The Quadruple Aim: Working Together, Achieving Success

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January 24, 2011

The Patient Safety Reporting System (PSR)
**Report Documentation Page**

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Form Approved
OMB No. 0704-0188

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std Z39-18
Session Objectives

- Become familiar with the Patient Safety Reporting System that is currently being deployed across the direct care facilities.
- Understand the capabilities of the system and the importance of capturing both medication and non-medication patient safety events in a standardized format which facilitates event capture, analysis, trending and learning from patient safety occurrences.

This session will consist of the following:
- 1. Discussion of the PSR application, application benefits, planned product enhancements, aggregate data to date
- 2. Service representatives will discuss PSR use and implementation from the Service Headquarters perspective
- 3. Lessons learned from an experience PSR user at the local MTF level
- 4. Roll out schedule of pending site implementations
A comprehensive, centralized program with the goal of establishing a culture of patient safety and quality within the MHS

Established under the 2001 Department of Defense Instruction (DoDI) 6025.17

DoD PSP identifies and reports actual and potential problems in medical systems and processes and to implement effective actions to improve patient safety and health care quality throughout the MHS

**Our Mission** is to promote a culture of safety to eliminate preventable patient harm by engaging, educating and equipping patient-care teams to institutionalize evidence-based safe practices.

**Our Vision** is to support the military mission by building organizational commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care.
MHS Quadruple Aim

**Readiness**
Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

**Experience of Care**
Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

**Population Health**
Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

**Per Capita Cost**
Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.
Why is Reporting Important?

- It’s important – to keep our patients safe
  - 44,000 – 98,000 deaths/year (IOM 1999)
  - $17 – $29B annually Lost income, production, disability and healthcare costs
    - Over half healthcare costs
  - 1.5M preventable adverse drug events annually in U.S. (IOM 2006)
    - $3.5B annual estimate

- In the DoD:
  - Approximately 128,000 potential and actual events reported in 2009
• Broadly applicable: Commercial Off-the-Shelf (COTS) reporting system
• Maintains confidentiality: Supports anonymous reporting
• Easily Accessible: Web-based application
• Secure: Supports role-based security; CAC enforced
• Simple to use: Intuitive point and click, drop downs, text for the user
• Promotes information sharing: Automates the non-standardized paper-based systems
Benefits

- **Helps improve patient safety**
  - Promotes depth of information necessary for the proactive improvement of patient safety
  - Supports the local, Service and enterprise-wide safety improvement strategy through systematic methodologies and comprehensive analytic tools

- **Enables greater ability to learn and share safety information**
  - Consolidates both medication and non-medication events in one tool
  - Standardizes data capture and taxonomy
  - Centralizes capture, collection and aggregation of event level data
  - Begins alignment with AHRQ Common Formats

- **Promotes fiscal responsibility**
  - Facilitates cost avoidance by reduction of preventable and avoidable health care events

- **Addresses DOD and Congressional Requirements**
  - Responds to the 2001 National Defense Authorization Act (NDAA) and DoD 6025.13
Typical Event Flow

1. Reporter
2. Patient Safety Manager Initial Review
3. Handler (Reviewer)
4. Investigator(s)
5. Patient Safety Manager Final Review
6. Service Headquarters, Patient Safety Analysis Center

De-identified at Service and PSAC levels

Within the MTF
Sample PSR Report Form

When
Selecting Down Arrows Displays Pick lists

Where

What

Answering “Yes” opens Provider section

Answering “Yes” opens Patient section

Answering “Yes” to either the medication or Equipment material sections opens up the additional sections

Optional

Click “Submit” when finished

Answering “Yes” opens Provider section

Answering “Yes” opens Patient section

Answering “Yes” to either the medication or Equipment material sections opens up the additional sections

Optional

Click “Submit” when finished
Major Implementation Milestones

- 44 sites online, 93 sites scheduled between now and 30 June 2011
- Completing and submitting hierarchy
- Determining who will have PSM and Reviewer roles
  - Get them registered
  - Complete AARF
- 45, 30, 15 day Pre-implementation meetings
  - Provide information
  - Assess readiness for training and implementation

Training
- Typically 3 – 5 days depending on facility size
  - Instructor led
  - PSM (8 hrs)
  - Reviewer/Investigator (4 hrs)
- Web-based training available for all roles including reporter

Implementation
- Immediately following training
Planned Enhancements

- Next version 10.2
- Overall enhancements
  - Approval status fields
  - Type ahead
  - Enhanced e-mail notifications
- Improvements to Searching and Reporting
  - Extra fields
  - Stacked bar, stoplight, gauges, change orientation etc
  - Define listing reports
The Quadruple Aim: Working Together, Achieving Success

Lt Col Beverly Thornberg, USAF, NC, DHA(c), MHA, RNC

January 24, 2011
Overview

- Limited Deployment Sites
- Full Deployment Sites
- Challenges
- Successes
Limited Deployment

- Wilford Hall Medical Center: San Antonio, TX
- Malcolm Grow Medical Center: Joint Base Andrews, MD
- Davis-Monthan Medical Group: Tucson, AZ
Full Deployment Sites Implemented to date:

- Bolling Air Force Base (AFB)
- Langley AFB
- Hanscom AFB
- MacDill AFB
- Wright-Patterson AFB
- Seymour Johnson AFB
- Whiteman AFB
- Robins AFB
- Little Rock AFB
- Patrick AFB
- Cannon AFB
- Keesler AFB
- Dover AFB
- Maxwell AFB
- McGuire AFB
- Altus AFB
Challenges

- Aggressive Training Schedule: Increased man hours on regional managers
- MTF Leadership Support Early In The Process: Support in completing security forms
- Sustainment After Training Is Completed: Recommend a recorded DCO/Continued WBT
- Transition From MMSR & JAMRS to PSR
- Role of Champions (Reviewer/Handler or SuperUser): Key to complete & accurate reporting for usable analysis
- Local Access Issues: Not the PSR system
Successes

- Regional Managers at *Air Force Medical Operations Agency* Involvement With Each MTF (75 total): Working together for success
- Reporting Increased Already!
  - 3 facilities reporting 4-52% more
- Tier 3 Support to Resolve Issues Rapidly
- PSR Has Broadened the Number of Reporters
- New Staff Involvement: Significant increase in reporting
- Already Using the Data
2011 Military Health System Conference

PSR Reporting – Navy Approach

The Quadruple Aim: Working Together, Achieving Success
Carmen C. Birk, RN, MS
January 24, 2011

Navy Bureau of Medicine and Surgery
An Implementation Strategy to Ensure Success!

Ensure Leadership Commitment and Support

Set Benefits Expectations and Targets

HQ Staff Participation in Site Training

Monitor Progress and Document Lessons Learned
Navy Implementation Strategy

- Ensure Leadership Commitment and Support
  - High visibility at SG Level
  - Championed by Command Leaders
  - Ownership and involvement by RM/PS
  - Support for staff training and transitioning to new reporting requirements
Navy Implementation Strategy

- Set benefits expectations and targets for an improved Event Reporting process
  - Increase in events reported
  - Expedite review and referral timeline
  - Consolidated record of problems and issues
  - Ability to perform real-time event tracking and trending at MTF level
  - Comprehensive data available at HQ level for event analysis
Navy Implementation Strategy

- Include HQ staff participation in site training
  - Support RM/PS ownership of and involvement in PSR implementation and use
  - Reinforce communication policies and procedures
  - Address and resolve issues as they arise
Navy Implementation Strategy

- Monitor progress and document lessons learned
  - Coordinate with site to ensure implementation schedule stays on target
  - Incorporate training updates into implementation process
  - Compile site experiences to share
Next Steps

- Follow up on progress of implemented sites
  - Continue to troubleshoot user problems and resolve issues
- Establish new baseline for Navy Medicine event reporting
  - Define HQ process for receipt and analysis of aggregate data
PSR Reporting – A Military Treatment Facility’s Perspective

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Suzie Farley

January 24, 2011
MTF Pre Implementation

- **Plan**
  - Develop the communication algorithm for flow of an event
  - Determine reviewers/investigators
  - Establish a contingency plan
  - Brief Leadership on benefits of the PSR system
  - Involve Middle Managers in process flow

- **Market**
  - Announce the PSR deployment to staff
  - Accessing the PSR
  - Review what to report
PATIENT SAFETY REPORTING PROGRAM

How To Report
5 Easy Steps for Using the Patient Safety Reporting System
1. Open your HUMC Intranet browser and Click on PSR icon
3. Enter other information as required.
4. Optional: Enter your information, or leave blank if you wish to remain anonymous.
5. Submit your report.

What To Report
Next Misses: An event or situation that did not reach the patient, but could have resulted in harm but did not, either by chance or timely intervention.
Adverse Events: An event that reached the patient, and either did or did not cause harm.
Sentinel Events: Unexpected occurrences involving death or serious physical or psychological injury or risk thereof.

PATIENT SAFETY EVENT REPORTING FORM

The Patient Safety Reporting System (PSR) tool located at the top of the Intranet homepage allows you access to the electronic reporting forms.

What To Report On PATIENT SAFETY FORMS

Patients who have been hospitalized, have been contacted by their healthcare team, and have any concerns about their care should report them using the PSR tool.

Patient Safety is Everyone's Responsibility
MTF Training

- Train
  - Middle Managers on event process
  - Reviewers and investigators on roles and responsibilities
  - New harm classification definitions
Go Live

- Throw a kick off party
  - Engaged Commander and leaders

- Held weekly meetings with reviewers and investigators
  - Supported and problem solved

- Attended Department Head meetings
  - Established checks and balances
Sustainment

- Updating reviewers/investigators regularly
  - Account Authorization Request Forms (AARF)
  - Continuous training

- Disseminating lessons learned
  - Prepare to be flexible
  - New users already requesting customized data reports
    • Excel proficiency essential
  - Increase focus on training on event categories
PSR Reporting – Army Approach

Medication Safety Focus

The Quadruple Aim: Working Together, Achieving Success

LTC Jorge D. Carrillo, PharmD, MS, BCPS
January 24, 2011
Army Implementation Strategy

- Limited Deployment Sites:
  - Madigan Army Medical Center, Ft Lewis, WA
  - Martin Army Community Hospital, Ft Benning, GA
  - Kimbrough Army Ambulatory Health Clinic, Ft Meade, MD
Partnership with Regional Medical Commands
CoS Implementation Memo – Nov 2010
Full Deployment Schedule
  – NRMC – Nov to Dec 10
  – SRMC – Nov 10 to Feb 11
  – WRMC – Jan to Apr 11
  – PRMC – Apr to May 11
  – ERMC – May to Jun 11
  – DENCOM – May to Jun 11
Transition of PS Data Reporting to HQ
Medication Safety Focus

- Medication Use Process
Medication Safety Focus

PSR System

Spreadsheet

JAMRS
Medication Safety Focus

- Pharmacy & Patient Safety Collaboration
- Increased Visibility of Medication Events
- Reporting of Adverse Drug Events
  - Medication Errors & Adverse Drug Reactions
- Standard Pharmacy Reports
- Pharmacy-Specific PSR Training
- Collaboration with the Institute for Safe Medication Practices (ISMP)
PSR Reporting – Conclusions

The Quadruple Aim: Working Together, Achieving Success

January 24, 2011
Implementation Challenges

- Transparency and Trust
- Three Services with very different cultures
- Existing reporting culture
  - Paper based reporting vs. electronic
  - “Tick-mark” reporting vs. text-based
- Expectation management
  - Customization
  - Transition to standardization
    - Agreement on taxonomy
    - Appropriate use of that taxonomy
    - Efforts to ease the transition
- Aggressive (8-month) full deployment schedule
Lessons Learned

- Leadership engagement
- User Buy-in
- Methods to accelerate integration process
  - Webinars
  - Weekly Office Hours
- Understanding implications of reporting culture shift from paper-based to web-based
- Importance of getting the site hierarchies correct
A system that provides the data granularity necessary to implement change and make our facilities safer for our patients

- Functional community engaged
- Good functional/IT community partnership
- Good Government/Vendor partnerships
Conclusions

- Reporting is good!
- Encourage reporting
- Routinely review and discuss trends
- “If you don’t report them you can’t fix them”
- The culture of safety begins with all of us!

McClinton died after being injected with chlorhexidine, an antiseptic, during a procedure for a brain aneurysm. The antiseptic was mistaken for another substance to be used in the procedure.

A third premature baby has died after being given an overdoes of an anti-clotting drug in an Indianapolis hospital.

Laurie Johnston, Ontario, Canada healthy breast removed in error…
For more information, contact your Service POC:

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