for Healthcare Research and Quality; October 2013. AHRQ Publication No. 14-0006-EF. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html. (c) National Center for Health Statistics. Fastats A-Z. Ambulatory Care and Hospital Utilization. Available at: http://www.cdc.gov/nchs/fastats/. (d) National Patient Safety Foundation. Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human. Boston, MA: National Patient Safety Foundation; 2015. Available at: http://www.npsf.org/free-from-harm.

And yet…



"Thought you all may like to know that we have eradicated CLABSI within our ICU & deem it to be like polio or smallpox, namely a disease of the past (see the photo). VAP still a challenge where we hit the 300 day target but we always get one as a rare event. Whole team at the RAH quite proud & rightfully so in my eyes."

-Kevin Rooney

NHS SCOTLAND

Safety II

	Safety-I	Safety-II
Definition of Safety	That as few thing as possible go wrong.	That as many things as possible go right.
Safety Management Principle	Reactive, respond when something happens or is categorized as an unacceptable risk.	Proactive, continuously trying to anticipate developments and events.
View of the human factor in safety management	Accidents are caused by failures and malfunctions. The purpose of an investigation is to identify the causes.	Things basically happen in the same way, regardless of the outcome. The purpose of an investigation is to understand how things usually go right as a basis for explaining how things occasionally go wrong.
Risk Assessment	Accidents are caused by failures and malfunctions. The purpose of an investigation is to identify causes and contributory factors.	To understand the conditions where performance variability can become difficult or impossible to monitor and control.

SOURCE: Hoffnagel E, Wears RL, Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida (US), and Macquarie University (Australia).
Available at: http://resilienthealthcare.net/onewebmedia/WhitePaperFinal.pdf

New Safety

1. From *as few things as possible go wrong*

   To *as many things as possible go right*

Learning from Success

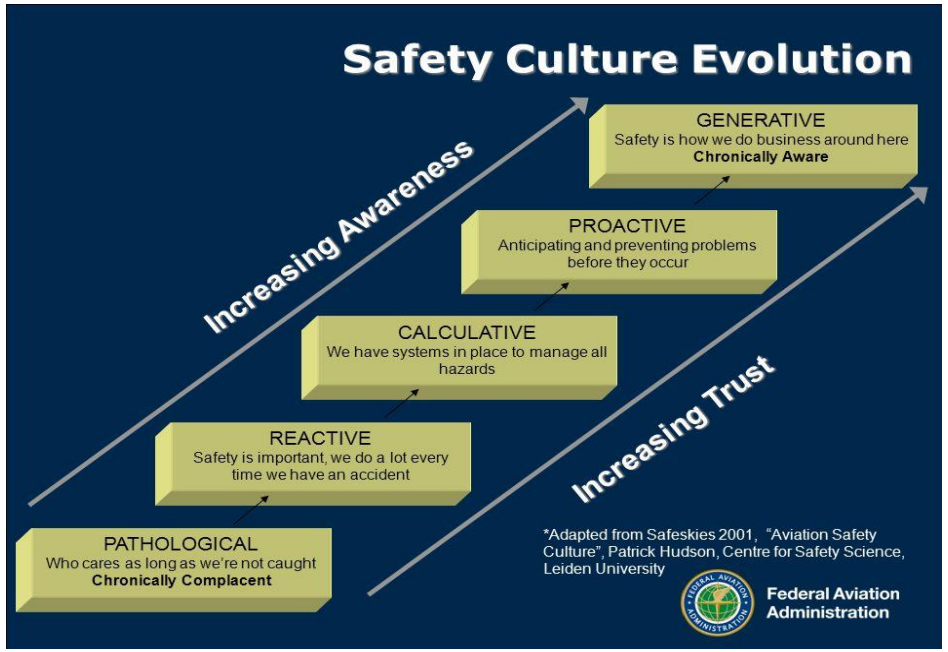
> 50%

SOURCE: Fried J, Heinemeier Hansson D. *Rework: Change the Way You Work Forever*. Vermilion: 2010.

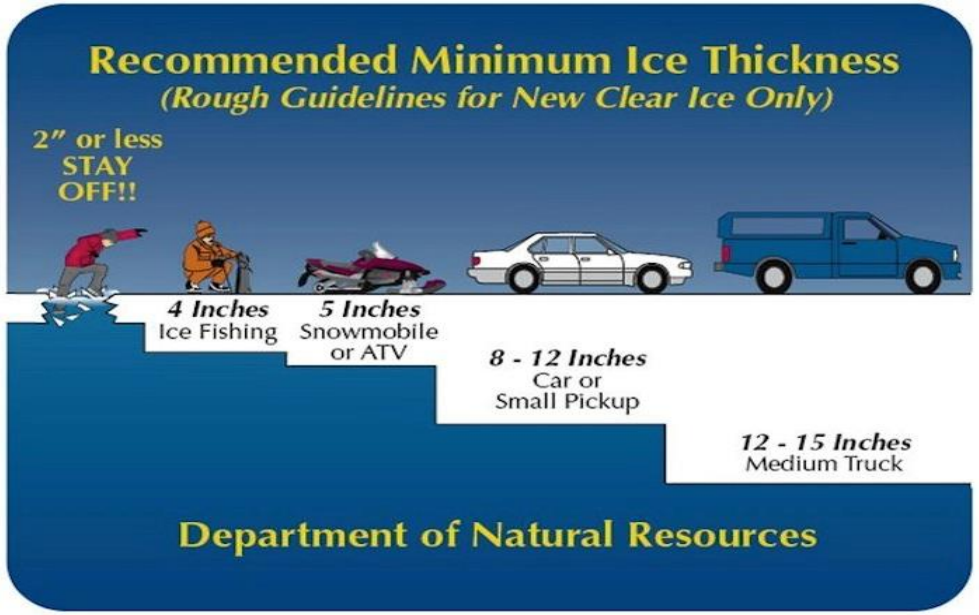
New Safety

2. From *reactive and responsive*

   To *proactive and generative*

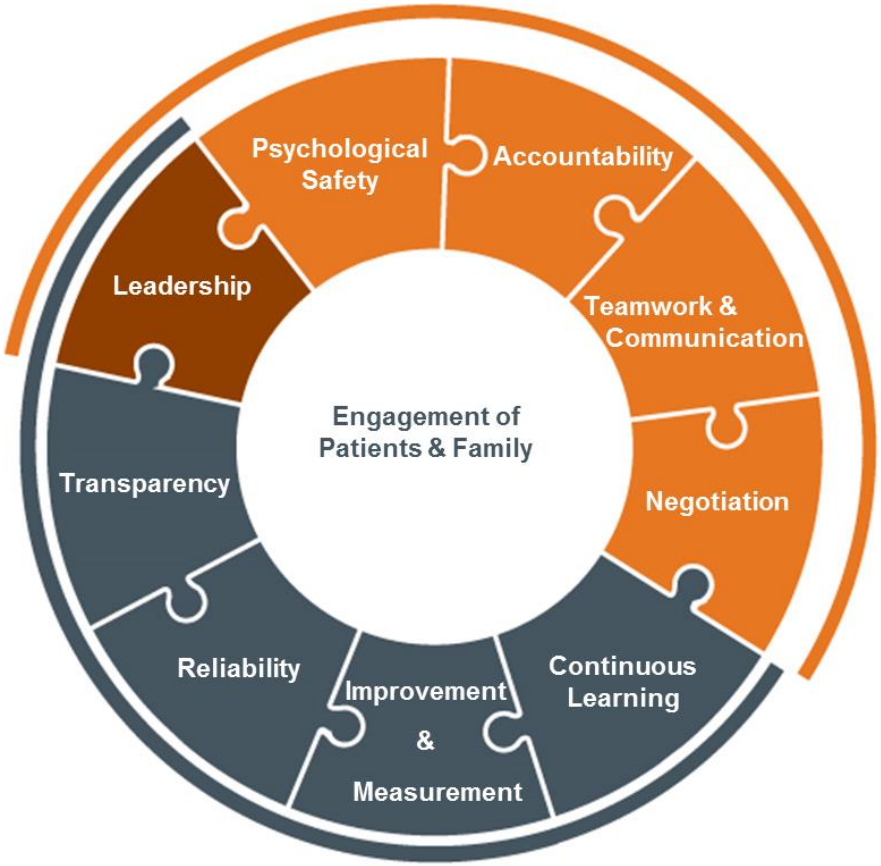


Getting to the Thickness of the Ice…..

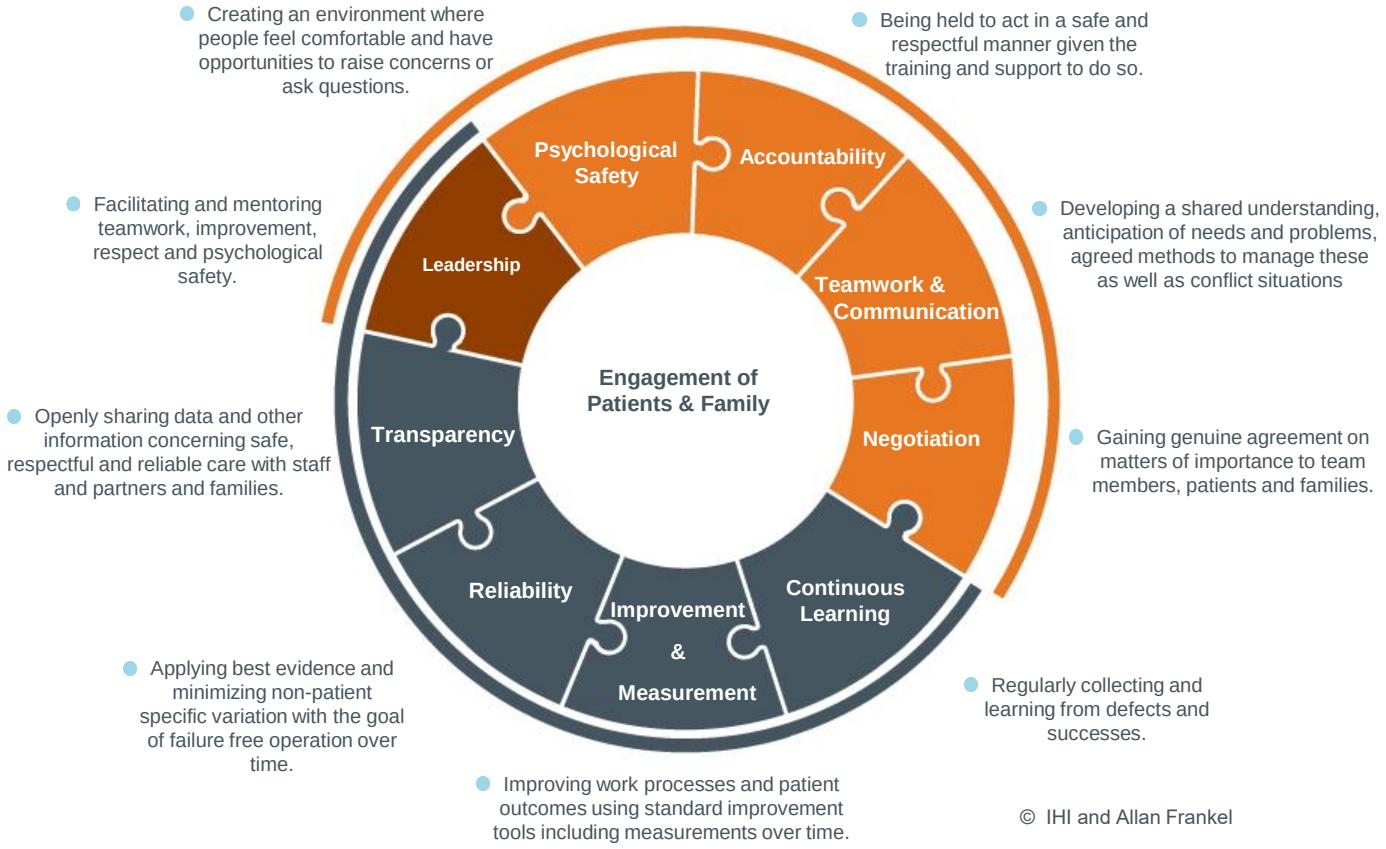


New Safety

3. From *safety projects*
   To *safety systems*



Framework for Safe, Reliable and Effective Care



New Safety

4. From *fear, blame and liability*

   To *humility, trust, transparency*

New Safety

5. From keeping patients safe

To co-producing safety

#asklistentalk

Safety 2.0

6. From *a narrow definition of harm*

   To *a broad definition of harm*

Absence of Dignity is Harm

https://www.youtube.com/watch?v=5XWoJZ4H9ns

BIDMC PREVENTABLE HARM SCORECARD

	FY15			FY16
	Q3	Q4	Q1	Q2

Favorable Comparison

Unfavorable Comparison

PREVENTABLE HARM

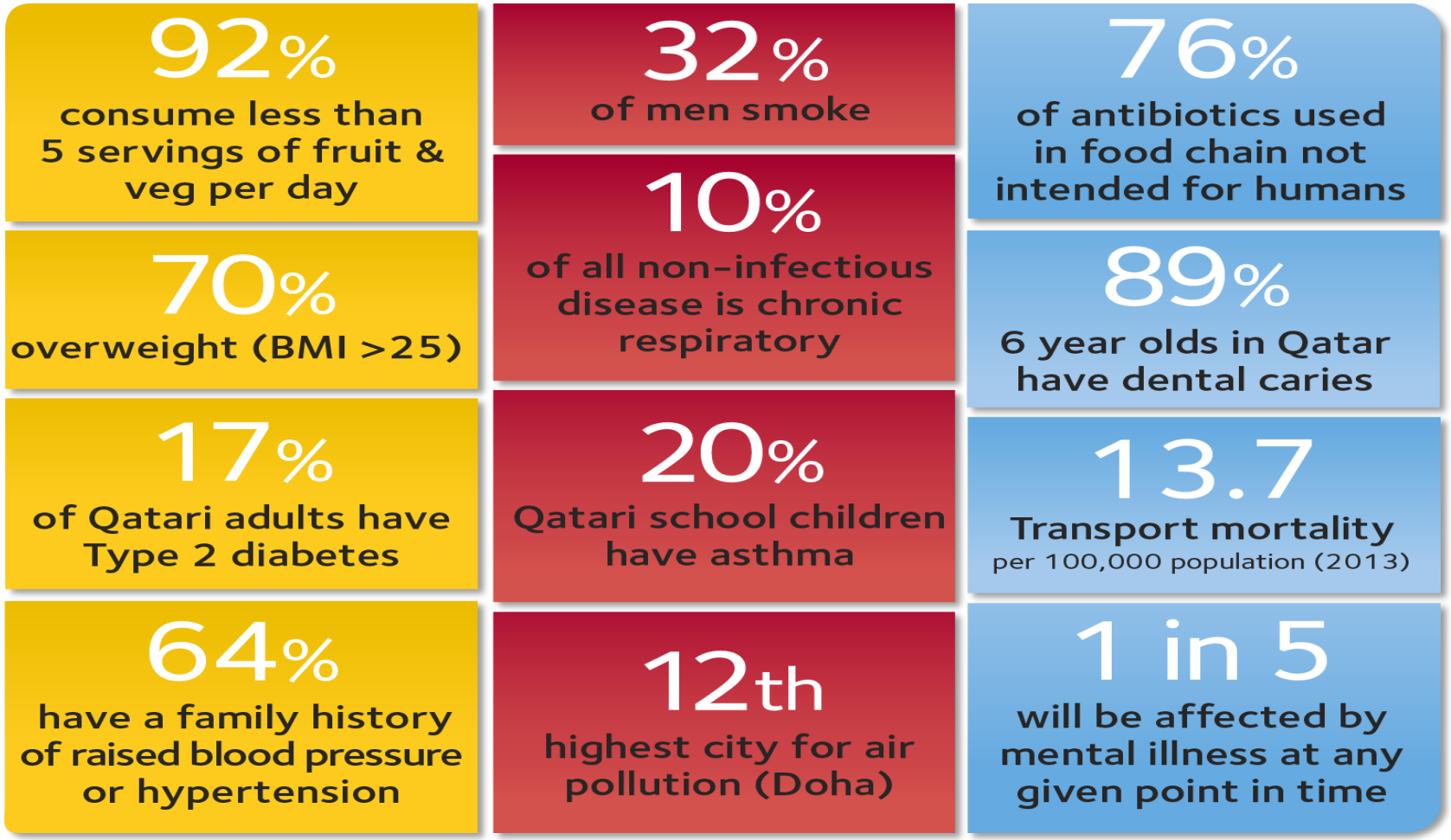
	AIM	FY15 Target	CHANGE	Q3 15	Q415	Q1 16	Q2 16
MEDICAL MANAGEMENT RELATED							
Disease Progression or End Organ Injury (reversible or permanent) Related to Medical Management	▼	0		2	2	1	0
Cardiac and/or Respiratory Failure or Arrest Related to Medical Management	▼	0		1	0	0	0
INFECTION RELATED							
Nosocomial Catheter Associated Bloodstream Infections	▼	0		0	0	0	1
Nosocomial Surgical Site Infections (SSIs)	▼	0		4	3	3	2
Nosocomial C. Difficile Infections	▼	0		0	13	0	0
Other Nosocomial Infection	▼	0		0	0	0	0
CARE RELATED							
Falls Resulting in Injury	▼	0		2	1	1	2
Soft Tissue Injuries (Includes Pressure Sores)	▼	0		1	0	1	1
Medication Related Adverse Events	▼	0		3	4	1	0
Procedure Related Harm/Complication (Non Infectious)- Surgical Services	▼	0		4	0	0	1
Procedure Related Harm/Complication (Non Infectious)- Non-Surgical Services	▼	0		1	1	3	1
Neonatal Harm/Complication (Non Infectious)	▼	0		0	1	0	0
subtotal				18	25	10	8
DIGNITY & RESPECT RELATED							
Disrespectful Communication	▼	0		11	12	14	17
Failure to Maintain an Environment That Preserves Dignity	▼	0		4	6	0	1
Failure to Provide Appropriate Care After Death	▼	0		2	0	1	0
Failure to Care for Personal Possessions	▼	0		0	2	0	0
Other Disrespect Causing Harm to Dignity	▼	0		0	0	1	0
subtotal				17	20	16	18
TOTAL	▼	0		35	45	26	26

Absence of Equity is Harm

New Safety

1. Focus on what goes right as well as learning from what goes wrong.
2. Move to greater pro-activity.
3. Create systems for learning from learning.
4. Be humble – build trust and transparency.
5. Co-produce safety with patients and families.
6. Safety is more than the absence of physical harm, it is also the pursuit of dignity and equity.

Health Challenges



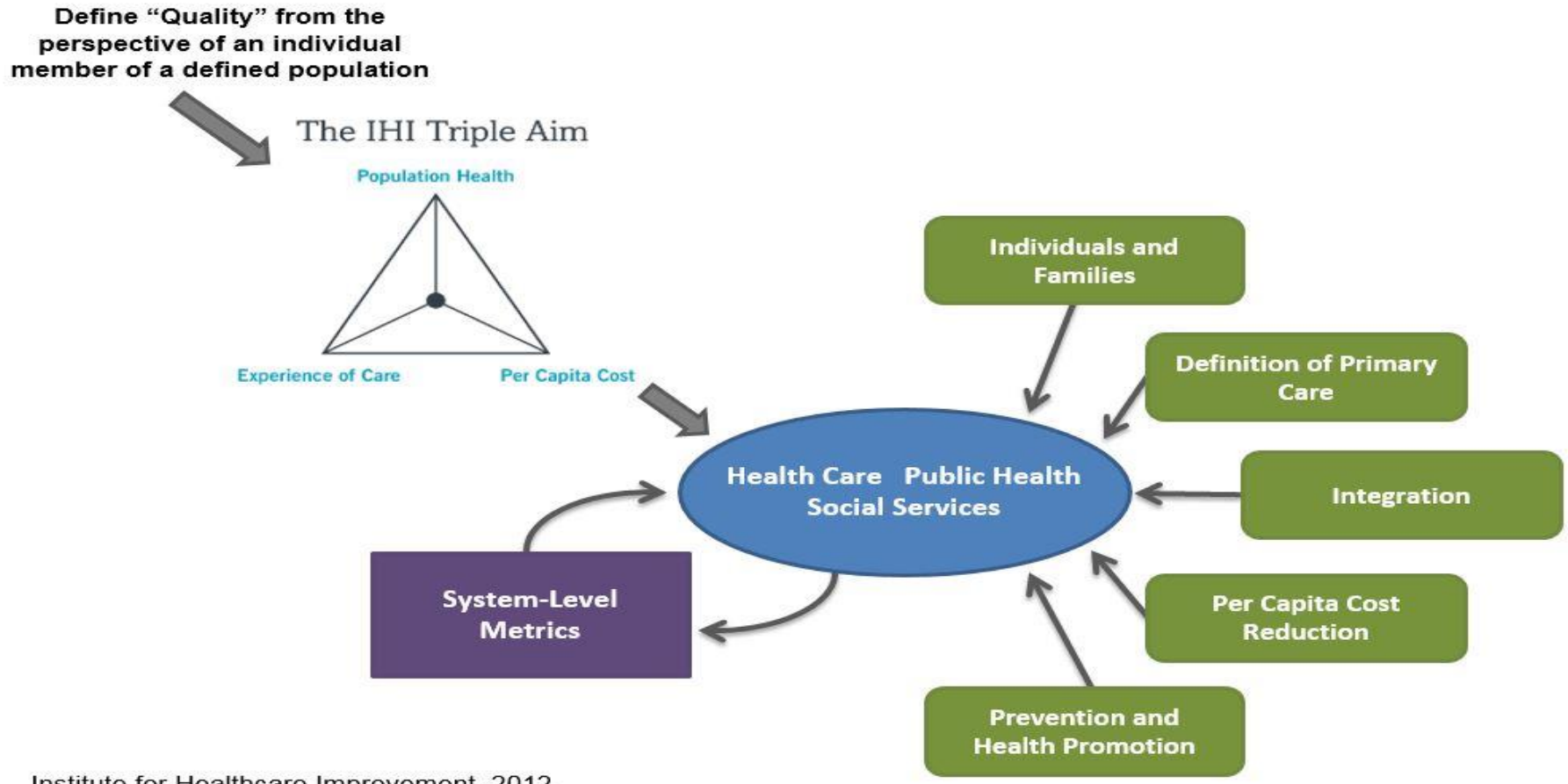
More to Come

- The GCC states are witnessing an alarming rise in obesity rates, with countries such as Kuwait and Qatar recording among the world's highest adult female obesity rates.
- Estimated prevalence of obesity among women in 2013 stood at 58.6 per cent in Kuwait (third highest in the world), and at 54.7 per cent in Qatar (sixth highest globally), according to a recent report by medical journal Lancet.
- Adult obesity rates stand at double digits across all the six Gulf states, the report found.

  - **Obesity rate in Kuwait: 43.4% (men) and 58.6% (women)**
  - **Obesity rate in Qatar: 44% (men) and 54.7% (women)**
  - **Obesity rate in Saudi Arabia: 30% (men) and 44.4% (women)**
  - **Obesity rate in Bahrain: 31% (men) and 42.9% (women)**
  - **Obesity rate in the UAE: 27.1% (men) and 33.2% (women)**
  - **Obesity rate in Oman: 20.6% (men) and 36.9% (women)**

Design Required

Design of a Triple Aim Enterprise



Institute for Healthcare Improvement, 2012

Building Blocks and Set Up

Aim: Apply the Triple Aim to a population served by your organization or a population of interest in your region.

- Choose a relevant ***Population*** for improved health, care and lowered cost
- Articulate a ***Purpose*** that will hold your stakeholders together
- Develop a ***Systems*** approach
- Create a ***Learning System*** and choose ***Measures*** that will show improvement for the population
- Develop a ***Portfolio*** (group) of projects that will yield Triple Aim results
  - No individual project can accomplish the Triple Aim but a portfolio of projects that are executed well can move closer to the aims.
- Build a ***Team*** of individuals who can manage this work: Executive Sponsor, Portfolio Lead, Project Lead, Content Expert, Improvement Advisor and Measurement Lead
- Develop a brisk and realistic plan for ***Execution*** on projects and accountabilities for results

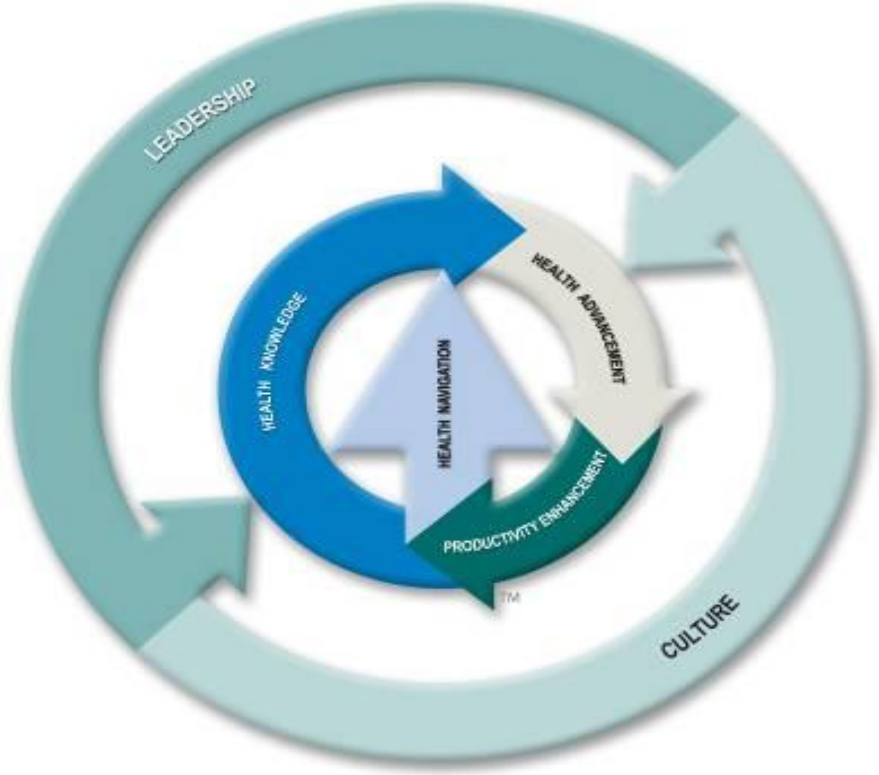
Health Navigation: Bellin Health

The new gateway to Bellin Health. Personal, tailored treatment to individuals' needs, learning styles and lifestyles.

Employers

Healthy Employees = Healthy Business

Employer Results



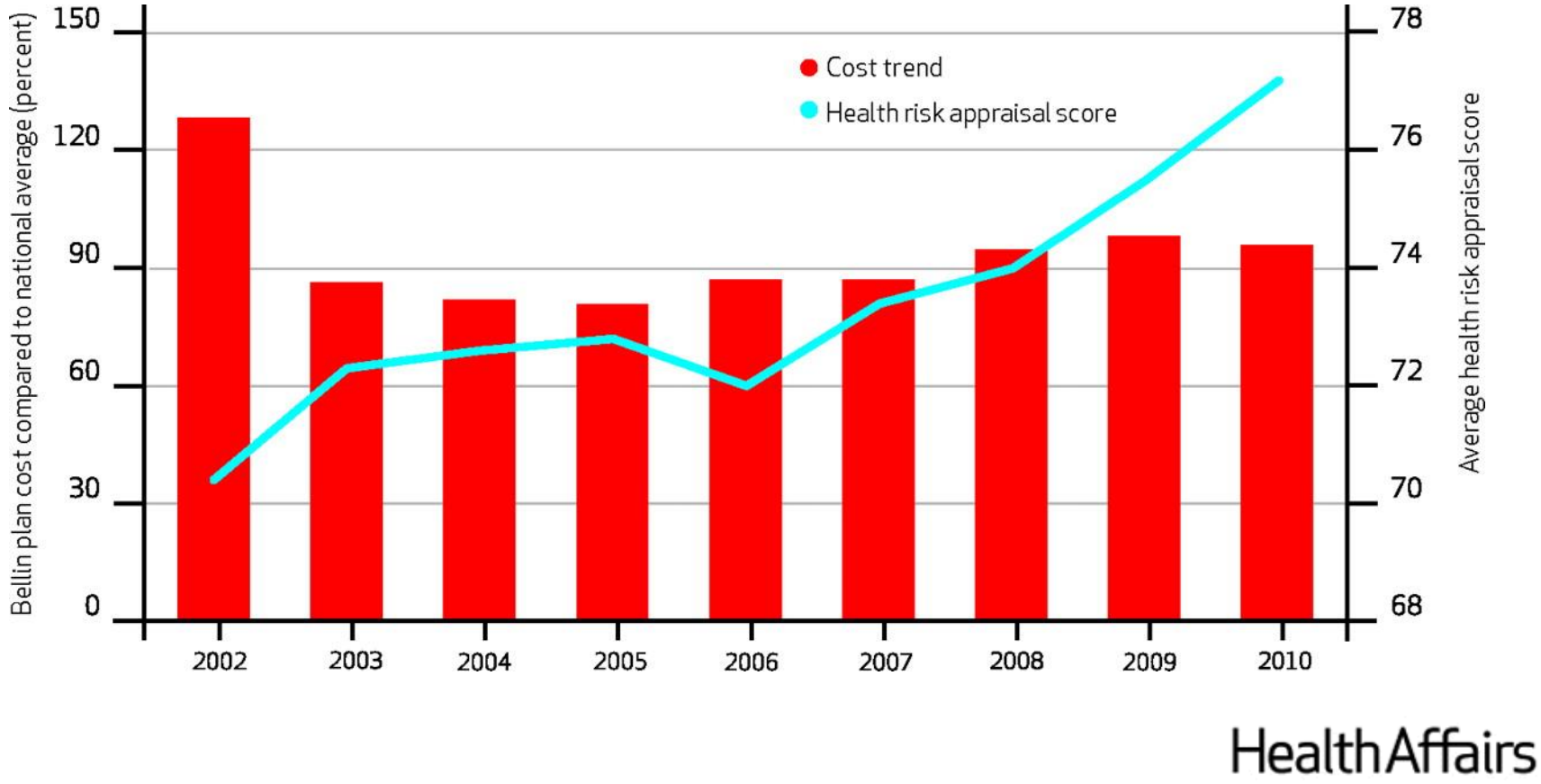
Employers with:

- Consumer Driven Health Plans
- Onsite services
- Incentives for participation
- Prevention coverage

…results 21% below cost average

http://youtu.be/1hoW-xZw4wk

Trends in Health Plan Costs and Health Measures
(Bellin Health, 2002-2010)



Feder J L. Health Aff. 2011;30:387-389

Bellin – Best Quality Pioneer ACO

20 Medicare ACOs with the highest quality scores in 2014

Written by Emily Rappleye (Twitter | Google+) | August 31, 2015 | Print | Email

90 Share Tweet 35 Share 3 G+1

The 353 Pioneer and Medicare Shared Savings Program accountable care organizations improved their performance for most quality measures in 2014, according to CMS.

The Pioneers increased average quality scores to 87.2 percent, up from 85.2 percent in 2013 and improved an average of 3.6 percent compared to 2013 on 28 of the 33 quality measures.

MSSP ACOs, on the other hand, showed improvement in 27 of 33 quality measures, especially in clinician-patient communication, patient ratings of physicians, tobacco screening and cessation, blood pressure screening and EHR use.

Here are the top 10 ACOs in each program who topped the list for highest overall quality scores. For more information on overall quality scores from CMS, click here.

Pioneer ACOs

1. Bellin-ThedaCare Healthcare Partners (Green Bay, Wis.) — 94.24 percent overall quality score
2. Beacon Health (Brewer, Maine) — 92.27 percent
3. Atrius Health (Newton, Mass.) — 91.40 percent
4. Mount Auborn Cambridge Independent Practice Association (Brighton, Mass.) — 91.36 percent
5. OSF HealthCare System ACO (Peoria, Ill.) — 90.26 percent
6. Franciscan Alliance (Indianapolis) — 89.65 percent
7. Partners HealthCare ACO (Needham, Mass.) — 88.85 percent
8. Beth Israel Deaconess Care Organization (Westwood, Mass.) — 87.89 percent
9. Dartmouth-Hitchcock Health Pioneer ACO (Lebanon, N.H.) — 87.62 percent
10. Trinity Pioneer ACO (Fort Dodge, Iowa) — 87.49 percent

Beckers Hospital Review, 2015:
http://www.beckershospitalreview.com/accountable-care-organizations/20-medicare-acos-with-the-highest-quality-scores-in-2014.html

HealthPartners, Minnesota

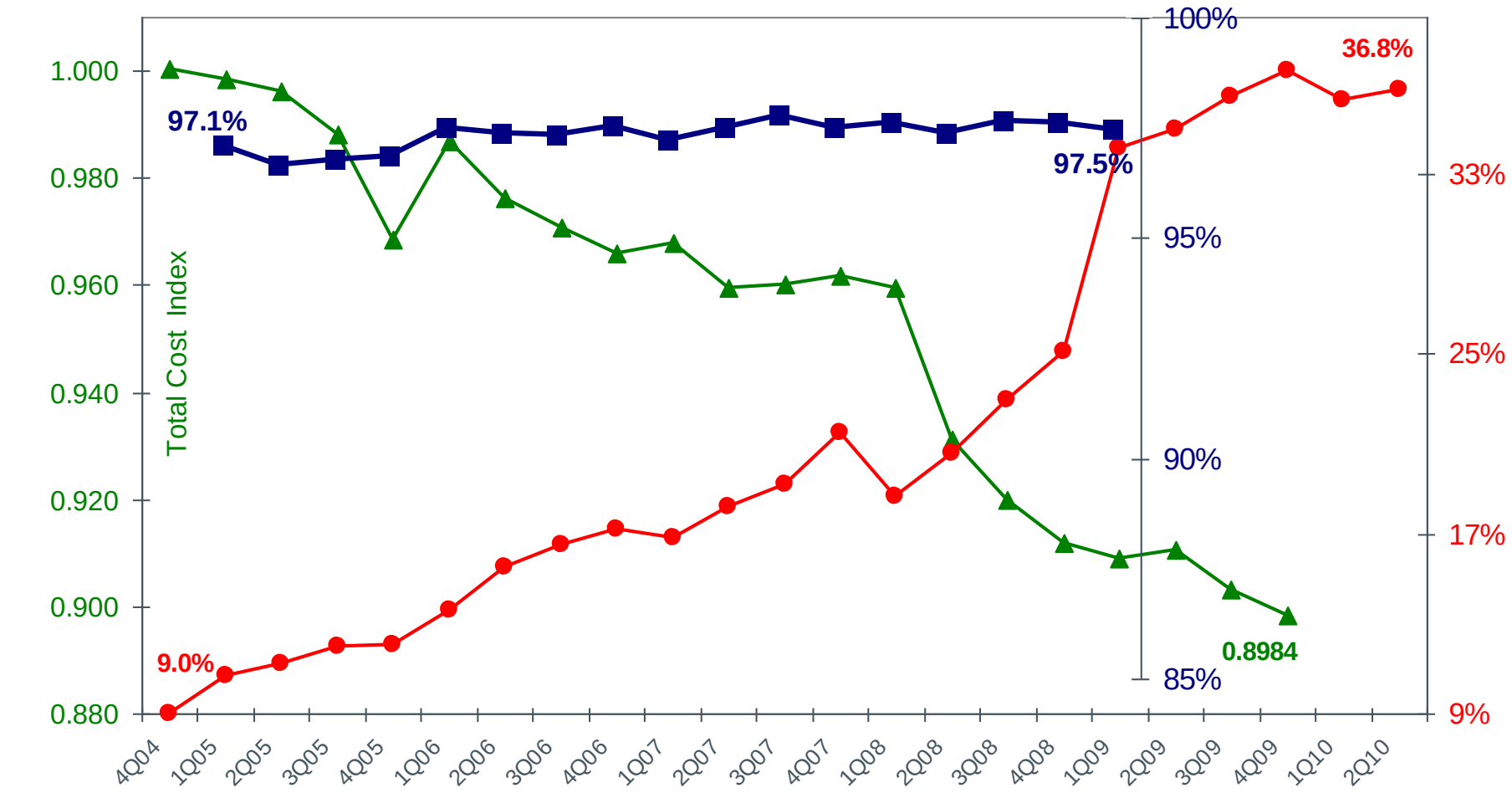
- Integrated health care organization providing health care services, health plan financing and administration, medical education and research.
- Approach:
  - Consistency: Reliable processes supported by electronic medical record
  - Customization: Adapted to individual needs and values and responding to patient values and preferences
  - Convenience: Access, on-line services, email, coaching
  - Coordination: Medical Home to reduce hospital use, and manage chronic illness

Partners for Better Health:
2014 Goals

Health Success	Experience Success	Affordability Success
Improved health for our customers and community as measured by: •Better well being, more satisfied and healthy lives. •The best local and national health outcomes and the best performing health care costs in the region.	**Deliver an exceptional experience that customers want and deserve at an affordable cost as measured by:** •The best performance on customer's willingness to recommend our clinics, hospitals and health plan to family and friends. •Feeling well-supported, respected and cared for throughout life.	**Lower health care costs for our customers as measured by:** •Cost trends that are at or below general inflation (Consumer Price Index, a leading economic indicator). •The best performing overall health care costs in the region. •HealthPartners clinics and hospitals will be in the best 10 percent in the region in overall costs of health care.

TRIPLE AIM: Health-Experience-Affordability

HealthPartners Clinics



Total Cost Index

(compared to statewide average)

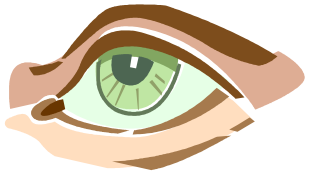
< 1 is better than network average

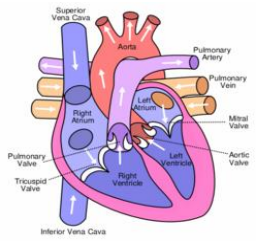
% patients with Optimal Diabetes Control *

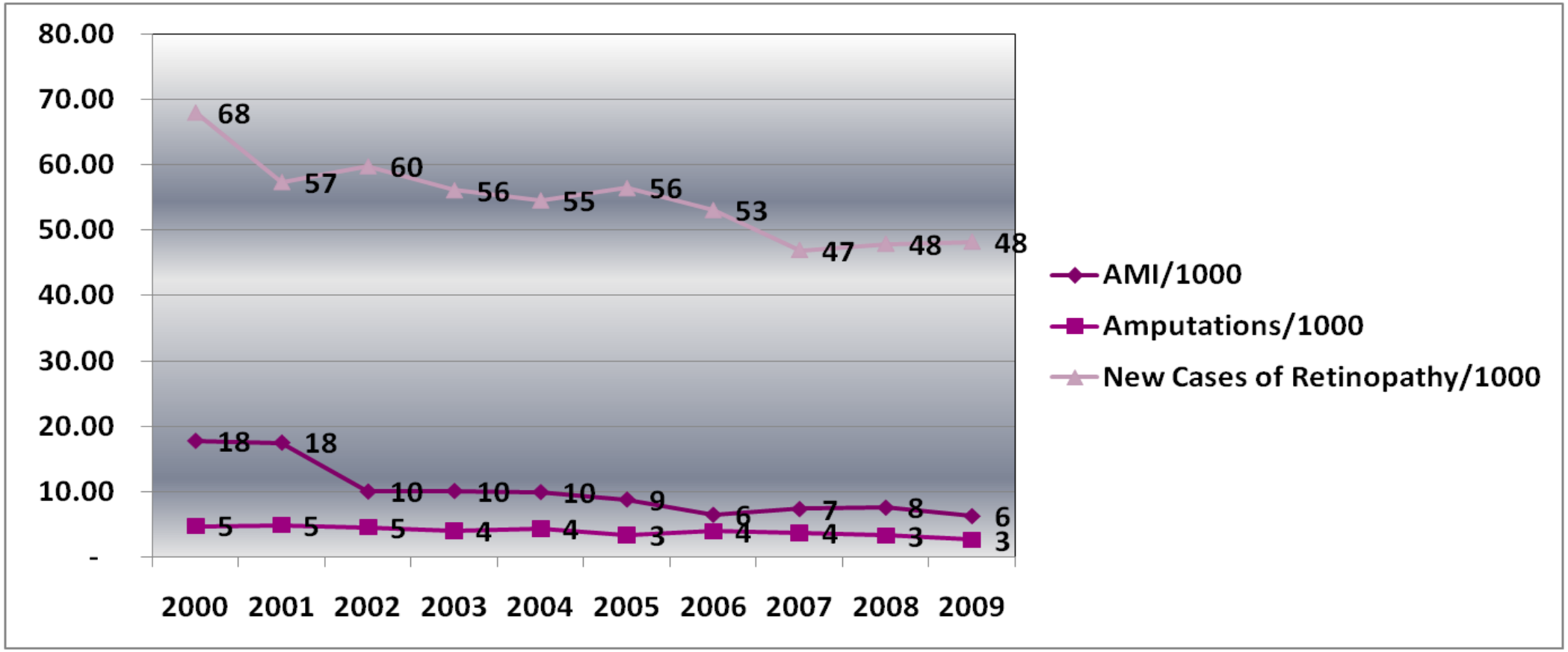
** controlled blood sugar (per ICSI guideline A1C changed from < 7 to < 8 in 1st quarter 2009), BP & cholesterol, AND daily aspirin use, AND non-tobacco user*

% patients "Would Recommend" HealthPartners Clinics

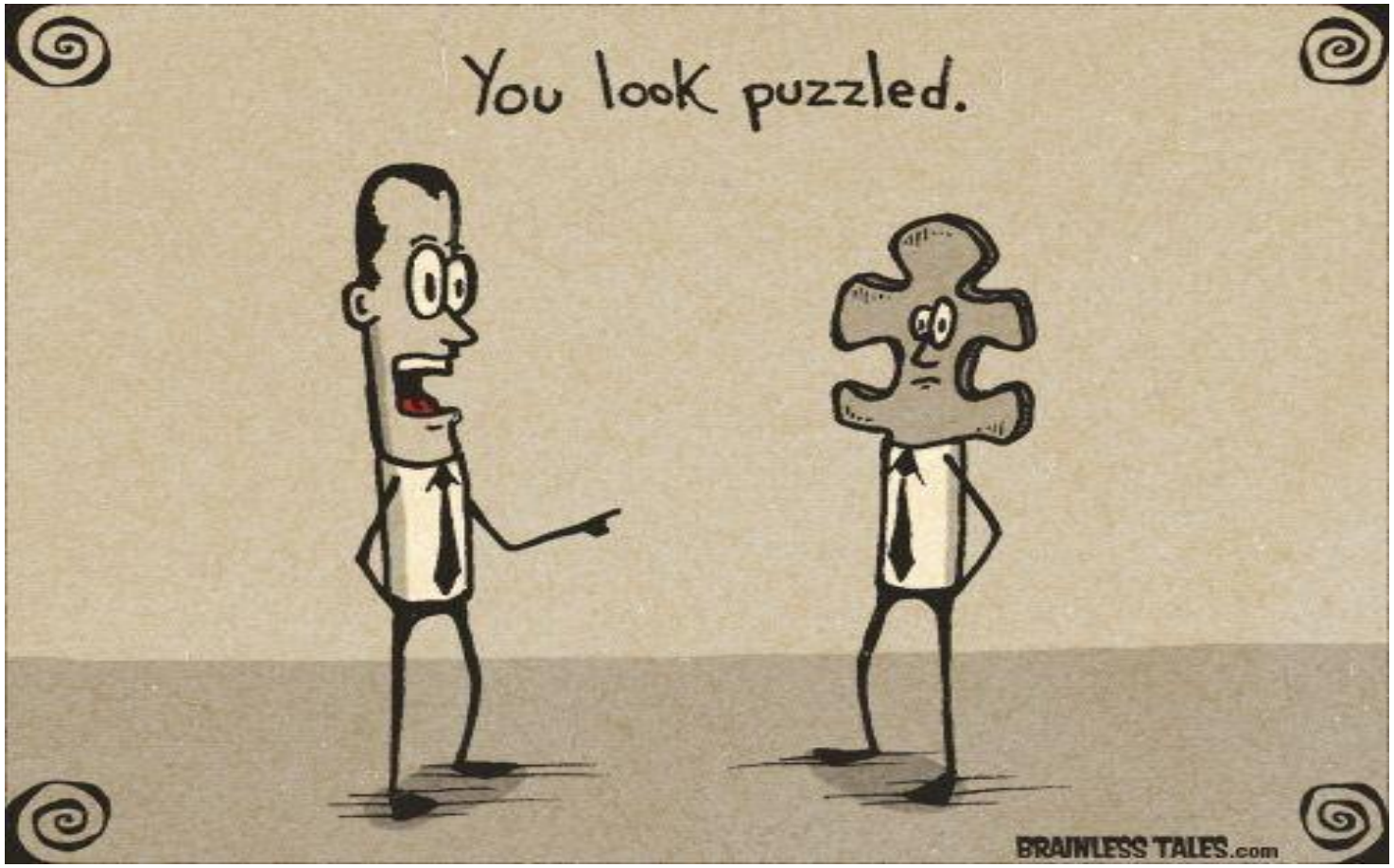
Saves 364 Hearts, 68 Legs & 625 Pairs of Eyes Each Year (Diabetic Population)







How do they do that?

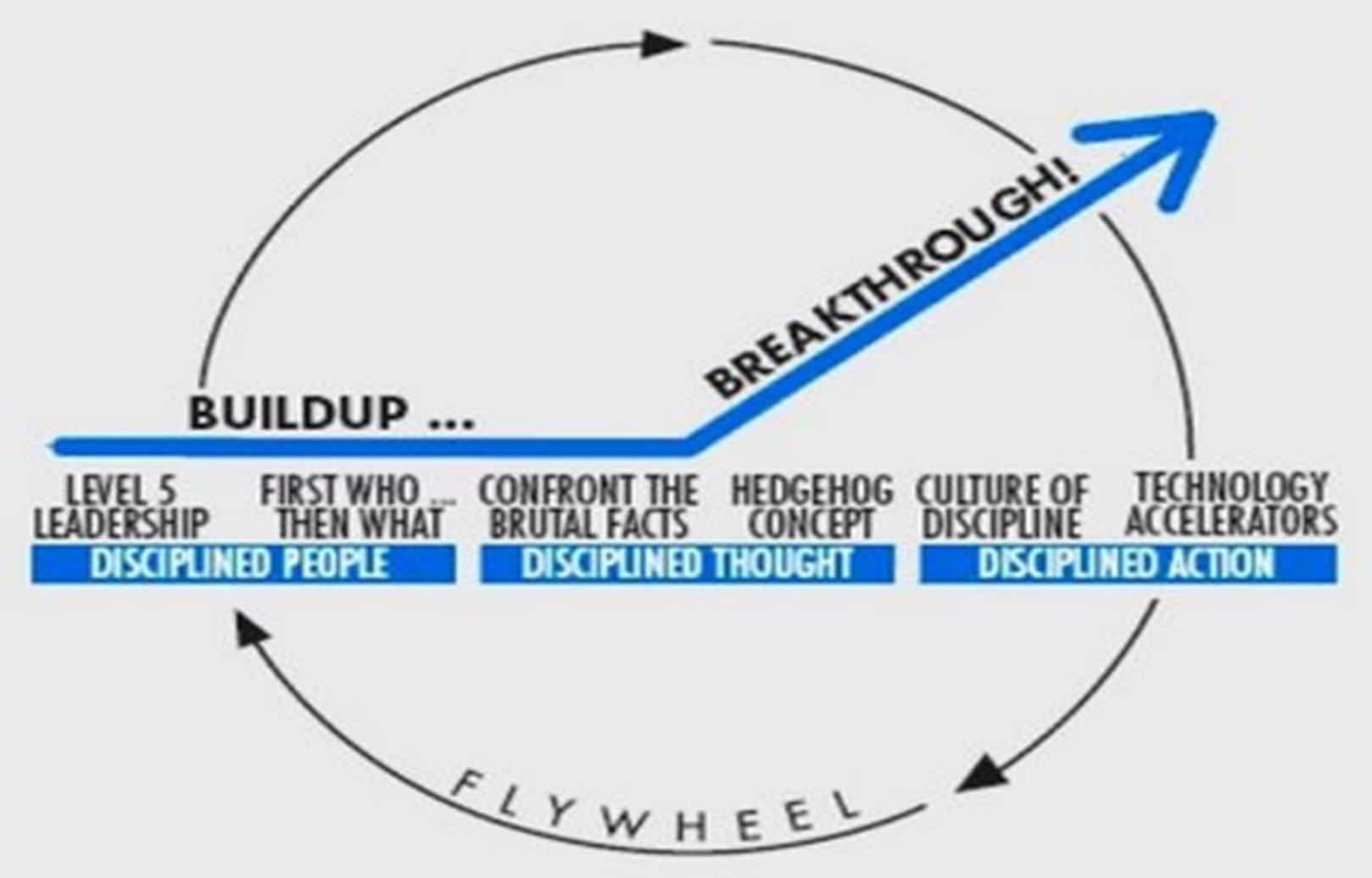


Typical v. Exceptional

Typical	Exceptional
They invest in comprehensive strategy development.	They have a bias toward starting.
They have general goals for adoption.	They have explicit national and local aims. (Aim Primacy)
Leadership creates standards.	Leadership removes barriers.
They have “theory lock.”	Improvisation is a virtue.
Data is for assessment.	Data is for rapid adjustment.

Adapted from work by Joe McCannon

Good to Great (Jim Collins)



The “Flywheel”

✓There was no single defining action, no grand program, no one killer innovation, no solitary lucky break, no miracle moment.

✓Instead they followed a predictable pattern of buildup and breakthrough.

✓Like pushing on a giant, heavy flywheel, it takes a lot of effort to get the thing moving at all, but . . .

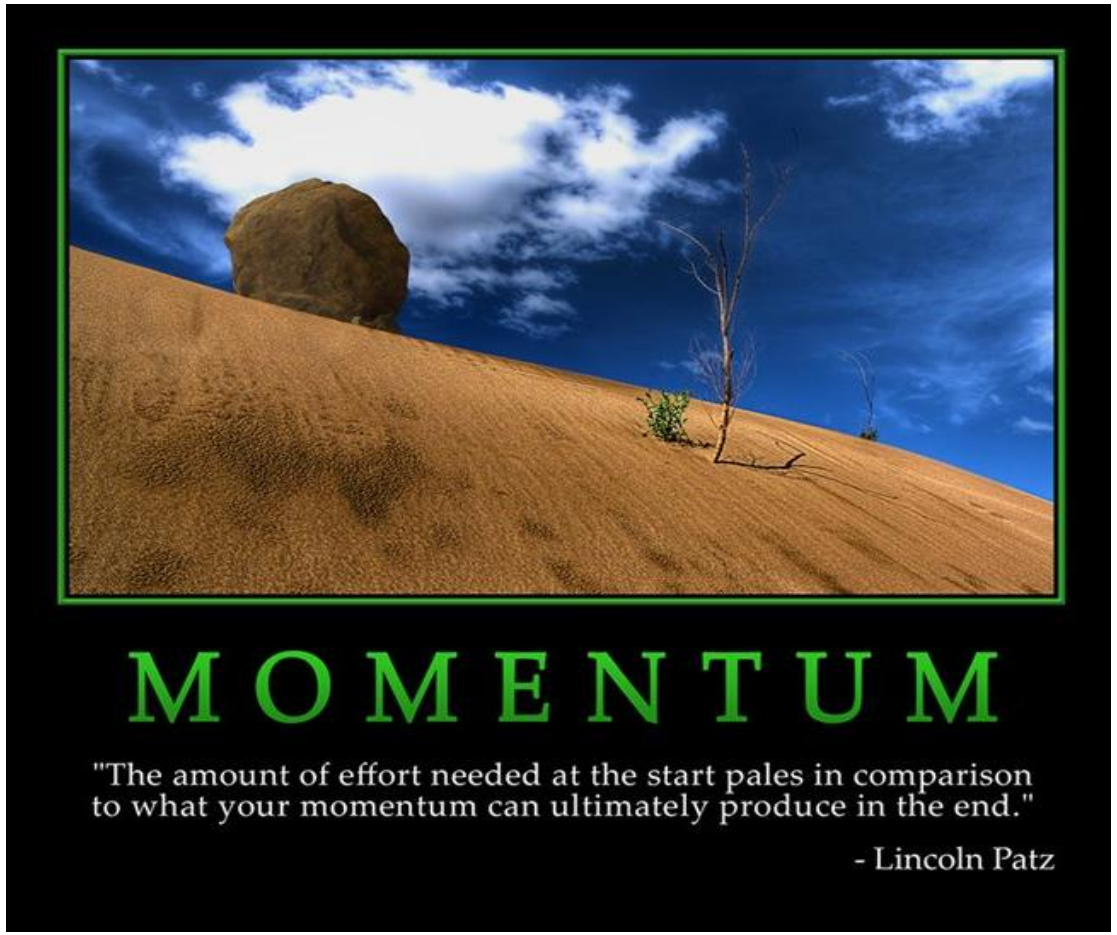
The “Flywheel”

✓The flywheel builds momentum. . .

✓Eventually hitting a point of breakthrough.

✓Alignment follows from results and momentum, not the other way around.

Momentum!


MOMENTUM
"The amount of effort needed at the start pales in comparison to what your momentum can ultimately produce in the end."
- Lincoln Patz


One Way to Keep Momentum going is to have constantly greater goals.
-Michael Korda