Roadmap to Health Care Safety for Massachusetts

EXECUTIVE SUMMARY • APRIL 2023

ABOUT THE MASSACHUSETTS HEALTH CARE SAFETY AND QUALITY CONSORTIUM

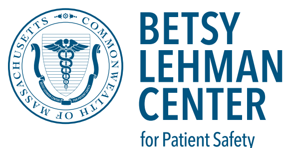
The Consortium is a public-private partnership of three dozen health care stakeholder organizations convened by the Betsy Lehman Center in 2019 in response to research showing tens of thousands of preventable harm events in a single year in settings across the Massachusetts continuum of care.

Through four task forces with more than 100 contributors, the Consortium produced the *Roadmap to Health Care Safety for Massachusetts*, a long-term plan to achieve a health care system in which providers — in partnership with patients, policymakers, payers, and others — continuously strive to eliminate preventable harm in every place where care is delivered in the Commonwealth.

WHAT DO WE MEAN BY 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
- Addressing disparities in safety outcomes, including those related to race, ethnicity, age, disability, sex, and gender

Examples of harm to patients include medication and surgical mistakes, infections, and missed or delayed diagnoses. Workforce harm includes injuries from hazards and violence, as well as stressful workplace conditions.



MASSACHUSETTS
HEALTH CARE SAFETY & QUALITY
CONSORTIUM

In recent decades, the United States health care system has made unprecedented strides in improving and extending the lives of patients, but these achievements have also resulted in care delivery that is more complex, time-pressured, insufficiently coordinated, and, ultimately, prone to error.

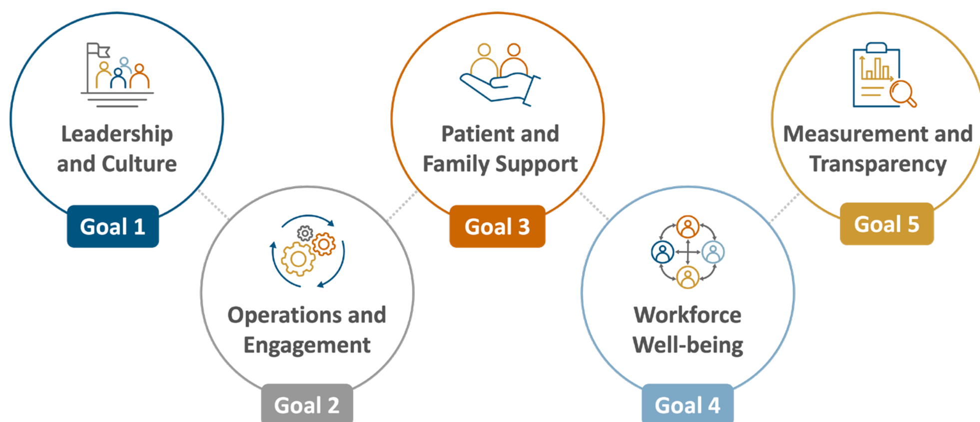
Betsy Lehman's death from an overdose of chemotherapy at a leading Massachusetts hospital in 1994 helped catalyze a national effort to improve safety. From the work of the last 25+ years, we now have a much better understanding of how to reduce risks of harm.

But bringing new approaches to myriad health care settings and prioritizing health care safety at the provider, state, and national levels have proven challenging, and our health care system is still not nearly as safe as it could be.

To accelerate progress, the *Roadmap to Health Care Safety for Massachusetts* sets five goals that will be reached through a sustained, collective statewide effort among provider organizations, patients, payers, policymakers, regulators, and others. Strategies and action steps for advancing these goals adhere to seven guiding principles:

- Move the health care system toward a mindset of zero tolerance for defects that can result in physical or emotional harm to patients, families, and staff;
- Support approaches to continuous, proactive safety improvement that break down silos and enable all stakeholders to carry out their respective roles;
- Promote a "just culture" by adopting a fair and consistent approach to safety improvement that fosters psychological safety in the health care workforce and holds leadership accountable for breakdowns and shortfalls;
- Advance health equity through the elimination of disparities in safety and quality outcomes on the basis of race, ethnicity, age, disability, sex, gender, language, and economic factors;
- Encourage an approach to health care and safety that maximizes the benefits of co-production, recognizing that patients and families provide expertise essential to person-centered care;
- Reduce low-value administrative burdens; and
- Remove all forms of waste from work, making it easier to do the right thing.

Massachusetts has a long history of breakthroughs on intractable health system challenges. During this time of recovery from the disruptions of the pandemic, we are well-positioned to chart a new course through a public-private partnership that leverages proven strategies to advance not only safety but also progress on other priorities, including health equity, workforce well-being, operational efficiencies that improve care and lower costs, and patient experience.



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 set the priorities, drive the culture, and are responsible for safety outcomes.
- Reliably safe health care depends on commitment at the highest levels of an organization.
- Leadership commitment to safety means better performance on safety and quality measures.

STRATEGIES

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.

1.2 Establish educational standards on safety for leaders and governing bodies.

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.

1.4 Reward exemplary performance and progress on continuous safety improvement through reduced liability insurance premiums and higher reimbursement rates.

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 and must be enabled and empowered to carry it out.
- Safety work must be integrated with routine operations and other organizational priorities.
- Continuous Improvement Systems can remove unnecessary tasks from workflows, promote teamwork and innovation, and activate staff.
- Patients and families are reliable observers of safety risks and can add to improvement efforts.

STRATEGIES

2.1 Support provider organizations as they implement appropriately scaled Continuous Improvement Systems within a culture of safety through a coordinated program of education, technical assistance, and experiential learning.

2.2 Establish standardized measure sets and self-assessment tools for use by provider organizations across the continuum of care in tracking their own safety outcomes and the effectiveness of their safety processes and structures.

2.3 Leverage new technologies, such as automated electronic health records surveillance, to detect and enable a nimble response to safety risks and events, inform improvement work, and reduce future harm.

2.4 Strengthen Patient and Family Advisory Councils (PFACs) to foster diverse representation, more patient and family involvement, and deeper partnership with the community on safety improvement.

2.5 Establish educational standards on safety for managers, clinicians, and staff in clinical and nonclinical roles.

2.6 Create an accessible statewide health care safety curriculum that fosters a shared understanding of fundamental principles and practices across diverse roles and care settings and enables greater engagement in improvement work by all members of the health care workforce.

2.7 Advocate for health care safety to be integrated into the curricula of training programs for the health professions.

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

- Informed patients and families can take steps to reduce the risk of harm in their care.
- Errors and harm can have long-lasting emotional impacts, including loss of trust in health care providers.
- Transparent, structured, culturally competent communication and support can improve the well-being of patients and families in the aftermath of harm.

STRATEGIES

3.1 Raise public awareness of health care safety challenges and initiatives.

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.

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.

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.

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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, reliable care.
- Workplace stress impedes an organization's ability to continuously improve.
- Workplace stress contributes to staffing disruptions and shortages that impact safety.

STRATEGIES

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.

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.

4.3 Expand programs that offer emotional support, learning, and well-being for clinicians and staff following safety or other traumatic events.

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.

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

- Efforts to achieve major gains in safety in the state will be successful only if combined with new approaches to information gathering and management.
- A more complete view of the Massachusetts health care safety landscape will increase provider, policymaker, and public understanding of safety risks and trends and inform public and private investment in improvement.
- Access to relevant data will allow patients to make safety-informed decisions in their care and take part in broader improvement initiatives.

STRATEGIES

5.1 Develop measure sets for benchmarking health care safety outcomes, processes, and structures in settings across the continuum of care.

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.

5.3 Publish dashboards containing timely, relevant, and actionable information about health care safety outcomes, processes, and structures in settings across the care continuum.

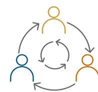
5.4 Report annually on the state of health care safety in Massachusetts, assessing progress toward the five *Roadmap to Health Care Safety* goals and identifying opportunities for continuous improvement at the state and provider levels.

Next steps

The *Roadmap's* strategies and associated action steps are grounded in a three-dimensional approach to transformational change.

Inform: Build essential awareness, knowledge, and skills to enable everyone to recognize and fulfill their roles in health care 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

In the coming year, five initial foundational proposals will jumpstart the state's investment in a long-term phased approach toward meaningful, sustainable safety improvement across the entire Massachusetts continuum of care.

READ THE FULL REPORT:
BetsyLehmanCenterMA.gov/Roadmap

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- Ariadne Labs (Susan Gullo*, RN, MS)
- Blue Cross Blue Shield of Massachusetts (Chrissy Allen, RN, CCM; Karl Laskowski, MD, MBA; Erika Wilkinson, JD; Katherine Dallow*, MD, MPH, CPE; Sandhya Rao*, MD)
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*An asterisk denotes a former representative on one of the Task Forces or the Massachusetts Health Care Safety and Quality Consortium who contributed to the development of the *Roadmap to Health Care Safety*, but has since moved on in roles or organizations.

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