The Massachusetts Health Policy Forum

# *Roadmap to Health Care Safety for Massachusetts*

Massachusetts Health Policy Forum • April 26, 2023

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# *Roadmap to Health Care Safety for Massachusetts*

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# What is “health care safety?”

- Enabling **conditions that foster safe practices and prevent harm** to tens of thousands of people each year across the Massachusetts continuum of care
- Eliminating **disparities in safety outcomes**, including those related to race, ethnicity, age, disability, sex, and gender

# Research reveals a pervasive problem of preventable patient harm

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**61,982**
patient harms

**$617M**
in excess costs

in **one year** in Massachusetts[1]

- **>1%** of state's Total Health Care Expenditures
- **1 in 5** MA residents experienced errors in previous 5 years
- **Conservative estimate**
- Errors occur in all health care settings

## The human toll of medical errors

- Long-lasting physical, emotional, and financial harms
- Loss of trust in providers and the health care system
- Avoidance of health care

*1.* Betsy Lehman Center for Patient Safety. The Financial and Human Cost of Medical Error and How Massachusetts Can Lead the Way on Patient Safety. 2019

# Safety issues affect the workforce too

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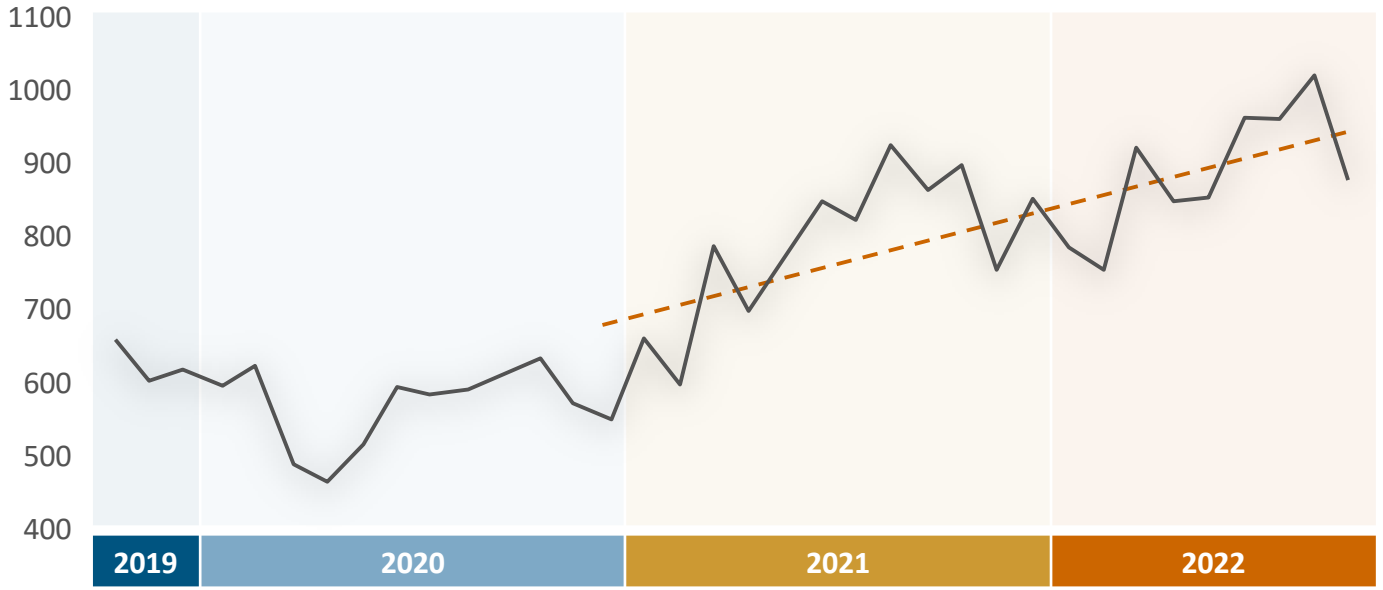


**Incidents of violence against health care workers in Massachusetts hospitals**

*(Courtesy of Massachusetts Health & Hospital Association)*

**Also experience harm from:**

- Back injuries
- Sharps injuries
- Chemical and drug exposure
- Latex allergies
- Stress

Sources: Massachusetts Department of Public Health and U.S. Centers for Disease Control and Prevention

# Response: Massachusetts Healthcare Safety and Quality Consortium

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- A statewide sustained collaboration to dramatically accelerate safety improvement across the continuum of care
  - 36 member organizations
  - 4 task forces
  - 117 individual participants

# Roadmap to Health Care Safety for Massachusetts

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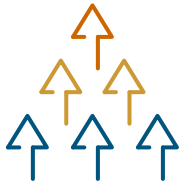
## A *long-term, phased* approach that:

**Recognizes that everyone plays a role in safety**

- Providers, patients and families, payers, policymakers

**Is adaptable and scalable to diverse settings**

- All sizes and complexity
- Across the care continuum



**Targets barriers to improvement**

- Low awareness of safety as a systemic challenge
- Misaligned incentives, lack of accountability
- Inadequate public/private investment in safety improvement
- Data gaps and silos on safety performance and progress

# Focusing on human and operational drivers of health care safety

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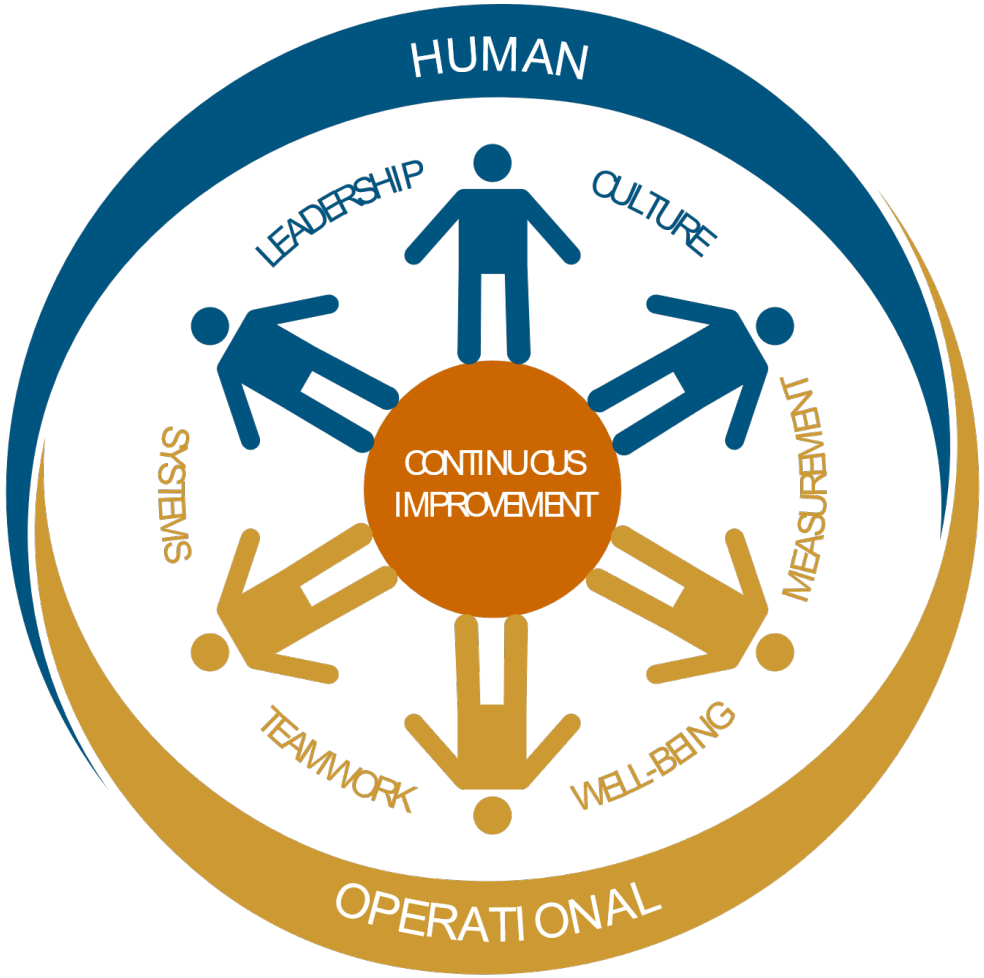
To improve safety, leaders must simultaneously:

- Build **safety culture**
- Integrate safety with other **priorities** including health equity, workforce retention, patient experience



# Guiding principles for Roadmap goals and strategies

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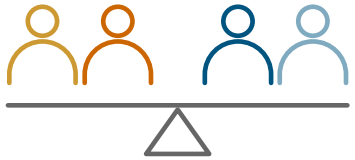
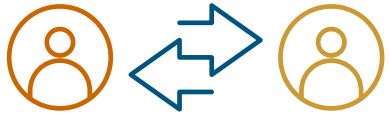
## Safety culture

Fostering a mindset of zero tolerance for defects that can lead to harm



## Health equity

Eliminating disparities in safety outcomes



## Patient engagement

Involving patients and families as partners in improvement

## Psychological safety

Encouraging staff to speak up and engage in safety

## Remove waste from work

Making it easier for staff to do the right thing

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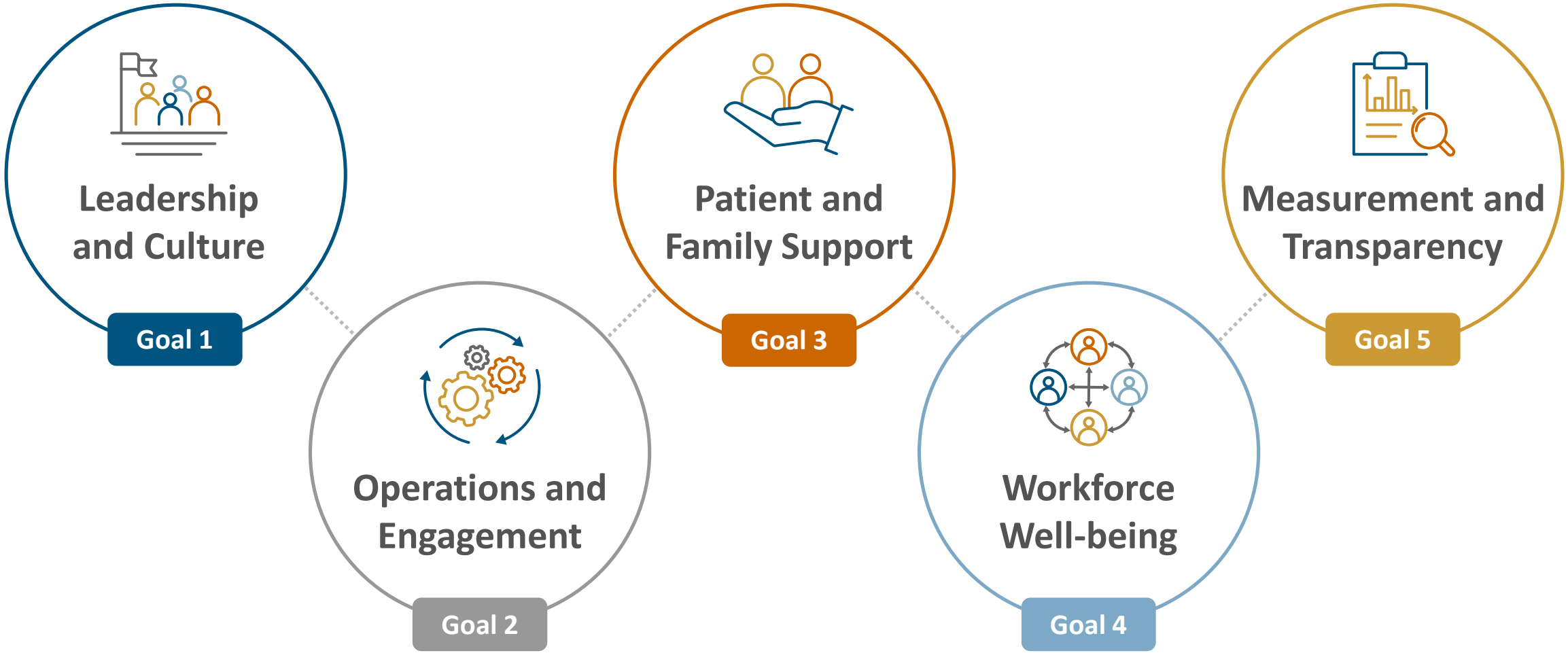
# Targeting safety goals in 5 key areas



Goal 1

# Leadership and Culture

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**All leaders of health care provider organizations across the continuum of care make safety a core value and enduring priority, continuously act to advance safety culture and operations, and are accountable for safety performance**

**Why this is important**

- Leaders communicate values and priorities that drive their organizations' culture and operations.
- Safety is achieved only when leaders make it visible as a core value and enduring priority.
- Safety outcomes are stronger when leadership is committed to safety.

Goal 1

# Leadership and Culture

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| Roadmap Strategies | |
|---|---|
| **Strategy 1.1** | Increase the **proficiency** of board members, executive leaders, and owners on leading and sustaining safety culture and continuous improvement systems through curricula, peer learning opportunities, toolkits, and other resources |
| **Strategy 1.2** | Establish **educational standards on safety** for leaders and governing bodies |
| **Strategy 1.3** | **Recognize** board members, executive leaders, and owners who achieve **high levels of competence and commitment** to safety for patients, families, and the workforce |
| **Strategy 1.4** | **Reward exemplary performance and progress** on continuous safety improvement through reduced liability insurance premiums and higher reimbursement rates |

# Operations and Engagement

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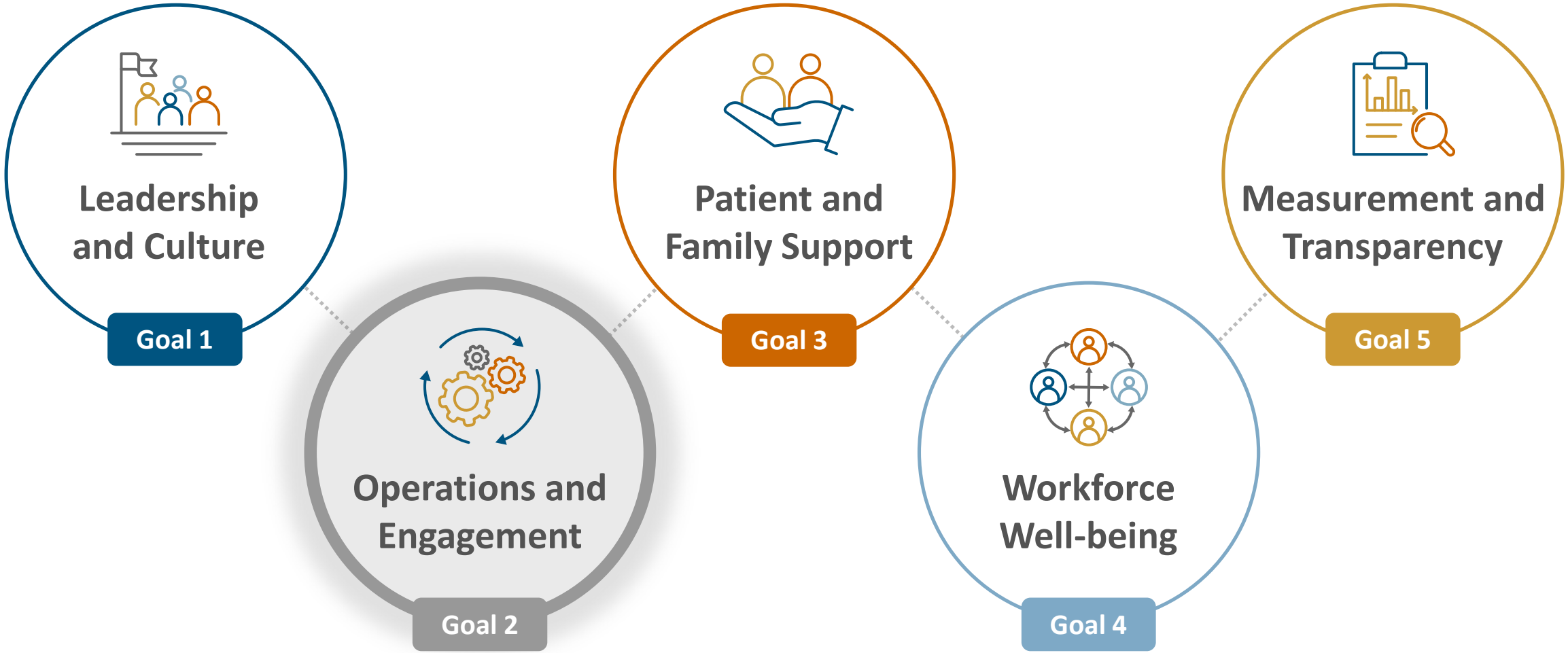

Goal 2

# Operations and Engagement

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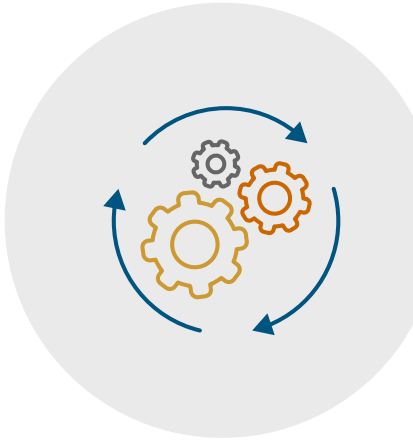
**All provider organizations have systems in place that enable leaders, managers, clinicians, and staff to continuously identify safety issues, resolve problems, integrate their operations with safety strategy and plans, and engage patients and families as partners in the work**

**Why this is important**

- Everyone plays a role in safety
- This work will have impact and be sustainable when woven into routine operations and integrated with other organizational priorities
- Continuous Improvement Systems enable this by removing unnecessary tasks from workflows, promoting teamwork and innovation, and activating clinicians and staff
- Patients and families are reliable observers of safety risks who can make important contributions



Goal 2

# Operations and Engagement

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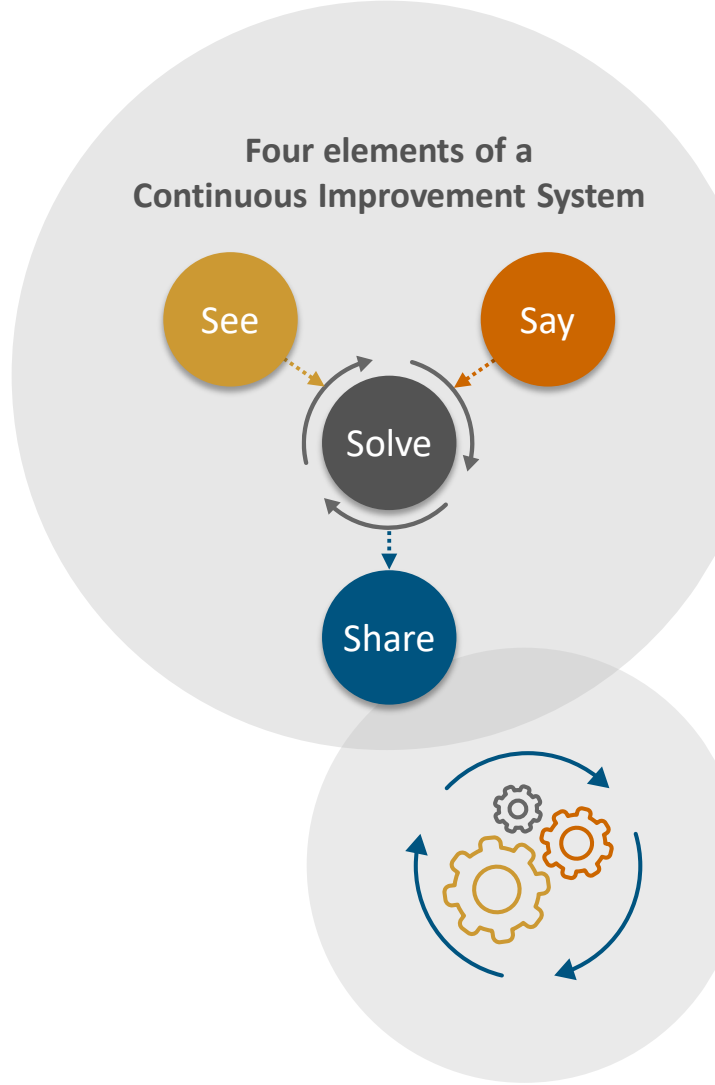
| Roadmap Strategies | |
|---|---|
| **Strategy 2.1** | Support implementation of appropriately scaled **Continuous Improvement Systems** within a culture of safety |
| **Strategy 2.2** | Establish **standardized measure sets and self-assessment tools** |
| **Strategy 2.3** | Leverage **new technologies** to detect and enable a nimble response to safety risks and events |
| **Strategy 2.4** | Strengthen **Patient and Family Advisory Councils** |
| **Strategy 2.5** | Establish **educational standards on safety** for managers, clinicians, and staff |
| **Strategy 2.6** | Create an accessible **statewide health care safety curriculum** |
| **Strategy 2.7** | Advocate for safety content in **health professions training programs** |



# Patient and Family Support

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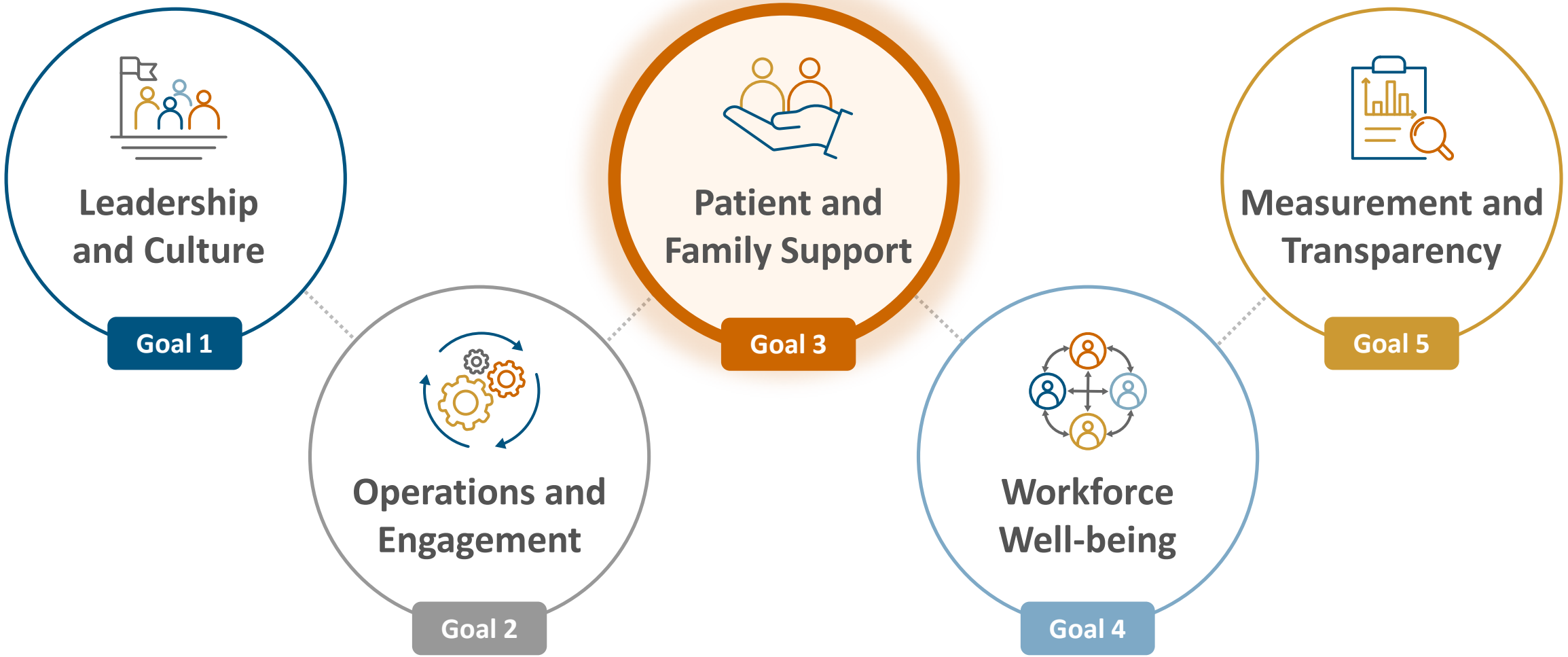

Goal 3

# Patient and Family Support

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**All patients and families are engaged and supported to avoid preventable harm in their own care, and receive timely, transparent, and continuing communication and support when things go wrong**

**Why this is important**

- Risk of preventable harm is reduced when providers engage and support patients and families in their own care
- After adverse events or unexpected outcomes, open communication and support can improve the well-being of patients, families, and members of the care team
- Events that are not addressed have long-lasting emotional impacts, including loss of trust that leads people to avoid getting the health care they need

Goal 3

# Patient and Family Support

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| Roadmap Strategies | |
|---|---|
| **Strategy 3.1** | Raise **public awareness** of health care safety challenges and initiatives |
| **Strategy 3.2** | Boost **health care literacy** to enable patients, including members of historically underserved or marginalized communities, to avoid preventable harm in their own care and to participate in the safety improvement work of provider organizations |
| **Strategy 3.3** | Assist patients and families who experience error, harm, or trauma in their care through programs offering culturally competent **emotional support** and **communication, apology, and resolution** as appropriate |
| **Strategy 3.4** | Build the skills of health care professionals to **communicate openly and effectively** with diverse patients and families, especially in instances of medical error or harm |

# Workforce Well-being

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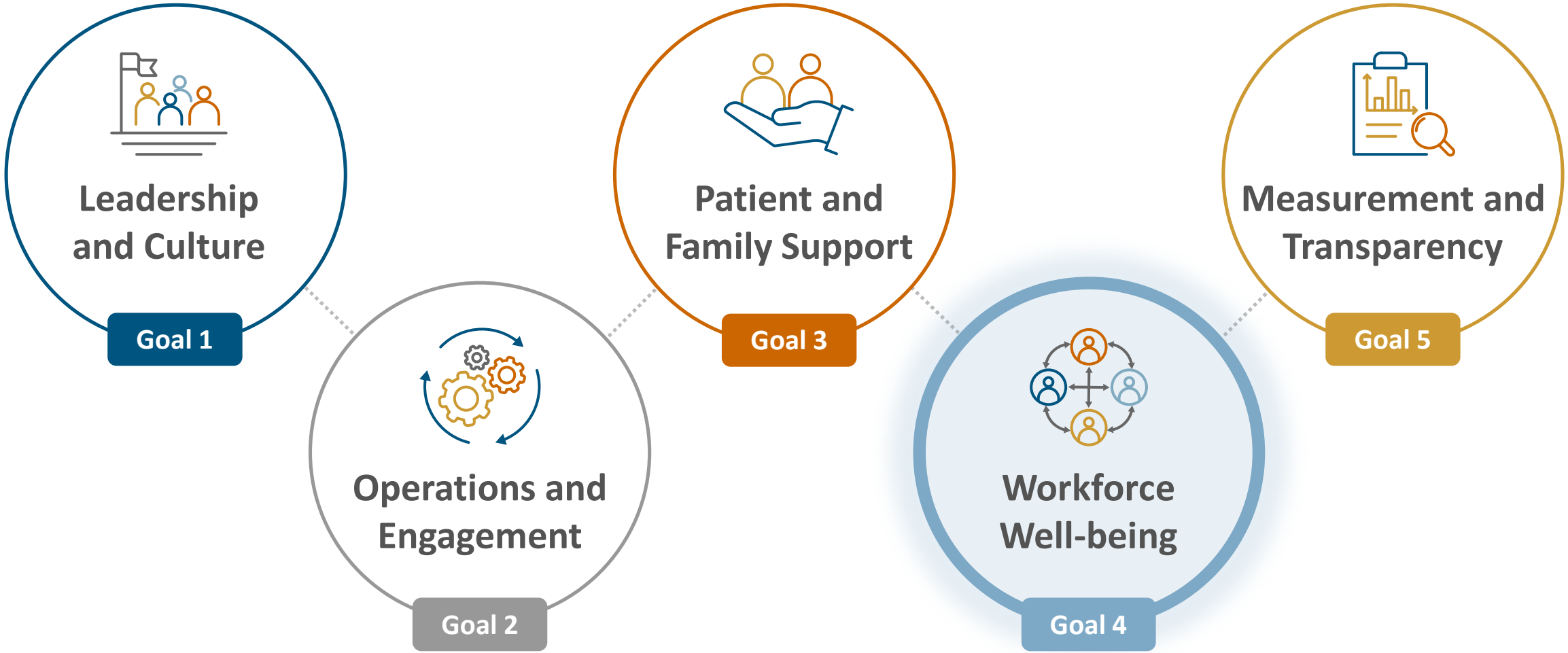

Goal 4

# Workforce Well-being

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**All provider organizations strive to eliminate undue workplace stresses and conditions that impact patient safety and the safety and well-being of the workforce, and clinicians and staff have the psychological safety and support they need to continuously engage in safety improvement**

**Why this is important**

- Healthy work environments and cultures of safety promote the delivery of safe and reliable care
- Workplace stress impedes an organization's ability to engage the workforce in continuous improvement
- Workplace stress drives clinicians and staff from their jobs, exacerbating disruptions and shortages that impact safety

Goal 4

# Workforce Well-being

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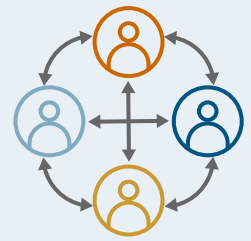
| Roadmap Strategies | |
|---|---|
| **Strategy 4.1** | Through provider organizations' Continuous Improvement Systems, **encourage routine clinician and staff observations and contributions** to address patient and workforce safety risks including unsafe cultures and ineffective workflows |
| **Strategy 4.2** | Support the development of a **fair and just culture and psychological safety** within a culture of safety to promote clinician and staff reporting of events and near misses |
| **Strategy 4.3** | Expand programs that offer **emotional support, learning, and well-being** for clinicians and staff following safety or other traumatic events |
| **Strategy 4.4** | Leverage current national and statewide **health care workforce well-being efforts** that advance a structured approach to reducing stress, moral injury, burnout, and compassion fatigue |



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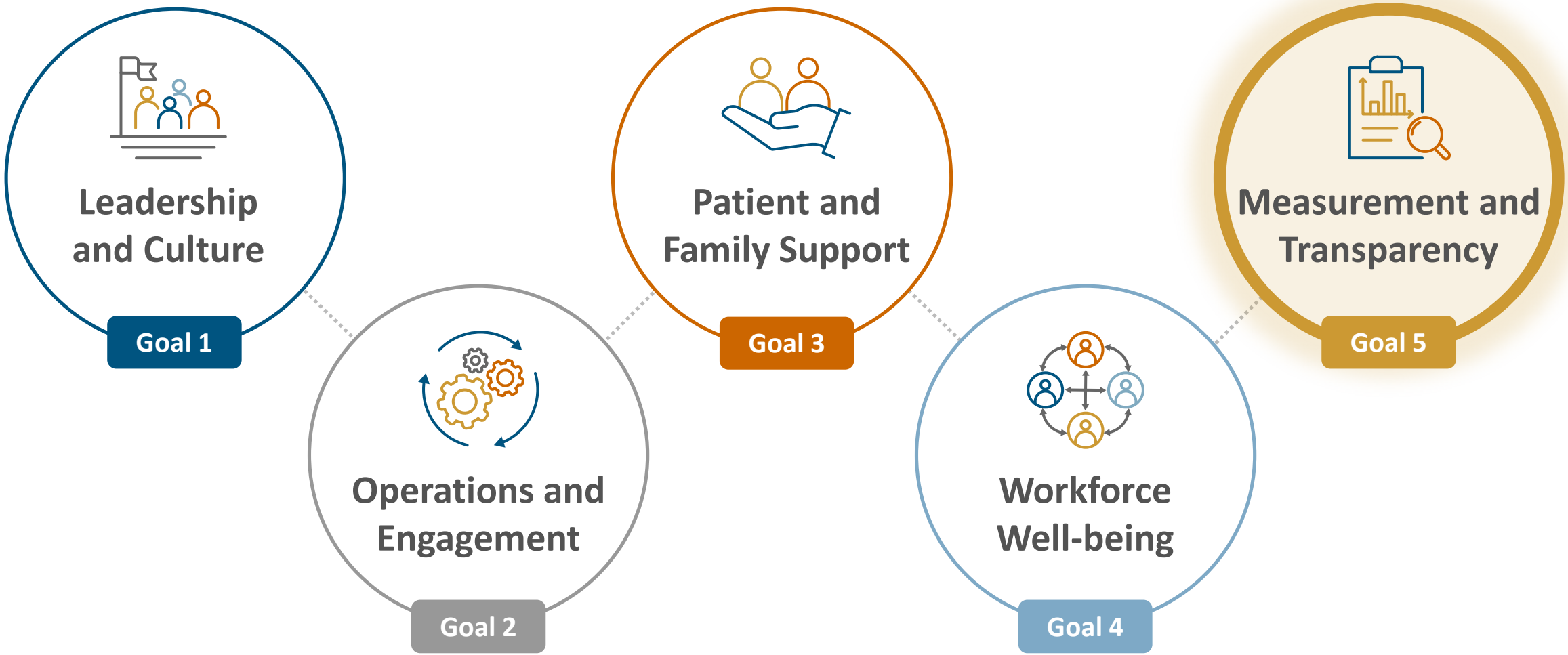
# Measurement and Transparency



Goal 5

# Measurement and Transparency

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**The state's health care safety data systems are optimized and harmonized, and provide timely and useful information about providers' safety performance for providers, policymakers, and the public**

**Why this is important**

- Increases awareness about safety risks
- Helps align resources to priority areas
- Allows patients to make safety-informed care decisions

Goal 5

# Measurement and Transparency

MASSACHUSETTS HEALTHCARE SAFETY & QUALITY CONSORTIUM

| Roadmap Strategies | |
|---|---|
| **Strategy 5.1** | Develop **measure sets for benchmarking** health care safety outcomes, processes, and structures in settings across the continuum of care |
| **Strategy 5.2** | **Improve state health care safety data systems** by streamlining reporting processes, addressing data duplication and gaps, ensuring that data can be stratified by race, ethnicity, and other characteristics, and promoting appropriate data analytics and sharing |
| **Strategy 5.3** | Publish **dashboards** containing timely, relevant, and actionable information about health care safety outcomes, processes, and structures in settings across the care continuum |
| **Strategy 5.4** | **Report annually** on the state of health care safety in Massachusetts, assessing progress toward the five *Roadmap to Health Care Safety* goals and identifying opportunities for continuous improvement at the state and provider levels |

# The path forward: Three-dimensional approach

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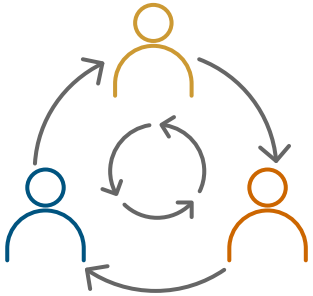
## Inform

**Build essential awareness, knowledge and skills** to enable everyone to recognize and fulfill their roles in safety

**Why** Leaders, managers, and frontline staff need a shared understanding of the foundations of safety to work as a team



## Implement

**Provide tools, peer learning opportunities, and other resources** to support provider organizations in advancing safety

**Why** Knowledge alone is not enough to build a safety culture and improve outcomes

## Incentivize

**Motivate everyone to prioritize and invest in safety improvement** with particular focus on those in leadership roles

**Why** Accountability structures and incentives that reward leadership engagement will accelerate change

# Getting started: Phase 1 action steps

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Action 1

**Education**

Action 2

**Improvement tools**

Action 3

**Automated risk detection**

Action 4

**Patient participation**

Action 5

**Safety data**

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# 1: Health care safety education

| | |
|---|---|
| **Action** | **Create a statewide program of foundational health care safety education through development of a safety curriculum designed for diverse care settings and roles** |
| **Objective** | Everyone in health care – from "board to bedside" and beyond – has a shared understanding of safety principles and practices |

# 2: Continuous Improvement Systems in small office practices

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## Action

**Pilot a voluntary program of technical assistance and support to help small office practices implement right-sized Continuous Improvement Systems that advance patient and workforce safety**

## Objective

Test a coaching model in small primary care office practices that, if successful, could be scaled to similar settings across the state's care continuum, building their capacity to routinely see and solve safety problems

# 3: Automated safety event surveillance in hospitals

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## Action

**Pilot a voluntary program that applies automated surveillance of EHRs to detect and analyze a wide range of patient safety events and enables a response and learning to reduce future harm**

## Objective

Evaluate how automated safety surveillance systems integrate with and support the Continuous Improvement Systems of acute care hospitals and their impact on reducing future harm events

# 4: Patient and family engagement

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## Action

**Support Massachusetts hospitals and ACOs in building the capacity of Patient and Family Advisory Councils (PFACs) to participate in organizational safety improvement structures and activities**

## Objective

Overcome existing barriers to diverse PFAC membership and effective engagement of patients and families in the safety improvement structures and activities of provider organizations

# 5: Harmonized safety data systems

## Action

**Through an interagency/multistakeholder collaboration, improve Massachusetts health care safety data systems by streamlining reporting processes, addressing data duplication and gaps, and promoting appropriate data sharing**

## Objective

Improved ability to track and trend emerging and persistent safety risks affecting diverse populations at the provider level and statewide to inform priority-setting and investment

# What's different about the *Roadmap?*

## Roadmap to Health Care Safety

Recognizes that while only health care providers can implement change in their organizations—policymakers, payers, and the public have roles to play in accelerating improvement across the state's entire continuum of care.

- Coordination and public-private partnerships to build awareness, support learning, manage change
- Adequate resources
- Accountability structures

# Moving health care safety to the top of the agenda—now

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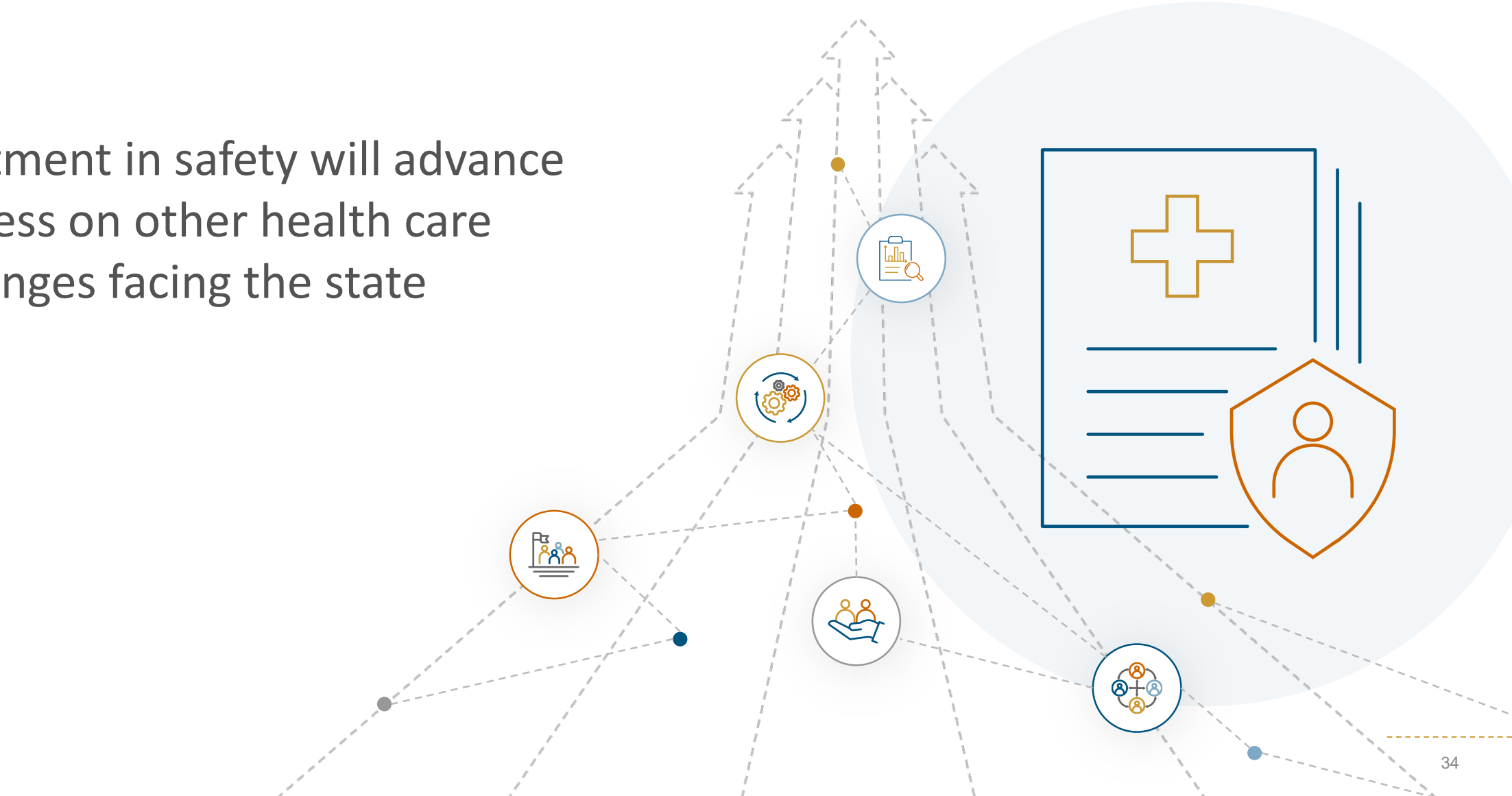
Investment in safety will advance progress on other health care challenges facing the state



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# See you next year

- We'll report back on our progress
- Define next year's action steps