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Learning Objectives

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- Discuss leading practices for improving patient safety, healthcare quality and outcomes.
- Describe strategies that promote continuous learning and improvement.
- Discuss case law updates related to the Patient Safety Work Product privilege.

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Opening Remarks

Ellen Flynn, RN, JD, MBA
Principal
Vizient, Inc.

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ACHIEVING DIAGNOSTIC EXCELLENCE THROUGH PREVENTION AND TEAMWORK

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Measuring and Reducing Diagnostic Errors

Andrew Auerbach, MD, MPH
Professor of Medicine
University of California San Francisco School of Medicine
San Francisco, Calif.

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Introduction

Act 1: Enter the Way Back Machine

Act 2: Diagnostic error prevalence and causes – The UPSIDE Study

Act 3: Diagnostic errors: Moving towards solutions

THE NATURE OF ADVERSE EVENTS IN HOSPITALIZED PATIENTS

Results of the Harvard Medical Practice Study II

LUCIAN L. LEAPE, M.D., TROYEN A. BRENNAN, M.D., J.D., M.P.H., NAN LAIRD, PH.D., ANN G. LAWTHERS, SC.D., A. RUSSELL LOCALIO, J.D., M.P.H., BENJAMIN A. BARNES, M.D., LIESI HEBERT, SC.D., JOSEPH P. NEWHOUSE, PH.D., PAUL C. WEILER, LL.M., AND HOWARD HIATT, M.D.

Abstract *Background.* In a sample of 30,195 randomly selected hospital records, we identified 1133 patients (3.7 percent) with disabling injuries caused by medical treatment. We report here an analysis of these adverse events and their relation to error, negligence, and disability.

Methods. Two physician-reviewers independently identified the adverse events and evaluated them with respect to negligence, errors in management, and extent of disability. One of the authors classified each event according to type of injury. We tested the significance of differences in rates of negligence and disability among categories with at least 30 adverse events.

Results. Drug complications were the most common type of adverse event (19 percent), followed by wound infections (14 percent) and technical complications (13 percent). Nearly half the adverse events (48 percent) were associated with an operation. Adverse events during surgery were less likely to be caused by negligence (17 percent) than nonsurgical ones (37 percent). The proportion of adverse events due to negligence was highest for diagnostic mishaps (75 percent), noninvasive therapeutic mishaps ("errors of omission") (77 percent), and events occurring in the emergency room (70 percent). Errors in management were identified for 58 percent of the adverse events, among which nearly half were attributed to negligence.

Conclusions. Although the prevention of many adverse events must await improvements in medical knowledge, the high proportion that are due to management errors suggests that many others are potentially preventable now. Reducing the incidence of these events will require identifying their causes and developing methods to prevent error or reduce its effects. (N Engl J Med 1991; 324:377-84.)

Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, Barnes BA, Hebert L, Newhouse JP, Weiler PC, Hiatt H. The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II. New England journal of medicine. 1991 Feb 7;324(6):377-84.

Table 1. Screening Criteria for Adverse Events.

1. Hospitalization within previous year for patients less than 65 years old and previous six months for older patients
2. Admission to any hospital after this discharge
3. Previous failure of medical management or unfavorable results
4. Trauma incurred in hospital
5. Unfavorable drug reaction in hospital
6. Transfer from general care to a special care unit
7. Transfer to another acute care hospital
8. Return to operating room during this period of hospitalization
9. Treatment for organ damage after an invasive procedure
10. Acute myocardial infarction, cerebrovascular accident, or pulmonary embolus during or after an invasive procedure
11. Neurologic deficit at discharge
12. Death
13. Temperature higher than 38.3°C on day before or day of discharge
14. Cardiac or respiratory arrest
15. Five-minute Apgar score <6, or complication of abortion or labor and delivery
16. Other undesirable outcome
17. Indication of litigation in the medical record
18. Length of hospital stay above 90th percentile for diagnosis-related group in patients under 70, and 95th percentile in those 70 or older

Hiatt, HH, Barnes, BA, Brennan, TA, et al. A study of medical injury and medical malpractice: an overview. N Engl J Med 1989;321:480-484

Table 1. Types of Adverse Events and Proportion of Events Involving Negligence.

Type of Event	No. of Events in Sample	Weighted Proportion of Events*		
		In population	Due to negligence	With serious disability
		percent		
Operative				
Wound infection	160	13.6	12.5†	17.9
Technical complication	157	12.9	17.6	12.0†
Late complication	137	10.6	13.6‡	35.7
Nontechnical complication	87	7.0	20.1	43.8
Surgical failure	58	3.6	36.4	17.5
All	599	47.7	17.0	24.0
Nonoperative				
Drug-related	178	19.4	17.7‡	14.1‡
Diagnostic mishap	79	8.1	75.2†	47.0‡
Therapeutic mishap	62	7.5	76.8†	35.4
Procedure-related	88	7.0	15.1	28.8
Fall	20	2.7	—	—
Fracture§	18	1.2	—	—
Postpartum¶	18	1.1	—	—
Anesthesia-related	13	1.1	—	—
Neonatal	29	0.9	—	—
System and other	29	3.3	35.9	36.0
All	534	52.3	37.2	25.3
Total	1133	100.0	27.6	24.7

*Dashes denote categories for which there were too few observations to determine a percentage.

†$P<0.001$ for the difference between this rate and all others in the same column.

‡$P<0.01$ for the difference between this rate and all others in the same column.

§Includes nonoperative fractures only.

¶Includes noncesarean deliveries only.

Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, Barnes BA, Hebert L, Newhouse JP, Weiler PC, Hiatt H. The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II. New England journal of medicine. 1991 Feb 7;324(6):377-84.

Incidence of Adverse Drug Reactions in Hospitalized Patients

A Meta-analysis of Prospective Studies

Jason Lazarou, MSc; Bruce H. Pomeranz, MD, PhD; Paul N. Corey, PhD

Objective.—To estimate the incidence of serious and fatal adverse drug reactions (ADR) in hospital patients.

Data Sources.—Four electronic databases were searched from 1966 to 1996.

Study Selection.—Of 153, we selected 39 prospective studies from US hospitals.

Data Extraction.—Data extracted independently by 2 investigators were analyzed by a random-effects model. To obtain the overall incidence of ADRs in hospitalized patients, we combined the incidence of ADRs occurring while in the hospital plus the incidence of ADRs causing admission to hospital. We excluded errors in drug administration, noncompliance, overdose, drug abuse, therapeutic failures, and possible ADRs. Serious ADRs were defined as those that required hospitalization, were permanently disabling, or resulted in death.

Data Synthesis.—The overall incidence of serious ADRs was 6.7% (95% confidence interval [CI], 5.2%-8.2%) and of fatal ADRs was 0.32% (95% CI, 0.23%-0.41%) of hospitalized patients. We estimated that in 1994 overall 2 216 000 (1 721 000-2 711 000) hospitalized patients had serious ADRs and 106 000 (76 000-137 000) had fatal ADRs, making these reactions between the fourth and sixth leading cause of death.

Conclusions.—The incidence of serious and fatal ADRs in US hospitals was found to be extremely high. While our results must be viewed with circumspection because of heterogeneity among studies and small biases in the samples, these data nevertheless suggest that ADRs represent an important clinical issue.

JAMA. 1998;279:1200-1205

METHODS

Definitions

One step we took to reduce heterogeneity was to exclude any data that did not use the following specific definitions:

Adverse Drug Reaction (ADR).—According to the World Health Organization definition,[8] this is any noxious, unintended, and undesired effect of a drug, which occurs at doses used in humans for prophylaxis, diagnosis, or therapy. This definition excludes therapeutic failures, intentional and accidental poisoning (ie, overdose), and drug abuse.[8] Also, this does not include adverse events due to errors in drug administration or noncompliance (taking more or less of a drug than the prescribed amount).[8] Using this conservative definition avoids overestimating the ADR incidence.

For editorial comment see p 1216.

Recently, some authors prefer the term

Lazarou J, Pomeranz BH, Corey PN. Incidence of Adverse Drug Reactions in Hospitalized Patients: A Meta-analysis of Prospective Studies. *JAMA*. 1998;279(15):1200–1205. doi:10.1001/jama.279.15.1200

RESEARCH ARTICLE

Incidence, causes, and consequences of preventable adverse drug reactions occurring in inpatients: A systematic review of systematic reviews

Dianna Wolfe[1], Fatemeh Yazdi[1], Salmaan Kanji[1,2], Lisa Burry[3], Andrew Beck[1], Claire Butler[1], Leila Esmaeilisaraji[1], Candyce Hamel[1], Mona Hersi[1], Becky Skidmore[1], David Moher[1,4], Brian Hutton[1,4]*

1 Clinical Epidemiology Program, Ottawa Hospital Research Institute, Ottawa, Ontario, Canada, **2** Department of Pharmacy, The Ottawa Hospital, Ottawa, Ontario, Canada, **3** Leslie Dan Faculty of Pharmacy, University of Toronto, Toronto, Ontario, Canada, **4** School of Epidemiology, Public Health and Preventive Medicine, University of Ottawa, Ottawa, Ontario, Canada

- Wrong dose
- Drug interactions
- Allergies
- Wrong patient
- Wrong drug
- Known adverse effect in vulnerable patient

Wolfe D, Yazdi F, Kanji S, Burry L, Beck A, Butler C, Esmaeilisaraji L, Hamel C, Hersi M, Skidmore B, Moher D, Hutton B. Incidence, causes, and consequences of preventable adverse drug reactions occurring in inpatients: A systematic review of systematic reviews. PLoS One. 2018 Oct 11;13(10):e0205426. doi: 10.1371/journal.pone.0205426. PMID: 30308067; PMCID: PMC6181371.

Electronic health records

Source: Image by rawpixel.com on freepik. Permission to use.

Reference standard databases

Source: freestocks on Unsplash. Permission to use

Policies, Procedures, Standards

Changes to the human-technology interface

Source: Image by freepik. Permission to use.

Changes in teams

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Diagnostic error – state of science

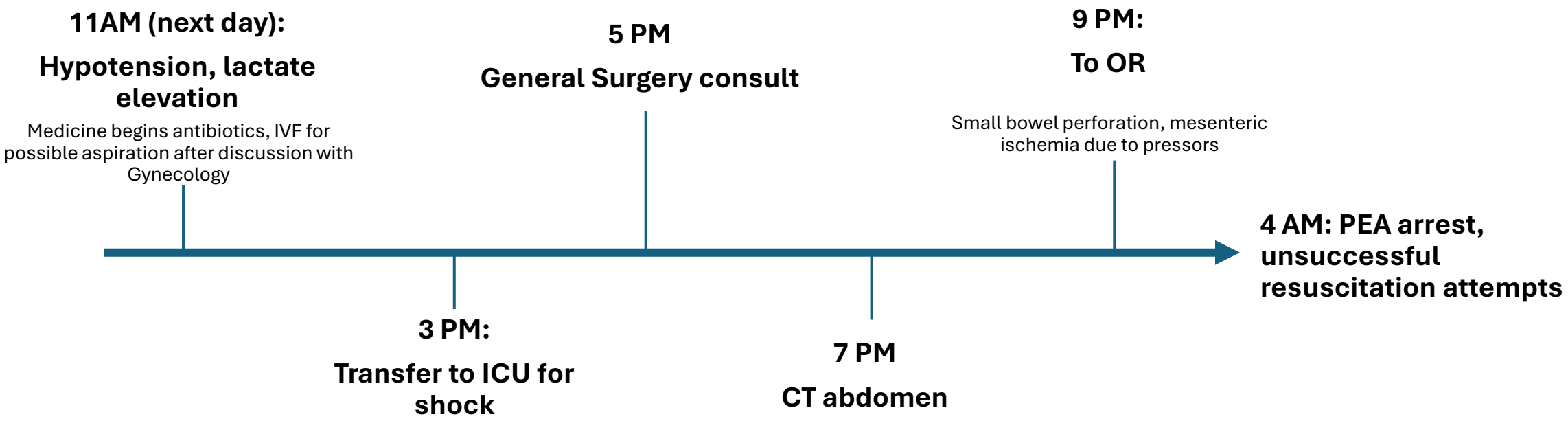
Somewhat like adverse drug event evidence circa 2000

- Disparate data on prevalence of diagnostic errors, few data on underlying causes
- Growing interest in policies and procedures
- Fundamentally limited by our ability to measure ‘diagnostic excellence’
- Maybe not building on what the safety world has learned so far….

Diagnostic error prevalence and causes: The UPSIDE study

Patient Story

- Elderly woman with chronic heart failure underwent hysteroscopy for a uterine mass, procedure complicated by uterine perforation.
- Admitted to Medicine in the evening for mild hypoxemic respiratory failure, thought due to intraperitoneal volume and acute heart failure.
- Patient's primary symptom at time of transfer is abdominal pain.



Hypothetical timeline

Was this a ‘good’ diagnostic process?

How would you know?

Symptom or sign

Diagnosis

Timely

Accurate

Diagnostic opportunity:

‘Distance’ between working diagnosis and ‘correct’ diagnosis

Timeliness according to some clinical standard

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3. Image by macrovector on Freepik
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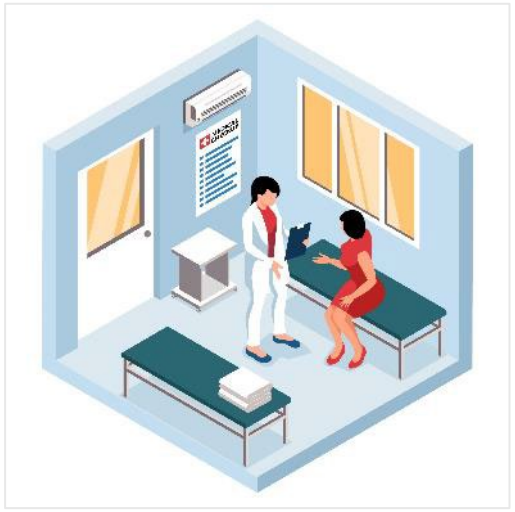

Symptom or sign

Chronic HF EF

Misdiagnosis

Correct diagnosis

Acute HF

Delayed Diagnosis

‘Correct’ diagnosis considered but deprioritized

Diagnosis made, but later than it should have

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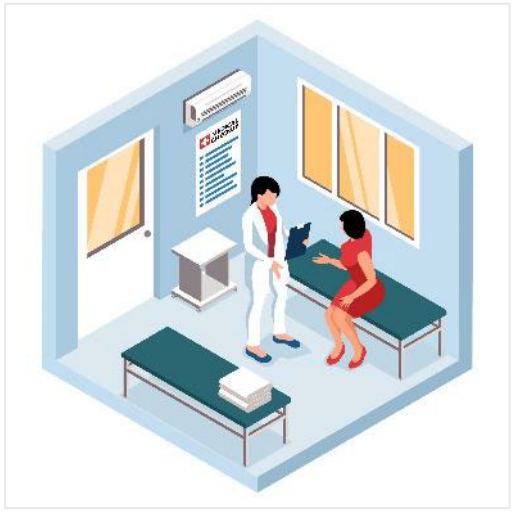

Symptom or sign

Benign positional vertigo

Diagnosis A

Diagnosis B

Stroke

Missed Diagnosis

The correct diagnosis unsuspected by clinician

Working and correct diagnosis so far apart that timing almost irrelevant

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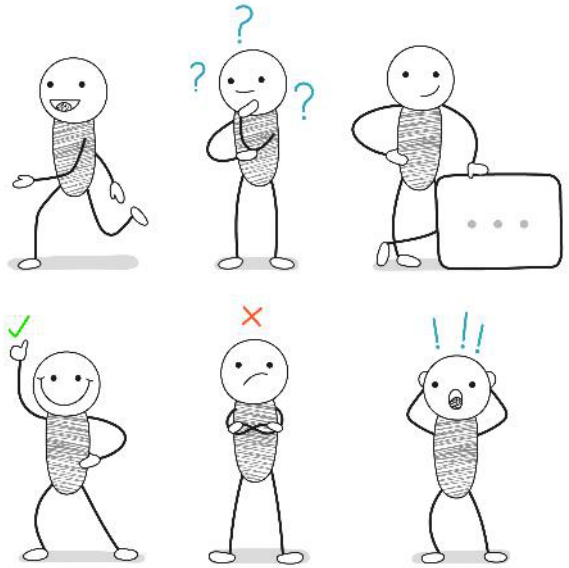
Symptom or sign











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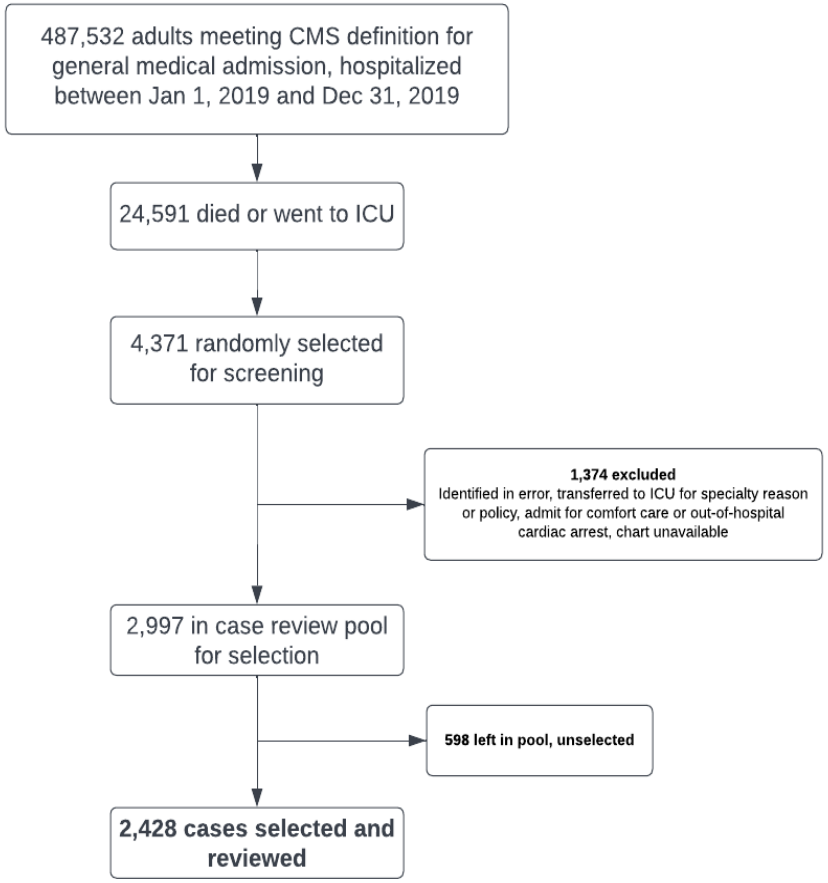
Method	Ease	Valid	Actionable diagnostic process identified?
Unexpected autopsy findings			
Symptom/Diagnosis discordance			
Chart based			

Method	Ease	Valid	Actionable diagnostic process identified?
Unexpected autopsy findings	Moderate (Need an autopsy)	High	Not usually
Symptom/Diagnosis discordance			
Chart based			

Method	Ease	Valid	Actionable diagnostic process identified?
Unexpected autopsy findings	Moderate (Need an autopsy)	High	Not usually
Symptom/Diagnosis discordance	High, using administrative data	Face value high (based on algorithm)	System focused
Chart based			

Method	Ease	Valid	Actionable diagnostic process identified?
Unexpected autopsy findings	Moderate (Need an autopsy)	High	Not usually
Symptom/Diagnosis discordance	High, using administrative data	Face value high (based on algorithm)	System focused
Chart based	Not at all easy	High	Provider process focused

Utility of Predictive Systems in Diagnostic Errors (UPSIDE)



- Did a diagnostic error happen?
- Did the error cause harm?
- Of 50 possible diagnostic processes, what went wrong?

Diagnostic Errors in Hospitalized Adults Who Died or Were Transferred to Intensive Care. Auerbach AD, Lee TM, et al: JAMA Intern Med; 2024;184 (February): 164-173

Audience Participation:

Did a diagnostic error happen?

In conclusion, based on all the above questions, the episode of care under review had a diagnostic error. Diagnostic Error: missed opportunities to make a correct or timely diagnosis based on the available evidence, regardless of patient harm.	◯ Strongly Agree ◯ Agree ◯ Slightly Agree ◯ Slightly Disagree ◯ Disagree ◯ Strongly Disagree

Diagnostic Error: missed opportunities to make a correct or timely diagnosis based on the available evidence, regardless of patient harm.

Source: Upside study. Permission to use.

Case

Did an error happen?

- Clinical course should have prompted earlier reconsideration of working diagnosis
- Diagnostic testing should have prompted earlier reconsideration
- Physical exam suggested alternate diagnosis

We agreed that an error took place

What were the contributors?

- Inaccurate or misinterpreted exam
- Failure to order needed tests (CT)
- Failure to recognize urgent condition
- Failure or delay in ordering referral to surgery
- Suboptimal consultation coordination/communication
- Overweighing lower likelihood diagnosis

Return to our case example

Interpretation of documentation by our adjudicators

- Considered possible bowel perforation
- Gynecology service did not have concern for pathology related to the procedure but more concerned about pulmonary process
- Reassurance from Gynecology service contributed to late engagement of general surgery

Now do that 2427 more times…..

- **23%** of patients had a diagnostic error
- Errors caused temporary or permanent harm, or death in **18%.**
- In patients who died, a diagnostic error contributed to death in **7%**

Diagnostic Errors in Hospitalized Adults Who Died or Were Transferred to Intensive Care. Auerbach AD, Lee TM, et al: JAMA Intern Med; 2024;184 (February): 164-173

Contributors to errors

Diagnostic Process faults	Prevalence (%)
Access/presentation faults	11%
Errors in history taking	15%
Errors in physical exam	3%
Errors in testing	9%
Errors in follow-up and monitoring	5%
Errors in obtaining referrals	4%
Errors in teamwork	1%
Errors in communication	0.3%
Errors in assessment	12%

Diagnostic Errors in Hospitalized Adults Who Died or Were Transferred to Intensive Care. Auerbach AD, Lee TM, et al: JAMA Intern Med; 2024;184 (February): 164-173

Contributors to errors Opportunities to improve diagnosis

Diagnostic Process faults	Prevalence (%)	Odds for error	Potential error reduction
Access/presentation faults	11%	NS	NS
Errors in history taking	15%	3	3%
Errors in physical exam	3%	7	4%
Errors in testing	9%	14	**17%**
Errors in follow-up and monitoring	5%	7	**7%**
Errors in obtaining referrals	4%	6	5%
Errors in teamwork	1%	10	NS
Errors in communication	0.3%	NS	NS
Errors in assessment	12%	14	**24%**

Diagnostic Errors in Hospitalized Adults Who Died or Were Transferred to Intensive Care. Auerbach AD, Lee TM, et al: JAMA Intern Med; 2024;184 (February): 164-173

Diagnostic errors: Moving towards solutions

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Identify errors

Case reviews by local team

Integrate with QI and Safety Teams

Event rate and causes shared internally

Benchmark against similar sites

Event rate and causes shared across sites

RRT calls, ICU transfers, deaths in medical patients at 15 sites

2 physician review using streamlined tools

Develop local countermeasures

Recalibrate and monitor local AI models

Develop broad insights

Generalizable diagnostic excellence programs

Achieving Diagnostic Excellence through Prevention and Teamwork (ADEPT). https://reporter.nih.gov/project-details/10642576. Accessed 8/2024.
ADEPT Achieving Diagnostic Excellence through Prevention and Teamwork. https://hospitalinnovate.org/projects/adept-study/. Accessed 8/2024.

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Ways diagnostic errors are <u>different</u>

- About work inside a physician's head
- Improvement may be more based on self reflection and adult learning
- Role of feedback from peers, coaches and teachers will be key

Ways diagnostic errors are <u>the same</u>

- Influenced on systems and teams
- Influenced by workload and stress
- Influenced by information systems and technology
- Influenced by context and culture

Feedback in diagnosis

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Feedback on diagnostic errors

- In other parts of safety – system factors emphasized
- For diagnostic excellence, provider feedback might be….

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Feedback in diagnosis

Encouraging news

- Diagnostic error reviews fit neatly into existing safety and M&M programs, operationally
- The work to identify a diagnostic error is a moderate amount of additional work for physician
- Physicians able to reflect on performance honestly
- Beginning to see improvement targets

Solutioning

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Data acquisition and monitoring problems

History taking

Delay in ordering or performing test

Erroneous test interpretation

CDS like changes, nudges

Cognition problems

Erroneous test interpretation

Failure/delay in considering diagnosis or complications

Prioritizing or weighting issues

Debiasing, coaching

Communication
Cognitive load
Workload

REFLECTION

THE SHIFT

A.I. Has a Measurement Problem

Which A.I. system writes the best computer code or generates the most realistic image? Right now, there's no easy way to answer those questions.

Roose, K. A.I. Has a Measurement Problem. The New York Times. April 16, 2024. Section B. Page 1.

Predictive AI

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Predictive models

- Strong need for decompensation or ‘not responding as expected’ models
- We must remain humble and while understanding how poorly these have performed in the past

Generative AI

- Diagnosis finders (patients and physicians already doing this)
- Test interpretation, diagnostic mishap indicator
- Chart summary for clinical use or to aid safety teams
- Adaptive workflows tailored to clinical scenario or clinician needs

Data acquisition and monitoring problems

History taking

Delay in ordering or performing test

Erroneous test interpretation

CDS like changes, nudges

Cognition problems

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Failure/delay in considering diagnosis or complications

Prioritizing or weighting issues

Debiasing, coaching

Communication
Cognitive load
Workload

Electronic health records

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Changes to the human-technology interface

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Reference standard databases

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Policies, Procedures, Standards

Changes in teams

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Lessons Learned

- Diagnosis is hard
- Diagnostic errors are common and harmful in seriously ill patients
- There are key processes, such as testing, clinical follow-up, and assessment, that may be high priorities for the future.

Key Takeaways

- Diagnostic process improvement is an achievable goal
  - New needs
    - A process for identifying errors
    - A process for coaching and guiding clinicians
  - But can build on a lot of things hospitals and safety programs already do well
    - System change
    - Training and educating clinicians

Questions?

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ACHIEVING DIAGNOSTIC EXCELLENCE
THROUGH PREVENTION AND TEAMWORK

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Contact:

Andrew Auerbach, Andrew.Auerbach@ucsf.edu

REFLECTION

Indiana University Health

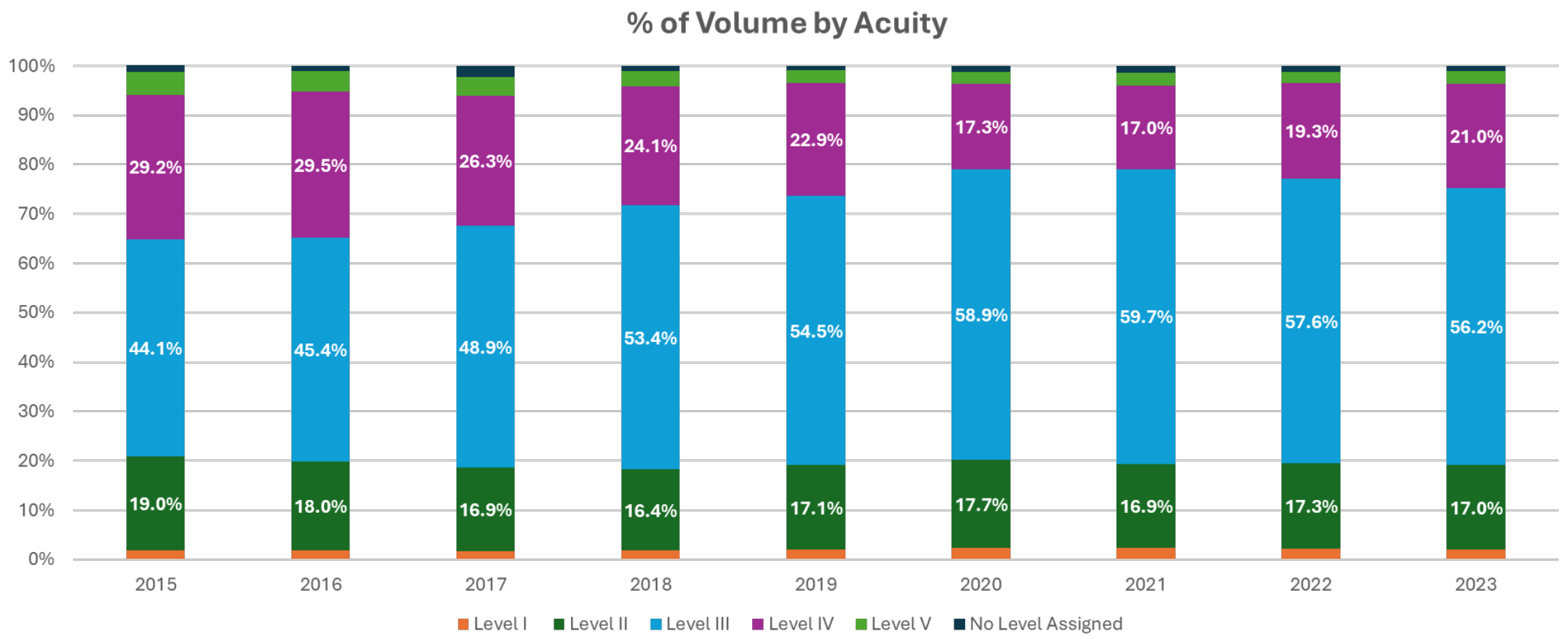
Emergency Department Rapid Intake and Split Flow Model Improves Throughput

Steven Roumpf, MD, MBA
Associate Chief Medical Officer
Medical Director and Section Chief Emergency Medicine
Indiana University Health and Indiana University School of Medicine

Reason for Action

- Progressive decrease of low acuity patients (Emergency Severity Index (ESI) 4/5) while mid-level (ESI 3) acuity patients have increased
- Marked increase in ED boarding
- Increasing wait times
- Undesirable Left Without Being Seen (LWBS) rate
- Flow of ESI 3 patients discharged to home hindered by inpatient holds
- Needed a rapid assessment and split-flow model for patients likely to be discharged home
  - “Vertical Flow” vs ESI acuity segregation
  - Space limited, but similar design and flow model to IU Health Medical Center future ED design

IU Health AAHC ED Acuity Volumes Year Over Year

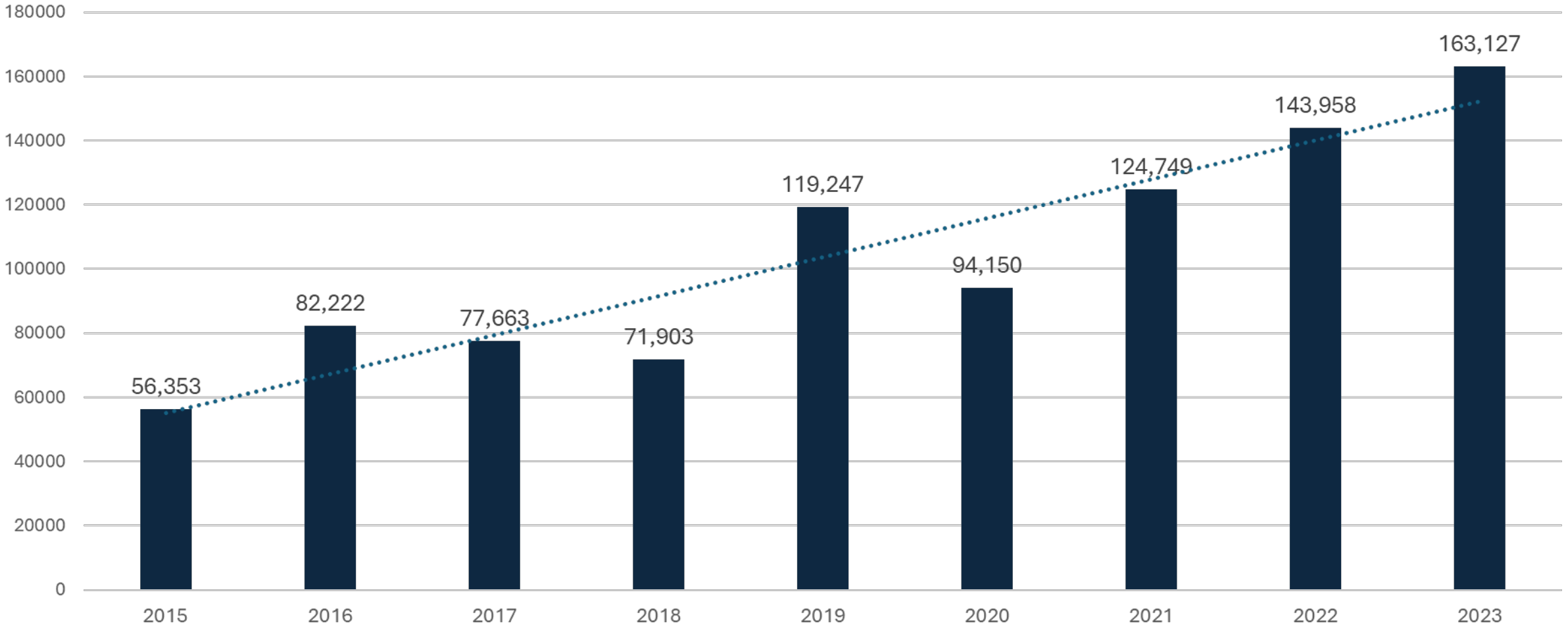


Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

ED Crowding is a Nation-Wide Crisis

- American College of Emergency Physicians – A Nation in Crisis, At a Breaking Point
- ED crowding is rampant
- Root cause is access to inpatient beds
- ED containment strategies necessary for patient safety

IU Health Methodist Hospital ED Boarding Hours



Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

Einstein's Parable

"Insanity is doing the same thing over and over and expecting different results"

- Albert Einstein

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Vision

Design	Efficient rapid assessment and split-flow model
Establish	Establish workflows that will support the new hospital ED design that has Rapid Intake Space/Results Waiting space
Goals	↓ the wait times, LWBS, LOS for discharged patients, and ↑ Patient Experience
Target	Target state cycle times for lower acuity patient
Go Live	ED Construction: started March 29 Go Live: April 17, 2023

Project Team Make Up

- ED APPs
- ED Physicians
- ED Nurses
- ED Nursing and Physician Dyad Leaders
- ED Registration
- ED Nursing Educators
- Experience Design Experts
- Process Improvement Leaders

Accelerated Care Unit (ACU) Capacity

Space: 8 Pod Rooms and 6 Results Pending Chairs

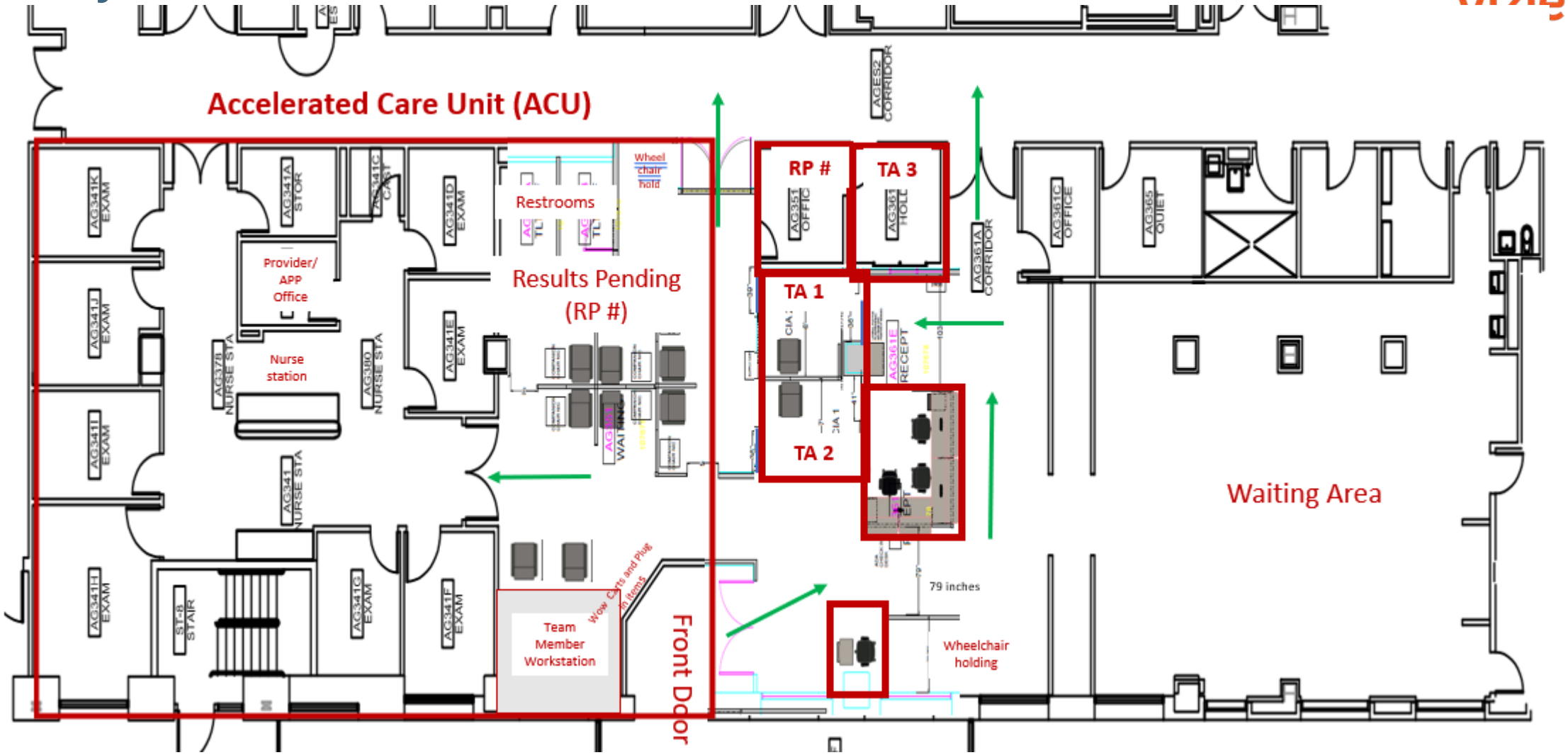
Hours of Operation 9am - 2am

Target Volume Opportunity: 36% of average daily census

- ESI-5: > 90%
- ESI-4: > 75%
- ESI-3: 25%

Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

ACU Layout



Source: IU Health Facilities. Permission to use.

Accelerate Care Unit (ACU) Criteria

ACCELERATED CARE UNIT (ACU)

ACU appropriate criteria

- Able to sit up comfortably
- Not in severe pain
- Not anticipating prolonged workup or admission

Patient examples:

- Headache
- Non traumatic flank pain
- Non-Pregnant vaginal bleeding
- Isolated extremity swelling or injury
- Mild asthma exacerbation
- Back pain (ambulatory)
- Chest pain < 30 years old with normal EKG
- Respiratory complaint with normal sPO2
- Minor head injury
- Well appearing nausea/vomiting/diarrhea
- Urinary complaints
- Minor epistaxis (nosebleed)
- Simple Abscess
- Minor MVC

ACU NOT appropriate criteria

- Needing to lay down
- Pregnancy/postpartum related complaints
- Likely to be admitted
- Pre-arrivals / consults
- Complex wound closures
- Needs orthopedic reduction
- Mental status change (intoxication, etc.)
- High fall risk

Patient examples:

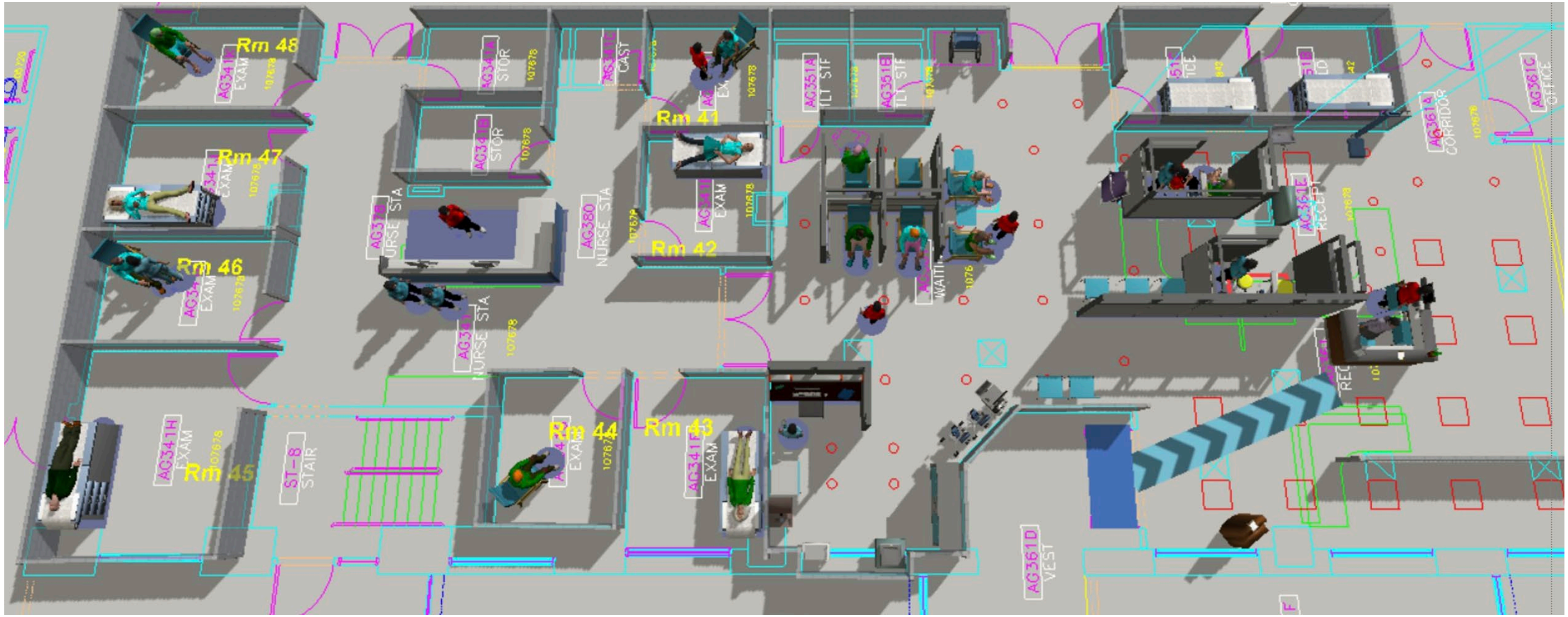
- Elderly abdominal pain
- Dyspnea > age 50
- Weak/dizzy
- GI bleeding
- Syncope / near syncope
- Sickle cell patients
- Psychiatric patients

Resources	Not Resources
Labs, Blood Urine	History& Physical (including pelvic)
ECG	Point of Care Testing
X-Ray CT MRI Ultrasound Fluids (hydrations, angiography	Saline or heplock
IV Fluids (hydrations)	PO Medication
IV IM or Nebulized medications	Tetanus immunization
Specialty Consults	Prescription Refills
Simple procedures =1 lac repair/foley)	Phone call to PCP
Complex procedure =2 conscious sedation)	Simple wound care (dressing -recheck)
	Crutches, splints and slings

Resources: Count number of different types of resources, not individual tests or x-rays (ex: CBC, electrolytes, and coags = 1 resource; CBC + Chest X-Ray = 2 Resources)

Source: IU Health. Permission to use.

Flow and Capacity Modeled with Simulation Software



Source: FlexSim software. IU has contract for use.

Significant Headwinds 2022-2023

- ↑ 4% ADC
- ↑ 1% admission rate
- ↑↑ 13% Boarding Hours (>1000 hours per month)

Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

Results

- LOS for treat and release by 9 minutes
- Time for decision to admit by 13 minutes
- Median door to provider by 6 minutes
- Left without being seen by 1%

- Patient experience in the ACU was consistently 9-10 points higher than the rest of the ED

Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

Results ACU Volume

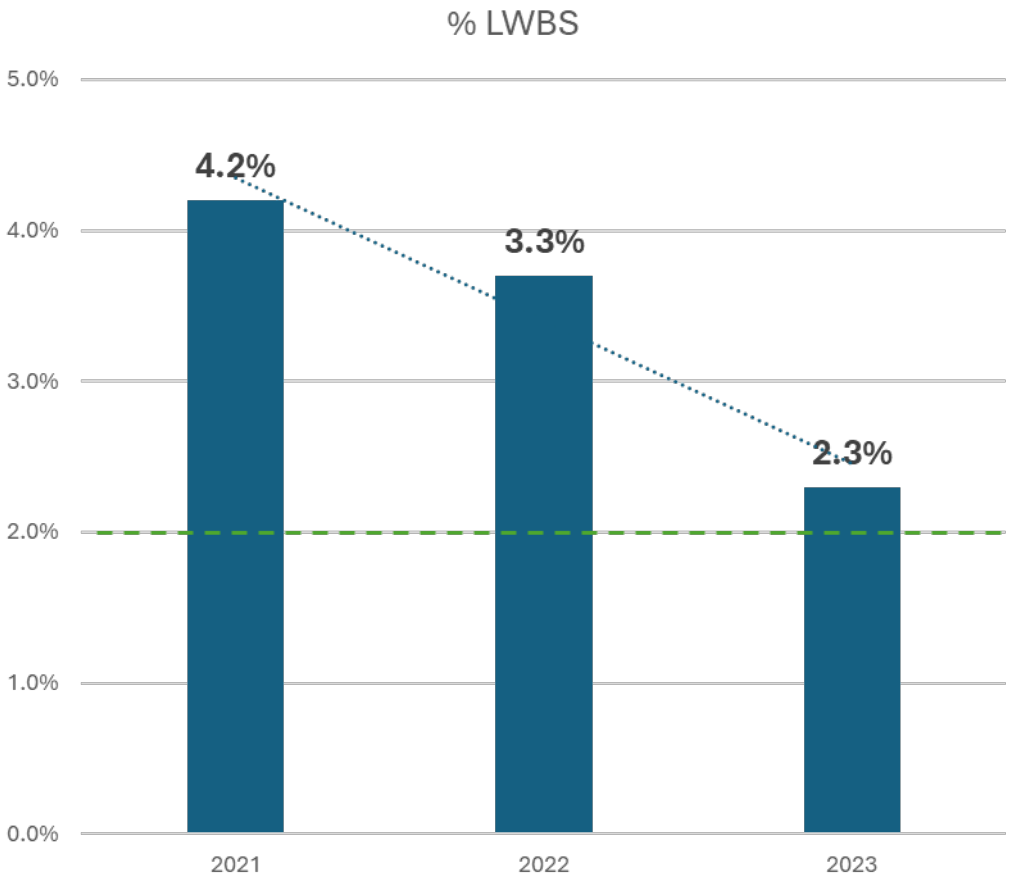
⬆ in % of total ED average daily census (14% ➡ **19%,** ~ 12-15 patients/day)

- Especially impactful on **high volume days**
- Higher **complex**ity patients (vs previous “Fast Track” model)
- Goal is 25% (2024 is up to 22%)

Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

Results: Left Without Being Seen – Target < 2%

- 1% Decrease in LWBS from 2022 to 2023
- Decline in waiting room length of stay



Data Source: IU Health Enterprise Analytics Emergency Department (ED) Cube_02

New IU Health Downtown Medical Campus Under Construction Opening late 2027

New ED Rapid Intake Space

- 3 intake screening rooms
- 8 “vertical” recliners
- 14 beds
- 30 results waiting/inner waiting room
- 46 WR chairs

- ACU allows team members to trial new workflows/concepts in preparation for the new ED
- Establish best practice
- Team member engagement

Lessons Learned

- Adoption of new workflow isn’t easy
- Sustainment is even harder
- Stakeholder accountability
  - Active engagement
  - 2-way communication
  - Support adherence to role expectations
  - Responsiveness to concerns
- Adaptability
  - Flexibility in approach
  - Adjust strategies and processes
  - Use data to support and drive actions

Key Takeaways

- **Multidisciplinary team** drives success and sustainment
- **LEAN** Rapid Improvement Event format was key to implementation
- ”Lower/**Vertical**” Acuity vs ESI segregation promoted overall efficiencies
- **Standard Work** for all roles
  - Specific actions/tasks, with focused on quality and timely care delivery
  - Consistent repeatable processes to hardwire new practice standards
- **Communication** and Training Plans
  - Multiple channels/modes to share data, feedback and ask questions
  - Written documentation with 1:1 team member training
- **Budget Neutral**
  - Leveraging existing assets
  - Maximize internal resources
  - Piloted without additional FTEs

Presentation and Team Member Credits

Presentation Assistance

- Jamie Birkle
- Allison Hemmelgarn
- Ben Hunter, MD
- Kate Pollard, MD

Team Member Credits

- Dre Alexander
- Ed Bartkus
- Jamie Birkle
- Taylor Bolin
- Jen Davis
- Samantha Dillman
- Timothy Ellender
- Lanna Guzman
- Geoffrey Hays
- Allison Hemmelgarn
- Curtis Hollen
- Ben Hunter
- Jairus Johnson
- Olivia Johnson
- Ty Kelly
- Liz Linden
- Chandler Manns
- Amanda Noth-Matchett
- Kayla Nussbaum
- Kate Pollard
- Riley Powers
- Rebecca Richey
- Michele Saysana
- Lora Stahl
- Carly Temple
- Joseph Turner
- Lauren Walter
- Jo Whitis
- Steven Wipprecht

Questions?

Indiana University Health

vizient.

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REFLECTION

Unlocking Value- Harnessing Patient Messages for Transformative Care

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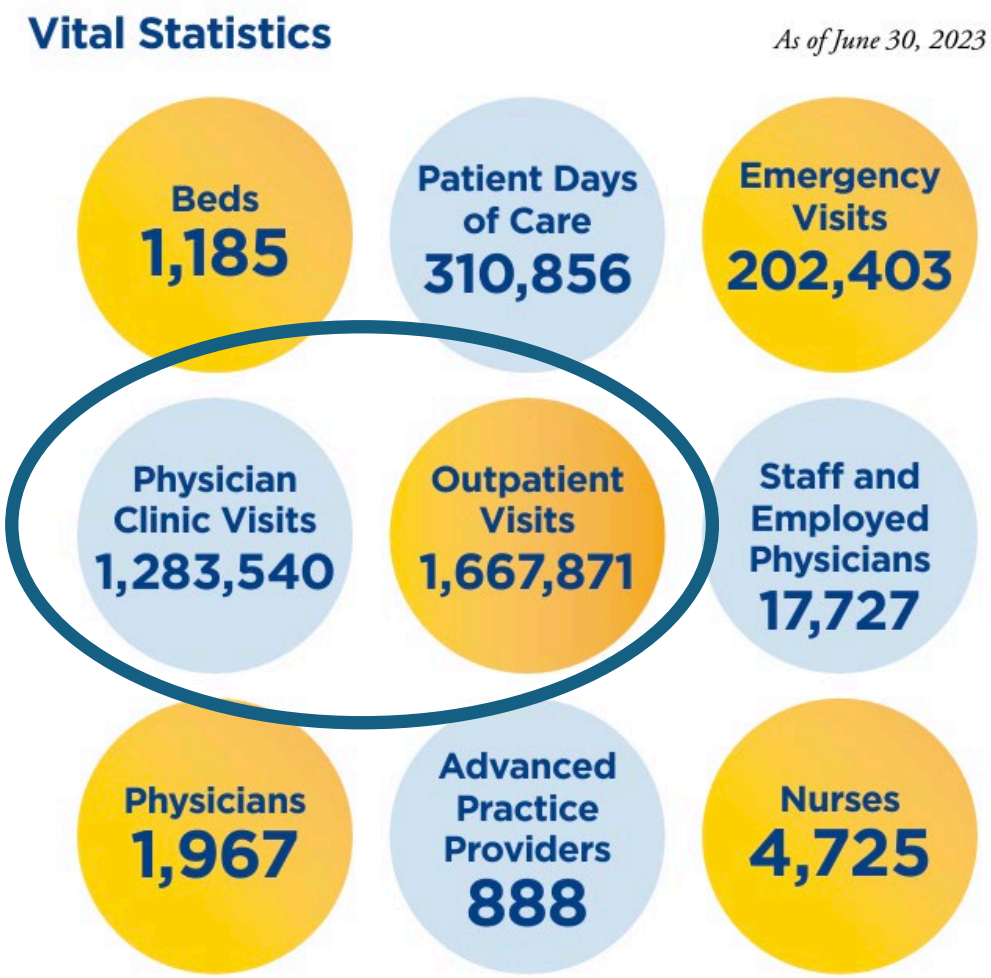
Froedtert and the Medical College of Wisconsin, New Berlin, Wis.

Erika Smith, PharmD, FACHE, FASHP, Executive Director, Transformation & Integration

Froedtert Health, Menomonee Falls, Wis.

Froedtert & Medical College of Wisconsin



Source: Froedtert & Medical College of WI Marketing Department. Permission to use.

- Regional Health Network
- Academic Medical Center
- Adult Level I Trauma Center
- 10 hospital locations
- >45 health centers and clinics

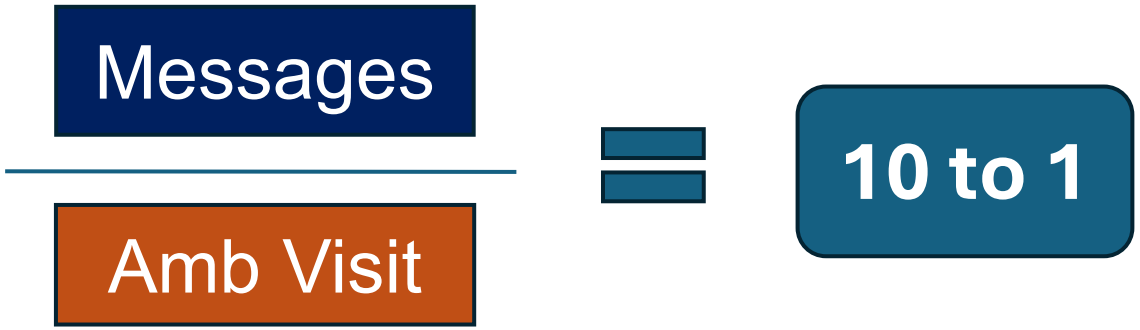
Patient Portal Messaging Has Surged

- Physicians receive 57% more patient portal messages than they did before the COVID-19 pandemic.[1]
- Digital engagement boom: 46% more patients access portals since 2020.[2]
- Health systems experienced a significant increase in workload to clinical care teams.[3, 4]

1. Lubell, J. When it comes to inbox overload, U.S. physicians have it worst. American Medical Association. Digital content. November 20, 2023.
2. Richwine C. Progress and Persistent Disparities in Patient Access to Electronic Health Information. JAMA Health Forum. 2023 Nov 3;4(11):e233883. doi: 10.1001/jamahealthforum.2023.3883. PMID: 37948063; PMCID: PMC10638642.
3. Ferguson K, Fraser M, Tuna M, Bruntz C, Dahrouge S. The Impact of an Electronic Portal on Patient Encounters in Primary Care: Interrupted Time-Series Analysis. JMIR Med Inform. 2023 Feb 6;11:e43567. doi: 10.2196/43567. PMID: 36745495; PMCID: PMC9941901.
4. Chavez A, Bracamonte J, Kresin M, Yardley M, Grover M. High Volume Portal Usage Impacts Practice Resources. J Am Board Fam Med. 2020 May-Jun;33(3):452-455. doi: 10.3122/jabfm.2020.03.190401. PMID: 32430378.

Impact on Our System

- More than 3 million messages sent in the last 2 years
- 1 million forwarded directly to the physician



Opportunity to transform the deluge of portal messages

- Triage
- Improve access for patients with complex messages—leverage telehealth
- Develop and implement standardized workflows: high reliability journey

Source: Froedtert & Medical College of WI MyDA database.

Addressing the Challenges

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Infrastructure

- Data
- Access
  - Video visit rate: 5.3%
- Primary care v. Specialties
- Guidelines/workflows, visibility to help triage

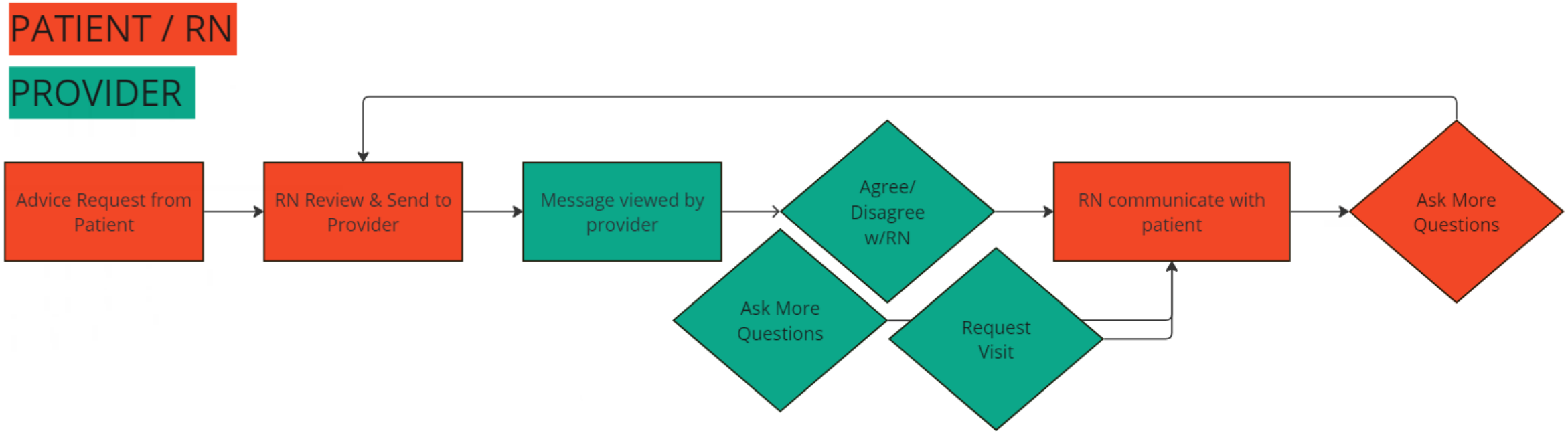
Clinical Practice

- Teams
- Culture and trust
- Dependence on physician to respond to portal messages
- Burnout, involvement, buy-in
- Unclear way to triage portal messages
- Guidelines/workflows, variability

Source: Froedtert & Medical College of WI MyDA database.

Our Hypotheses

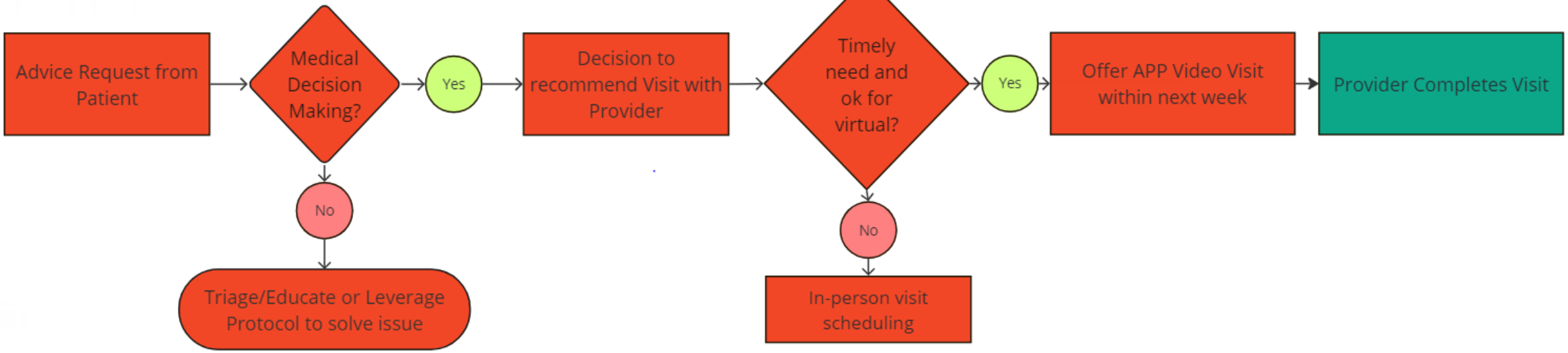
Offering patients a timely, APP led video visit (VV) will result in faster response to complex needs, less messages hitting primary care physician inbox and increase VV utilization overall



Adapted Workflow

PATIENT / RN

PROVIDER



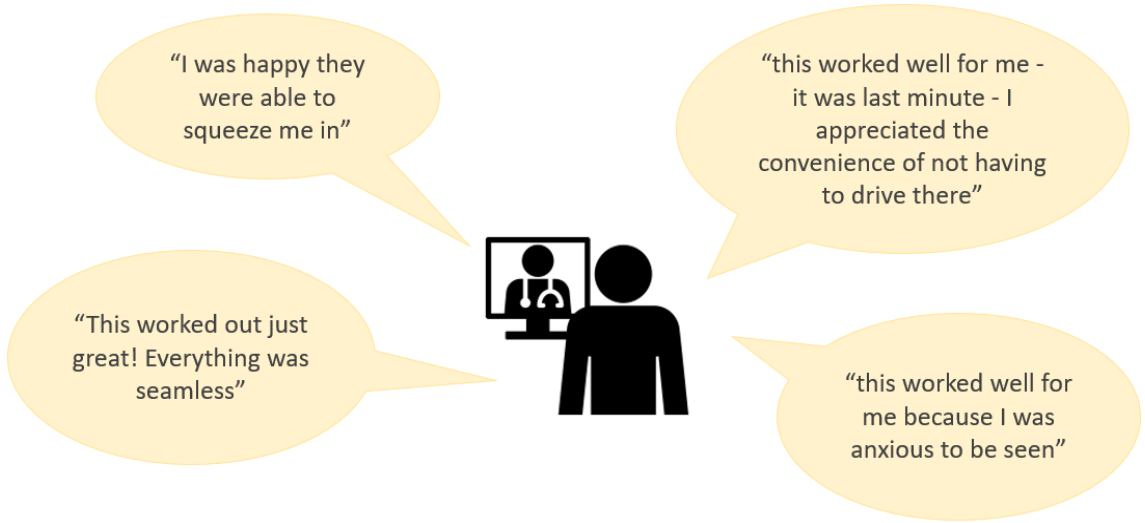
Guidance & Empowerment

Easy Button

"Our Standard"

Early Results

- PDSA approach: 3-month pilot
- 12 providers: 6 MD, 6 APPs
- Standard work = safer work
- Early Outcomes
  - 44% reduction of patient messages sent to physicians*
  - 24% increase in video visits led by APPs*
  - 92% Top Box score in patient satisfaction**
- Pilot Teams feedback - RN/APP
- Ongoing pilot provider success



*Source: Froedtert & Medical College of WI MyDA database; relative change comparing intervention vs. Control
** Post visit patient experience survey call

Scale & Sustainment Phase

Set Up Standard Work

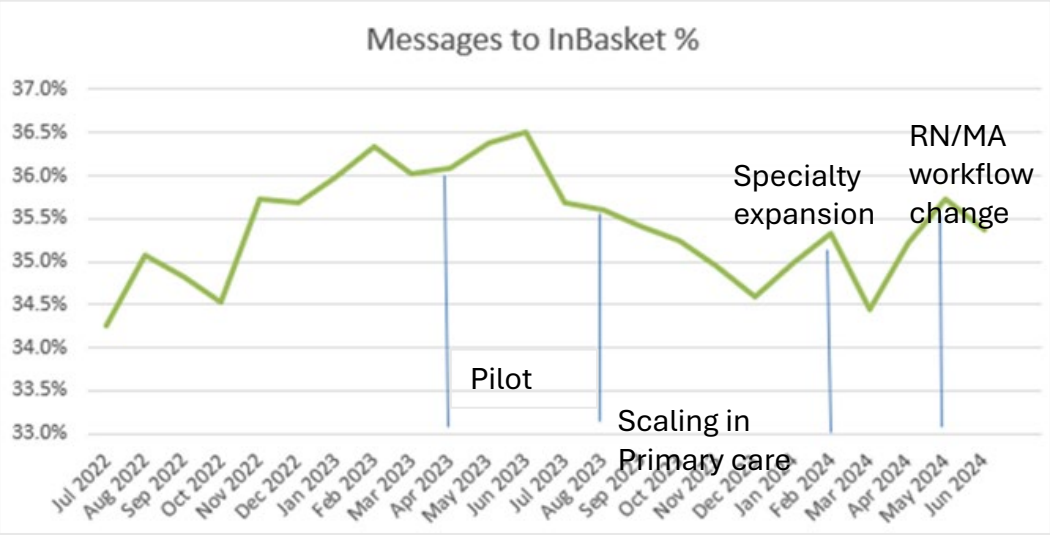
Alignment with Goals and Incentives

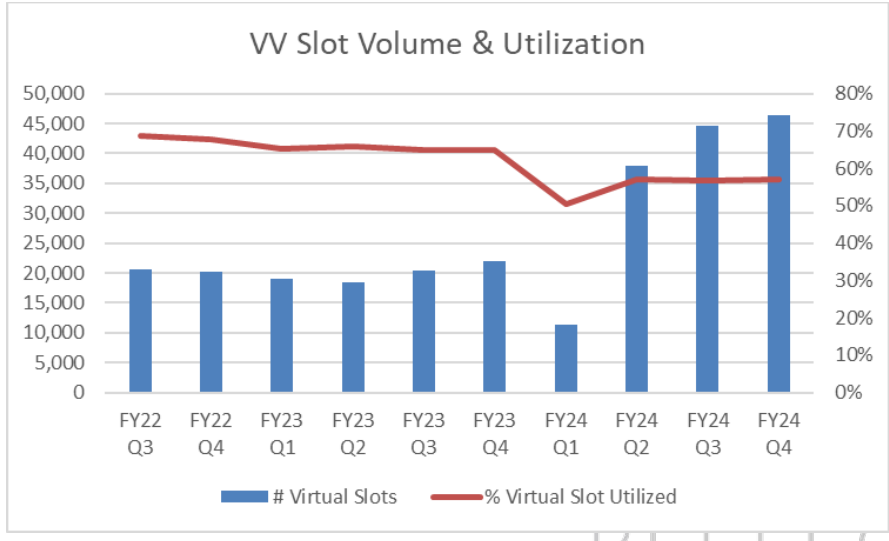
Highlight Best Practices

Alignment with Related Strategy- Blocks

Alignment with Related Strategy- Tickets

Keep Refining



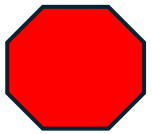


Source: Froedtert & Medical College of WI MyDA database.

Lessons Learned

Boosters

- Team approach to the project
- Analytics support & PDSA
- Leadership & rounding
- Patient response
- Aligning incentives and approaches



Barriers

- Portal structure for the patient to submit
- Protocols and tools for team to address needs with a top of license approach
- Infrastructure to "make it easy"
- Visibility into the problem

Key Takeaways

- Patient connections to their clinical team between clinic visits ("asynchronous care") continue to increase, requiring novel solutions to finding balance for patients and clinicians

- We aligned enterprise priorities to address the deluge of patient portal messages, digital engagement, access, and telehealth to meet patient and clinician needs

- Proof of concept rapid iteration, intentional sustainability strategies, evolving infrastructure and addressing clinical practice challenges (culture) helped us to accelerate learnings and outcomes

Thank you!

vizient.

Project Leadership:

Dr. Mark Obermyer, Dr. Lakshmi Kurre, Dr. Sunu Eapen, Dr. Josh Meskin

Support Teams:

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Executives:

Dr. Ian Schwartz, Dr. Amir Ghaferi, Caryn Esten

Pilot Clinics:

Lincoln Ave Health Center, Sunnyslope Health Center, Westbrook Health Center

Key Leadership:

Dr. Amy Miller, Dr. Kim Gecsi, Ann Tesmer, Arthi Susai, Jennifer Fleischman, Bryan Yagodzinski, Dr. Bryan Beaumont

REFLECTION

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Using AI to Improve End-of-Life Care

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BJC Healthcare, St Louis, Mo.

Patrick White, MD, PhD
Stokes Family Endowed Chair and Chief of Palliative Medicine, Washington University in St. Louis
BJC Healthcare/Washington University, St Louis, Mo.

Background

- Advance care planning (ACP) is critically important for improving quality of care, increasing patient/family satisfaction, and reducing unnecessary costs
- ACP and palliative care are significantly underutilized in nearly every health system in the US
- Major barriers:
  - Accurate identification of high-risk patients
  - Engaging providers to participate in goals of care discussions

Algorithm

Electronic medical record data is obtained 24 hours after admission analyzing 500+ variables including:

1. Diagnoses
2. Vitals
3. Labs
4. Medications/therapies

Death or hospice occurred in 1.4% of low encounters, 5.2% of medium encounters, and 18% of high-risk encounters.

Workflow

- Small group, in person trainings with standardized patients
- Semi automated alerts to providers
  - Hospital floor
  - ICU
  - Primary Care
- Phased rollout to 8 hospitals of various types

Pilot

- Hospitalist Service
- Non-ICU
- Full code, no documented goals of care
- Jan – July 2021
- Community hospitals

Original Investigation | Health Informatics

Advanced Care Planning for Hospitalized Patients Following Clinician Notification of Patient Mortality by a Machine Learning Algorithm

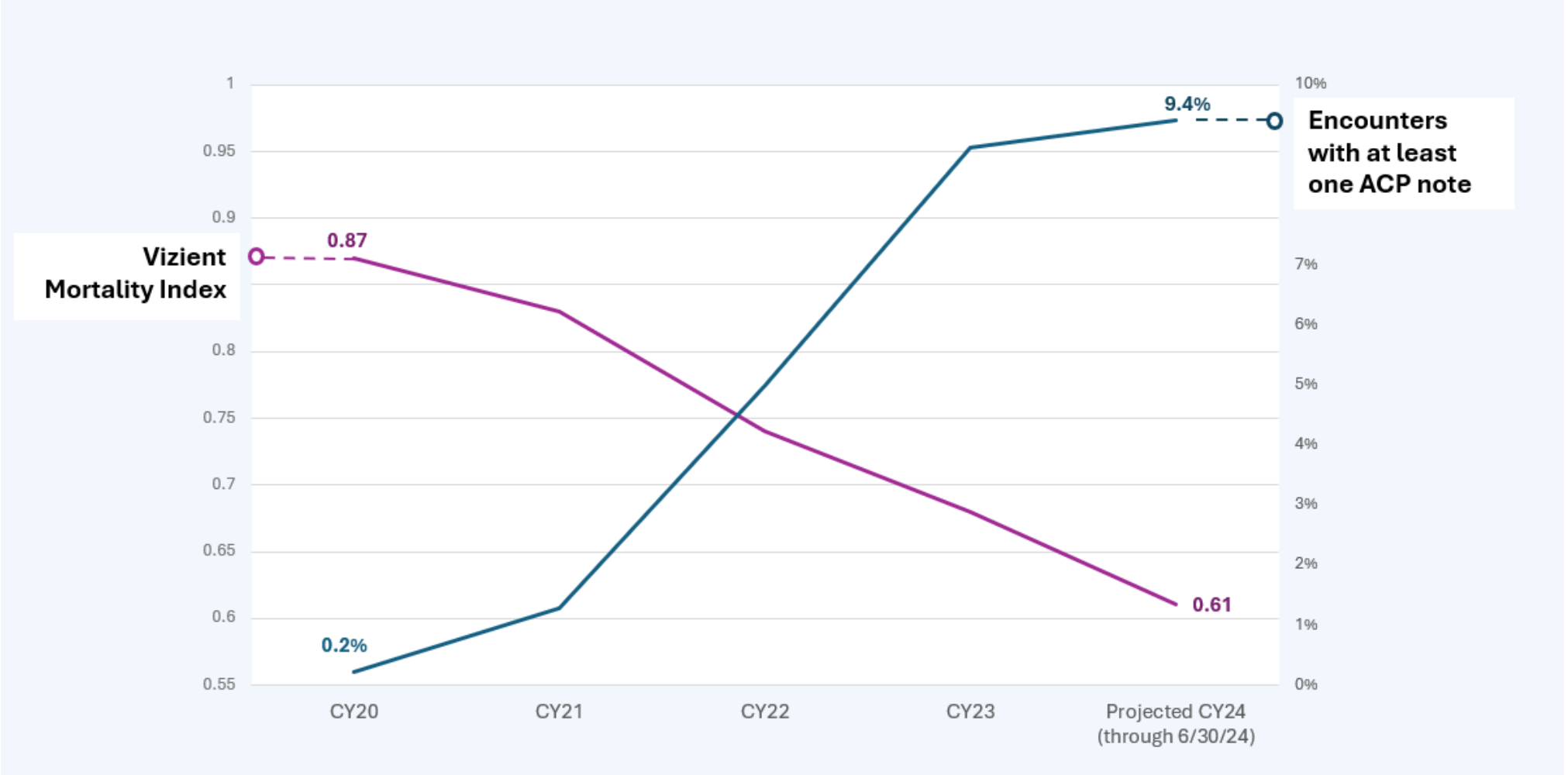
Chi S, Kim S, Reuter M, Ponzillo K, Oliver DP, Foraker R, Heard K, Liu J, Pitzer K, White P, Moore N. Advanced Care Planning for Hospitalized Patients Following Clinician Notification of Patient Mortality by a Machine Learning Algorithm. JAMA Netw Open. 2023 Apr 3;6(4):e238795. doi: 10.1001/jamanetworkopen.2023.8795.

Outcomes

- 87% response rate
- **5x increase in documented advance care planning (ACP)**
- **ACP occurred 2x earlier** during hospitalization
- **3x higher rate of code status changes**

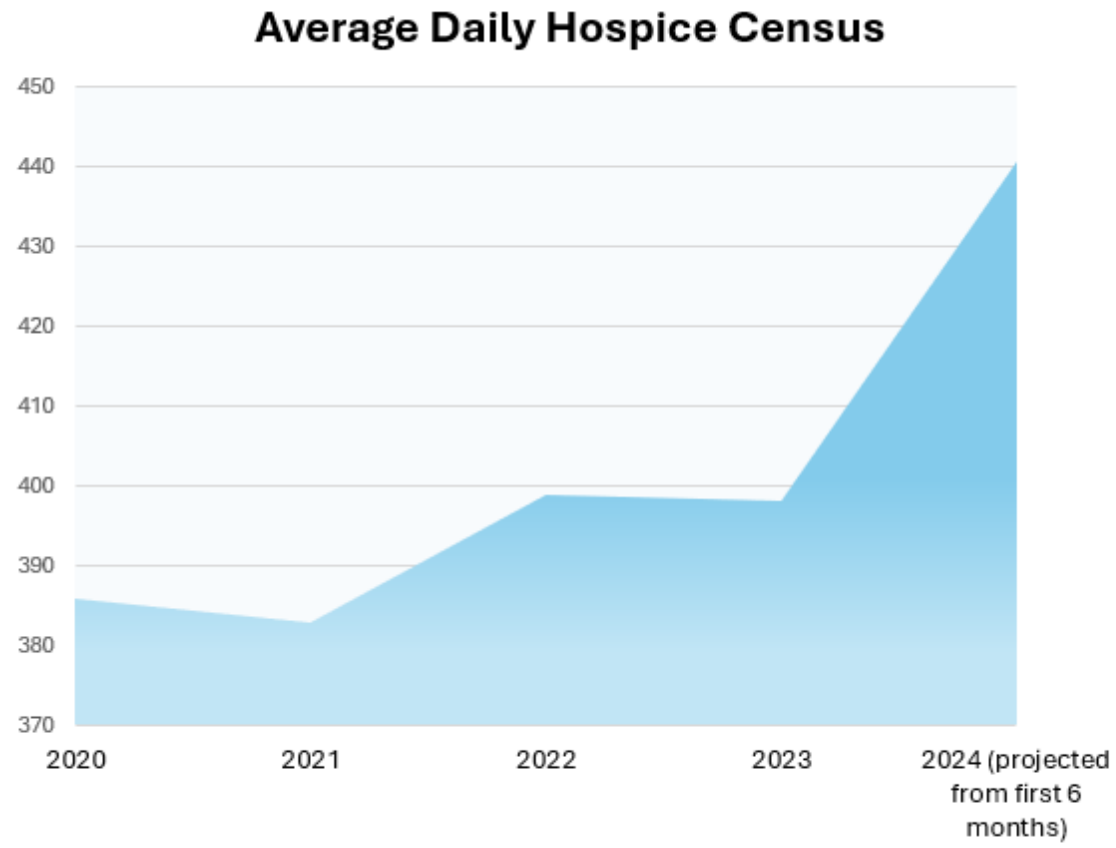
Source: BJC HealthCare data

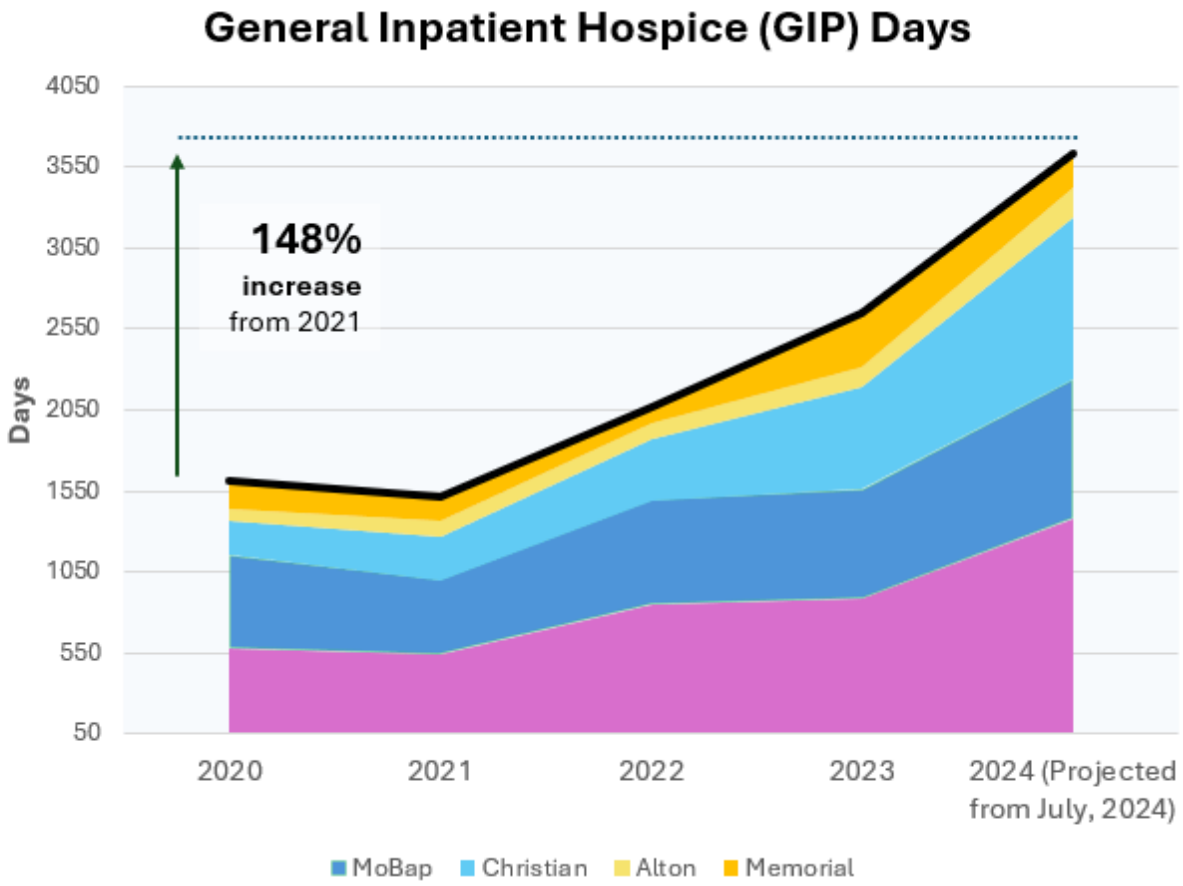
System Wide Results



Source: BJC HealthCare data

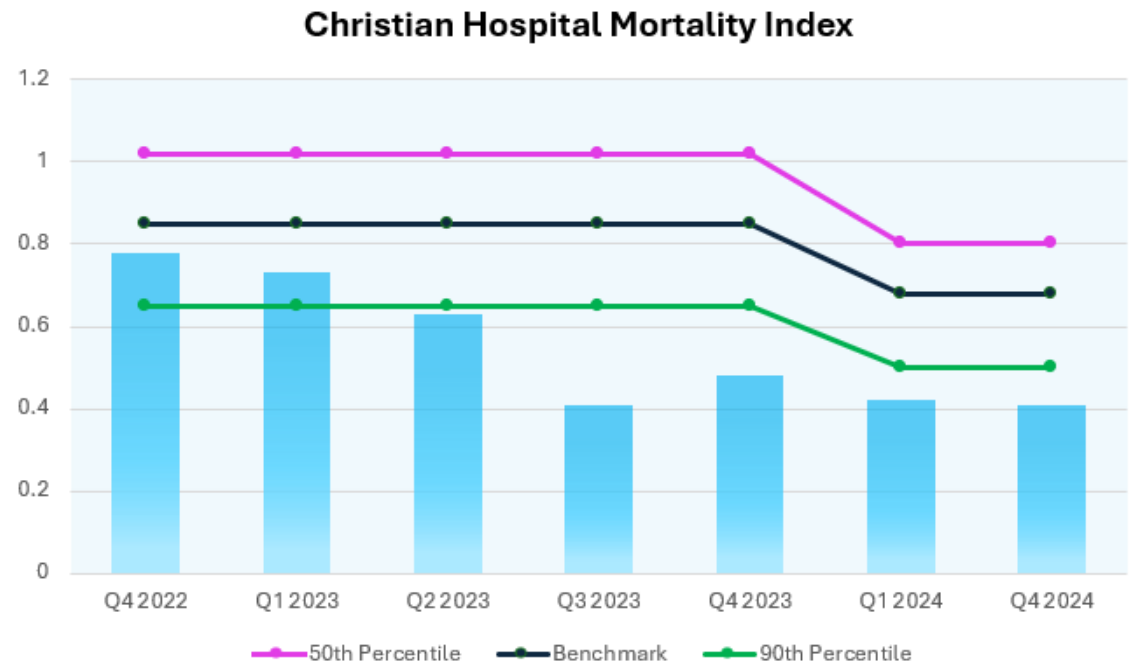
System Wide Results

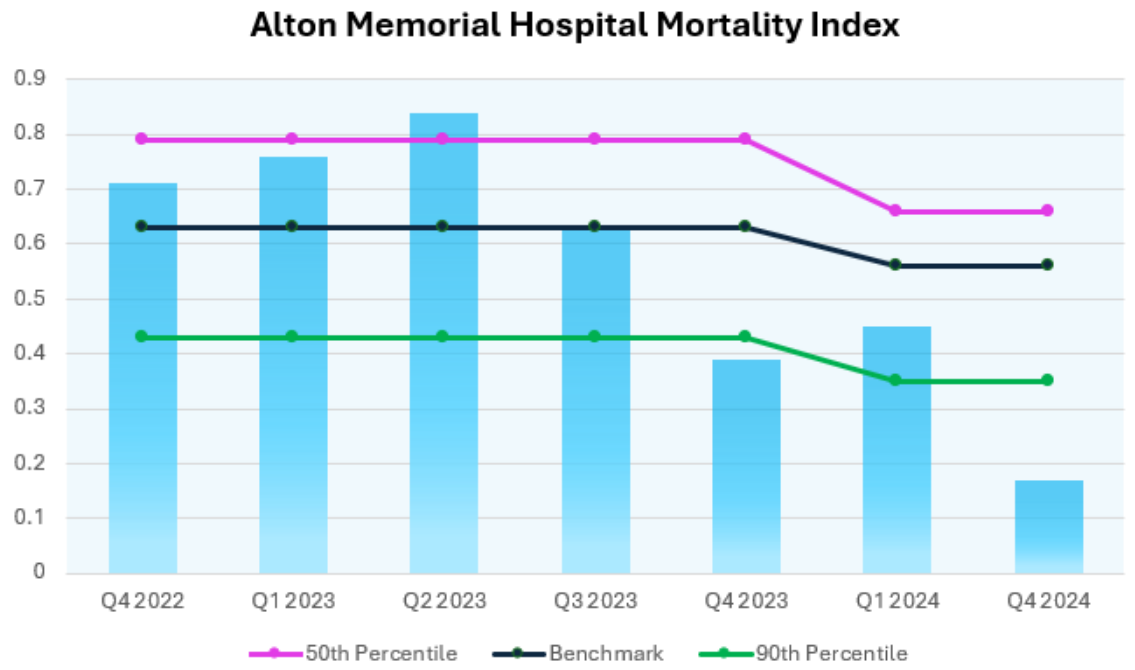




Source: BJC HealthCare data

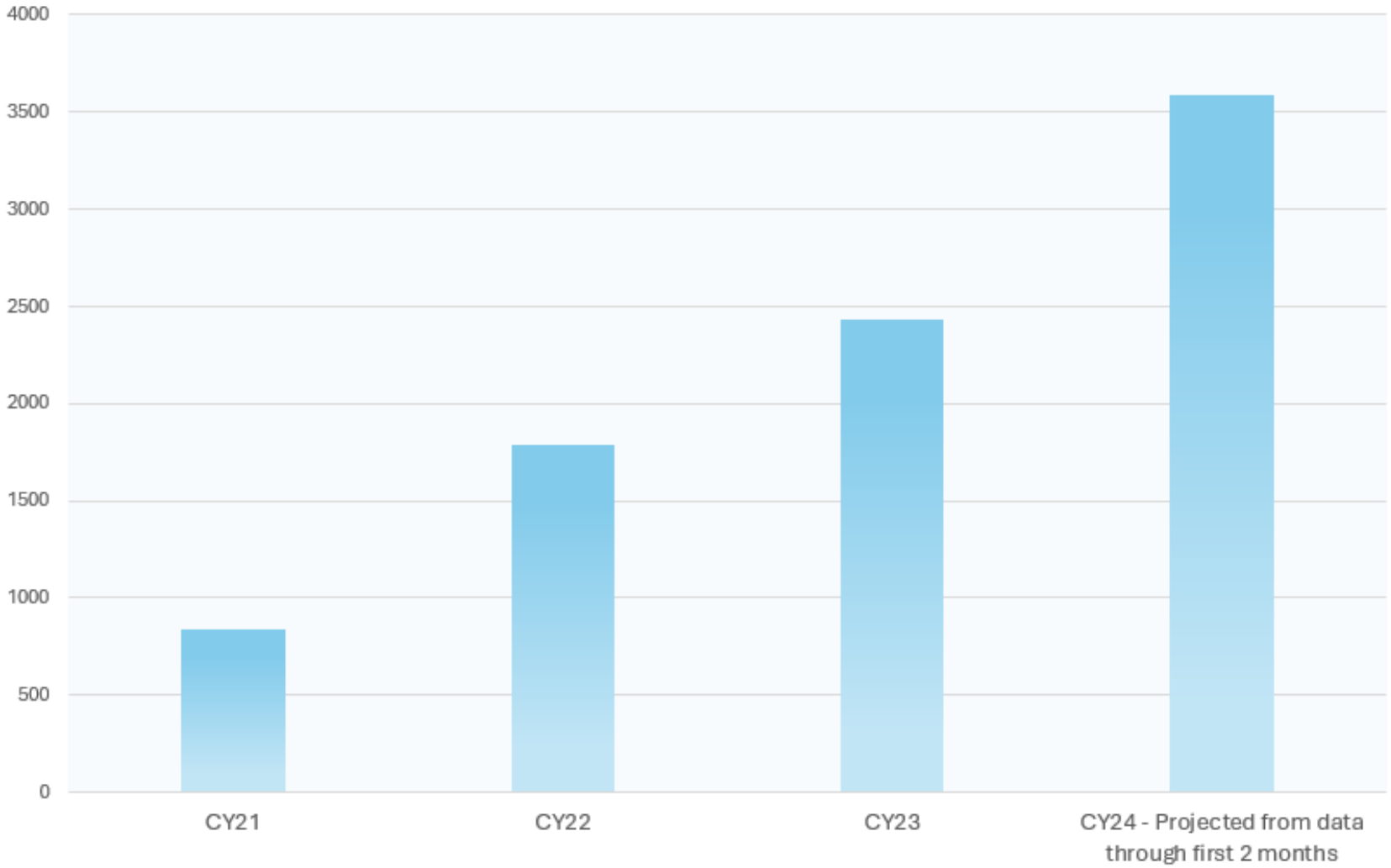
Focus on 2 Hospitals





Source: BJC HealthCare data

Outpatient Palliative Care Visits



Source: BJC HealthCare data

Next steps

- Home care patients
- Enhancing algorithm with unstructured data and notes
- Validating at external sites

Lessons Learned

- Providers are more likely to engage with champions from their own institution and feel that it is beneficial to patients and partners
- Collaboration between informatics, palliative care and hospital medicine is essential
- Providers are willing to engage in difficult conversations if they are given appropriate direction and training (even without financial incentives)

Key Takeaways

- We **can** do better for patients near the end of life
- Work backwards - algorithms are useless without appropriate clinical workflows and training
- Strive for high signal: noise to drive provider engagement

Questions?

Contact:

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From Incident to Improvement: Enhancing Patient Safety Through Standardization and Effective Cause Analyses

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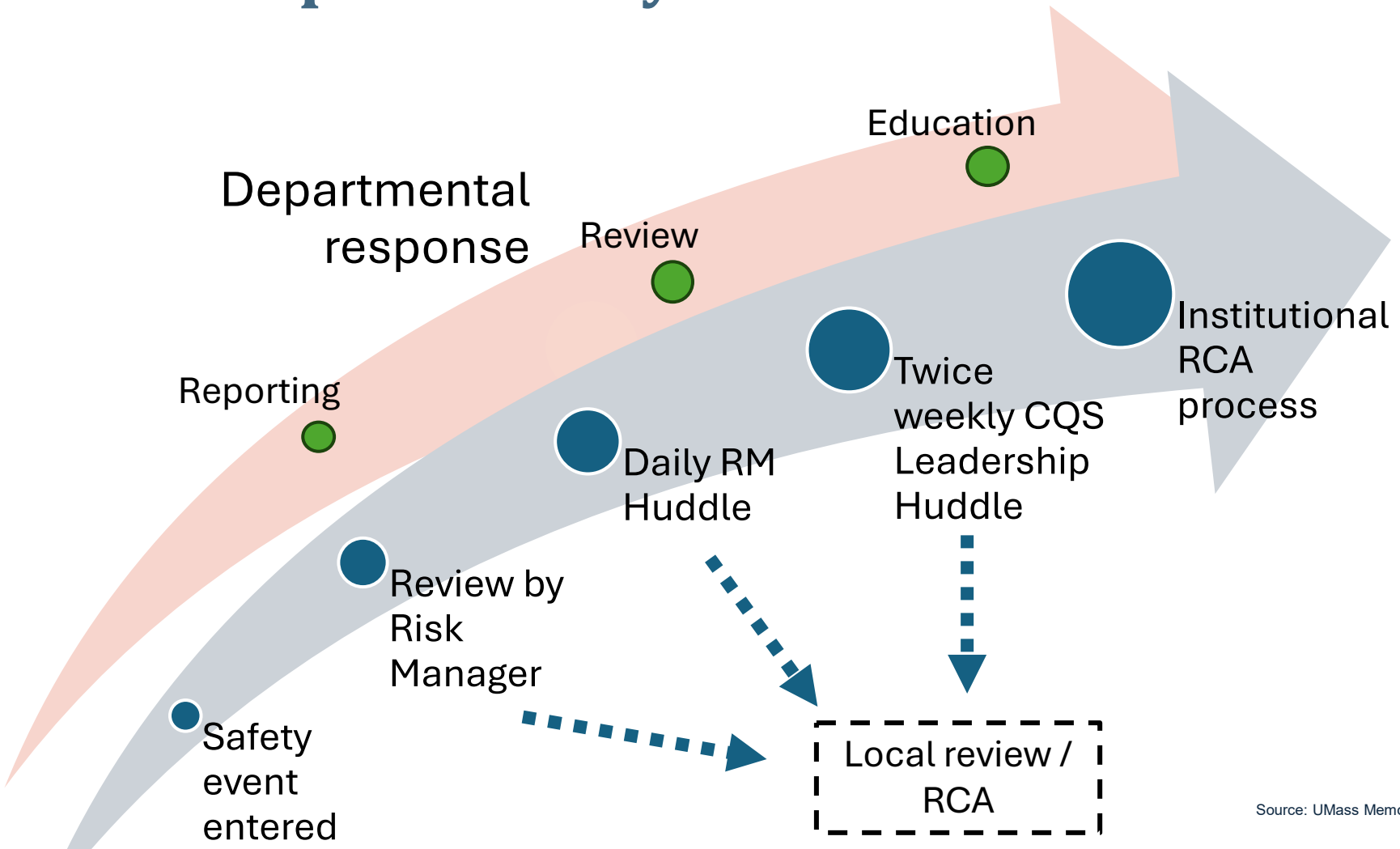
Medical Director Center for Quality & Patient Safety, Associate Professor, Department of Anesthesiology & Perioperative Medicine

Safety Event Report life cycle



Source: UMass Memorial Health. Used with permission.

Essential Components

Mentoring and Support
- Standardize Cause Analysis education.
- Provide CA intervention and support.
- Implement simulation learning.

Problem Solving
- Collaborative problem-solving.
- Understand cause and effect.
- Application of analysis tool.

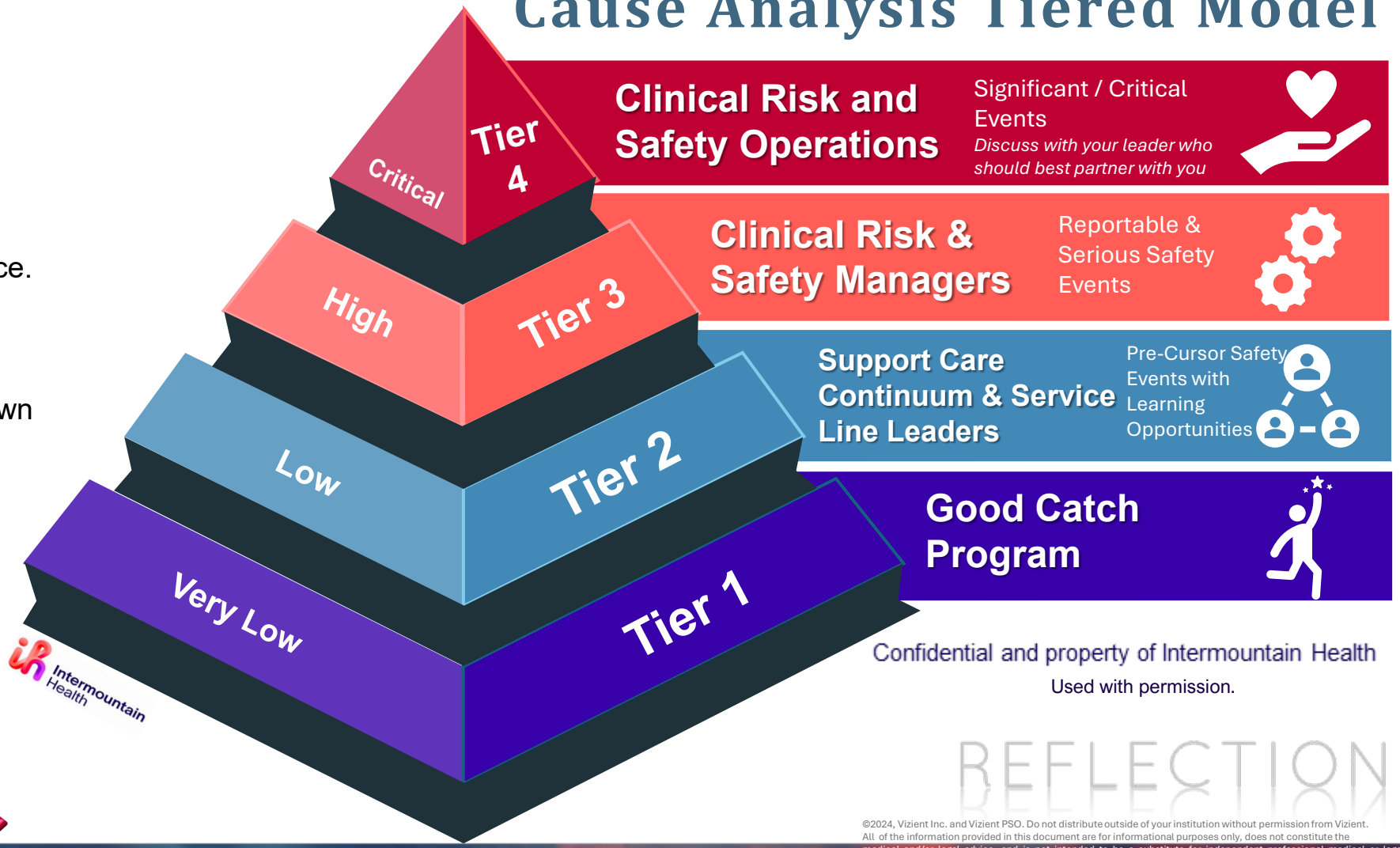
Data & Assessments
- Engage caregiver perspectives.
- Review for equitable patient experience.
- Evaluation of common cause.

Stakeholder Engagement
- Solicit Executive Sponsor ownership.
- Empower leaders and caregivers to own safety.
- Close Loop with involved teams.

Solution Implementation
- Research based solutions.
- Include patient voice/experience.
- Involve caregiver champions.
- Engage interdisciplinary teams.
- Share solutions and lessons learned.
- Define measurements of success.
- Monitor action plans for sustainability.

T1 T2 T3 T4

Cause Analysis Tiered Model



REFLECTION

The Cause Analysis tiered model is a fluid collaborative approach to finding opportunities and sharing solutions across the system.

Which of these circumstances/characteristics are *present* in this patient's journey?

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HEALTH EQUITY DEFINITIONS

Health Equity: *Ensuring that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care (Braveman et al., 2017).*

Characteristic	Definition	Examples
Which of these circumstances or characteristics are present in this patient's journey?		
None	-	-
Age	Age is the amount of time that has passed since a person was born. It is often measured in years and can be used to describe how old a person is. Age impacts many aspects of life, including health, education, and social interactions.	• Dismissing concerns due to age • Agism • Ability to complete activities of daily living • Young pregnant patient • Inability to manage care / understand expectations
BMI	Body mass index (BMI) is a measure of body fat based on height and weight that applies to adults. BMI screens for weight categories that may lead to health problems, but it does not diagnose the body fatness or health of an individual.	• Furniture or equipment that does not accommodate people of size and may limit access to diagnostic studies • Fatism (implicit bias towards people of size) • Inability to complete activities of daily living • Inability to access care due to transportation issues (unable to fit in vehicles)
Community	Community is defined as people and organizations who are impacted by the programming and solutions. These are people and organizations outside hospital walls but within a hospital's service area / town / city / county.	• Identity based communities (e.g., LGBTQ community; Pacific Islander community; Deaf community) • Community groups or community-based organizations • Faith-based organizations • Urban vs. rural disparities • Value-based communities (e.g., plural family communities)
Culture Values, Attitudes, Awareness	Culture refers to the shared values, beliefs, and attitudes of a community or group. This can include a wide range of things, such as language, religion, food, social habits, music and arts, approach to healthcare, holiday celebrations, and death or funeral traditions. Culture is an important part of a person's identity and can influence their beliefs and behaviors.	• Political affiliation • Dress • Tattoos • Holistic/Homeopathic beliefs • Marijuana use • Tone of voice
Homelessness	Temporary, short-term, or long-term state of being without access to stable housing.	• Unstable housing • Discharge disposition • Use of community resources
Interpersonal Violence Abuse, Assault, Neglect	The World Health Organization (WHO) defines violence as: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation".	• Child/Elder abuse • Intimate partner violence • Domestic violence • Work-place violence (WPV) • Community/Stranger violence
Medical Diagnosis	The process of identifying a medical condition or disease based on a person's symptoms, medical history, and other diagnostic tests. It is typically made by a medical professional and will guide treatment and management of the condition.	• Infectious Diseases (HIV, Rabies, COVID) • Palliative Care Issues • Code Status • Obesity
Mental Health or Behavioral Health	Emotional, psychological, and social well-being. A person's ability to function in everyday life and the behaviors exhibited based on their cognition and perceptions.	• Addiction • High utilization of healthcare related to diagnosis • Extensive mental health history • Depression • Anxiety • Suicidal ideation • Schizophrenia • Alert pop ups in medical record • Drug seeking behavior / history of drug seeking in medical record
Neurodiversity	This refers to differences in how people think and understand the world around them, including differences in intellectual and cognitive capabilities.	• ADHD • Intellectual disabilities • Autism spectrum • Traumatic Brain Injuries (TBI) • Dyslexia • Dyspraxia
Physical Ability	This refers to physical traits that affect a person's ability to move around, such as their strength, endurance, or any visible conditions that affect their mobility.	• Patients with ambulatory restrictions (prosthetics, wheelchair, walker, cane, etc.) • Diagnosis that impacts their physical ability
Preferred Language	This refers to the language that a patient or family caregiver would like to use when receiving healthcare services. It does not have to be their first language, and they can choose to use English if they prefer.	• Interpretation Services not available, offered or used • Patient language not available on iPad • Family member used for interpretation • Discharge paperwork or other forms not available in patient's preferred language • Patient is conversational in English but better understands healthcare in their preferred language (literacy) • Medical explanations use too much jargon and are not at the correct reading / comprehension level
Race or Ethnicity	Race refers to a social construct that categorizes people based on shared physical traits, such as skin color. Ethnicity, on the other hand, refers to a social grouping of people who share common characteristics, such as language, nationality, geography, and cultural heritage. While race is often based on physical characteristics, ethnicity is based on cultural and social features.	• Discrimination • Racism • Incorrect assumptions • Cultural insensitivity • Slang/slur • White privilege
Religion or Spiritual Beliefs	Set of deeply held personal beliefs and practices that impact how individuals approach life, death, and healing.	• Religion • Spiritual beliefs • Dietary restrictions • Blood transfusions
Sex, Gender, and Gender Identity	Sex refers to the anatomical organs a person has, such as a vagina, uterus, ovaries, penis, or testicles. Gender identity, on the other hand, is an individual sense of their own gender, such a being a woman, man, genderqueer, or nonbinary. Gender identity is internal and may not be visible to others. It is important to note that gender identity applies to all individuals, not just transgender or gender-nonbinary individuals.	• Misgendering or using incorrect pronouns. • Using "dead name" • Caregiver unable to provide resources on gender affirming care • Gender change
Sexual Orientation	This refers to a person's attraction to others, which can be physical, romantic, or emotional, or all. Sexual orientation is often described as straight, lesbian, gay, bisexual, or queer. It is important to note that gender identity and sexual orientation are not the same. For instance, transgender people can identify as straight, lesbian, gay, or bisexual. Similarly, lesbian, gay, and bisexual people can identify as cisgender.	• Policies that do not consider same sex couples • Bias associated with sexual orientation or identity
Societal Factors	Societal factors are the multifaceted conditions, circumstances, and causes that influence the health of patients. This includes social determinants of health (SDoH), social needs, safety, and systemic causes that are the fundamental causes of the social inequities that lead to poor health.	• Racism • Food deserts • Sexism • Generational poverty • Redlining • Toxic geographies
Socio-Economic Status Education, Income, Occupation	Complex measure of social standing that considers personal and household income as well as educational attainment, occupational prestige, and subjective perceptions of social status and social class. Socioeconomic standing (SES) includes a wide range of quality-of-life attributes and opportunities available to people within a society and is a consistent predictor of a vast array of health outcomes. In other words, a person's SES can impact their access to resources and opportunities that can affect their health and well-being (adapted from APA, 2019).	• Healthcare Literacy • Medical literacy • Pre-natal care • Underserved population • Undocumented immigrants
Visual or Hearing Ability	This refers to how well a person can see or hear based on their physical abilities.	• ASL interpretation not available, offered or used • Corrective lenses or hearing aids • Patient prefers to read lips but is unable to due to masks or other barriers • Braille documents not available

REFLECTION

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Lessons Learned

- Creating a standard operating procedure document for the cause analysis process can create clarity amongst different teams that participate in the evaluation of an event and the improvement.
- Having a standardized centralized process helps to augment and encourage stronger departmental event review and follow-up.
- To ensure skills and confidence are sustained for effective cause analysis practices, provide ongoing training with tools and resources such as lunch n' learns, simulation exercises and mentoring support (an expert mentor dedicated to the cause analysis program).
- Partner with health equity experts to collect the correct data by objectively asking the right questions to capture equity characteristics present in the patient's journey.
- Provide education and training through simulation to ensure knowledge and skills of key stakeholders in facilitating conversations about equity issues.

Key Takeaways

- A standardized process for triaging potential significant safety events, as well as templated follow up processes, helps to achieve consistent improvement and leadership accountability.
- Establish shared file for the quality and safety leadership team to review and track cases and their progress at defined intervals.
- A tiered cause analysis model improved caregiver and leader engagement, reduced time to implement solutions, and reduced action plan variation.
- Integrate health equity into safety event investigations by developing a comprehensive tool to capture equity characteristics present in the patient's journey.
- Identification of equity trends resulted in proactive partnerships with community health leaders surrounding interpersonal violence and suicide.

Questions?

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

Barnett Benvenuti & Butler PLLC.

ATTORNEYS AT LAW

vizient.

PSWP Case Law Update

Wes Butler

Partner Attorney

Barnett Benvenuti & Butler PLLC

REFLECTION

Overview

- Approximately 125 published decisions in legal reporters
- Most cases are in Federal court
  - 75 opinions from Federal courts – 6th, 9th, 10th, and 11th Circuits
  - 50 opinions from State courts – FL, VA, CA, PA, and KY
- General observations
  - Favorable opinions tend to focus on the text of the Act
  - Unfavorable opinions tend to find that the health care provider failed to prove the privilege applied
- Interesting trends
  - Increasing number of employment law cases addressing the PSWP privilege
  - Prison cases

Manazer v. Adena Health System

- U.S. District Court in Ohio – Federal court – June 12, 2024
  - James Manazer, M.D. – Chief of Surgery for 10 years before being terminated by Hospital
  - In 2022, 2 MDs began performing TVAR, but only one was credentialed to perform TAVR
  - Ohio State Medical Bd investigated and Dr. Manazer provided info, data and verbal reports to OSMB
  - Dr. Manazer claimed that info, data and verbal report were provided to Adena "intended for a PSO"
  - Hospital CEO asked Dr. Manazer to meet with reporters inquiring on TAVR
  - Dr. Manazer claims he was going to tell reporters the truth and not Adena's version of the truth
  - An anonymous Facebook account reported on uncredentialed surgeons performing TAVR at Adena
  - Dr. Manazer denied being the Facebook account, but was terminated anyway
  - He alleged termination in violation of the PSQIA, defamation, and tortious interference

Manazer v. Adena Health Sys., No. 2:23-cv-2798, 2024 U.S. Dist. LEXIS 104475 (S.D. Ohio June 12, 2024)

Manazer v. Adena Health System

- Federal Court dismissed Dr. Manazer's PSQIA whistle-blower claim
  - PSQIA prohibits adverse employment actions taken because "an individual in good faith reported information" – 42 USC § 299b-22(e)
    - (A) to the provider with the intention of having the information reported to a PSO; or
    - (B) directly to a PSO
  - An individual that suffers an adverse employment action as a result of a good faith report may bring a civil action to obtain equitable relief – 42 USC § 299b-22(f)(4)(A)
  - Hospital argued that Dr. Manazer did not report directly to a PSO or with the intent that a report be forwarded to a PSO
  - Court found that Dr. Manazer failed to prove that he intended info to be forwarded to a PSO
    - Noted that neither Ohio State Medical Board or Adena are listed PSOs
    - Dr. Manazer offered no evidence of "intent" other than his claim
    - With the PSQIA claim dismissed, federal jurisdiction was lost, and the case was returned to State court

Manazer v. Adena Health Sys., No. 2:23-cv-2798, 2024 U.S. Dist. LEXIS 104475 (S.D. Ohio June 12, 2024)

In re BayCare Medical Group

- U.S. Court of Appeals for the 11th Circuit – May 14, 2024
  - Hospital sought writ of mandamus to prohibit trial court from ordering production of quality files
  - Underlying case involves Dr. Loux claiming employment discrimination
  - Hospital claims Dr. Loux was fired for surgical errors
  - Dr. Loux sought discovery of Hospital's internal documents on the performance of other MDs
  - Hospital claimed that some of the files were privileged as PSWP
    - Specifically, quality files and referral logs stored in rlDatix database
  - Hospital described in detail its process for deciding whether to make a report to a PSO
    - Complaint → Referral to Quality Coordinator → Quality File for Dep't input → Clinical Risk → PSO
  - Hospital explained how it complied with State recordkeeping and reporting obligations w/o PSWP
    - Hospital created additional documents from a "separate system" to comply with State laws
  - Hospital acknowledged that info in rlDatix is used for more than just PSO reporting – e.g., RM, QA, PR or RCAs

In re BayCare Med. Grp., Inc., 101 F.4th 1287 (11th Cir. 2024)

In re BayCare Medical Group

- U.S. Court of Appeals for the 11th Circuit – May 14, 2024
  - Magistrate Judge reviewed the documents *in camera* and recommended the PSWP privilege be applied
  - District Judge disagreed, saying the PSWP privilege does not apply if the info has a "dual purpose"
    - If info is not "solely to report to a PSO" then no PSWP privilege applies
    - This includes the use of such info for internal purposes, such as internal safety analysis and peer review
    - Plus, Dr. Loux needs the documents for her case
  - Federal CoA held that Hospital is entitled to a writ of mandamus because the District Court erred when it applied the wrong legal analysis
    - Hospital claimed "deliberations or analysis" prong on the PSWP definition and rlDatix contains its PSES
    - Question: Does the PSQIA have a "sole purpose" test for the PSWP privilege:
    - Court: No, a "sole purpose" test is not supported by the text of the PSQIA
    - Hospital "may use PSWP for any purpose within its legal entity."
    - AHRQ's 2016 Guidance is not law

In re BayCare Med. Grp., Inc., 101 F.4th 1287 (11th Cir. 2024)

Lessons Learned

- *Manazer*
  - Does your PSES policy give internal reporters to your PSES an argument that when they reported to the PSES they intended the info to be forwarded to a PSO?
  - Who decides whether info is submitted to the PSO?
  - Are there intermediate steps before the decision to report to a PSO is made?
  - Does your PSES policy make clear who has the right to assert the PSWP privilege?
- *In re BayCare*
  - Have you developed a flowchart of your PSES process for PSO reporting?
  - Have you identified potential "State mandated reports/records"?
  - Is your defense counsel ready to argue on the nuances of the PSWP privilege?

Manazer v. Adena Health Sys., No. 2:23-cv-2798, 2024 U.S. Dist. LEXIS 104475 (S.D. Ohio June 12, 2024)

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Key Takeaways

- Assure that defense counsel makes a good record in the trial court on the PSWP privilege with an appeal in mind
- Many courts applying a “purpose” test for PSWP – be ready to cite *BayCare* as an advantage to your PSWP privilege claim
- PSO reporting is still a reliable part of the PSWP privilege argument
- Take a close look at your PSES policy with legal arguments in mind

Questions?

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Closing Comments

For more information about the Vizient Patient Safety Organization, email PSO@vizientinc.com.

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