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Patient Safety: The Highest Priority

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MEET OUR EXPERTS

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Patient Safety: The Highest Priority

Incident Reporting in Healthcare

WEBINAR AGENDA

1. Patient safety and incident reporting: What progress has been made?
2. Finding value in incident and adverse event reporting
3. Moving from reporting to analytics
4. Importance of actionable information
5. How to maximize incident reporting in my organization
6. Questions & answers

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About MorCare

- 30-year history of providing exceptional products and solutions
- Workflow automation across the continuum
  - Risk/Patient Safety
  - Quality Management
  - Care Management
- Scalable
  - Critical Access hospitals
  - Independent hospitals
  - Large national health systems
- Bi-directional interfaces with all major EMRs

Our Mission

Is to collaborate with healthcare partners to provide enterprise software solutions that deliver actionable information to improve patient outcomes across the continuum.

What if ...

Your leadership could articulate the primary patient safety issues in the organization?

You were confident that patient incidents were being reported and shared appropriately?

You had the information you need to improve patient safety in your organization?

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Institute of Medicine Landmark Study:

To Err is Human: Building a Safer Health System

Report by Institute of Medicine

IOM Findings:

- As many as 98,000 people die each year from medical errors in US hospitals
- 8th Leading cause of death each year: More than motor vehicle accidents, breast cancer, or AIDS
- Total national costs of preventable adverse events: estimated at $29 billion/year
- Adverse events occurred in approximately 3% of hospitalizations

Cost of Healthcare Events

Approximately 2 out of every 100 admissions experienced a preventable adverse drug event, which increased hospital costs on average by **$4,700 per admission**

The increased hospital costs alone of preventable adverse drug events for inpatients are **about $2 billion** for the nation as a whole.

Opportunity costs: Dollars spent on having to repeat diagnostic tests or treat adverse drug events are dollars unavailable for other purposes. Extended LOS following patient safety events

But not all costs can be directly measured.

Errors are also **costly in terms of loss of trust in the system** by patients and diminished satisfaction by both patients and health professionals

Conclusions

A comprehensive approach to improving patient safety is needed

It is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort **"First do no harm"** *Hippocrates*

Institute of Medicine (IOM) Recommendations:

- Incident Reporting (IR) should be utilized as a means to improve patient safety
- Purpose of IR is to analyze the information gathered and identify ways to prevent future errors from occurring
- Change in culture: Shift in focus from **blaming individuals** to a focus on **preventing future errors**, and **designing safety** into the system

Changes have occurred …

Electronic systems for Incident Reporting have proven valuable

- Provide structure for Incident Reporting
- Accessible to all staff members - everyone has access to the IR system, and everyone can report
- Easier to submit, with fewer barriers
- Allow for input and perspective from multiple departments
- Lessons can be shared within and across organizations

Observed CULTURE changes over time

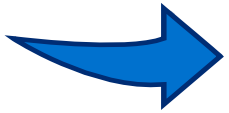
- Shift from punishment, to a system perspective and more of a No Blame Culture
- Reporting observed incidents has become the norm
- Looking for system failures, vs. individuals

Where are we now?

Medical errors are still a widespread problem

- Est. more than 1.5 million people are sickened, injured or killed by medication errors each year
- Approximately 17% of all hospitalized patients experience preventable harm
- The third leading cause of death in the US
- More than 400,000 patients per year die from these injuries in the United States

Under-reporting of events remains a major issue for incident reporting systems, estimated that as many as 95% of adverse events go unreported



Patients today are experiencing 10x the rate of preventable harm as they were in the 1990s

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Change is needed:

Need for ***action***

- Less time reporting incidents, more time on actually implementing change
- Learn from what went wrong, instead of just reporting that something went wrong again
- Improve feedback mechanisms so that the reporter is informed about the results
- Visible outcomes: share that measures are taken based on the incidents reported

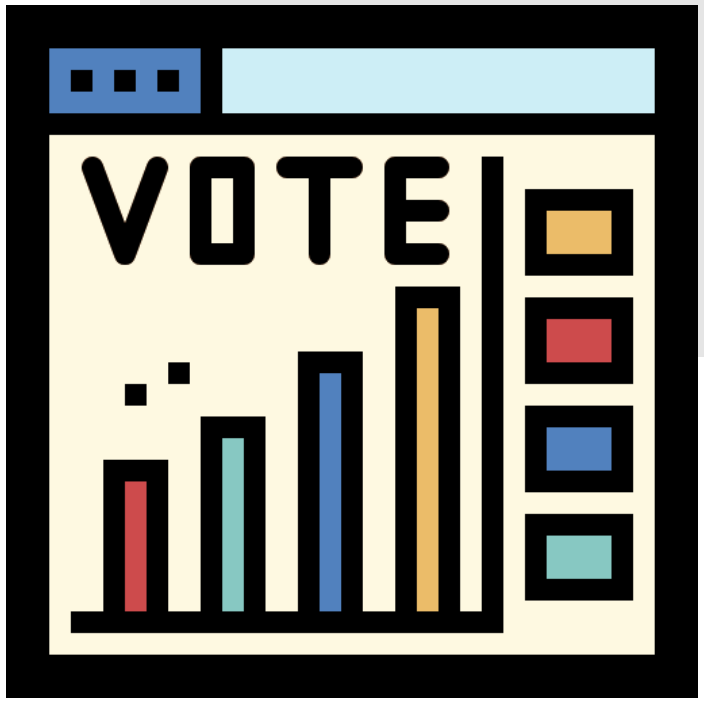
If changes are not implemented and recognized, motivation to continue reporting will decrease.

Going forward...

Understand: What events are highest priority for reporting?

- Events that have previously **caused harm** should be priorities
- Focusing on **preventable events** will advance safety more than reporting non-preventable ones
- Identify and share that specific events are **current short-term priorities**, update this list as existing problems are mitigated and new ones emerge

Share with everyone…



Has the pandemic brought more attention and impact to patient safety as a strategic priority for your organization?

TAKE THE POLL

Finding value, success and ROI from an automated system…

Why our customers think a solution is important:

- Instant reporting and efficiency
- Structured, consistent and reliable process
- Department managers receive incident notifications
- No more notification delays
- Ability for managers to record comments, upload supporting images or files, forward events to others who need to know
- Reduce preventable harm
- Dashboards provide visibility and allow for data-driven decisions to be made

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Value Based Care: The Role of Risk Management

What is needed now, to support value-based health care:

- Cost saving should be a strategic value of Risk Management activities
- Culture focused on implementing change for improvement
- Tools and resources focused on using data and metrics to support patient safety

Evidence shows that **patient safety is more cost-effective**, in addition to being the right thing to do.

Providing a business case will support enhanced safety and demonstrate added value.

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Calculating ROI for Risk Management

Healthcare - Acquired Condition	Average Cost per Event	# of Events in Your Facility	Your Facility's Average Cost
Medication Errors/ Adverse Drug Events (ADE)	$1,000 - $9,000		
Catheter-Associated Urinary Tract Infections (CAUTI)	$5,000 - $30,000		
C. Difficile Infections (CDI)	$4,000 - $32,000		
Falls	$3,000 - $15,000		
Pressure Ulcers	$9,000 - $21,000		
Surgical Site Infections (SSI)	$12,000 - $42,000		
Ventilator-Associated Pneumonia (VAP)	$19,000 - $80,000		
Venous Thromboembolism (VTE)	$11,000 - $32,000		
		Total Cost:	

Source: Agency for Healthcare Research and Quality. (2016, December 9) AHRQ Tools to Reduce Hospital-Acquired Conditions. Retrieved from https://www.ahrq.gov/hai/hac/tools.html

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Calculating ROI for Risk Management Continued

Healthcare - Acquired Condition	Average Cost per Event	Average Number of Events	Average Cost to CAH Facility: 1,000 Admissions	Average Cost to Facility: 2,500 Admissions
Medication Errors/ Adverse Drug Events (ADE)	$1,000	1.2 per 100 admissions		
Falls	$3,000	.67 per 100 admissions		
Pressure Ulcers	$9,000	3.6 per 100 admissions		
		Total Cost:		

Sources:
Agency for Healthcare Research and Quality(2016, December) National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data From National Efforts To Make Health Care Safer. Retrieved from https://www.ahrq.gov/hai/pfp/2015-interim.htm
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“The ultimate purpose of collecting data is to provide a basis for action…”

– *W. Edwards Deming*

- **The focus on building incident reporting systems and data has led to our current problem with incident reporting:** ***we collect too much and do too little***
- **Looking forward, we must refocus efforts and develop better processes for investigation, learning, sharing, and changing**
- **We need to ensure that safety incidents are routinely resulting in system wide improvements**

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Data Analytics and Dashboards

MorCare Risk Management Dashboard

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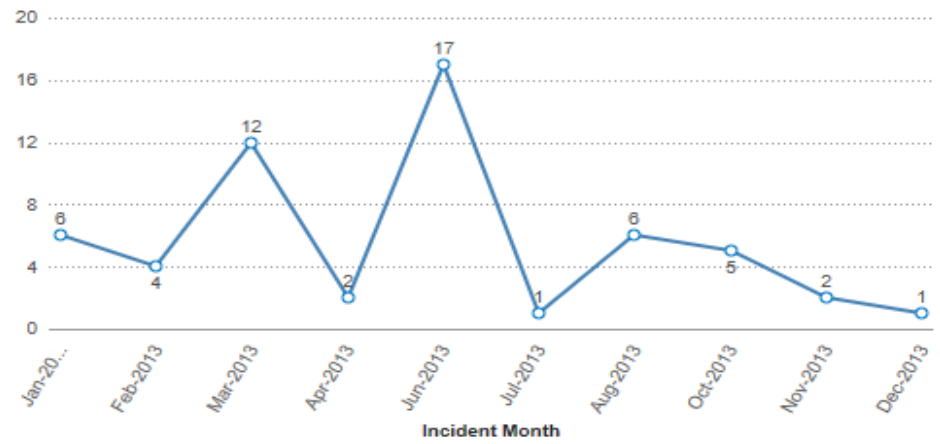
TOTAL NUMBER OF INCIDENTS

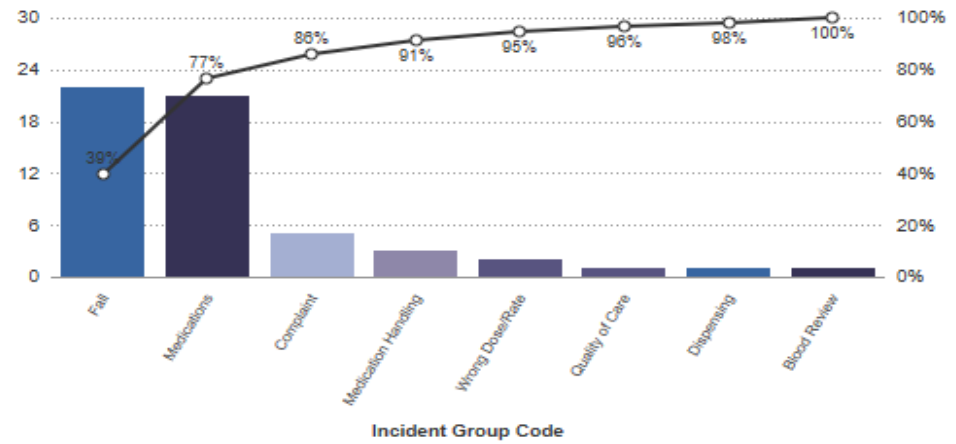
Current Time Period:		Previous Year Period:
12/31/2012 To 12/30/2013		01/01/2012 To 12/30/2012
56	Increase 71%	16

Incident Date Range
01/07/2013 — 12/03/2013

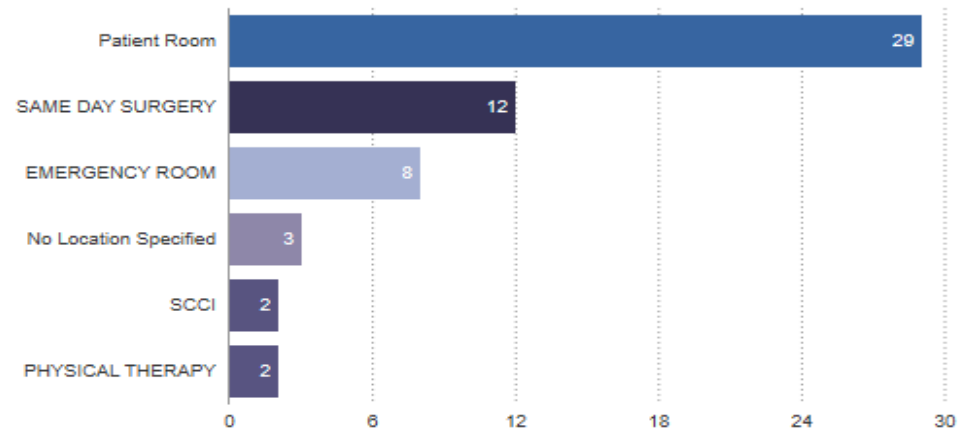
INCIDENT VOLUMES BY MONTH



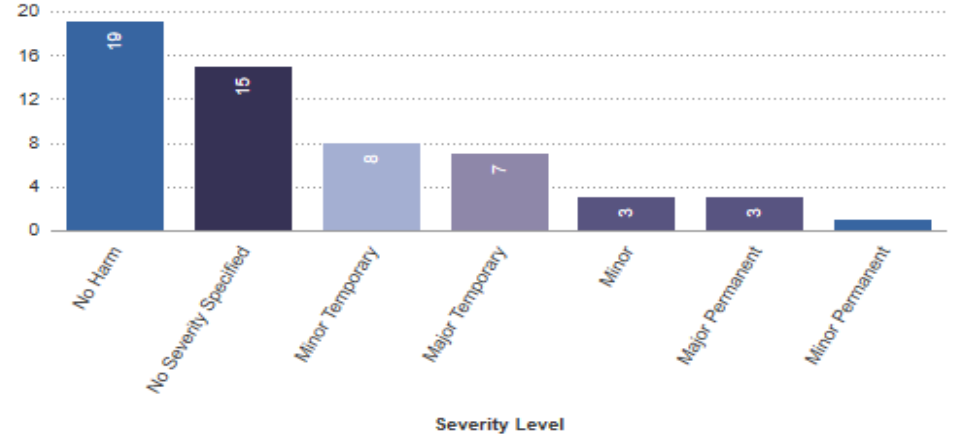
INCIDENT VOLUMES BY INCIDENT GROUP CODE



INCIDENT VOLUMES BY LOCATION



INCIDENT VOLUMES BY SEVERITY LEVEL



Facility
Memorial Hospital

Incident Category
All

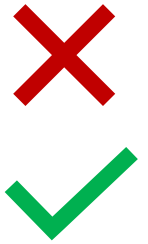
Incident Group
- [ ] Blood Review
- [ ] Complaint
- [ ] Dispensing
- [ ] Fall
- [ ] Medication Handling
- [ ] Medications
- [ ] Pressure Ulcer
- [ ] Quality of Care
- [ ] Wrong Dose/Rate

Severity Level
All

Location
- [ ]
- [ ] EMERGENCY ROOM
- [ ] Patient Room
- [ ] PHYSICAL THERAPY
- [ ] SAME DAY SURGERY
- [ ] SCCI

Time to reflect…

HOW MANY OF THESE CHECKBOXES DOES YOUR ORGANIZATION'S CURRENT PROCESS OR SOLUTION INCLUDE?		
1	A system to document incidents or adverse events electronically from your workstation or mobile devices	☐
2	A user-friendly wizard which enables events to be reported quickly and efficiently	☐
3	Easy access by patient safety leaders to the collected data	☐
4	An interactive dashboard that allows for easy visualization of incident data, including trends, drills downs, graphical displays?	☐
5	Ability to automate and electronically route reports to leadership	☐
6	The ability to allow for anonymous submission of incidents, if desired	☐
7	The ability to change or update the types of incidents being tracked, as priorities change within the organization?	☐



Please answer the polling question.

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In Summary….

The search for safety starts,
rather than ends, with incident reports.

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How MorCare Can Help

- Single solution (quality, risk, care management)
- Web-based incident reporting tools – easily configurable by the customer
  - Easy to submit Incident Reports
  - Easy to change
- Out-of-the-box AHRQ standard format

  -or-
- Definable, organization-specific workflows and incident formats
- Automated process
  - Immediate automated routing to appropriate department managers
  - Provides visibility into next steps
- Dashboards and analytics
  - Real-time actionable information
  - Drill down to the patient level
- **Scalable to size and budget**

Questions & Answers

Can we answer any questions?

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www.MorCareLLC.com

Check out our Knowledge Hub for articles, blogs and valuable information, as well as keep up-to-date on upcoming webinars

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THANK YOU!

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