MedStar Health

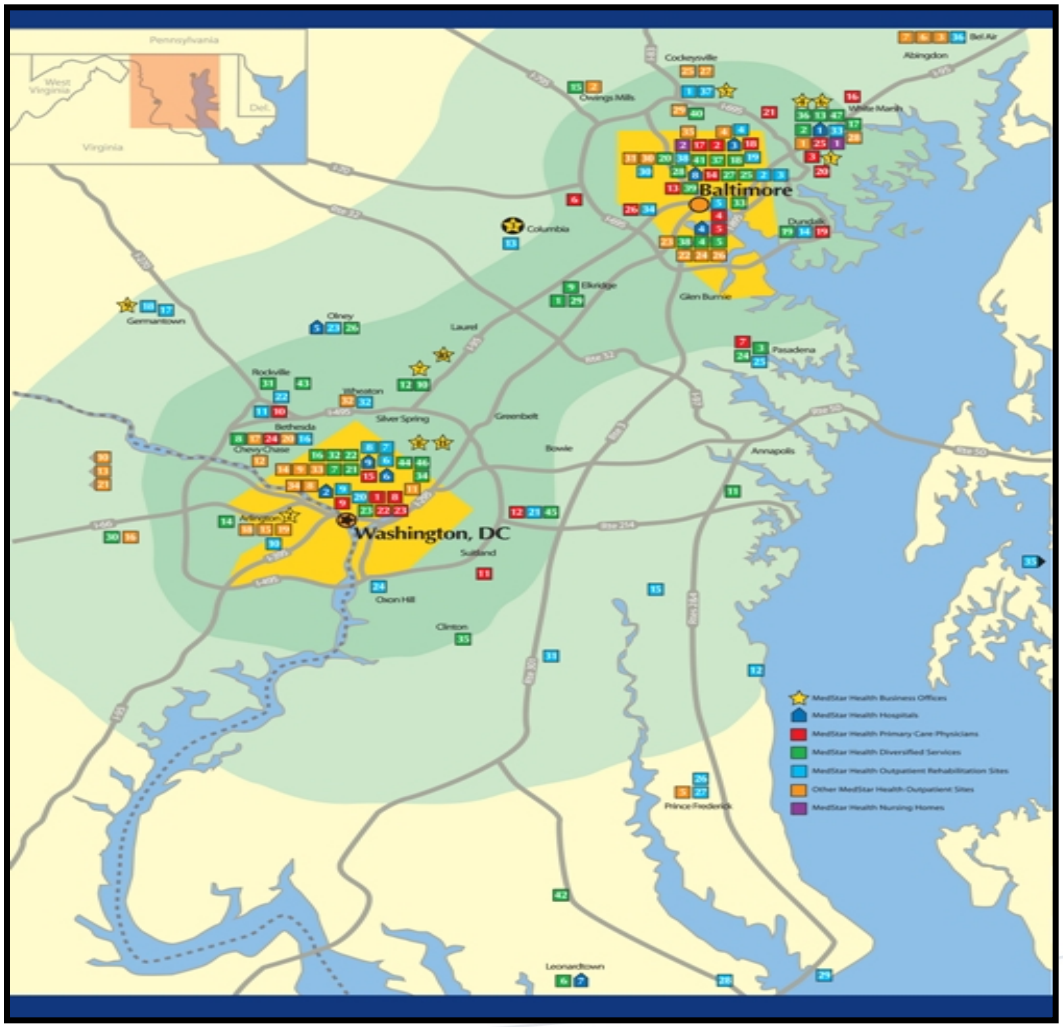
Knowledge and Compassion
Focused on You

Creating a Culture of Safety

David Mayer, MD
Corporate Vice President for Quality and Safety
MedStar Health

MedStar Health

- Mid-Atlantic Region
- Large Healthcare System
- Ten hospitals
- Medicaid Managed Care Organization
- Center for Human Factors Engineering in Healthcare
- Research Institute
- Home Health Agency
- 150 Outpatient sites of care
- 26,000 Associates
- 6,700 Physicians
- 162,000 Inpatient Admissions
- 762,000 Inpatient Days
- 1,492,000 Outpatient Visits
- 215,000 Home Health Visits



Creating a Culture of Safety

Educate the Young…

Creating a Culture of Safety

Educate the Young…

and Regulate the Old

Healthcare's *Triple Aim*

Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health and Lower Costs. Maureen Bisognano and Charles Kenney. 2012

- Strong Leadership Commitment
- Transparency
- Patient Engagement
- Interprofessional Teamwork
- Reporting Everything
- Measuring Everything
- Organizational Respect and Support

Creating a Culture of Safety

- High Reliability
- Transparency
- Patient-Centered, Patient-Engaged, Patient-Driven
- Just Culture
- Respect for fellow workers

Creating a Culture of Safety

- **High Reliability**

Creating a Culture of Safety

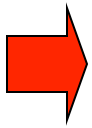
High-reliability organizations, or HROs, share two essential characteristics:

1. They constantly confront the unexpected
2. They operate with remarkable consistency and effectiveness

Improving crew attitudes and competencies in error management

Initial attitudes, awareness and competencies

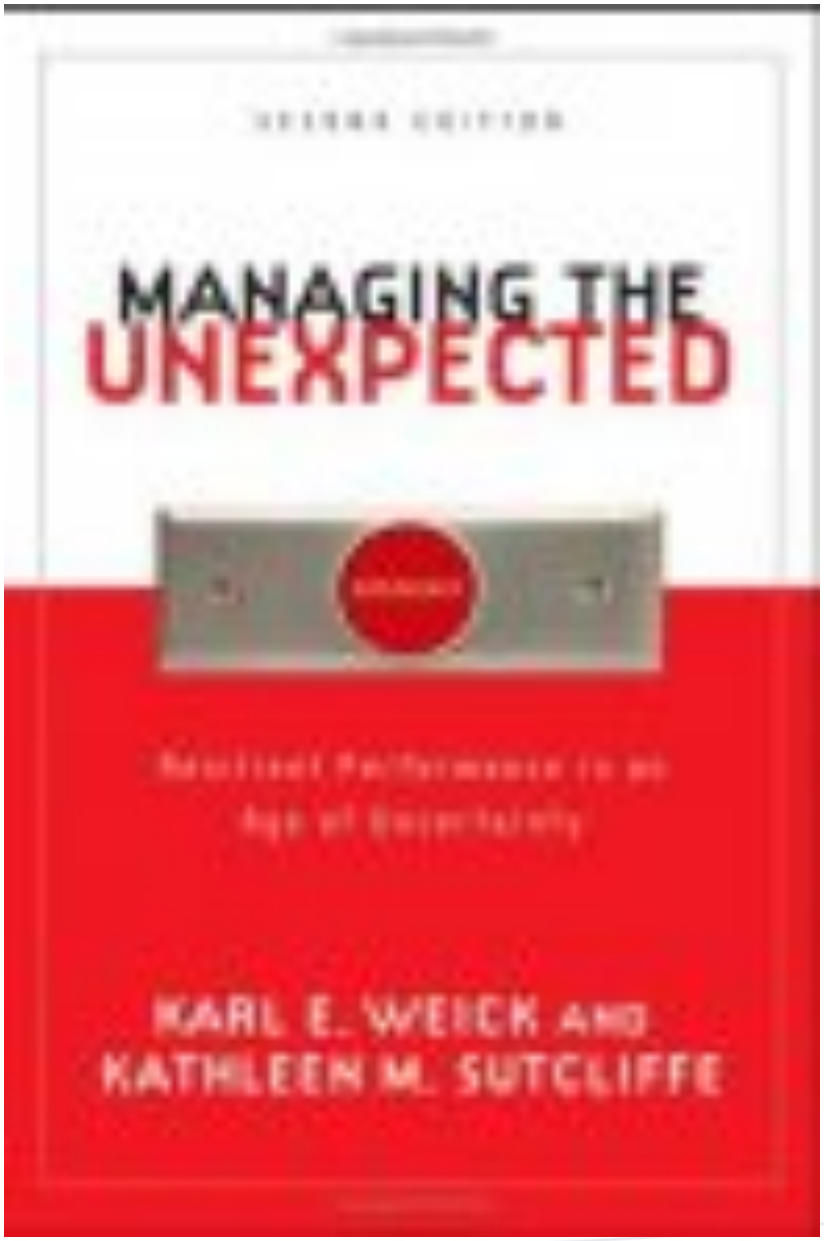
Poor leadership skills
Ineffective communication
Stress management
Poor teamwork



Mishap

Improving crew attitudes and competencies in error management

Improving medical attitudes and competencies in error management



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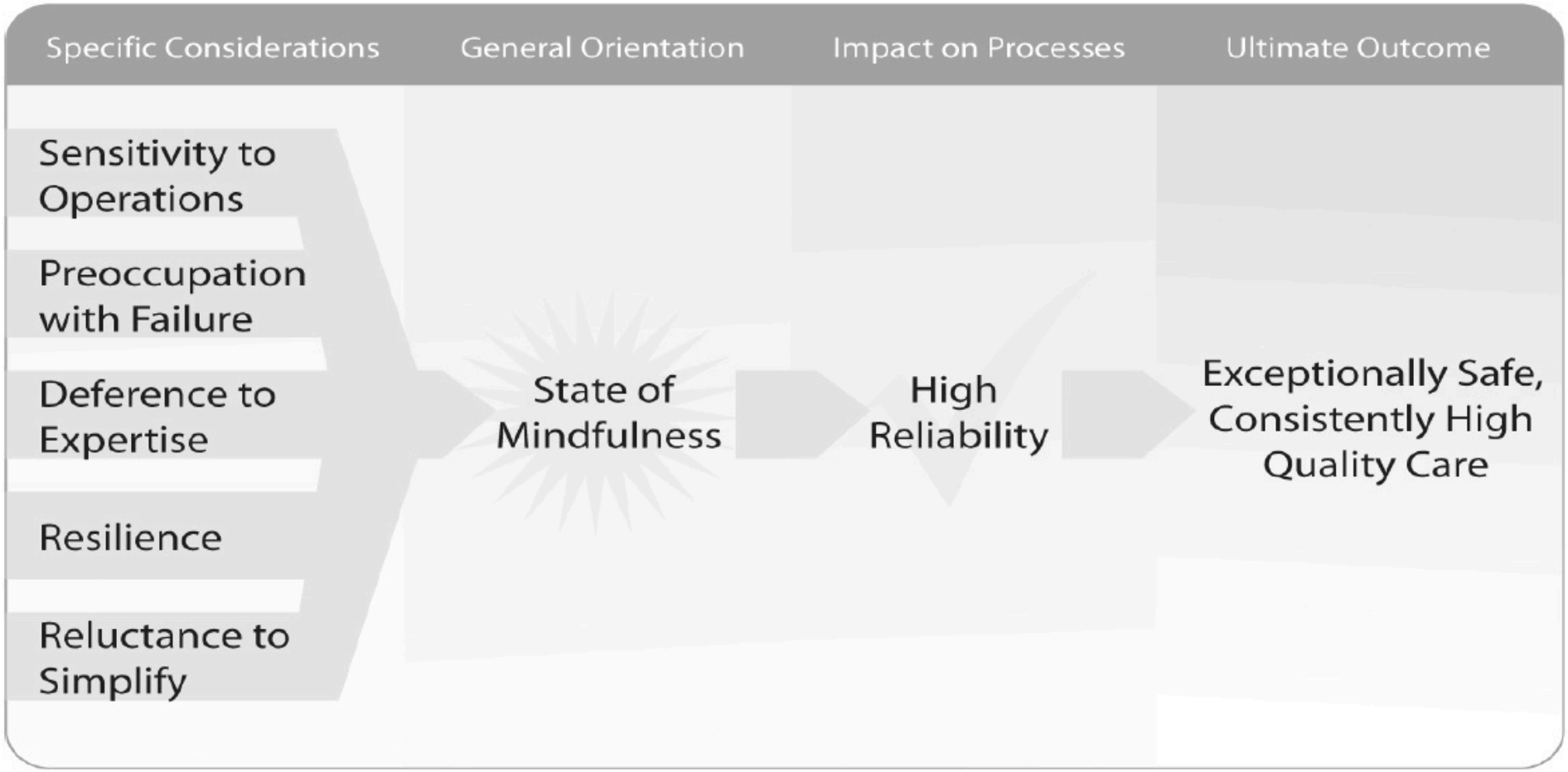
The five habits of highly reliable organizations:

1. Don't be tricked by your success (Preoccupation with Failure)
2. Defer to your experts on the front line (Deference to Expertise)
3. Let the unexpected circumstances provide your solution (Commitment to Resilience)
4. Embrace complexity (Reluctance to Simplify)
5. Anticipate -- but also anticipate your limits (Sensitivity to Operations)

Figure 1. The five specific concepts that help create the state of mindfulness needed for reliability, which in turn is a prerequisite for safety



From AHRQ "Becoming a High Reliability Organization: Operational Advice for Hospital Leaders"

Collective Mindfulness

Goals of mindful practice:

- To become more aware of one's own mental processes, listen more attentively, become flexible, recognize bias and judgments, and thereby act with principles and compassion.

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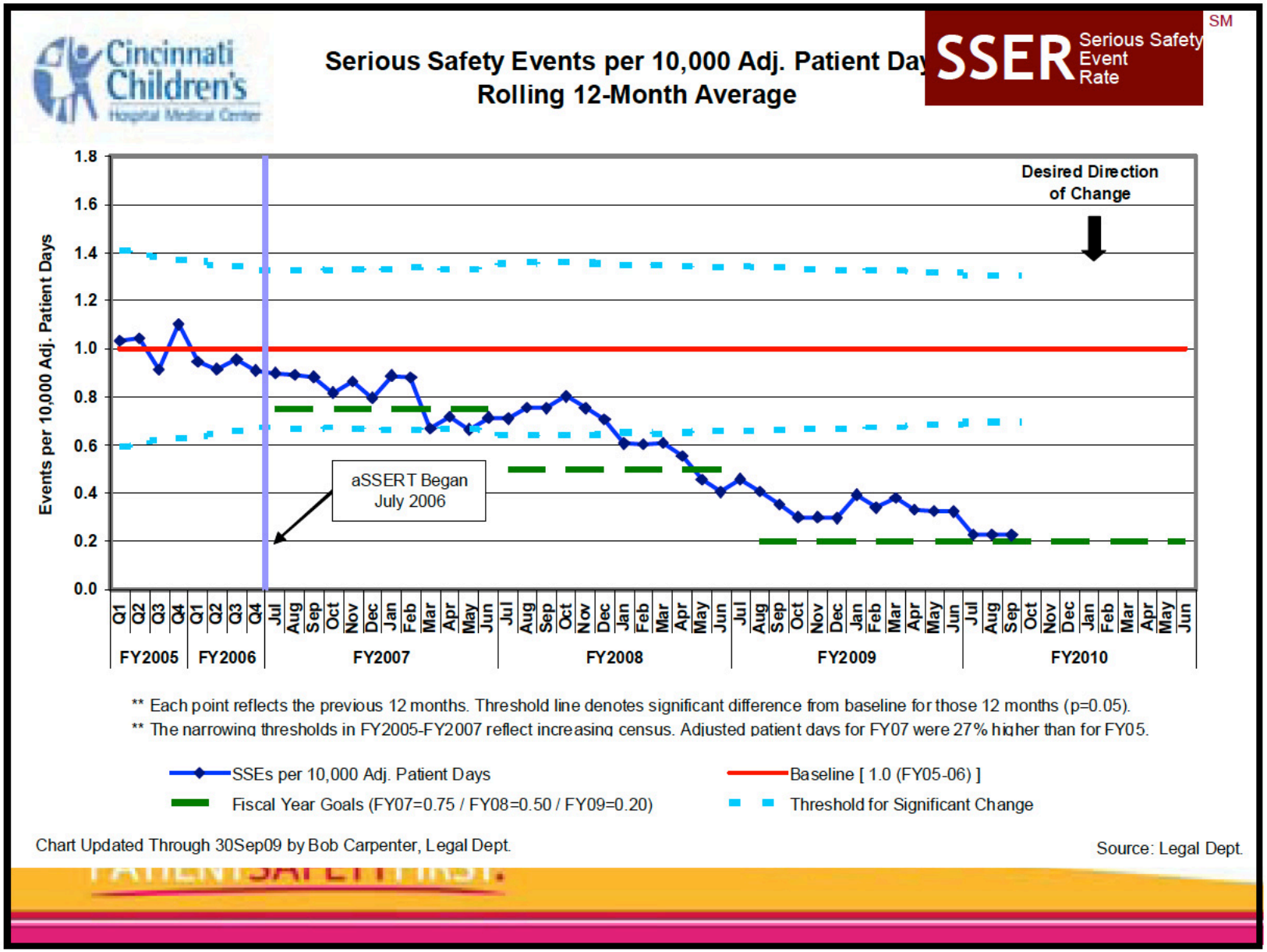
The Ongoing Quality Improvement Journey: Next Stop, High Reliability

Mark Chassin and Jerod Loeb

Health Affairs, 30, no.4 (2011):559-568

- Leadership
- Safety Culture
- Robust Process Improvement



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For more information on High Reliability

Educate the Young blog --
www.educatetheyoung.wordpress.com

Creating a Culture of Safety

- High Reliability
- **Transparency**

Definition of Professionalism

AAMC & NBME:

- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership

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- **Transparent**
  - **Transparency in Reporting**

Creating a Culture of Safety

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  - **Transparency in Outcomes**

Creating a Culture of Safety

- High Reliability
- **Transparent**
  - **Transparency in Reporting**
  - **Transparency in Outcomes**
  - **Transparency in Communications**
    - **Informed consent/Shared-decision making**
    - **Disclosure after harm**

National Recognition of the "Seven Pillars" Program

News Release

FOR IMMEDIATE RELEASE
Friday, June 11, 2010

Contact: HHS Press Office: (202) 690-6343
AHRQ Public Affairs: (301) 427-1855

HHS Announces Patient Safety and Medical Liability Demonstration Projects

Funds Allocated to Develop, Implement, and Evaluate Patient Safety Approaches and Medical Liability Reform Models

Largest federal investment connecting medical liability to quality

National Recognition of the "Seven Pillars" Program

Navigating the Health Care System

Advice Columns from Dr. Carolyn Clancy

AHRQ Director Carolyn Clancy, M.D., has prepared brief, easy-to-understand advice columns for consumers to help navigate the health care system. They will address important issues such as how to recognize high-quality health care, how to be an informed health care consumer, and how to choose a hospital, doctor, and health plan. Check back regularly for new columns.

Dr. Clancy, a general internist and researcher, is an expert in engaging consumers in their health care.

Select for Previous Columns.

Revealing Medical Errors Helps Chicago Hospitals Build a Safer Health System

The Seven Pillars process works because it spells out and follows steps that we know make a lasting difference in building a safer health system. Reporting, communicating, creating a culture of learning, and other improvements move us closer to identifying and fixing patient safety gaps, rather than simply assigning blame.

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  - **Dana Farber**
  - **Virginia Mason**
  - **Cincinatti Children's Hospital**

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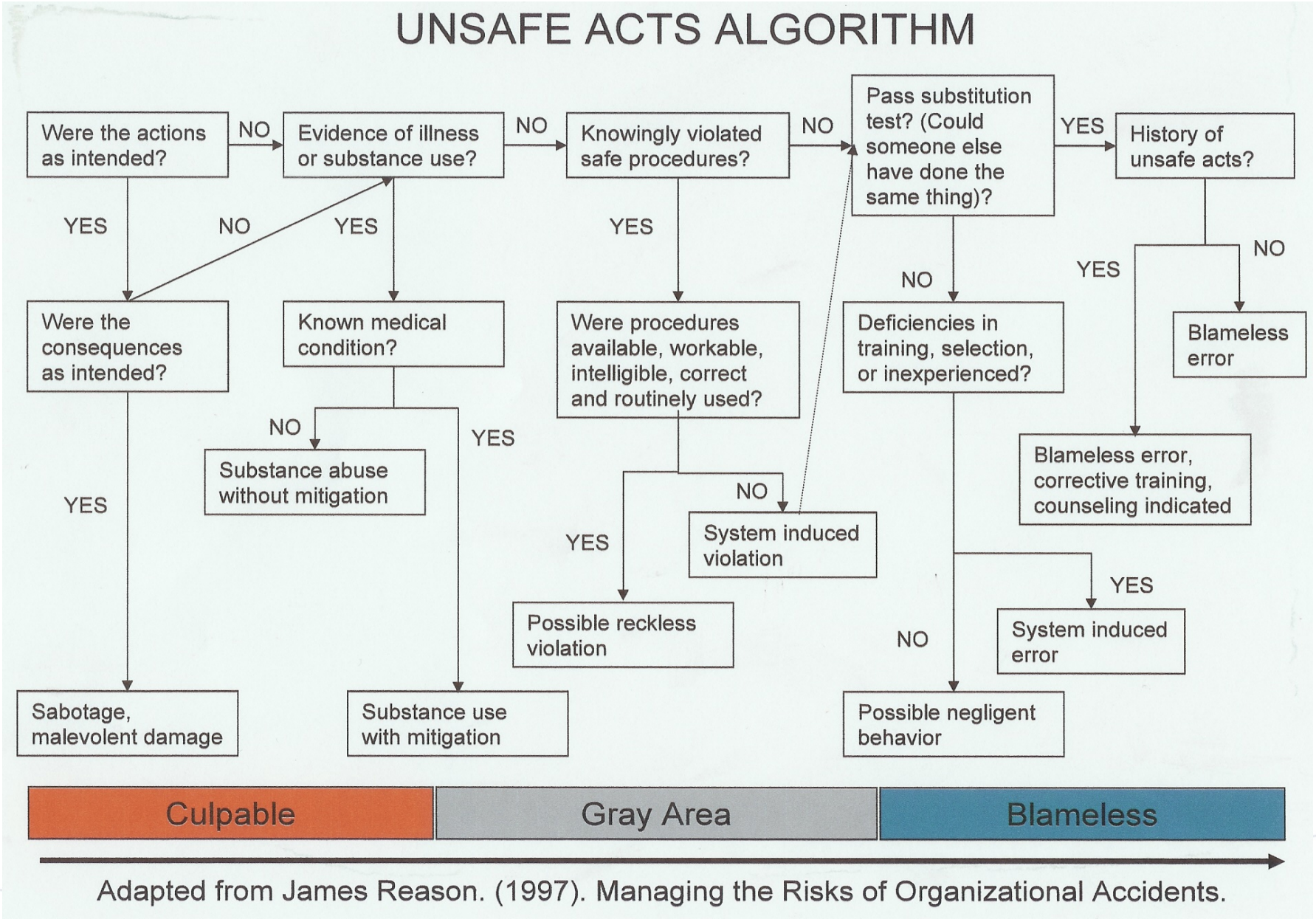

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- **Respect for fellow workers**

Paul O'Neill on Safety

Every worker's experience, every day:

- I am treated with respect by everyone else, regardless of position, education or pay
- I have the education and training, the tools, and the support to develop to my full potential
- My work is noticed and appreciated

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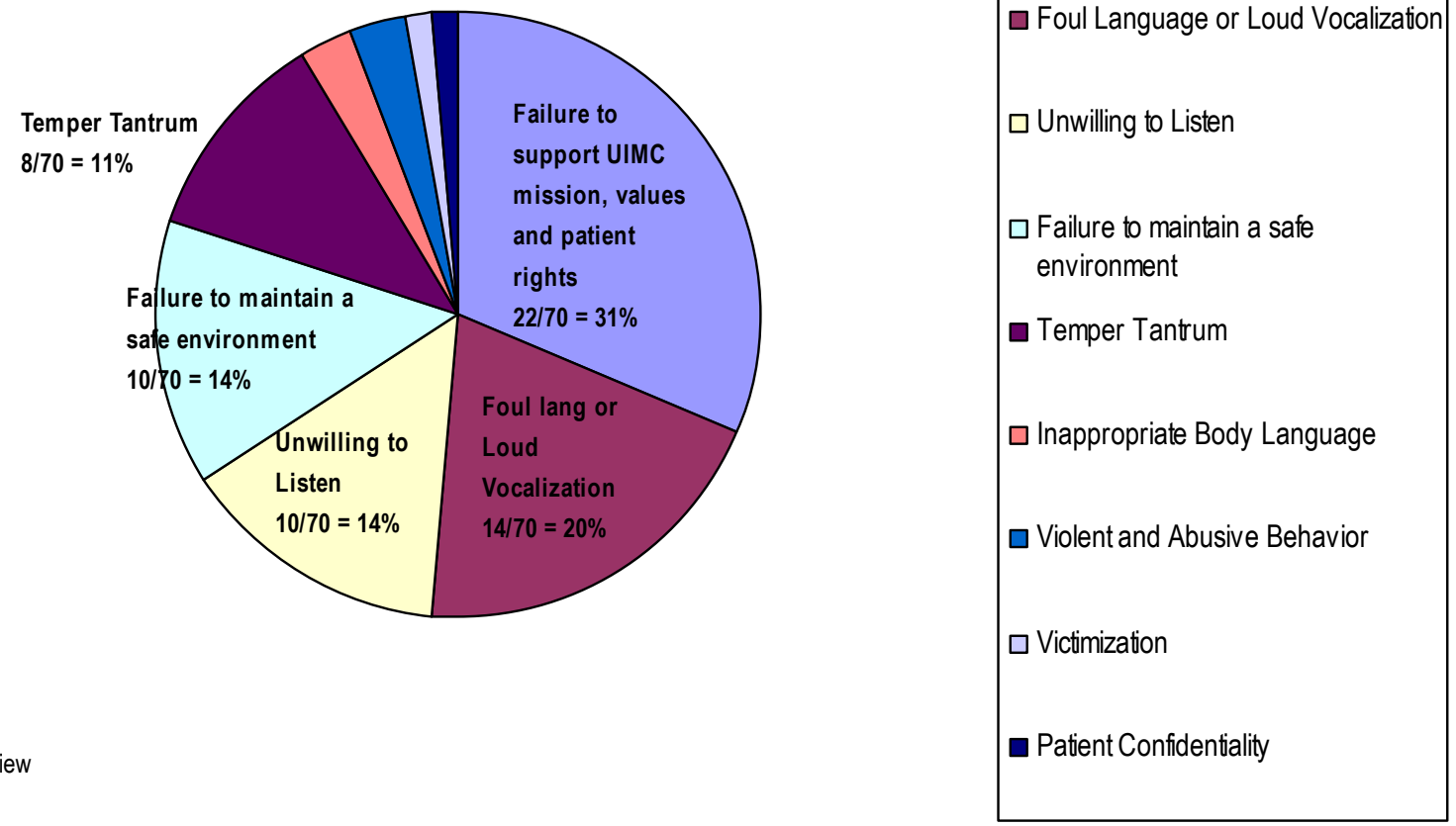
CODE OF CONDUCT OBJECTIVE:

UIMC strives to maintain a work environment free from intimidating, demeaning, abusive or disruptive behavior. These behaviors undermine a healthy work environment that supports patient safety and teamwork.

Number and Percentage of Attending Physician Disruptive Behavior Reports by Category
October 2010 - March 2011



1 case are pending review

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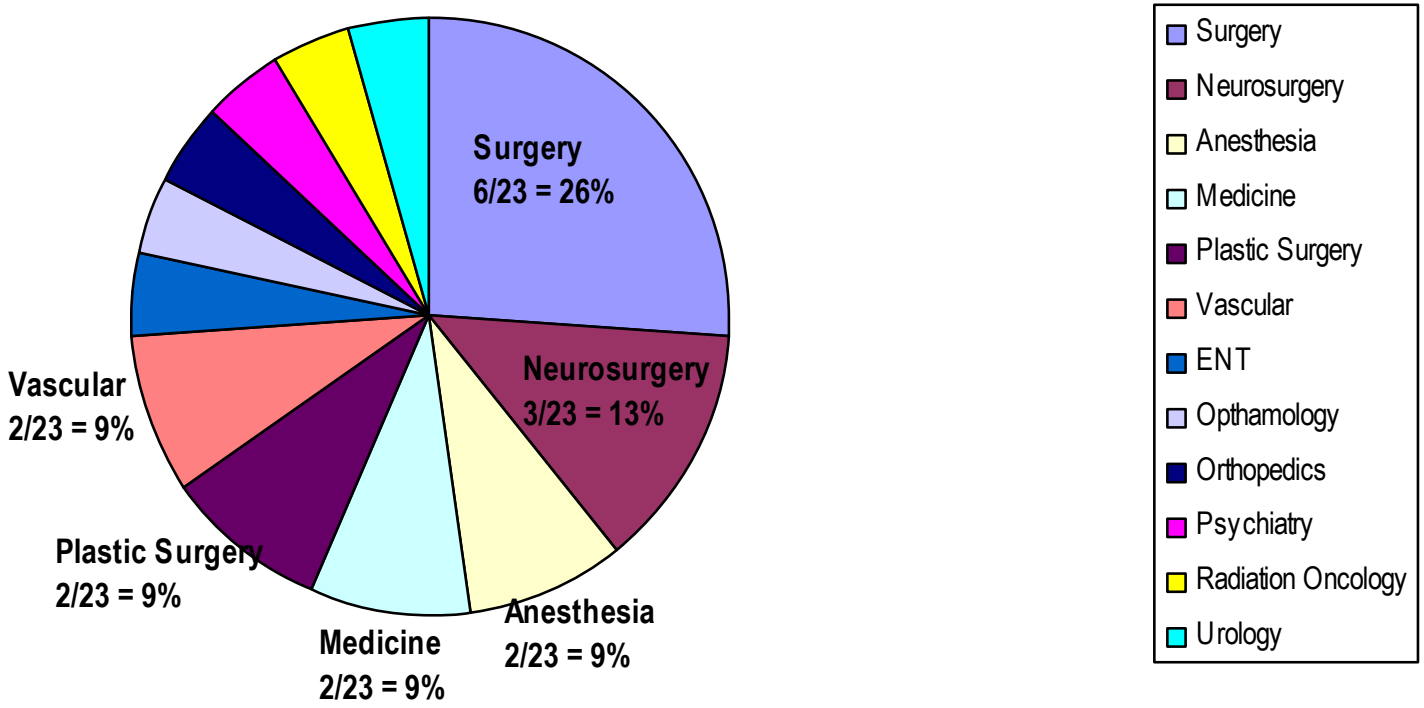

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Humiliation

The *emotional* response of people (individuals, families, nations, and other groups) to their perception that another person or group has unfairly or unjustly lowered, debased, degraded, or brought them down to an inferior position, that they are not receiving the respect and dignity they believe they deserve.

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Humiliation

Sense of powerlessness; “power gradient” in place

Wide variation among people in their response to the trauma of humiliation and their ability to either grow from or be damaged by the experience

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1. Think about a time when you were humiliated and how you felt when it happened.

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2. **Think about a time when you saw one caregiver humiliate another caregiver and how you felt when it happened.**

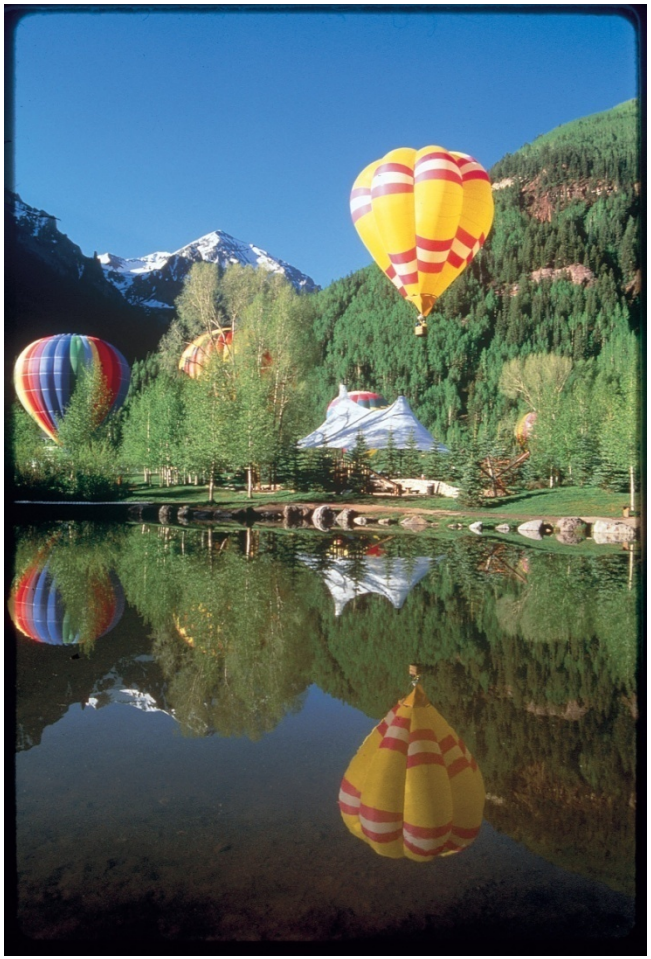
Creating a Culture of Safety

1. Think about a time when you were humiliated and how you felt when it happened.
2. Think about a time when you saw one caregiver humiliate another caregiver and how you felt when it happened.
3. **Think about a time when you saw an open, honest and professional discussion between caregivers and how you felt when it happened.**

Eighth Annual Roundtable: "The Power of Change Agents: Teaching Caregivers Effective Communication Skills to Overcome the Multiple Barriers to Patient Safety and Transparency"

June 25th – June 28th, 2012

Telluride, CO



Sponsored by TDCF, MedStar Health and UIC IPSE

Telluride Roundtable Vision

To create an annual retreat where stakeholders in patient safety, patient advocacy and health science education come together in a relaxed and informal setting to discuss, develop and refine curricula that support a culture of patient safety, transparency and optimal outcomes in health care.

Telluride Roundtable Vision

"Teaching Open, Honest and Professional Communication Skills to Overcome the Multiple Barriers to Transparency"

Telluride Patient Safety Student and Resident Summer Camps

http://www.solidlinemedia.com/2012/01/transparent-health-telluride-patient-safety-roundtable-documentary-video-production/

Telluride Summer Camp Goals

Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

1. Describe at least three reasons why open, honest and professional communication between caregivers, patients and family members is critical to patient safety, transparency and reducing harm in healthcare.

Telluride Summer Camp Goals

Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

2. Utilize tools and strategies to lead change specific to improving communication and reducing patient harm.

Telluride Summer Camp Goals

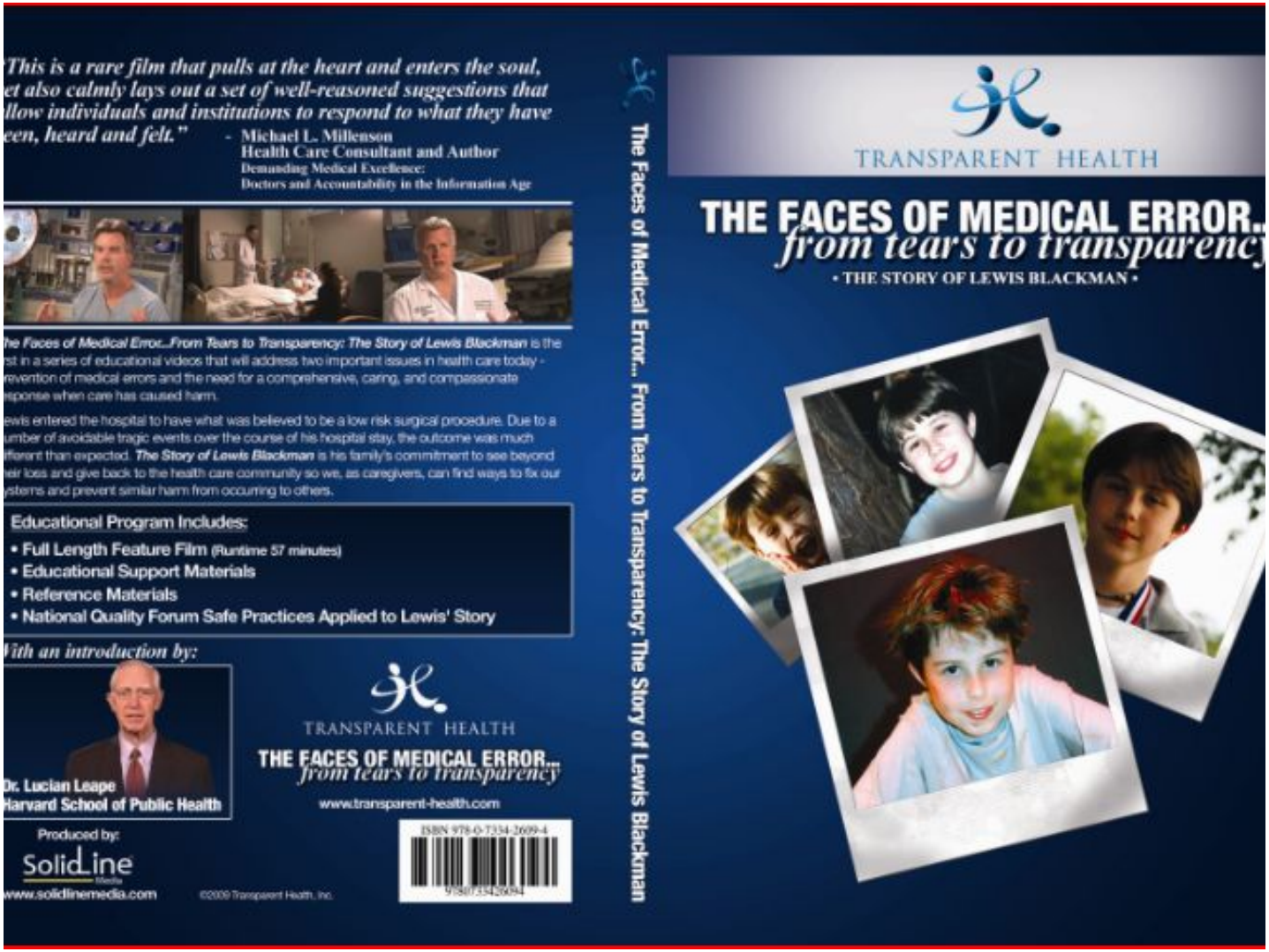
Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

3. Implement, lead and successfully complete a Safety/QI project at their institution over the next twelve months.

Leading Change
John Kotter

1) Establish a sense of urgency
2) Create the guiding coalition
3) Develop a vision and strategy
4) Communicate the changing vision
5) Empower broad-based action
6) Generate short-term wins
7) Consolidate gains and produce more change
8) Anchor new approaches in the culture



The Faces of Medical Error…*from tears to transparency*:
The Story of Lewis Blackman
www.transparentlearning.com

Telluride Blogs

- Transparent Health -- Telluride www.transparenthealth.wordpress.com

- http://runningahospital.blogspot.com/2012/06/telluride-patient-safety-camp-day-1.html

Telluride Reflections

Almost all medicals students acknowledged that the four days they spent on patient safety education at the Telluride Summer Camp was more training than they get in their four years of medical school. While all schools have some training in patient safety, it is still infrequent and rarely longitudinal.

Telluride Reflections

"I don't think that I've ever thought so much about informed consent as I did today. A discussion about informed consent to the level of detail that we had today needs to be part of all residency training in the first days of orientation and as refresher training later on in training. All physicians can, and should, do much better in providing informed consent."

Telluride Reflections

"Our discussion on the roles of nurses at different institutions was eye-opening in the sense that many of my peer medical students had very little knowledge about other allied health professionals."

Telluride Reflections

"The discussion about nursing and doctoring reminded me of conversations I had with fellow classmates at school. We were studying for the NBME Behavioral Sciences exam and joking about the ethical dilemma practice questions we were working on. A common theme that we noticed is that any answer involving soliciting a nurse for help or consulting with a nurse would invariably be wrong…

Telluride Reflections

…We agreed that answers involving nurses can be crossed off and it would be nice to get one on the test because we could narrow down the answers easier. Almost like how there used to rarely be positive depictions of minorities in the cinema, early medical education is nearly void of positive depictions of nurses.”

Knowledge and Compassion **Focused on You**

MedStar Health

Telluride Summer Camp

http://www.youtube.com/watch?v=FrA4GxCWgjw&feature=player_embedded

Jordan Chanler-Berat