Appendix C
Safer Care Subgroup

Hospital Quality Reporting Steering Committee
"Safer care and avoiding harm" Sub-Group Charter

Sub-Group Overview
Patient safety emerged as one of the high priority areas for measuring hospital care for the SQRMS Hospital Quality Reporting Steering Committee at its October 2014 meeting. Members of the Committee volunteered to be part of a short-term sub-group to focus on "safer care and avoiding harm" and bring options and/or recommendations to the full Committee for consideration, building from the October 2014 discussion.

Summary scope statement
Three themes emerged from the Committee in the "safer care and avoiding harm" arena:
1. Measuring safety as a system attribute
2. Measuring safety in ways meaningful for consumers
3. Measuring safety by measuring delayed and missed diagnosis/misdiagnosis

The sub-group will:

- Review the current performance of Minnesota hospitals in safety to understand strengths and opportunities for improvement *(Stratis Health and MHA to provide a data snapshot)*
- Review existing measures or measurement approaches, including data collection systems and data repositories, which support the three themes identified (whether Minnesota or elsewhere) *(Stratis Health to develop a high level inventory of available measures)*
- If there are not adequate measures or measurement approaches currently available to meet the goals and needs, identify and debate options for developing new measures aligned with one or more of the three themes, including pros and cons
- Recommend to the HQRSC an approach for moving forward with measuring "safer care and avoiding harm" in Minnesota hospitals

Goal/Aim of the sub-group
To recommend to the HQRSC an approach for moving forward with measuring "safer care and avoiding harm" in Minnesota hospitals, in enough detail and with enough time to include a safety measure recommendation in the Committee's April 2015 report to MDH.

In recommending a measurement approach, clarify the purpose of publicly reporting of safer care measures – whether for hospitals to improve, and/or for consumer understand and use, or for both.

Milestones

- *Scheduled sub-group conference calls:*
  December 19, 2014
  January 7, 2015

- *Next HQRSC meeting:* January 9, 2015

- *Report and Recommendations Due to MDH:* April 1, 2015

Document date: December 10, 2014

Recommendation for SQRMS Hospital Quality Reporting Steering Committee from HQRSC Safer Care Sub-Group

To be included in the Committee's recommendations and reports for 2016 SQRMS Hospital Measures

(to set the direction for future measures work, not specific to any new 2016 reporting)

March 26, 2015

Patient Safety Composite or Index

Why Measure?

Patient safety consistently emerges as a high priority for both health care delivery organizations and for patients and families. There are many hospital safety measures currently reported at a state and national level, yet they do not provide a comprehensive picture of how safe care is at a hospital or health system, nor do today's clinical only safety measures reflect the growing body of research related to organizational properties and systems which are essential for safety. Today's measures tend to be condition-specific or harm-specific (e.g., surgical site infection, falls, sepsis), and do not include how reliable a hospital's care is, or whether the culture is set up for reliability and learning.

To make patient safety hospital measurement meaningful and comprehensive, and more understandable to consumers, SQRMS could build upon the reporting individual hospital safety measures with reporting of a multi-faceted patient safety index or composite measure. The index or composite would include a balanced set of process, outcome, and structural measures, and can at least somewhat be derived from existing measures and indices put together in a combination to meet community needs. The composite or index approach is consistent with both national measurement strategies from CMS (e.g., the Hospital Total Performance Score) and with composite measurement that MN Community Measurement has developed in the ambulatory setting (e.g., the D5 for diabetes).

A composite approach meets needs identified by the Hospital Quality Reporting Steering Committee for measuring the safety of hospital care in Minnesota. The intent is that a composite measure bring value – that it is more than an additive list of measures, rather, that the whole is greater than the sum of its parts as the composite represents essential components of safer care. First, it is a single score, easy to understand by patients and consumers. Second, it brings a sharp focus to what is otherwise a long list of measures to help ensure that safety remains a priority for hospital leaders, clinicians, and staff. Lastly, the underlying data elements which comprise the composite score are available to hospitals, making it actionable for improvement.

Vision

Minnesota assesses and publicly reports the safety of its hospital care through a balanced set of measures that meaningfully reflects safety in a single composite score easily understood by consumers and actionable by hospitals.

Principles/Assumptions:

- Methodology and calculation of the composite are transparent
- Underlying elements of the composite will be available to the hospitals so that they can identify their performance by indicator to be able to improve

- Draw on existing measures for which data are available and are widely collected to the extent possible
    - Expect the composite to evolve over time as measures, evidence, and infrastructure evolves
- Measure not only harm to patients but organizational and system characteristics of hospitals
    - Such as reliability, culture, transparency and learning systems
- Reflect evidence-based practices to the extent feasible
- Be attentive to rural and small volume hospitals, such that they are neither advantaged or disadvantaged
- Consider unintended consequences
- Develop for an audience that is consumers and hospitals
    - Addresses patient safety in PPS and CAH (need to clarify if Children's hospitals would be included)
- Consider risk adjustment when appropriate
- Hospitals should be able to verify their results

Proposed Process/Timeline

- MNCM/Stratis Health would co-facilitate
- 18-24 month process
- Includes measure testing and pilot
- Opportunity for community and stakeholder involvement and endorsement
    - Build in opportunity for consumer and hospital input and feedback
- Incorporate discussion and possibly measurement to ensure there are not harmful unintended consequence
- Explore NQF endorsement