
2023 VIZIENT CONNECTIONS SUMMIT
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SEPT. 18–21, 2023
WYNN, LAS VEGAS
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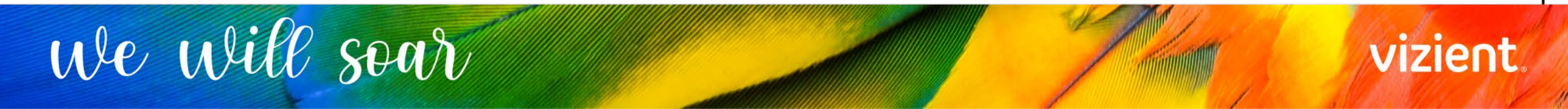
The Vizient Patient Safety Organization Accelerating Improvement Through Collaboration

Opening Remarks

Ellen Flynn, RN, MBA, JD

Principal

Vizient, Inc.



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Learning Objectives

- Discuss strategies for improving patient safety, healthcare quality, and healthcare outcomes.
- Identify key components of a strong workplace culture and high reliability organization.
- Discuss recent case law updates related to the Patient Safety Work Product privilege.

Vizient PSO Participants

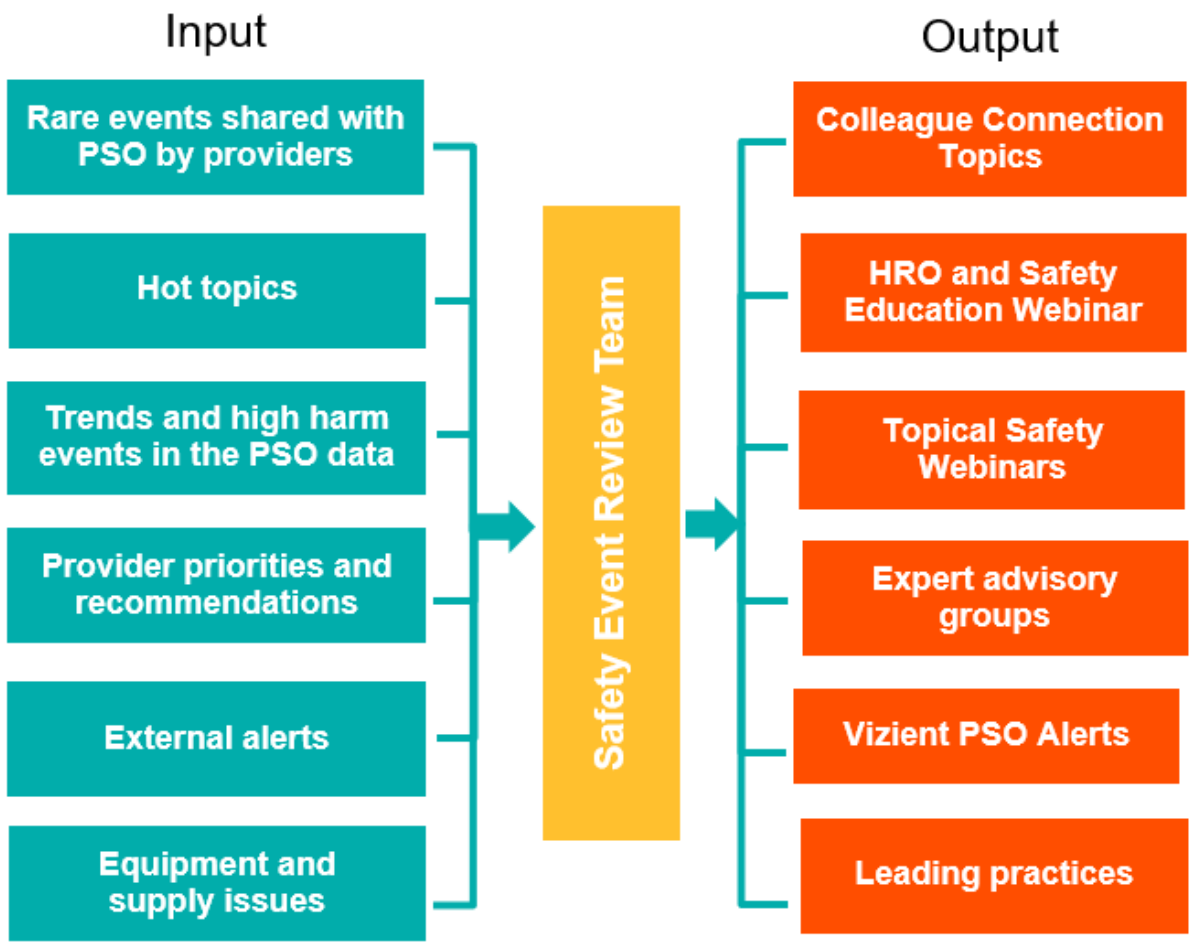
Description	Number
Number of states with participating organizations	38
Number of organizations participating	436
Number of participating health systems	34
Number of health system providers	408
General, specialty (e.g., behavioral), or critical access hospitals	266
Academic medical centers	40
Ambulatory clinics, physician groups, ambulatory surgical centers, and other ambulatory sites	116
Long Term Care Facilities / Hospice/ Home Health / Rehabilitation providers	18
Other: ambulances, emergency medical technicians, and paramedics	1

Vizient PSO 2024 plans

- Eliminate comparison of voluntary event reports
- Convene a monthly SERT (Safety Event Review Team)
  - Identify ways to bring more value from voluntary event reports and RCAs reported to the PSO
- Encourage reporting of rare events or new trends to their PSO program director via a secure confidential call within a PSES
- Support members in building a culture of safety and high reliability through partnership with Vizient safe and reliable
- 2024 focus
  - ED
  - Ambulatory
  - Failure to detect clinical deterioration
  - Maternal
  - Medication use

Join our Safety Event Review Team (SERT)

- SERT will meet monthly for 1-hour
- Discuss safety topics and data from multiple sources
- Review or suggest important safety topics
- Determine the best method for disseminating issues, learnings, and recommendations



2023 Vizient Patient Safety Organization (PSO) Calendar

Month	*HRO & Safety Education Webinars	*Topical Safety Webinars	PSO operations
	*Continuing education is provided for nurses, physicians and pharmacists		
January			January 11: PSO Orientation Register Here
February	February 22: Building capabilities for coping with and recovering from adverse events to improve patient safety outcomes Register Here	February 16: Identification, evaluation and learning from inpatient diagnostic errors Register Here	February 21: PSO Power Learning Register Here
March		March 8: Managing Drug Shortages Register Here	March 14: PSO Orientation Register Here
April	April 18: Redesigning work to support safe practices and critical thinking Register Here	April 12: Preventing "wrong" surgery events Register Here	
May		May 1-3: PSO Semi-annual In-person Spring Meeting (Chicago)	May 17: PSO Orientation Register Here
June	June 20: Conducting an effective cause analysis Register Here	June 14: Prevention of high harm maternal events Register Here	June 19: Case Law Update (2pm) Register Here June 13: Power Learning Register Here
July			July 18: PSO Orientation Register Here
August	August 29: Trust and collaboration: Partnering with patients for enhanced outcomes Register Here		
September		PSO Semi-annual In-person Meeting at Summit- (Las Vegas) Sept. 7: Proactive management of incidental Radiology findings across the continuum of care Register Here September 13: Early identification and response to clinical deterioration Register Here	September 12: PSO Orientation Register Here
October	October 17: Improving RCA outcomes; including involved staff and external expertise Register Here	October 11: Creating a safe, empathetic, respectful, violence free care environment Register Here	October 10: Case Law Update Register Here October 4: Power Learning Register Here
November	November 14: PSO privilege and confidentiality protections to support a Just culture Register Here	November 8: Intentional rounding to improve outcomes Register Here	November 1: PSO Orientation Register Here
December			

Potential leading practice advisory projects and workshops	Other PSO collaborative meetings and information
Project Advisory Group Topics ❖ Creating an environment of safety in healthcare organizations to prevent workplace violence ❖ Early recognition and response to clinical deterioration ❖ Using event reports to improve to improve culture of safety, learning and accountability ❖ Appropriate indications and oversight of emergent medication orders ❖ Preventing harm in perinatal care ❖ TBD: National Patient Safety Imperatives **Colleague Connections** ❖ Topical Colleague Connections ❖ Safety and Medical Leader ❖ Applying the Patient Safety Act	**All webinars start at 1:00pm Central Time unless otherwise noted.** **Topical Colleague Connections** *Thursday 2:30pm-3:30pm 2x per month* The meeting provides an opportunity for members to collaborate on and increase awareness of safety issues, and to ask peers about their processes, practices, and P&Ps. To join, contact the PSO Inbox. **Safe Tables:** The meeting provides an opportunity for member collaboration around specific safety topics and 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 Daniele Klebern. **PSO Power Learning:** The purpose of the Power Learning webinars is to share key learnings from our colleague connections, expert advisory calls, data analysis, and research; provide PSO updates; and seek member input. Please have at least one representative attend from your organization. **PSO orientation:** This session provides information on the Patient Safety Act, working with a PSO, and the steps your organization needs to take in defining your PSES. **Contact Information** PI Program Manager Jessie Blackwell (312) 775-4234 PI Program Manager Daniele Klebern (847) 779-5525 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

Aggregate analyses and leading practices

2016

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

2017

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

2018

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

2019

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

2020

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

2021

- Preventing pressure injuries
- Preventing AMA discharges
- Impactful RCA
- Retained central line guidewires
- Management of high-alert infusions

2022

- Wrong site surgery
- Pediatric sedation
- Mislabeled specimens
- Maternal health
- Pediatric sedation

Vizient PSO Safety and Medical Leaders Call

3rd Thursday of the month at 12-1 p.m. CT

- Forum for safety and medical leaders to connect and collaborate on safety and quality issues through the leadership lens
- Member-generated open discussion.
- Leaders bring their successes, challenges, and safety and quality issues for an all teach, all learn conversation among peers
- Opportunity to network with a diverse group of inpatient and outpatient leaders

Example topics

Hardwiring safety behaviors	Reinvigorating huddles	Root cause analysis
Workforce safety	Staffing and efficiency	Supply chain
Closed loop feedback	Surge capacity	Advanced care planning

For more information on joining this group, contact Kathryn.Merkeley@vizientinc.com

Applying the Patient Safety Act

1st Friday of the month at 3-4 p.m. CT

- Opportunity for members to expand on the information they learned during their PSO Orientation.
- Network with other organizations in the PSO and learn from members who have developed their PSES.
- Bring your questions or just listen in!

Example topics

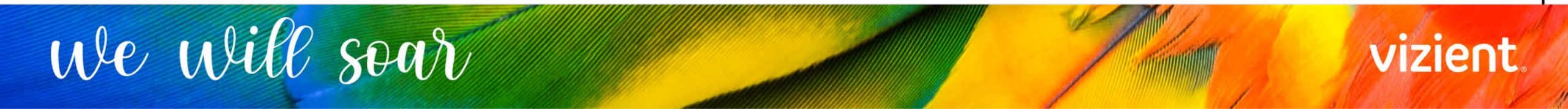
Affiliated providers	CMS surveys	Submitting data to a PSO
Licensed healthcare provider	Meeting regulatory requirements	Copies of PSWP
System PSES	Patient safety work product (PSWP)	Affidavits

For more information on joining this group, contact Christina.Driskill@vizientinc.com

Questions?

Contact: PSO@vizientinc.com

This educational session is enabled through the generous support of the Vizient Member Networks program.

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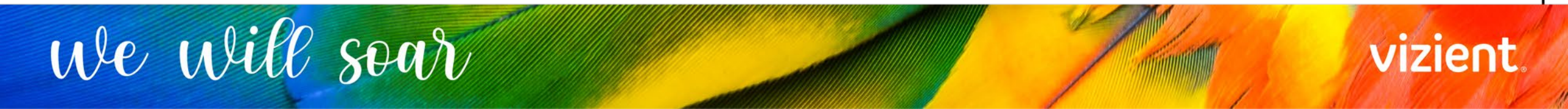
Culture is Everyone's Responsibility

Allan Frankel, MD, *Executive Principal, Vizient, Inc. and Safe and Reliable Healthcare*



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Culture is Everyone's Responsibility

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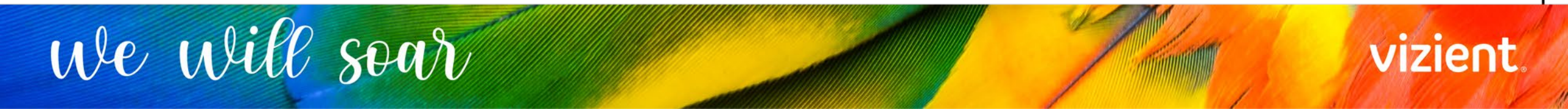

Turn to one of your neighbors.

Take a moment to look quietly at their facial features – eyes, nose, mouth, hair, ears.

With pen and paper or in clay, how many of you have the artistic skill to create an accurate representation of your neighbor?

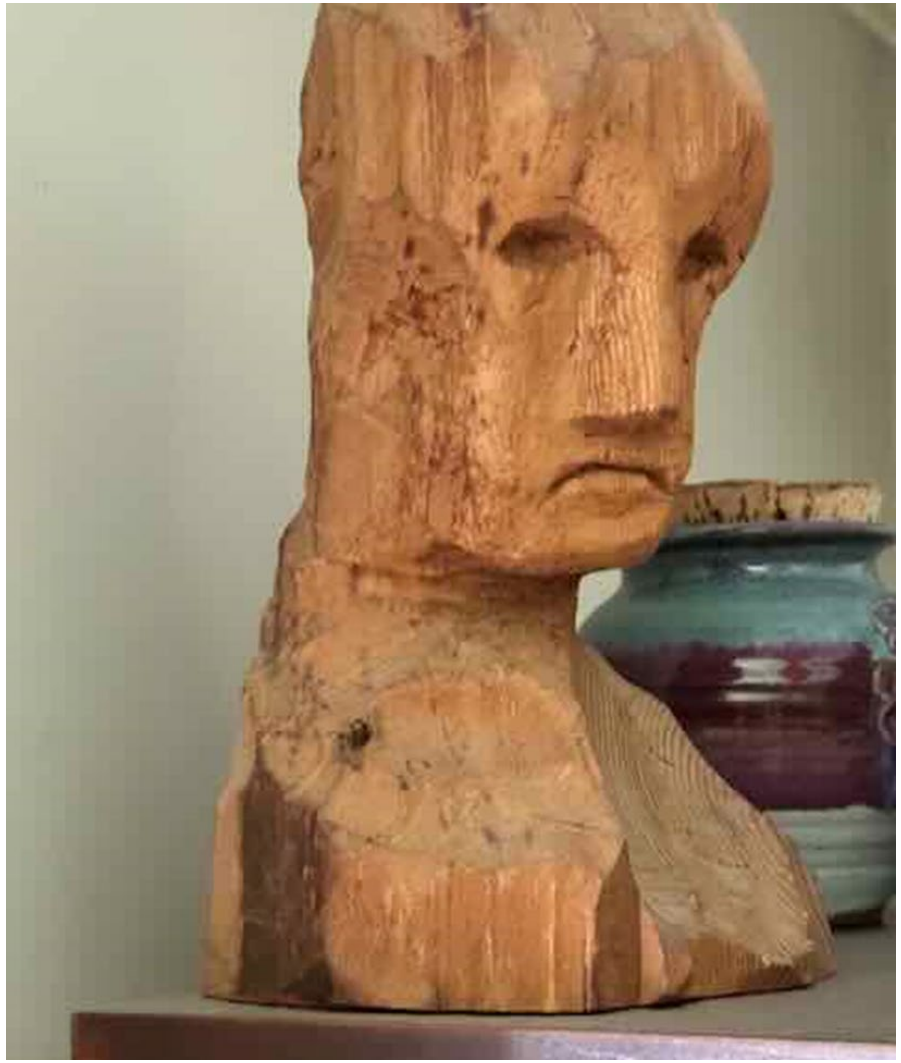

Image source: Allan Frankel. Image used with permission.

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Image source: Allan Frankel. Image used with permission.

- Observation skills
- Proportions
- Placement
- Knowing what is Essential
- Knowing what is Unnecessary
- Technical skills
- Understanding Expression

Image source: Allan Frankel. Image used with permission.

Reflect on different Units in your organization.
Is there one that is fabulous?
Is there another that is dysfunctional?

Turn to your neighbor and explain why you know this? (Are you confident in your assessment?)

Could applying some of Fabulous' characteristics to Dysfunctional make it better?

Why has your organization not done so already?

High Reliability is a cultural phenomenon: What people say……

"I earn a reasonable wage."

"I feel good about myself because of what I did today."

"My ideas count. I can speak up and my voice is heard."

"If something goes wrong and I'm involved I know I'll be treated fairly."

"I'm accountable for what I do but not for flaws in the system."

"My values and the values of the people who run this place are aligned."

"The people around me care about me."

"I know my role in achieving organizational priorities."

"I am empowered and competent to lead improvements."

Safety Culture and High Reliability are cultural phenomena: THE UNDERPINNINGS OF HEALTHY CULTURE

HUMAN RESOURCES

“I earn a reasonable wage.”

MISSION AND ENGAGEMENT

“I feel good about myself because of what I did today.”

INDIVIDUAL EMPOWERMENT EXECUTION OF ACTIONS

“My ideas count. I can speak up and my voice is heard.”

JUST CULTURE

“If something goes wrong and I’m involved I know I’ll be treated fairly.”

HUMAN FACTORS

“I’m accountable for what I do but not for flaws in the system.”

VALUE ALIGNMENT

“My values and the values of the people who run this place are aligned.”

COMMUNITY

“The people around me care about me.”

FUNCTIONAL LEADERSHIP EFFECTIVE GOAL SETTING

"I know my role in and help achieving organizational priorities."

AN EMPLOYED AND FUNCTIONAL IMPROVEMENT METHDOLOGY

"I am empowered and competent to lead or achieve improvements."

Framework for High Reliability Healthcare

Management Systems

Infrastructure (systems and processes) to support strategy/PI plan deployment; everyone has a role.

Leadership

Every leader models a healthy culture and holds everyone accountable; demonstrating the required high reliability behaviors and activities every day and in every interaction.

Learning

A continuous learning mindset with competencies in improvement science. Deep dive to learn why……

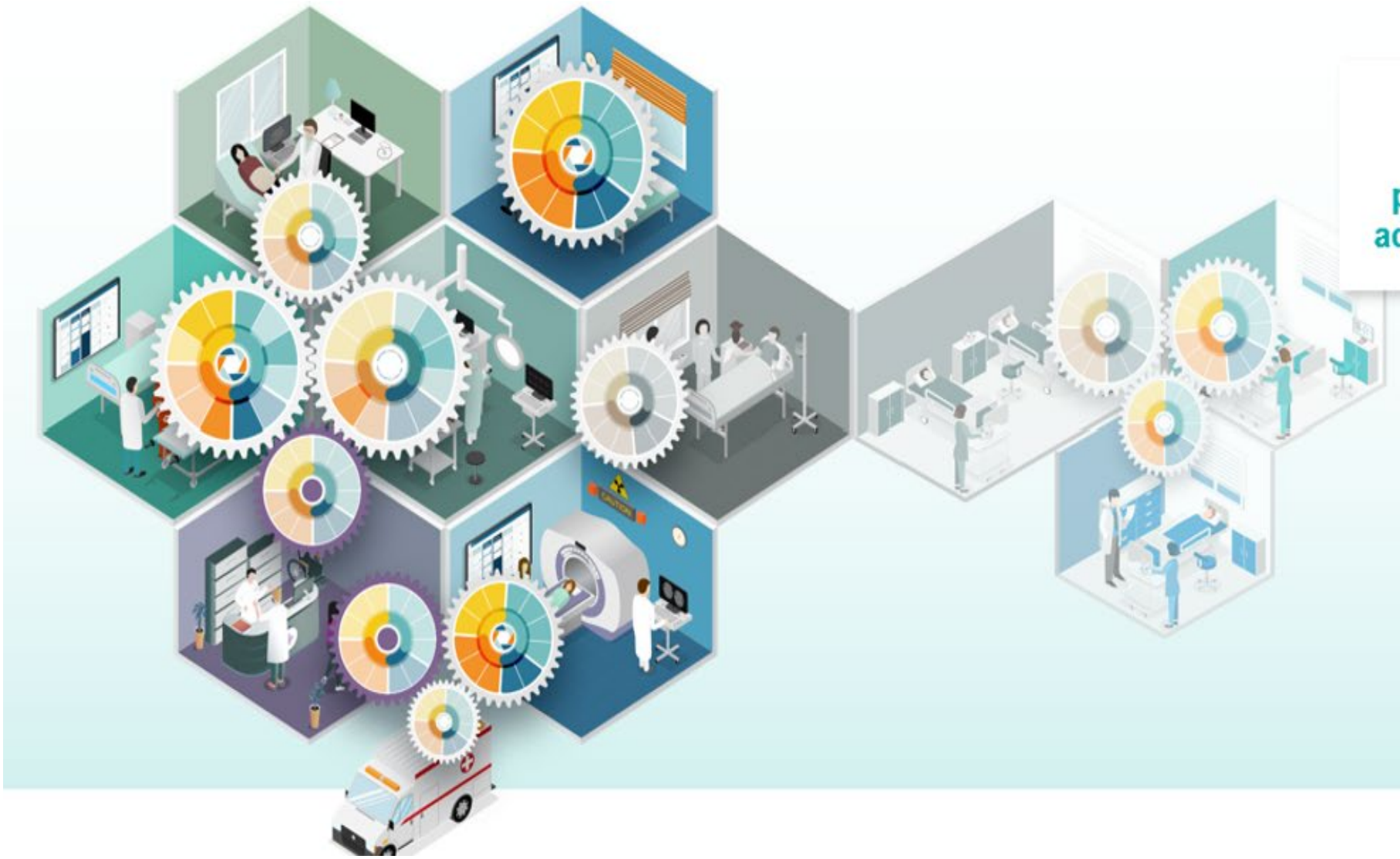
Culture

"I am responsible for creating a positive culture around me and collaborating to achieve shared goals."

Knowledge

Transparent, actionable, and visible clinical, operational, and cultural data to prioritize opportunities and track performance towards goals. Deep dive to learn what…..

Source: Safe and Reliable Healthcare. Image used with permission.



Culture is local – units vary in how prepared they are to achieve high reliability

Source: Safe and Reliable Healthcare. Image used with permission.

Source: Safe and Reliable Healthcare. Image used with permission.

A Culture of Safety is Everyone’s Responsibility

Lessons Learned

- We know with reasonable clarity the components that make up high reliability.
- Understanding and seeing these components is a skill that must be learned and practiced.
- Being an effective change agent requires a clear-eyed assessment of the initial substrate – this requires an understanding of the key departments and individuals who can influence the change process.
- Technical expertise in the change process is more often achieved through failure than success. Try to make the failures small ones because the big failures are painful.
- Be humble because this is a lifetime of daunting work.
- Every expert in this field, when they get to the end of their careers, highlights that the only means to success includes love of the work, and love of the individuals you work with. If your mindset does not include this tenet, your efforts will be transient, mediocre or fail.

Key Takeaways

- Culture is everyone’s responsibility.
- Safety culture and high reliability are cultural phenomena.
- Local culture has a significant impact on ability to achieve high reliability.

Questions?

Contact:

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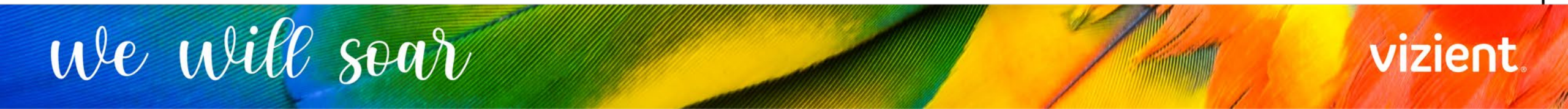


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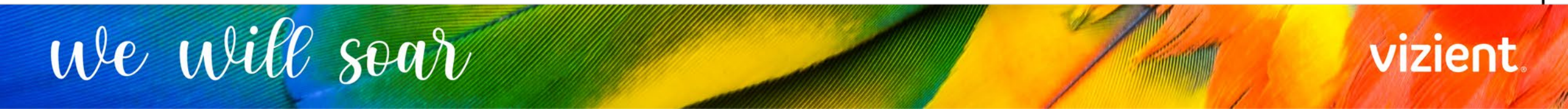
UCSF

University of California
San Francisco

Missed Opportunities in Diagnosis: Mitigating Error With Diagnostic Performance Feedback

Benjamin Rosner, MD, PhD, FAMIA
Associate Professor of Medicine
Division of Clinical Informatics and Digital Transformation
Division of Hospital Medicine



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Missed Opportunities in Diagnosis: Mitigating Error With Diagnostic Performance Feedback

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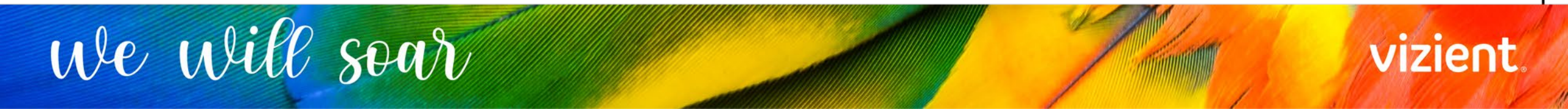


Diagnostic Error

Diagnostic Error

The failure to establish or communicate accurate and timely assessment of a patient's health problem.

Affects 12 million Americans annually, leading to over 700,000 permanent disabilities and 40,000-80,000 deaths in the U.S. annually.[1,2]

1. Newman-Toker DE, Nassery N, Schaffer AC, *et al* Burden of serious harms from diagnostic error in the USA, *BMJ Quality & Safety* Published Online First: 17 July 2023.

2. National Quality Forum: Reducing Diagnostic Error: Measurement Considerations - Final Report. 2020. https://www.qualityforum.org/. (Accessed March 6, 2022).

Diagnostic Error

Many causes

Highly multi-factorial

Major Error Category	Description	Frequency
No fault		7%
	Masked or unusual presentation of disease Patient-related (e.g. lack of cooperation, or deception)	
System related		65%*
	Problems with policies and procedures, inefficient processes	
	Problems with teamwork and communication	
	Equipment failures	
Cognitive		74%*
Faulty synthesis: Faulty information processing	Faulty context generation: Lack of consideration of aspects of patient's situation	
	Mis-estimating usefulness of a finding: Clinician is aware of symptom but mis-estimates its value	
	Faulty detection: Failure to observe a noticeable symptom, sign, or finding	
Faulty synthesis: Faulty verification	Premature closure: Failure to consider other possibilities once an initial diagnosis is reached	
	Failure to order or follow up on appropriate test: Does not use or take appropriate next steps after a test	
Faulty data gathering	Incomplete history, physical exam, and workup	
Faulty knowledge	Insufficient knowledge or diagnostic skills	

From Graber *Arch Intern Med.* 2005; 165 (13):1493-1499

* Overlap

Illustration 1

Inpatient delay in stroke team activation

MD was notified that patient was having new right sided deficits in the AM. MD texted and said this is sleep paralysis and will observe the patient when she is awake. Team assessed patient about 4 hours later. Patient still flaccid in the left arm and having aphasia. Consulted neuro 4.5 hours later, who came to assess patient and immediately called a stroke alert.

Resources that can help:

Safer Dx Stroke

- Safer Dx Stroke – a framework – is a modified version of the structured medical record review tool Safer Dx, used to specifically identify false negative strokes and sources of diagnostic error.

*Facts contained in illustration 1 have been altered from the original case

Types of Bias and Heuristics that can Lead to Diagnostic Error

Aggregate	Gender	Psych-out
Anchoring	Hindsight	Representativeness restraint
Ascertainment	Multiple alternative	Search satisficing
Availability and non-availability	Omission	Sutton's slip
Base-rate neglect	Order effects	Triage cueing
Commission	Outcome	Unpacking principle
Confirmation	Overconfidence	Vertical line failure
Diagnosis momentum	Playing the odds	Ying-yang out
Fundamental attribution error	Posterior probability	Zebra retreat
Gambler's fallacy	Premature closure	

From Croskerry, ACAD EMERG MED, November 2002, Vol. 9, No. 11, 1184-1204

Diagnostic Performance Improvement

Improving Diagnosis in Healthcare

Editors: Erin P. Balogh, Bryan T. Miller, and John R. Ball. Authors: Committee on Diagnostic Error in Health Care; Board on Health Care Services; Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine. Washington (DC): National Academies Press (US); 2015 Dec 29.

Diagnostic Performance Improvement

Goal 1: Facilitate more effective teamwork in the diagnostic process among health care professionals, patients, and their families

Goal 2: Enhance health care professional education and training in the diagnostic process

Goal 3: Ensure that health information technologies support patients and health care professionals in the diagnostic process

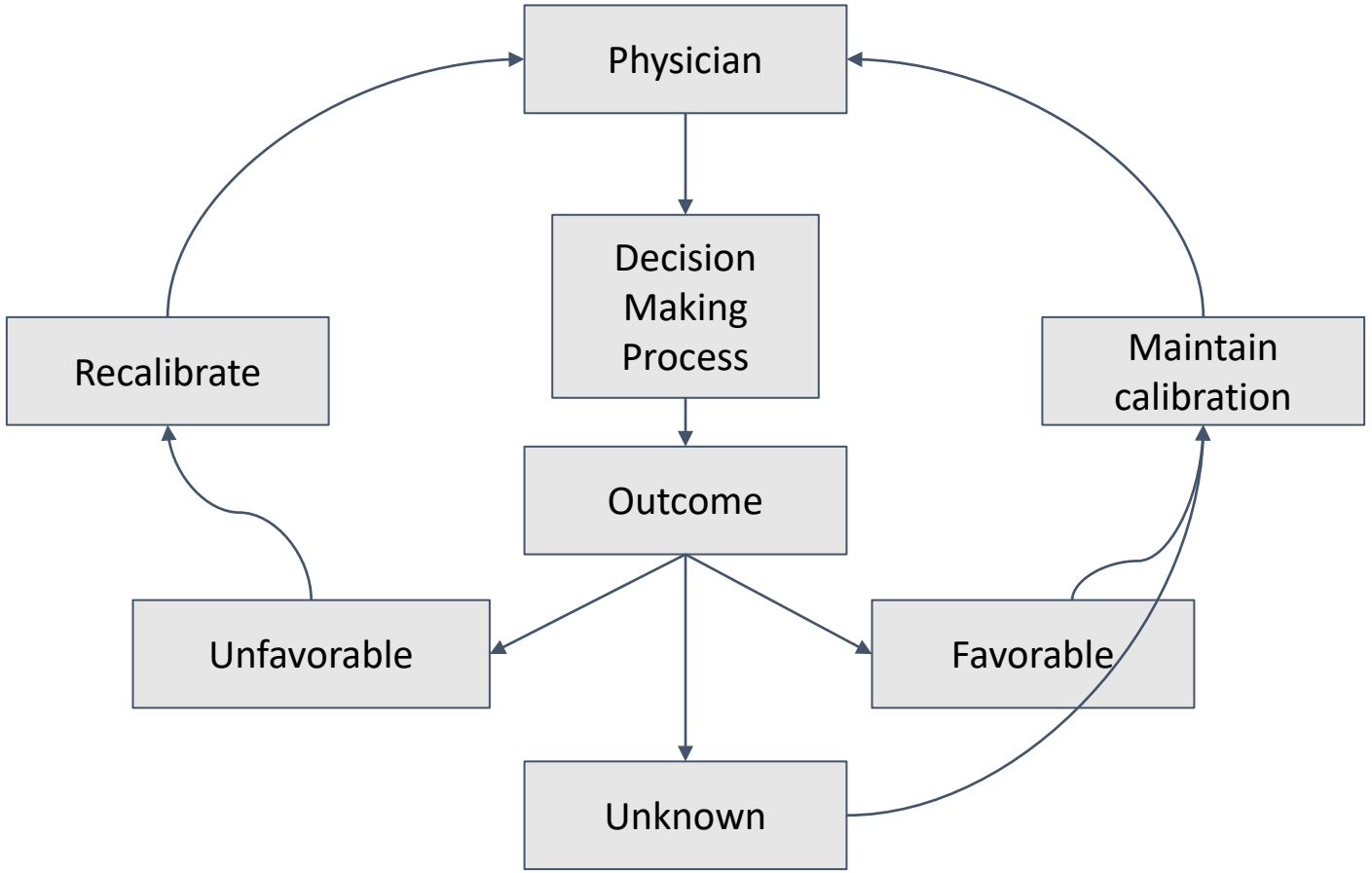
Goal 4: Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice

Goal 5: Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance

Goal 6: Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses

Goal 7: Design a payment and care delivery environment that supports the diagnostic process

Diagnostic Performance Improvement - Feedback



Adapted from: Croskerry, Acad Emerg Med, Nov 2000, Vol 7, No 11, 1232-8

Diagnostic Performance Improvement - Feedback

Feedback can help clinicians improve their diagnostic abilities as well as their **calibration**, which is the alignment between a clinician's confidence in the accuracy of his/her diagnostic decision-making with his/her own actual accuracy.[3,4]

3. Meyer AND, Payne VL, Meeks DW, Rao R, Singh H. Physicians' diagnostic accuracy, confidence, and resource requests: a vignette study. JAMA Intern Med. 2013 Nov 25;173(21):1952–8
4. Nederhand ML, Tabbers HK, Splinter TAW, Rikers RMJP. The effect of performance standards and medical experience on diagnostic calibration accuracy. Health Professions Education, 4(4), 2018 Dec; 300-307.

Diagnostic Performance Improvement - Recalibration

Why is recalibration so difficult?

Diagnostic Performance Improvement - Feedback

Feedback can help clinicians improve their diagnostic abilities as well as their calibration, which is the alignment between a clinician's confidence in the accuracy of his/her diagnostic decision-making with his/her own actual **accuracy**.[3,4]

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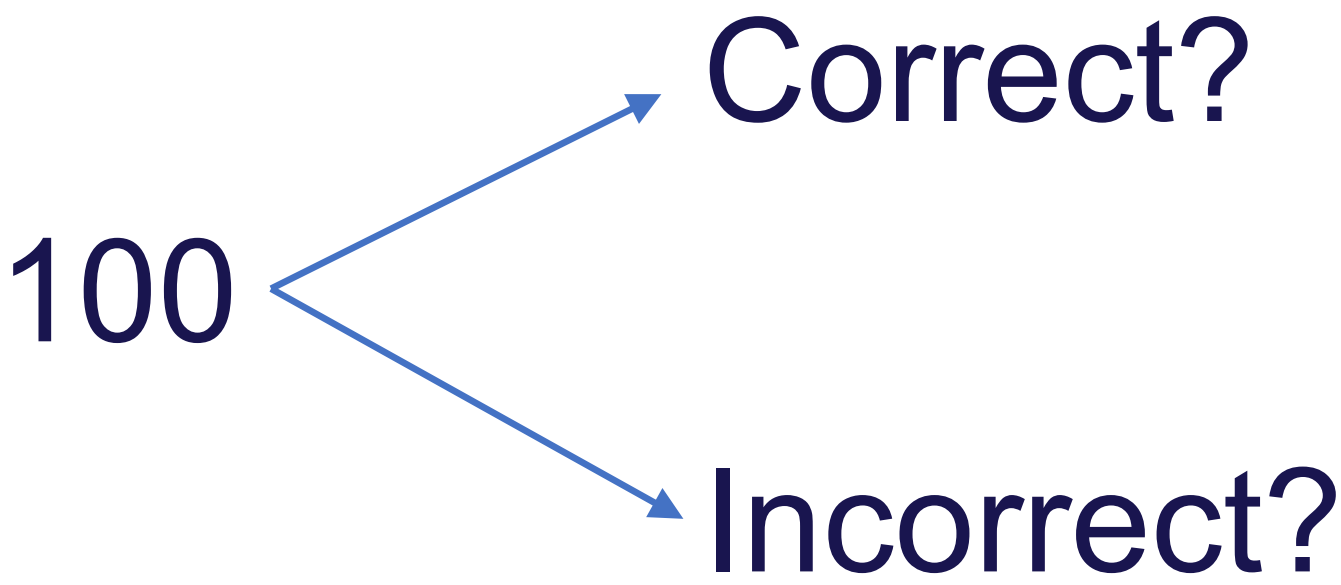
Diagnostic Performance Improvement - Feedback



Diagnostic Performance Improvement - Feedback

If you can’t measure it, you can’t improve it. – Lord Kelvin (1824–1907)

Diagnostic Performance Improvement - Feedback

Feedback is the de facto means to improve performance in many fields of human performance.[5]

5. Fernandez Branson C, Williams M, Chan TM, Graber ML, Lane KP, Grieser S, et al. Improving diagnostic performance through feedback: the Diagnosis Learning Cycle. BMJ Qual Saf. 2021 Dec;30(12):1002–9.

Feedback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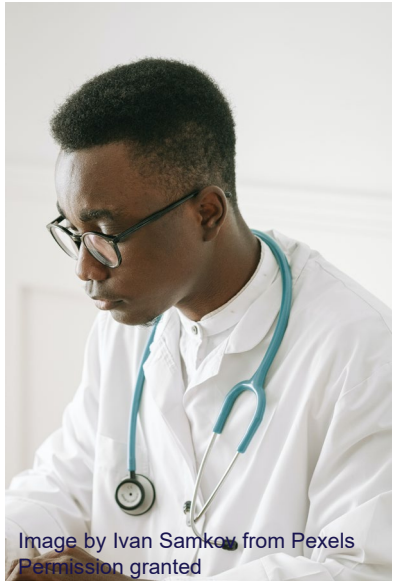
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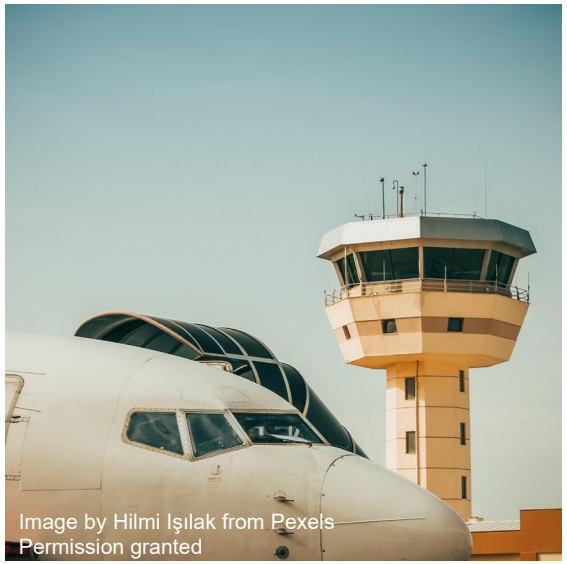
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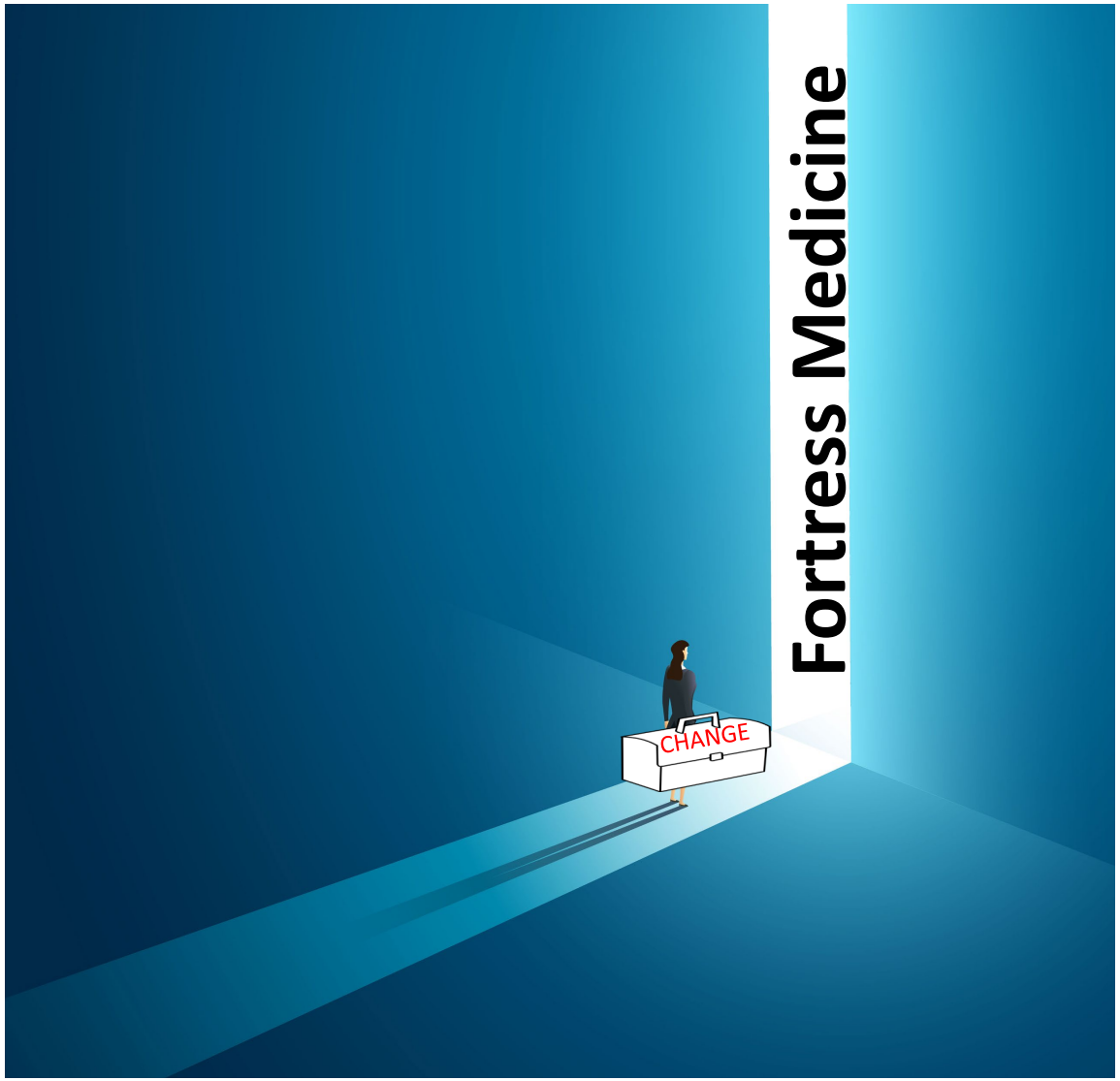
Fortress Medicine



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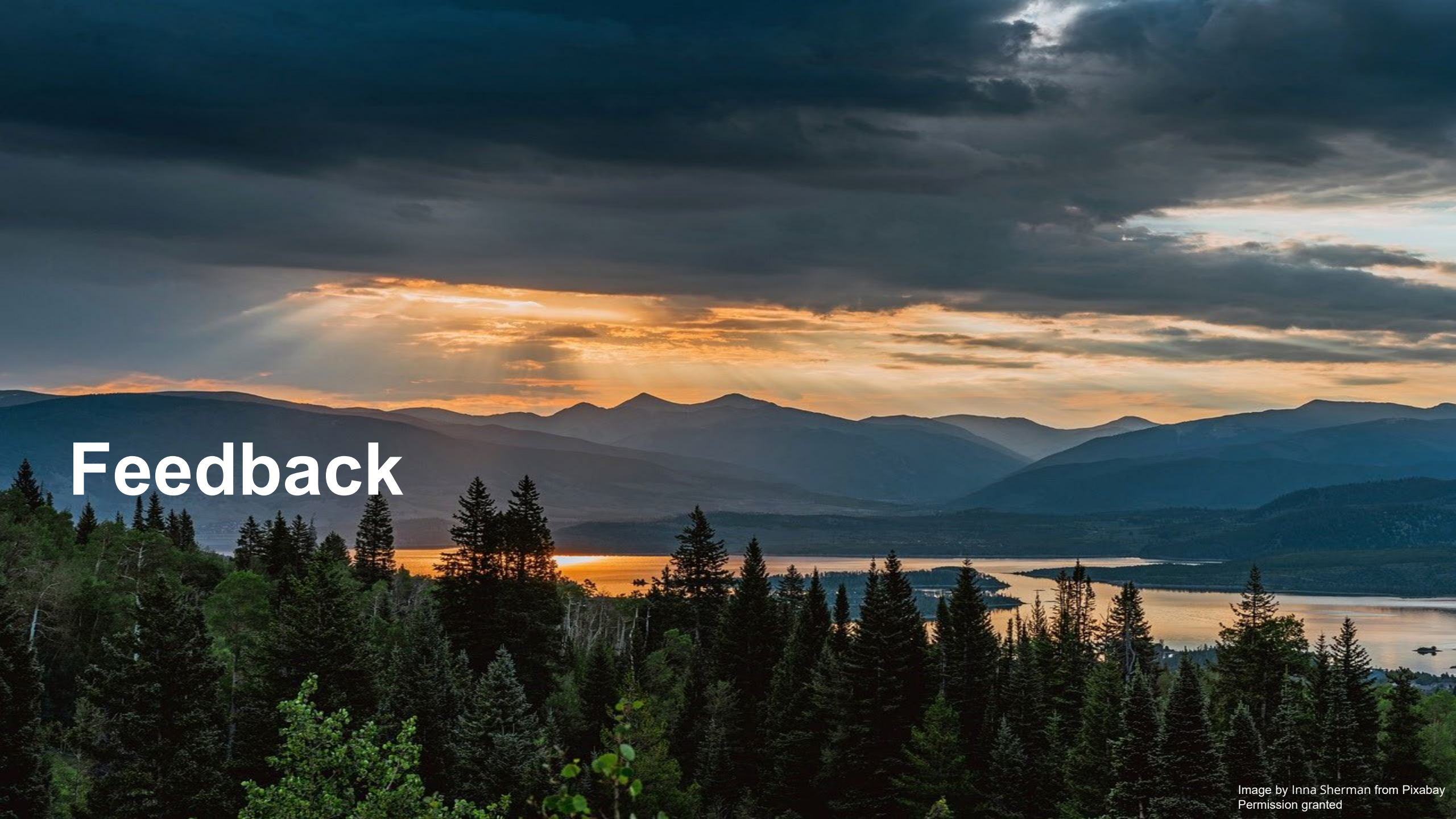
Feedback



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Creating a Public Diagnostic Performance Feedback Library

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Why Build a Library?

Internet Search Engine

Diagnostic performance feedback tools

Why Build a Library?

Scholarly articles for diagnostic performance feedback tools

The diagnostic performance feedback "collaboration gap"…Omron – Cited by 17

…feedback on their diagnostic performance in a learning…Meyer – Cited by 10

Improving diagnostic performance through feedback…Branson – Cited by 6

https://www.abc.com> human-resources>research

Employee Experience Survey: Diagnostic Tools and Resources

Use XXX employee diagnostic suite and benefit from employee experience surveys to monitor and improve Engagement of new to role employees

https://performanceXXX.com > diagnostic tools

Diagnostic Tools – Performance XXX

Diagnostic Tools – Executive Decision Making Style Assessment (EDMSA) – Leadership Effectiveness Assessment – Tuned 360 Multi-Rater Feedback – Culture Evaluation

https://qualitysafety.bmj.com>content

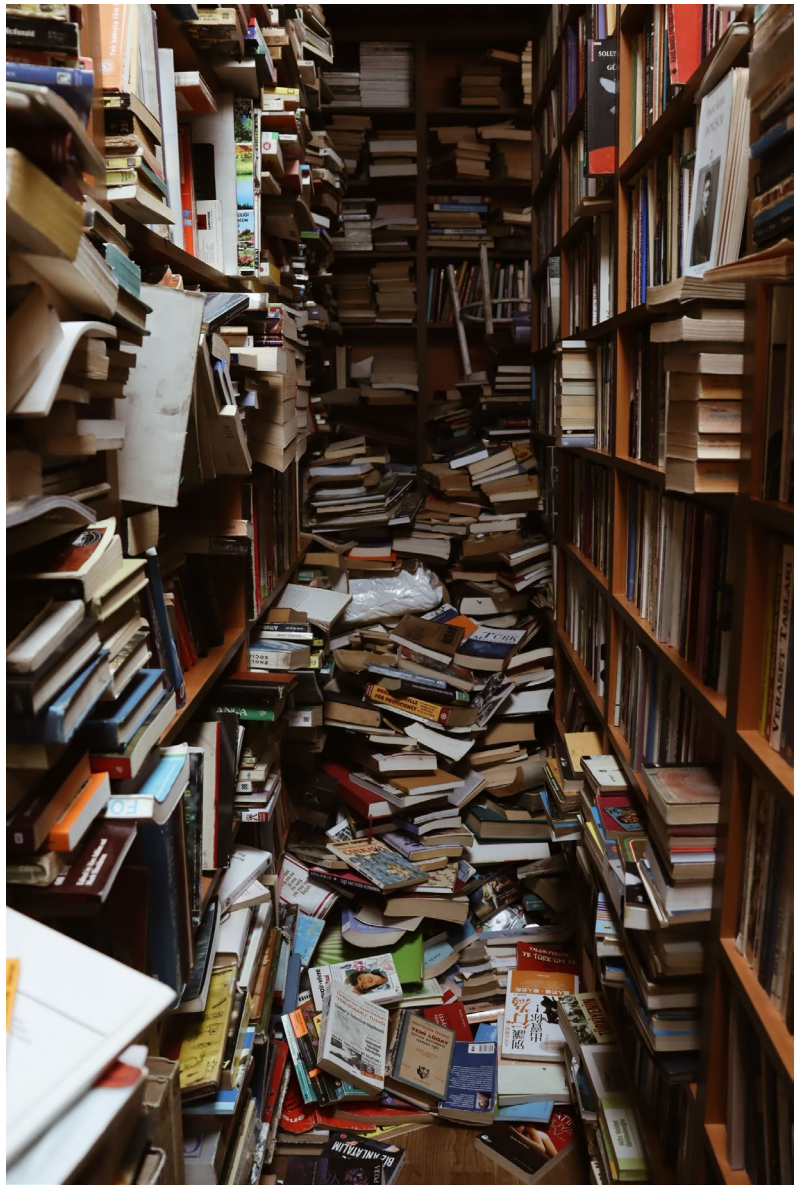
Improving diagnostic performance through feedback

By CF Branson – 2021 – Cited by 6 – This model outlines a clear process for diagnostic learning, identifies the data that need to be captured and offered to providers as feedback, an…

https:unidentifiedpeoplemanagementfirm.com>tools>performan…

Jan 4, 2022 – Find the best performance management tools to track KPIs, hold performance appraisals…

This is Why



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Permission granted

Building a Library

Develop an online, publicly available, free-to-use diagnostic performance feedback resource library for the public good

- Single, unbiased, continuously evolving location to find implementable resources for diagnostic performance feedback
- User experiences posted from others with similar job titles de-risks implementation decisions

Collaborators in Building the Public Diagnostic Performance Feedback Library

Johns Hopkins Kelly Gleason, Allen Kachalia	AHRQ Margie Shofer
University of Michigan Zach Landis-Lewis	Premier Blair Childs and Mike Grow
Department of Veterans Affairs, Baylor College of Medicine Ashley Meyer	Vizient, Inc. Ellen Flynn
University of Minnesota Andrew Olson	Mayo Clinic Platform John Halamka
University of California, San Francisco Gurpreet Dhaliwal, Julia Adler-Milstein, Glenn Rosenbluth, Andrew Auerbach, Ben Rosner	HCA Healthcare Chris Ott
University of California, San Diego Rob El-Kareh	CRICO Dana Siegel
Kaiser Permanente Michael Kanter	The Doctors Company Leslie Castaneda
Gordon and Betty Moore Foundation Daniel Yang	Intermountain Healthcare Mike Woodruff

Illustration 2

Hip x-ray was obtained to evaluate for hip pain. Was read as negative. Radiologist missed a lytic bone lesion. Led to nearly 2-month delay in new diagnosis of likely metastatic cancer.

Resources that can help:

RADPEER

RADPEER is a tool that allows peer review to be performed during routine image interpretation. Discordant interpretations will be marked. After submission of practice data, the group chair or medical director can access the reports online at any time which include summary statistics and comparisons by modality for every participating physician, group summary data by modality, and data summed across all RADPEER participants.

*Facts contained in illustration 2 have been altered from the original case

Source: Gooddx.org

Curating the Collection

Any tool, framework, program, or technology, that has been or can readily be automated or semi-automated, and that leads to an endpoint of measuring and providing individual and/or aggregate diagnostic performance feedback to the clinician, healthcare team, and/or system. This excludes interventions that reduce diagnostic errors without providing feedback for the purpose of clinician recalibration.

Imagine

Imagine a world of diagnostic excellence fueled by continuous diagnostic feedback.

GoodDx.org

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Requisite Resource Capabilities

	ID the diagnostic encounter ⓘ	ID the diagnostician ⓘ	ID unclosed loops on diagnostic testing ⓘ	ID diagnoses and potential missed opportunities for diagnosis (MODs) ⓘ	Built in mechanism to adjudicate (or support adjudication) of missed opportunities for diagnosis (MODs) ⓘ	Calculate diagnostic performance ⓘ	Render performance (metrics or visualization) ⓘ	Built in mechanism to share performance or results with reviewer or diagnostician ⓘ
RapRad, Radiology Dx for Pneumothorax ⓘ	✓	✓	−	✓	✓	✓	✓	✓
Coverys (Diagnosis Related Claims Analysis) ⓘ	✓	✓	✓	✓	✓	✓	−	✓
Symptom-Disease Pair Analysis of Diagnostic Error (SPADE) ⓘ	✓	✓	−	✓	✓	✓	✓	−
Candello Explore by CRICO ⓘ	✓	✓	−	✓	✓	−	−	✓
Case Share App - Bay State Medical Center ⓘ	✓	✓	−	✓	✓	−	−	✓

Source: Gooddx.org image used with permission

Requisite Resource Capabilities Illustrated by Use Case

ID the diagnostic encounter ⓘ	ID the diagnostician ⓘ	ID unclosed loops on diagnostic testing ⓘ	ID diagnoses and potential missed opportunities for diagnosis (MODs) ⓘ	Built in mechanism to adjudicate (or support adjudication) of missed opportunities for diagnosis (MODs) ⓘ	Calculate diagnostic performance ⓘ	Render performance (metrics or visualization) ⓘ	Built in mechanism to share performance or results with reviewer or diagnostician ⓘ

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Use Cases

Three diagnostic use cases
to illustrate resources in the GoodDx.org library

Use Case 1 – Inpatient Feedback

A 67 year old female with Graves' disease, non small cell lung cancer currently undergoing neoadjuvant chemotherapy with cisplatin and etoposide, presents to the hospital with a fever of 100.8F.

Vitals:
T 100.8F
P 120
BP 110/70
R 24
Pulse Ox 92% on room air

Exam is notable for mild exophthalmos, thyromegaly, tachycardia, and tachypnea.

Labs are notable for an elevated lactate of 2.2, white cell count of 14k, and a chest Xray with subtle patchy infiltrates at the bases.

Treatment

- The patient is treated empirically for sepsis pneumonia and put on IV fluids and antibiotics. A TSH to rule out hyperthyroidism is ordered and pending, and patient is admitted by **Physician A** to an acute care bed.

Use Case 1

Course

One day later, under the care of **Physician B**, she goes into respiratory failure, and is emergently transferred to the ICU and placed on a mechanical ventilator. It is found that the patient has a pulmonary embolus (PE).

Missed Opportunity

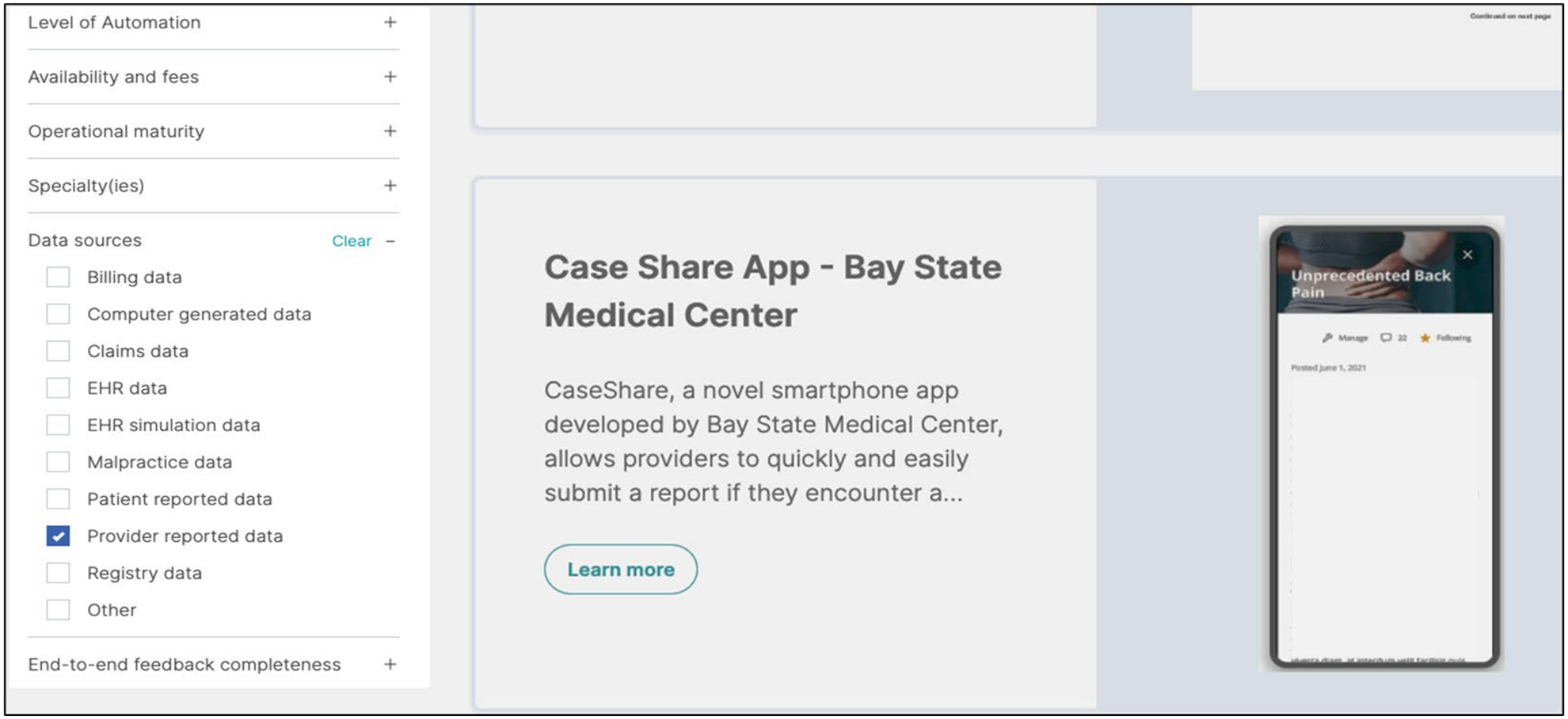
Clues for the diagnosis of PE are tachycardia and tachypnea in a patient with hypercoagulable risk factors (active cancer). While sepsis and hyperthyroidism are both potential causes of tachycardia too, the missed opportunity in diagnosis was not anchoring on those causes alone, and having a broader differential.

Although Physician A knows that Physician B had missed the opportunity for diagnosis, this missed opportunity for recalibration passes without any learning. Why?

- No mechanism to report anonymously
- A culture that makes reporting feel punitive

If you were the patient safety officer, what tools could you find to overcome those barriers?

Use Case 1 – Anonymous Reporting Tool



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Use Case 1 – Approach to Adjusting the Culture

Safer Dx Learning Lab Feedback Resource

Safer Dx Learning Lab Feedback Resource is a guide for facilitators to conduct effective diagnostic feedback sessions to clinicians about missed opportunities in diagnosis (MODs) as learning opportunities. This resource was developed at Geisinger, a large integrated health care system in rural Pennsylvania.

Appendix 1. Feedback Toolkit

Geisinger Committee to Improve Clinical Diagnosis
General Recommendations for Feedback/Debrief
References used to develop this guide are below.[1–11]

Feedback is an essential part of learning in the clinical setting, whether it be at the level of student, resident, or attending. The following are a few suggestions for leading a debriefing in the clinical setting, as we address opportunities to enhance the diagnostic process:

Source: Gooddx.org image used with permission

Use Case 1

	ID the diagnostic encounter ⓘ	ID the diagnostician ⓘ	ID unclosed loops on diagnostic testing ⓘ	ID diagnoses and potential missed opportunities for diagnosis (MODs) ⓘ	Built in mechanism to adjudicate (or support adjudication) of missed opportunities for diagnosis (MODs) ⓘ	Calculate diagnostic performance ⓘ	Render performance (metrics or visualization) ⓘ	Built in mechanism to share performance or results with reviewer or diagnostician ⓘ
Case Share App - Bay State Medical Center ⓘ	✓	✓	−	✓	✓	−	−	✓

Source: Gooddx.org image used with permission

Use Case 2 – Primary Care Feedback

A 27 year old male with no prior medical history presents to Primary Care Clinic with a chief complaint of generalized abdominal pain, reflux, and early satiety. He endorses drinking a 4 cups of coffee daily, and often has a large last meal of the day 20 minutes before going to bed.

Vitals
T 98.6F
P 87
BP 110/60
R 12
Sp02 97% on room air

Exam
Largely unremarkable. No abdominal tenderness, no rebound, no bruits.

Assessment and Plan:
PCP suspect gastroesophageal reflux disease and suggests that patient Reduce caffeine, avoid food for a hour before bedtime, and pick up and use an over the counter H2 blocker.

Use Case 2

Course

3 days later, the patient presents to the emergency department where he is found to have low hemoglobin suspicion for gastrointestinal bleeding, and a duodenal mass that is visualized on endoscopy.

Missed Opportunity

Is there a way to use an emergency room encounter or a hospitalization as an automated trigger for a possible missed opportunity in diagnosis?

Use Case 2

Electronic Health Record-Based Surveillance of Diagnostic Errors in Primary Care

This e-trigger resource identifies possible diagnostic errors in the primary care setting by identifying cases with an index primary care visit followed by an unplanned hospitalization or a return primary care, urgent care or emergency department visit within 14 days. Triggered cases are then manually reviewed for diagnostic error defined as a missed opportunity to make or pursue the correct diagnosis when adequate data was available at the index visit. e-Trigger Criteria: Trigger 1: A primary care visit followed by an unplanned hospitalization that occurred between 24 hours and 14 days after the visit. Trigger 2: A primary care visit followed by 1 or more unscheduled primary care visits, an urgent care visit, or an ER visit that occurred within 14 days (excluding Trigger 1- positive index visits). e-Trigger Performance: The positive predictive value (PPV) for Trigger 1 is 20.9% and the PPV for Trigger 2 is 5.4%.

Source: Gooddx.org image used with permission

Use Case 2

	ID the diagnostic encounter ⓘ	ID the diagnostician ⓘ	ID unclosed loops on diagnostic testing ⓘ	ID diagnoses and potential missed opportunities for diagnosis (MODs) ⓘ	Built in mechanism to adjudicate (or support adjudication) of missed opportunities for diagnosis (MODs) ⓘ	Calculate diagnostic performance ⓘ	Render performance (metrics or visualization) ⓘ	Built in mechanism to share performance or results with reviewer or diagnostician ⓘ
Development and Validation of Electronic Health Record–based Triggers to Detect Delays in Follow-up of Abnormal Lung Imaging Findings ⓘ	✓	✓	✓	✓	−	✓	−	✓

Source: Gooddx.org image used with permission

Use Case 3 – Emergency Department Feedback

A 12 year old female with asthma presents in the middle of the night to the emergency department with wheezing, cough, and runny nose.

Vitals
T 99.8F
P 110
BP 100/60
R 22
Sp02 93% on room air

Exam
Lungs: Expiratory wheezes with end-inspiratory crackles at bases, no retractions, no nasal flaring
Heart; Tachycardic, no murmurs
Skin: Warm and dry

Labs: Notable for WBC 12k, normal procalcitonin
Chest Xray as interpreted by the ED physician notable for atelectasis

Assessment and Plan
The ED physician considers the patient most likely to have an asthma exacerbation and treats her in the emergency department with albuterol nebulization. Her wheezing resolves. Patient still has mild cough and a heart rate of 100, and is discharged home with instructions to follow up with PCP or return to the ED.

Use Case 3

Course
The patient improves and has no recurrence.

Missed Opportunity
How does the ED physician, who self-interpreted a borderline chest xray at night (because radiology report for plain films won't occur until the next morning), know whether there was an early pneumonia or not?

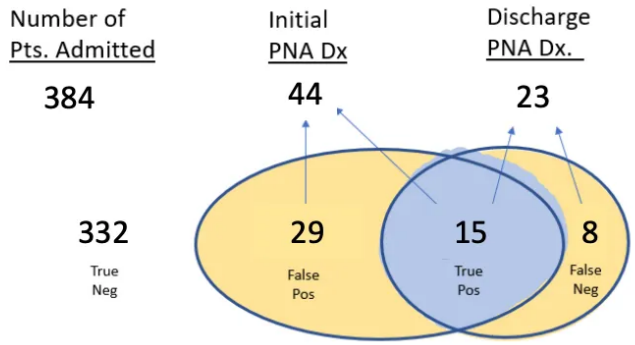
Should she make a note to check the radiology report sometime the next day? Call the patient to follow up and inquire how she's doing?

Use Case 3

PROVIDER DIAGNOSIS FEEDBACK TOOL: "DX-CONNECT"

Agreement in Initial & Discharge Pneumonia Diagnosis in Patients Admitted by S Doctor, MD

12 Months → December 31, 2021



Measure	12 Months	Oct-Dec 2021
PPV* ED Dx vs. CXR	66	67
Sensitivity* ED vs. CXR	32	29
PPV* ED vs. Discharge Dx	34	47
Sensitivity* ED vs. Discharge Dx	65	64

*Review Definitions

View Department Measures

PNA Case Details **Dx Discordance**

Pt ID	Admission Dx	CXR Results	Discharge Dx	Admit Date	Age	Sex	LOS	ED Treatment	Disposition
1	Encephalopathy Covid-19 Possible stroke	New infiltrate	Encephalopathy Covid PNA	12/05/2021	67	F	3	O2 Supplementation	Home Health Care
2	Ataxia PNA in MDM	No infiltrate	Sensory ataxia	12/05/2021	46	F	3	None	Home
3									

Source: Gooddx.org image used with permission

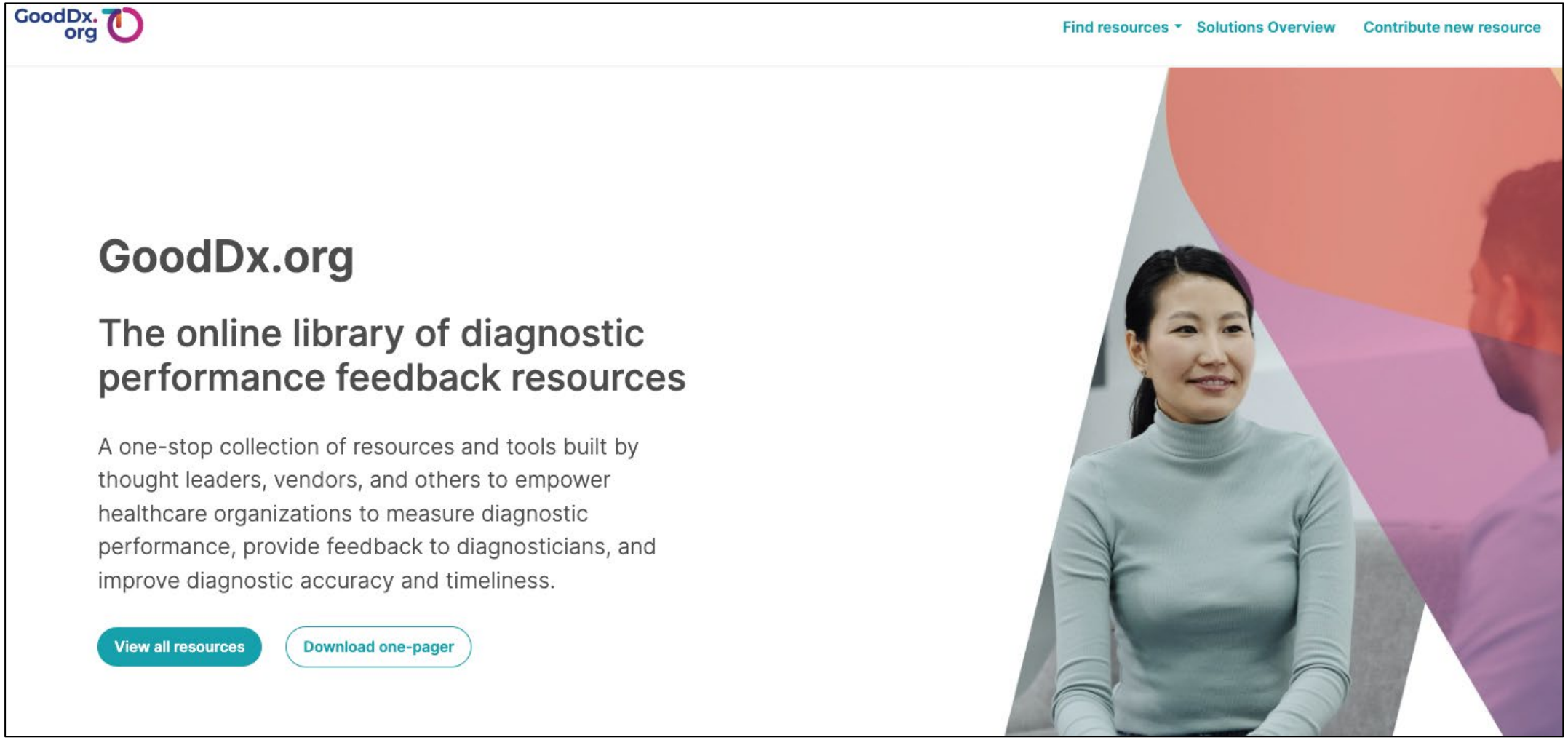
Fully automated reporting on diagnostic accuracy of pneumonia in the Emergency Department

Use Case 3

	ID the diagnostic encounter ⓘ	ID the diagnostician ⓘ	ID unclosed loops on diagnostic testing ⓘ	ID diagnoses and potential missed opportunities for diagnosis (MODs) ⓘ	Built in mechanism to adjudicate (or support adjudication) of missed opportunities for diagnosis (MODs) ⓘ	Calculate diagnostic performance ⓘ	Render performance (metrics or visualization) ⓘ	Built in mechanism to share performance or results with reviewer or diagnostician ⓘ
DxConnect - U of Utah ⓘ	✓	✓	−	✓	✓	✓	✓	✓

Source: Gooddx.org image used with permission

GoodDx.org – A free-to-use Public Resource for the Public Good



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Lessons Learned

- MODs are highly multi-factorial. System-related and cognitive failures tend to predominate as causes
- Recalibration is difficult to accomplish
  - We need measurement, feedback, and a supportive way to provide that to physicians
  - Physicians need protected time to review diagnostic performance feedback and use it to thoughtfully recalibrate
- An increasing number of tools and resources are becoming available to help provide diagnostic feedback to the physician

Key Takeaways

Source: Gooddx.org image used with permission

Acknowledgments

This work has been supported by a grant from the Gordon and Betty Moore Foundation

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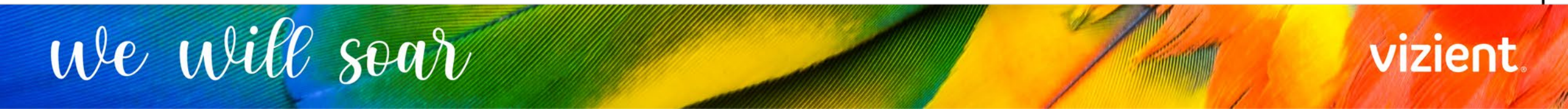


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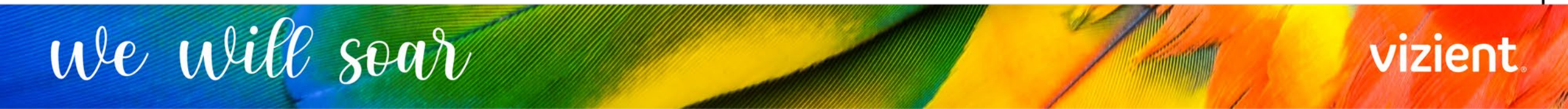
Using a High Reliability and Health Systems Management Approach to Improve Patient Outcomes



Panelists

Jenny Anderson, MAS, RN, CPHQ Patient Quality & Safety Officer Norman Regional Health System	**Sumita Markan-Aurora, MD** System Director for Patient Safety and Clinical Outcomes SSM Health
Allan Frankel, MD Executive Principal Vizient Safe and Reliable Healthcare	**Maxine Simon, MS, FACHE, CHC, CHCP** Chief Regulatory Officer NYU Langone Health

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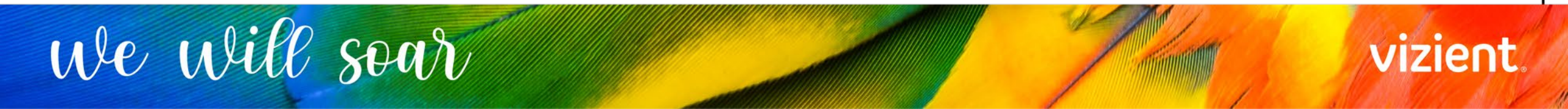
Using a High Reliability and Health Systems Management Approach to Improve Patient Outcomes



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Panel Discussion

Jenny Anderson, MAS, RN, CPHQ
Patient Quality & Safety Officer
Norman Regional Health System

Allan Frankel, MD
Executive Principal
Vizient Safe and Reliable Healthcare

Sumita Markan-Aurora, MD
System Director for Patient Safety and Clinical Outcomes
SSM Health

Maxine Simon, MS, FACHE, CHC, CHCP
Chief Regulatory Officer
NYU Langone Health

Lessons Learned

- High Reliability works to target our most common causes of serious safety events such as failures of communication, escalation and adherence to existing protocols.
- HRO helps us to improve Patient Experience (ideal patient experience for each patient, every time), Quality (right care, in the right way, at the right time) and Safety (eliminate preventable harm).
- Building a foundation of trust and understanding is important in improving system thinking.
- Organizations cannot achieve HRO without quality as a high priority.

Key Takeaways

- HRO's are high consequence industries (aviation, healthcare, nuclear power etc.,) who manage risk by significantly reducing the probability of loss events.
- Reliability is the “right mix” of performance shaping factors at the blunt end of the work system.
- Transforming an organization requires not only looking at what we do, but also examining and challenging the very assumptions and beliefs that underlie the way we do things.
- The successful HRO journey is a long term commitment to improving culture, knowledge and processes and can serve as a catalyst to excellence beyond safety.
- The strategic plan is shared throughout the organization so the ‘why’ is understood by all and is key to the alignment of goals within the system.

Questions?

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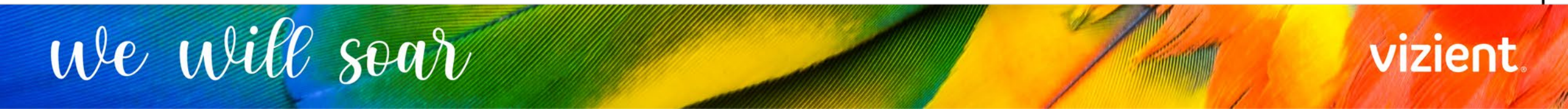
NYU Langone Health

Empowering Efficient Care Through Transparent Discharge Planning

Brian Bosworth, MD, Chief Medical Officer

Julia Gardner, MBA, RN, Director, Clinical Operations and Resourcing

NYU Langone Health



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Learning Objectives

- Discuss integrating real-time visibility into post-acute referrals, acceptances and insurance authorizations within the electronic medical record to enhance resource allocation and streamline patient care.
- Describe strategies to establish systems that transparently communicate pending actions for post-acute care to all care team members, reducing length of stay.
- Analyze a case study showcasing the successful implementation of activity-driven, post-acute care coordination status updates, resulting in improved efficiency and reduced length of stay.

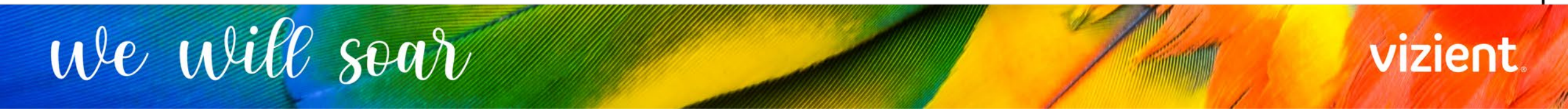
NYU Langone Health

Empowering Efficient Care Through Transparent Discharge Planning

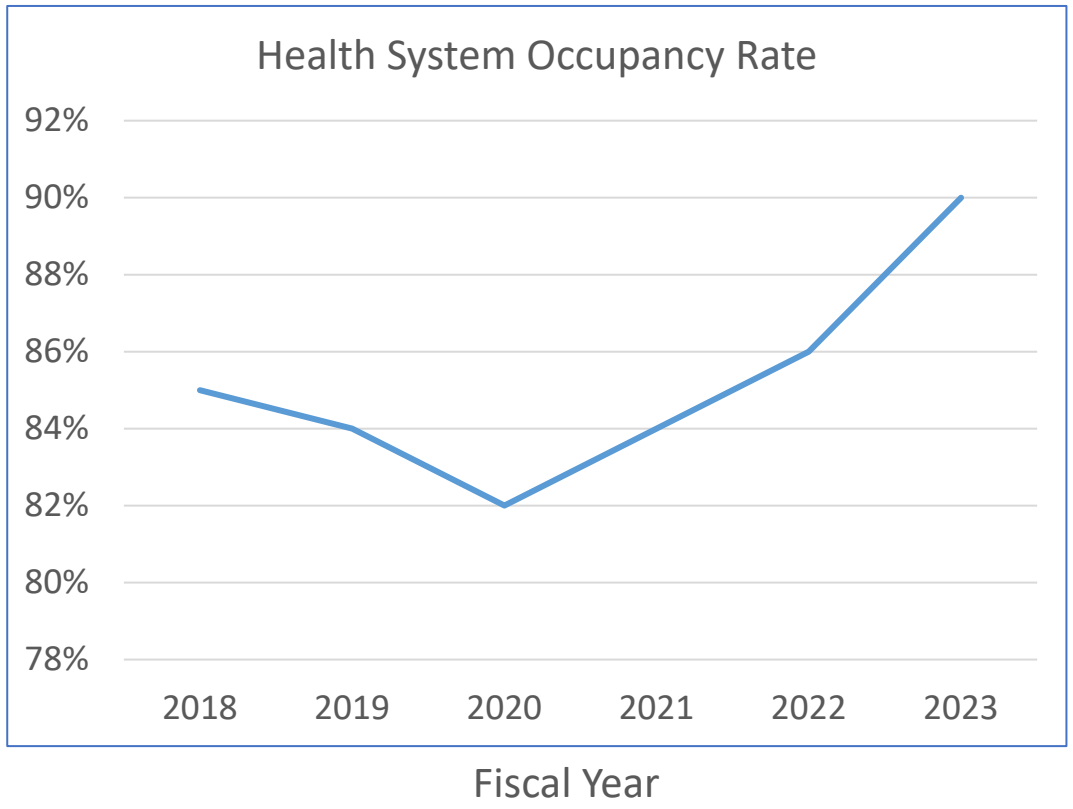
Brian Bosworth, MD, Chief Medical Officer

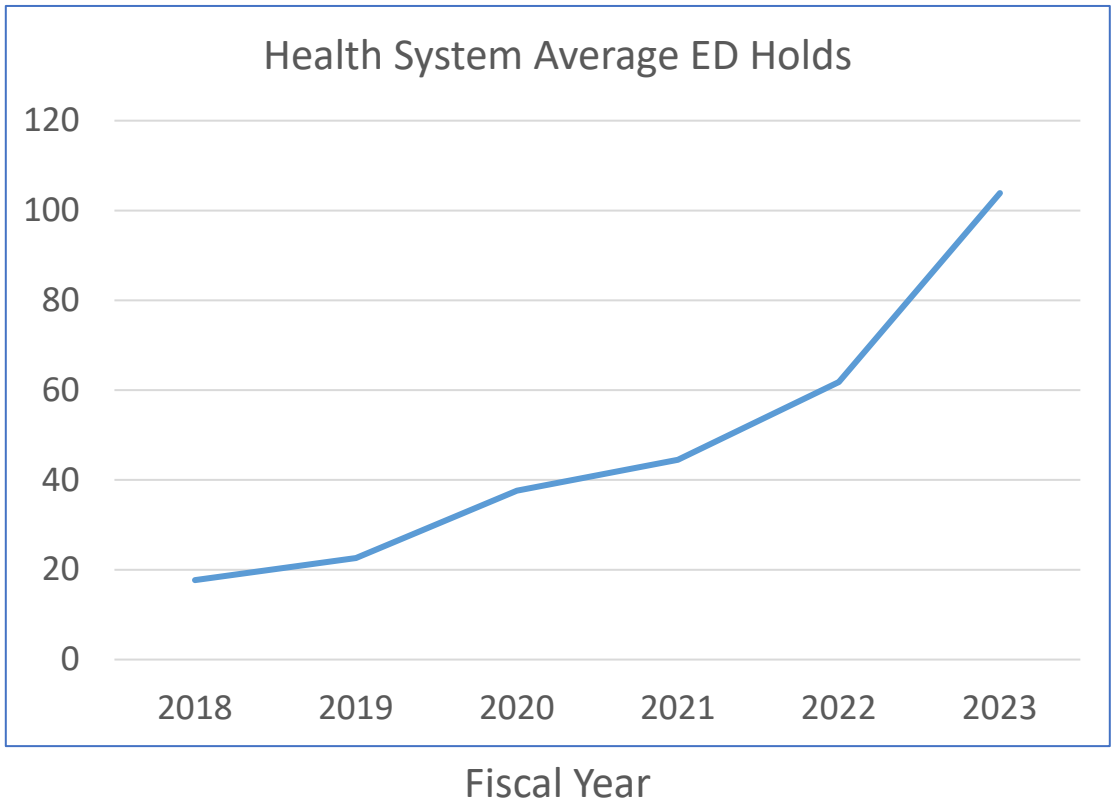
Julia Gardner, MBA, RN, Director, Clinical Operations and Resourcing

NYU Langone Health



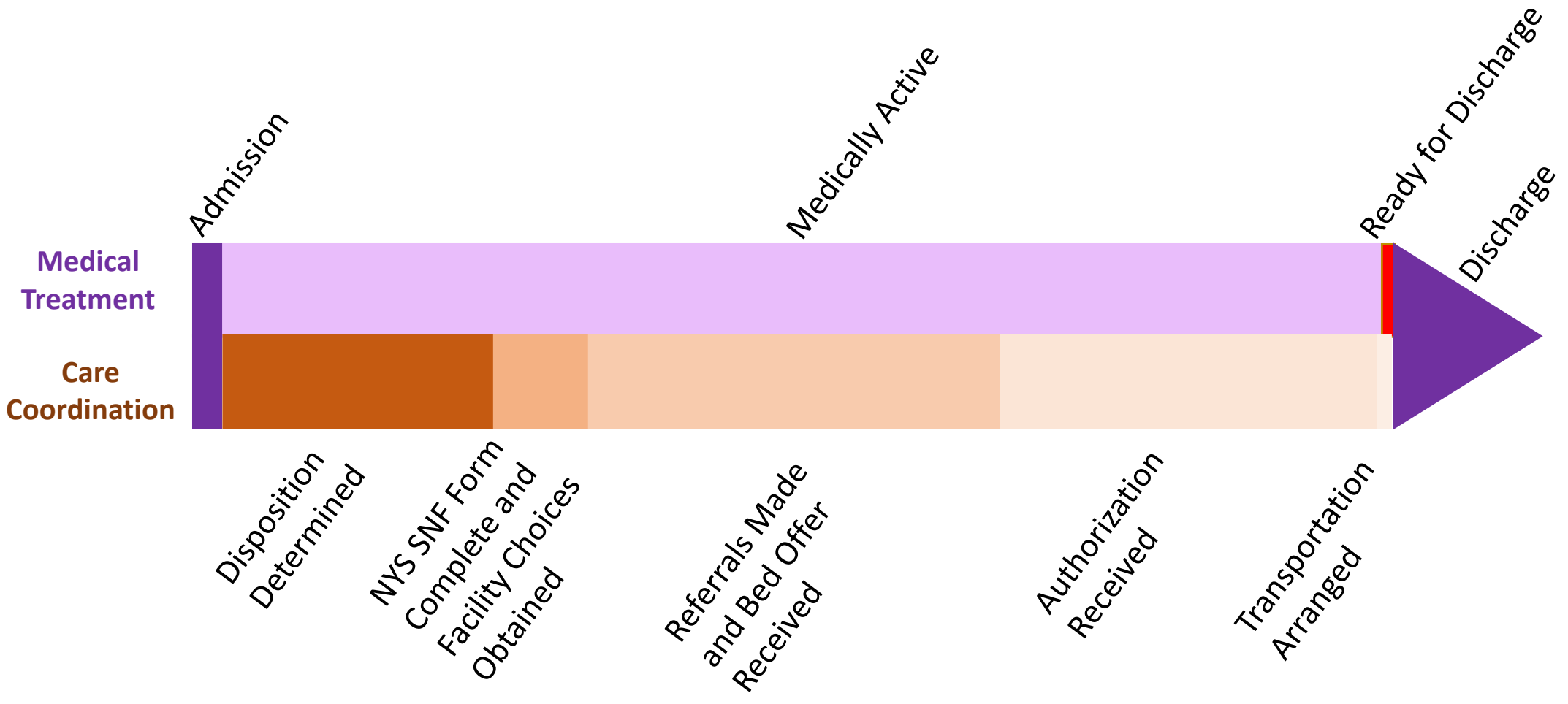
Background and Pressures



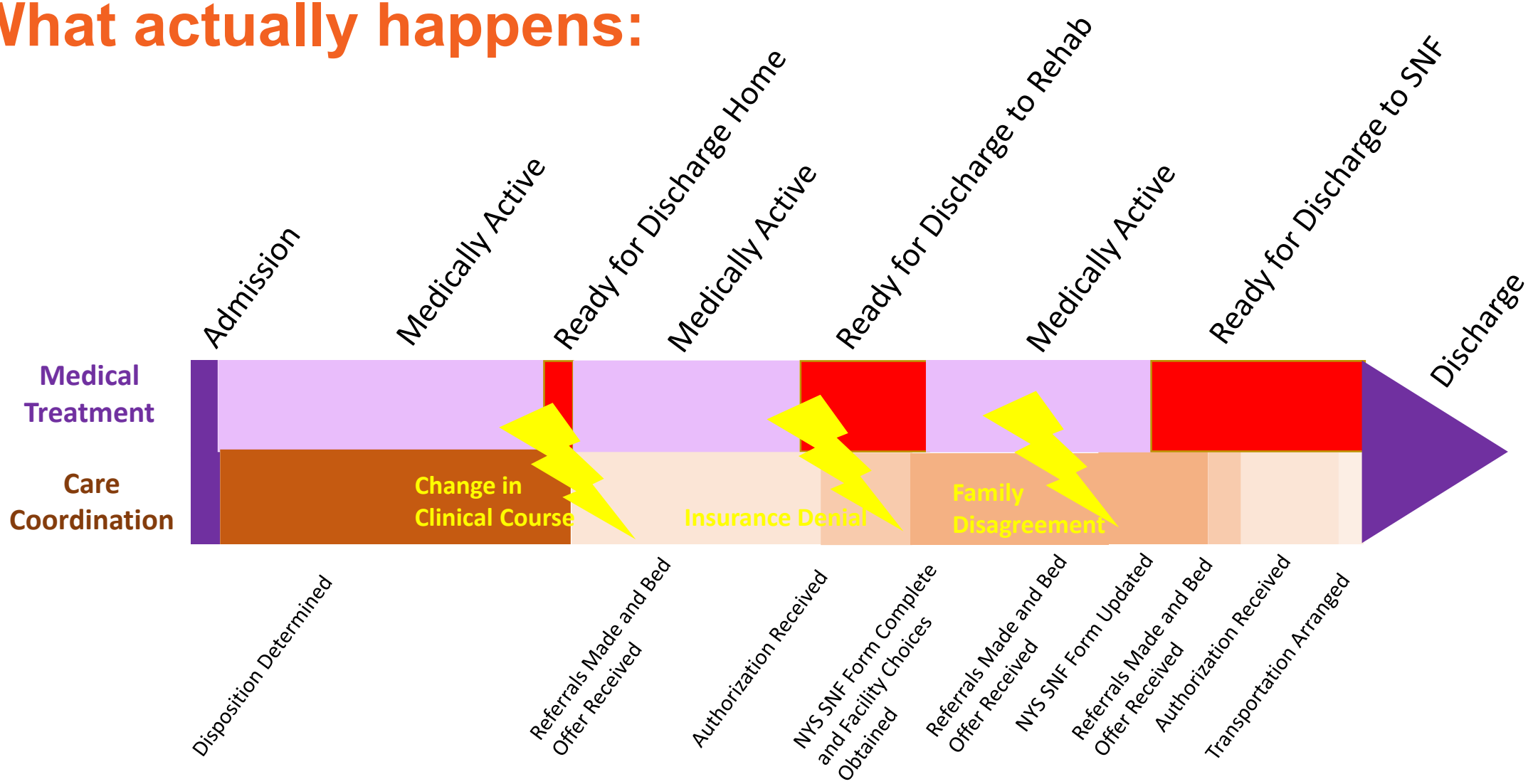


Data source: NYU Langone Analytics Center

What we want to happen:



What actually happens:



Team communication is essential to navigating a complex environment and minimizing avoidable days

Avoidable Day(s)

Information Flow and Availability

Electronic Medical Record (EMR)

Access:
Providers
Nurses
Care Coordinators
& other Care Team Members

Post Acute Services Referral Management Platform

Access:
Care Coordinators

Images: Permission for image use granted. Source: NYU Langone Brand Center

Real-time Information Flow and Availability

Electronic Medical Record (EMR)

Access:
Providers
Nurses
Care Coordinators
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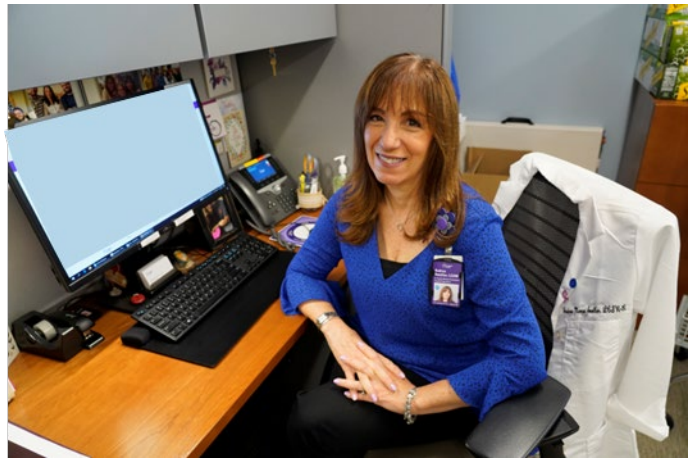
Post Acute Services Referral Management Platform



Access:
Care Coordinators

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Information Availability Allows for Action Locally and Globally

Unit Based Management (Local)

Real-time detail at the patient level integrated into the EMR allows for efficient patient progression:

- 8 unique views, formatting 21 different data points
- Care Team members can choose their view(s) based on their role
- Care Team reviews all information together at standardized rounds

Data points available (select examples):

- Referral Created; Time and Type
- # of Referrals
- First 'Yes' Post-Acute Provider
- Post Acute Authorization Status

Information Availability Allows for Action Locally and Globally

House-wide Oversight (Global)

Summary information displayed in a dashboard allows for;

- Staffing resource optimization
- Early intervention around delays by the Care Coordination Leadership Team

Summary available (select examples):

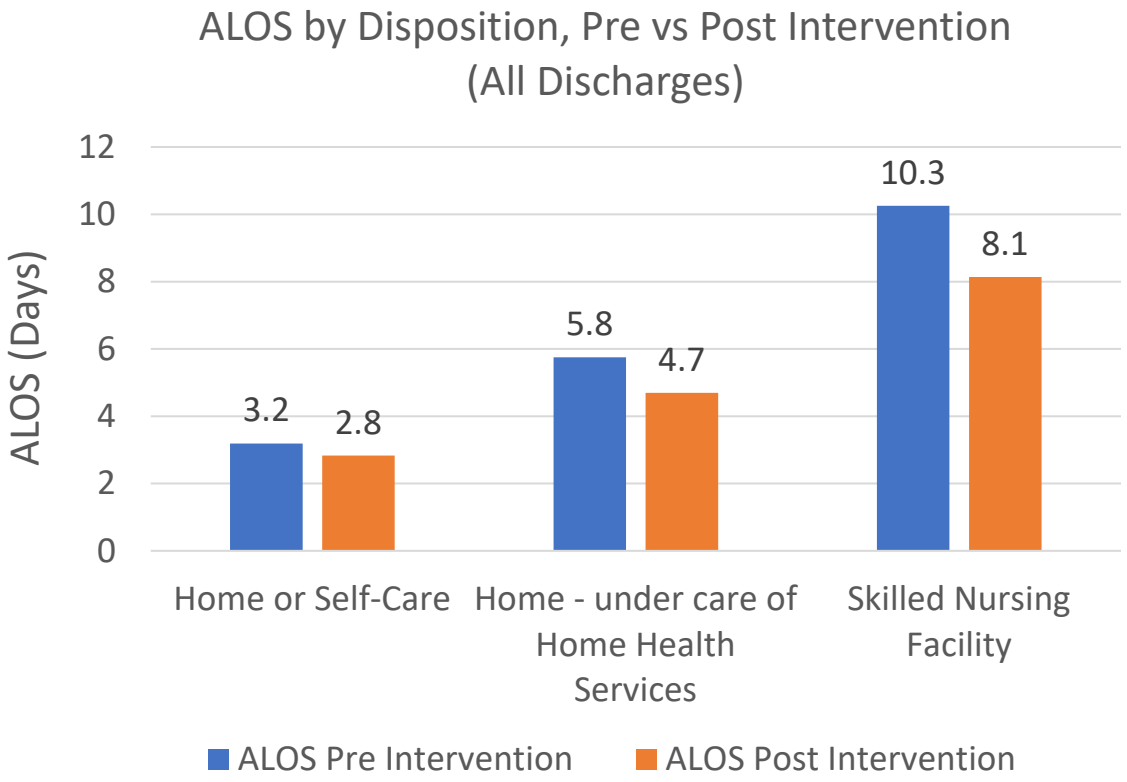
- Patients with missing referrals
- Patients with <5 referrals
- Patients with delay in post acute authorization initiation
- Patients with delay in transportation request

Maintaining a shared mental model through standardized rounding touch bases

Time	Touch Base	Attendees
6:00 – 9:30am	Clinical Bedside Rounds	Attending, Advanced Practice Practitioner or House Staff, Nursing
7:00 – 7:30am	RN and APP Hand Off	Nursing and Advanced Practice Practitioner (1:1 discussion)
★ 9:30 – 10:00am	Interdisciplinary Rounds	Attending, Advanced Practice Practitioner or House Staff, Nursing
★ 2:00 – 2:25pm	Afternoon Touch Base	Attending, Advanced Practice Practitioner or House Staff, Nursing
7:00 – 7:30pm	RN and APP Hand Off	Nursing and Advanced Practice Practitioner (1:1 discussion)
10:00 – 10:15pn	Evening Touch Base	Advanced Practice Practitioner or House Staff, Nursing

★ Care Teams review the current status of referrals and revise the discharge disposition plan as needed

Results – 3 Months Post Intervention



Discharges from NYU Langone Health between 4/1/2022 – 7/16/2023
Pre Intervention = Admissions prior to 4/19/2023
Post Intervention = Admissions on or after 4/19/2023

Data source: NYU Langone Analytics Center

Lessons Learned

- Activity completed by care coordinators and information received via electronic platforms should be transparent to all care team members in real time (e.g., submitting referrals, requesting authorization, etc.).
  - Relying on manual documentation introduces inherent delays to information availability
- Electronic system integrations can be labor intensive and must be thoughtful to maximize IT resources.
- Structured daily information-review processes need to be in place for full benefit of additional information availability (e.g., Interdisciplinary rounds).

Key Takeaways

- A shared mental model among the care team members is essential to efficient discharges and requires both information availability and structured review processes.
  - Information availability allows for more nimble decision-making and reduces avoidable inpatient time.
- There are likely many more opportunities to have actions generate relevant documentation, which will reduce staff documentation burden and allow for real-time awareness of team activity.

Questions?

Contact:

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Julia Gardner, Julia.Gardner@nyulangone.org

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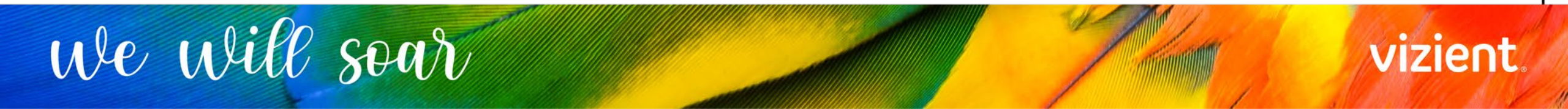
Creating a Thriving Workplace Culture



Panelists

Michael Leonard, MD

Executive Principal, Vizient, Inc., Safe and Reliable Healthcare

~~~~~~

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Allison Luu, MD, MS, CPPS

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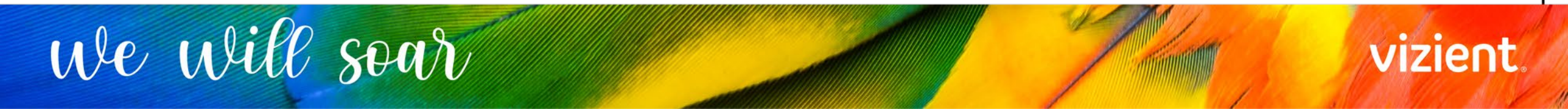
Creating a Thriving Workplace Culture



Panelists

Michael Leonard, MD

Executive Principal, Vizient, Inc., Safe and Reliable Healthcare

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Arun Patel, MD, JD, MBE

Director of Patient Safety, LA County Department of Health Services

Allison Luu, MD, MS, CPPS

Patient Safety Officer, LA County - LA General Medical Center, Los Angeles, Calif.

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Chris Buesing, MBA

Director, Worker's Compensation and Workforce Safety

Kathryn Burns, MFS

Organizational Development Consultant

Stormont Vail Health, Topeka, Kan.


Panel
Discussion

Lessons Learned

- Showing vulnerability as a leader is uncomfortable at first, but the impact on staff engagement, just culture, and willingness to speak up is profound.

- Giving team members intentional time away from their typical work—patient care and otherwise—to connect as human beings is critical to the health of an organization. Shifting our culture to a restorative mindset and utilizing restorative practice is key to creating an environment in which people feel welcomed, valued, and a sense of belonging. It sets the stage for organizations to be better equipped to support team members when crisis—personal or professional—arises.

Key Takeaways

- Simple behaviors, that are consistently practiced provide sustainable results.
- In a healthy workplace culture, staff feel safe to speak up and leaders listen **and** respond to what they say.
- Genuine and meaningful communication between leaders and staff has a profound impact on engagement, performance and culture.

Questions?

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ATTORNEYS AT LAW

Case Law Update

Wes Butler, Esq.
Member Attorney
Barnett Benvenuti & Butler PLLC

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Case Law Update

Wes Butler, Esq.
Member Attorney
Barnett Benvenuti & Butler PLLC

Caveats

- No conflicts to disclose
- Presentation is educational, not legal advice
- Presentation has two parts:
  - Case law update
  - Discussion of litigation topics
- Love questions, but if I don’t address your question contact me
- Thanks for improving patient safety and quality

Overview

- Approximately 111 published decisions in legal reporters
  - Cases have plateaued since 2021 – pandemic backlog?
- Most cases are in federal court
- Employment law cases and prison cases continue to grow
- Florida, Virginia and California lead the nation in published opinions, but more cases arising in the Midwest

Cases

Loux v. Baycare Med. Grp

- Federal Dist. Court in Florida decided June 27, 2023
- Civil rights case involving a claim of discrimination
- Plaintiff sought to discover quality info, particularly quality comparators to show she was treated differently than peers
- Hospital asserted PSWP privilege for responsive quality info
- Court denied provider's PSWP privilege claim

Cases

Loux v. Baycare Med. Grp

- The PSWP info was "… created for multiple uses and are not solely the protected [PSWP]. This information is not prepared and kept solely for provision to a [PSO], despite the artful declarations provided."

- "The first place to examine to determine if this information is put to dual or multiple uses is BayCare's own description of its "Patient Safety Organization" protocol."

Cases

Loux v. Baycare Med. Grp

- “[PSWP] may be provided … for analysis to over a dozen local entities….”
- “… permissible disclosures … include … accrediting agencies; grantees, contractors, and researchers sanctioned by “the Secretary;” the Food and Drug Administration; those recipients “the Secretary” or Florida or Federal law deem necessary for business operations and are consistent with relevant goals; and to law enforcement if the discloser reasonably deems it “necessary for criminal law enforcement purposes.”
- “BayCare thus designates many sources beyond a PSO as possible recipients for its PSWP.”

Cases

Loux v. Baycare Med. Grp

- Court conducted in camera review – court's private review of the privileged documents in chambers and out of the presence of plaintiff's attorneys
- "Nothing visible refers to a PSO or indicates the items are sent to a PSO."
- "It is not the 'PSO committee' that is referred to here. The PSO does not counsel the physician subject to the counseling. The local Quality Department does the 'Track and Trend,' not the PSO."

Cases

Loux v. Baycare Med. Grp

- “And possibly two comparators were placed on ‘Focused Review’ (a review not by the PSO) to address surgical issues. Plaintiff is entitled to review the matters to prove (if she can) that she was treated disparately than her professional peers, for discriminatory purpose. BayCare’s current posture makes her unable to have proper litigation discovery.”

Cases

Loux v. Baycare Med. Grp

- “The same information from the [PSES] is provided to the root cause analysis teams. This is not the PSO. These teams are ‘facilitators who move around the system dependent on future events,’ where events occurred—interdisciplinary teams brought from several sources such as the President of the facility, the local experts in the hospital system, etc. This has nothing to do with the PSO, but these utilize the data in the [PSES]. Clearly this information serves multiple functions for multiple parties within this large system.”

- “Root cause teams use this system and data. Root cause teams are risk management. HHS guidance states that information prepared for risk management is not PSWP.”

Cases

Ratliff v. CoreCivic

- Federal Dist. Court in New Mexico decided June 1, 2023
- Wrongful death suit against a prison
- Plaintiffs sought a mortality review in discovery
- Def's objected, but did not assert PSWP initially
- "Defendants conceded they did not raise the [PSWP] defense as an objection to their discovery responses because they did not know of the applicability of the privilege until they were briefing the motion to compel."

Cases

Ratliff v. CoreCivic

- “The Court finds that CoreCivic waived the privilege when it did not assert the objection at the time it responded to Plaintiffs discovery request.”

- “Clearly, a party cannot create a document for the purposes of asserting a privilege related to a statute of which the party was unaware. Additionally, the fact the party was unaware of the statute proves that the document was not created pursuant to that law, so the party cannot now seek the statute's protection.”

Cases

Franco v. Yale New Haven Hosp.

- State Court in Connecticut decided March 31, 2023
- Disruptive visitor claims injury from physical restraints
- Hosp. performed investigation within PSES and provided affidavit that investigative notes were submitted to a PSO
  - Notes were prepared and maintained in PSES and not distributed or maintained outside of that system
  - All of affiant's knowledge regarding the incident was obtained through her patient safety activities within the PSES

Cases

Franco v. Yale New Haven Hosp.

- Plaintiff sought to depose the affiant and production of all investigative materials
- Court granted a protective order under PSQIA and state law
  - Connecticut has a state law companion to PSQIA
- "This court concludes that the foregoing establishes that [affiant's] participation in the safety huddle, interview of the emergency room nurse, and creation of notes regarding those discussions is PSWP within the meaning of the PSQIA."

Cases

Nelms v. Wellpath

- Federal Court in Eastern Michigan decided March 31, 2023
- Prison health care case
- Patient had heart attack in jail
- Plaintiff requested discovery of full M&M Review
- Wellpath provided part of M&M (patient information and attendee list), but withheld “Reports and Recommendations”
- PSWP privilege upheld for M&M documents

Cases

Nelms v. Wellpath – Court holdings

- Two prongs for PSWP privilege: (1) is document created for the purpose of reporting to PSO and (2) is it reported
- Wellpath affidavit stated a “PSO purpose” of the M&M Review
- Wellpath submitted copy of PSES Policy showing M&M Review is created as part of its PSES and designated as PSWP
- Wellpath affidavit confirmed that withheld portion was reported to a PSO on a specific date

Cases

Nelms v. Wellpath – Court dispenses with opposing arguments

- Delay in PSO reporting
  - Long delay weakens the patient-safety rationale for the privilege, but 13-month delay does not negate patient safety purpose
- Review did not include participation of treating providers
  - Law does not require the best or most-informed analyses for privilege
- Discrepancies in affidavit
  - No evidence of discrepancies

Cases

Nelms v. Wellpath – Court dispenses with opposing arguments

- Delay suggests Review was not created for PSO-reporting
  - Provider confirmed Review was maintained within the PSES for PSO-reporting and not used for any non-patient-safety purpose
- Review had a dual purpose
  - No evidence provider used the Review for a non-PSQIA obligation
- Despite concerns about Wellpath's handling of patient information, the evidence establishes PSQIA applies

Lessons Learned

- Asserting the PSWP privilege is like chess – to win you must see several moves ahead.
- Courts are applying the “purpose” test for PSWP which can lead to different results depending upon the facts – and judge.
- Assert the PSWP privilege with an appeal in mind – preserve your record.
- Report PSWP information to a PSO.

Key Takeaways

- Plan and test your PSWP privilege arguments in advance to see your strengths and weaknesses
- Prioritize PSO submissions and if you are unsure what information or documents to submit, discuss with Vizient and with counsel
- Educate defense counsel periodically and make sure they are ready to assert the PSWP privilege at the start of discovery
- Self-critically examine your patient safety activities under the “purpose” test
  - Is there a persuasive argument or evidence that your patient safety activities are performed for a purpose other than reporting to a PSO?

Questions?

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