In order to Facilitate Shared Learning from Every Death

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MedStar Health’s mission is to continuously improve the care that we deliver. The aim of this project is anchored in the philosophy that every death provides an opportunity to learn something new about how to improve care; whether the death is from an unanticipated event or the natural progression of illness. MedStar Health is a distributed care delivery network, comprised of seven Community Acute Care Hospitals, two Academic Acute Care Hospitals, one Rehabilitation Hospital and seven hundred Ambulatory Care Locations. MedStar Health is the largest healthcare provider in Maryland and the Washington, D.C. region with over 30,000 associates and 5,000 affiliated physicians.

Background

MedStar strives to continuously improve the care that we deliver. The aim of this project is anchored in the philosophy that every death provides an opportunity to learn something new about how to improve care; whether the death is from an unanticipated event or the natural progression of illness.

Project Aim

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Project Strategy

MedStar Health, in consultation with the Mayo Clinic and their physician champion, Dr. Jeannie Huddleston1, and Vizient Inc.2, embarked on an initiative to develop and implement a standardized system-wide mortality review process with the intent of learning from every death; sharing identified opportunities for improvement and leveraging improvement activities across the system. System leaders selected representatives from each MedStar Health Acute Care Hospital to design and implement the initiative (the advisory group). The advisory group developed the following tactics:

• Create a standardized review process that can be implemented across the system at each individual hospital.
• Agree upon a standardized mortality review form for data collection and application to be implemented across the system.
• Design a process and application for reporting opportunities for improvement at both the local hospital level and the system level.
• Design a searchable Shared Learning Library/Repository for storing details of implemented improvement activities from across the system.

Actions Taken

• Each acute care hospital formed a physician and nurse led multidisciplinary Mortality Review Committee. Membership from other disciplines varied, but often included pharmacy, palliative care, clinical documentation specialists, unit level staff, etc.
• Identified opportunities for improvement are referred to hospital leadership (CMO/CNO, Clinical Dept. Heads, Quality & Safety Leaders, Unit Managers, etc) who are responsible for prioritizing and initiating improvement activities.
• A summary dashboard updated monthly and is available to all sites for use at local or system level meetings.
• Case summaries will be provided to leaders on institution specific timelines.

Anticipated Outcomes

Short-Term:

• Through repeated reviews, a greater awareness of patient and family experiences with our hospitals and providers during death episodes.
• A better understanding of the utilization of the palliative care model.
• Identification of previously unknown Quality and Safety issues

Intermediate-Term:

• The beginning of ongoing monitoring for trends and patterns at the system and local levels.
• Learning something actionable from each death.

Long-Term:

• Creation of system-wide communications process for the sharing of discoveries and improvement actions taken.
• Include transferring system hospitals in the review process to expand the review of the continuum of care to the entire patient experience within the system.
• Using knowledge to drive change. Each anticipated death will be a better death, and any unanticipated death will not be a result of a known issue.

Impact So Far

• Improved multidisciplinary communication within the Mortality Review Process
• Standardized Mortality Review Process is in place – some hardwiring still needed
• Changed perceptions of Mortality Review from person focused (who did it) to system and Process Focused (why did it happen)
• Improved case review from focus only on the unit and service where the patient died but to the entire continuum of care.
• Identification of underutilization of Palliative Care and identification of many other opportunities for improvement.

High-Level Project Timeline

High-Level WorkFlow

Review Process:

Each hospital is responsible for conducting mortality reviews following a standardized process consisting of an MDL/RP review and an RN review. The goal of the review process is to identify process and system failures (not individual provider or staff failures – this is not peer review). The reviewers and associated staff are only responsible for identifying opportunities for improvement (OFIs) and reporting findings to hospital and system leaders by producing timely, accurate and actionable case summaries which will be distributed to appropriate hospital and system leaders on a regular basis.

Improvement Process:

Improvement activities are the responsibility of the local and system-level leaders, and the Mortality Review Team. Case Summary Reports containing identified OFIs will be sent to local leaders and managers for appropriate action. Senior Leadership will be responsible for prioritizing OFIs and initiating improvement teams and activities. Department heads and managers may also receive case summaries related to their specific areas of responsibility for further review/investigation as deemed necessary (e.g.: peer review).

System Process:

The intent of the System Process is to facilitate shared learning and identify improvement activities that could be applied at specific sites or across the system. Site-Level Quality Leadership will share specific OFIs and corrective action taken to minimize repeat occurrences. Recommendations for system level implementation may be determined and operationalized by senior hospital and system leaders.

Identified Opportunities for Improvement

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MedStar St. Mary’s Hospital
MedStar Union Memorial Hospital

1 This project was greatly influenced by participation in the “Multi-Center Collaborative to Move Beyond Mortality Review and Create the Next Generation Safety Learning System” and the UHC/Vizient Enhanced Mortality Review Collaborative.
2 Vizient Inc.: https://www.vizientinc.com/