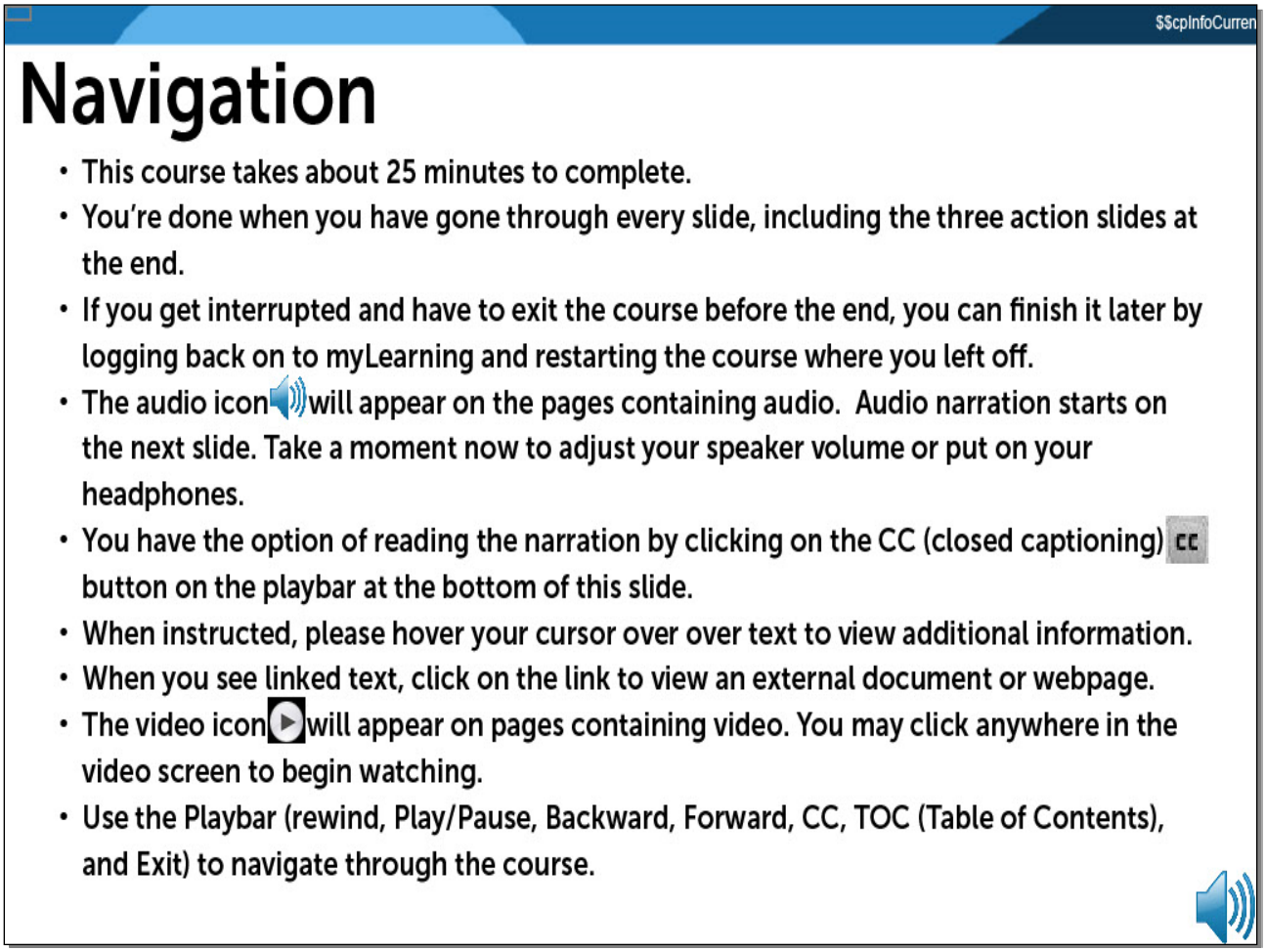
Slide 1 - Course First Page

Slide notes

Welcome to the 2022 Annual Code of Conduct and Compliance Education: Speaking Up for Safety: Our journey to become a High Reliability organization.

Slide 2 - Navigation



Slide notes

Please take a moment to review the navigation instructions.

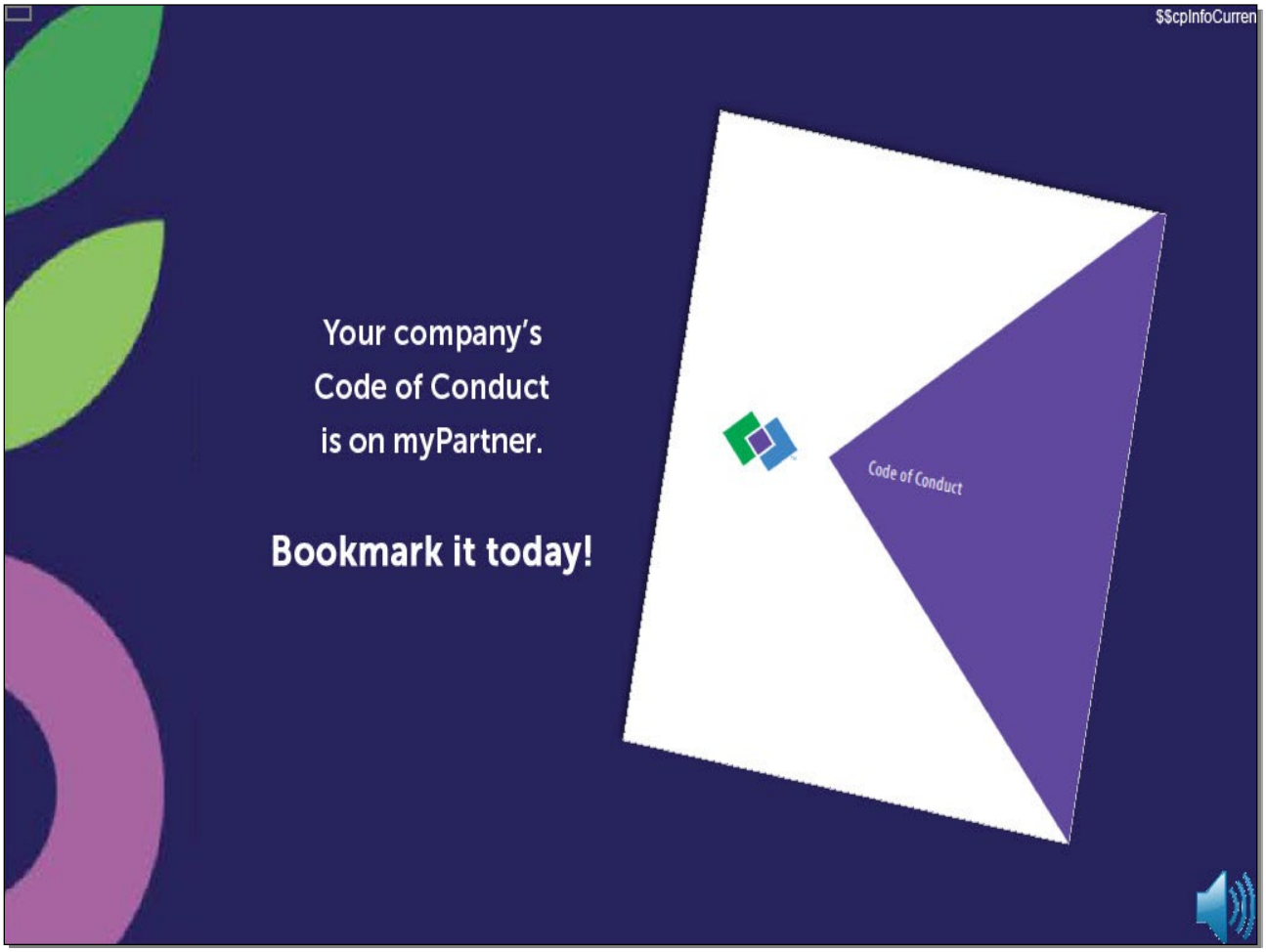
Slide 3 - Andrea Walsh

Slide notes

Hi, I'm Andrea Walsh, HealthPartners' President and CEO.

Here at HealthPartners, we share a vision that is easy to get behind: Health as it could be, affordability as it must be, through relationships built on trust. That kind of trust is a big responsibility. And that's why every year, during our Code of Conduct education, we focus on a topic that helps us earn the trust of the people and communities we serve.

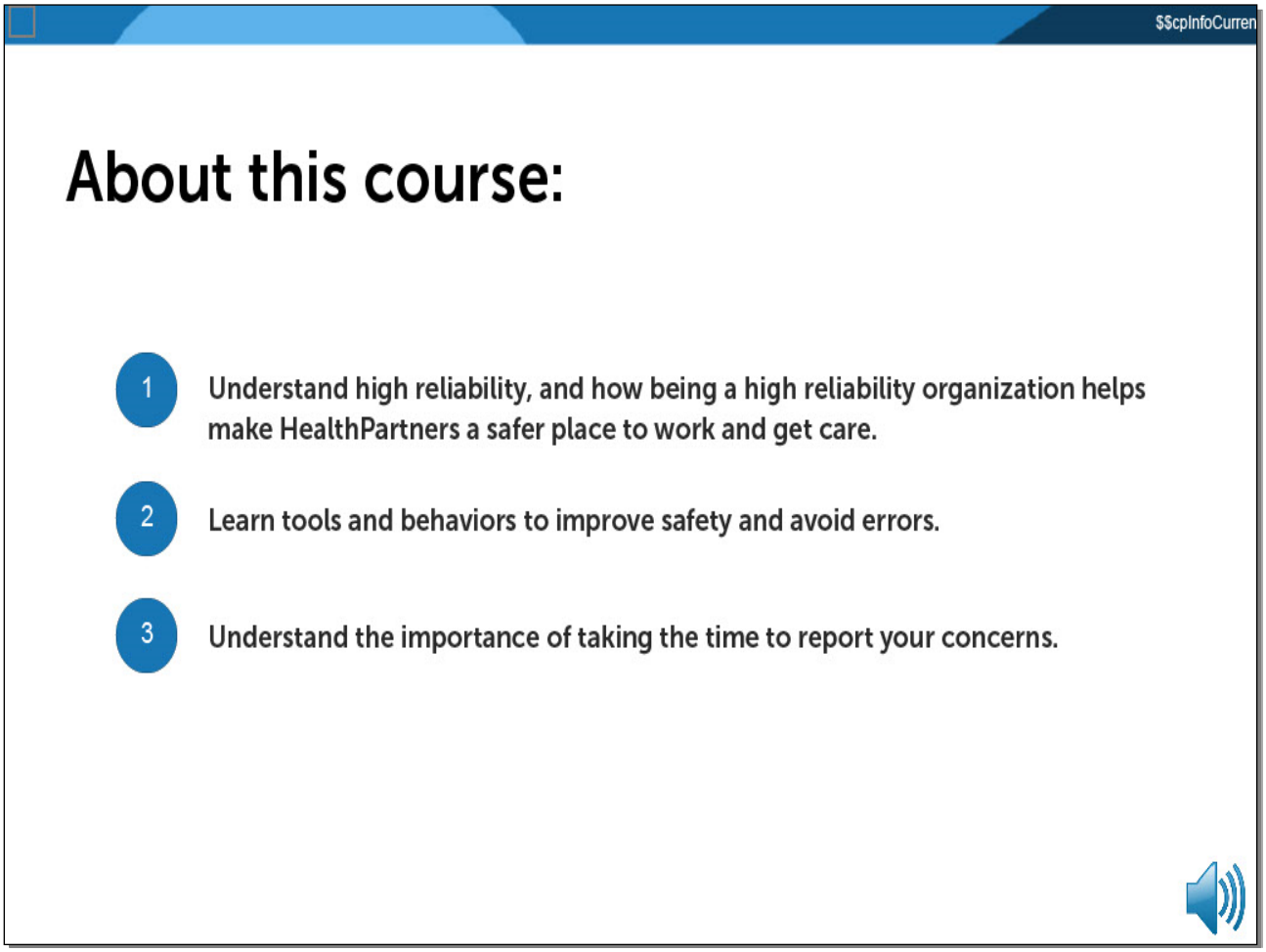
Slide 4 - Slide 4



Slide notes

I can't think of anything more important to building trusted relationships than safety. And that's why I'm so pleased that this year's Code of Conduct education is about renewing our commitment to safety, and to speaking up for safety. No matter where you work in our organization or what your job is, the information in this course will help all of us meet that commitment every day.

Slide 5 - About This Course



Slide notes

In this course, you'll be learning about something called high reliability organizations, and how being a highly reliable organization helps make HealthPartners a safer, more secure, and more trusted place. You'll also learn about the tools and behaviors that high reliability organizations use to improve safety and to avoid errors of all kinds - not just safety errors. And you'll understand that true safety requires each of us to speak up and take the time to report concerns.

Slide 6 - People in High Reliability Organizations…

Slide notes

You may be wondering why we're asking all colleagues to learn about safety, when so many of us work in settings or roles that aren't directly connected to patient care. I strongly believe that these highly reliable and safety behaviors will improve all the work we do together - in our hospitals and clinics, in community and research settings, and in our health plan and administrative work.

Let me give you some examples of these behaviors: People in high reliability organizations check details to avoid mistakes or catch errors early to avoid harm - like double-checking to make sure that we're authorizing the correct medication for a member.

People in high reliability organizations work hard to communicate clearly, to avoid misunderstandings - taking the time to make sure that online forms use clear instructions.

People speak up when they notice something that doesn't seem right, so there's a chance to fix problems before they cause harm - like a food and nutrition colleague speaking up when they see something on a meal tray that's on the patient's food allergy list.

And high reliability organizations keep improving - we learn from mistakes to avoid problems in the future - like colleagues who work together to create a new checklist after they realize that everyone on the team is using a slightly different process.

By the end of this course, I hope you'll see that these 4 safety behaviors are an important part of everyone's job - including yours and mine.

Slide 7 - People in High Reliability Organizations…

Slide notes

Thank you again for your time and commitment to safety, high reliability - and speaking up. Together, we're building a strong, safer HealthPartners on behalf of those we serve, and for each other.

Slide 8 - What is a High Reliability Organization?

Slide notes

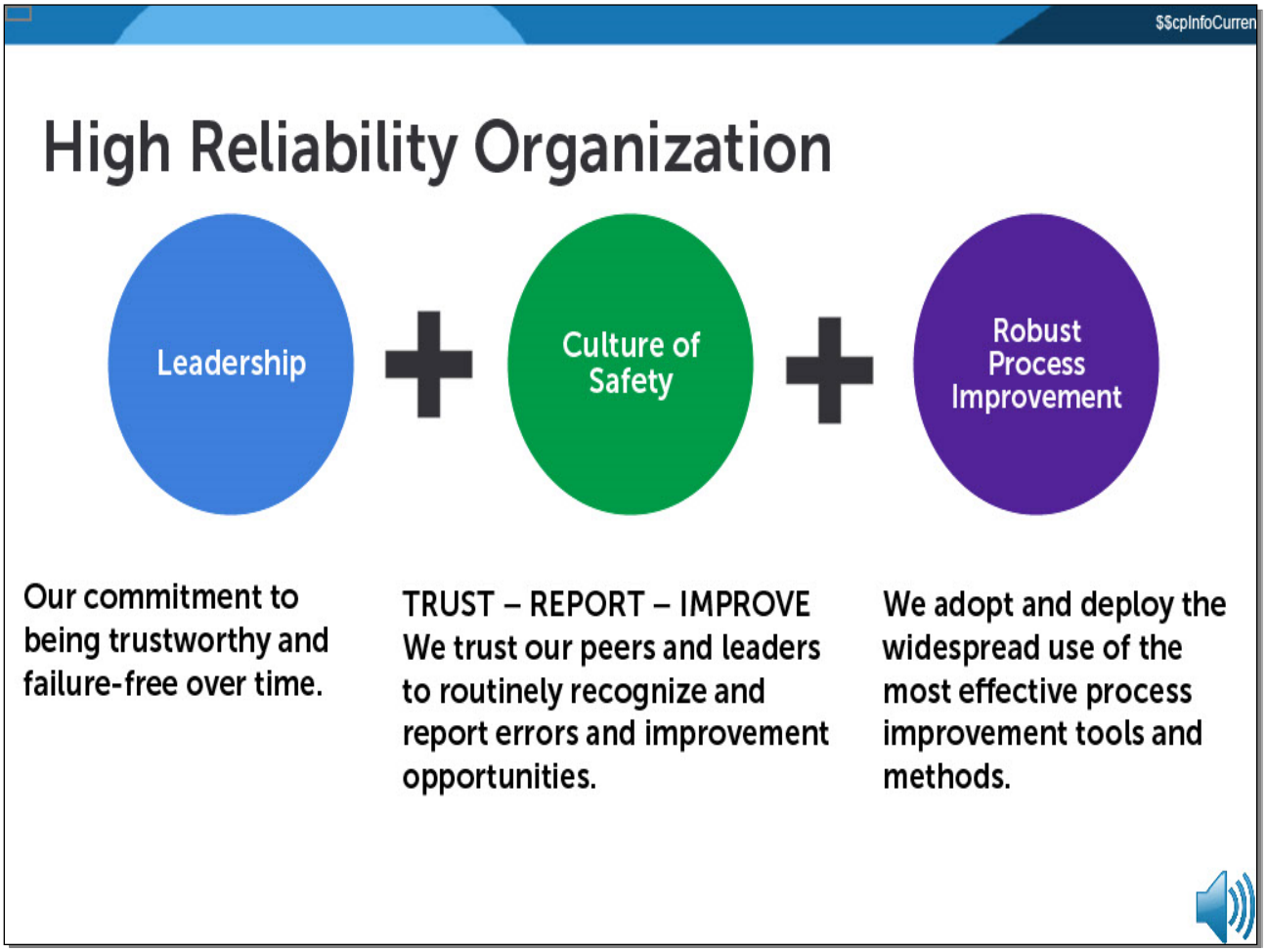
Let’s start by learning more about an important term that Andrea just introduced: a “high reliability organization” or HRO. A high reliability organization is one that has systems in place to operate consistently and effectively in a complex, high risk environment.

Think about industries like nuclear power, emergency services like fire and rescue, and commercial air travel - all of these industries involve a lot of risk, are very complicated and people can get seriously injured when something goes wrong.

But when people in these industries focus on high reliability, they’re able to meet their goals and avoid catastrophic errors. Health care is similar to these industries in many ways. We do critical but complicated work that can involve high risks - and the potential for grave harm when something goes wrong.

Becoming a high reliability organization will help us avoid preventable harm to our patients. It will also help us avoid other kinds of costly errors, so we can keep delivering on our mission, vision and values.

Slide 9 - High Reliability Organization



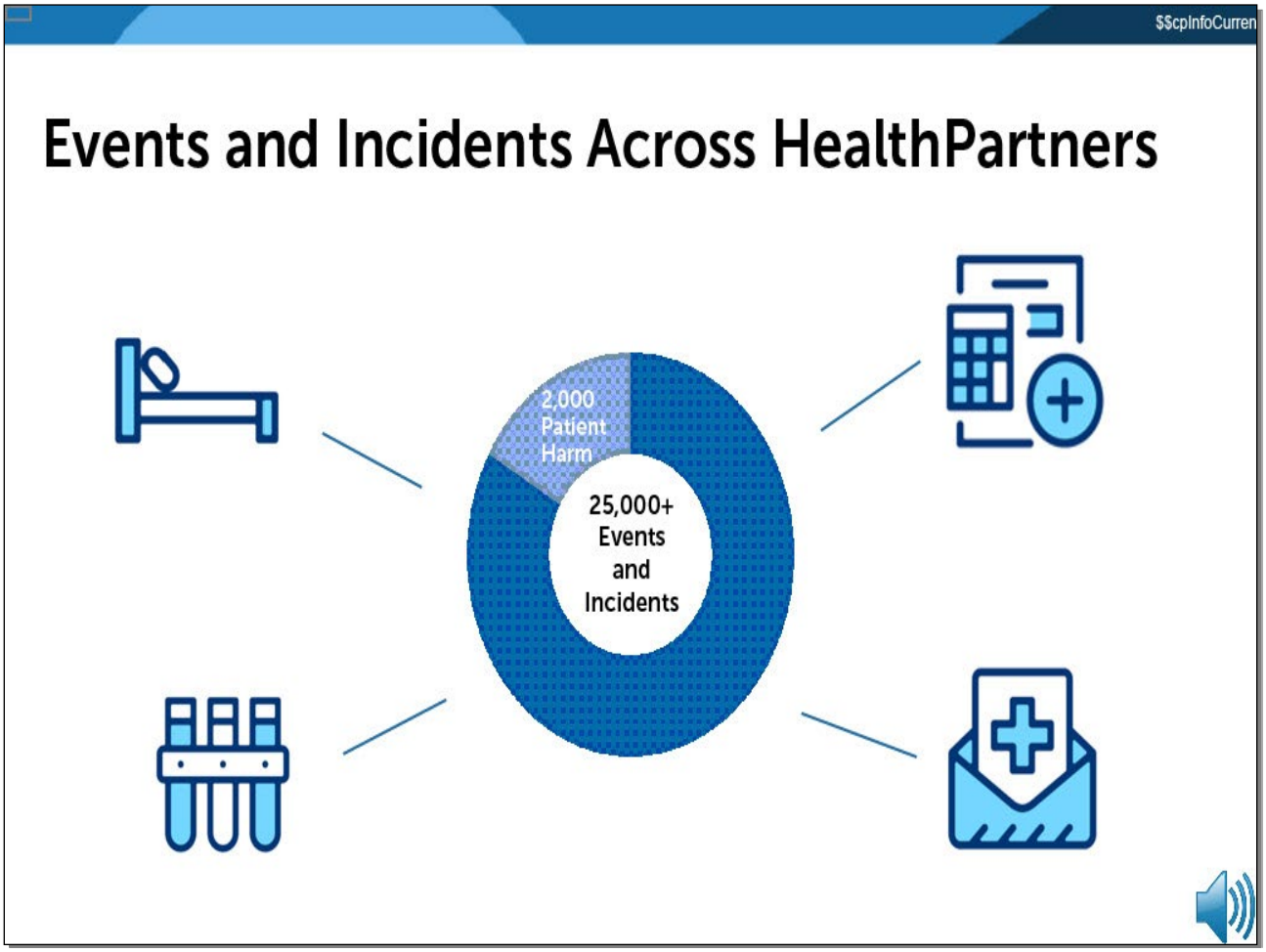
Slide notes

Here's how HealthPartners is becoming a highly reliable organization: First, leadership at every level of the organization is committed to being failure-free over time. A health care system with zero errors? We won't get there overnight, but our leaders are focused on making that happen.

Next, we are committed to robust process improvement. This means that at HealthPartners, we adopt and use effective process improvement tools and methods - so we can all keep learning and improving.

And lastly, to become a highly reliable organization, we must have a culture of safety. That starts with creating an environment where all colleagues, in every role, know how to spot potential problems and speak up about them. It also means that everyone is encouraged to ask questions, and everyone feels comfortable raising their concerns.

Slide 10 - Safety Events Across HealthPartners



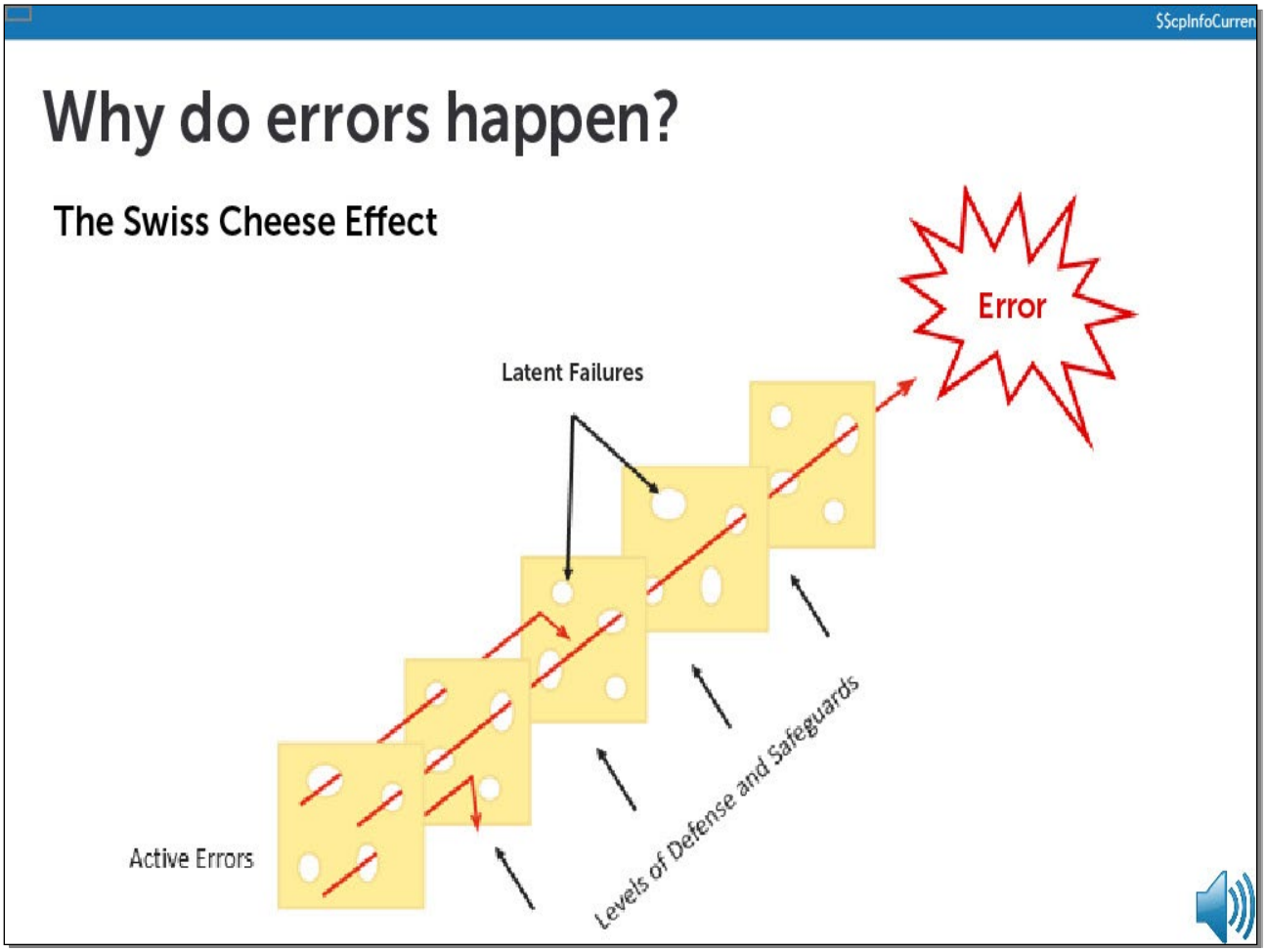
Slide notes

So why is becoming a highly reliable organization so important? Because, as the term “high reliability” suggests, our patients, members and colleagues should be able to rely on us to keep them safe and avoid errors that could negatively impact their health and well-being. The good news is that we know our colleagues are paying attention.

Last year, across HealthPartners, our colleagues spoke up over 25,000 times when they saw or experienced errors, unsafe conditions and other concerns. They reported events and incidents like: When a bed ridden patient fell while trying to get out of bed. And when a lab specimen was labeled with the wrong patient.
They spoke up when an Explanation of Benefits went to the wrong member. Or, noticing that a patient and their health plan were overbilled when the provider selected the wrong procedural code. Of the events and incidents that were reported within our organization last year, around 2,000 led to some level of patient harm.
Typically, a small percentage of those might even lead to permanent harm or even death. These kinds of events can also receive media attention and many need to be reported to our regulators. The people we serve trust us with their health and well-being. They expect us to keep them safe. With something as complicated and potentially risky as health care, it takes a commitment from every colleague in every part of our organization to fulfill this tall order.

With something as complicated and potentially risky as health care, it takes a commitment from every colleague in every part of our organization to fulfill this tall order.

Slide 11 - Why do errors happen?

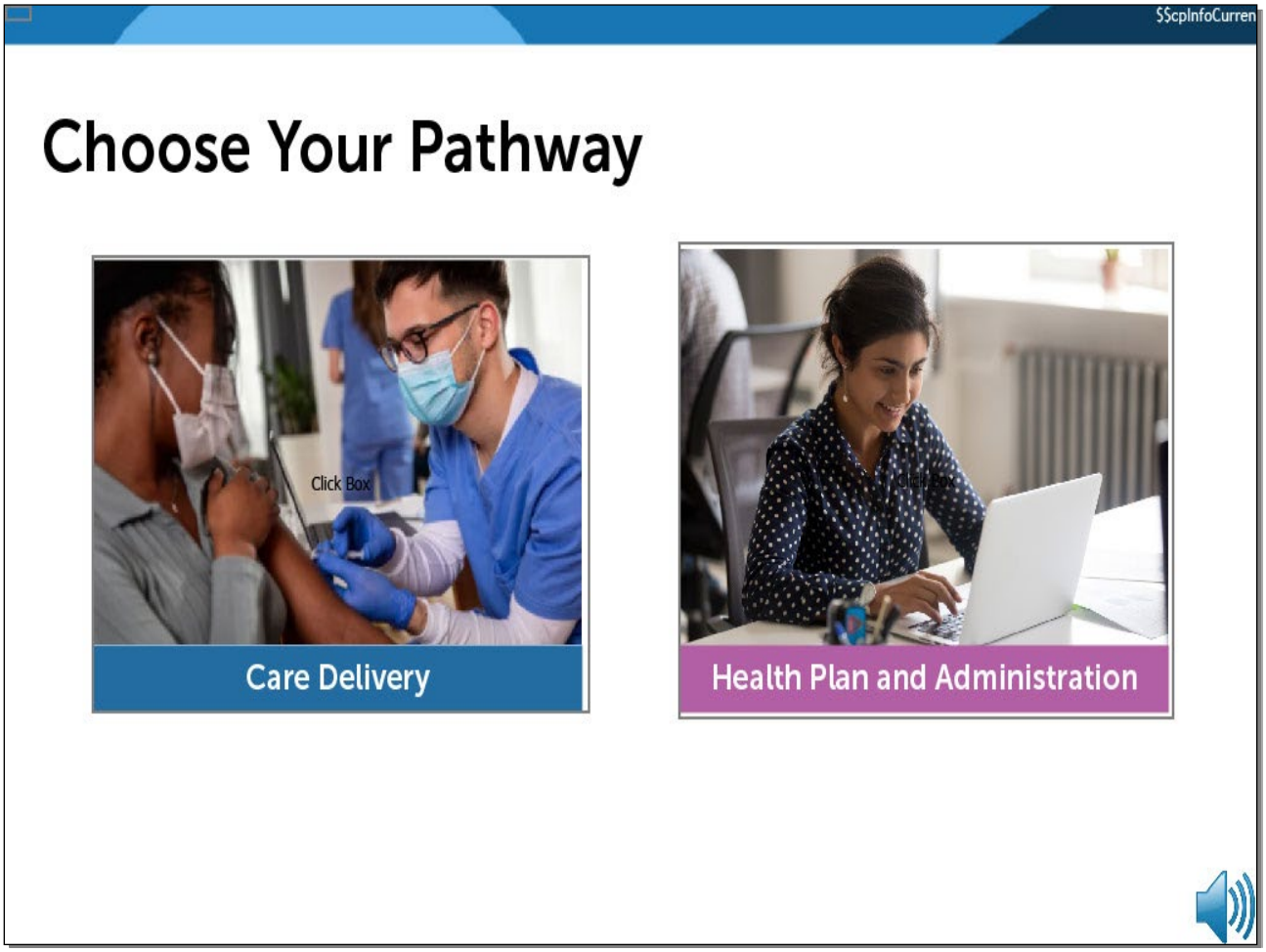


Slide notes

We sometimes use the metaphor of Swiss cheese to help understand how safety events and other errors happen. Imagine a stack of Swiss cheese slices. Each slice of cheese represents a step in a process. Most of the time, each step in the process - the slices of cheese -- goes smoothly, without mistakes.

But sometimes there are weaknesses in the process - like holes in the cheese. One or two holes in one slice of Swiss cheese doesn't normally cause a problem - other parts of the process - other slices of cheese - can catch things before there's harm. But on the rare occasion when holes in each slice of cheese line up just right, there's nothing to catch the problem, and there can be some very bad results.

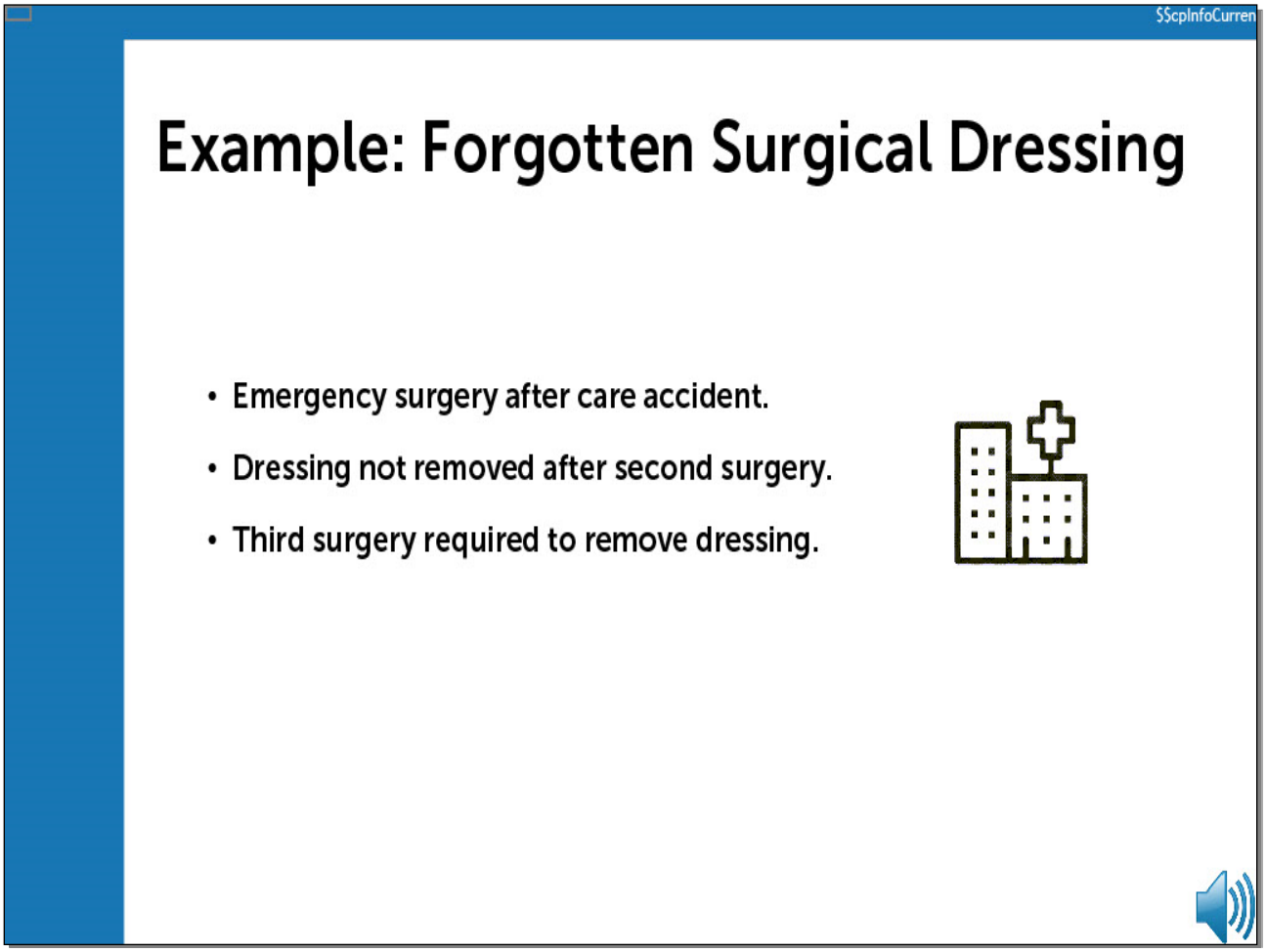
Slide 12 - Choose Your Pathway



Slide notes

Let’s use the Swiss Cheese model to look at a couple of examples. If you mostly work in a patient care setting - like a hospital, clinic or community-based care - follow the care delivery path by clicking on the box on the left.

Slide 13 - Example: Forgotten Surgical Dressing

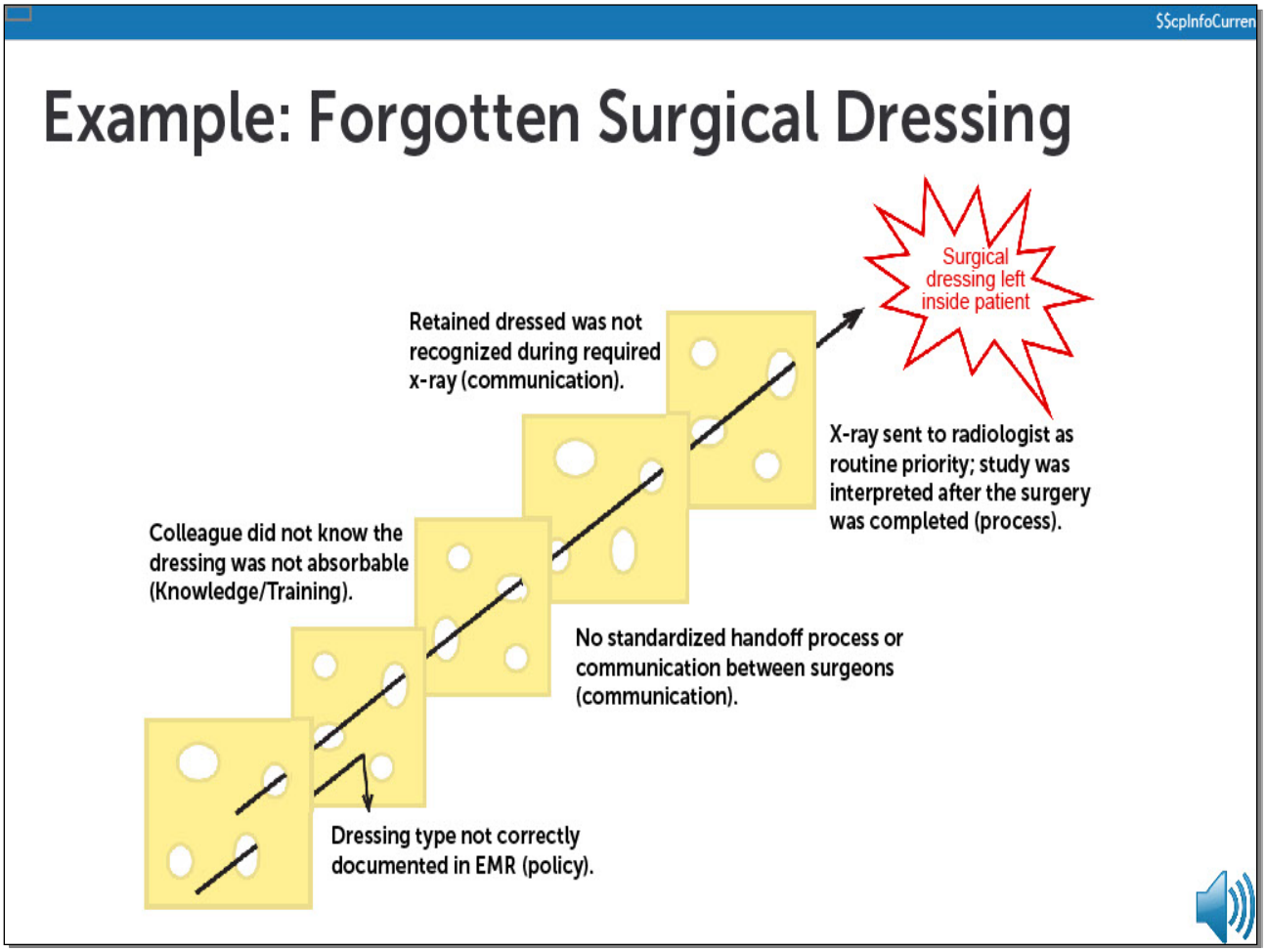


Slide notes

In our first example, a patient was admitted to the hospital for an emergency surgery after a bad car accident. During the surgery, a dressing was placed inside the wound to help stop bleeding. Due to the nature of this patient's injury, the operating team chose to use a non-absorbable dressing. The team knew the patient would need a second surgery the next day, and they'd remove the dressing at that time.

But the dressing was not removed during the second surgery. When the patient's care team realized the dressing was not taken out, the patient had to have a third surgery, just to have the dressing removed.

Slide 14 - Example: Forgotten Surgical Dressing



Slide notes

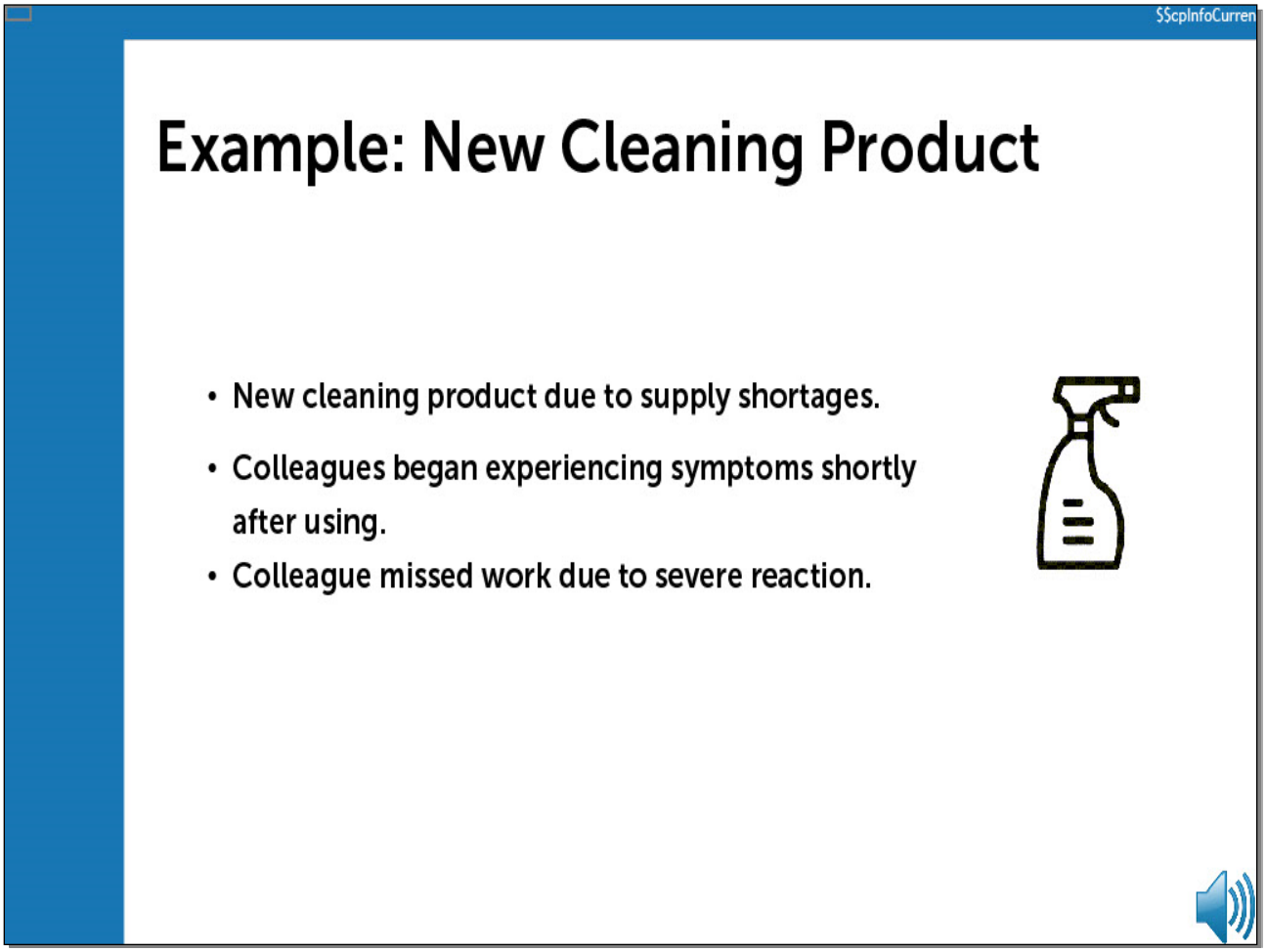
Let's use the Swiss cheese model - where we see layers of errors - to understand how this safety event happened. First, the dressings used during the patient's initial surgery should have been documented in the medical record as an intentionally retained item. Unfortunately, the nurse who documents intentionally retained items did not know the dressing the OR team chose to use was not absorbable like many dressings.

So, it wasn't documented in the medical record as needing to be removed in the subsequent surgery. In addition, when the first surgeon did a verbal handoff to the surgeon performing the scheduled second surgery, they didn't follow a standardized handoff process, which was designed to reliably communicate about things like objects intentionally placed, with intent to remove during the next surgery.

Finally, a post-surgery x-ray was performed just before closing the patient's second surgery site. If the x-ray had been sent to the radiologist as a STAT priority, which is what was supposed to happen, the radiologist would have interpreted in time to catch the retained dressing before the surgery was completed. Unfortunately, the x-ray was not sent to the radiologist as a priority, so the retained dressing was not seen by the radiologist until after the surgery was completed.

Several steps in the surgery process were designed to prevent safety errors like this one. Each of those steps - medical record documentation, standardized handoffs and pre-closure x-rays - is like a slice of Swiss cheese. But when errors occurred at each step - when the holes in each slice of cheese lined up just right - the safety process failed, the organization incurred extra expense, and, most important, the patient experienced unnecessary pain and risk.

Slide 15 - Example: Forgotten Surgical Dressing



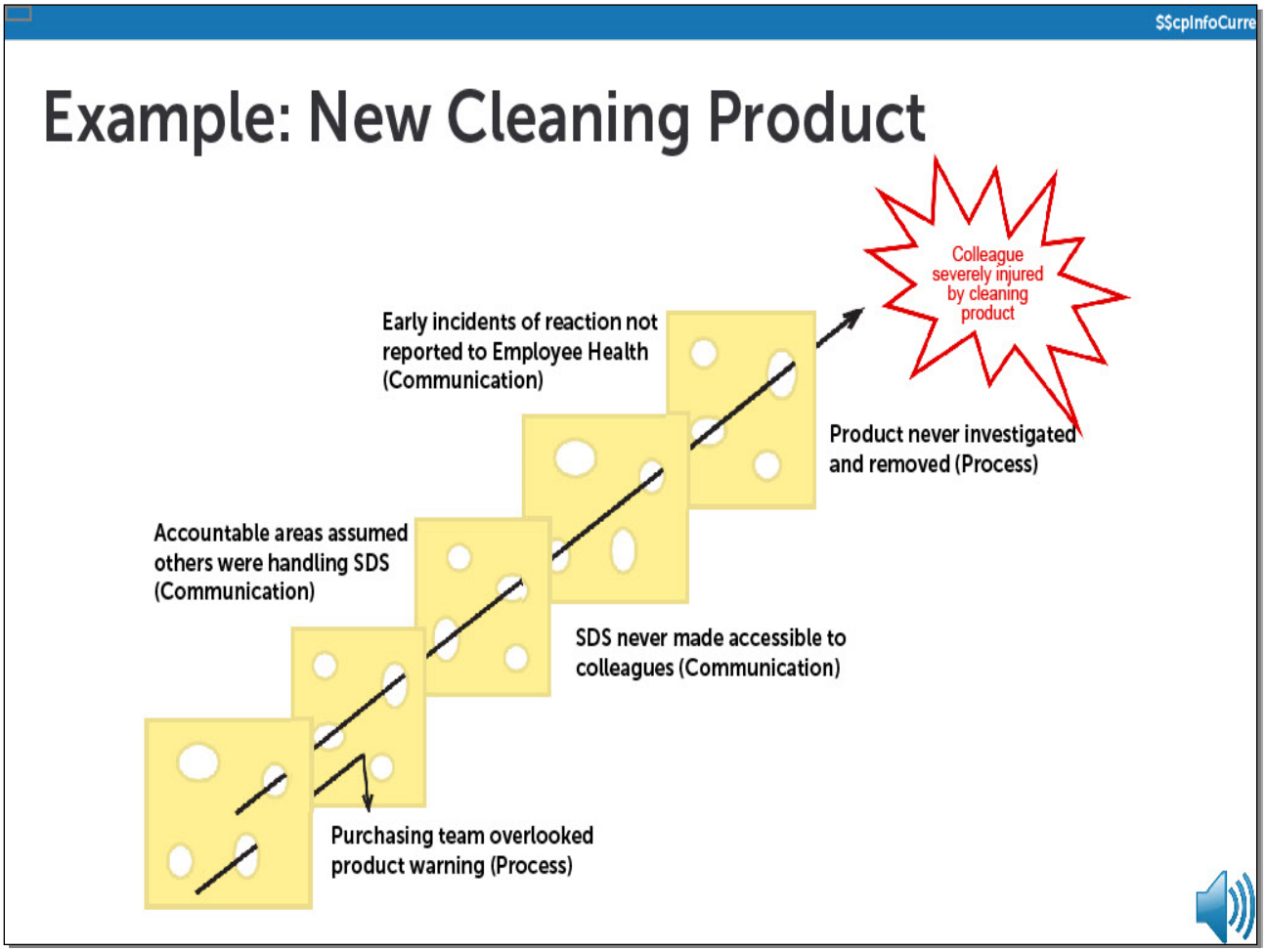
Slide notes

Here's another example of a series of errors that the Swiss cheese model can help us understand: Recently, due to supply shortages, we had to find a replacement for one of the products we use to clean hard surfaces like tables and countertops in breakrooms and conference rooms. When the new product arrived, care and administrative teams added it to the cleaning solution spray bottles in their areas.

Shortly after teams began to use the new cleaning product, a number of colleagues began complaining of headaches and nausea. In one of our administrative sites, a colleague experienced a seizure immediately after spraying her desk with the new cleaner. And, two weeks after we started using the product in our hospital cafeterias, a colleague in food and nutrition services experienced such severe eye irritation that they had to miss work for a week while their eyes remained bandaged.

Our safety processes are supposed to protect people from exposure to harmful chemicals in our facilities, including chemicals that are found in cleaning solutions. So how could this have happened?

Slide 16 - Example: New Cleaning Product



Slide notes

Once again, Swiss cheese can help us understand. If our processes had been followed, here's what would have happened: Before the product was selected, the purchasing team should have noticed a warning that this particular cleaning solution should not be used in offices or health care facilities - instead, a member of the purchasing team overlooked the detail in the warning.

An accountable area would have made sure that the SDS (safety data sheet) for this product was available through myPartner - instead, Employee Health, Environmental Services and Supply Chain all assumed the other areas were taking care of it. Colleagues would have known they should wear masks, gloves and face shields, when using the product, according to the SDS - instead, because department leaders didn't check for the SDS, no one noticed it hadn't been loaded into myPartner.

Leaders would have reported their colleagues' illnesses and injuries to Employee Health sooner so the product could have been investigated and removed from use as soon as injuries started showing up - instead, it wasn't until the colleague with the eye injury mentioned cleaning chemicals to her doctor in the Emergency Department that someone raised the concern to Employee Health.

At each step along the way, we missed an opportunity to prevent - or at least reduce - serious harm from this safety event. We all have an important role in preventing harm to others or other serious problems - to do that, we need to check details, communicate clearly speak up when something doesn't seem right, follow our processes - and keep improving those processes. In other words, use the behaviors of a high reliability organization.

An accountable area would have made sure that the SDS (safety data sheet) for this product was available through myPartner - instead, Employee Health, Environmental Services and Supply Chain all assumed the other areas were taking care of it. Colleagues would have known they should wear masks, gloves and face shields, when using the product, according to the SDS - instead, because department leaders didn't check for the SDS, no one noticed it hadn't been loaded into myPartner.

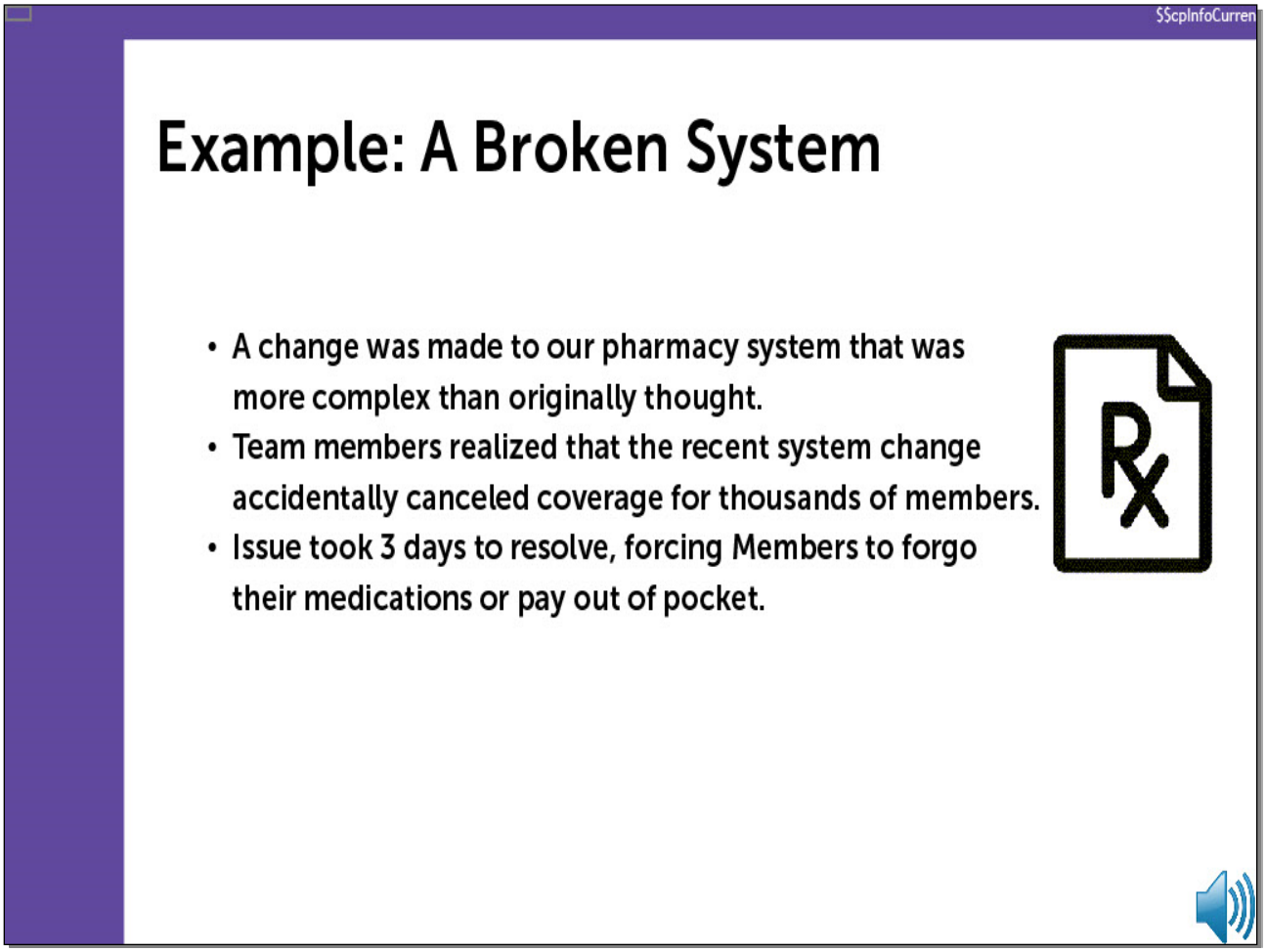
Slide 17 - If you have a patient safety concern…

Slide notes

And if you see something or have a safety concern, report them using our AWARE safety system.

And if you see something or have a safety concern, report them using our AWARE safety system.

Slide 18 - Example: A Broken System



Slide notes

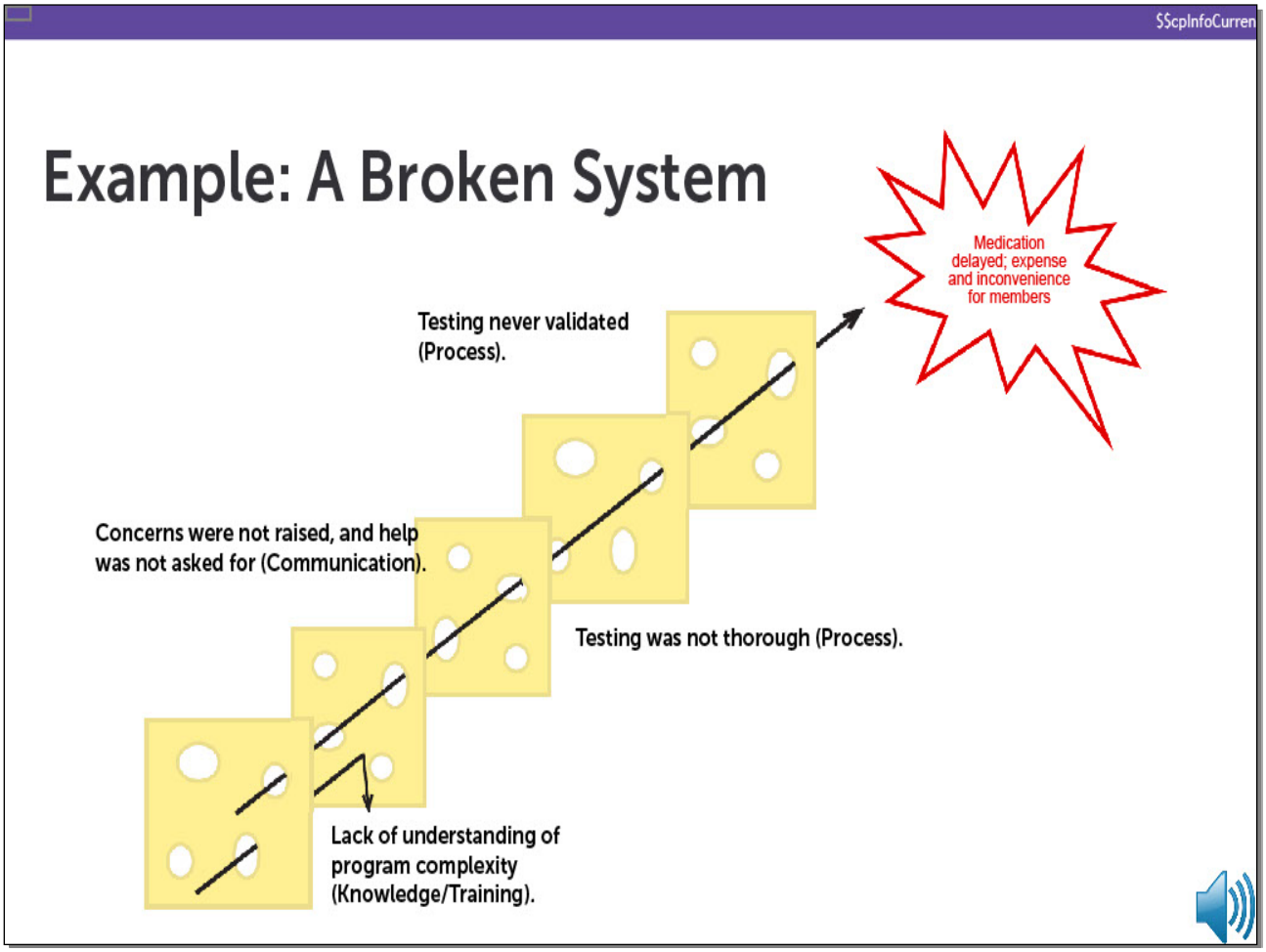
Here's an example of a series of errors that the Swiss cheese model can help us understand: In response to a health plan customer request, we committed to making a change to our pharmacy system for a January 1st implementation date, three months away. Shortly after the team began working on this change, they realized that it would be more complicated than they originally thought, which caused delays for the project.

A few days before the January 1 go-live date, the team successfully tested the programming change they had made. But they decided there wasn't time to do a full test to make sure that the change didn't affect other parts of the system. Then, before it went live, the department leader signed off on the change - normally, the project manager and key tester would do this sign off, but they were both out on PTO because of the New Year's holiday.

On January 1, Member Services started getting a very high number of calls from upset members. These members weren't able to get their prescriptions filled because our pharmacy system showed their coverage had expired on December 31. Team members quickly looked into the problem and realized that the recent system change that had been made for the one health plan customer had accidentally canceled coverage for thousands of members.

It took three days to resolve this issue and resend enrollment information to our pharmacy system. During this time, many members paid for their expensive medications themselves, while others, who couldn’t afford to pay those costs out of pocket, didn’t get their prescriptions filled until the system was fixed. Our health plan systems are designed to make sure that members get coverage and care quickly and seamlessly. So how could this have happened?

Slide 19 - Example: A Broken System



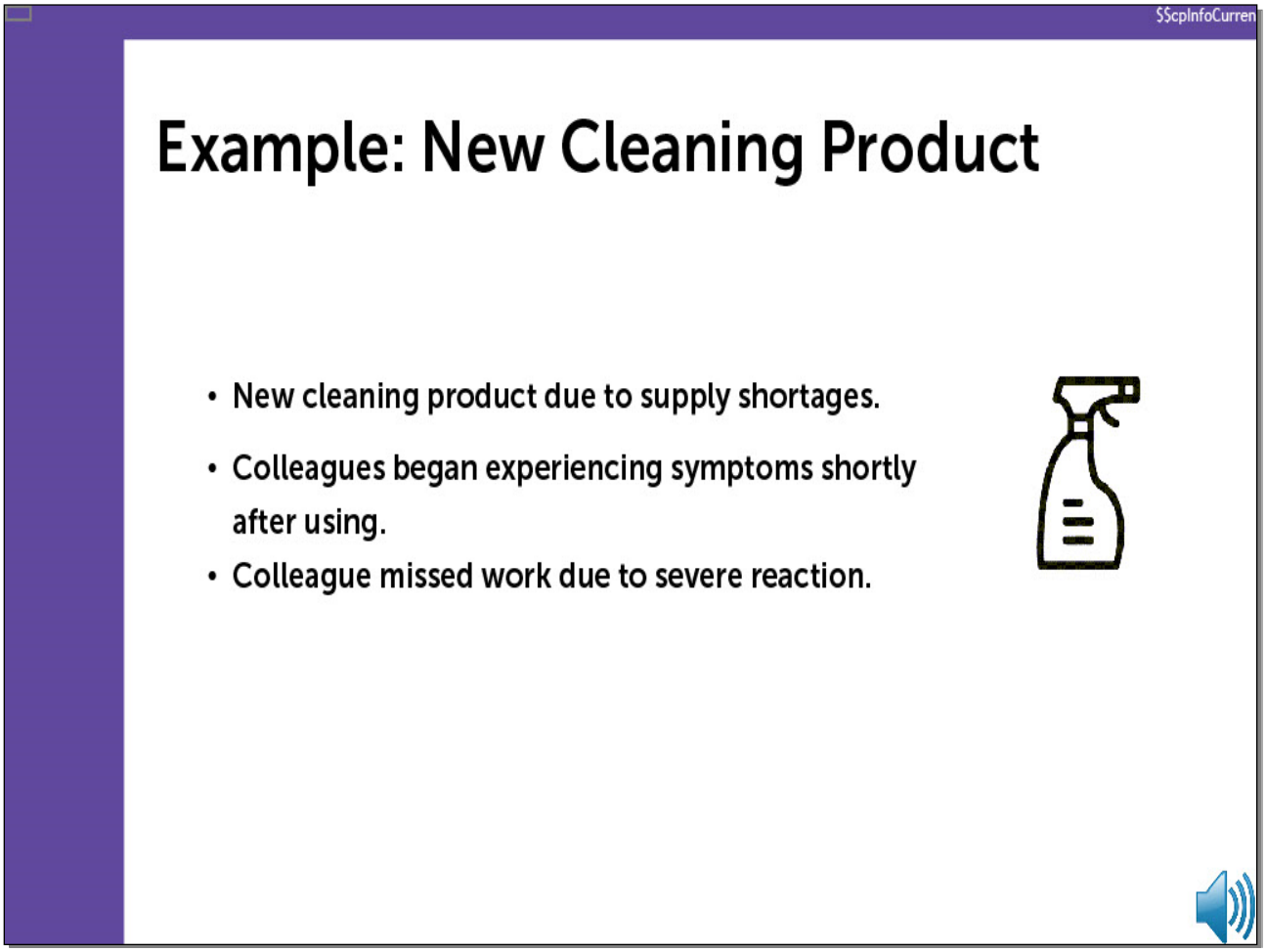
Slide notes

Let's see how this safety event happened…
The dressing that was placed during a surgery was not identified as an item that needs to be documented in the medical record when it's placed. While some members of the OR team who have used this dressing previously may have known about this. The nurse that documents intentionally retained items did not know the dressing was not absorbable like many items are.

So, it was not documented in the medical record as a retained object to be removed in the subsequent surgery. When the verbal handoff occurred between the first surgeon and the subsequent surgeon, they didn't follow a standardized handoff process to reliably communicate that a dressing was placed with intention to remove in subsequent surgery.

Finally, although a required post-surgery x-ray was performed following the second surgery, the x-ray was sent to the radiologist as a routine priority, so the study was not interpreted until after the surgery was completed.

Slide 20 - Example: Forgotten Surgical Dressing



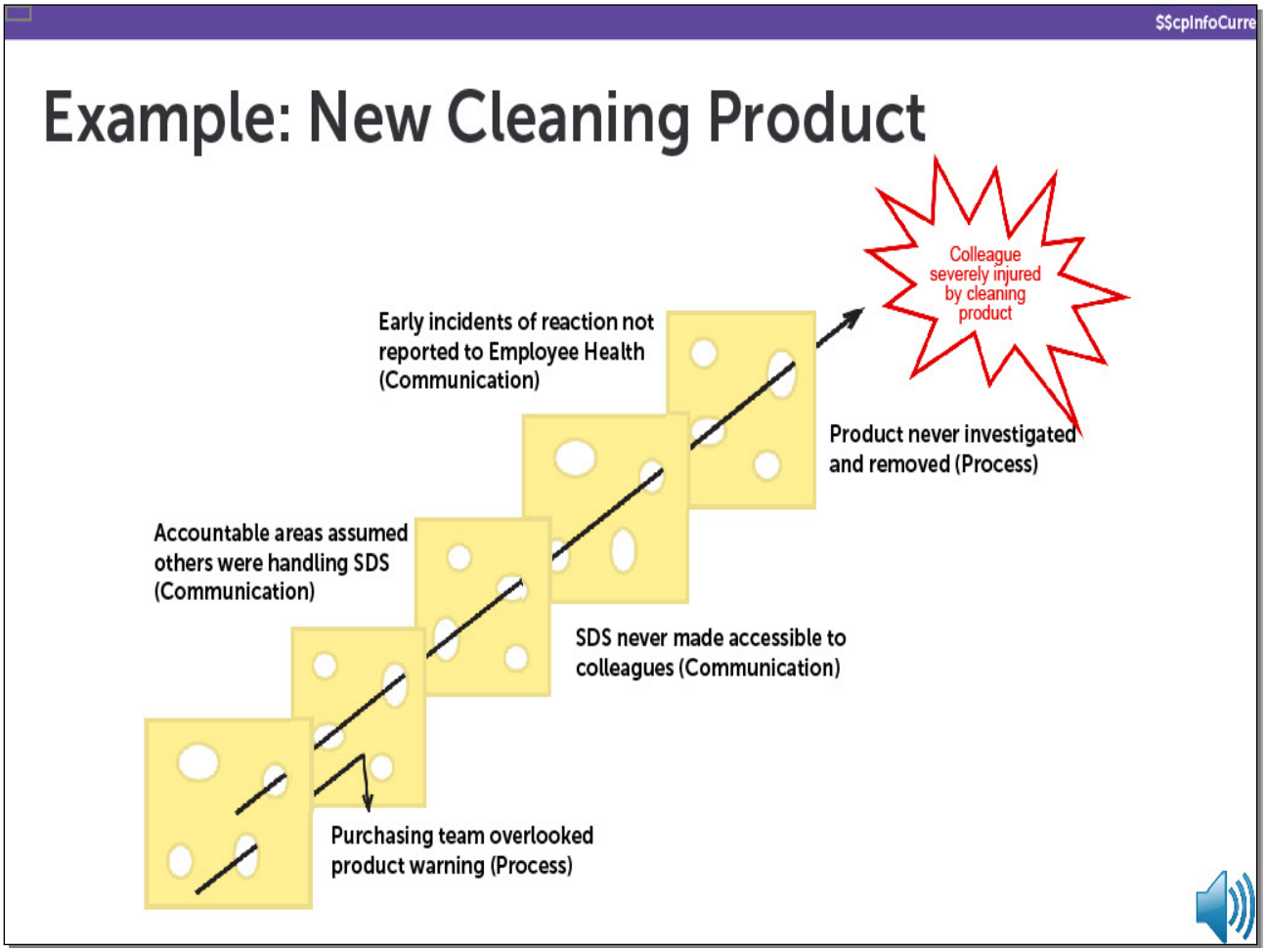
Slide notes

Here's another example of a series of errors that the Swiss cheese model can help us understand: Recently, due to supply shortages, we had to find a replacement for one of the products we use to clean hard surfaces like tables and countertops in breakrooms and conference rooms. When the new product arrived, care and administrative teams added it to the cleaning solution spray bottles in their areas.

Shortly after teams began to use the new cleaning product, a number of colleagues began complaining of headaches and nausea. In one of our administrative sites, a colleague experienced a seizure immediately after spraying her desk with the new cleaner. And two weeks after we started using the product in our hospital cafeterias, a colleague in food and nutrition services experienced such severe eye irritation that they had to miss work for a week while their eyes remained bandaged.

Our safety processes are supposed to protect people from exposure to harmful chemicals in our facilities, including chemicals that are found in cleaning solutions. So how could this have happened?

Slide 21 - Example: New Cleaning Product



Slide notes

Once again, Swiss cheese can help us understand. If our processes had been followed, here's what would have happened: Before the product was selected, the purchasing team should have noticed a warning that this particular cleaning solution should not be used in offices or health care facilities - instead, a member of the purchasing team overlooked the detail in the warning.

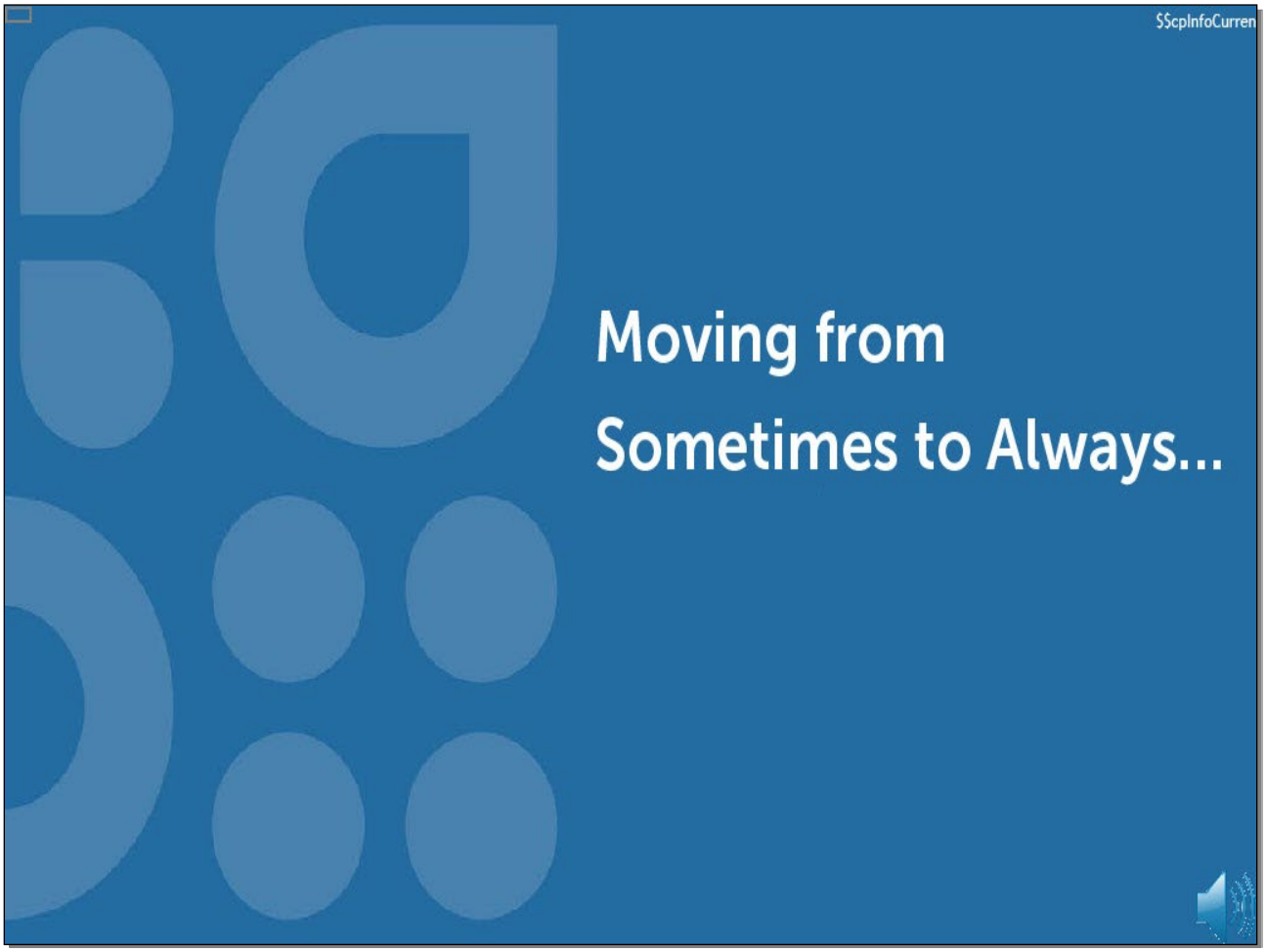
An accountable area would have made sure that the SDS (safety data sheet) for this product was available through myPartner - instead, Employee Health, Environmental Services and Supply Chain all assumed the other areas were taking care of it. Colleagues would have known they should wear masks, gloves and face shields, when using the product, according to the SDS - instead, because department leaders didn't check for the SDS, no one noticed it hadn't been loaded into myPartner.

Leaders would have reported their colleagues' illnesses and injuries to Employee Health sooner so the product could have been investigated and removed from use as soon as injuries started showing up - instead, it wasn't until the colleague with the eye injury mentioned cleaning chemicals to her doctor in the Emergency Department that someone raised the concern to Employee Health.

At each step along the way, we missed an opportunity to prevent - or at least reduce - serious harm from this safety event. We all have an important role in preventing harm to others or other serious problems - to do that, we need to check details, communicate clearly speak up when something doesn't seem right, follow our processes - and keep improving those processes. In other words, use the behaviors of a high reliability organization.

An accountable area would have made sure that the SDS (safety data sheet) for this product was available through myPartner - instead, Employee Health, Environmental Services and Supply Chain all assumed the other areas were taking care of it. Colleagues would have known they should wear masks, gloves and face shields, when using the product, according to the SDS - instead, because department leaders didn't check for the SDS, no one noticed it hadn't been loaded into myPartner.

Slide 22 - Moving from Sometimes to Always…



Slide notes

We just reviewed and applied the Swiss Cheese model to learn how safety events and other serious errors can occur. Every high reliability organization understands that everyone can make mistakes. Many mistakes are so small that sometimes people don't even notice them. But in a high-risk and complicated environment like health care, any error, of any size, could cause significant harm.

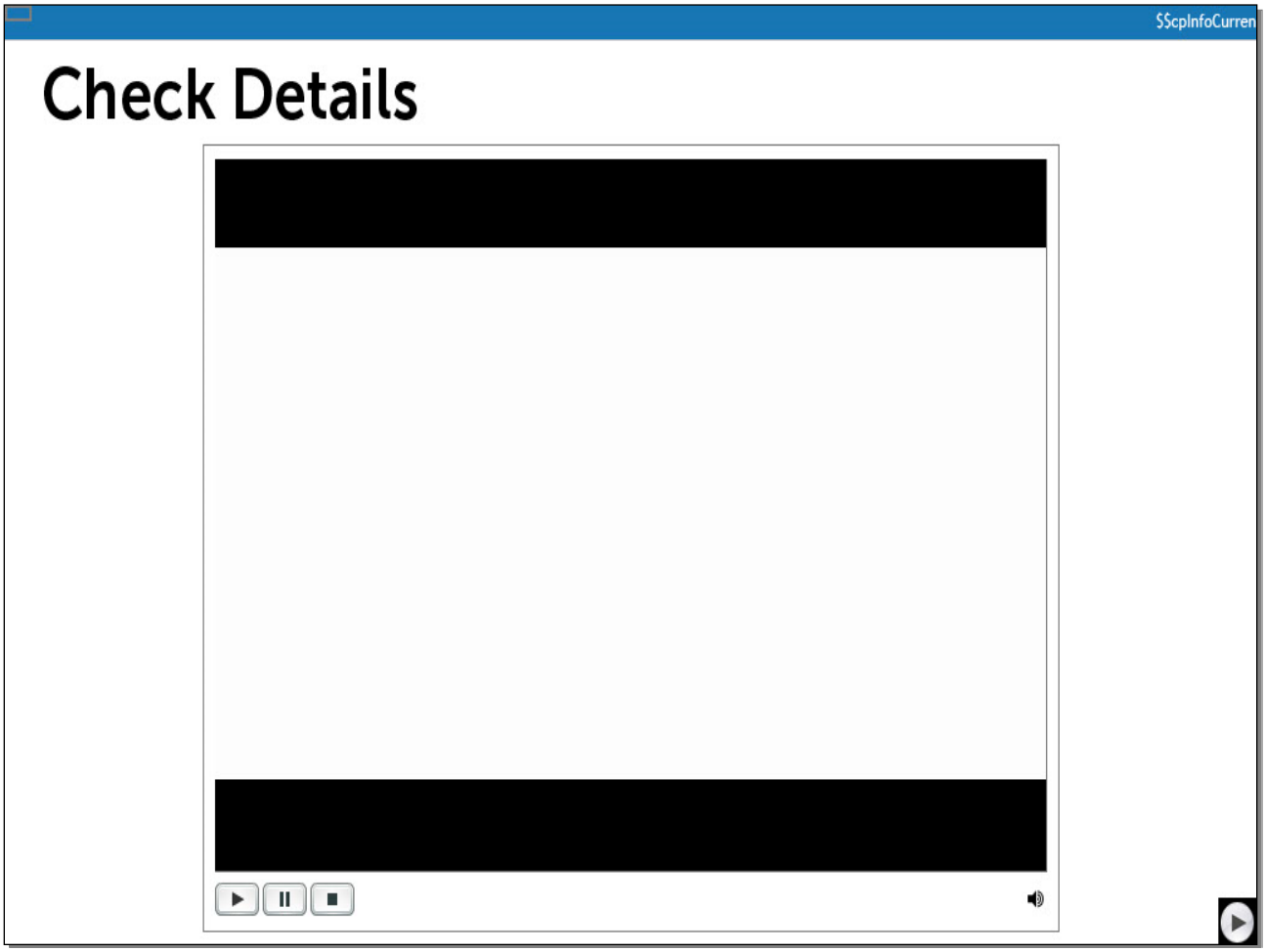
So how do we improve safety and avoid errors? We need to move our safety practices and behaviors from "sometimes, to always" …. In the examples you just saw, it wasn't enough to sometimes follow the processes that were designed to keep people safe - those processes should always be followed.

Slide 23 - People in High Reliability Organizations…

Slide notes

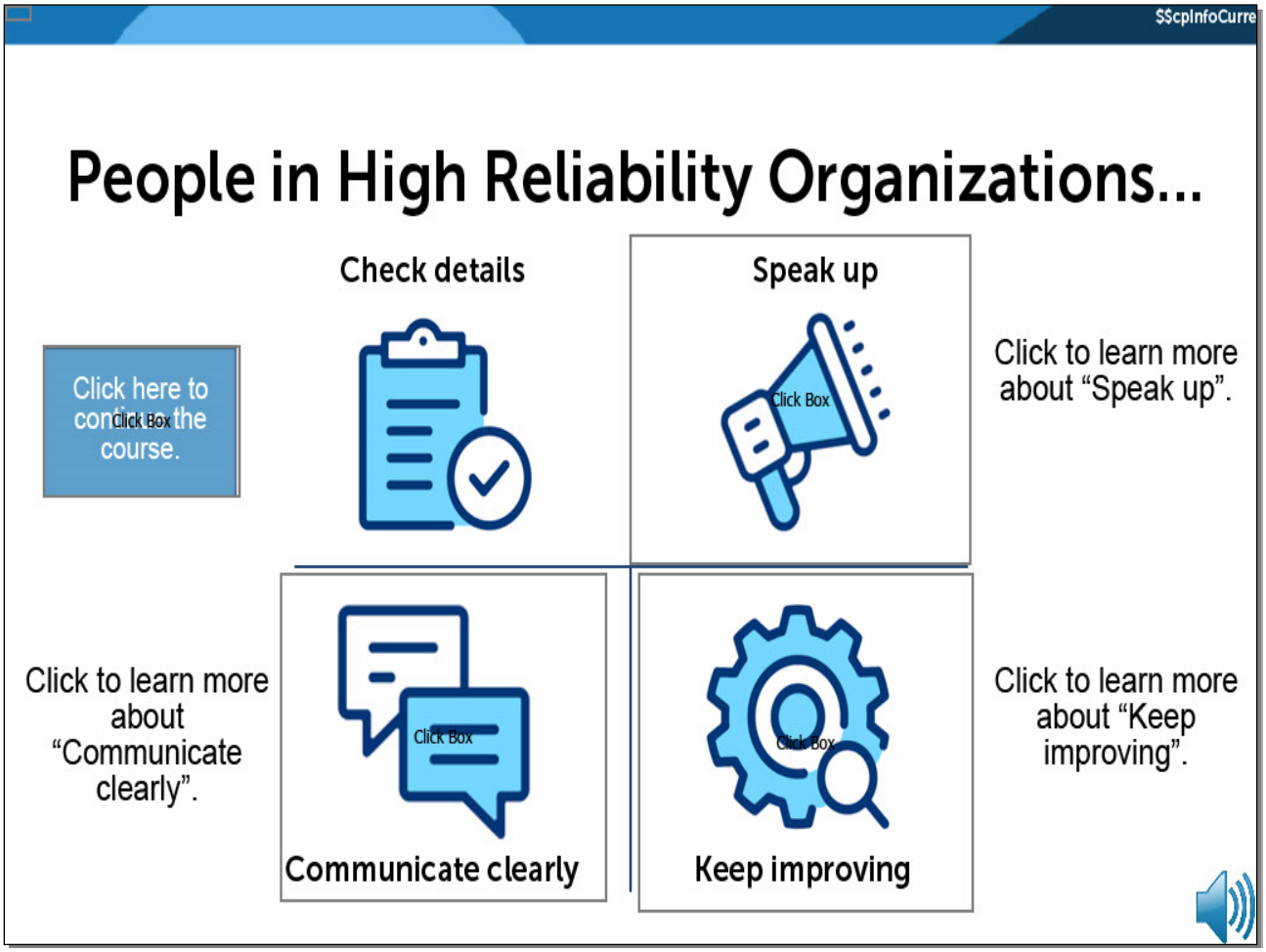
Does this slide look familiar? Earlier in this course, Andrea Walsh introduced these 4 behaviors that people in high reliability organizations always use - not just sometimes, but always. Check details, Communicate clearly, Speak up, And always, Keep improving. Let’s take a closer look at the first behavior, Check Details, and learn about a simple tool we can all use every day to help us avoid errors.

Slide 24 - Check Details



Slide notes

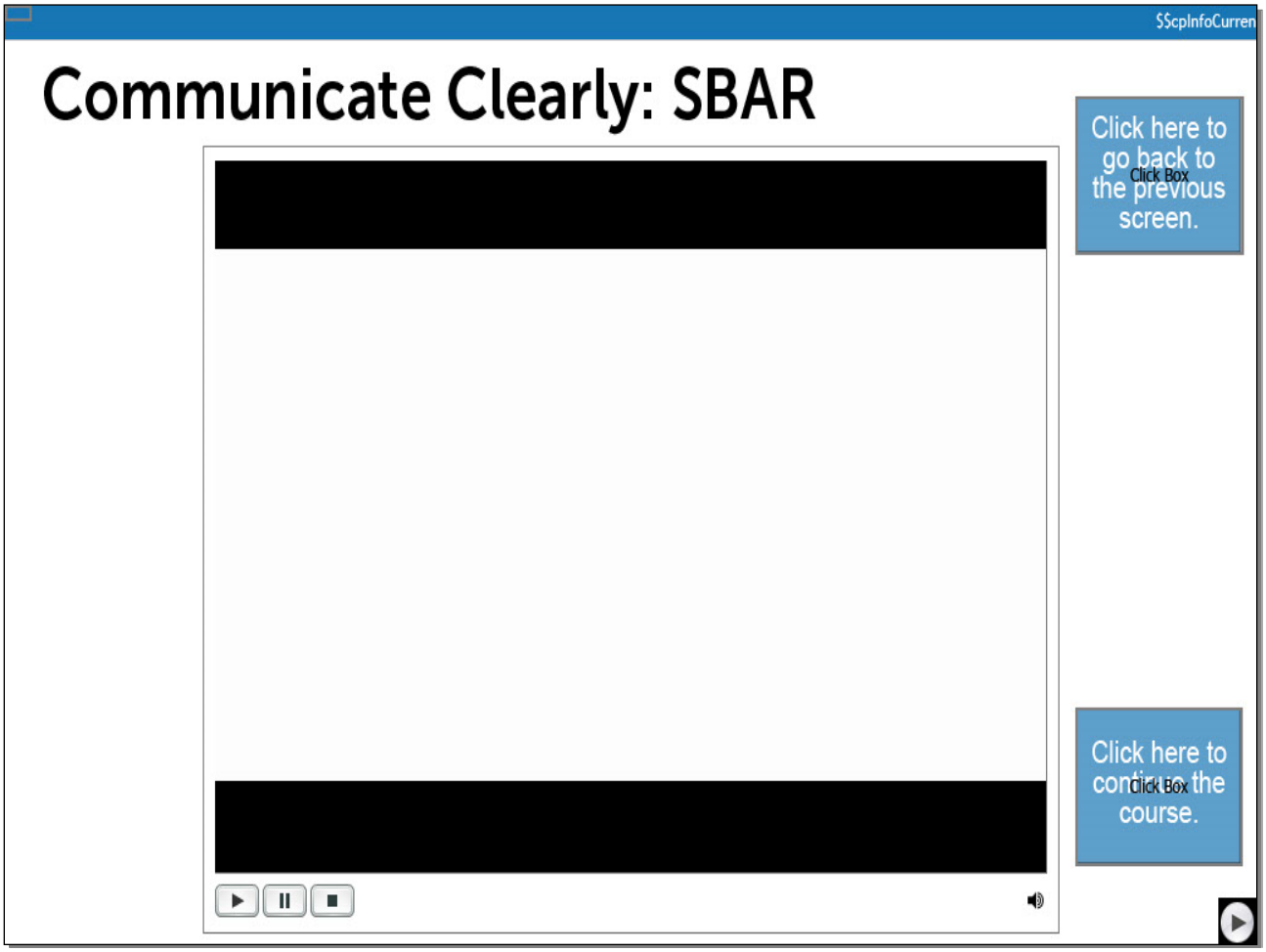
Slide 25 - People in High Reliability Organizations…



Slide notes

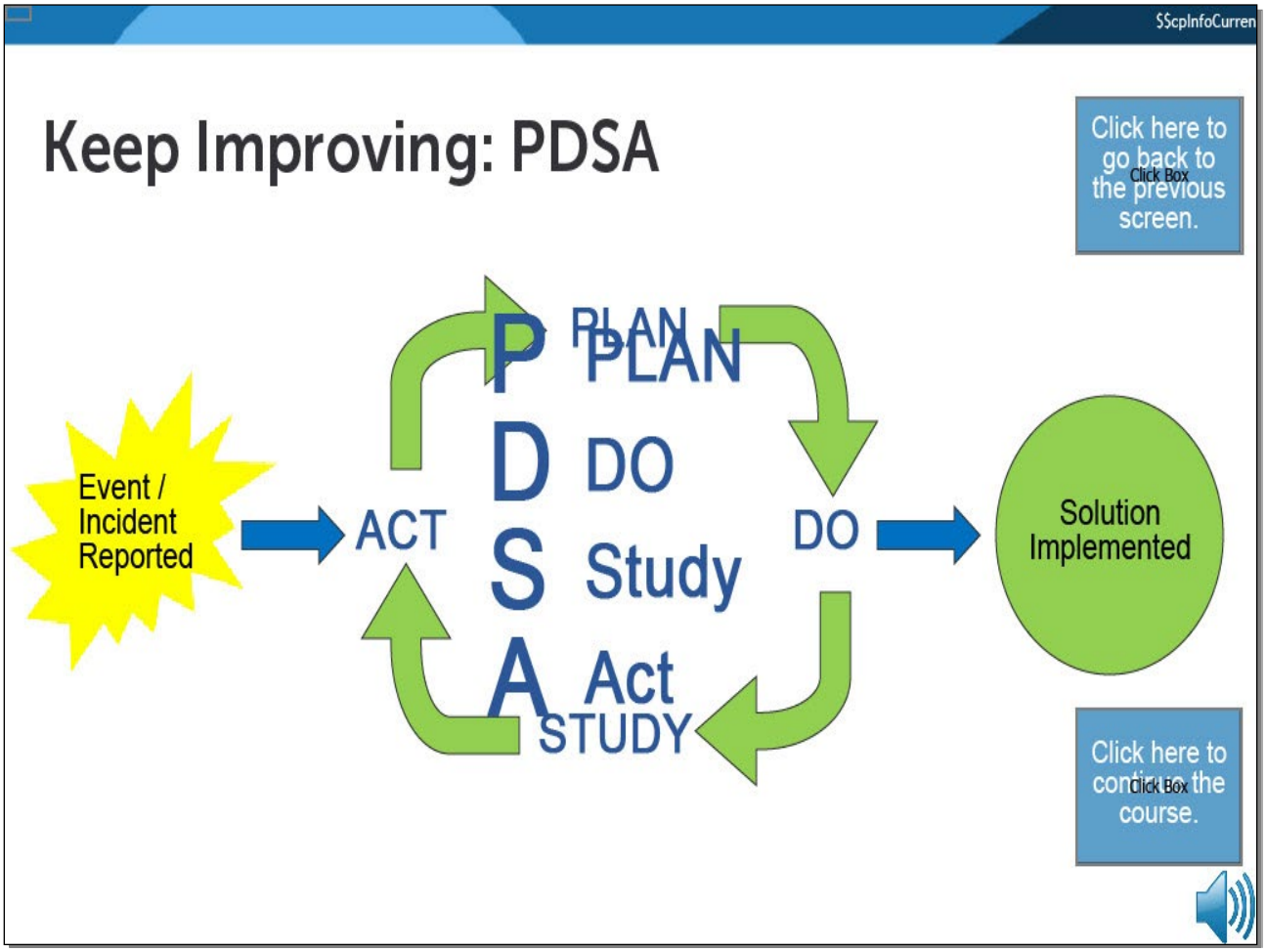
If you’d like to learn more about the other 3 high reliability behaviors, and tools we use at HealthPartners to support these behaviors, click on the icon. Or, you can take time later to explore these behaviors and tools, which are always available on the Quality Improvement site on myPartner.

Slide 26 - Communicate Clearly: SBAR



Slide notes

Slide 27 - Keep Improving: PDSA



Slide notes

We hear about safety issues through many different avenues. You may become aware of a safety event at a huddle, in a conversation with a colleague, or as an event in our safety reporting system, AWARE. As a highly reliable organization, we have a responsibility to take action and keep improving when we are alerted to safety issues. Using the PDSA methodology, which stands for Plan, Do, Study, Act. We can ensure we are working towards highly reliable processes and workflows. Let's look at an example.

The manager of a primary care clinic receives an AWARE report about a safety event at her clinic. Yesterday, a patient was found in the hallway bathroom after falling while getting up from the toilet. When asked, the patient said they pulled the emergency cord for assistance, but no one came so they tried to get up on their own. The patent was uninjured and able to leave the clinic with their daughter as a driver.

As the leader was investigating the event, it came to her attention that the emergency cord has a history of malfunctioning. In making a plan to fix this specific cord - the manager also decided to gather the clinic team to test all of the emergency cords in the clinic. In the Do portion of this PDSA, this plan was executed, and the team found one other cord that wasn't working, and facilities was contacted to do the repairs.

To check on the success of the plan after the repairs, the clinic instituted a monthly check of the emergency cords so that they could act or adjust that plan, if there were any future issues. The PDSA cycle allows teams to take plan-ful actions in response to safety events and create solutions that are rooted in proactive systems thinking.

We hear about safety issues through many different avenues. You may become aware of a safety event at a huddle, in a conversation with a colleague, or as an event in our safety reporting system, AWARE. As a highly reliable organization, we have a responsibility to take action and keep improving when we are alerted to safety issues. Using the PDSA methodology, which stands for Plan, Do, Study, Act. We can ensure we are working towards highly reliable processes and workflows.

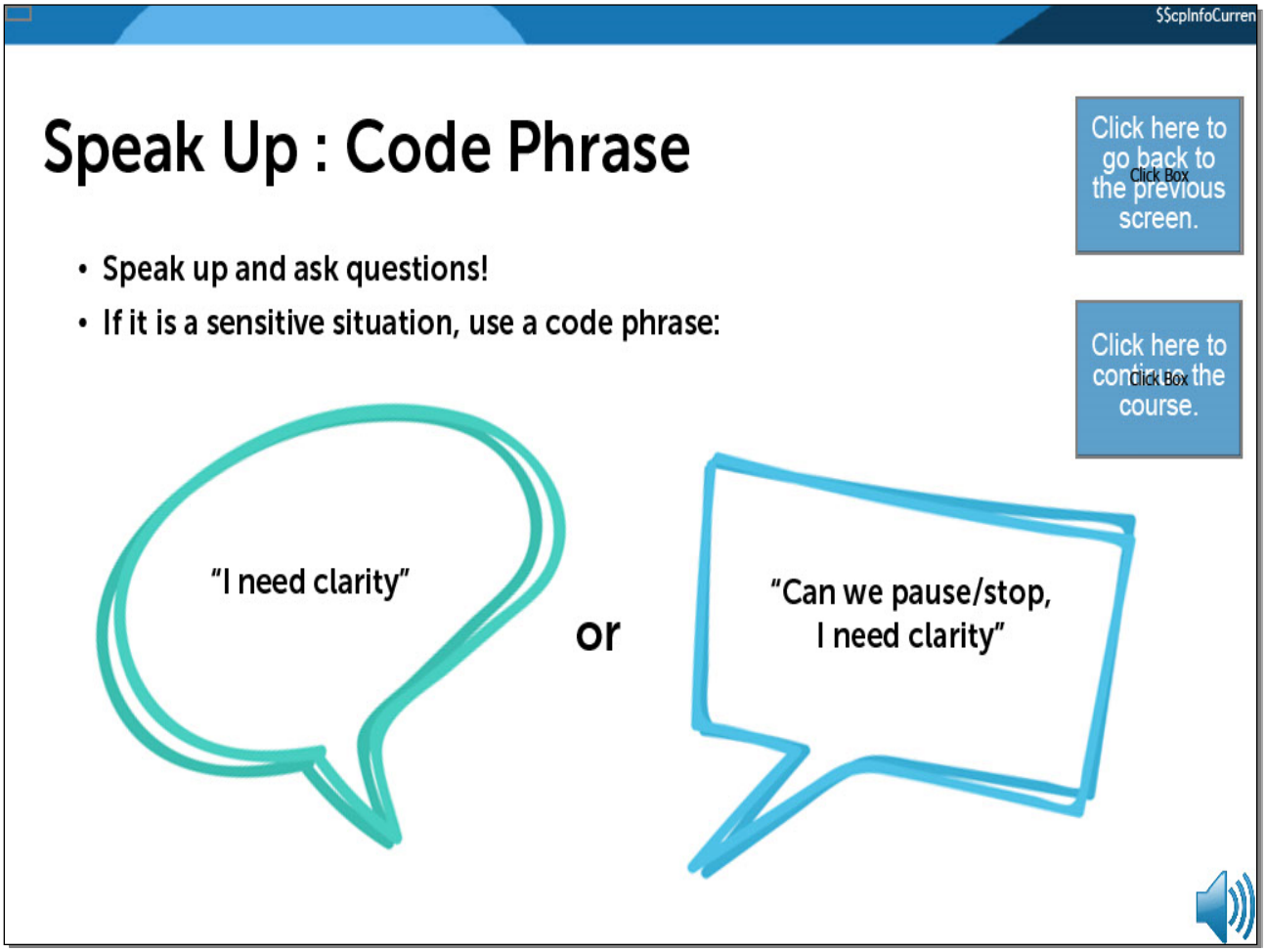
We hear about safety issues through many different avenues. You may become aware of a safety event at a huddle, in a conversation with a colleague, or as an event in our safety reporting system, AWARE. As a highly reliable organization, we have a responsibility to take action and keep improving when we are alerted to safety issues. Using the PDSA methodology, which stands for Plan, Do, Study, Act. We can ensure we are working towards highly reliable processes and workflows. Let’s look at an example.

The manager of a primary care clinic receives an AWARE report about a safety event at her clinic. Yesterday, a patient was found in the hallway bathroom after falling while getting up from the toilet. When asked, the patient said they pulled the emergency cord for assistance, but no one came so they tried to get up on their own. The patent was uninjured and able to leave the clinic with their daughter as a driver.

As the leader was investigating the event, it came to her attention that the emergency cord has a history of malfunctioning. In making a plan to fix this specific cord - the manager also decided to gather the clinic team to test all of the emergency cords in the clinic. In the Do portion of this PDSA, this plan was executed and the team found one other cord that wasn’t working and facilities was contacted to do the repairs.

To check on the success of the plan after the repairs, the clinic instituted a monthly check of the emergency cords so that they could act or adjust that plan, if there were any future issues. The PDSA cycle allows teams to take plan-ful actions in response to safety events and create solutions that are rooted in proactive systems thinking.

Slide 28 - Speak Up : Code Phrase



Slide notes

Speak up is a foundational behavior for us at HealthPartners, as it is one way we demonstrate living our integrity. “If you see something, say something” is a principle we expect all of our colleagues to use, to keep each other, our patients, and members safe.

If you feel you are in a sensitive situation, or you don’t feel your colleague is hearing your question or concern, we can use our code word; which is “clarity”. You can say “I need clarity,” or “can we pause or stop, I need clarity.” By having a non-threatening approach, and using the code phrase, “I need clarity”, we can increase situational awareness on a concern that we have or on a question, without making others feel defensive.

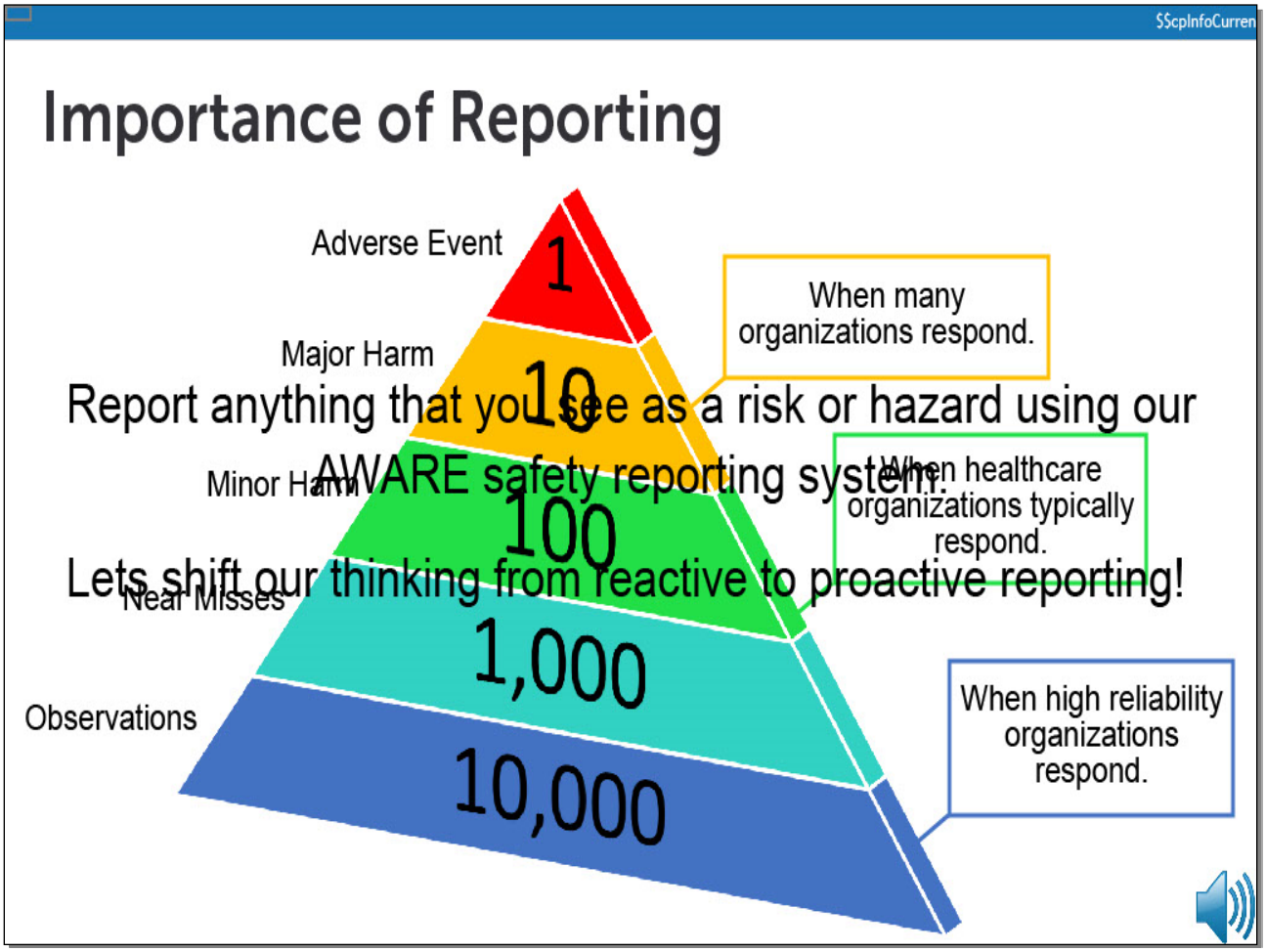
Slide 29 -

Slide notes

At HealthPartners, we strive to have a culture of trust and fairness, learning, continuous improvement, and a shared accountability for patient and colleague safety. Some might know this as a Just Culture. In our Culture colleagues are safe to, and need to, report mistakes or errors so we can improve our systems and processes.

Our Culture is one that avoids punishing or placing blame on someone for human error. We focus first on system and process breakdowns to understand the root cause of the errors, so we can work to mistake-proof against them. This approach is about creating an environment that supports all of our colleagues, to ensure that the error is less likely to ever occur again.

Slide 30 - Importance of Reporting



Slide notes

We can't fix a problem that we don't know about, which is why speaking up is so important. We need every colleague to report risks and hazards as soon as they see them. Not just after an injury or error already happened - but beforehand, too, when you see that something could cause an injury or other problem if it were ignored. This is the difference between reactive reporting - speaking up after someone gets hurt, for example - and proactive reporting - speaking up before someone gets hurt.

Let me give you an example. Say we have an everyday hazard pop up like a bad hole or crack in the sidewalk outside one of our clinics. Every day, 10,000 people might walk by and see that hazard without reporting it. 1,000 people might stub their toe or graze the hole, and still not report it. Maybe they assume someone else will report it, or that our maintenance crew already knows about it. Unfortunately, 100 of those 10,000 people will trip and have a minor injury - maybe a skinned knee or elbow.

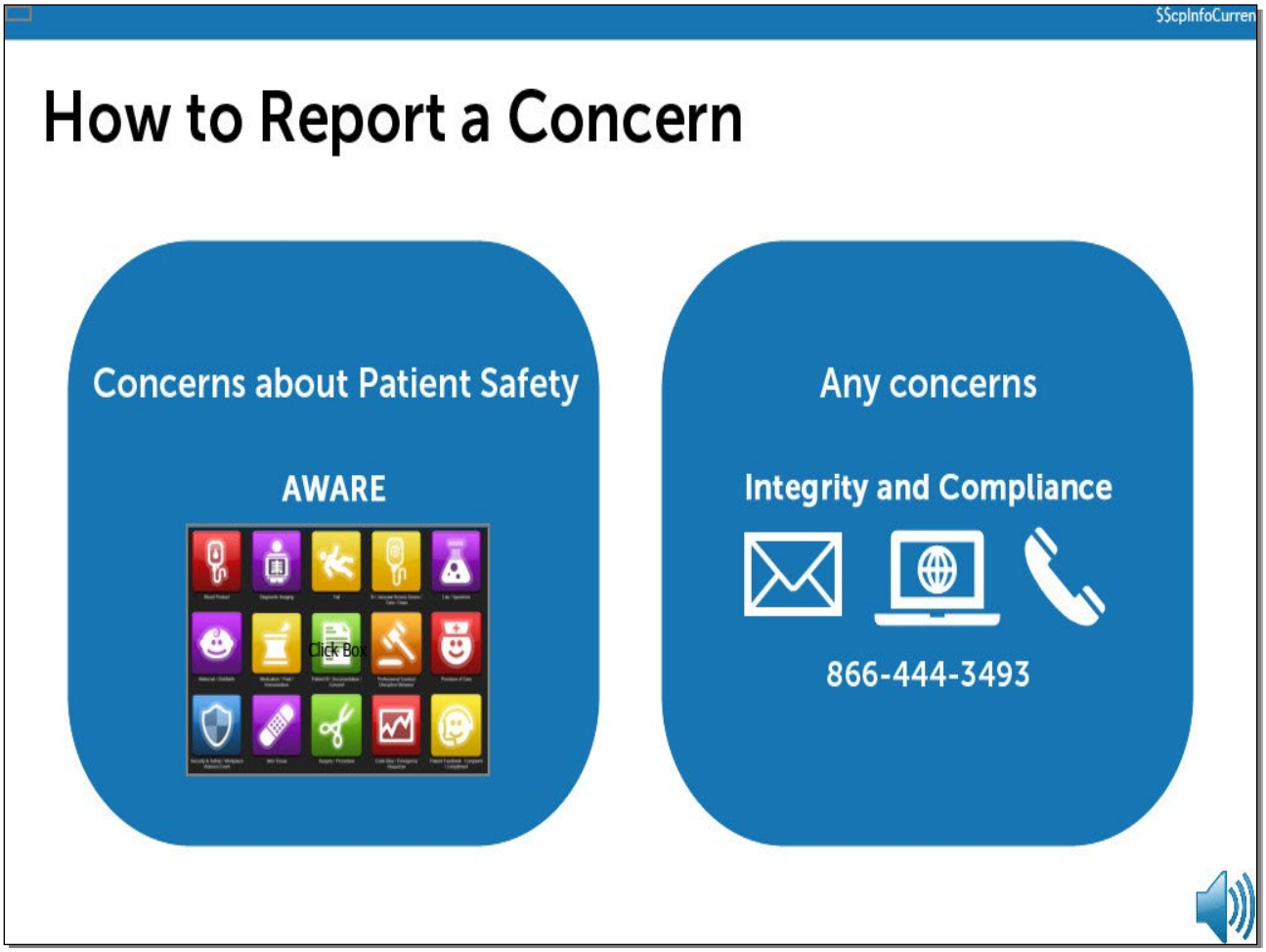
They are more likely to tell the clinic about the sidewalk problem, but by then they've already been injured. 10 people might end up with an injury serious enough to require care and time away from work.

And maybe 1 person will even have serious event like an irreversible head injury. Imagine, though, if more people reported the sidewalk problem proactively - before someone gets hurt. In health care, we're used to reporting safety errors after someone is injured.

And sometimes we even report what we call near misses - when someone almost got injured due to an error. But people in highly reliable organizations take a proactive approach to reporting - they pay attention to what could go wrong, speak up about it, and then fix unsafe or high-risk situations. We need everyone to take the time to report concerns - safety concerns, financial concerns, privacy or compliance concerns, and things that just seem wrong, even if you're not sure why.

That way we can look into the concern, fix it, and learn how to improve. Don't wait until a mistake happens or until someone gets hurt. High reliability happens BEFORE harm is done.

Slide 31 - How to Report a Concern



Slide notes

There are many ways to report concerns, whether about safety, compliance, privacy or anything else that you think needs attention. To report concerns about patient safety, use the online AWARE system. For all other concerns, use one of the Integrity and Compliance reporting channels. You can send an email, call or, if you want to report anonymously, call the Integrity and Compliance Hotline.

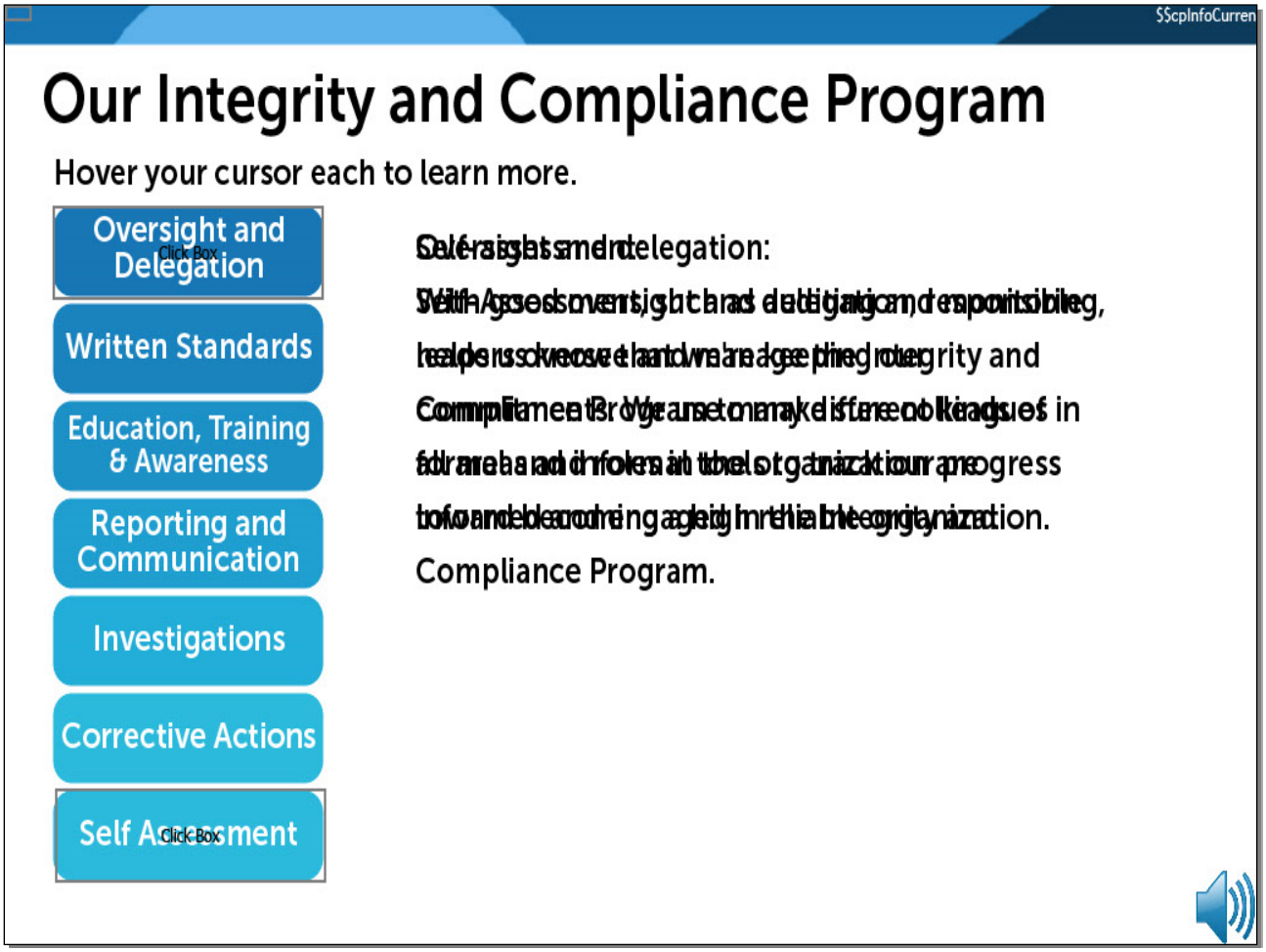
The Integrity and Compliance myPartner site also has lots of other information about where to report your concerns, what happens after you report, and protecting colleagues who speak up in good faith. If you aren't sure whether or where to bring your concerns and questions, check out our site. Or just call the Hotline, and they'll make sure your report gets to the right place.

Slide 32 - Tobi Tanzer

Slide notes

Hi, I'm Tobi Tanzer, HealthPartners' Chief Compliance Officer. In this course you learned that speaking up is an important part of safety and becoming a high reliability organization. Speaking up is also one of the ways you participate in our Integrity and Compliance Program. This Program helps us prevent, find, and fix violations of the legal, regulatory, and policy standards that we follow.

Slide 33 - Our Integrity and Compliance Program



Slide notes

That's why, every year, at the end of our Code of Conduct education, we take time to review the Seven Elements that make up our Integrity and Compliance Program. The course you took today focused on one of those Seven Elements: speaking up. A moment ago, you heard how to do just that - how to report patient safety and other concerns.

To learn about how the other six elements of our Integrity and Compliance Program can support our work toward becoming a high reliability organization, hover your cursor over each of the boxes on this screen.

Hover your cursor each to learn more.

Written standards:
The Code of Conduct and other written standards set clear expectations for how each of us is expected to act, including our responsibility to speak up and report concerns.

Education, training & awareness: Education, training and awareness help us understand these expectations and apply them in our daily work. For example, all colleagues are taking this course because it is everyone's responsibility to understand their role in reducing or preventing errors, creating a safe processes and environments to receive care, services and work.

Reporting and communication: Reporting and communication channels are in place to allow for open communication, so that everyone can ask questions and voice their good faith concerns in a safe, non- retaliatory environment. We want all colleagues to immediately report concerns. You'll learn more about how to report your concerns in a moment.

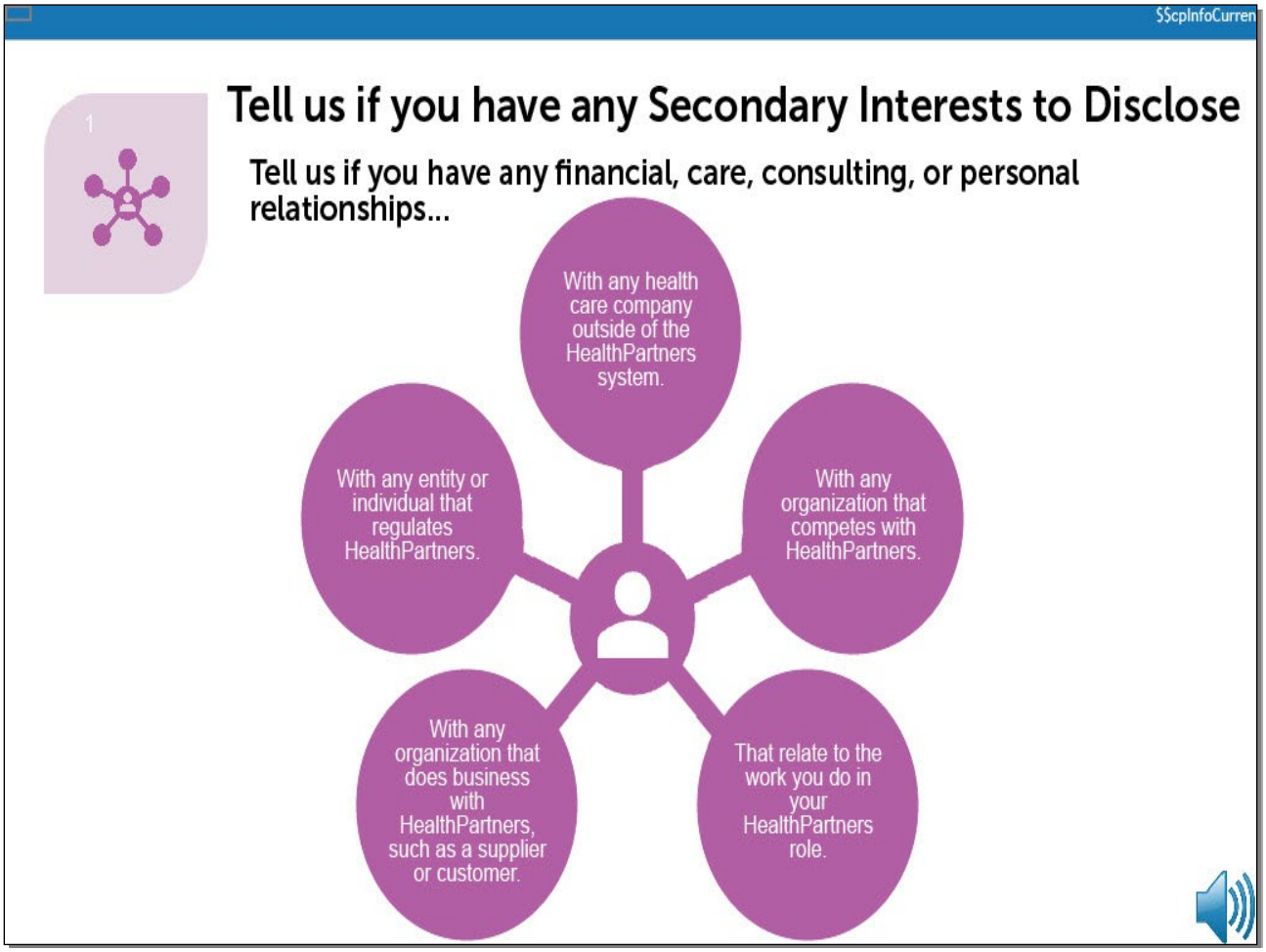
Investigations: We conduct investigations that are objective and thorough. Objective investigations mean that the organization reviews and takes seriously reported concerns - and this includes concerns raised by patients, members, colleagues and others about safety and quality.

Corrective actions: We take corrective action, including discipline, to fix concerns that have been identified through reporting channels, self-assessment or other means. This also helps prevent similar problems in the future. It can take time to fully resolve some concerns.

Self-assessment: Self-Assessment, such as auditing and monitoring, helps us know that we're keeping our commitments. We use many different kinds of formal and informal tools to track our progress toward becoming a high reliable organization.

Oversight and delegation: With good oversight and delegation, responsible leaders oversee and manage the Integrity and Compliance Program to make sure colleagues in all areas and roles in the organization are informed and engaged in the Integrity and Compliance Program.

Slide 35 - Tell us



Slide notes

You will need to disclose your Secondary Interests. Our patients, members and colleagues need to be able to trust that the decisions we make are based on good clinical and business judgment. Our decisions should not be influenced - or even appear to be influenced - by our personal interests, relationships, or outside activities.

We call outside activities, interests and relationships Secondary Interests. We all have Secondary Interests - after all, we have active lives outside work. And most Secondary Interests are unrelated to our HealthPartners work and wouldn't influence our work in any way.

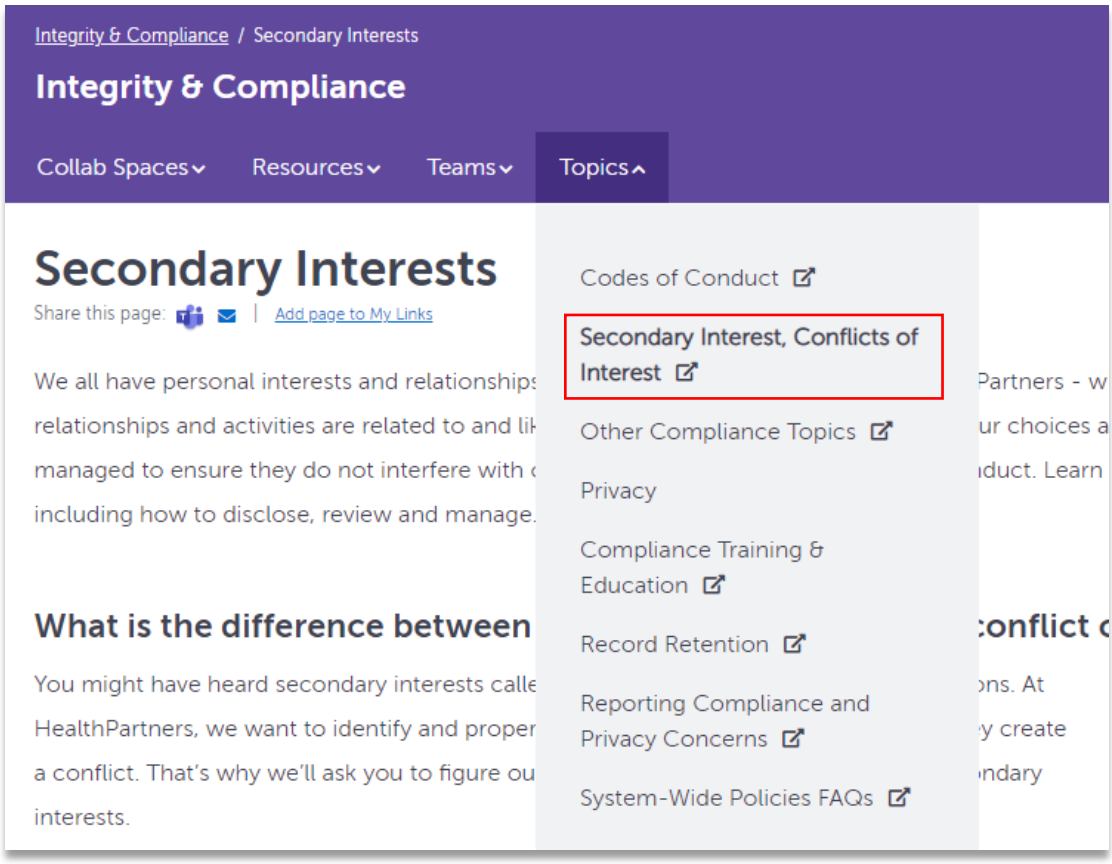
But sometimes, our outside activities, interests and relationships do relate in some way to our HealthPartners work - and we need you to tell us if you have any of those kinds of Secondary Interests. Because telling us - something we call disclosure -- helps avoid the possibility that colleagues' Secondary Interests could influence, or appear to influence, their clinical or business decisions at work.

This screen describes the kinds of Secondary Interests you should tell us about - the things you need to disclose. For example, you should tell us about personal, financial, care, and consulting relationships you have with: Any health care company outside of the HealthPartners system. Any organization that does business with HealthPartners, such as a supplier, vendor or customer. Any organization that competes with HealthPartners. Any entity or individual that regulates HealthPartners.

And any personal, financial, care or other relationship that relates in any way to the work you do in your HealthPartners role.

If you have any Secondary Interests to disclose, please do so through ServiceNow or talk with your leader.

You can see more information on myPartner > Integrity and Compliance > Secondary Interests, Conflicts of Interest



Continue Your Learning

Slide notes

Continue learning by going to any of these pages on myPartner!