

2023 VIZIENT CONNECTIONS SUMMIT

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SEPT. 18–21, 2023  
WYNN, LAS VEGAS

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# Establishing a High Reliability Frame of Mind: The Continuous Journey (Part 2 of 2)

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***Elyse Bueno, MS, APRN, ACCNS-AG, NE-BC, Sr. Director of Clinical Quality and Patient Safety, University of Colorado Hospital, Aurora, Colo.***

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# Learning Objectives

- Explain how to deploy a “Just Culture” framework.
- Outline the structure of a collaborative case review committee grounded in Just Culture.
- Describe the process to establish a standard collaborative case review process across all departments in an institution.

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# University of Maryland Medical Center Downtown Campus



Medical Staff Profile	
998	Physicians (SOM Faculty)
93	Specialty Training Programs
709	Residents
210	Fellows

FY 2023 Hospital Statistics	
8,246	Employees
739	Licensed Beds FY23
24,496	Admissions
4,015	Observation Visits
18,431	Surgical Cases
48,157	Emergency Room Visits
284,467	Outpatient Visits
1,874	Births

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# Just Culture Improves Safety Culture

## **PROBLEM:**

In 2018, UMMC recognized the opportunity to create a culture of safety  
*(Not unique to our organization)*

## **SOLUTION:**

Embark on a Just Culture Journey as part of cultural transformation

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# Why Just Culture – Foundational to High Reliability



Leadership



Safety  
Culture



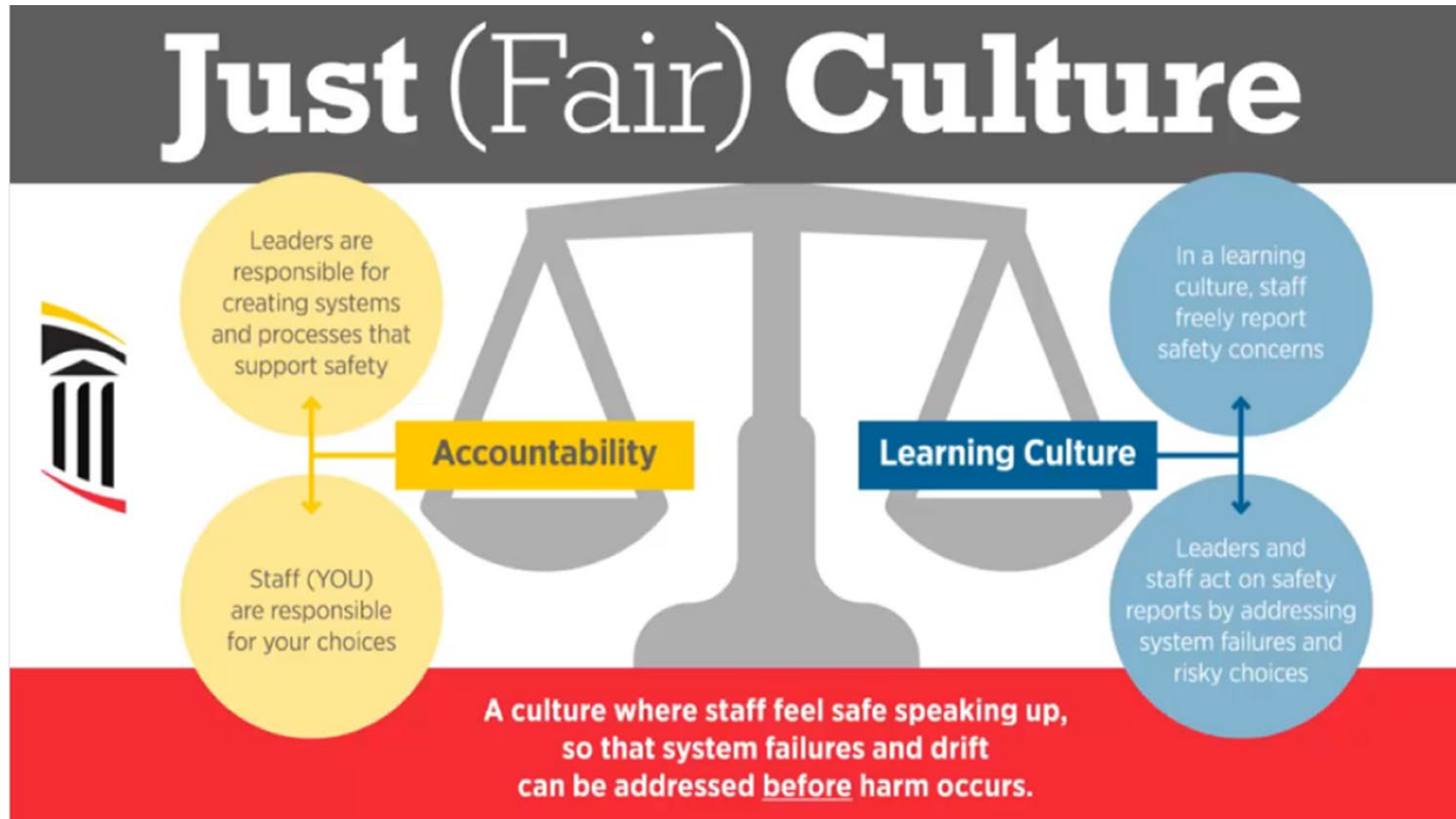
Robust  
Process  
Improvement

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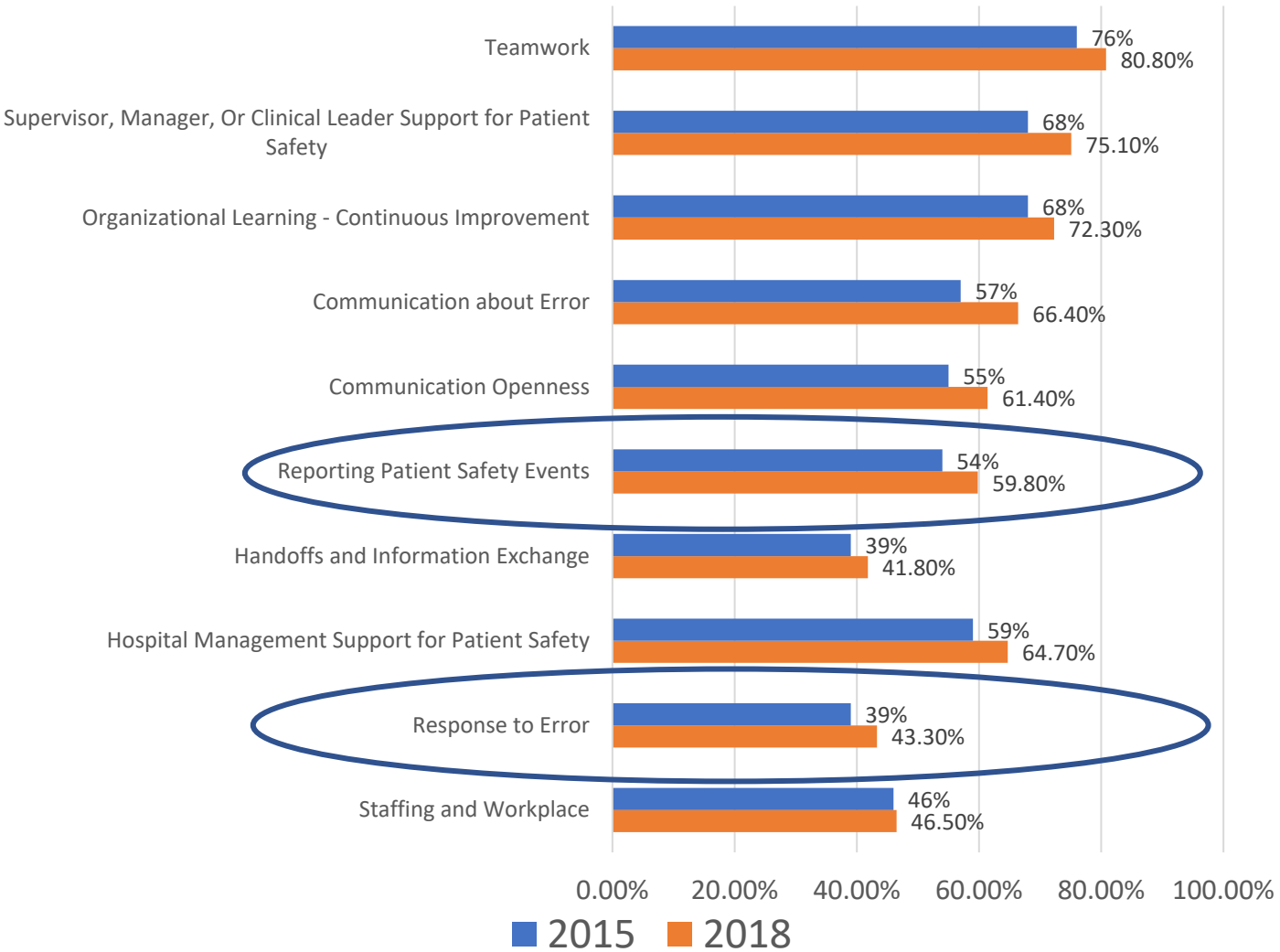
# Just Culture is Accountability & Learning Culture



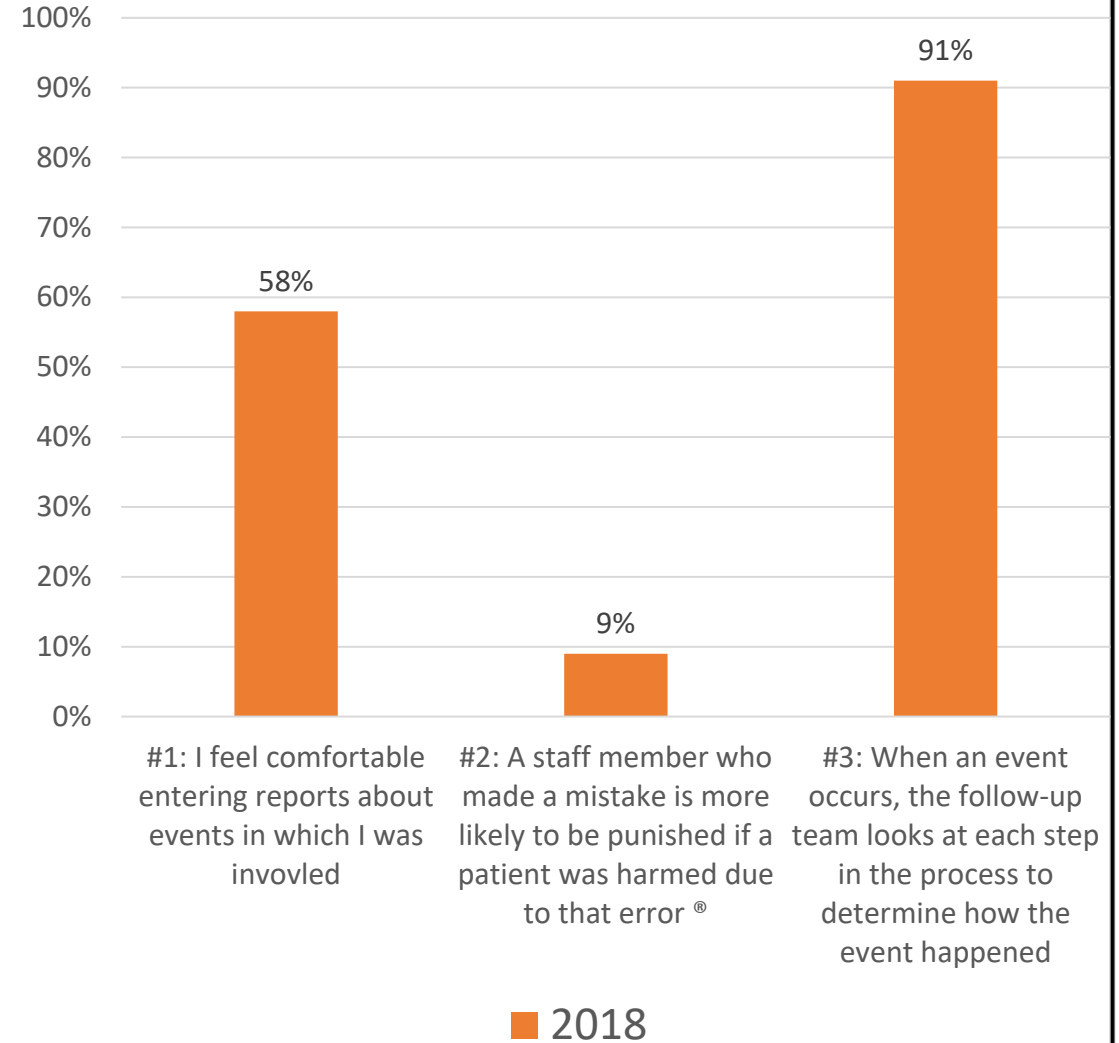
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## AHRQ Safety Culture Survey : UMMC (% favorable response)



## Just Culture Questions (% favorable response)



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# UMMC's Homegrown Approach – Methodology

## Ready

**Goal:** Identify and manage dependencies

**Steps:**

- Form a core team
- Establish conceptual model
- Perform Stakeholder Analysis
- Form Steering Committee
- Collect baseline data
- Perform policy review

## Train

**Goal:** Give them the tools to react differently

**Steps:**

- Create curriculum
- Identify & train instructors
- Identify & train facilitators
- Train existing leaders
- Plan future training for new leaders
- Train existing frontline staff
- Embed frontline training into new orientation

## Sustain

**Goal:** Make Just Culture part of normal operations

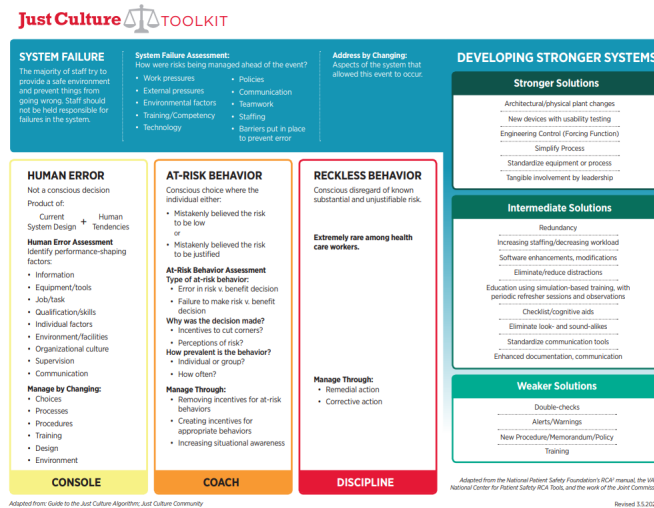
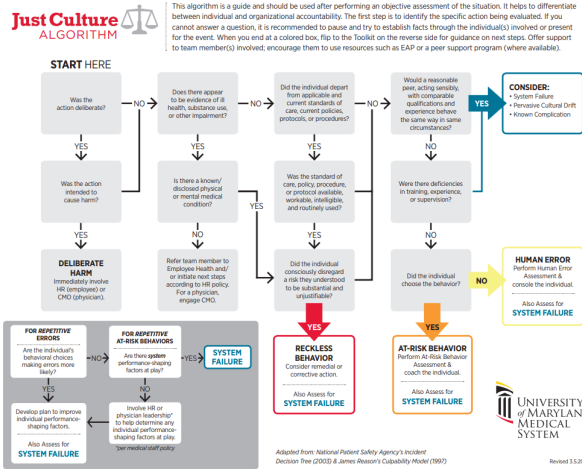
**Steps:**

- Embed into RCAs & Clinical Peer Review
- Embed into HR processes
- Standing agenda item for leadership meetings
- Assess progress

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# UMMC's Homegrown Approach – Tools & Resources



The UMMC Insider (Intranet) | The UMMC Midtown Insider | For help with this site, email [Communications@umm.edu](mailto:Communications@umm.edu)

Clinical Information Systems | Outlook WebApp | Pager | SOM Outlook | UMMC in the Community

**the UMMC INSIDER**

DEPARTMENTS & SERVICES | NURSING & PATIENT CARE SERVICES | POLICIES & PROCEDURES | HUMAN RESOURCES | MANAGEMENT ADMIN TOOLS | PHYSICIANS

Home > Departments & Services > Division of Quality & Safety > Just Culture Resource Center

- Just Culture Resource Center
- Just Culture for Leaders' Workshop
- Just Culture Journey
- Facilitator Training

## Just Culture

**Just Culture Resource Center**

Welcome to UMMC's Just Culture Resource Center! A Just Culture is one that balances organizational and individual accountability while maintaining an environment that supports continuous learning. Please refer to this page to download relevant files, view training opportunities, and view information about how to become a Just Culture Facilitator.

- Resources**
- Just Culture Algorithm & Toolkit (Laminated copies are available for pick-up in the Patient Resource Center (W1L131) on the downtown campus. This is down the hall from The Great Cookie)
  - UMMC Just Culture Policy (Available in Policy Store)
  - Just Culture News & Views Article from Summer 2019
  - Just Culture in Action PowerPoint Template



- Training**
- Just Culture for Leaders' Workshop**
- All leaders within UMMC and SOM are required to attend this workshop. From UMMC, this includes: SVPs, VPs, Directors, Managers, Assistant Managers, Supervisors, Lead NP/PA's, HR Business Partners, and Unit-Based Safety Clinicians. For Physicians, this includes: Associate Deans, Department Chairs, Division Chiefs, Service Line Quality/Safety Champions, Unit/Department Medical Directors, Residency and Fellowship Program Directors, and Chief Residents. **You may also enroll electively!**

**Contact Us!**

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# UMMC's Homegrown Approach – Training Structure

## 1 Basic Knowledge

Attend **Just Culture for Leaders | UMMC** (2.5hrs)

## 2 Facilitator

- Attend **Just Culture Facilitator Onboarding | UMMS** (1.5hrs)
- Co-Facilitate **Just Culture for Leaders | UMMC** Part III Breakout group with experienced Facilitator 1+ times (1hr)

## 3 Facilitator+

- Attend **Just Culture Facilitator+ | UMMS** (1.5hrs)
- Co-Instruct **Just Culture Facilitator Onboarding | UMMS** with experiences Facilitator+ 1+times (1.5hrs)

## 4 Instructor

- Complete Assigned reading
- Co-instruct **Just Culture for Leaders | UMMC** with experienced instructor 1+ times (2.5hrs)

1	<b>Total Trained</b>	>2,500
2	<b>Total Facilitators</b>	105
3	<b>Total Facilitator+</b>	3
4	<b>Total Instructors</b>	16

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# UMMC's Homegrown Approach – *Training Structure*

## 1 Basic Knowledge

Attend **Just Culture for Leaders | UMMC** (2.5hrs)

### Workshop Outline

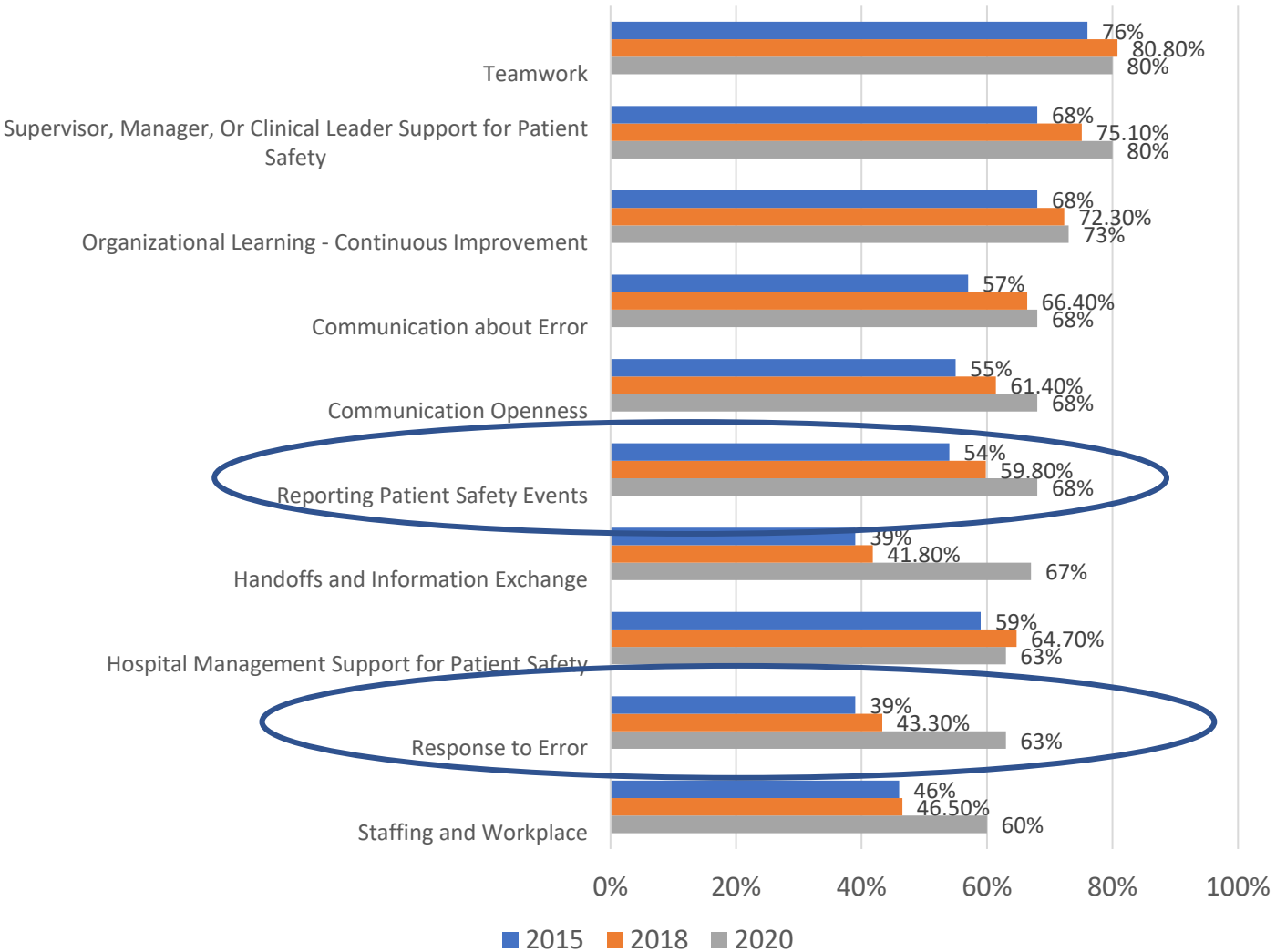
<b>Part I: Didactic</b>	<b>Part II: Guided Case</b>	<b>Part III: Breakout Groups</b>	<b>Closing Remarks</b>
<b>45 minutes</b>	<b>45 minutes</b>	<b>45 minutes</b>	<b>15 minutes</b>
UMMC baseline data, tenets of a Just Culture theory, system failures, algorithm introduction	Instructors describe recent UMMC Case, walk all participants through algorithm, address common questions	Facilitators join small groups, guide discussion, give participants practice in applying Just Culture tools	Review repetitive actions and key takeaways

<b>Total Trained</b> ★
>2,500
<b>Total Facilitators</b>
105
<b>Total Facilitator+</b>
3
<b>Total Instructors</b>
16

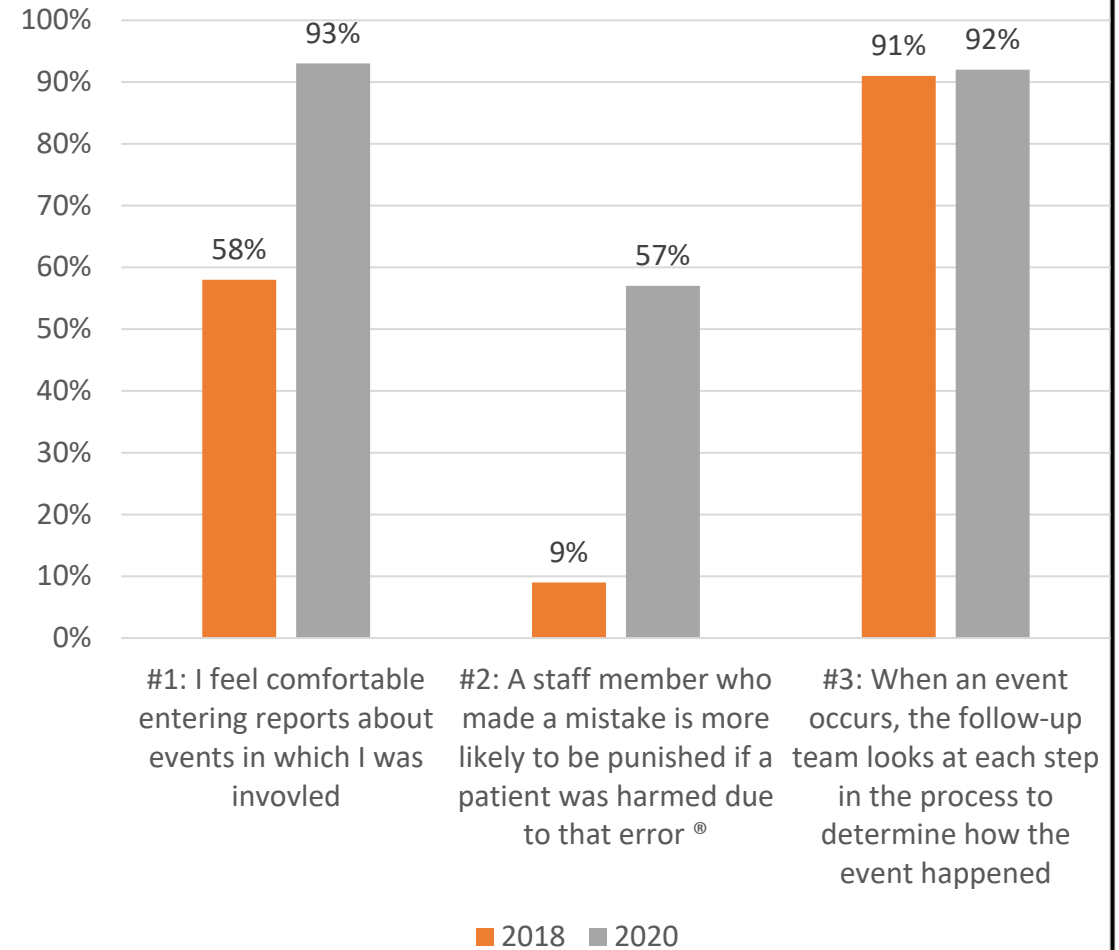
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# AHRQ Safety Culture Survey : UMMC (% favorable response)



## Just Culture Questions (% favorable response)



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# About

**12**  
Hospitals

4 Northern Colorado  
4 Metro Denver  
4 Southern Colorado

**2K**  
Available

Hospital beds  
584 Northern Colorado  
897 Metro Denver  
527 Southern Colorado



**Poudre Valley Hospital**  
Fort Collins



**Medical Center of the Rockies**  
Loveland



**Greeley Hospital**  
Greeley



**Longs Peak Hospital**  
Longmont



**Broomfield Hospital**  
Broomfield



**University of Colorado Hospital**  
Aurora



**Highlands Ranch Hospital**  
Highlands Ranch



**Memorial Hospital North**  
Colorado Springs



**Grandview Hospital**  
Colorado Springs



**Memorial Hospital**  
Colorado Springs



**Pikes Peak Regional Hospital**  
Woodland Park



**Yampa Valley Medical Center**  
Steamboat Springs

More than

**29K** employees

**97K** surgeries

**2.7M** unique patients

**7M** outpatient, urgent care and emergency room visits

**14K** babies delivered

**6K** affiliated or employed providers

**149K** inpatient admissions and observation visits

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# UCHealth: University of Colorado Hospital

*University of Colorado is the largest academic health center in the Rocky Mountain region*

## University of Colorado Hospital

- 1,817,278 outpatient visits
- 166,088 ED visits
- 50,769 inpatient and observation admissions
- 28,696 surgeries
- 3,614 babies delivered
- 703 available beds



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# UCHealth University of Colorado Hospital

Collaborative Case Review

## AHRQ & National Quality Forum:

Structured, multidisciplinary review is required to identify system processes that may result in failures in care, adverse events, and mortality.

## VISION:

Eliminate avoidable harm and develop high functioning review groups as a means to (i) improve faculty and staff self-reported patient safety culture and (ii) ensure high reliability healthcare.

## MISSION

Use a just culture framework via a transparent, fair, collaborative, inter-professional review of patient care with the purpose of learning through retrospective review about how to improve future care delivery.

Agency for Healthcare Research and Quality (AHRQ). Toolkit for Using the AHRQ Quality Indicators, Available at:

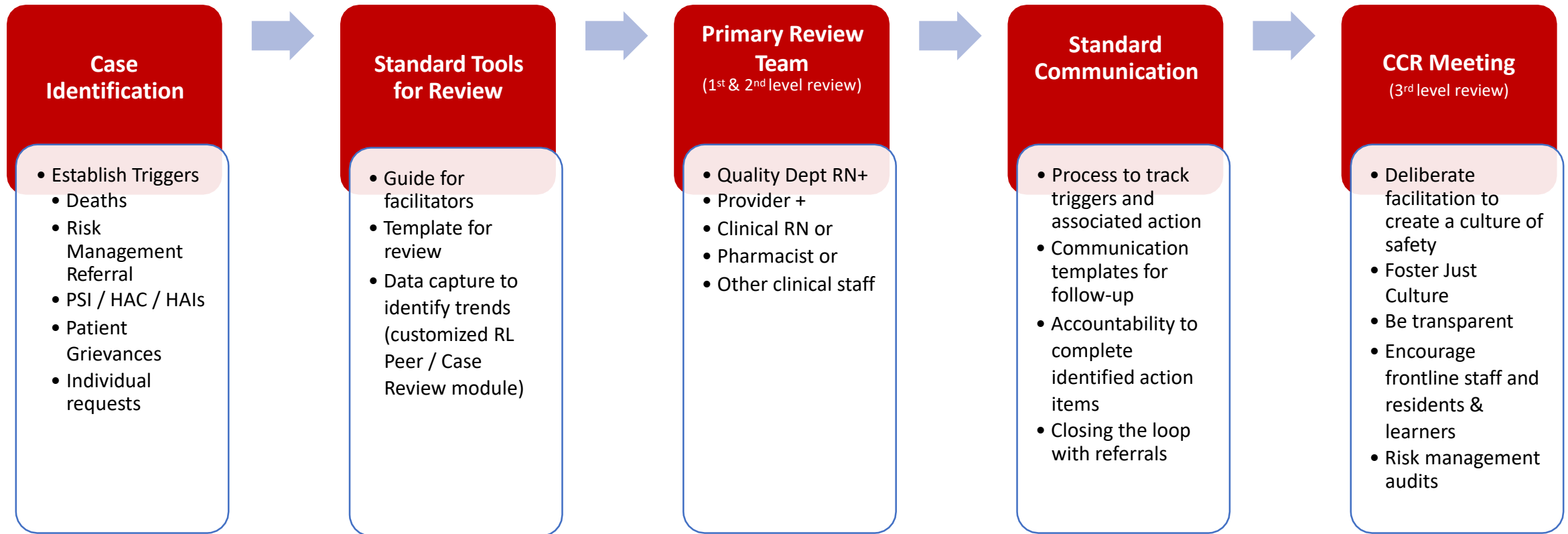
[https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/combined/d4n\\_combo\\_iqi-mortalityreview-bestpractices.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/combined/d4n_combo_iqi-mortalityreview-bestpractices.pdf). Accessed 28 July 2023

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# Collaborative Case Review Basics

## Five Essential Elements



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# RCA<sup>2</sup> vs M&M vs CCR

## RCA<sup>2</sup>: Root Case Analysis and Action

- Practice regulated by TJC
- Led by Safety Department
- **Required** for the following events:
  - Death
  - Permanent Harm
  - Severe Temporary Harm with life sustaining intervention needed
  - Sentinel Event per Joint Commission
  - Or a near miss of these outcomes
- Uses structured RCA<sup>2</sup> tools
- Triggers are serious safety events
- Should occur rarely

## M&M: Morbidity & Mortality

- Main purpose is for trainee education
- May or may not include patient safety focus
- Often does not include non-physician or APP participants

## CCR: Collaborative Case Review

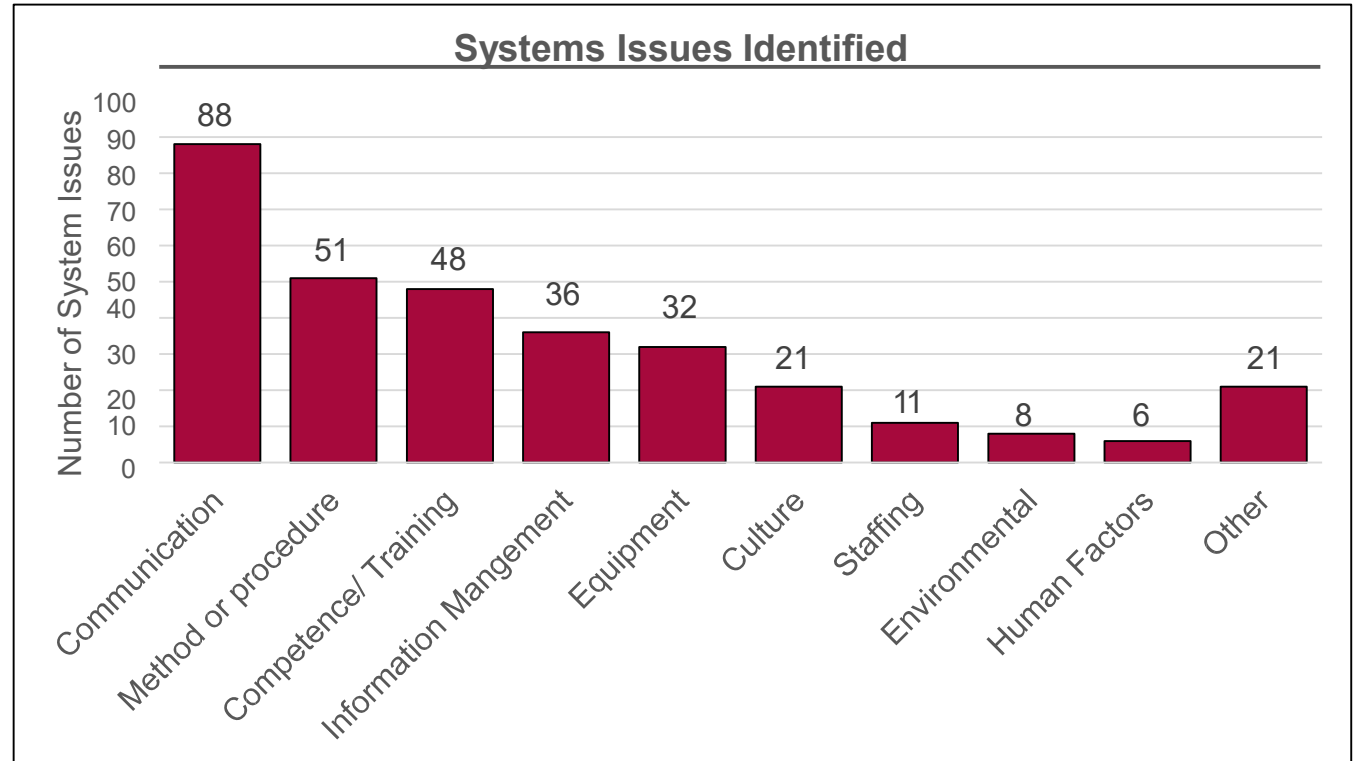
- Cases identified from various sources including:
  - Specialty triggers
  - Risk management
  - Self referrals
  - Sampling
  - Deaths
  - Patient complaints
- Not necessarily based on poor patient outcome or harm
- Action oriented; addressing system issues
- Should occur monthly
- Co-chaired by MD and RN
- Run at service or department level

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# Results

- 46 CCRs launched, June 2020 – June 2023
  - 32 service line, specialty or program (eg ENT, trauma)
  - 10 geographic (eg STICU)
  - 4 metric based (eg Colon SSI)
- In CY2022
  - 310 cases reviewed in CCR
  - 322 system issues identified
  - 330 action items initiated



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VISION

# Collaborative Case Review Housestaff Impact

FY2023 Survey Responses\*

Will anything you learned during this CCR result in a change in your current practice? (Yes)

74%  
Yes

1475 Responses

This conference provided a positive example of systems improvement.

86%  
Agree or Strongly Agree

1719 Responses

The process of evaluating prior system errors is an educational experience.

87%  
Agree or Strongly Agree

1752 Responses

\*% of positive responses out of total responses to that specific question

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# Panel Discussion

## University of Maryland Medical Center



## University of Colorado Health



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# Top Ten Just Culture Considerations

- Focus on transparency and clarity in communication
- Clearly define expectations
- Differentiate between human error and reckless behavior
- Learn from errors
- Institute fair and consistent disciplinary measures
- Deploy a non-punitive reporting system
- Ensure leadership commitment
- Strive for continuous improvement
- Involve and empower employees and key stakeholders
- Engage in external reporting and collaboration

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# Key Takeaways

- Just culture is essential to high reliability in healthcare
- Homegrown programs are effective and sustainable
- Cultural transformation takes time
- Having a systematic and highly reliable approach to reviewing care ensures clinicians and staff are collaborating to improve care for future patients
- Collaborative case review can be a valuable tactic to improve patient safety culture

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# Questions?



## Contact:

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# Member Education Satisfaction Polling

Thank you for attending

How satisfied are you with this  
Establishing a High-Reliability  
Frame of Mind: The Continuous  
Journey (Part 2 of 2) forum?



Scale of 1 to 10 with 10 being extremely satisfied,  
and 1 being least satisfied.