The Future of Mortality Review: Learning from the Living

Jeanne Huddleston, MD, MS
Hanan Foley
Patty Atkins
Vicki Nolen
Valerie Craig
Lacey Hart, MBA, PMP

December 11
AM Session

#IHIFORUM
Agenda

Welcome, Introductions & Logistics

Why Mortality Review?

Case Review

Findings Report Out (Shout Out)

SLS Training

Cheat Sheet Review

10-10:30 Break

Collaborative SLS Lens Review

Medstar Experience

Sharp Experience

Methodist Experience

Gratitude
Logistics: Business for the Day

- Locations
- Lunch tickets
- What’s on the table?
  - Collaborative information
  - Patient chart
  - Fun
  - Survey
- Plus/Delta
- “Coffee”
- Time for agenda
  - 10:00 break
- Success depends on…. You!
Sticky Note Shuffle

- Physician (blue)
- NP or PA (blue)
- Nurse (yellow)
- Pharmacist (green)
- Quality Department (pink)
- Administration/Department (pink)
This is an Interactive Session

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Enter our Session PIN

The event screen will show until presenter launches a question:

Enter 5 digit event number

74573

Ok, next

The Future of Mortality Review

IHI National Forum

Waiting for a new question.
(When your host is ready to start a new question.)

Sometimes, after a (very) long time, a reconnect is needed, use purple button below to reconnect.

Reconnect
Leave event

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Do you have direct contact with patients?

1. In your staff position, do you typically have direct interaction or contact with patients?

- YES, I typically have direct interaction or contact with patients: 48.3%
- NO, I typically do NOT have direct interaction or contact with patients: 51.7%

(58 users voted)
Which of these objectives is most important to you?

2. Of the three session objectives, which is of most interest to you:

- Implement a learning system that embodies principles of high reliability — specifically, deference to expertise: 22.6%
- Move beyond the medical model of peer review to a process of interprofessional learning that leads to actionable information and change: 58.5%
- Define the largest safety problems facing health care today: acts of omission, not commission: 18.9%

53 users voted
Why mortality review?

The tip of the iceberg:
incident reporting, peer review, global trigger tool
Why do things differently?

The tip of the iceberg:
incident reporting, peer review, global trigger tool

No targeted QI initiatives.
No measurable improvement!
Every Life Matters

Under the Water: The *real* patient, nurse, and physician experience.
Doing Things Differently

Safety Learning System™

Identify, measure, & improve the process failures that:
- prevent your providers from doing their best job every day
- lower quality rankings
- impede great patient experiences
Audience Case Review

Instructions:

1. Review case in folder
2. 15 minutes
3. One finding per sticky note
   - Use your color!
   - If none, then write “NONE”
4. Group “Shout Out”
3. In my hospital mortality reviews feel like a person is being written up, not addressing system problems

- Strongly Agree: 1
- Agree: 12
- Neutral: 15
- Disagree: 10
- Strongly Disagree: 3
Let’s hear from you

4. In my hospital mortality reviews have led to process and system change

- Strongly Agree: 12.3%
- Agree: 33.3%
- Neutral: 24.6%
- Disagree: 21.1%
- Strongly Disagree: 8.8%

57 users voted
Every Life Matters

Jeanne M Huddleston, MD, MS

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Disclosure

• I am fundamentally biased about the potential this work has to save lives, improve systems of care delivery, build effective teams, create a culture of safety and just plain make a difference.

• I am a co-founder of the international SLS Collaborative & HB Healthcare Safety, SBC and nonprofit

“I want to be a lawyer - they still get recess.”
Learning From Every Death

Jeanne M. Huddleston, MD,*† Daniel A. Diedrich, MD,§ Gail C. Kinsey, RN,∥
Mark J. Enzler, MD,‡ and Dennis M. Manning, MD*

The concepts of peer review and the venerable morbidity and mortality conference are familiar improvement approaches to health care providers. These 2 entities are typically provider or patient centric and are not typically extended within hospitals and health systems as a tool for organizational learning for care process or system failures. Out of a desire to deepen our understanding and accelerate learning about quality and safety opportunities in our hospitals, Mayo Clinic embarked on journey to analyze the stories of all patient deaths. This paper illuminates the lessons learned through the development and evolution of the Mayo Clinic Mortality Review System (Rochester, MN).

Guiding principle of Mayo Clinic Mortality Review System:
“No one should ever suffer or die as the result of process of care or system failure.”
“No one should ever suffer or die as a result of process of care or system failures.”

MCR Mortality Review Subcommittee, May 2007
Review Process Guiding Principles:

The Non-Negotiables

1. System review (not peer review)
2. Deference to expertise: Every case is reviewed by a practicing nurse and physician
3. All findings are recorded in the central registry
4. Multidisciplinary, multispecialty sessions used to build consensus re: findings
5. Implementation is local
Examples of Process & System Fixes

• Admission transfer center
  – 62 fold increase risk of failure to rescue death if patient triaged to wrong level of care at admission

• Palliative care order sets and triggered consultation

• Standardized evaluation for mesenteric ischemia

• Standardized care for deteriorating patients with escalation of expertise (with/out sepsis) in ED, ICU and general care wards
MOVING FROM MORTALITY REVIEW TO A SAFETY LEARNING SYSTEM
In 2014, Mayo Clinic’s CQO asked the mortality review team…

“WHEN CAN WE START LEARNING FROM THE LIVING? DON’T YOU THINK SOME PATIENTS ARE SURVIVING IN SPITE OF US?”

Mayo Clinic recognized that their review methodology could be used to learn from any “problem” patient cohort (eg., readmissions).
Compare and Contrast

Peer Review

Problem identified
Reviewed and discussed by peers
Individual contributes or “notified”

Safety Learning System

Patient is a member of a cohort* of interest
Reviewed and discussed by group of multi-disciplinary and multispecialty practicing providers
Opportunity identified
Learning shared broadly

*A cohort could be any group of patients that your system wants to improve performance
What is an Opportunity For Improvement?

Could I passively watch a member of my family experience this care… without wanting to intervene?
When it’s your Mom...
Let’s hear from you

5. I believe process based mortality review will offer a new perspective to drive meaningful change

- Strongly Agree: 45.2%
- Agree: 50.0%
- Neutral: 2.4%
- Disagree: 2.4%
- Strongly Disagree: 0%

42 users voted
Let's hear from you

6. I believe this methodology would be easily supported and adopted in my hospital

- Strongly Agree: 6.0%
- Agree: 30.0%
- Neutral: 24.0%
- Disagree: 38.0%
- Strongly Disagree: 2.0%

50 users voted
Caution…

• Reviewing deaths does not save lives
• Reviewing readmissions does not prevent readmissions
• Reviewing high cost cases does not lead to cheaper care

**ONLY identifying common patterns of process failures AND**

targeting/prioritizing those with an improvement initiative will make a meaningful (measurable) difference
ROI Depends on Leadership

WITHOUT action from leadership:
• Physician and nursing engagement
• Patient safety culture enhancement

WITH action from leadership
• Cost avoidance (eg, ICU days, wrongful death suits)
• Improved efficiency (eg, time-to-therapy, flow, LOS)
• Improved efficacy (eg, right provider, right place)
• Improved diagnosis (eg, accurate, timely diagnoses)
• Improved outcome (eg, decreased mortality rate)
• Improved patient experience (eg, “good” deaths)
International and Multicenter

SAFETY LEARNING SYSTEM COLLABORATIVE
Collaborative Members

Members joined in 2016

Mayo Clinic Rochester
Regions Hospital/Health Partners, Minneapolis
Beaumont Health, Michigan
Sharp HealthCare
MedStar Health
University of Mississippi Medical Center
University of Washington Medical Center

More joined in 2017*

Mayo Clinic Health System
Aurora Healthcare
Eastern Maine Healthcare System
Methodist Hospital System, Dallas
Parkview Healthcare, Indiana
University Medical Center, Lubbock
State of Tasmania, Australia
Hoag Hospital System
Providence Health, Vancouver
UT Southwestern, Dallas
University of Colorado
Wake Forest Baptist Health System
Orlando VA Medical Center
University of Utah Medical Center
WellStar Healthcare System
SLS™ Collaborative Results

Traditional patient safety:
Spend 80% of time, money and energy on HACs & HAIs

Collaborative findings for the next generation patient safety:
80% of the opportunities of improvement are omissions – but less than 20% of opportunities are HACs and HAIs
Opportunities for Improvement
Preliminary Results from 2016 Members

OFI - Category
1=End of Life Opportunities
2=Documentation Opportunities
3=Treatment Opportunities
4=Delayed or missed diagnosis
5=Communication Opportunities
6=Transition of Care/Triage Opportunities
7=Hospital Acquired Infections
8=Other
9=Delay in care of acutely deteriorating patients (exceed local MET/RRT criteria)
10=Medication/Blood Events
11=Surgical/Procedural Issues
12=Prophylaxis Opportunities
13=Miscellaneous Hospital Acquired Conditions

N=493
End of Life Opportunities
Preliminary Results from 2016 Members

Getting to the next layer down… but not root cause

OFI - Sub-Category 1
1=Palliative care team could have assisted (earlier/at all)
2=Goals of care not evident or uncertain
3=Excessive/Futile care
4=Other
5=Family support/dynamics
6=Excessive Pain
7=Delirium/Agitation
8=Supportive care
9=Tachypnea/Dyspnea
Learning from Collaboration on Mortality Reviews: The Journey

Hanan Foley, MSN, RN, CPHQ
Disclosure Information

Hanan Foley, MSN, RN, CPHQ has nothing to disclose.
Objectives

- Describe mortality review background at MGUH
- Provide a SWOT analysis for MedStar Health Mortality Review Collaborative
- Identify strategies that helped at MGUH
- Describe the evolution of system shared learning
MedStar Georgetown University Hospital

Not-for-profit, acute-care teaching and research hospital in Washington, DC

Part of MedStar Health, a 10-hospital system and the largest healthcare provider serving the greater Baltimore/Washington, DC region

MGUH Centers of Excellence

- Lombardi Cancer Center
- Neurosciences
- Transplant Institute
- Tertiary GI

Magnet Status x 3
MedStar Health At a Glance

- 10 hospitals and a comprehensive network of outpatient centers and physician offices
- 31,000 Associates
- 8,700 Nurses
- 5,400 Credentialed Physicians
  - 2,600 Employed Physicians
- 1,100 Residents/Fellows
- 158,000 members enrolled in MedStar Family Choice and MedStar Medicare Choice
- Medical Education and Clinical Partnership with Georgetown University

FY 2017 data (except the nurses number, which reflects FY 2015 data)
MedStar Health Week At a Glance

- Admits more than 2,600 patients
- Treats 9,600 patients in our EDs
- Sees about 90,100 patients in outpatient services
- Performs 1,500 ambulatory surgeries
- Delivers 200 babies
- Conducts more than 5,700 home care visits

FY 2017 data
Mortality Review Background at MGUH Past State (2015)

- Did not have 100% mortality review in all service lines
- No formal process for case selection
- No standard process for case review
- M&M’s done by each department
  - Peer review
  - Not multidisciplinary
  - No organizational distribution/ follow-up
MedStar Mortality Review Collaborative

Review Workflow

Case Summaries →

Review Process

Mortality Review Committee Meeting

Review and Prep Team

Reconciler Review

Specialty Review

Pharmacy Review

Optional

MD/LIP Review

RN Review

Tier 1 Review (Optional)

Create Case:
Basic Patient Demographics
Entered and MD/RN Reviewers Assigned

Knowledge and Compassion Focused on You
MedStar Mortality Review Collaborative

High-Level Workflow

System Process

Quarterly Process

Monthly Process

Collaborative Site Leaders Team (Logistics and Operations)

Mortality Review Committee Meeting

Review and Prep Team

Reconciler Review

Specialty Review

MD/LIP Review

RN Review

Tier 1 Review (Optional)

Create Case:
Basic Patient Demographics
Entered and MD/RN Reviewers Assigned

Optional

Case Summaries

Mortality Review Subcommittee

Quality Directors Coordinating Council (QDCC) – Share Findings and Actions/Activities

System Leadership Team

System Safety Team
- Share unidentified PSE Cases

Notify Clinical Heads
- Share case reports with OFIs related to clinical area

Notify Unit Managers
- Share case reports with OFIs with associated Units/Areas

Notify Senior Clinical Leadership
- Share all new case reports with OFIs

Report Findings to local Quality Council
- Share all new case reports with OFIs
S.W.O.T. Analysis

Strengths

What are the benefit?
What's being done well?
Is there engagement?

S

Enhanced Collaboration across disciplines
- Committee Meetings are very high energy with medicine physicians, surgeons, and nurses engaged in review partnership and discussions concerning patient care
- Mid-Level Providers, Pharmacy, Palliative Care Social Worker, others, added to teams at some sites.

Non-Punitive approach to Mortality Review – Open and honest conversations about patient case across discipline

Not related to preventability

Consensus driven

Identifying similar opportunities across sites and sharing strategies for improvement

Capture events not reported in the PSE System

Review findings leading to educational opportunities, such as Grand Round and other lectures
S.W.O.T. Analysis

What are the Problems?
What’s Not being done well?
What needs Improvement?

**Weakness**

- **Resources** to complete reviews is a major problem across all sites – *availability of Physician and Nurse Reviewers*

- **Time** needed to complete reviews – *30 to 60 minutes, sometimes longer*

- **Lack of standardized reviewer training** to ensure consistent and reliable findings

- **Steep learning curve**

- **Transitioning from a “peer review” mindset to a systems approach** - focusing on OFIs

- Goal of 100% mortality review may not be feasible

- Limitations with the **initial** version of the Safety Learning System Mortality Review Application
S.W.O.T. Analysis

Where can we expand?

What can we include?

What else could or should be done?

Opportunities

- Conducting joint reviews with other MSH entities – *Looking at the continuum of care and care transitions*
- Expand review beyond inpatient areas (*ED, Practice Offices, etc.*)
- Expand use of application and process to other types of reviews (*sepsis, readmissions, PSI, etc.*)
- Use the application and process to look at documentation issues and possibly add CDI and coding staff to review team
- Utilize the committee process to enhance medical and nursing education (*GME; Nurse residency program*)
- Add a focus on PSIs and Vizient Risk-Adjusted Values
S.W.O.T. Analysis

Where are the Obstacles to Success?

What might cause a problem in the future?

T

Threats

- Lack of allocated resources
- Not a top priority or lost in the many priorities
- Greater demand for nurse and physician time across the system than supply – competing priorities and initiatives
- True value of initiative not recognized because of narrowly focused metrics [we’re not measuring pain scores, time to initiate palliative care, time till RRT is called, etc.]
- Seen as not achieving goals [Not achieving Vizient Top Quartile because other sites improve as well]
- Reviewer burn-out and/or turnover
What has worked for us

• Executive support
• Physician champions
• Having a project manager
• Dedicated quality coordinator to finalize cases
• Having set date for committee discussion every month
• Providing lunch at committee meetings
How shared learning is accomplished

- Monthly system wide meetings for Mortality Review leaders to discuss implementation issues and individual site findings
- Case summaries distributed to service chairs and chiefs and nursing leadership of units where patients were cared for
- Development of a system wide interactive "Tableau" Dashboard that provides data on OFI findings for individual hospitals as well as overall system data.
Next Step: Phase II

• Analysis and determination of MHS Mortality Review Committee leadership and structure needs

• Standardization
  – Training
  – Level of Scrutiny
  – Quality of Reporting
  – Supervision

• Potential
  – Augmentation of Departmental QI efforts
  – Sub-group data validation of institutional QI efforts
  – Data driven formulation of system / institutional / departmental QI goals
Thank YOU!

December 11, 2017
Mortality Review Initiative
Sharp HealthCare

Patricia Atkins, RN MS CNS FACHE CPPS
VP Quality, Patient Safety & Lean Six Sigma
Sharp HealthCare
San Diego, CA
Four Acute Care Hospitals

- Sharp Memorial Hospital
- Sharp Grossmont Hospital
- Sharp Chula Vista Medical Center
- Sharp Coronado Hospital and Health Center

Three Specialty Hospitals

- Sharp Mary Birch Hospital for Women
- Sharp Mesa Vista Hospital
- Sharp McDonald Center
Not-for-Profit
Serving 3.3M San Diego County Residents

- Largest private employer in San Diego
- 2084 licensed beds
- 3.4 billion in annual operating revenues

18,000+ employees
2,600+ affiliated physicians
2,100+ volunteers
3 skilled nursing facilities
22 medical clinics
5 urgent care centers
2 inpatient rehabilitation groups
2 affiliated medical groups

Plus
Home Health
Hospice
Home Infusion

Sharp Health Plan
Next Gen ACO
Mortality Review Process Workflow

Q-Centrix
Screen all deaths to appropriate level of detail for:
• Complete admit source (eg SNF)

Quality Dept Reviewer
Review all deaths to appropriate level of detail for:
• Safety Event or other quality issue (eg Core Measure fallout, triage error, AIM issue)?
• SOI/ROM OFI – (in collaboration with CDI and Coding)?
• General overview to discern which Unit RN / MD to review

Specialty RN Reviewer*
Review only specialty dx cases for:
• Patient selection
• Missed or delayed dx or treatment
• EBM, System or team OFI
• Record Coding OFIs

Unit RN Reviewer
Review for:
• Clinical issues and care coordination
• See 4-page Mortality Review Guidelines

MD Reviewer
Review for:
• Patient selection OFI
• Missed or delayed dx
• Missed, delayed, inapprop treatment
• EBM, System or team OFI

Committee
Review for:
• System OFI
• Team OFI
• EBM OFI
• Reconcile and finalize OFIs
• Review aggregate reports

Feedback/Learning for:
• Safety Event Review Process
• CDI: MDs and Coders
• Clinical Operations

Feedback/Learning for:
• Dept-specific PI
• Dept team PI
• Individual feedback / coaching

Feedback/Learning for:
• Physician feedback / coaching

Feedback/Learning for:
• Clinical Operations PI
• Quality: PI Project
• Lean Six Sigma Project

*Specialty RN Reviewers:
• AMI, HF, CABG
• Stroke
• Oncology
• Sepsis
• COPD, PN
• Total Joint
Challenge: Differentiating Mortality Review from Peer Review and Patient Safety Event

- Mortality Review (System OFIs)
- Physician Peer Review (Individual MD OFI only)
- Safety Event Review (RCA) (Deviation and causation)

6% of the 535 cases were classified as potentially preventable, which is in line with rates published by other institutions.
Mortality Review OFI* Pareto
May-Oct, 2017

Number of Times OFI Entered

Care Issues, Potential Physician-Related
Aim Missed Opportunity for End of Life... Care Issues, Non-Physician-Related
Delayed/Misdiagnosis Diagnosis Communication and Teamwork Issues
Aim: Possible Avoidable Inpatient Admission Failure to Rescue
Documentation Issues Insufficient/Inadequate Evaluation Surgical/Procedural Issue
Transition/Transitions of Care Error Individual Failure Modes
Equipment/Device Problem Organizational/Leadership Issues
Post-Acute Care, Management, and 30 Day...
OFI Subcategories for ‘Care Issues, Potential Physician Related’

Care Issues, Potential Physician-Related

- Delayed or missed treatment: 26
- Procedure not warranted or...: 17
- Excessive/skille care with no...: 10
- Care processes/clinical pathways...: 8
- Medication Ordering Issues...: 7
- Other (specify): 7
- Intensity of care not sufficient for...: 5
- Inappropriate treatment: 4
- Failure to directly assess and...: 3
- Protocol may be inadequate or...: 2
- Overutilization of testing/treatment: 1
Recognizing OFIs: The Known Complications Test*

A known complication is an adverse outcome related to a procedure, treatment, or test that occurs as a result of patient care.

If the patient experienced a “known complication,” ask:

1. Was the care indicated and appropriate?
2. If the event was common enough to anticipate, were steps taken to mitigate the risk?
3. Was the complication identified in a timely manner?
4. Was the complication treated appropriately and in timely manner?

If the answer to any question is no, the event is a Safety Event.

* Adapted from:
Engaging Physicians/Sr. Execs

- Tie to organizational goals / annual incentives / contracts
- Mayo Clinic / Dr. Huddleston credibility
  - 1:1 CMO mentoring by Dr. Huddleston plus a ‘how-to guide’ for physicians
- Reference best practices from published studies
- Focus on system OFIs
  - Fix things that matter and make work easier/more reliable
    - e.g. improve order sets, reduce delays and defects
- Stories compel, data convinces
  - Mortality Dashboard
  - AIM Dashboard
  - RRT/Code Blue Dashboard
  - Cluster Reports
Cluster Reports
Completed and In Progress

• Failure to Rescue
  – Failure to recognize deterioration
  – Failure to effectively escalate concerns
• Handover Communication Failures
• Missed Opportunity for Goals of Care Discussion
• Inadequate Palliation
• Mis-management of agitation
Mortality ‘Cluster Reports’: Emphasize No Deliberation on Causation

Patient Safety Work Product

Date: August 7, 2017
To: System Safety Steering
From: VP Quality and Patient Safety; Chair, Mortality Review
Re: Mortality Review Cluster Report: Failure to Effectively Escalate Concerns

Situation:
• The Mortality Review process has revealed a cluster of events where there was evidence that nurses did not fully escalate concerns beyond the patient’s physician.
• Note: Mortality Review does not deliberate on causation, rather focuses on identifying opportunities for improvement in systems, structures and processes.

Background:
• Below are brief descriptions of some of the identified cluster events.
• Entity names were intentionally not included as these trends span all entities.

Actions:
• Implementing Early Warning System in EHR
• Updating Chain of Command Policy and broad education re: speaking up for safety
Closing Thought

Remember to care for the care providers
(and reviewers)
Death can create moral distress for everyone
Trusted care for more than 90 years

- Founded in 1927 as a community hospital in Dallas
- Today the nonprofit system has 10 hospital locations, 25 family health centers and 10 ambulatory sites
- Methodist has more than 8,500 employees, 2,000 volunteers, 1,500 physicians on the medical staff and 290 affiliated physicians
Mission and Vision

• Our mission is to improve and save lives through compassionate, quality healthcare
• Vision for the Future: To be the trusted choice for health and wellness
Honors and Recognitions

• In 2015, Methodist earned the Texas Award for Performance Excellence (TAPE) Award from the Quality Texas Foundation

• Methodist has been ranked by *Dallas Business Journal* as a “Best Place to Work” for 13 years straight

• Methodist’s four major campuses are pursuing Magnet certification; Methodist Mansfield and Methodist Richardson received certification in 2017
Methodist Health System Safety Learning System Journey
IHI Mini Course
December 2017
Why the Case for Change?

**Current State:**
- Traditional peer review process
- Problem identified
- Reviewed + discussed by peers
- Individual notified

Focused on *acts of commission*. Missed opportunities for learning & improvement.

**Future State:** Safety Learning System Process
- Patient is a member of a cohort of interest
- Case reviewed/discussed by multidisciplinary + multispecialty practicing providers
- Process opportunities identified + tracked system wide
- Learning shared broadly

Includes *acts of omission*. All opportunities are captured and shared.
Current State

- Different at each campus
- Peer Review – no information sharing
- Inability to identify system/hospital trends

Future State

- Unified process of review
- Sharing of system/local trends
- Targeted improvements
- Measurable method for tracking results of improvement efforts
**AIM:** Develop and pilot a standardized method for mortality review, focused on identifying process of care opportunities, in 100% of all selected case type mortalities across MHS by July 31st, 2017.

**Background:** The project will pilot both the Mayo clinic evidence based practice & HBHS Safety Learning System (SLS) tool.

- Initial populations:
  - Sepsis & HLV
- Quality, Physician & RNs review cases to identify OFI
- HLV Quality Subcommittee and Sepsis Steering Committee will serve as the committee reviewers

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**Project Leaders**

- All Quality Directors
Progress and Findings To Date

**Case Reviews**
- 32 case reviews completed
- 75% of cases with OFIs (24 cases)

**Committee Reviews**
- Sepsis and HLV committees completed 3 sessions each
- All cases with OFIs reviewed/ discussed at committees

**OFI Findings**
- 48 opportunities identified
Differences in Populations

Greatest Opportunity

Sepsis OFI Findings

HLV OFI Findings

Greatest Opportunity

- Treatment/Care Opportunities
- Delayed or missed diagnosis
- End of Life Opportunities
- Documentation Opportunities
- Communication Opportunities
- Deteriorating patient
- Medication/Blood Draw
- Surgical/Procedural
- Tracheal Opportunities
- Hospital Acquired Inf
- Other opportunities

- Ofi Categories
- Cumulative %
Safety Learning System

https://www.youtube.com/watch?v=0lOo7RH-eNA&sns=em
**Purpose:** To complete onsite process mapping sessions at various MHS entities, update existing Sepsis process maps, utilize learning's to inform areas of focus for mortality reviews.

**Background:**
- Initial sepsis process maps were completed in 2016
- Working to understand some opportunities identified during the MMMC process mapping session due to Epic conversion. Currently running data to validate

**Project Leaders**
- Sepsis steering committee
Lessons Learned

1. Change is not easy
2. Work with key leadership to leverage accountability and change
3. Be flexible to change
4. Education is critical
5. Committee review sessions drive culture change
6. Keep revising the process to fit stakeholders needs
7. Add campus specific review sessions to reduce backlog
8. Start small
9. Keep encouraging!
Next Steps

System Improvement Projects

2018 system leadership goal: produce > 1 system project that targets the greatest opportunity as identified through the SLS data for each cohort

Increase Scope of Review

Add additional cohorts to the review process
Additional Resources

• Additional Webinars:
  – http://hbhealthcaresafety.org/coach/

• Joining the Collaborative Flyer & Web-link:
  – http://hbhealthcaresafety.org/research/
Contacts

Dr. Jeanne Huddleston, huddleston@hbhealthcaresafety.org
Hanan Foley, hxf5@gunet.georgetown.edu
Patty Atkins, Patricia.Atkins@sharp.com
Vicki Nolen, VickiNolen@mhd.com
Valerie Craig ValerieCraig@mhd.com
Lacey Hart, hart@hbhealthcaresafety.org