Child Health PSO Implementation Webinar
Q2 2014

Tuesday, May 6, 2014
8:00 am PT / 9:00 am MT / 10:00 am CT / 11:00 am ET

Reminders
• All lines have been MUTED
• Time will be allotted for Q&A during the session
• Session is being recorded

To ask a question, use one of the following:

1 Raise Your Hand
   • your line will be unmuted during Q&A

2 CHAT
   • type your question
   • send to ALL PANELISTS
   • facilitator/presenter will respond or unmute your line

3 Q&A
   • type your question and send
   • facilitator/presenter will respond or unmute your line

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Maximizing PSO network participation

1. Identify business goals/value
2. Assign an executive champion
3. Assemble multidisciplinary stakeholders
4. Reaffirm purpose and goals
5. Develop PSES
6. Develop PSO structure
7. Enter data
8. Actively learn

Today’s objectives

1. Position you to better understand and communicate value from the PSO
   - Understand why data submission is critical to the value received
2. Support you on your implementation so what you contribute is protected
Today’s Presenters

Fiona Levy, MD, MBA (PSO Steering Committee Chair)
Chief Quality Officer
Steven and Alexandra Cohen Children’s Medical Center of New York

Jodi Simon, MD
Director of Quality Services
Akron Children’s Hospital

J. Autumne Bailey, MSN, RN, PCNS-BC
Interim Administrative Director, Performance, Management and Improvement Manager, Nursing Quality
Monroe Carell Jr. Children’s Hospital at Vanderbilt

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Child Health PSO Value
Fiona Levy, MD, MBA
PSO Steering Committee Chair
Chief Quality Officer of Steven and Alexandra Cohen Children’s Medical Center of New York
Why the PSO

“We want to end the era where each of our hospitals need to experience an SSE in order to improve the root causes. Our goal is to reduce the SSER by 25% and then keep going.”

-- Stephen Muething, MD 4/16/2014
Cincinnati Children’s

Key PSO activities

**Weekly Safety Huddle.** Modeled after daily safety calls, this safety huddle is being tested to support multicenter institutions to provide both a mechanism for early notification of events and a way to request help from other PSO participants.

**Meaningful event learning.** With a focus on Serious Safety Events, the PSO Steering Committee conducts quarterly non-identifiable (blinded) data reviews to enable:

- Prioritized monthly virtual SSE learning opportunities from member presentations
- Prioritized safety alerts for spread
- Identification of participant coaching needs: classification, improvement resources
- Recommendations for quality improvement collaboratives based on trends

**Leverage national expertise to support participation in Child Health PSO**

- Alignment with the high reliability journey through SPS
- Regulatory interpretation and compliance to maintain protections
Safe Tables driven by case submissions to PSO

Enable the conversations needed to correct comparable problems or pro-actively identify similar risks.

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<tr>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
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<tbody>
<tr>
<td>Steering Committee Data Review</td>
<td>Failure to Recognize</td>
<td>Failure to Escalate</td>
<td>Steering Committee Data Review</td>
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<td>Senior Leader as the RCA Owner</td>
<td>Corrective Action Planning - Linking action items to Culture Domains</td>
<td>ALERT cutaneous fungal outbreak/Infections of IV Venous Sites</td>
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<tr>
<td>MAY</td>
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<tr>
<td>ALERT in process</td>
<td>Steering Committee Data Review</td>
<td>Patient Identification</td>
<td>Case topic TBD</td>
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<td>Diagnostic Errors</td>
<td>Care Coordination</td>
<td>Coding from Interview Process: Deviations with Individual and System Failure Modes</td>
<td>Action plans/use of portal (cycle time)</td>
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<td>Root vs. proximate causes</td>
<td>SEP</td>
<td>OCT</td>
<td>NOV</td>
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<td>Steering Committee Data Review</td>
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Notes: * Weekly PSO Safety Huddles in pilot expansion

Extended Life of the Alerts

Wrong-Size Tracheostomy Tube

Released March 2014
- Variety of pediatric cuffed tracheostomy tube packaging contributed to event
- Improvement needed on stocking and verification processes/practices

Blind NG Tube Placement Alert – A Must Read

Industry momentum and awareness continue!

First released August 2012
- Further escalated nationally by Beth Lyman, MSN, RN, of Children’s Mercy Hospitals and Clinics (Kansas City).
- Engaged clinicians and experts in special work group: NOVEL (New Opportunities for Verification of Enteral Tube Location) with sponsorship by the American Society of Parenteral and Enteral Nutrition.
- To be highlighted in June 2014 publications
  - Nutrition in Critical Care Nurse
  - Nutrition in Clinical Practice

Champions for Children’s Health

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Reporting progress

SEPT '13
28 combined
Reporting focus
• 8 SSE details
• 24 SSER

2013 YE
29 combined
Reporting focus
• 9 SSE details
• 27 SSER

NOV 2014
Goal 40 combined
May markers
• 20 SSE details
• 35 SSER

To date
32 combined
• 16 SSE (5 in process)
• 28 SSER

Child Health PSO
How two institutions are implementing
Akron Children’s Hospital
Jodi Simon, MD
Director of Quality Services

The Advantages of PSO Membership

Jodi Simon-Director of Quality Services
Akron Children’s Hospital Profile

Ranked a Best Children's Hospital by US News & World Report, Akron Children's is the largest pediatric provider in northeast Ohio. With two pediatric hospitals, and 20 primary care and 67 pediatric specialty locations, we handle more than 600,000 patient visits a year. We have 300 inpatient beds across the service area. We also serve as a major teaching affiliate of Northeast Ohio Medical University, and offer a number of pediatric subspecialty fellowship programs. We are committed to providing quality, family-centered care, and improving the treatment of childhood illness and injury through research.

Intro to PSO

- Ohio Revised Code provides for strong protection
- Sharing of SSE inside Ohio through the OCHSPS collaborative was under way
- Because of strong OH protections, sharing SSE event information was fairly easy
- PSO allowed for additional learning opportunities
- More closely matched a true HRO model-Airline, Nuclear Power, Big Industry (Celanese)
- Many unexplored opportunities…Peer Review, ACA learning, Vendor Pressure through data, Library
- What other opportunities do we have?
Leadership

Funny you might ask……

- No convincing necessary
- Quality Committee of BOD asking how we can learn from PSO
- Currency among Ohio CEOs is “All Teach, All Learn”
- First step was internal notification
- Second Step was external process
- Third was leveraging OH and PSO effectively

Current Process

PSO Safety Alert Arrives in Quality

Quality Determines Best Resource Quarter Back

Resource Shares with Appropriate Groups

Groups Assess for Risk & Suggest Mitigation Opportunities

Group May Take Immediate Action

Resource Reports back to Quality for Evaluation of Potential Mitigation Actions

Quality Evaluates and Assigns Resources for Mitigation Actions
Changes to Safety Practices

Safety Committee was a newly formed
Formed to address Safety Concerns identified by
- In-situ simulation
- Executive Safety Rounds
- SOD rounds
- Orphaned cross departmental safety concerns (BVM)
- Newest Addition-PSO Safety Alerts
Where Are We Now?

- Entering Events SSE (PSWP)-into PSO
- Have made SSE PSO entry process part of our Standard Work Instructions
- We will join the Safety Huddles May 7th
- PSES-Pt. Safety Evaluation System-Quality/Legal evaluations
- Still learning what the PSO can do for us in terms of legal protections or other unrecognized opportunities

Barriers

- Management and appropriate loop closure of action items
- Prioritization
- Safety change overload and parking lot overcrowding
Next Steps

Leverage other Leadership Methods to Spread learning
• DSB
• Executive Safety Rounds
• RTI
• Huddles

Documentation of actions implemented in timely manner.

Tracking alerts and internal response

Monroe Carell Jr. Children’s Hospital at Vanderbilt
J. Autumn Bailey, MSN, RN, PCNS-BC
Interim Administrative Director, Performance, Management and Improvement Manager, Nursing Quality
Who We Are

- 271 Inpatient beds
- 129 Acute Care beds
- 42 PCCU beds
- 100 NICU beds
- 16 bed BMT unit
- 16 operating rooms
- 38 Pediatric ED beds

This information is confidential and privileged pursuant to TCA 68-11-272 et seq., and has as one of its purposes to improve the quality and safety of patient care. It is protected from use or disclosure to any third parties.

Peer Review History

- TCA 63-6-219
- TN Supreme Court decision May 2010
- Lee Medical, Inc. v. Beecher
- Limited protection to peer review committees “that involve a physician’s conduct, competence, or ability to practice medicine”
TN Patient Safety and Quality Improvement Act of 2011

- Addresses gaps in quality review protection in wake of Lee Medical
- Renders Quality Improvement Committee (QIC) records privileged and confidential
- A QIC is: Committee formed ... one purpose ... to evaluate safety, quality, processes, costs, appropriateness or necessity of services,
- Protects “health care providers” and “health care organizations” – very broad, not physician-centric


Benefits of the Act

- Clarifies peer review to specifically protect documents ...occurrence reports
- Broadens peer review protection to include hospital quality improvement activities
- Strengthens peer review protections lost by Lee Medical v. Beecher
Patient Safety Evaluation System Approach

- Collaboration with Risk Management and General Counsel
- Engagement of senior leadership
- Slow and thoughtful

Value

- All teach, All learn
- Standardize processes for reporting
  – Serious Safety Event details
Implementation

- Daily Safety Brief
- PSO SSE Safety Event Alerts
  - Loop closure
- Sharing of examples

Challenges

- PSES Scope
  - Defining what is encompassed
- PSWP Collection
  - Managing extensive amount of information throughout the organization
Next Steps

• Continue to collaborate with risk management and general counsel
• Draft PSES policy
  – Careful deliniation
• Loop closure of PSO SSE Alerts

Implications to apply the privilege protections
Michael R. Callahan, Partner
Katten Muchin Rosenman, LLP
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What Do I Do When I Receive a Subpoena for PSWP

- Compare list of requested documents to materials protected either as PSWP or under state statutes.
- Determine what is and is not or may not be protected.
  - Not protected:
    - Patient’s medical records
    - Mandated adverse event or other required reports (protected under state law?)
    - Any disciplinary action taken

What Do I Do When I Receive a Subpoena for PSWP (cont’d)

- Any information that is not referenced in PSES or is not protected under state law;
  - Any information that was collected for an unrelated purpose.
- Subject to protection:
  - Everything else.
- What if collected in PSES for reporting but not yet reported?
  - Is still protected but need to provide explanation for why it was not yet reported.
  - Remember, once reported it is privileged and confidential and not subject to discovery or admissible into evidence which means hospital cannot introduce PSWP for defense purposes.
What Do I Do When I Receive a Subpoena for PSWP (cont’d)

- PSO contract.
- Board resolution reflecting decision to participate in or form a PSO.
- Blank forms used to collect and report PSWP.
- Affidavits.
  - Affidavit from Hospital person(s) responsible for PSO who can establish:
    - Effective date of protection
    - Establishment of PSES
  - Requested materials were collected for reporting to PSO and are referenced in PSES

What Do I Do When I Receive a Subpoena for PSWP (cont’d)

- Date on which documents were actually or functionally reported
- If not yet reported provide an explanation as to why
- Documents were not collected for a purpose unrelated to improving quality and patient safety
- No other documents exist that are relevant to the request and are not protected.
What Do I Do When I Receive a Subpoena for PSWP (cont’d)

- Affidavit from PSO:
  - Copy of AHRQ certification/recertification letter
  - Confirm hospital participation
  - Confirm receipt of PSWP or if PSO has access to PSWP in hospital’s PSES (functional reporting)
  - Confirm that PSO received and analyzed PSWP and, where true, produced reports, analysis, etc., within its PSES
  - PSES and Policies.

BEFORE A SUBPOENA
the Purpose of a Patient Safety Organization ("PSO") Under the Patient Safety and Quality Improvement Act ("PSA")

- To encourage the expansion of voluntary, provider-driven initiatives to improve the quality and safety of health care; to promote rapid learning about the underlying causes of risks and harms in the delivery of health care; and to share those findings widely, thus speeding the pace of improvement.
  - Strategy to Accomplish its Purpose
    - Encourage the development of PSOs
    - Establish strong Federal and greater confidentiality and privilege protections
    - Facilitate the aggregation of a sufficient number of events in a protected legal environment.

Definition of Patient Safety Work Product ("PSWP")

- Any data, reports, records, memoranda, analyses (such as Root Cause Analyses (RCA)), or written or oral statements (or copies of any of this material) which could improve patient safety, health care quality, or health care outcomes;
  And that:
  - Are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, either physically or "functionally", which includes information that is documented as within a PSES for reporting to a PSO, and such documentation includes the date the information entered the PSES; or
  - Are developed by a PSO for the conduct of patient safety activities; or
  - Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a PSES
PSO Reporting Process

What is NOT PSWP

- Patient's medical record, billing and discharge information, or any other original patient or provider information
- Information that is collected, maintained, or developed separately, or exists separately, from a PSES. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered PSWP
- PSWP assembled or developed by a provider for reporting to a PSO but removed from a PSES and no longer considered PSWP if:
  - Information has not yet been reported to a PSO; and
  - Provider documents the act and date of removal of such information from the PSES
Patient Safety Evaluation System ("PSES") Definition

- PSES Definition – Development, Documentation and Implementation is Key to Obtaining and Maintaining Confidentiality/Privilege Protections
  - Body that manages the collection, management, or analysis of information for reporting to or by a PSO (CFR Part 3.20 (b)(2))
    - Determines which data collected for the PSO is actually sent to the PSO and becomes Patient Safety Work Product (PSWP)
    - PSES analysis to determine which data is sent to the PSO is protected from discovery as PSWP

Patient Safety Evaluation System ("PSES") Definition (continued)

- Establish and Implement a Patient Safety Evaluation System (PSES), that:
  - Collects data to improve patient safety, healthcare quality and healthcare outcomes
  - Reviews data and takes action when needed to mitigate harm or improve care
  - Analyzes data and makes recommendations to continuously improve patient safety, healthcare quality and healthcare outcomes
  - Conducts RCAs, Proactive Risk Assessments, in-depth reviews, and aggregate RCAs
  - Determines which data will/will not be reported to the PSO
  - Reports to PSO(s)
### Resources to support operationalize

- **September 2013 Reference Guide**
  - Member policies
- **Recorded webinars**
  - December 3, 2013 Master the Ladder (Callahan)
    - Fundamentals of the PSO, PSES and PSWP
  - December 12, 2013 Peer Connect (Children’s Mercy)
    - Policy and approach example
  - February 4, 2014 Master the Ladder (Callahan)
    - Preparing for a subpoena
    - Peer review as part of the PSES
- **ECRI Institute PSO PSES Pathway Toolkit**
  - Policy and organizational templates

Email [barbara.weis@childrenshospitals.org](mailto:barbara.weis@childrenshospitals.org) for a link to any of the above
Questions & Open Discussion

Webcast Evaluation

Please evaluate today’s session using the poll on the right side of your screen

- Provide response to evaluation questions
- Click “SUBMIT”
Upcoming Implementation Webinars

Gather your interdisciplinary teams (e.g., quality, risk and legal) and join the following:

- **Quarterly Webinar Series**
  - Featuring Michael Callahan
  - 8:00 am PT / 9:00 am MT / 10:00 am CT / 11:00 am ET
  - Duration: 90 minutes
  - Tuesday, August 5, 2014
  - Tuesday, November 4, 2014
Define a Patient Safety Evaluation System ("PSES") (continued)

- Designing Your PSES
  - Events or Processes to be Reported
    - Adverse events, sentinel events, never events, near misses, HAC, unsafe conditions, RCA, etc.
  - Committee Reports/Minutes Regarding Events
    - PI/Quality committee, Patient safety committee, Risk Management committee, MEC, BOD
  - Structures to Support PSES
    - PI plan, safety plan, RM plan, event reporting and investigation policies, procedures and practices, grievance policies and procedures
Define a Patient Safety Evaluation System ("PSES") (continued)

- Criteria-based Prioritization
  - Suggested criteria
    - Promotes culture of safety/improves care
    - Impressions/subjective data that is not available in the medical record
    - Information that could be damaging during litigation
    - Not required to report elsewhere
    - Required to report elsewhere, but data for reporting could be obtained from medical record
    - Data will not be used to make adverse employment decisions