Patient Safety Organization
Semi-Annual User Group Meeting

Agenda

Time	Session	Organization / Speakers
1:00	Welcoming remarks	**Vizient Patient Safety Organization** **Ellen Flynn, RN, MBA, JD -** Principal
1:15	Operational Implementation of Just Culture Across a Health System: One System's Experience	**Intermountain Health, Peaks Region** **Heidi Wald, MD, MSPH –** VP, Quality and Safety Officer **James Ritchey, MS, SPHR** - VP of Human Resources Medical Group, Corporate **Venus Buckner, BSN, MA, CPPS, CPHRM -** System Director, Risk & Patient Safety **Anne Millman, MS, CPPS -** Patient Safety and Just Culture Advisor
2:15	It's Easier to Change What You Can See. Learning Systems Approach to Employee Safety	**SSM Health** **Jennifer Luer MSN, RN, CPHQ, CPPS -** System Director, Employee Safety
2:35	Destination Wellness: A Collaborative Approach to Caregiver Safety, Resilience, and Engagement	**Intermountain Health, Lutheran Medical Center** **Sarah Hodgson, MS, MEd, CPHQ, PMP -** Program Manager of Patient and Caregiver Safety **Heather Liska, MPA, BSN, RN -** Director of Nursing Professional Practice and Education **Heather Speaks, BSE, CAPM -** Manager, Integrative Health
2:55	A System Approach to Workplace Violence	**UMass Memorial Medical Center** **Sheryl Van Vliet, RN, BSN -** Manager, Department of Risk Management **Janell Forget, RN, BSN, JD, CPHRM -** Associate Vice President, Risk Management
3:15	Break	
3:30	Patient Safety Improvement Journey of an Academic Medical Center in Uncertain Times From One to Four CMS stars	**University of Toledo Medical Center** **Pallavi Yadav, MBBS, MHA, CQPA -** Director, Quality Management
3:50	Transforming Regulatory and Safety Awareness into a System-Wide Leadership Virtual Patient Safety Group	**NYU Langone Health** **Brian P. Bosworth, MD, FACG, FACP -** Chief Medical Officer **Maxine Simon, FACHE, CPC, CHPC -** Chief Regulatory Officer
4:10	Conducting Patient Safety Activities Across a Health System and Case Law Update	**Barnett Benvenuti & Butler PLLC** **Wesley R. Butler, Esq.**
4:55	Closing Remarks	**Vizient Patient Safety Organization** **Ellen Flynn, RN, MBA, JD -** Principal

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Tips for Attendees

During Q&A, please raise your hand and we will bring a microphone to you

There is a 15-minute break scheduled for 3:15. Light refreshments and beverages are available.

There is a charging station at the table in the back of the room if you need to charge your devices

This meeting is not privileged and confidential

- When sharing information or asking questions, please do not share Patient Safety Work Product (PSWP) or Protected Health Information (PHI) such as actual events that happened at your organization, dates, ages, or references to data submitted to PSO.

- Actions taken to improve care are not PSWP and may be shared.

- Verbal contributions could be phrased using examples below to protect your organization

  - "In my experience, I've found that…"

  - "I've heard of [insert topic here] happening at organizations…"

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Disclosure of Financial Relationships

Vizient, Inc., Jointly Accredited for Interprofessional Continuing Education, defines companies to be ineligible as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

An individual is considered to have a relevant financial relationship if the educational content an individual can control is related to the business lines or products of the ineligible company.

No one in a position to control the content of this educational activity have relevant financial relationships with ineligible companies.

Learning Objectives

- Describe methods employed to implement just culture across disciplines within a health system

- Describe the framework and processes necessary for establishing workforce wellness, safety, and resilience

- Identify successful strategies for prioritizing quality improvement and reducing harm during COVID 19

- Analyze case studies to identify ways to conduct patient safety activities across a health system within a Patient Safety Evaluation System (PSES) such a peer support, huddles, and current findings from case law.

Opening Remarks

Ellen Flynn, RN, MBA, JD
Principal, Vizient Patient Safety Organization

Meet our PSO team

**Ellen Flynn
RN, MBA, JD**
Principal

PSO leader and Patient Safety Act subject matter expert

**Tammy Williams
MSN, RN, CPPS**
PSO Program Director

Patient safety and Patient Safety Act subject matter expert

**Christina Driskill
MPH, RN, CPHQ**
PSO Program Director

Patient safety and Patient Safety Act subject matter expert

**Kathryn Merkeley
RN, MHSA, PMP, CPPS**
PSO Program Director

Patient safety and Patient Safety Act subject matter expert

Jessie Blackwell
PSO Program Manager

Provides technical support

Daniele Klebern
PSO Program Manager

Provides technical support

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Empathetic and effective response to sentinel events and root cause analysis (RCA)

Immediate response → **Investigate** → **Analysis** → **Action planning** → **Implement** → **Monitor & evaluate** → **Surveillance**

This resource builds on other existing recommendations to incorporate current thought leadership to support an empathetic, effective, and sustainable response after a sentinel event. The key distinctions in the resource include:

- **Maintain a continuous safety surveillance system** integrating RCA action plans to warn of impending risks in high volume, high risk, problem prone areas
- Provide **standard, role-based education** to the healthcare team on communicating with patients and families after a serious adverse event
- Facilitate **real-time communication and support for the patient and family** involved in an adverse event aligning with the Cures Act
- **Include the healthcare team involved in the event** in the RCA meetings, selection of solutions, and creating the action plan

- Develop criteria for **identifying when external support is required** for an objective RCA
- Use a **standard format for triggering questions and taxonomy of causal factors/descriptions** including health equity, health information technology and access to care issues
- **Integrate action plans into standard work** and **provide leadership oversight** at the local, organization and system levels
- **Real time monitoring** consisting of daily manager observations, in-the-moment coaching, and document compliance on a visual management board

2023 PSO focus areas

Leading practice advisory projects

- Delay in recognizing clinical deterioration

- Perinatal

- Managing the ambulatory experience to prevent disruptive behavior

- Informed consent/Advanced directives across the continuum of care

- Ambulatory procedure complications; e.g., colonoscopy, sedation

Colleague Connection topics

- Falls

- Drug shortage risks

- Environmental safety; e.g., metal detectors

- Stage 3 or 4 pressure injuries

- Environmental safety; e.g., metal detectors and other safety design

Topical webinars

- Transfusion

- Physician oversight of medication not reviewed by pharmacy

- Pediatric sedation

- Transfers along the continuum of care

- Managing drug shortages

Value metrics

- Mislabeled specimens

- Wrong patient, side, site or implant

Innovation project

- Retained Guidewire

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Culture of safety topics

- RCA/ACA
- Workplace safety, resilience and wellness
- Culture of vigilance, learning and accountability
- Health system management – sustaining gains
- Safety 2
- Civility, respect, empathy, dignity and caring
- Staffing to support critical thinking and vigilance
- Health Equity assessment

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Vizient PSO Provider Profile

Provide contacts names:

- 2 key PSO contacts

- List of individuals to be added to the Vizient PSO listserv

- Pharmacists to be added to pharmacy listserv

- Ambulatory contact

- Pediatric contact

Work with the PSO program manager to update your profile at daniele.klebern@vizientinc.com

Vizient PSO offerings

Education
- Safety alerts, checklists and white papers
- Evidence-based and expert consensus recommendations
- Patient safety officer education on high reliability and culture of safety
- Topical webinar series
- PSO operations orientation
- Case law updates

Collaboration
- Colleague connections
- Safe Table forum participation
- Leading practice development projects
- Two in-person PSO conferences
- Quarterly virtual PSO user group
- PSO listserv email list participation

Other
- PSWP privilege and confidentiality protection
- Multidimensional analytic tool access
- Annual evidence-based feedback report with comparative data
- Quarterly comparative data reports
- Dedicated PSO Program Director Coach

Additional services (incremental fee)
- PSES documentation support
- Quarterly feedback report

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Vizient PSO calendar

Collaborative groups
- Topical
- Safety and Medical Leader
- Cancer Care
- Radiation Oncology
- Legal/operations

Listservs
- PSO
- Pharmacy
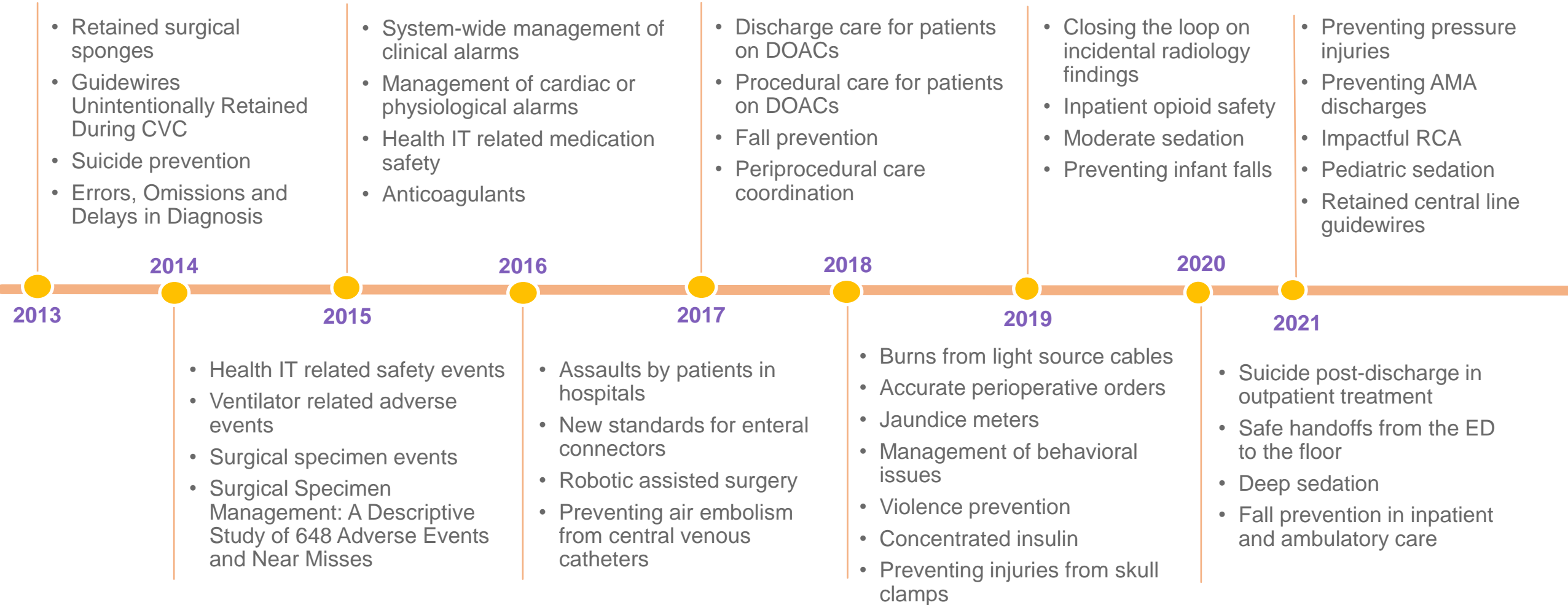- Radiation Oncology
- Cancer center

Month	*HRO & Safety Education Webinars Click Here to Register for series *Continuing education is provided for nurses, physicians and pharmacists	*Topical Safety Webinars Click Here to Register for series	PSO operations Click Here to Register for series	Leading practice advisory projects and workshops	Other PSO collaborative meetings and information
January		Jan 7. Workplace safety Stand Alone Meeting Registration Link (No CEs provided)		**Projects/Advisory Groups** ❖ Wrong site/side, procedure, implant, and patient surgery ❖ Mislabeled specimens ❖ Workplace safety ❖ Voluntary reporting to learn and improve patient safety outcomes ❖ Pediatric sedation	All webinars start at 1:00pm Central Time unless otherwise noted. **Weekly Colleague Connections** *Thursday 2:30pm-3:30pm* The meeting provides an opportunity for members to collaborate on and increase awareness of safety issues, and to ask peers about their processes, practices, policies and procedures. To join, contact Jessie Blackwell.
February		Feb. 23: Mislabeled specimens	Feb 22: PSO Orientation Feb 15: PSO Power Learning		**Safe Tables:** The meeting, which provides another opportunity for member collaboration around specific safety topics, occurs in a Privileged & Confidential learning space under the Patient Safety Act. Attendees must sign the confidentiality and disclosure agreement which is valid for 3 years and return to Jessie Blackwell.
March	March 22: Effective and impactful RCA	March 30: Wrong site/side, procedure, implant, and patient surgery		**Collaboration Groups** ❖ Safety and Medical Leader ❖ Radiation oncology meeting and listserver ❖ Cancer Centers meeting and listserver ❖ One approach	
April		April 8: Vizient Semiannual ambulatory meeting			**PSO Power Learning:** The purpose of the Power Learning webinars is to share key learnings from our colleague connections, safe tables, expert advisory calls, data analysis, and research. Provide PSO updates and seek member input. Please ensure you have at least one representative attend from your organization.
May	May 24: Cause Analysis and Aggregate RCA		May 25: Case Law Update	**Workshops** ❖ RCA and Just Culture ❖ PACT collaborative (starts Jan. 2022) For more information, click here. ❖ Diagnostic error	
June		June 16: Promoting Diagnostic Safety in the ED	June 21: PSO Orientation June 15: PSO Power Learning		**PSO orientation:** This session provides information on the Patient Safety Act, the process of working with a PSO, and the steps your organization needs to take in defining your patient safety evaluation system.
July					
August		August 10: Cancer care - monitoring oral chemotherapy			**Contact Information** PI Program Manager Jessie Blackwell (312) 775-4234 Program Directors Christina Driskill (214) 574-3826 Kathryn Merkeley (214) 574-3301 Tammy Williams (312) 775-4380 Associate Vice President, Safety Ellen Flynn (312) 775-4294
September		September 19: Vizient PSO Semi-Annual Meeting at 2022 Connections Education Summit	September 9: PSO Orientation		
October		October 12: Proactive identification of clinical deterioration and response	October 4: PSO Power Learning		
November	November 9: Safety 2 November 15: Protected space for learning	November 7: Upside (12pm Central)			
December		December 7: Radiation oncology			

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Aggregate analyses and leading practices

2013
- Retained surgical sponges
- Guidewires Unintentionally Retained During CVC
- Suicide prevention
- Errors, Omissions and Delays in Diagnosis

2014

2015
- Health IT related safety events
- Ventilator related adverse events
- Surgical specimen events
- Surgical Specimen Management: A Descriptive Study of 648 Adverse Events and Near Misses

2016
- System-wide management of clinical alarms
- Management of cardiac or physiological alarms
- Health IT related medication safety
- Anticoagulants

2017
- Assaults by patients in hospitals
- New standards for enteral connectors
- Robotic assisted surgery
- Preventing air embolism from central venous catheters

2018
- Discharge care for patients on DOACs
- Procedural care for patients on DOACs
- Fall prevention
- Periprocedural care coordination

2019
- Burns from light source cables
- Accurate perioperative orders
- Jaundice meters
- Management of behavioral issues
- Violence prevention
- Concentrated insulin
- Preventing injuries from skull clamps

2020
- Closing the loop on incidental radiology findings
- Inpatient opioid safety
- Moderate sedation
- Preventing infant falls

2021
- Suicide post-discharge in outpatient treatment
- Safe handoffs from the ED to the floor
- Deep sedation
- Fall prevention in inpatient and ambulatory care

- Preventing pressure injuries
- Preventing AMA discharges
- Impactful RCA
- Pediatric sedation
- Retained central line guidewires

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Vizient PSO alerts and toolkits

Click on the link below to access our alerts and toolkits with leading practices.

- Guidewires unintentionally retained
- Empathetic and effective response to sentinel events and Root Cause Analysis
- Discharge against medical advice
- Fall prevention in hospitals, ambulatory care, and the emergency department (ED)
- Pressure injury prevention
- Preventing infant drops and falls in health care
- Managing behavioral issues in inpatient medical settings
- Violence prevention program
- Ensuring safe handoffs from the emergency department to the inpatient unit

- Preventing suicide after discharge and in outpatient care
- Closing the loop on actionable radiology findings
- Improve safety with lessons learned from opioid-related events requiring naloxone
- Risks associated with concentrated insulin
- Preventing patient injury from skull clamp systems
- Perioperative phases of care orders
- Burns from light source cables

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Operational Implementation of Just Culture: One Healthcare System's Experience

Intermountain Healthcare, Peaks Region

Anne Millman, MS, CPPS Patient Safety and Just Culture Advisor

Venus Buckner, BSN, MA, CPPS, CPHRM, System Director, Risk & Patient Safety

Jim Ritchey, Vice President, Human Resources
Shared Services & Diversified group

Heidi Wald, MD MSPH, Vice President, Chief Quality and Safety Officer

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Just Culture

Introduction

Anne Millman, MS, CPPS
Advisor, Patient Safety and Just Culture
Intermountain Healthcare, Peaks Region

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Learning Objectives

1. Describe the Just Culture model used by Intermountain Healthcare, Peaks Region as part of standard work

2. Outline the implementation plan and execution in collaboration between Quality and Safety, Human Resources and Medical Staff.

3. Share lessons learned and insights of the implementation at the height of COVID-19 pandemic

Intermountain Healthcare and SCL Health Merged on April 1, 2022

Intermountain Healthcare

- Non-profit, integrated health system
- Primary service areas: Utah, Idaho. Nevada
- 42,000 caregivers
- 225 clinics, 24 hospitals (+ virtual hospital and 1 under construction)
- 2,800 employed and 5,100 affiliated physicians and APPS
- SelectHealth: insurance plans with 1 million members in 3 states
- Secular operations

SCL Health

- Non-profit health system
- Primary service areas: Colorado, Montana, Kansas
- 16,000 associates
- 160 clinics, 8 hospitals
- 150 employed physicians/APPS (SCL Health Medical Group)
- Strong financial ratings by bond agencies
- Mix of religious (Catholic) affiliation and secular operations

Intermountain Healthcare Regions

- Desert Region
- Canyons Region
- Peaks Region

- Hospitals
- Region HQ
- Saltzer Health
- Affiliate / Outreach Partnerships
- Air Medical Transport Bases
- Kansas Safety Net clinics

Intermountain Healthcare

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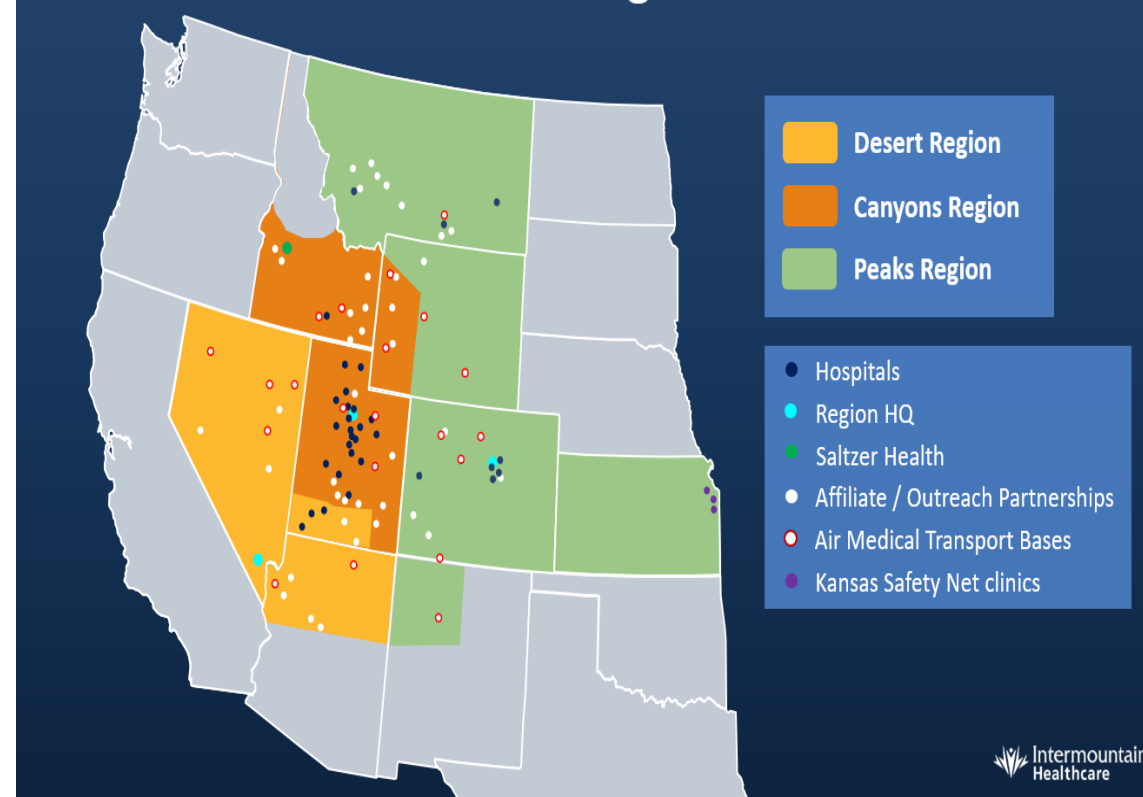
Historical Background of Just Culture

1997: James Reason's "Managing the Risks of Organizational Accidents" introduces the concept of a "just culture" and a decision tree for determining the culpability of an unsafe act and the 'substitution test.'

2001: David Marx's "Patient Safety and the 'Just Culture': A Primer for Healthcare Executives" expands on Reason's work, including the concept of disciplinary decision-making strategies related to procedures, expected outcomes, and risk of harm to values.

What is a Just Culture?

Just Culture is a **system of workplace justice** that emphasizes the balance between **personal accountability for one's choices** and the role that **system/process issues** may play in both clinical and non-clinical situations.

A Just Culture:

- Recognizes that all people will make mistakes

- Does <u>not</u> consider the severity of outcome

- Commits to a robust investigation

- Promotes a culture of accountability and commits to learning

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Just Culture

"Just Culture is, first and foremost, about the prevention of the harm. It is about the managerial responsibility to design good systems, and help employees make good choices, knowing they are inescapably fallible creatures with a very strong propensity to drift."

"Just Culture is also about the relationships between employees on the floor – creating the environment and building the skills to coach each other, living out the idea that we, too, can be our brothers' and sisters' keepers."

~ David Marx, Outcome Engenuity

Analysis Update, March 26, 2022

The Just Culture Company 2022

- David Marx
Outcome Engenuity

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The Three Duties

The duty to avoid causing unjustifiable risk or harm

Refrain From

The duty to produce an outcome

The duty to follow a procedural rule

To Do

How To
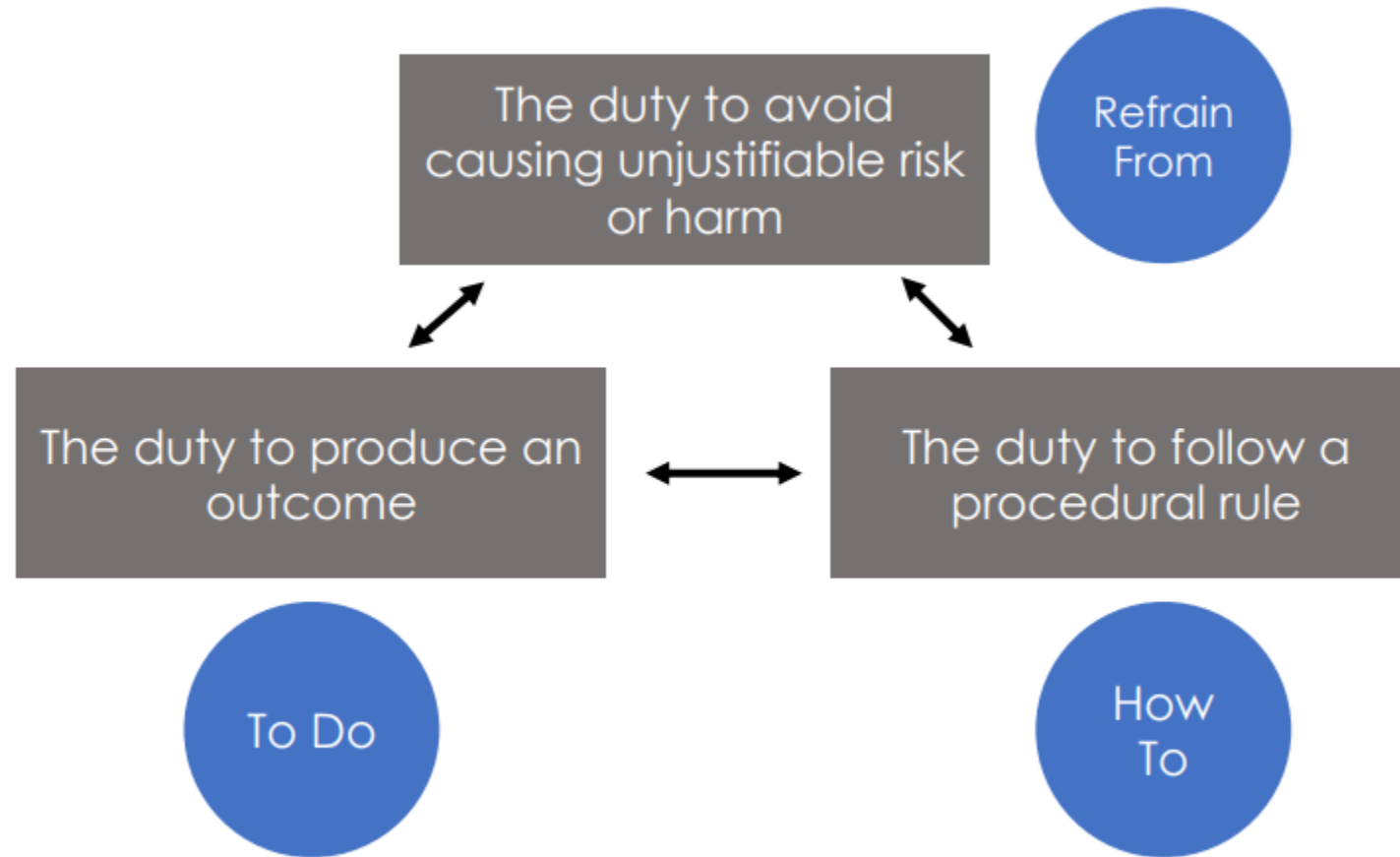
© The Just Culture Company 2022

The Five Behaviors

Human Error	At-Risk Behavior	Reckless Behavior	Knowledge	Purpose
Unintended conduct; a person does other than what they intended to do.	A choice where **risk is not recognized**, or is **mistakenly believed to be justified.**	**Conscious disregard** of a substantial and unjustifiable risk.	**Knowingly** causing harm (sometimes justified).	A **purpose** to cause harm.
Accept	Coach	Sanction	Sanction	Sanction

The Just Culture Company 2022

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Operational Implementation

Venus M. Buckner, RN, BSN, MA, CPHRM, CPPS
Director of Risk & Patient Safety
Intermountain Healthcare, Peaks Region

Medical errors in the news

A former nurse was criminally prosecuted for a fatal drug error and convicted of gross neglect of an impaired adult and negligent homicide

Implications

- Criminalizing medical error
- Chilling effect on reporting safety concerns for improvement
- Contributes to the "The Big Quit" movement

Organizational Response

Process & Culture

- Clear communication from our leaders and stakeholders regarding ongoing process improvements
  - ➢ Mitigation strategies rolled out
  - ➢ Partnership between Quality & Safety and other stakeholders, such as Medication Safety group
  - ➢ Opportunity to promote our commitment to hardwire our Just Culture way

Just Culture Implementation

Why?

"Guided by our Mission, Vision and Core Values, the commitment to justice is deeply rooted in SCL Health's identity and culture."

Launched: September 2020

Relaunched: April 2021

NASA's Space Launch System (SLS) rocket with the Orion spacecraft aboard
Image Credit: NASA/Joel Kowsky

https://www.nasa.gov/image-feature/we-are-going-artemis-i-on-launch-pad

Fostering a Just Culture

Kotter, 2006: Our Iceberg Is Melting . . .
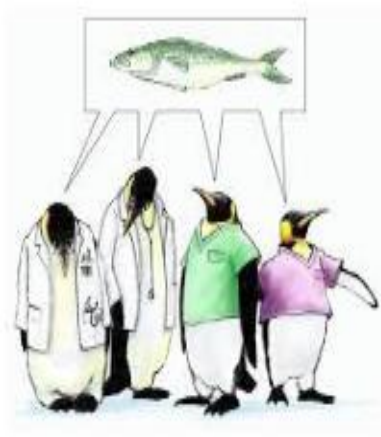
- **Objectives: System-wide** implementation of the just culture philosophy in our **daily operations**
  - **Promote psychological safety** and **accountability**
  - **Reduce unwarranted variation in the use of just culture principles**
  - **Implement standard work across the entire organization**
- **Goal:** create a shared mental model and consistent application of the principles

SCL Health Safety Grant Program (2020 - 2023)

Our Journey

- **Sept. 2020:** Executive Retreat Launch with David Marx, Outcome Engenuity
- **Delayed** due to COVID surge
- **April 2021:** Relaunched
- **~ 17 months** on the road (stop/go) and lots of gain
- Currently on phases 4 & 5 focused on hardwiring and alignment

Just Culture Implementation: *People*

Executive Support

Develop Deep Subject Matter Expertise "Champions"

Managerial Training & Competency Development

Sharing Expectations & Engaging Staff

Operational:
Senior VP of HR
Clinical: Senior VP of quality
Care Sites:
Presidents

- Just Culture Certification Course
- Steering Committees
- Triad **(CMO/CNO/Quality)**
- Risk & Patient Safety Leaders
- Others

- Just Culture 4 Hour Web-based on demand) Foundational Training
- Community of Learners (Internal/External)
- Others - Select Medical Staff

- Associate/Staff on-boarding
- Medical Staff communication
- Board

Just Culture Implementation: *Process*

Governance

Policy Alignment

Onboarding & Operations

Evaluation

What is "in scope"?

Following the tenets of Just Culture and not the luck of the outcome?

Are disciplinary policies or SOP aligned?

(Is it procedurally possible to execute the principles of Just Culture?)

Process to sustain over time?

Are Champions operationally connected in a way that assures rewards & punishment reflect Just Culture principles?

How do we know it's working?

Competency & Proficiency supported, such as, the Community of Learners

Community of Learners

Purpose: To promote competency and proficiency of leaders in the application of just culture principles in their daily operations.

- Practice application
- Provide support
- Resource
- Small group
- Diverse
- Hardwire onboarding
- Confidential

Tiered Huddles

Harrison, Marc. **How a US Health Care System Uses 15-Minute Huddles to Keep 23 Hospitals Aligned**

- **Tiered Huddle Reporting for awareness and early resolution**
  - Tiers 1 - 7

- **Embed psychological safety to promote reporting:**

  - ❖ Patient safety events
    - ➤ Serious Unanticipated Events
  - ❖ Safety Concerns
  - ❖ Caregiver Injuries
  - ❖ Celebration

Reporting through tiered huddles in addition to reporting events in the Patient Safety Occurrence Reporting System

Intermountain Healthcare

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Flight Plan In Progress: Build, Train and Sustain

Continue the Spread and Hardwire

- Training
  - System Service Group - Regional Office (Broomfield)
  - Assignment of 4-hour Foundational web-based training for all new caregivers, new managers and on-demand
  - In-person training
    - 3 hours @ Broomfield - Open to anyone
    - CEUS & CMEs available
  - Board Presentation by David Marx

- Infuse into daily operations
  - Patient and non-patient
  - Huddles
  - Safety events

- Executive Presentation to the Board
  - David Marx, Guest Speaker

- Incorporate into the Patient Safety Stories Shared Learning

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Alignment
Human Resources

Jim Ritchey
Vice President, Human Resources
Shared Services and Diversified Group

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Alignment – Human Resources

- Executive Support - Senior Vice President of Human Resources

- Quality & Safety Department participation in the HR leadership retreat

- Appointment of Partners

  - Jim Ritchey, VP Human Resources

  - Champions' training for all Human Resource Leaders at every care site

- Alignment with messaging and communication

- HR leaders as co-chair of the Steering Committee

- Active participation in building proficiency through the Community of Learners process

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Practical Applications

- Use of the Algorithm for consistency

- Policy versus Guidelines

- Support resiliency efforts to combat burnout

- Harmonization in the "new" world from an HR perspective - In progress

    – Diversity and inclusion

Use of Just Culture Algorithm

- Requires rigor & discipline

- Shared accountability

- Consistent application regardless of location
  - Acute

  - Ambulatory / Medical Group

  - Employed v. Hospital-employed

    o Role of Medical Staff

Alignment

Medical Staff and Other Providers

Heidi Wald, MD, MSPH, CPPS
Vice President, Chief Quality and Safety Officer

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The Why

- Enhance peer review as a performance improvement tool

- Improve the reliability and effectiveness of peer review

  – reduce cognitive bias and improve inter rater reliability,

    protects the reviewer and the reviewee

- Create a process perceived as fair and just

- Ensure alignment with the healthcare team

Where Just Culture Fits In

Identification — How a case gets to peer review. A hospital-based and MSO supported process described in bylaws

Decision — How Peer Reviewers and Committee assess cases and make recommendations

Action — What happens after an action is recommended. A hospital-based and MSO supported process described in bylaws

Medical Staff and Other Providers - Alignment

All Physician Executives and Med Staff Office Leaders are trained Champions

All Medical Staff Presidents and Peer Review Chairs have taken just culture training

Med Staff reps participate in care site steering committee

All MEC members and committee chairs are encouraged to get training

Med Staff Newsletter articles and presentations

Provider task force: CMOs, Med Staff Presidents, Peer Review Chairs and Med Staff Office Leaders

Provider Toolkit

Peer Review Policy

> 4. The Medical Staff is committed to, and accountable for, ensuring a reputable and non-punitive Peer Review process that supports the elements in the [Just Culture Guiding Principles - SCL Health - Supporting Document](#).

Step by Step Guide for Peer Reviewers

Peer Review Scoring Crosswalk (optional)

Aligned documentation in Medical Staff Software

Provider case vignette library for developing proficiency

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Metrics

1. Proportion of leaders who have completed training (4-hour, Champions)

2. Proportion of selected executives/leaders who are trained champions (among hospital Presidents, CMOs, CNOs, Human Resources Leaders, Risk, Quality & Patient Safety leaders)

3. Pulse survey of self-perceived proficiency of leaders with Just Culture work

4. Proportion of instances (in staff and provider review processes) where use of the Just Culture Algorithm is documented

5. Improvement on 5 Just Culture-sensitive items on the Employee Engagement Surveys
    - 2022 Employee Engagement Survey In process - Sept. 1 - 30, 2022

Pulse Survey

<u>Intent</u>: To understand the comfort level with and frequency of application of Just Culture principles within the daily work of leaders who received training.

<u>Instrument</u>:

Demographics: Care Site, Leadership Level, previous experience with Just Culture, type of training received, participation in Community of Learners

Items (Strongly Disagree to Strongly Agree):

- I feel comfortable applying the Just Culture principles in my interactions with Associates.
- The use of Just Culture principles in my interactions with people who report to me will help build trust and promote fairness
- The Community of Learners meetings have been helpful for my application of the Just Culture principles in my daily work

Items (Free Text)

- Please share the ways in which you have promoted Just Culture within your organization (e.g. which committees, meetings, or other venues have you used)
- Please list any suggestions that would help you become more comfortable applying Just Culture principles in your daily work.
- Please provide any other feedback you have about the Just Culture Initiative - training, implementation, etc - so that we can continue to improve.

Just Culture-sensitive Items

	SCL 2021	National Healthcare Avg 2021
5. There is a climate of trust within my work unit.	4.02	3.88
32. I can report patient safety mistakes w/o fear of punishment.	4.23	4.23
33. In my work unit, we discuss ways to prevent errors from happening again.	4.26	4.21
34. Associates will freely speak up if they see something that may negatively affect patient care.	4.17	4.15
37. When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person.	3.96	3.90
39. I feel free to raise workplace safety concerns.	4.19	4.17

Source: Employee Engagement Survey - Culture of Safety

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Application of Just Culture Principles

In the past 60 days, how often have you applied the Just Culture principles in your day-to-day work?

135 responses
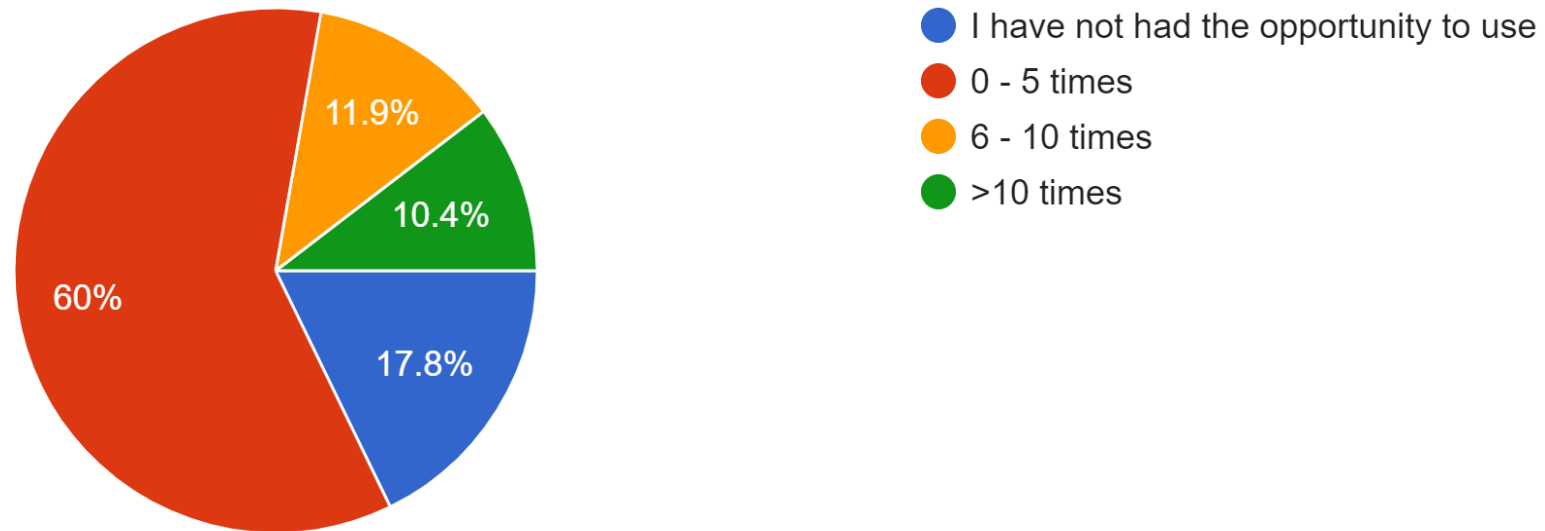
- 🔵 I have not had the opportunity to use
- 🔴 0 - 5 times
- 🟠 6 - 10 times
- 🟢 >10 times

I Feel Comfortable Applying the Just Culture Principles in My Interactions with Associates.

- 0%
- 0%
- 16%
- 42%
- 42%

Legend:
- ■ Strongly Disagree
- ■ Disagree
- ■ Neutral
- ■ Agree
- ■ Strongly Agree

The Use of Just Culture Principles in My Interactions with People Who Report to Me Will Help Build Trust and Promote Fairness.

- 0%
- 0%
- 12%
- 32%
- 56%

Legend:
- ■ Strongly Disagree
- ■ Disagree
- ■ Neutral
- ■ Agree
- ■ Strongly Agree
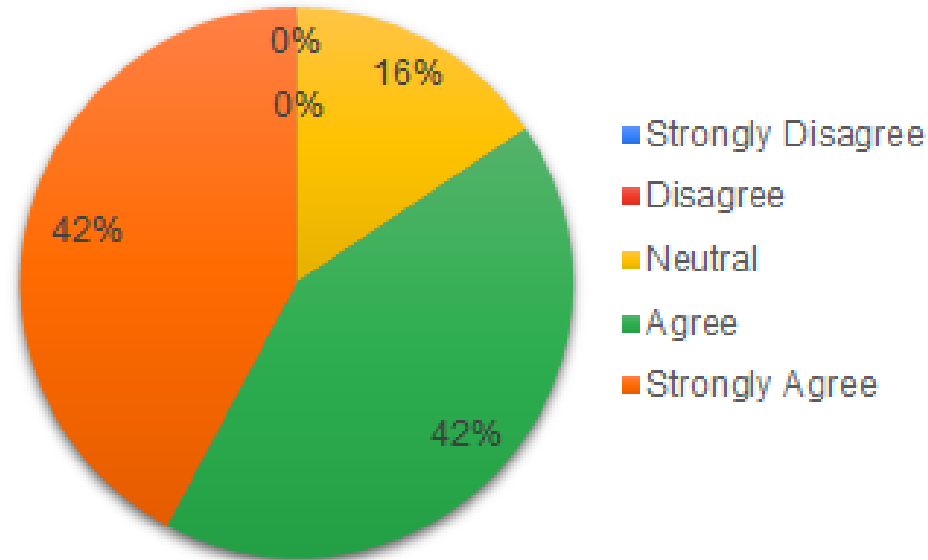
84% (agree & strongly agree) of respondents feel comfortable in applying the JC principles when interacting with associates

88% (agree & strongly agree) of respondents believe that using the JC principles will help build trust & promote fairness

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Accomplishments and Work in Progress

1. Created Just Culture [Guiding Principles](#)
2. Built "resource center" on *The Landing - Intranet*
3. Launched at all 8 hospitals and160+ Physician Offices/ Medical Group (CO & MT)
4. Trained 147 champions who completed 16-hr training and 85% of leaders (managers and above) completed the 4-hour web-based training and/or 3-hr in person training
5. Incorporated into OnBoarding of new caregivers and leaders
6. Active "Communities of Learners" to promote proficiency at 7 hospitals
7. Collaboration with Union Leaders in Montana
8. Presidents' video message to leaders and frontline staff
9. Launched Provider/Medical Staff Task Force for alignment
10. Continuous support from the regional office

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Shared Learning

1. Focus on the end goal

   ➢ Persistence in spite of the pandemic

2. Adaptable and flexible from the original plan

3. Clarity on the "why"

4. Get the "must have" support

   – Senior Executives (Clinical, Human Resources. Operational)

   – Quality & Risk/Patient Safety, Medical Staff, Marketing/Communication

   – System and local champions

5. Early identification of the stakeholders/partners

6. Be ready for change and attrition (merger)

7. ALWAYS go back to the "why"

"The only mistake in life is the lesson not learned"

Albert Einstein

Questions?

Speaker contact information

Venus Buckner

venus.buckner@imail.org

Workforce Safety, Wellness, and Resilience
Power Learning Hour

It's Easier to Change What You Can See Learning Systems Approach to Employee Safety

Jennifer Luer, MSN, RN, CPHQ, CPPS

System Director Employee Safety, SSM Health

Learning Objectives

1) Identify opportunities via improved visibility to current data using a learning systems approach

2) Engaging front line teams and senior leaders in the commitment to Zero Harm

SSMHealth.

Through our exceptional health care services, we reveal the healing presence of God.

Healing Power of Presence

Our Heritage of Healing

At SSM Health, we believe in the healing power of presence. While we do not discount the physical healing that takes place across our system, we know that exceptional health care is more than medicine.

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Why we do this work...we believe

- Everyone has enormous potential
- All ideas are valuable
- Everyone deserve recognition
- We can learn from each other
- In healthcare we should not do anything alone
- We can prevent harm together

Strategy
Deployment

Performance
Visibility

Breakthrough
Innovation

Daily
Improvement

Shared
Learning

People
Development

Leadership
Cadence

Strategic Pillar	**Community** Health equity for all	**Culture and Inclusion** A flourishing culture that promotes the individual dignity and well-being of team members	**Exceptional Care and Performance** A high-performing system that helps people live healthy lives	**Growth and Sustainability** A value-based economic model that delivers health care transformation

It is hard to change what you cannot see…

Where we started:

- Static manual monthly reports
- Limited visibility due to event type
- Reports with character limits
- Staffing
- Turnover
- TIME

Worker's Compensation Costs

- 2019 $10.6 million
- 2020 $10.5 million
- 2021 $11.7 million

Average of three employees injured every day

Far from our goal of Zero Harm

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Demo SSM Health Employee Safety Dashboard Report

Demo SSM Health Employee Safety Dashboard Report

Demo SSM Health Employee Safety Dashboard Report

Demo SSM Health Employee Safety Dashboard Report

Demo SSM Health Employee Safety Dashboard Report

Strategic Roadmap

Our Mission: *Through our exceptional health care services, we reveal the healing presence of God.*
Our Vision: *Peace, hope and health for every person, family and community, especially those most in need.*
Our Values: *Compassion, Respect, Excellence, Stewardship, Community*

	Community *Health equity for all*	Culture and Inclusion *A flourishing culture that promotes the individual dignity and well-being of team members*	Exceptional Care and Performance *A high-performing system that helps people live healthy lives*	Growth and Sustainability *A value-based economic model that delivers health care transformation*
Strategic Pillar				
Focus Areas	• Community Health • Care Gaps • Healthy Environments	• Development & Formation • Well-being & Safety • Diversity	• Quality, Safety & Service • Primary Care Evolution • Digital & Home-Based Care	• Value-based Contracts • Diversification • Smart Growth
Strategies	• Address the underlying causes of health disparity through a comprehensive, integrated approach to community health. • Collaborate with health care providers and other community partners to meet care gaps in the health care landscape. • Champion healthy environments as a component of overall health.	• Create a safe, thriving workplace designed to help team members achieve their full potential and carry forward the heritage of SSM Health. • Establish a comprehensive talent approach to address staffing model evolution, talent mix, pipeline and retention. • Build on our leadership in social justice by fostering a workplace of diversity, inclusion and belonging.	• Redesign platforms and processes to deliver the highest quality care, safety and service at the most affordable cost. • Address changing site-of-care expectations by embracing home-based and mobile-first technologies and services. • Develop a new model of primary care to enhance care management, capacity and integration across the continuum.	• Achieve financial stability with a significant shift towards value-based payment models. • Invest in new sources of revenue to enable transformation, expand core competencies and reduce overall financial risk. • Expand our impact through growth in attributed lives and network integrity.
2022 KPIs	• Community Health Improvement • Long-Term Goal: Health Equity • Long-Term Goal: Behavioral Health • Long-Term Goal: Care for Creation	• Employee Engagement • Long-Term Goal: Diversity, Equity and Inclusion • Long-Term Goal: OSHA Incidence Rate	• Vizient Quality and Safety Score • Patient Experience • Annual Wellness Visits • Long-Term Goal: CMS 5-Star	• Net Operating Income • Philanthropy $ Raised • Growth in Unique Lives • Attributed APM (alternative payment model) & DHP (Dean Health Plan) Lives • Long-Term Goal: Operating Margin

Performance Boards

Through our exceptional health care services, we reveal the healing presence of God.

Huddle Schedule

General Ideas

	Growth and Sustainability	Exceptional Care and Performance	Community	Culture and Inclusion
WHAT →	True North KPI Definition, Goal, and Run Chart (Lagging)	True North KPI Definition, Goal, and Run Chart (Lagging)	True North KPI Definition, Goal, and Run Chart (Lagging)	True North KPI Definition, Goal, and Run Chart (Lagging)

New

Safety Section

| **HOW** → | Daily Measurement Metric Definition, Goal, and Run Chart (Leading) | Daily Measurement Metric Definition, Goal, and Run Chart (Leading) | Daily Measurement Metric Definition, Goal, and Run Chart (Leading) | Daily Measurement Metric Definition, Goal, and Run Chart (Leading) |

In Progress

Complete

| **BARRIERS** → | Root Cause Analysis | Root Cause Analysis | Root Cause Analysis | Root Cause Analysis |

Win Tracker

| **IDEAS** → | Ideas/ Interventions | Ideas/ Interventions | Ideas/ Interventions | Ideas/ Interventions |

Recognitions/ Celebrations

Leader Communication, Safety Area

Daily Team Engagement & Improvement

Ideas, Celebrations, Win Tracking

#vizientsummit

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SSM Health Operating Model
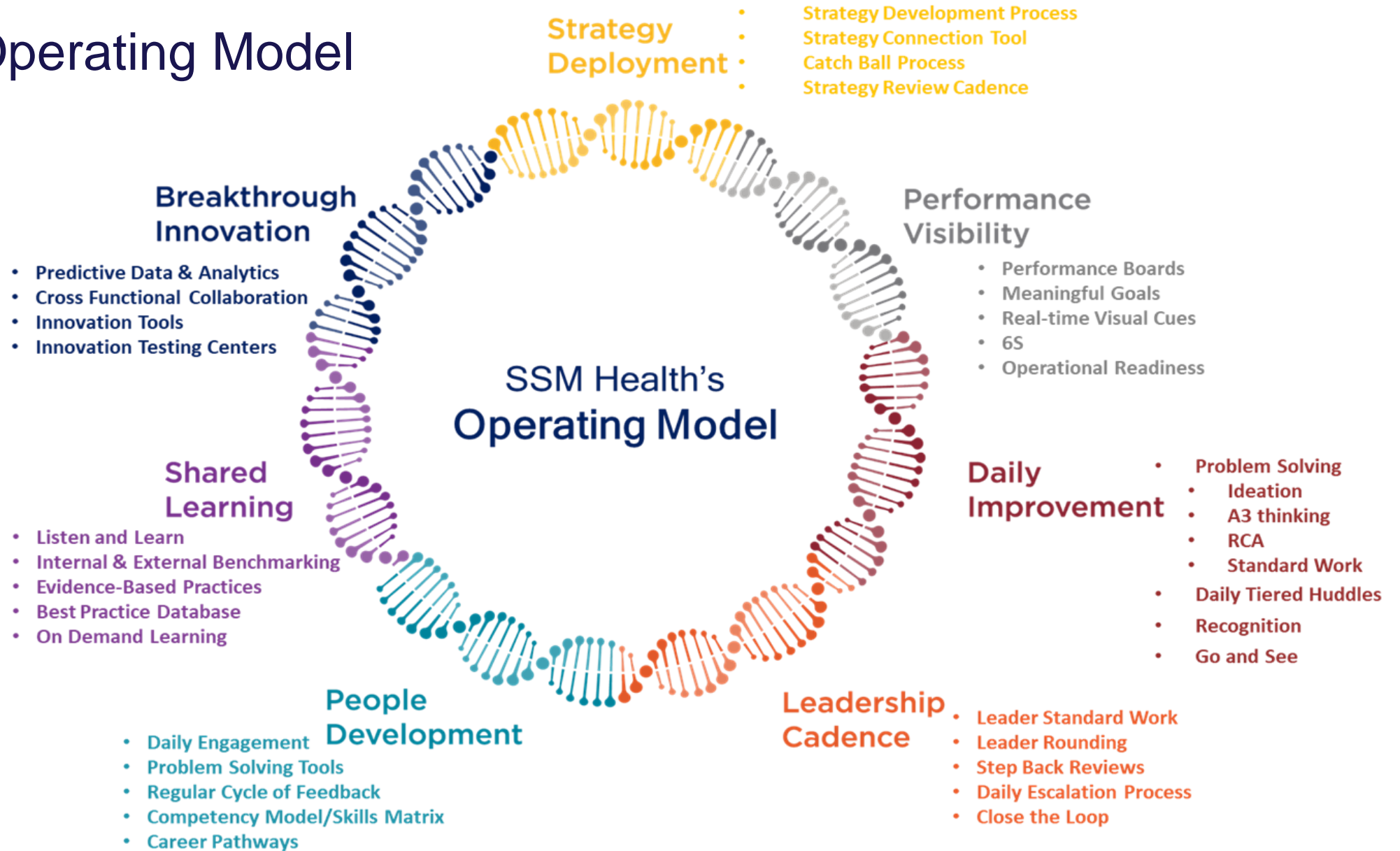
Now we can see…

The teams have the information they need to drive their work

- They are monitoring improvements using their learning and performance boards

- They are using problem solving tools

- Concerns **and** solutions are escalated using tiered huddles

- Leaders "go and see" and celebrate the ideas

You can't manage what you don't measure.

-W. Edwards Deming

Striving for Zero Harm

Speaker contact information

Jennifer Luer

Jennifer.luer@ssmhealth.com

Destination Wellness:
A Collaborative Approach to Caregiver Safety, Resilience, and Engagement

Sarah Hodgson, MEd, MS, CPHQ, PMP

Heather Liska, MPA, BSN, RN

Heather Speaks, BS, CAPM

About Lutheran Medical Center

- Lutheran Medical Center is an acute-care, community hospital in Wheat Ridge, Colorado that has provided care for the greater Jefferson County community for more than 100 years.

- Lutheran Medical Center is part of the Intermountain Healthcare system which is based in Utah with locations in seven states (Colorado, Idaho, Kansas, Montana, Nevada, Utah, and Wyoming) and additional operations across the western U.S.

- By the numbers (2021):
  - 1,554 FTEs (caregivers)
  - 1,091 Medical Staff
  - 15,544 Inpatient Admissions
  - 54,471 ED Visits
  - 338 Licensed Beds
  - 1,995 Births

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Learning Objectives

- Connect Lutheran Medical Center's Destination Wellness model and aims to the needs of today's healthcare workforce.

- Evaluate how the Destination Wellness model could be adapted and applied in other healthcare settings.

Our Why

The bad news …

- Prior to the COVID-19 pandemic, healthcare worker burnout rates on average ranged from **30% to 50%**. Now, burnout rates range from **40% to 70%**.
- 1:5 clinicians are leaving the profession in 1-2 years because of burnout, moral distress, and empathy fatigue.

The good news …

- Resilience and wellbeing are not inherited nor are they reliant on environmental factors.
- Aspects of resilience and wellbeing may be learned and adopted.

The fact is …

- Personal resilience, psychological safety, physical safety, recognition, and engagement in the workplace all contribute to levels of burnout.

The Purpose of Destination Wellness

Promote the **resiliency, engagement, and safety**

of our providers and caregivers through a

unified, interdisciplinary, and holistic approach.

We aim to increase compassion for

ourselves, our patients and their families, our community, and each other.

Destination Wellness

SCL Health LUTHERAN — Now Intermountain Healthcare

Destination Wellness Steering Committee

Executive Sponsor: Chief Nursing Officer

Membership: Representatives from Caregiver Safety, Resilience, and Engagement work groups

Purpose: Promote the resilience, engagement, recognition, and safety of providers and caregivers through a unified, interdisciplinary, and holistic approach.

SAFETY
Leader:
Caregiver Safety Manager

Commitees/Groups:
Safety Town Hall

Just Culture Steering Committee

Caregiver Safety Committees

Improvement Project Teams

ENGAGEMENT/ RECOGNITION
Leader:
Manager of Integrative Health

Commitees/Groups:
Engagement Committee

Recognition Committees (Monarch, Daisy, Nightengale)

Enhancing the Caregiver Experience

RESILIENCE
Leaders:
Caregiver Safety Manager & Dir. of Professional Practice

Commitees/Groups:
Code Caring

Event Debriefs

Schwartz Rounds Steering Committee

Research-Related Activities and Education/Training

Unit-Based Acitivies

Spiritual Wellbeing · Social Wellbeing · Emotional Wellbeing · Financial Wellbeing · Environmental Wellbeing · Occupational Wellbeing · Intellectual Wellbeing · Physical Wellbeing

---

Destination Wellness Steering Committee Membership:

- Chief Nursing Officer – Executive Sponsor
- Manager of Integrative Health
- Engagement/Recognition Committee Chair
- Caregiver Safety Manager
- Just Culture Steering Committee Representative
- Code Caring Lead
- Schwartz Rounds Representative
- Behavioral Health Representative (Zero Suicide Committee Representative)
- Spiritual Care Representative
- Professional Nurse Practice Council Representative
- Clinical Education Representative
- Ancillary Services Representative
- Community Outreach and Partnership Manager
- Director of Patient Experience
- Director of Medical Staff Services
- Manager of Communications
- Director of Human Resources
- Other Frontline Representatives

Resilience Strategy

Resilience Results

Measure of Success: Connor Davidson Resilience Scale 10 (CD-RISC-10)

Responses: 578 (~36% response rate)

Overall Baseline Resilience Score: 2.99 (scale of 0 to 4)

Baseline Results:

Question	Score
Having to cope with stress can make me stronger.	2.52
I am not easily discouraged by failure.	2.58
I try to see the humorous side of things when I am faced with problems.	2.89
I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	2.95
Under pressure, I stay focused and think clearly.	2.99
I tend to bounce back after illness, injury, or other hardships.	3.13
I believe I can achieve my goals, even if there are obstacles.	3.15
I think of myself as a strong person when dealing with life's challenges and difficulties.	3.16
I can deal with whatever comes my way.	3.16
I am able to adapt when changes occur.	3.33

Targeted interventions needed!

Resilience Results

11. What resilience/wellbeing offerings have you participated in at LMC?

More Details

- Code Caring (peer to peer supp... 52
- "Office Hours" for Building Psyc... 10
- Traumatic Event Emotional Debr... 40
- Schwartz Rounds 67
- Wellness Fair 72
- Educational Sessions 60
- I have not attended any offerings 386
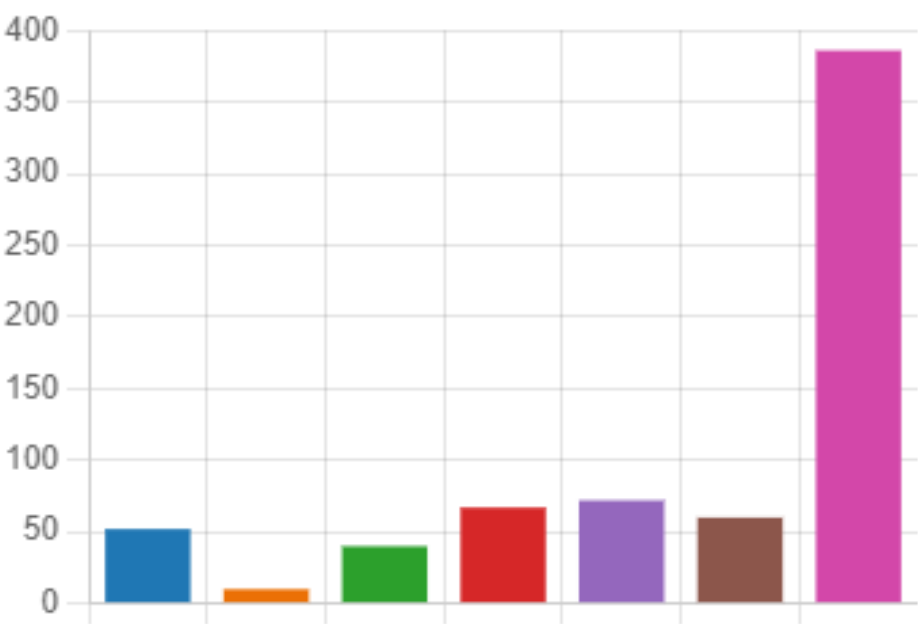
Safety Strategy
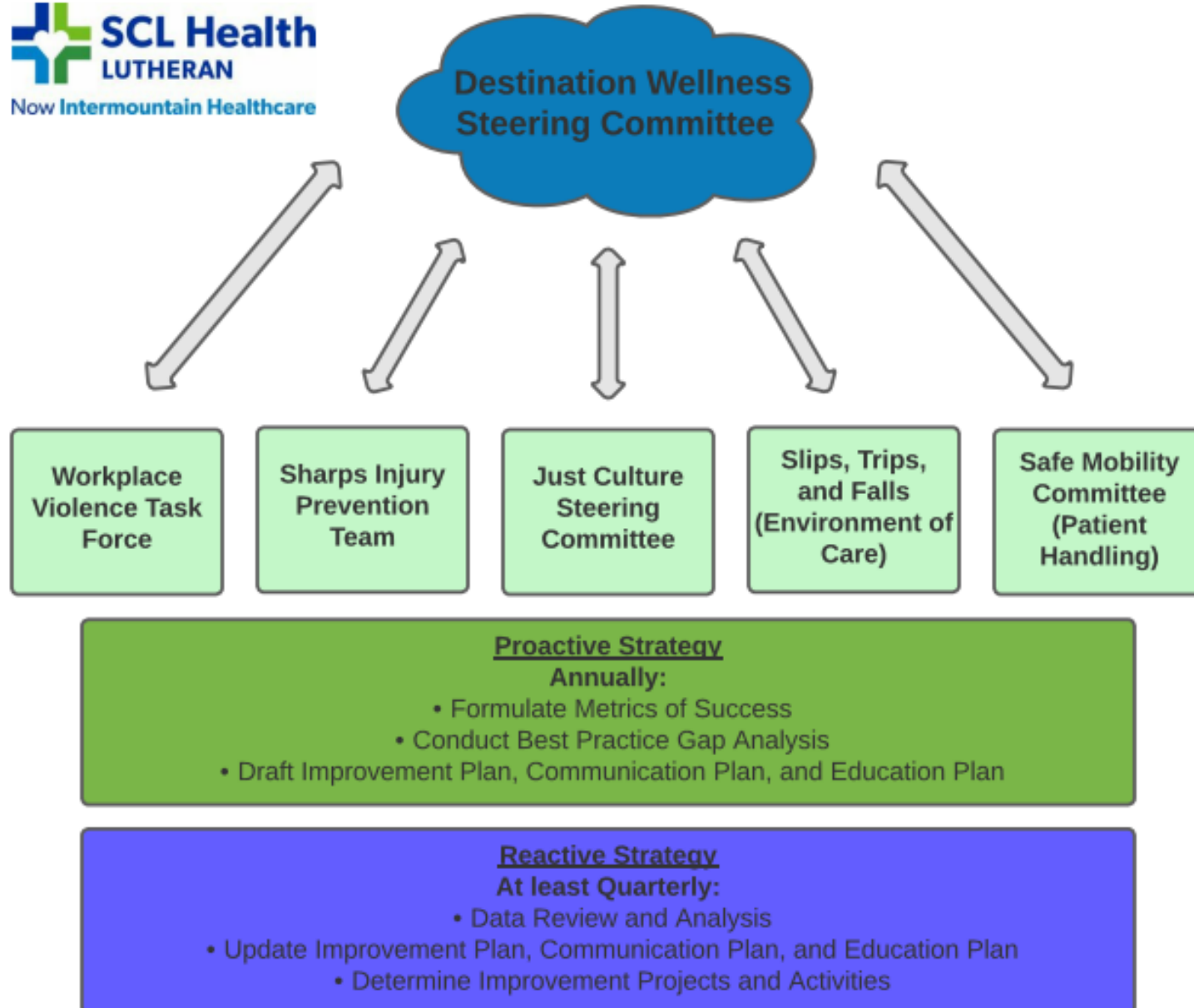
Safety Results

Measure of Success: OSHA Recordable Injury Rate (# OSHA Recordable Injuries/100 FTEs)

Stretch Goal: 3.50

Lutheran Medical Center OSHA RIR

Legend: LMC Rate — Goal = 3.5 — Average

Destination Wellness Chartered
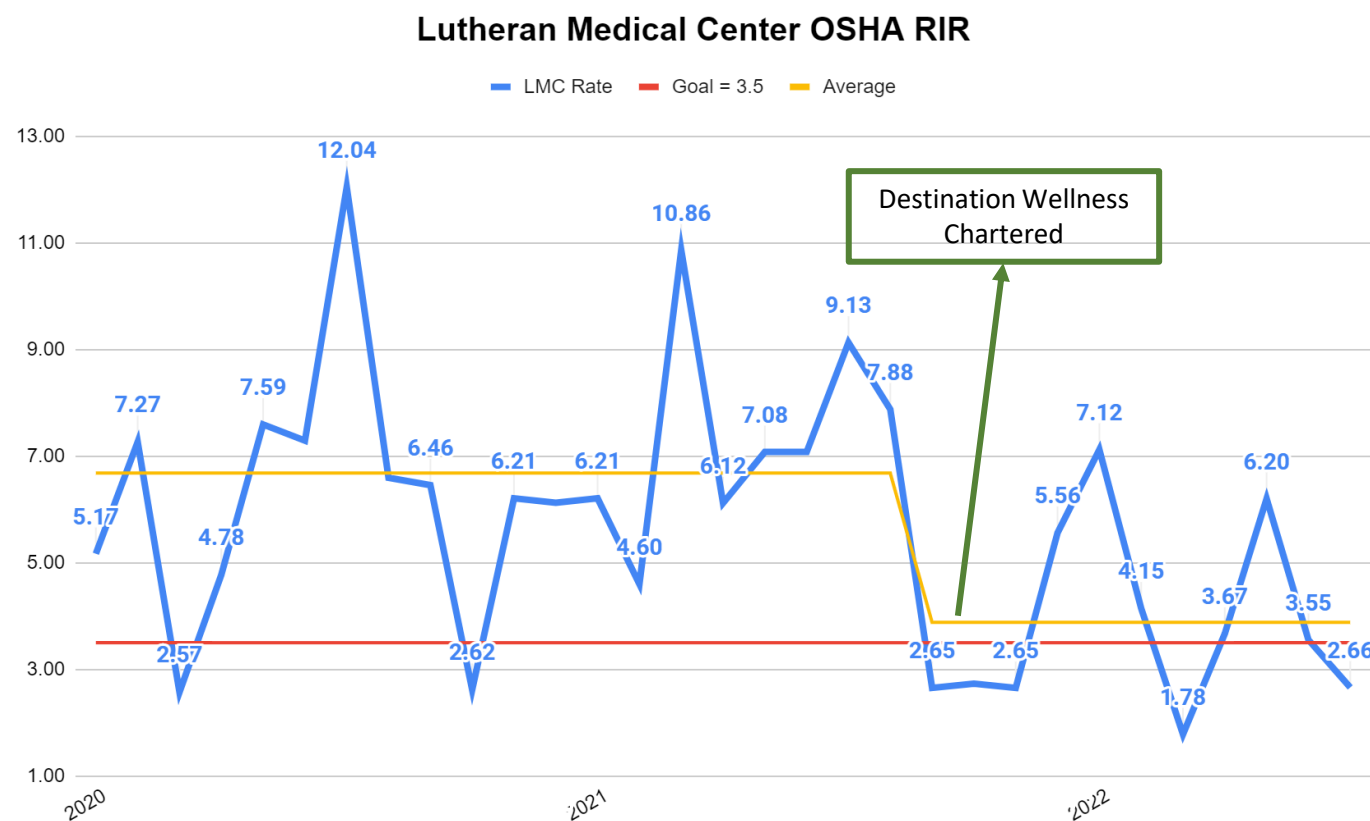
Average OSHA RIR

Prior to Destination Wellness: **6.68**

After Destination Wellness: **3.96**

Reduction (YTD through July) from 2021 to 2022: **41%**

Data points on chart: 5.17, 7.27, 2.57, 4.78, 7.59, 12.04, 6.46, 6.21, 6.21, 2.62, 4.60, 10.86, 6.12, 7.08, 9.13, 7.88, 2.65, 2.65, 5.56, 7.12, 4.15, 1.78, 3.67, 6.20, 3.55, 2.66

Engagement/Recognition Strategy

To develop, plan, implement and monitor hospital wide initiatives around total wellness, recognition, personal and professional growth and community involvement for all caregivers.

Wellness- Focusing on the 8 Dimensions		Awards & Recognition	Events	Community Engagement
Spring Wellness Fair	Annual Biometric Health Screenings	Daisy Award	Years of Service Event	Community Flu Shot Clinics
Fall Benefits & Wellness Fair	Discounted rec center memberships	Monarch Award	Lutheran Fall Fest	Denver Zoo TB Clinic
Weigh and Win Kiosk	Partnership with Financial institutes for education on Financial Health	Recognizing You	Hospital BBQ 2x annually	School Supply Drive
Weight Watchers @ Work		Collaborative Practice	Hospital and Nurses Week	Gobble, Gobble Give
Quarterly Wellness Events		Good as Gold	Quarterly Appreciation Events – Hospital Wide	Diaper Drive
Acupuncture for stress relief	Bike to Work Day	Nightingale	Quarterly Department Celebration	Breakfast with Santa
Monthly Lunch and Learns	Managers "Recess"		Achievement Celebrations	

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Engagement/Recognition Results

Measures of Success:

- Increased caregiver participation in activities and events

- More caregiver contributions in idea generation, planning, and execution of engagement activities

- Improved Caregiver Engagement Survey results (annual)

- Caregiver retention

- Rise in # of award nominations with a variety of nominees and service lines being represented.

Key Takeaways

- Post pandemic burnout rates in healthcare have reached epic proportions.

- Ramifications of high burn out levels among caregivers include:
  - compromised caregiver/patient safety and experience.
  - absenteeism, high turnover rates, and caregivers leaving the healthcare profession all together which is resulting in economic distress for the industry.

- Having a streamlined, collaborative, and structured approach to caregiver wellbeing, safety, resilience, engagement, and recognition can be transformative for an organization.

- Organizations must provide caregivers with the tools to incorporate resilience and wellbeing as a way of life and help them thrive in the healthcare environment.

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Lessons Learned

- Strong executive sponsorship and buy-in is a must.

- Find the people who are passionate, organized, and connected, and who can run with ideas You don't need a Chief Wellness Officer to do this work!

- Engage and get feedback from your frontline to create targeted interventions for your organization.

- Look for internal and community funding opportunities.

- This is a culture shift. It takes time and effort, but it's worth it!

"Something works, nothing doesn't."

Heather Speaks

Speaker contact information

Sarah Hodgson

sarah.hodgson@imail.org

Learning Objectives

1) Identify one area your organization that may be able to implement a risk aggression screening tool

2) Identify at least one way your organization increase reporting of WPV events.

3) Assess the ability to perform interdisciplinary reviews of WPV events with staff in your organization.

What is Workplace Violence?

The National Institute for Occupational Safety and Health (NIOSH)

Workplace violence ranges from offensive or threatening language to homicide.

NIOSH defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.

NIOSH,2022

Who is at Risk?

Although anyone working in a hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk.

Other hospital personnel at increased risk of violence include emergency response personnel, hospital safety officers, and all health care providers. NIOSH,2022

What are the Effects of WPV?

Minor/ Serious physical injuries

Temporary/ Permanent disability

Psychological trauma

Death

Low worker morale

Increased job stress

Increased turnover

Reduced organizational trust

Hostile working environment

The Data

The National Quality & Safety Forum found 71% of all nonfatal WPV occurring in healthcare settings.

Healthcare workers are four times more likely to experience violence at work compared to those in the private industry *Phillips,2016

The Problem "*Defined*"

- Section 5(2)(1) of the OSH Act, often referred to as the General Duty Clause, requires employers to "furnish to each of his employee's employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

- Section 5(a)(2) requires employers to "comply with occupational safety and health standards promulgated under this Act."*OSH Act 5(2)(1)

Joint Commission Standards

The high incidence of workplace violence prompted the creation of new accreditation requirements by the Joint Commission.

Effective January 1, 2022, new and revised workplace violence prevention standards were applied to all Joint Commission-accredited hospitals and critical access hospitals.

Joint Commission Defines WPV with new standards!

"An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors." (JCHO,2019)

New Joint Commission Standards

Developing effective workplace violence prevention systems

Leadership oversight

Reporting systems

Data collection & analysis

Post-incident strategies

Training and education on WPV

(JCHO,2019)

The Interventions

Step 1
DEFINITIONS AND DATA COLLECTION

Define WPV to include verbal, emotional, and physical assaults

Align data collection to gain a clearer picture

Internal reporting systems that identify actionable interventions and follow-up

Benchmarking and data analysis

The Challenge

- Multiple reporting systems

- Inconsistent data

- Low reporting rates

- Inability to capture various types of WPV events in event reporting system

The Solution

First, the data needed to be collected and organized an a more meaningful way.

New fields and additional questions were added to the event reporting system to better ascertain:

- Level of violence
- Type of persons engaged in violence
- Most importantly **the level of impact on the caregiver**

Preliminary Cause of Death (PCOD)	

Add another

Event Basics

* Event Type ❓	Behavioral event ▼
CLICK HERE to see a list of available event types	
* Event Category	Disruptive behavior ▼
Disruptive Behavior Subcategory	▼
	Verbal abuse
Violence Contributing Factor	Threat of Serious Harm ▼
	Physical aggression
Staff Injury	Physical and verbal agression ▼
Did clinical staff ask for patient / visitor / staff to be put into restraints?	▼
Patient / Visitor Overall Condition	▼
* Event discovery date	📅
* Event occurrence date (MM/dd/yyyy) ❓	📅 **Demo information**

Add another

Event Basics

* Event Type ⊘ | Behavioral event ▾

CLICK HERE to see a list of available event types

* Event Category | Disruptive behavior ▾

Disruptive Behavior Subcategory | ▾

Violence Contributing Factor | ▾

	Agitated or Dissatisfied Patient
Staff Injury	Agitated or Dissatisfied Visitor
	Anesthesia / Post Op
Did clinical staff ask for patient / visitor / staff to be put into restraints?	Dementia / Alzheimers
	Grief reaction
Patient / Visitor Overall Condition	Mental / Behavioral Health Condition
	Other
* Event discovery date	Substance Use Disorder
	Unknown

* Event occurrence date (MM/dd/yyyy) ⊘

Event occurrence time (hh:mm)

Use the military time format.

Demo information

Preliminary Cause of Death (PCOD)	

Add another

Event Basics

* Event Type ❓	Behavioral event ▾

CLICK HERE to see a list of available event types

* Event Category	Disruptive behavior ▾
Disruptive Behavior Subcategory	▾
Violence Contributing Factor	▾
Staff Injury	No Injury Reported ▾
Did clinical staff ask for patient / visitor / staff to be put into restraints?	No Injury Reported
	No Treatment Required
Patient / Visitor Overall Condition	minor Injury - First Aid Required
	Moderate Injury - Medical Attention Required
* Event discovery date	Serious Injury - Medical Attention / Time off Required
	Emotional Trauma - Medical Attention / Time Off Required
* Event occurrence date (MM/dd/yyyy) ❓	

Event occurrence time (hh:mm)

Use the military time format.

Demo information

Event Basics

* Event Type ⍰ | Behavioral event ▾ |

CLICK HERE to see a list of available event types

* Event Category | Disruptive behavior ▾ |

Disruptive Behavior Subcategory | ▾ |

Violence Contributing Factor | ▾ |

Staff Injury | No Injury Reported ▾ |

Did clinical staff ask for patient / visitor / staff to be put into restraints? | Yes ▾ |

Yes

No

Patient / Visitor Overall Condition | ▾ |

* Event discovery date

* Event occurrence date (MM/dd/yyyy) ⍰

Event occurrence time (hh:mm) | |

Use the military time format.

Was any type of code or a rapid response called? | ▾ |

Is this related to a potential / actual COVID-19 exposure? | ▾ |

Was health information technology (HIT) implicated in this event? | ▾ |

How did you learn about the event?

Demo information

Step 2
ANALYZE AND SHARE DATA

Share	Share stories and data to cultivate and raise awareness of the need for a culture of safety
Engage	Engage patients, families, and caregivers to understand and analyze the root cause
Use	Use data to inform follow-up activities and interventions
Research	Research to understand data, trends, contributing factors, and effective solutions to prevent healthcare workplace violence

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The Challenge

- Siloed approach to addressing WPV

- Lack of overarching review of data

- Varying approaches to addressing WPV across the system

- Need for systematic approach to understanding the data

The Solution

Development of a WPV Dashboard where WPV committee members can access, review and trend the data.

WPV Committee and Root Cause Analysis/ "Debrief"

WPV comities at both the local and system level review and trend the data at their respective monthly meetings.

Request an RCA/Debriefing

Goal:

Identify correctable system failures.

Meaningful mitigation strategies.

Key Elements of the RCA/ Debriefing

MULTIDISCIPLINARY ALL RELEVANT PARTIES INCLUDED

MAY INVOLVE MULTIPLE DEPARTMENTS OR LOCATIONS
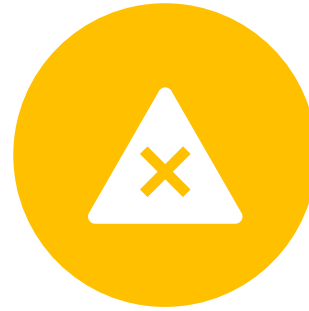
OFTEN "NO-HARM" OR "NEAR MISS" EVENTS

SUBSTANTIVE CORRECTIVE ACTION PLANS DEVELOPED AND SHARED

Step 3 INVEST IN SAFETY

Engage	Engage various quality committees
Encourage and facilitate	Encourage and facilitate violence prevention through engineering controls
Recognize	Recognize that healthcare workers practice across the care continuum
Support	Support evidence-based research

The Challenges

Developing meaningful approaches

Education/ training

Standard expectations

Electronic notification

Facility security physical Plant

Engaging law enforcement

The Solutions

A specialist was hired to:

Assess the level of workplace violence

Develop a variety of trainings specific to the needs of the staff in their respective areas.

Offer training to all levels of caregivers across the entire organization.

Align WPV Prevention Program with joint Commission recommendations.

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"Level-set" expectations for patient and visitor conduct

A patient and visitor code of conduct was developed to...

Set expectations for both patients and visitors.

Provide guidance to staff.

Develop training materials to teach staff how to

addressing inappropriate behaviors.

Guidance on how and when to escalate threatening situations.

UMass Memorial Health
UMASS MEMORIAL MEDICAL CENTER

Patient & Visitor Code of Conduct

In order to effectively provide medical treatment to you, we require a commitment by staff, patients, and visitors alike. Mutual trust and respect can help us provide the right treatment plan, in a safe and respectful environment that promotes healing.

Below we've outlined the Code of Conduct expectations for all Patients and Visitors designed to help make your hospital stay, appointment, or visit successful:

- Patients, visitors, and staff will address each other in a respectful manner.
- Patients are encouraged to speak with their providers about their therapeutic care plan.
- This is a smoke free campus. Tobacco use is forbidden on campus grounds.
- Weapons, illegal or dangerous items, alcohol, marijuana, and illicit drug use, as well as possession of related paraphernalia, is forbidden in all areas and campus grounds. For patients, we may request a witnessed urine or blood sample for drug screening purposes from you if prohibited substance use is suspected or considered a significant issue in your treatment plan. Refusal will be considered an acknowledgement by the patient that such prohibited substance use has occurred.
- Patients, visitors, and staff will refrain from exhibiting threatening or abusive behavior towards each other. We have zero tolerance for threatening or abusive behavior.
- Profanity, racial or cultural slurs or other derogatory remarks towards others of any kind is not tolerated, including, but not limited to, slurs or remarks targeting another's age, race, ethnicity, religion, culture, disability, language, sexuality or sexual orientation, gender identity, socioeconomic status, marital status, or ancestry.
- The following expectations are also required of hospitalized patients:
  - Patients will remain on the unit for their safety, and to facilitate timely care. Being on the unit allows for prompt testing, timely medication administration and frequent assessment by healthcare providers. Patients are encouraged to walk in the hallway of their unit.
  - Patients who do leave the unit must develop a therapeutic plan for being off the unit with their physician and nursing team prior to leaving the unit.
  - Leaving the unit, if not part of your therapeutic care plan, may be considered leaving against medical advice and could result in your discharge.

A safe and respectful environment is central to promoting a healing environment, therefore, if the above stated expectations are not followed:

- Patients: If you choose not to comply with your therapeutic care plan or the above expectations, we may discharge you from the hospital or your appointment. For subsequent appointments or admissions, we will follow our standard continuity of care practice and seek to have you cared for by the same care team.
- Visitors: If you fail to comply with the above expectations, you may be asked to leave campus, and may be restricted from future visitation privileges.

Date Approved: November 10, 2021

But there was more . .

Security Police Interventions

Patient stabbed an emergency department nurse multiple times, leaving her with critical injuries and a lengthy healing process

Leadership Commitment Across the Organization

Instillation of metal detectors

Hiring of professional screeners

Issuing of Tasers

Implementation of body cams

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Mandatory Active Shooter Program

Active Shooter education developed in collaboration with emergency management, campus police, campus security and local law enforcement.

The education is offered through a Health Stream education module and part of yearly competency for all caregivers.

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Alert and response time to violence

The integration of a staff assist devices

Utilizes GPS technology and is attached to the employee badge.

When pressed, all staff in the vicinity are alerted and can aid the caregiver in need.

Visitor Check-In Kiosk

Kiosk is customized with patient/visitor specific questions designed to optimize safety and can prompt alerts of potential threats.

Kiosk flags visitors who have been identified as posing a potential or actual threat to patient and staff safety allowing law enforcement or security to monitor or remove potential threats.

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DASA Scoring in Emergency Departments

Dynamic Appraisal of Situational Aggression (DASA)

Goals: identification, de-escalation, intervention and incorporation of standard language among staff.

Risk Management Grant award.

Community Emergency Department Pilot

Seven (7) question tool at time of Triage

Determines the patient's current level of risk for aggression and/or violence (0-7).

Interventions are implemented based on scoring.

Re-assessment occurs every 8 hours, more frequently if needed.

Customized Violent Patient Safety/Security Plan

Patient has demonstrated overt aggression, such as any of the following:

- Assault of staff, patient or visitor
- Physical or verbal threats of violence to staff, patient or visitor
- Failure to disclose the presence of a weapon
- Failure to relinquish a weapon upon request

Patient Name

DOB:

Violent Patient Safety/Security Plan

- Violent Patient Flag placed in EPIC – 2/7/19

- Letter to patient from CEO and Notice of No Trespass delivered by Constable on 2/15/19

- Safety/Security Care Plan

  ➢ Notice of No Trespass – patient cannot be on <u>any</u> Marlborough Hospital property unless purpose is to receive medical care (copy of notice is on file with Marlborough Police Dept.)
  ➢ Patient may present to the ED for care any time
  ➢ Elective, non-emergent appointments (radiology, lab, <u>etc</u>) must be scheduled in advance with security staff
  ➢ Patient will be required to change into paper scrubs at every hospital encounter and will be <u>accompanied by security staff at all times</u>
  ➢ Admission to Granger 3 requires approval from the Administrative Director or Medical Director of Granger 3

4/26/21 – Updates to plan

  ➢ All staff should exercise extreme caution with patient. **NEVER** approach patient alone. **Staff should be aware of their position in room when with patient. Do not allow patient to block exit.**
  ➢ All furniture shall be removed from the room (EXCEPT stretcher), garage door must be <u>kept in down position at all times.</u>
  ➢ The patient must remain in the main ED core for the duration of his stay in the ED. This patient cannot be moved to the ED BHU area.
  ➢ Staff should not hesitate to summon MPD if patient displays aggressive behavior. Examples of aggressive behavior: unwilling to follow directions, easily angered if a request is denied, verbal threats, physical posturing.
  ➢ If patient refuses to leave property following discharge, notify MPD. Patient has active No Trespass Order in place.

This Plan was developed by: Chief of Emergency Medicine, Chief of Psychiatry, Nursing Director Emergency Services, Director of Behavioral Health, Risk Manager, Director of Security

4/22/21 Update to plan following review/discussion by Administration, ED and Behavioral Health Leadership, Risk Management, Security and Capt. Of MPD

4/26/21 – update per Chief of Emergency Medicine, Nursing Director Emergency Services,

v. 4/26/21

Step 4 COLLABORATE AND SCALE EFFORTS

Share — Share lessons learned, best practices, and innovative solutions

Communicate — Communicate with and engage internal security departments and external law enforcement as partners in the violence prevention program

Collaborate — Collaborate with the community, advocacy groups, and leaders to raise awareness

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- RCA/Debrief
- Patient Risk Assessment Standard Work
- Visitor Management
- Visitor Control Workgroup
- Visitor Control - Visitation Policy
- Visitor Control – Visitor Kiosk
- Patient and Visitor Code of Conduct
- WPV Training
- Safety Event Tracking and Trending System Standardization

Sources

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- Occupational Safety and Health Administration (OSHA). Workplace Violence in Healthcare. Washington, DC; 2015. https://www.osha.gov/Publications/OSHA3826.pdf.

- Phillips KP. Workplace violence against health care workers in the United States. N Engl J Med. 2016;374:1661-1669.

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- The Joint Commission Division of Healthcare Improvement. (2019) Quick Safety: de-escalation in health care. Issue 4

- The Joint Commission EC.02.01.01: Issue 30, June 18, 2021The hospital manages safety and security risks. wpvp-r3-30_revised_06302021.pdf (jointcommission.org)

- The dynamic appraisal of situational aggression: an instrument to assess risk for imminent aggression in psychiatric inpatients James R. P. Ogloff J.D., Ph.D., F.A.P.S, Michael Daffern Ph.D.

Questions?

UMass Memorial Health
UMASS MEMORIAL MEDICAL CENTER

CONTACT:
Sheryl Van Vliet – Manager, Risk management
774-443-7833
Sherylf.Vanvliet@umassmemorial.org

Janell Forget – AVP System Risk Management
774-442-1556
Janell.Forget@umassmemorial.org

Workforce Safety, Wellness, and Resilience Questions?

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Break
We will restart the meeting at 3:15

Learning Objectives

1) What objectives are needed to focus on safety. How to develop a meaningful Quality Plan

2) How to utilize Quality committees to increase accountability

3) What really works for improving Quality and Safety outcomes – learning through experience

Rockets are going *EPIC*, Quite Literally.
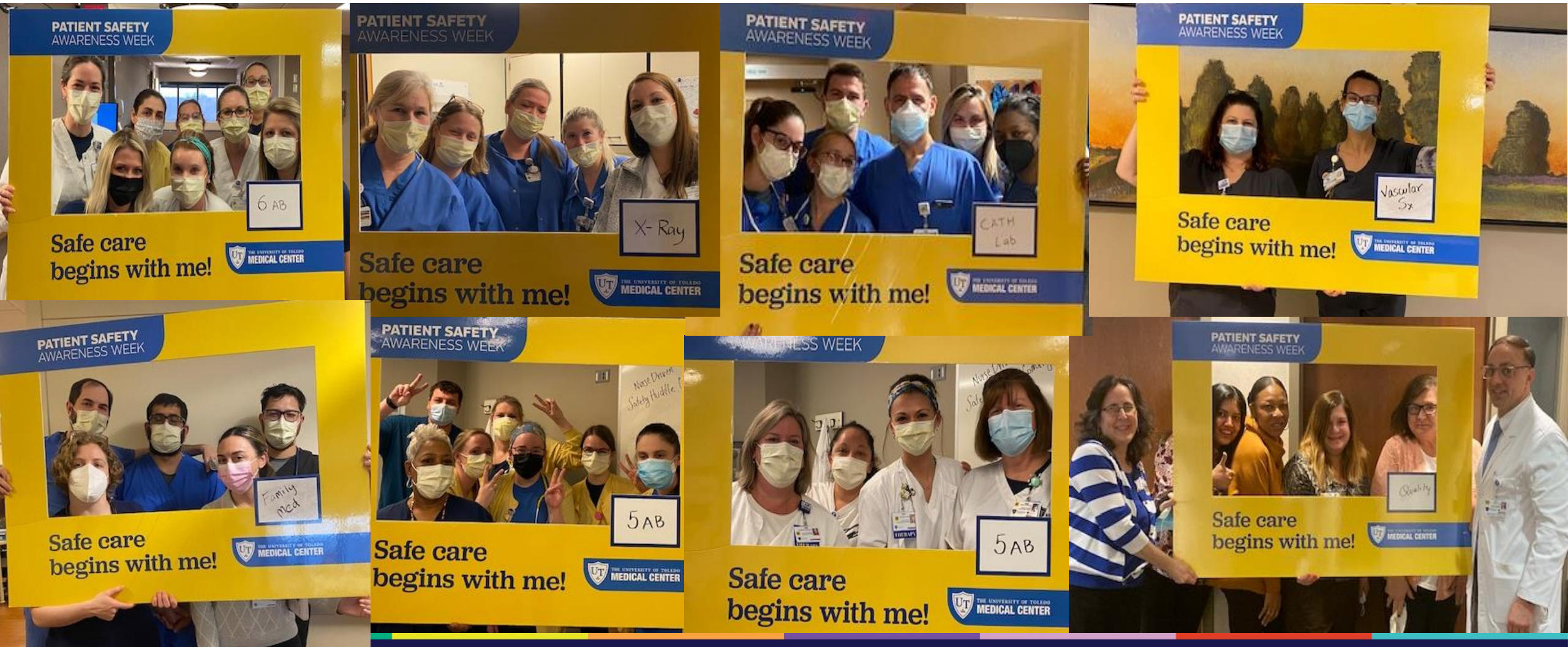
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Recently We Were Celebrated in the NEWS

June 2, 2020: University of Toledo Medical Center exterior (WNWO)

A culture of safety: UTMC receives four-star rating

Chief Medical Officer Dr. Michael Ellis said the hospital's hard work can be summed up in one word: safety.

Trustees Congratulate UTMC on CMS 4-Star Rating

August 2, 2022 | News, UToday, UTMC

But Two Years Ago, We Were Up for Sale

Going Gets Tough

- Financial peril (hospital was up for sale)
- Staffing shortages (mass exodus in 2020)
- COVID-nursing and EVS staff shortages
- Outdated EMR
- Residents and Faculty left for "greener pastures"
- Trauma level was down from 1 to 3
- Quality department was a revolving door (5 directors in 2 years)
- High PSI and HAI numbers. CMS one Star

The Tough Get Going

- Very engaged leadership whose motto has been "*Safe hospital or no hospital*"
- Quality and Patient Safety Council reinvigorated with accountable reporting from all departments and sub committees. PDSA methodology.
- Clinically experienced Quality department RNs partnered with IT department and key Physician leaders.
- Data focused. Developed score cards and dashboards. Shared them widely.

UTMC Inpatient Pay-for-Performance $

Data Source: CMS HAC Reduction Program dataset, 1/26; CMS HAC Reduction program resources, accessed 1/28
Care Compare website located at www.medicare.gov/care-compare/

Breakdown of Pay for Performance Savings by Program

Fiscal Year	Total P4P $	P4P%	Hospital Readmission Reduction Program	Hospital Acquired Condition Reduction Program	Value Based Purchasing Program
2022	($28,202)	-0.07%	($28,202)	$0	N/A
2021	($481,909)	-1.22%	($122,208)	($394,754)	$35,054
2020	($672,792)	-1.70%	($98,707)	($392,826)	($181,259)
2019	($897,696)	-1.76%	($118,051)	($506,275)	($273,371)
2018	($941,703)	-1.56%	($114,518)	($601,454)	($225,732)

Data Source: CMS HAC Reduction Program dataset, 1/26; CMS HAC Reduction program resources, accessed 1/28

P4P $ by Program
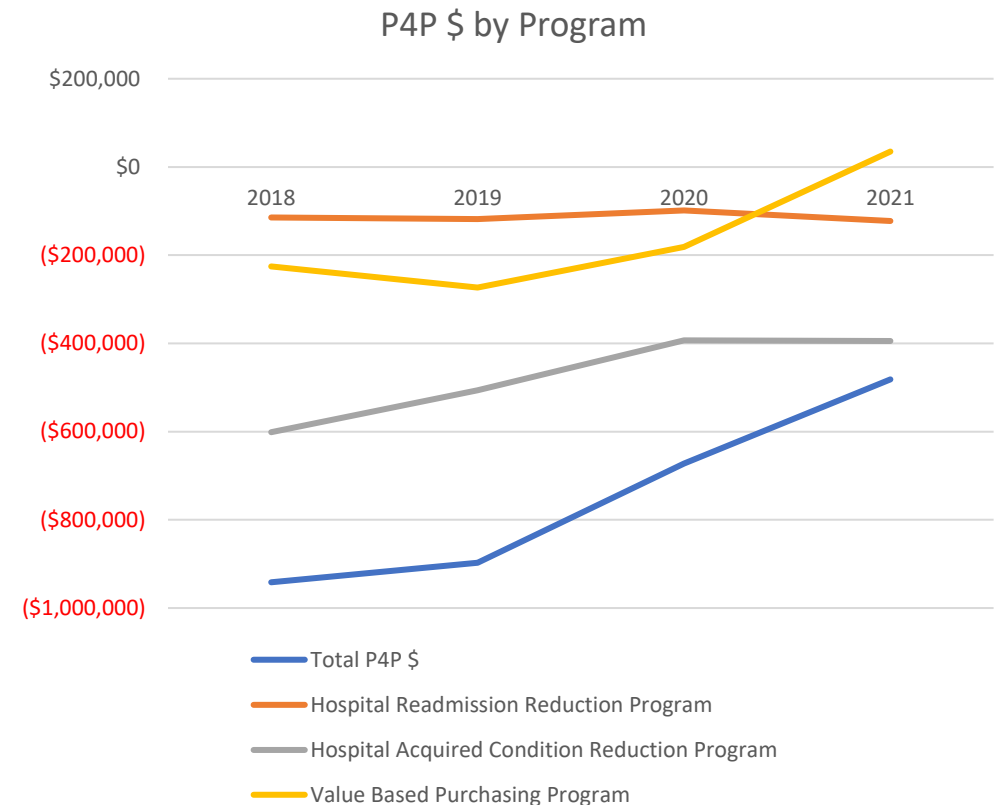
FY 2022 P4P Performance in Toledo Area

Nearby Hospitals	Total P4P Impact ($)	Total P4P Impact (%)
UTMC	$28,202.00	0.07%
ProMedica Toledo Hospital	$547,623.00	0.39%
ProMedica Baypark	$35,843.00	0.45%
Wood County	$48,944.00	0.81%
St Lukes	$352,820.00	1.16%
Mercy St V	$385,722.00	0.56%
Mercy St Ann	$136,963.00	0.74%
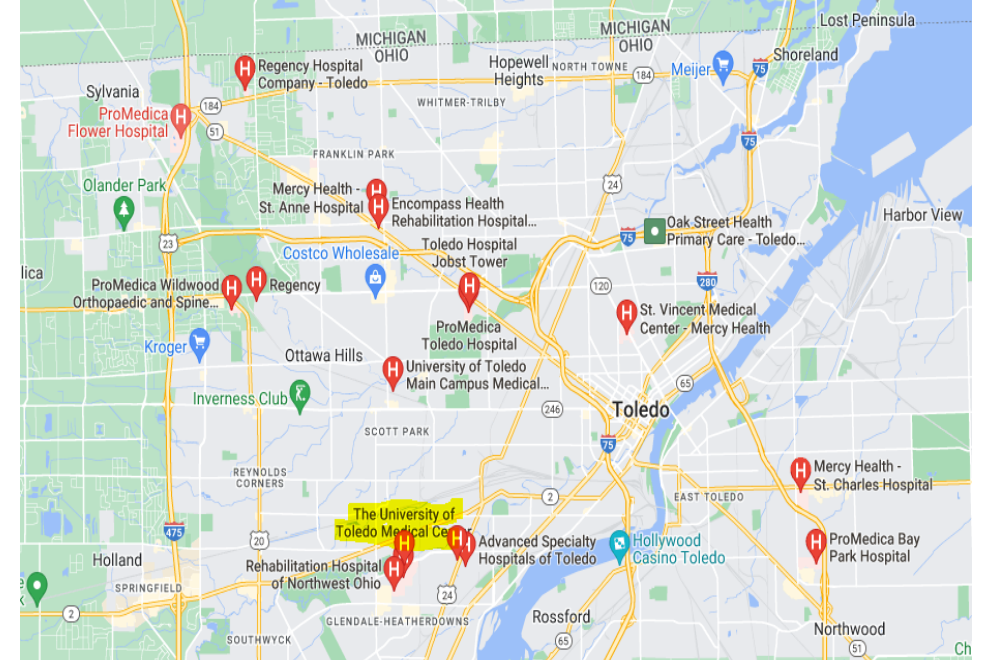
UTMC had the lowest penalty in 10 years and the lowest in the city.

Source: CMS HAC Reduction Program dataset, 1/26; CMS HAC Reduction program resources, accessed 1/28

Quality and Accountability Scorecard Vizient 2017-2021

Overall Score

(Line chart showing Overall Score by year)
- 2017: 40
- 2018: 42
- 2019: 44
- 2020: 52
- 2021: 54

Year	Overall Score (rounded)
2017	39.74
2018	41.59
2019	44.11
2020	52.2
2021	54.05

2021 Vizient median: 52.88

Vizient Rank

(Line chart showing Vizient Rank by year)
- 2017: 89
- 2018: 80
- 2019: 63
- 2020: 48
- 2021: 45
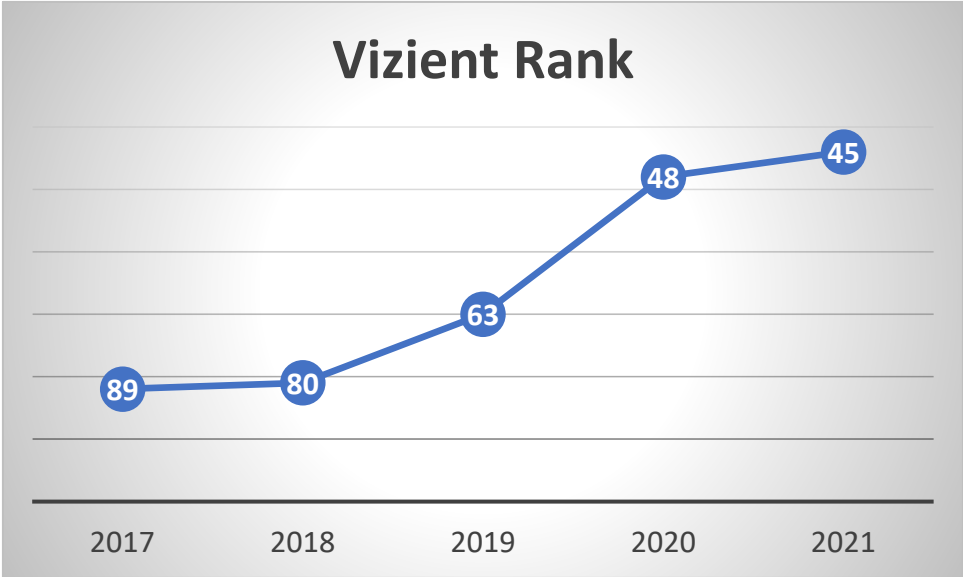
Year	Vizient Rank	Vizient Stars
2017	89	★★
2018	80	★★
2019	63	★★★
2020	48	★★★
2021	45	★★★

Data Source: Vizient

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Understanding our patient population

Specific Domains and Components with High Vulnerability: The University of Toledo Medical Center

	high		extreme	
Overall Vulnerability Index (VVI)	32%	15%	13%	3%
Economic Domain	23%	7%	2%	
- Poverty	23%	11%	2%	1%
- Unemployment	4%	3%		
- Median Income	23%	10%	4%	1%
Education Domain		1%		
- Bachelors Degrees	4%	1%		
- 15-17 Year Olds in School		3%		1%
- 3-4 Year Olds in School	1%	3%		
Health Care Access Domain		8%		2%
- Uninsured		8%		2%
Neighborhood Domain		1%		
- Park Access	2%	5%		
- Food Deserts	3%	6%	2%	1%
- Alcohol Sales		9%		1%
Housing Domain		10%		1%
- Homeownership	37%	27%	2%	9%
- Incomplete Plumbing				
- Crowding		8%		3%
- Extreme Housing Costs	1%	29%		9%
Clean Environment Domain	3%	6%	1%	
- Air Quality	1%	7%		4%
- Water Quality	3%	10%	1%	
Social Domain	11%	7%		
- Voting Participation		10%		2%
- Two Parent Households	32%	15%	11%	4%
Transportation Domain	23%	14%	2%	5%
- Access to Car or Public Transportation	23%	14%	2%	5%

A zip code with "high" vulnerabilities has index values greater than 1 standard deviation above the mean. A zip code with "extreme" vulnerabilities has index values greater than 2 standard deviations above the mean. In every case a higher number is a greater vulnerability (e.g. Higher poverty is a greater vulnerability, and lower median income is a greater vulnerability. Both have higher index values representing higher vulnerability.)

The percents reported here in orange represent the percent of this hospital's distinct patients residing in zip codes identified as having "high" or "extreme" vulnerabilities.

Any vulnerability affecting the zip codes in which less than 1% of the hospital's total patient population resides is left blank.

CDB-wide averages (in grey) are provided for comparison.

Source: CDB distinct patients of any age seen in any setting, 2019-2020. Vulnerability Index linked by patient zip code. In case of multiple zip codes, the last encounter in the time period is used.

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Data Source: Vizient

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Patient Safety Indicators

Sum of AHRQ Safety Numerator by Discharge Year

Fewer is better
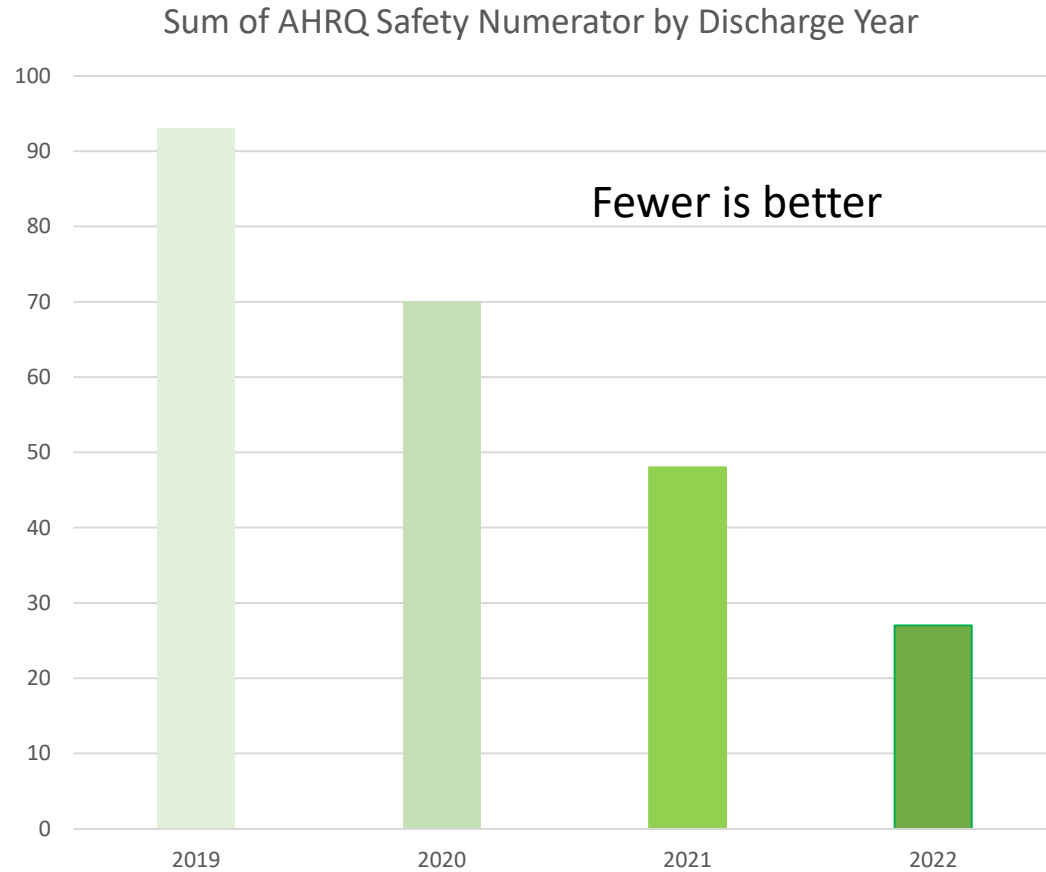
AHRQ List of Patient Safety Indicators

PSI02 Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)

PSI03 Pressure Ulcer Rate

PSI04 Death Rate Among Surgical Inpatients with Serious Treatable Conditions

PSI04a Death Among Surgical Stratum A: DVT or PE

PSI04b Death Among Surgical Stratum B: Pneumonia

PSI04c Death Among Surgical Stratum C: Sepsis

PSI04d Death Among Surgical Stratum D: Shock or Cardiac Arrest

PSI04e Death Among Surgical Stratum E: GI Hemorrhage or Acute Ulcer

PSI05 Retained Surgical Item or Unretrieved Device Fragment Count

PSI06 Iatrogenic Pneumothorax Rate

PSI07 Central Venous Catheter-Related Blood Stream Infection Rate

PSI08 In Hospital Fall with Hip Fracture Rate (AHRQ 5.0/4.5a Postoperative Hip Fracture Rate)

PSI09 Postoperative Hemorrhage or Hematoma Rate

PSI10 Postoperative Acute Kidney Injury Requiring Dialysis (AHRQ 5.0/4.5a: Postoperative Physiologic and Metabolic Derangement Rate)

PSI11 Postoperative Respiratory Failure Rate

PSI12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate

PSI13 Postoperative Sepsis Rate

PSI14 Postoperative Wound Dehiscence Rate

PSI14a Postoperative Wound Dehiscence Rate Stratum 14A: Open Approach

PSI14b Postoperative Wound Dehiscence Rate Stratum 14B: Non-Open Approach

PSI15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate (AHRQ 5.0/4.5a Accidental Puncture or Laceration Rate)

Hospital Acquired Conditions

Sum of Cases by Discharge Year

Fewer is better
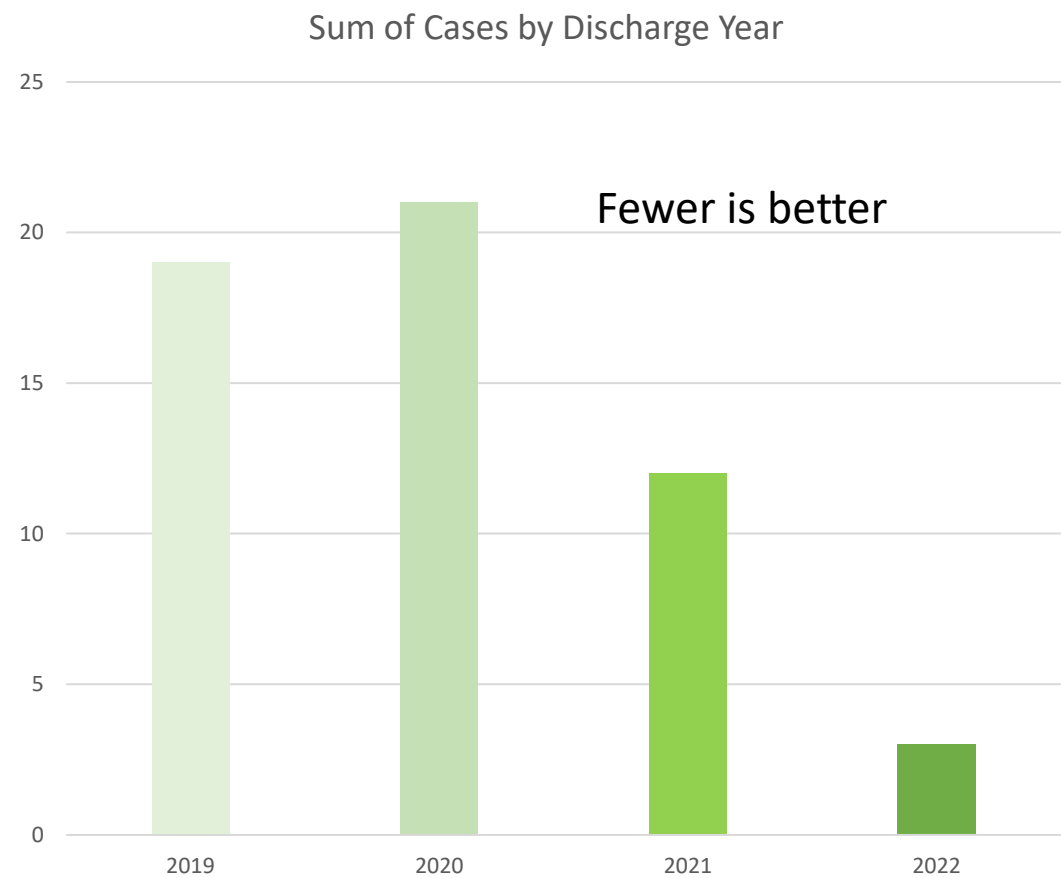
Pressure Ulcer and Iatrogenic Pneumothorax increased in 2020

List of Hospital Acquired Condition
Air embolism
Blood incompatibility
Catheter associated UTI
DVT/PE after knee or hip replacement
Falls and trauma
Foreign object retained after surgery
Iatrogenic pneumothorax W/ venous catheterization
Infection after bariatric surgery
Infection after CABG
Infection after certain orthopedic procedures of spine, shoulder & elbow
Manifestations of poor glycemic control
Stage iii & iv pressure ulcers
Surgical site infection following cardiac device procedures
Vascular catheter-associated infection

Quality: Structure and Processes

Quality Plan and Council
- Declared our focus on PSI and HAI reduction-approved by BOT
- Information sharing through A3 and PDSA format
- Tracked attendance and physician accountability through action plans
- Broader participation; included a community member

Data

- Quality scorecards for service chiefs, chairs, outcome management, etc. etc. etc.
- Detailed data analysis at sub-committees
- Increased tracking and trending of cases to identify common causes

Quality Assessment, Performance Improvement, and Patient Safety Plan FY 2023

I. Introduction
  a. Purpose
  The purpose of the Quality Assessment, Performance Improvement (QAPI) and Patient Safety Plan is to support the University of Toledo Medical Center (UTMC) mission and strategic vision by outlining priorities, objectives and overall improvement strategies.

  b. Mission
  The mission of The University of Toledo Medical Center is to improve the human condition by providing patient-centered, university-quality care.

Refocusing Quality Staff's activities

- Case analysis at sub committees that report to the Quality Council
- Understanding definitions and criteria for PSI and HAI
- Harnessing IT for focused and real time reporting
- Quality RN – training on definition and criteria, best practices

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What Worked for us?

PSI and HAC Reduction

IT
Daily potential PSI, Core measure flag reports

(e.g., lactate >4, MEWS alert, EPC compliance report)

Quality RNs
Real time auditing

Checking AHRQ/CMS Definitions, criteria, chart review, admission type, coding errors

Coding team corrects or provides rationale for their coding

HIM corrects admission type when applicable

Is it a PSI/HAC?

NO → **Quality** Case work-up logged in Quality for future reference

YES → **Quality** Case review summaries, prepped; including core measure compliance

Nursing Leadership as appropriate for feedback

Provider review (or committee chair)

Sub committee meetings- Case summaries are discussed, and action plans formulated

QPSC: Summaries dashboards PDSA A3

Peer review

MEC high level summary and numbers

Meetings

- Quality meeting: Bi-Weekly (registration, RN all who touched the process were invited)
- PSI specific task-forces committees (physician champions, RN champions)
- Ad-Hoc Quality meetings, in-dept. huddles, retreats, nursing orientation, Quality RN Rounding- weekly

Education

- Quality RN orientation with all new providers (talk about PSI, core measures etc.) Heavy emphasis on sepsis, post op resp failure etc.
- Quality RNs visit department meetings'(closing the loop on feedback)
- Nursing Orientation education on Core Measures, PSI, Safety Science

Examples

DVT prophylaxis: Every pt. gets EPC cuffs orders regardless of the Risk (we found that most of our patients qualify to be high risk). Compliance is monitored by Quality daily. All our beds have EPC cuffs. If the patient refuses, then at first, we provide re-education on the importance, if they still refuse then we communicate with the physician who may or may not add chemical prophylaxis depending on clinical need.

Mortality: We review 100% mortalities. CMO is **very** engaged, and briefly reviews previous day's mortalities along with Quality. Cases with Code Blues and RRTs have additional review. Data shared appropriately in real time and systematically in monthly score cards (provider-level information).

HAI Reduction

CLABSI
- Education to physicians on infection prevention insertion practices. Train the trainer programs by Infection Prevention . Nurses covered at orientation.
- Weekly audits performed on all CVC and PIVs by PICC team while doing weekly dressing changes on all CVCs.
- Insertion checklist implemented – the procedure is to be stopped if sterile technique is breached.
- Apparent cause analysis (ACA) performed on all HAI-CLABSI cases – staff involved in patients care at the time of the infection are interviewed.
- Annual whole house Vendor audits performed – review care and maintenance of CVC and PIV dressings. with real time feedback – Insertion practices review.

CAUTI
- Algorithms guided appropriate testing (e.g., UA w/ reflex; exception is urology and ID teams)
- Routine foley needs audit performed by IP and completed daily by lead nurses for units.
- Apparent cause analysis (ACA) performed on all HAI-CAUTI cases – staff involved in patients care at the time of the infection are interviewed.
- Data – cases are entered in PSN for detailed tracking – we have unit info, provider info, ACA analysis is completed.
- Annual whole house Vendor audits performed – review care and maintenance and insertion practices review with real time feedback provided.

C. diff
- Focus on appropriate testing – bundle, testing and treatment algorithms established
- Stewardship Pharmacist reviews all inpatient cases for appropriate antibiotic usage

SSI
- House-wide SSI collection – including those required for CMS reporting
- Engaged IP Medical Director who also serves a dual role as the CMO
- Surgeon report card to hospital leadership and chairs on a monthly basis.
- Intrinsic and extrinsic SSI factors individualized and shared with the prospective surgeon twice a year.
- Real time feedback provided to surgeons for each SSI via email and PSN - Track and trend by provider.
- Pharmacy – engaged with appropriate Pre-op antibiotic prophylaxis – protocol established.
- Practice Bundles established for colorectal and spinal surgeries.
- Increased case observations by IP. Metrics collected on skins prep, timeouts, door closure etc.
- EVS cleaning protocols. Unannounced florescent marking audits done twice a month.
- Provider education – didactic once a month with some specialties.
- Sterile Processing Dept. process improvement projects – monitoring of loaner tray practices; eliminated IUSS in OR; new cart washer; purchased closed case carts

Barriers/opportunities within COVID with HAI

- No increase in Infection Prevention staffing – majority of the time dedicated to COVID activities.
- Bundles and practice algorithms followed by staff (e.g., *C. diff* testing, urine culturing)
- IP Director was called in to be the Incident Commander for the University.
- Hand hygiene improved; Increased compliance with Standard Precautions.
- IP rounding decreased. Census decreased and elective surgical cases were postponed.
- Dedicated COVID units were incorporated into part of one step-down unit and the ICU.
- Sicker pts needing Sx – case mix has changed. Data does not show if it helped or harmed us.

Questions?

Contact:

Pallavi Yadav

Pallavi.Yadav@utoledo.edu

Learning Objectives

- Discuss the original objectives of the Patient-Regulatory-Safety group and describe the journey to its current Virtual Patient Safety Group format.

- Describe the methods used by the current Virtual Patient Safety Group to identify, mitigate and prevent patient harm so that the work done by the group supports the high reliability goals of the organization.

NYU Langone - 2007

- ***Walking the Tightrope Between Patient Needs and Regulatory Requirements (November 2008)***
    - NYU School of Medicine
    - NYU Hospitals Center
    - Affiliated Ambulatory Centers

NYU Langone Health – *Walking The Tightrope between Patient Needs and Regulatory Compliance (2008)*

2007

- NYU School of Medicine   1100 residents

- NYU Hospitals Center (3 sites)
    - Tisch Hospital/Rusk Pavilion
    - NYU Hospital for Joint Disease

        o 1,069 inpatient beds
        o 42,252 discharges
        o 1850 physicians; 1550 Nurses
        o 4000 other employees involved in patient care
    - Miscellaneous Data
        o ED visits   37,071
        o Ambulatory Visits   585,728

2022

- NYU Grossman School of Medicine & NYU Long Island School of Medicine   2550 residents

- NYU Langone Hospitals – (6 sites) Tisch/Kimmel/Hassenfeld Children's Hospital; Langone Orthopedic Hospital; NYULH-Brooklyn; NYULH – Long Island
        o 2,104 inpatient beds
        o 71,779 discharges
        o 4,335 physicians; 7,643 Nurses
        o >43000 total employees
    - Miscellaneous Data
        o ED visits   183,900+
        o Ambulatory Visits   >9.6m

- NYU Long Island Community Hospital

2007 – The Beginning

The Vision:

- Systems that work
- Unity of effort
- Coordination to reduce duplication
- Communication
  - Between individuals
  - Between groups
  - Between departments
- Strong organizational learning
  - Rapid Cycle Improvement Process
  - ESC Compliance
  - Institutional Culture Change

2008 - The Work Begins

- Where to start?
  - Identify what we know
  - Organize for accountability
  - Breakdown the silo mentality

- Improve what we do
  - Improve communication
  - Identify concerns
  - Reduce duplication
  - Develop responses
  - Track activities & ensure follow-up
  - Communicate new regulatory mandates
  - Maximize organizational learning

Who Leads?

- **P**hysicians→Patient Centered Teams
- **Q**uality
- **R**isk/**R**egulatory
- **S**afety
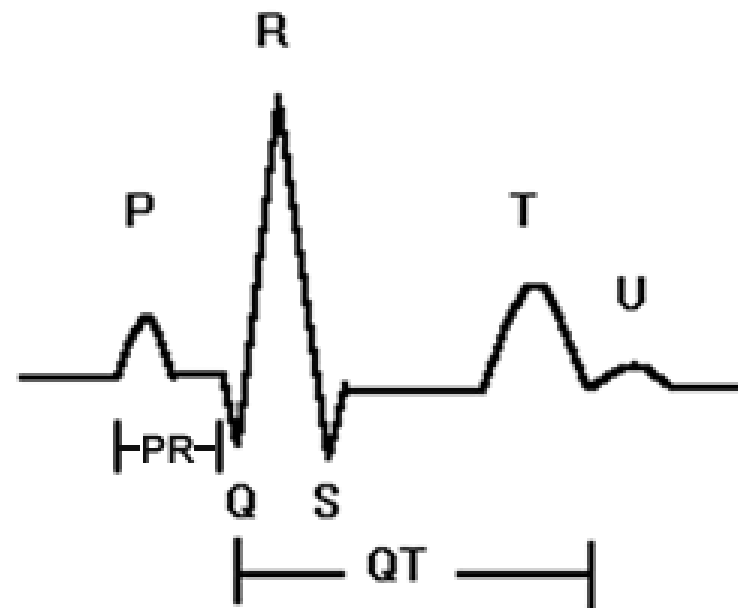
"The heartbeat of the hospital"

PQRS

Reduce the Silos

Patient Care Standards

- Regulatory Compliance Plan

Bylaws, Rules, Regulations Administrative Policies

- Quality & Safety Performance Improvement Plan
- Serious Event Reporting

CQO
CQE
Project Mgr

PSD

DON RM
RM

CRO
Dir
Accreditation
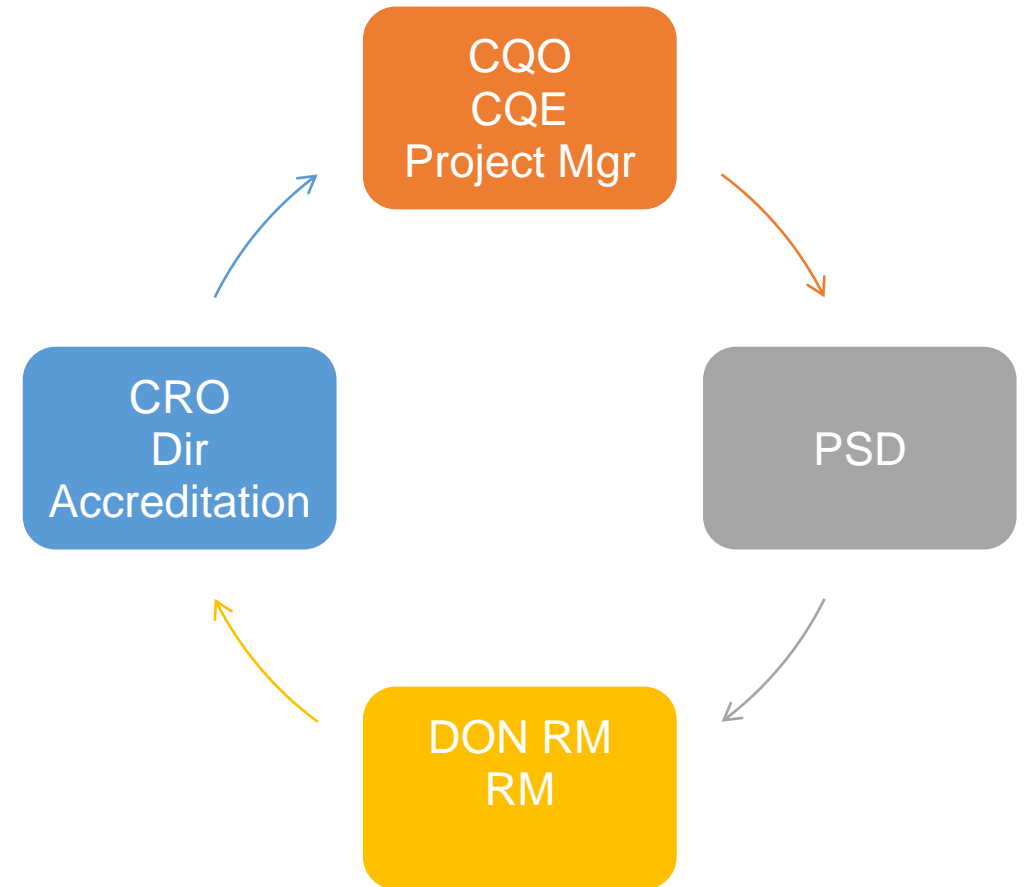
Enable Shared Organizational Information
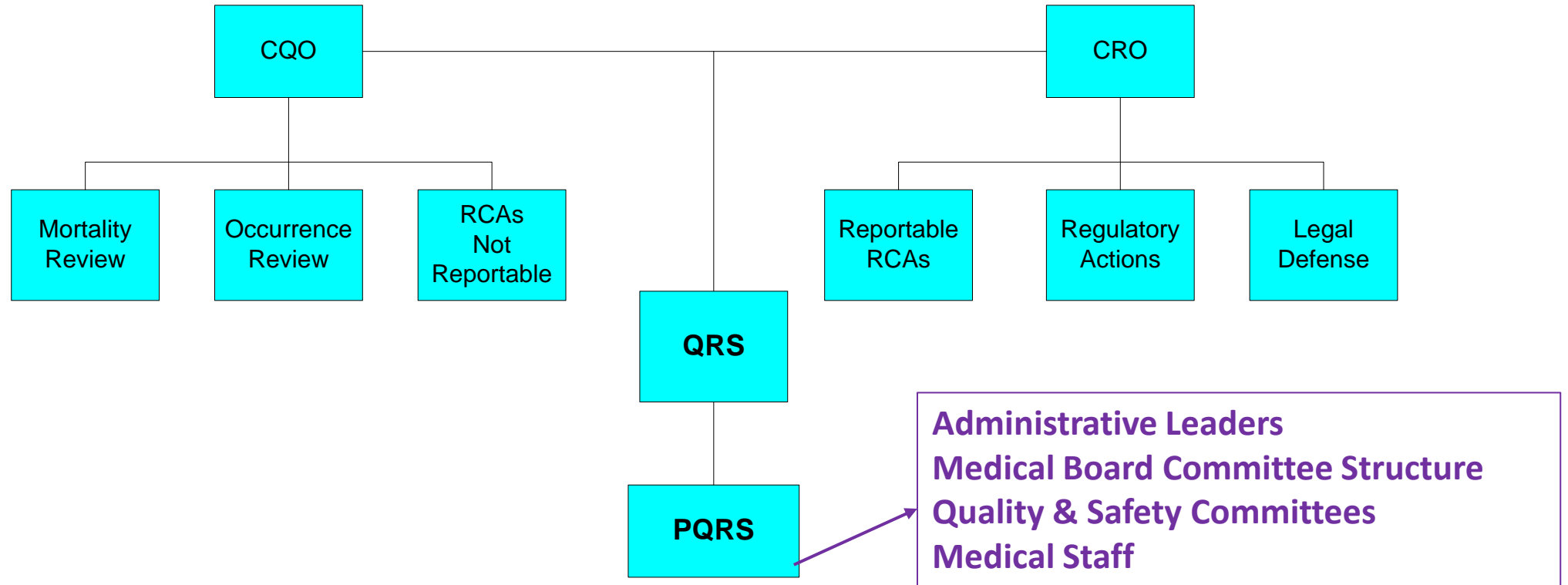
Develop the QRS Structure

- Support information sharing; determine actions; shared learning; foster improvement
- QRS weekly meeting – events; morbidity & mortality; licensing and accreditation
- 2008 - QRS group; verbal reports to leadership

Chief Hospital Operations	Chief Medical Officer
Chief Nursing Officer	Chief Quality Officer
Chief Regulatory Officer	Patient Safety Director Director Risk Management

- **2010** – Transitioned to monthly formal meeting chaired by CMO
- 2012 – Bi-weekly meetings
- 2016 – + Langone Orthopedic Hospital; NYULH – Brooklyn CMO
- **2016 –** *Transitioned to Virtual Call 3x week*
- 2018 – + NYULH – Long Island; + Family Health Centers; + Office of Legal Counsel

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Early Results

- Improved Organizational Learning
  - Occurrence and RCA themes
    - o Identified
    - o Communicated
    - o Actionable
- Other Improvements
  - Managers refer issues to QRS
  - Improved collaboration between QRS participants
  - Communication feedback loop between QRS and individuals/departments/committees
  - Timely reports
  - Sharing of themes from occurrence/mortality reviews and RCAs with clinical leadership

2011- 2022

- Risk Management renamed Patient Safety-Risk Management and takes responsibility for Incident Reporting System (PSI)
- PS-RM leads event related investigations, RCA process established; NYSDOH reporting requirements
- Patient Safety Committee of the Medical Board established
- Patient Safety Officer becomes involved in resident and professional staff education
- Chief Quality Officer begins focus on Hospital Acquired Conditions
- Chief Regulatory Officer expands focus to additional programs, sites and policy
- 2014 – High Reliability Journey begins; Safety Action Group initiated
- 2016 – Lutheran Hospital and Medical Center merges into NYU Langone Hospitals
- 2017 – Partnership between Patient Experience & Risk Management implemented
- 2018 – Winthrop University Hospital merges into NYU Langone Hospitals
- 2022 – Long Island Community Hospital joins the NYU Langone Health System
- USNWR ranks NYU Langone Hospitals #3 in nation

How is NYU Langone Health Structured?

NYU Langone Health

New York University

NYU LI School of Medicine
- UME & GME

NYU Grossman School of Medicine
- UME & GME
- Faculty Group Practice
- Research
- Affiliation Agreements

Dean + CEO

NYU Langone Hospitals*
- Main Campus
  - Tisch Hospital
  - Kimmel Pavilion
  - Hassenfeld Children's Hospital
- NYU Langone Hospital-Brooklyn
- NYU Langone Hospital-Long Island
- NYU Langone Health Cobble Hill
- NYU Langone Orthopedic Hospital
- Rusk Rehabilitation
- Perlmutter Cancer Centers
- Article 28 clinics and Family Health Centers
- School-based health/dental clinics

City of NY H&H — Bellevue Hospital

US Veterans Administration — VA NY Harbor

Long Island Community — LI Community Hospital

Private Practice Physicians

* Medical Staff is comprised of FGP & Voluntary Medical Staff

Our High Reliability Journey…Is Our Journey to Exceptionalism

2008
Built Lean problem-solving capacity through trainings and rapid improvement events

2009
Introduced Chair orientation and leadership programs

2012
Leveraged Epic go-live to optimize workflows and enhance quality

2015
Daily Safety Brief (DSB) call initiated

2016
System leaders convene safety huddle three mornings per week to review issues across hospitals and FQHC

2016
HRO Training launched

2019
Launch of Unit Scorecards and Weekly HRO message

2019
EXPRTS Committee established, aligning approach to External Reporting

2019
Establishment of Inpatient Management Committee

2020
Initiation of weekly Hospital Operations call

2020-2021
HRO Principles and Tools used to guide Covid-19 response

2021
Implemented Asset Control and Tracking Executive Steering Committee

2021
Unit focused operational support and tracking of needs established

2022
Daily Safety Brief (DSB) call transitioned to Exception Reporting

#1 Clinical Goal: To provide our patients a *highly reliable experience*

PATIENT EXPERIENCE
Ideal patient experience for each patient, every time

HRO
High Reliability Organization

QUALITY
Right care, in the right way, at the right time

SAFETY
Eliminate preventable harm

2022
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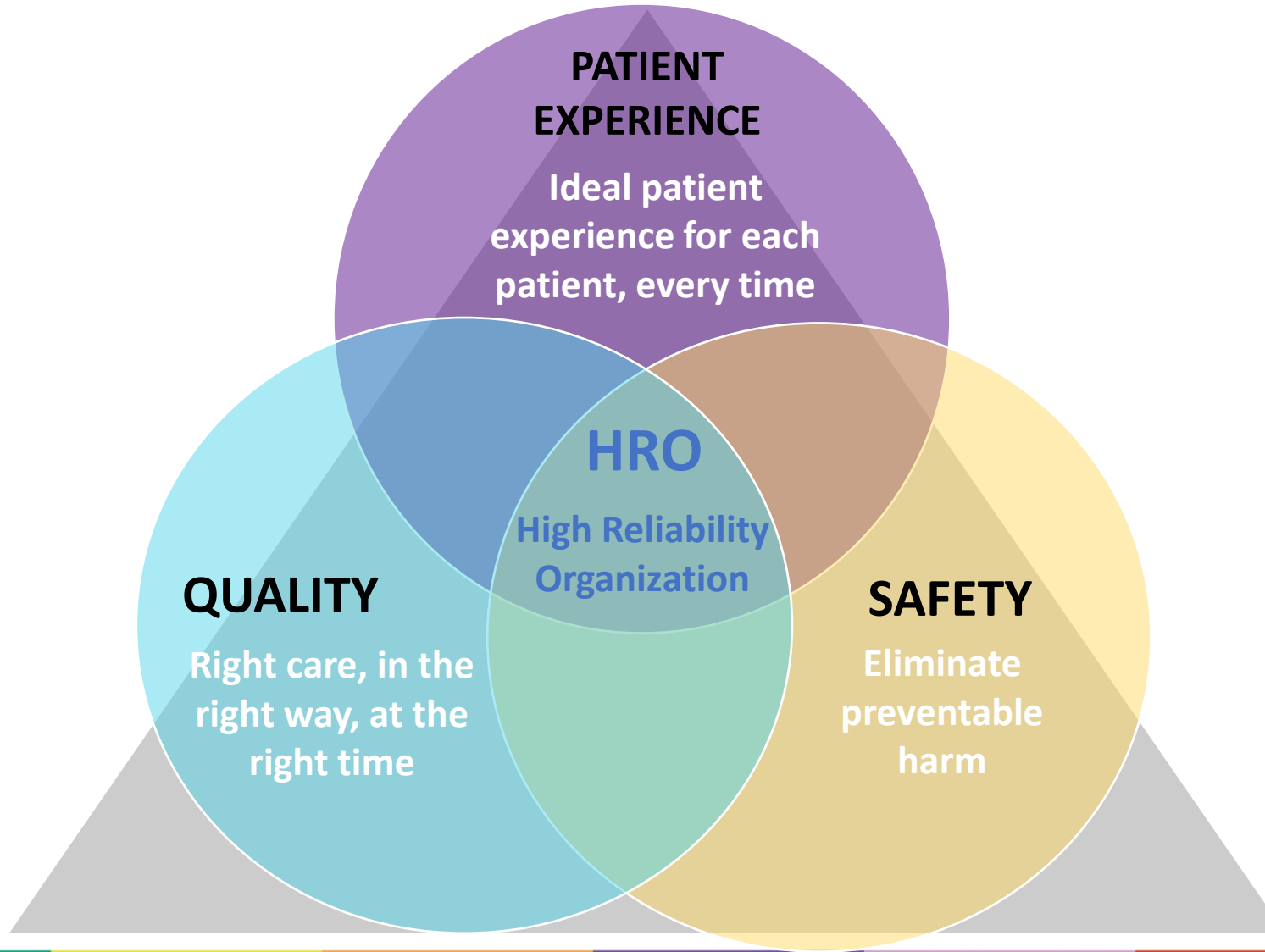
Our Patients Experience Your Efforts

Supportive Interactions

Education About Medications and Conditions

Keeping Families Informed

Decision Making Guidance

Rounding Touchpoints

Planning for Discharge

Plan for Each Day of Hospitalization

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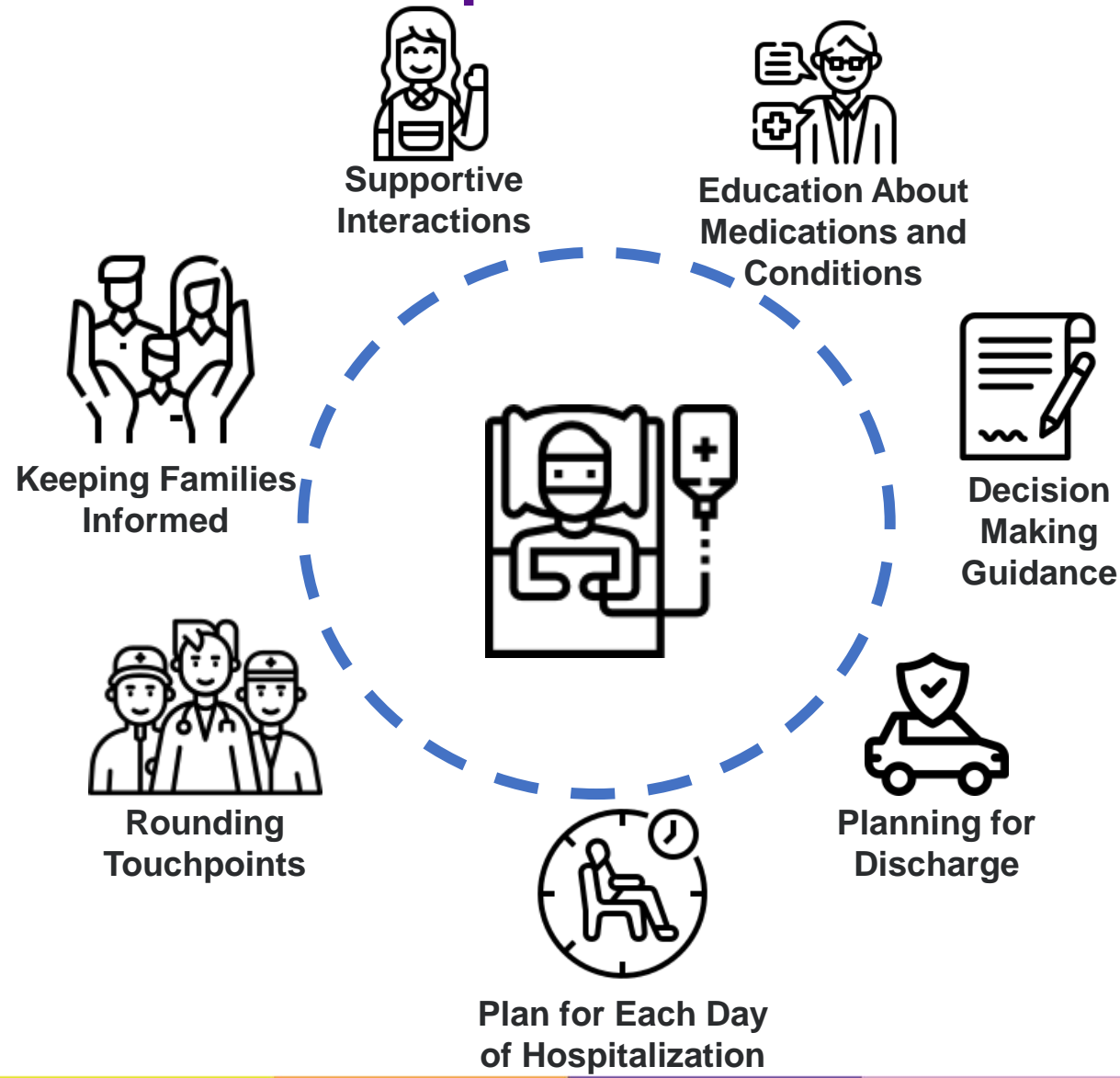
Next Phase of HRO: Exceptionalism in Action

1	**Staff Engagement**	• **Improve engagement**
2	**Clinical Care**	• **Deliver service excellence to patients and families**
3	**Unit-Based Management**	• **Improve two-way communication**
4	**Predictive Support**	• **Pro-actively manage** all aspects of quality, safety, patient experience, efficiency, and resource management
5	**Infrastructure Operations**	• **Promote High Reliability culture**

Next Phase of HRO: How We Succeed Together

1 **Staff Engagement**
- **Communication** promoting "Care Team" identity for all team members
- Recognition
- Celebrations

2 **Clinical Care**
- **Rounding** Structure
- Capacity Management
- Patient Experience; Care Transitions, Communication, Responsiveness

3 **Unit-Based Management**
- Resource Review and Management
- Quality, Safety, Efficiency, **Patient Experience**

4 **Predictive Support**
- Operational Management
- **Early Warning Systems**

5 **Infrastructure Operations**
- **Transparency** of all break/fix needs
- Furniture and Equipment availability
- Integration of liaisons from support departments as members of Care Team

Virtual Patient Safety Group

- System-wide leadership meeting
- Occurs 3x weekly at 7am
- Average duration 15 minutes
- Health System and Hospital leads
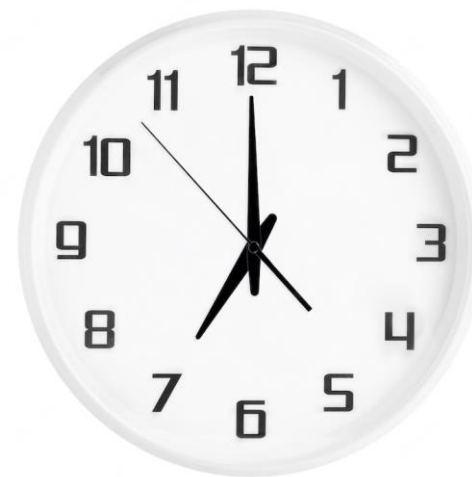
Virtual Patient Safety is both Horizontal

Nursing
Regulatory
Quality
Patient Experience
Risk
Patient Safety
Legal

VPSG: Safety Events

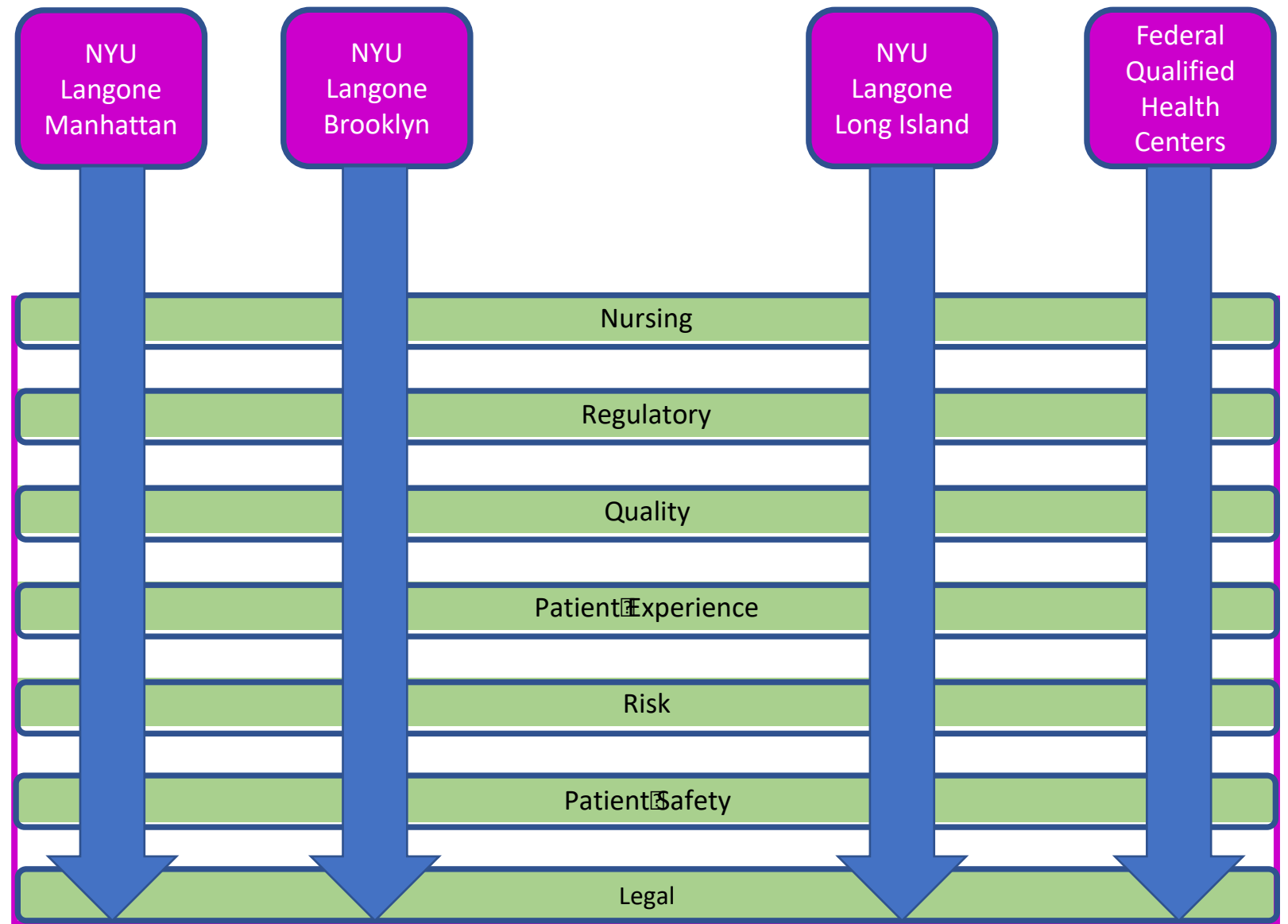- Patient Safety Intelligence (PSI) system is the mechanism for reporting incidents from Unsafe Conditions (Level 1) to Mortalities (Level 9)

- All VPSG participants are notified if there is an event where harm has reached the patient (PSI-level 6 and above)

- Discussion at VPSG for significant events across the campuses within 2 days of a safety event

- Early RCA planning

- Shared Experiences and Local Solutions that develop into System Policies

VPSG: Patient Experience

- Mobilize resources for support.

- Service Recovery by Patient Experience for safety events raised at VPSG

- Awareness provided to Risk Management about patients submitting grievances while currently admitted.

We are keeping the promise to "First, Do No Harm"

- **42.9% Reduction:**

  Rate of Hospital Acquired Conditions

- **63% Reduction:**

  Serious Safety Events
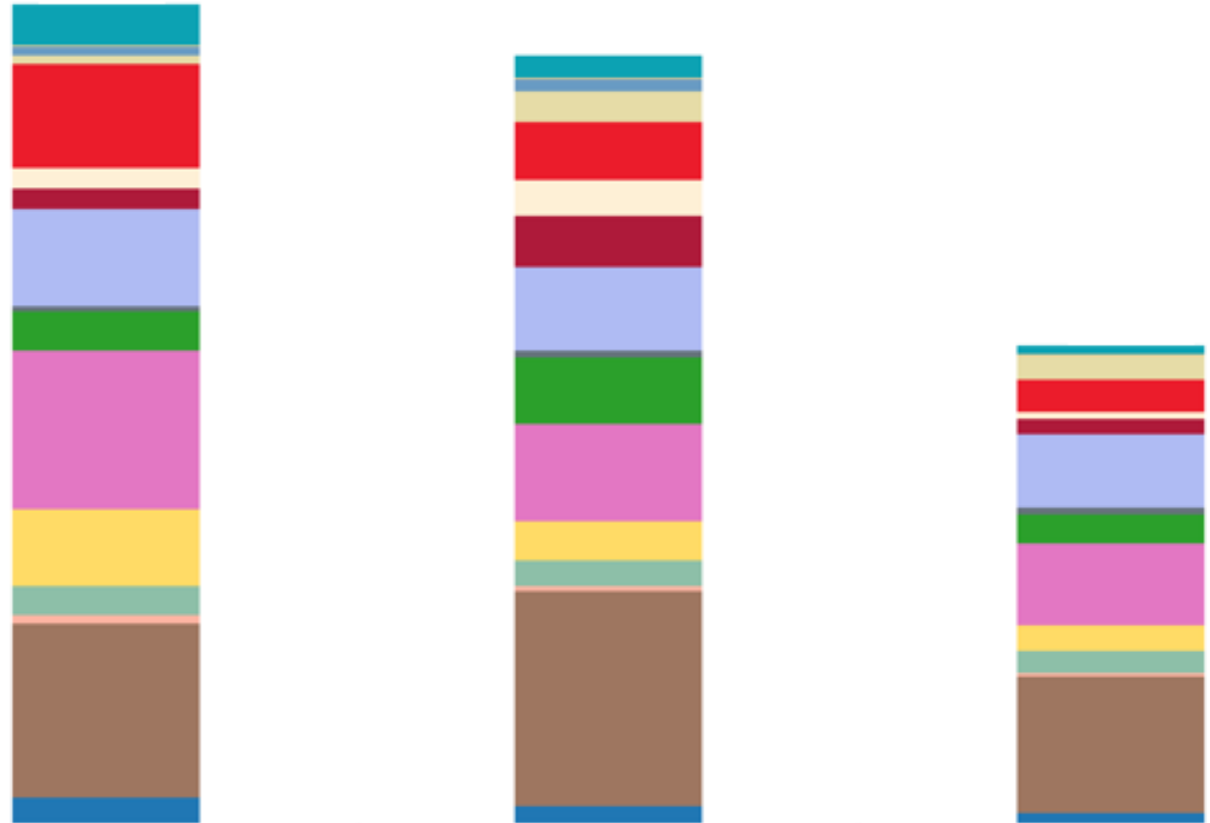
Questions?

Speaker contact information

Brian Bosworth, MD - Chief Medical Officer

brian.bosworth@nyulangone.org

Maxine Simon, FACHE - Chief Regulatory Officer

maxine.simon@nyulangone.org

Conflicts and Caveats

- I have no conflicts to disclose
- My presentation is educational and not legal advice
  - Slides offer practical guidance and are not comprehensive statements of law
  - Slides promote best practices, but situations require common sense and flexibility
  - Privilege claims always involve case-by-case analysis
- Love questions
- Thanks for all you do to improve safety and quality

Learning Objectives

- Address compliance standards and strategies to assure providers meet program integrity expectations

  - Principles for sharing PSWP within a complex health system

  - What it means to be a "provider" and its implications for health system organizations and joint venture arrangements

  - Event reporting constructs and considerations

- Analyze a few select case opinions on the PSWP privilege to identify lessons and strategies for operations and litigation

Patient Safety Act Compliance

- Competing principles
  - Protects PSWP with strong <u>privilege and confidentiality</u> protections
  - Encourages the <u>sharing</u> of lessons learned
- How are these principles balanced?
- Can we share lessons learned from PSWP info internally?
- Can we share PSWP among affiliated providers? Parent entities?
- When are we jeopardizing the PSWP privilege by sharing PSWP?

Patient Safety Act Compliance

- <u>Rules of thumb on sharing PSWP information</u>

1. Sharing PSWP <u>internally</u> within the provider is a <u>use</u> and is <u>allowed</u>

2. Sharing PSWP <u>externally</u> from the provider is a <u>disclosure</u> and is generally <u>prohibited</u> – 42 USC § 299b-22(b)

3. Sharing PSWP externally <u>may be allowed</u> if it fits any one of ten (10) specific "Disclosure Permissions" listed in the Act

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Patient Safety Act Compliance

- *Internal* Sharing of PSWP – "Use"

- Providers may <u>use</u> PSWP information <u>internally</u> with few restrictions
  - Rule does <u>not</u> regulate uses of PSWP within a "single legal entity"
    - Extends to workforce and providers holding privileges
  - Free to discuss and share PSWP in identifiable form for educational, academic, or other professional purposes (p. 70778)
  - "Use" does not include adverse employment actions for PSO-reporting
  - Practical application and common-sense reasoning

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Patient Safety Act Compliance

- *External* Sharing of PSWP – "Disclosure"
- Providers are prohibited from disclosing PSWP
  - Disclosure means divulging PSWP held by one party to "another legally separate" party other than a workforce member or provider holding privileges – 42 CFR § 3.20
  - Sharing PSWP with a legally separate person/entity is a disclosure
  - Sharing with workforce and a provider holding privileges is not a disclosure – it is a use (see prior slide)
  - Practical application and common-sense reasoning

Patient Safety Act Compliance

- _External_ Sharing of PSWP – "Disclosure Permissions"

- The Act identifies 10 circumstances where a provider may disclose PSWP externally, yet maintain protections – "Disclosure Permissions"

  - These are exceptions to the prohibition on disclosure

- Sharing PSWP through a Disclosure Permission does <u>not</u> waive privilege or confidentiality – 42 USC §299b-22(d) and 42 CFR §3.208

  - Rule says even impermissible disclosures are still privileged

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Patient Safety Act Compliance

- *External* Sharing of PSWP – "Disclosure Permissions" (*cont.*)
- **Disclosure Permission "to carry out patient safety activities"**
  - 42 USC § 299b-22(c)(2)(A)
- Four scenarios under the "Patient Safety Activities" Disclosure Permission
  - Provider-to-PSO disclosures
  - Provider-to-Contractor disclosures
  - **Provider-to-*Affiliated* Provider disclosures**
  - Provider-to-Unaffiliated Provider disclosures

Patient Safety Act Compliance

- External Sharing of PSWP – "Disclosure Permissions" (*cont.*)
- Provider-to-*Affiliated* Provider disclosures
  - A provider can permissibly disclose PSWP to a legally separate provider if that entity is:
    - The parent organization of the provider
    - Under common ownership, management or control of the provider
    - Owned, managed or controlled by the provider
- In complex health care systems, care should be taken to consider which entities are (and are not) an *affiliated provider*

Patient Safety Act Compliance

- <u>Permissible disclosures to affiliated providers</u> (cont.)

- The PSO Program is designed for providers

- A "provider" is either:

  - An individual or entity licensed under State law to provide health care service (*Statutory Providers*)

  - A parent organization of a provider even if the parent organization is not licensed under State law to provide health care services (*Deemed Provider*)

Patient Safety Act Compliance

- Permissible disclosures to affiliated providers (cont.)
- A "parent organization" is an entity that
  - Owns a controlling or majority interest in a component organization;
  - Has the authority to control or manage agenda setting, project management, or day-to-day operations; or
  - Has the authority to review and override decisions of a component organization
- Safe to follow a "one-step" rule on the organizational chart

Patient Safety Act Compliance

- Permissible disclosures to affiliated providers (cont.)
- Can I share PSWP with this entity as an affiliated provider?
  - Does the entity qualify as a "provider" under the Statute?
    - If so, is the entity under common ownership, management or control with us?
  - If the entity is not a "provider" under the Statute, does it qualify as our "parent organization"?
    - Is the entity "one-step" away from us on the org chart?
- Joint Venture relationships

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Patient Safety Act Compliance

- Constructing an event reporting module to exclude certain information from being PSWP

  - What are your survey experiences with event reporting?

  - The *above-the-line* approach to event reporting

  - Distinguishing *factual* information from *opinions/analyses*

  - Clear signs to divide facts from analyses

    - Pop-ups, access limitations, labels or signs

Example: Distinguishing potential PSWP from data that may not be eligible

Medical record data –not PSWP

Start
- Who was affected by the event?
- Date of admission or ambulatory encounter

People affected by the event
- Type
- MRN
- Subtype
- Last, first name, middle initial
- Date of birth
- Gender

Event Location
- Site, primary location/service name
- Site, other location/service name
- Clinical service

Event Basics
- Event type, category, subcategory
- Event discovery/occurrence date/time

Providers should consult with their Legal Counsel in determining which fields should or should not be labeled PSWP, taking into consideration State Reporting and CMS requirements.

Potential PSWP

Event Basics
- Was the event related to a handover/handoff?
- Was health information technology (HIT) implicated in this event?
- How did you learn about the event?

Event Detail
- Describe the event in your own words
- Describe any factors contributing to the event, lessons learned, and/or recommendations to prevent recurrence
- Extent of harm and harm score
- How long after the incident was harm assessed?
- Was any intervention attempted to prevent, reverse, or halt the progression of harm?

Miscellaneous Information
- Who was notified? (consider if this should be labeled "not PSWP")
- Was anybody else involved in the event?

Reporter Information
- Reporter role, name, contact phone number, email address

Event Specific Detail Questions

Manager Reviews

If deliberations and analysis, they must be created in PSES to be protected.

PSWP Case Opinions

- ***Estate of Hultman v. County of Ventura***

- Federal Court in M.D. of California decided May 2022

- Prison argued M&M review and autopsy reports were PSWP

- Court denied Prison's PSWP claim

  – Resided in PSES with no intention of reporting to a PSO

  – "Serious concern provider is over-designating documents as PSWP"

  – Evidence report was prepared for purposes other than a PSO

PSWP Case Opinions

- ***Walker v. LTACH @ Riverside***

- State Court in Newport News, Virginia decided April 2022

- Hosp. argued policy and procedures were privileged as PSWP

- Court found P&Ps do not meet the definition of PSWP

  - Cited guidance on what constitutes an "original provider record"

  - Suggested that P&Ps are outside the PSES – i.e., not for the purpose of reporting to a PSO

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PSWP Case Opinions

- ***McNamara v. City of Philadelphia***

- Federal Court in E.D. of Pennsylvania decided June 2022

- Prison health care provider argued mortality reviews were PSWP

- Court rejected PSWP privilege claim

    - "Bare recitation of statute" not sufficient to state PSWP claim

    - Evidence to suggest mortality reviews were conducted for reasons other than the PSO Program (contractual requirements and accreditation requirements)

Questions?

Speaker Contact Information
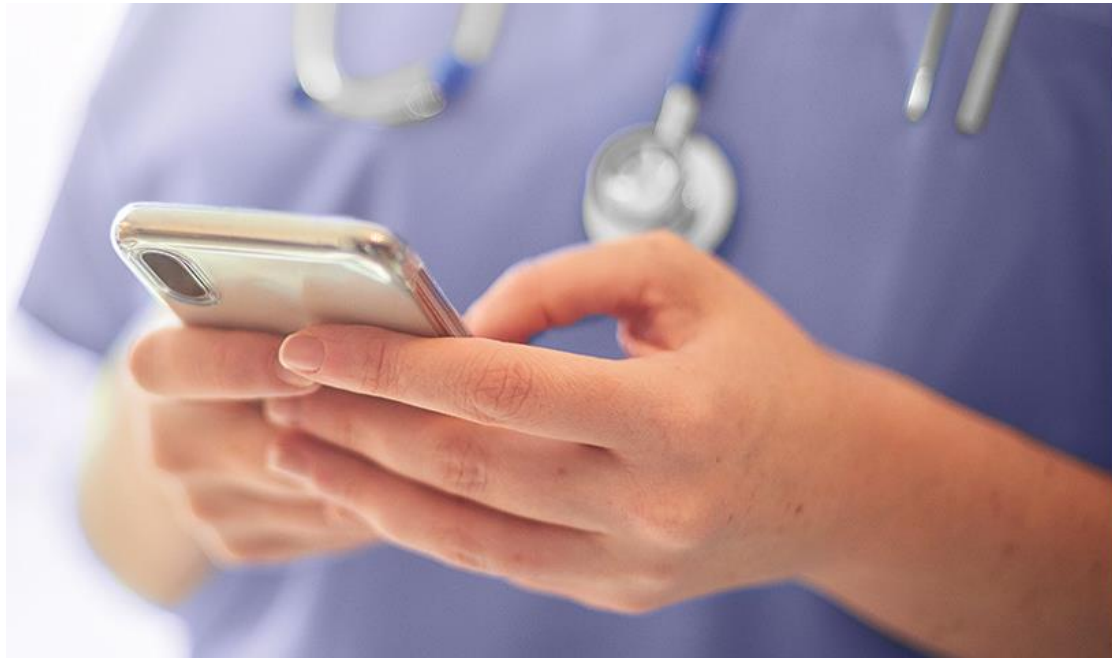
Wes Butler

wes.butler@bbb-law.com

Closing Remarks

Ellen Flynn, RN, MBA, JD
Principal, Vizient Patient Safety Organization