End of Life Care: Learning from Mortality Reviews

April 19, 2018
Webinar Month 112

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www.safetyleaders.org
Welcome

Charles Denham, MD

Chairman, TMIT

TMIT High Performer Webinar
April 19, 2018
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Surfing the Healthcare Tsunami: Bring Your Best Board™

TMIT presents our Discovery Channel documentary, Surfing the Healthcare Tsunami. The incoming healthcare tsunami threatens all but the best. Will you surf, swim, or sink?

Surfing the Healthcare Tsunami: Bring Your Best Board™

High Performance 5 Rights Collaboratives

We are undertaking high impact research activities in the fields of Imaging of Adults and Children, Pain Care, Back Care, Testing, and Surgery to convert Waste to Value and Harm to Healing. For more information on each collaborative, click Imaging, Imaging Children, Back, Pain, Testing, Cancer, or Surgery.

Surfing the Healthcare Tsunami Hospital Leaders Toolbox

The Surfing the Healthcare Tsunami Hospital Leaders Toolbox has been released online! Go deeper into the subject matter of the documentary by exploring the 5 Rights of Imaging™, the Boardroom, Racing & Aviation, and much more. Click here for more details.

Click here to watch the entire 50-minute documentary online.
High Performer Webinar

End of Life Care: Learning from Mortality Reviews

April 19, 2018, 12:00 pm – 1:30 pm CT / 1:00 pm – 2:30 pm ET

Session Overview

What the Mayo Clinic calls Opportunities for Improvement (OFIs) are enormous when we examine end of life issues. Our audience continuously requests more learning from mortality reviews led by Dr. Jeannie Huddleston. Her emphasis along with other speakers in her collaborative this month will be on Opportunities for Improvement in this space.

Patty Atkins, MS, RN, FACHE, CPPS, who is Vice President of Quality and Patient Safety at Sharp HealthCare, will discuss this important topic with attention to end of life goals in the ED, a nurse-led approach to end of life issues, and the barriers to nurse-led Advanced Illness Management (AIM) programs.

Additional speakers will address these issues and a panel of patient advocates and experts will react to the presentations.

We offer these online webinars at no cost to our participants.
If you wish to follow us on Twitter, go to: http://twitter.com/TMIT1 or use #safetyleaders hashtag

Also, go to:
www.facebook.com/SafetyLeaders and related sites
TMIT Purpose Statement

Our Purpose:
We will measure our success by how we protect and enrich the lives of families...patients AND caregivers.

Our Mission:
To accelerate performance solutions that save lives, save money, and create value in the communities we serve and ventures we undertake.
Disclosure Statement

The following panelists certify: that unless otherwise noted below, each presenter provided full disclosure information; does not intend to discuss an unapproved/investigative use of a commercial product/device; and has no significant financial relationship(s) to disclose. If unapproved uses of products are discussed, presenters are expected to disclose this to participants. None of the participants have any relationship medication or device companies discussed in their presentations.

Jeanne M. Huddleston, MD, FACP, FHM, is a past President of the Society of Hospital Medicine, the founder of Hospital Medicine and past Program Director of the Hospital Medicine Fellowship at Mayo Clinic, Rochester, MN. She is Chairperson of Mayo Clinic’s Mortality Review Subcommittee, a multi-disciplinary group of providers that review every death in search of where the health care delivery system may have failed the providers and/or the patient. She received her MD degree in 1993 from the College of Human Medicine, Michigan State University. She completed her residency in internal medicine and advanced general medicine fellowship at Mayo Clinic. Dr. Huddleston is a Harvard Macy Scholar (both in the Physician Educator and the Leadership Programs) and alumnus of the Health Forum/AHA Patient Safety Leadership Fellowship. Dr. Huddleston has received Masters’ Degrees in both Clinical Research and Industrial Engineering. This education equipped her scholarly translation of systems engineering to health care delivery in an effort to improve the value of the healthcare experience for patients, their families and the providers through her work in mortality reviews and patient threat safety. She has nothing to disclose.

Patty Atkins, RN, MS, CNS, CPPS, is responsible for Quality, Patient Safety and Lean Six Sigma for Sharp HealthCare, the largest healthcare system in San Diego, CA. In 2016, Patty led a team to launch a mortality review process in collaboration with Dr. Jeanne Huddleston from the Mayo Clinic. She is a Certified Profession in Patient Safety by the National Patient Safety Foundation and has been a Critical Care Clinical Nurse Specialist. In addition, she served as Category Lead for The Malcolm Baldridge Quality Award Application, Category 4: Measurement, Analysis and Knowledge Management in 2007 and the Baldridge Application Coordinator in 2013 for Sharp HealthCare. Patty received her bachelor’s degree from The University of Tulsa and her Master of Science from The University of Oklahoma Health Science Center in 1991. She is trained as a Lean Six Sigma Black Belt, Master Change Agent and Master Team Trainer. She has nothing to disclose.

Timothy Jessick, DO - Dr Jessick is a physician with Aurora Healthcare. He is board certified in Palliative Care and Family Medicine. He is the co-founder and President of the Palliative Care Network of Wisconsin and a member of the American Academy of Hospice and Palliative Medicine and the American Academy of Family Physicians. Dr Jessick received his Doctor of Osteopathy from Kirksville College of Osteopathic Medicine in 1994 and his Bachelor of Science in Exercise Physiology from the University of Wisconsin –Madison in 1990. He has presented both locally and nationally on the topics of palliative care, pain management, advanced directives and end of life care and participated in numerous initiatives related to these topics. Dr. Jessick is also the co-founder of the Palliative Care Network of Wisconsin. He has nothing to disclose.

Dr. Vikram Kumar, MD is an anesthesiologist at Eastern Maine Medical Center. He attended University College of Medical Sciences, and Medical College of Wisconsin, and is a member of the American Board of Anesthesiology. He has nothing to disclose.

Dan Ford, MBA, LFACHE, developed a deep passion for patient safety as a result of medical errors experienced in Illinois by his first wife, Diane, and the treatment he experienced when he started asking logical and genuine questions. The mother of three children (11, 14, and 17 at the time) and age 47, Diane was pursuing her second master’s degree, and suffered a morphine-induced respiratory arrest following a hysterectomy. She has permanent brain damage/short-term memory loss and a poor quality of life, and resides in an independent living facility. He has nothing to disclose.

Charles Denham, MD, is the Chairman of TMIT; a former TMIT education grantee of CareFusion and AORN with co-production by Discovery Channel for Chasing Zero documentary and Toolbox including models; and an education grantee of GE with co-production by Discovery Channel for Surfing the Healthcare Tsunami documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers. HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. He does not currently work with any pharmaceutical or device company. His current area of research is in threat management to institutions and continuing professional education and consumer education. Dr. Denham is a collaborator with Professor Christensen.
Speakers and Reactors

Jeanne M. Huddleston
Patty Atkins
Vikram Kumar
Timothy Jessick
Dan Ford
Charles Denham
Voice of Patient and Family

Dan Ford

Voluntary Patient Safety Advocate
Voluntary Spectrum Health EPFAC and Hospital Group
Board Quality & Safety Committee
Voluntary TMIT Patient Advocate Team Member
Retired Healthcare Executive Search Consultant
Rockford, MI

TMIT High Performer Webinar
April 19, 2018
In the News Update and March 2018 Webinar National Survey

Charles Denham, MD
Chairman, TMIT
TMIT High Performer Webinar April 19, 2018
Leapfrog found that only about one-third of hospitals (34.5%) meet the group's requirements for using the technology effectively.

Leapfrog's standards include four steps:
1. A bar-code system is in place across all of the hospital's intensive care, medical and surgical or labor and delivery units.
2. The bar codes for patients and medications are both scanned in 95% of bedside medication administrations.
3. All seven decision support elements that are deemed essential by Leapfrog's BCMA Expert Panel are in place.
4. The five best practices the group has outlined to prevent dangerous workarounds have been deployed.

A significant number of failures occur at the second step, according to the report, with nearly half of studied hospitals (42%) missing the mark when it comes to scanning bar codes. This can pose a significant patient safety risk, according to Leapfrog.

Among the risks to consider they identified are:

1. **New patient populations:** Merging entities don't just consolidate facilities, they also consolidate patients. New groups of patients may have new needs and may even require health systems to invest in new capabilities. For example, health systems that have expanded their patient populations may encounter far more people who do not speak English, increasingly the likelihood that they are unable to understand providers.

2. **Varied infrastructures:** Each party involved in a merger brings its own documentation protocols, supply chains or technology platforms, which must be unified.

3. **Physicians on the move:** The researchers found that it's extremely common for doctors to be relocated to new sites of care during a merger.

The six-year study found no negative impact on patient safety when approximately 900 University of Miami Health System physicians received sovereign immunity from medical malpractice claims while working at Jackson Memorial Hospital, a public hospital that also serves as the University of Miami’s main teaching hospital. In fact, the incidence of harmful events decreased by 13 percent over a four-year period.

“This study suggests that without the threat of malpractice lawsuits, physicians are still committed to delivering the safest, highest quality patient care possible,” said Dr. David A. Lubarsky, chief medical and systems integration officer at the University of Miami Health System and the study’s lead author.

Source: General Announcement. New Study Finds Patient Care Improved when Hospital Physicians Received Immunity from Malpractice Suits. Litigation Finance Journal. 2018 Apr 11.
Apple, Nvidia, and Oracle are among the companies that have sought trauma training from Stanford Health Care, which is preparing for an uptick in interest in the wake of an active shooter incident at YouTube's headquarters.

The United States surgeon general issued a rare national advisory on Thursday urging more Americans to carry naloxone, a drug used to revive people overdosing on opioids.

The last time a surgeon general issued such an urgent warning to the country was in 2005, when Richard H. Carmona advised women not to drink alcohol when pregnant.

A GAO report found that the Centers for Medicare and Medicaid Services isn’t ensuring beneficiary data is secure.

CMS shares Medicare beneficiary data with Medicare Administrative Contractors (MAC) that perform processing and distribution functions in support of the payment of Medicare benefits, research organizations (researchers) that use Medicare beneficiary data to study how healthcare services are provided to beneficiaries and qualified public or private entities that use claims data to evaluate the performance of Medicare service providers and equipment suppliers.

While CMS has developed guidance for MACs and qualified entities, it has not developed equivalent guidance for researchers. Researchers must adhere to broad government wide standards, but are not given guidance on which specific controls to implement.

Duplicate patient EHRs cost hospitals an average of $1,950 per patient per inpatient stay, according to a 2018 Black Book survey about the use and value of enterprise master patient index (EMPI) solutions.

Black Book researchers surveyed 1,392 health IT managers about patient identification processes from the third quarter (Q3) of 2017 to the first quarter (Q1) of 2018. Problems were found surrounding patient EHR matching and that it has a significant effect on hospital spending and patient safety.

Respondents included hospital executives, clinicians, IT specialists, and health IT implementation project participants.

The Innocence Project, founded in 1992 by Peter Neufeld and Barry Scheck at Cardozo School of Law, exonerates the wrongly convicted through DNA testing and reforms the criminal justice system to prevent future injustice.

The Healthcare Innocence Project builds on the successful model of The Innocence Project. Where it used the new technology of DNA 25 years ago, we will use the new technology of electronic records and the digital DNA in the E.H.R. and administrative records to protect the medical identity of patients and the professional identity of caregivers. Both patients and caregivers may be unjustly treated through intentional or unintentional behaviors of insiders or outsiders of healthcare organizations. They include weaponization of HR, sham peer review, discrediting patients and families after healthcare accidents, or unjust harm through outsider cybersecurity issues.
Real Fraud, Ethical Breach, and Crime

Sham Peer Review and Abuse of Power

Editorial: 
Tactics Characteristic of Sham Peer Review

Source: Tactics Characteristic of Sham Peer Review - Journal of the American ...
by LR Huntoon - 2009
Sham Peer Review Tactics

- Ambush Tactic and Secret Investigations
- Depriving Targeted Caregiver of Records Needed to for Defense
- Guilty Until Proven Innocent
- Numerator-Without-Denominator Tactic
- Misrepresenting the Standard of Care
- Trumped-Up and/or False Charges
- Abuse of the “Disruptive Physician” Label
- Ex-Parte Communications
- Dredging Up Old Cases to Justify Summary Suspension
- Hospital Attorney or Conflicted Attorney Used to Influence the Peer Review Process
- Bias
- Peer Validation Tactics Characteristic of Sham Peer Review
Anonymous Survey Questions

I am interested in MORE DETAIL regarding the:
HEALTHCARE INNOCENCE PROJECT

72% Agreed and 52% Strongly or Very Strongly Agreed, and 32% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: High Impact Case Studies – March 15, 2018
Specific HEALTHCARE INNOCENCE PROJECT FOCUS
I would like to SEE covered includes:

- Just culture among employees
- Errors and false documentation
- Weaponizing of HR
- Sham peer review detection and mitigation
- Legal representation
- Opioid use
- All of it... I've never heard of it before today.
- Case studies
- How relates to patient safety in the hospital
- Case studies
- I am new to this, so I have no specifics.
- Innocent project and just culture
- Deterioration of patients and failure of providers to respond
- How information is obtained from EHR. What if a hybrid chart is used. Differences in EHR products and how information can be obtained.
- 2nd victims
- Specific examples where the project was able to help those negatively impacted after an adverse event.
- Case studies.
- Accuracy of the information gathering
- How it would work when electronic documentation is overall so poor.
- Just some general information about what types of cases they would consider.

- Big picture, first time seeing this.
- Protecting the DNA of EHR
- Mortality review
- Better understand how to handle these situations
- Any topic that helps ensure we do justice for all concerned-patients, families, staff, providers
- Fraud, conflict of interest, ethics, honesty
- Open to all suggestions
- Healthcare disparities; use of data in medical and nursing board discipline
- Child abuse charge but child with med condition
- Case studies are very helpful.
- Academic fraud and fraudulent harm intended to discredit caregivers and patients in order to protect the finances of the organization
- Not sure what this is...Even just googled
- All areas actually
- Education of errors about specific instances to staff- revealing outcomes or breaks in processes or delays as a result
- What specifics are being studied & how will it work and be used
- No specific information, need more information
- Unable to answer as I'm not clear what healthcare innocence project focus
- Examples and how the cases were resolved or settled.

Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: High Impact Case Studies – March 15, 2018
Just Culture: High Impact Case Studies

David Marx, JD
Just Culture Leader & Innovator
Principle, Outcome Engenuity Center
Eden Prairie, MN

TMIT High Performer Webinar
March 15, 2018
THE JUST CULTURE ALGORITHM V3.2

One method that works across all values

One method that works both pre and post event
Anonymous Survey Questions

I am interested in MORE DETAIL regarding: JUST CULTURE CASE STUDIES

90% Agreed and 70% Strongly or Very Strongly Agreed, and 60% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: High Impact Case Studies – March 15, 2018
Specific JUST CULTURE CASE STUDY DETAIL & SCENARIOS
I would like to be FURTHER covered includes:

- Examples of repetitive at risk behavior Medications
- Medication errors
- Clinical and administrative case studies
- More healthcare related cases
- Repeat. Scenarios, disruptive behavior
- Working the algorithm better. Practice makes perfect, right?
- Getting executive leadership buy in
- HR issues
- Cases regarding data collection, analysis, etc.
- Review of the model again
- Love the algorithms! Happy to hear anything more.
- Failure to recognize patient deterioration and escalate care
- Scenarios which are more complex and include system-induced errors in combination with at risk behaviors - sometimes there are multiple issues at play
- Clinical bedside case studies
- More information/discussion on repeat at risk behaviors.
- More cases for when the system failure is the problem. Would like to see case studies that have been arbitrated in a unionized context.
- Continue with real case studies, perhaps asking for contributions
- Discovery of issues within the process of quality and regulatory reporting.
- Repetitive issues related to physician burnout
- Workplace violence and assault; patient suicides
- I enjoy the discussion of the case studies.
- Tracing of a medicine and the various errors associated.
- Difficult scenarios when there is a difference in opinion when doing RCA/investigation. How does that get reconciled.
- Ones like the nurse manager passing the room and going to assist without using proper hand hygiene - cases where there could be a "gray" area.
- Those involving serious patient safety events
- Falls. Peer review, delays in diagnosis and treatment
- Cases where employees are encouraged to push beyond their limits by their employees
- Conflicts between nursing and physician
- More around medications when the culture is to migrate (as evidenced by using the substitution test) and how to move through the flows.
- Scenarios are so impactful for actually understanding how to use the process in real world
- Repetitive at risk behaviors
- Executive misconduct,
- Practitioner level mistake when policy exists, but busy/harried conditions consistently exist, the system does not address.
- Any are welcome

Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: High Impact Case Studies – March 15, 2018
Welcome to

Learn from Mortality Review AND the Living:

Next Generation Safety Learning System

For resource downloads go to:
www.safetyleaders.org
Anonymous Polling Questions

I am interested in DEEP DIVE webinars on Mortality Reviews and Safety Learning Systems

98% Agreed and 87% Strongly or Very Strongly Agreed, and 68% Very Strongly Agreed

Anonymous Polling Questions

Would your hospital be interested in participating in a 100-case safety learning system collaborative

53% Agreed and 29% Strongly or Very Strongly Agreed, and 17% Very Strongly Agreed

Anonymous Polling Questions

I am interested in a webinar with speakers who have launched Mortality Review from scratch

84% Agreed and 71% Strongly or Very Strongly Agreed, and 57% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Part 2 – A Deeper Dive – August 18, 2016
Anonymous Polling Questions

I want more information on PERFORMANCE IMPROVEMENT using MORTALITY REVIEWS

95% Agreed and 88% Strongly or Very Strongly Agreed, and 75% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Saving Lives Putting Mortality Reviews to Work: It does pay off! – January 15, 2017
Anonymous Survey Questions

I am interested in a webinar on MORE DETAIL ON MORTALITY REVIEWS and how to safely introduce them in an organization

93% Agreed and 81% Strongly or Very Strongly Agreed, and 66% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Mortality Reviews: Great Learning from Our Early Journey – February 16, 2017
Anonymous Survey Questions

I am interested in: END OF LIFE OPPORTUNITIES FOR IMPROVEMENT that can impact Patient and Caregiver Safety

71% Agreed and 47% Strongly or Very Strongly Agreed, and 33% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: High Impact Case Studies – March 15, 2018
Specific END OF LIFE OPPORTUNITIES FOR IMPROVEMENT

Information I would like to be FURTHER covered includes:

- How to use just culture in allocation of scarce resources in end-of-life care
- Working with family members
- Palliative care
- Never heard of it.
- Caregiver burnout
- Unsure
- Current and future state
- I am new to this, so I have no specifics.
- Treatment of pain and/or comfort interventions related to potential adverse respiratory/cardiac status
- Educating physicians on how to have these conversations
- Use of end-of-life cases to improve performance.
- Patient choice that goes against all the medical folks
- How to make end of life decision making easier for patients and families.
- Best indicator of quality of life deteriorate
- Palliative/hospice involvement
- Peer review structure, delay of diagnosis and treatment - omission and commission
- How do you handle the increasing use of narcotics to further the speed of death?
- Palliative care consulting family involvement
- Topics that help us do better with correct timing regarding bringing up the topic of being allowed to die
- Cultural aspects of decisions - why these may actually lead to harm of patient and prolonged end of life
- Any welcome
- Where is the process of the conversation best begun? Training medical students for the conversation
- Helping broach the conversation
- Especially for people with developmental disabilities that they were born with or acquired in early childhood, what will be an ethical good way to approach it.
- Approach patient/family; provider
- Proper pain management so patients can be aware of their families in their final days.
- Role of supportive and palliative care
- None specifically.
- Sandra fly
- Code status conversations earlier
- Family expectations of the patient and the dying process
- Reluctance to initiate the discussion. Scenarios of how to- MD, RN,

Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: High Impact Case Studies – March 15, 2018
End of Life Care: Learning from Mortality Reviews

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Chairperson of Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

TMIT High Performer Webinar
April 19, 2018
Safety Learning System™ Collaborative

THE NEXT GENERATION OF PATIENT SAFETY
Disclosure

- I am fundamentally biased by how much potential this work has to save lives, improve systems of care delivery, build effective teams, create a culture of safety and just plain make a difference.

- I am a co-founders of the international research SLS Collaborative, a social benefit corporation, and a nonprofit foundation from which I receive absolutely no remuneration.

“\textit{I want to be a lawyer - they still get recess.}”
15 years of learning about process of care failures...

SPECIAL ARTICLE

Learning From Every Death

Jeanne M. Huddleston, MD,*† Daniel A. Diedrich, MD,§ Gail C. Kinsey, RN,∥
Mark J. Enzler, MD,‡ and Dennis M. Manning, MD*

The concepts of peer review and the venerable morbidity and mortality conference are familiar improvement approaches to health care providers. These 2 entities are typically provider or patient centric and are not typically extended within hospitals and health systems as a tool for organizational learning for care process or system failures. Out of a desire to deepen our understanding and accelerate learning about quality and safety opportunities in our hospitals, Mayo Clinic embarked on journey to analyze the stories of all patient deaths. This paper illuminates the lessons learned through the development and evolution of the Mayo Clinic Mortality Review System (Rochester, MN).

Guiding principle of Mayo Clinic Mortality Review System:
“No one should ever suffer or die as the result of process of care or system failure.”

1. To create a meaningful mechanism to review deaths at MCR hospitals:
   - Thoroughly understandable
   - Measurable
   - Improvable

2. To identify and quantify unanticipated deaths

3. To identify rate of adverse events in patients who die in MCR hospitals

4. To classify and quantify system level changes which will improve mortality rate.
How it evolved...

1. To create a meaningful mechanism to review deaths at MCR hospitals:
   - Thoroughly understandable
   - Measurable
   - Improvable

2. To identify and quantify unanticipated deaths
3. To identify rate of adverse events in patients who in MCR hospitals
4. To classify and quantify system level changes which will improve mortality rate.
The Next Generation Patient Safety for Healthcare Leaders

1. To create a *meaningful mechanism* to learn about opportunities for improvement:
   – Thoroughly understandable
   – Measurable
   – Improvable

2. To identify and quantify opportunities for improvement.

3. To identify rate of opportunities for improvement in patients.

4. To classify and quantify system level changes which will improve performance.
An International Journey to Healthcare Delivery Free from Harm

Alpha Collaborative Member Hospitals | Beta Collaborative Member Hospitals
Overview of Participation

SLS™ Collaborative Methods & Output:

- Review at least 100 cases using the Mayo Clinic methodology to identify process and system failures, with their human factor contributors, that lead to patient harm and adverse outcomes.

- Discuss opportunities for improvement (OFIs) in a interdisciplinary, multispecialty group and reach consensus on final OFIs with their contributing human factors.

- Share lessons learned through local reports, presentations, publications, and benchmarking between collaborative sites to decrease patient harm and improve outcomes.
Compare and Contrast

Peer Review

1. Problem identified
2. Reviewed and discussed by peers
3. Individual contributes or “notified”

Safety Learning System

1. Patient is a member of a cohort of interest
2. Reviewed and discussed by group of multi-disciplinary and multispecialty practicing providers
3. Opportunity identified
4. Learning shared broadly
Learn what it takes to become a systems-thinker and improve patient safety within your healthcare system.

We will coach you to become a systems-thinker that supports transparency for system learning.

Make an international difference by becoming master and advocate of the Safety Learning System.

Our Healthcare Safeware® technology provides solutions that monitor the actions and inactions that lead to harm.

Revolutionize healthcare by sharing lessons learned through our research program.

We expand knowledge within the healthcare community through our Multicenter Collaborative to better improve patient safety worldwide.
| Safety Learning System™ Collaborative Offerings |
|---|---|---|---|---|---|
| Retreat and Conference Engagement | Diagnostic Evaluation of Care Delivery Vulnerabilities | Review Process Cultivation with Staff Engagement and Culture Change | Peer and Change Management Coaching: Increasing Value by Moving to System Review | Benchmarking with Analytics Report Generation | Codesign pilot projects to address shared opportunities for improvement | Study and Disseminate Safety Improvement Efforts with Academic Output |
| **Healthcare Safeware®** |
SLS™ Collaborative Results

Traditional patient safety:
Spend 80% of time, money and energy on HACs & HAIs

Collaborative findings for the next generation patient safety:
80% of the opportunities of improvement are **omissions** —
but less than 20% of opportunities are HACs and HAIs

95-100% NOT found in existing patient safety reporting mechanisms
Opportunities for Improvement
Preliminary Results from 2016 Members

OFI - Category
1=End of Life Opportunities
2=Documentation Opportunities
3=Treatment Opportunities
4=Delayed or missed diagnosis
5=Communication Opportunities
6=Transition of Care/Triage Opportunities
7=Hospital Acquired Infections
8=Other
9=Delay in care of acutely deteriorating patients (exceed local MET/RRT criteria)
10=Medication/Blood Events
11=Surgical/Procedural Issues
12=Prophylaxis Opportunities
13=Miscellaneous Hospital Acquired Conditions
End of Life Opportunities
Preliminary Results from 2016 Members

Getting to the next layer down… but not root cause
THE BEST PART… IT’S A REAL LEARNING COLLABORATIVE
SLS™ Collaborative Colleagues

- Patty Atkins RN, MS, CNS, CPPS
  - Vice President, Quality and Patient Safety
  - Sharp HealthCare, San Diego
- Taya Wallis, RN, BSN, OCN
  - Program Manager, Advanced Illness Management
- Tim Jessick, MD
  - Cofounder and Chair, Palliative Care Network, Wisconsin
  - Aurora West Allis Medical Center
- Vikram Kumar, MD
  - Medical Director, Performance Improvement
  - Eastern Maine Medical Center
Nurse Led End of Life Care

Patty Atkins, RN, MS, CNS, CPPS
Vice President, Quality, Patient Safety & Lean Six Sigma
Sharp HealthCare
San Diego, CA

TMIT High Performer Webinar
April 19, 2018
Mortality Review Initiative
Improvement Focus: Advance Illness Management
TMIT Webinar April 19, 2018

Patricia Atkins, RN MS CNS FACHE CPPS
VP Quality, Patient Safety & Lean Six Sigma
Sharp HealthCare, San Diego, CA

Taya Wallis, RN, BSN, OCN
Program Manager, Advanced Illness Mgt
Sharp Memorial Hospital, San Diego, CA
Four Acute Care Hospitals

- Sharp Memorial Hospital
- Sharp Grossmont Hospital
- Sharp Chula Vista Medical Center
- Sharp Coronado Hospital and Health Center

Three Specialty Hospitals

- Sharp Mary Birch Hospital for Women
- Sharp Mesa Vista Hospital
- Sharp McDonald Center
Not-for-Profit
Serving 3.3M San Diego County Residents

- Largest private employer in San Diego
- 2084 licensed beds
- 3.4 billion in annual operating revenues

18,000+ employees
2,600+ affiliated physicians
2,100+ volunteers

3 skilled nursing facilities
22 medical clinics
5 urgent care centers
2 inpatient rehabilitation groups
2 affiliated medical groups

Plus
Home Health
Hospice
Home Infusion

Sharp Health Plan
Mortality Review OFI* Pareto May-Oct, 2017

Number of Times OFI Entered

- To some degree, you find what you’re looking for

*Opportunity for Improvement
What Are We Learning and Improving So Far

- Teamwork and Communication
  - Communication and escalation of deterioration
- Missed or delayed diagnosis / treatment
  - Sepsis; Stroke; GI Bleed, etc
- Protocols: Abd pain, pre-op work up, anticoag, etc
- Recognizing Subtle Signs of Deterioration
  - Teach graphical trending in EHR
  - Future: Early Warning System / The Nurse Factor?
- Rapid Response Team
  - Address why nurses don’t call?
  - Automate Triggers; Family initiated calls?
- Advance Illness Management (AIM)
  - Addressing needs in the ED
  - Reliable access to POLST form
  - Bioethics Team
- Clinical Documentation Improvement (CDI)

Early Data Helped Build Momentum for AIM Program

ED AIM Consults

<table>
<thead>
<tr>
<th>Month</th>
<th># of consults</th>
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Defining Advanced Illness

• The Coalition to Transform Advanced Care (CTAC) defines advanced illness as “occurring when one or more conditions become serious enough that general health and functioning decline and treatments begin to lose their impact. This is a process that continues to the end of life.”

• Advanced Illness Management (AIM) is used as the overarching term to categorize the set of services available to patients and families during the trajectory of their illness.
Advanced Illness Management at SMH

• Program logistics:
  – Palliative care and hospice teams de-siloed and are now working together as one team to manage patients at any point in their chronic illness trajectory
  • 6 RNs cross-trained in palliative care and hospice
    – “AIM Navigators”
    – In-house coverage 7 days/week, 365 days/year, with extended hours
Order Stratification

Consult to Advanced Illness Management

• New chronic illness diagnosis
• Goals of care discussion
• Advance care planning
• Palliative care
• Hospice
• Withdrawal of life support
• Transition to comfort care
• LVAD/TAVR evaluation
• Other (special instructions)

• “Palliative care” and “Hospice” exist as synonyms
Program Goals

• Establish a palliative care presence in the ED to discuss goals of care and code status prior to admission

• Move in-house palliative care services upstream in chronic illness

• Streamline services for patients living with/dying from chronic or terminal illness
Barriers to Success

- **Culture**
  - Hospital
  - Society

- **Physician/Staff Buy-In**
ED AIM Consults

2017 Total: 1,463
2016 total: 901
AIM CONSULT DATA ED VS. INPATIENT 2016

Inpt. Consults by Month CY16
- Jan: 116
- Feb: 128
- Mar: 178
- Apr: 148
- May: 163
- Jun: 158
- Jul: 168
- Aug: 141
- Sep: 164
- Oct: 151
- Nov: 123
- Dec: 157

ED Consults by Month CY16
- Jan: 22
- Feb: 36
- Mar: 38
- Apr: 68
- May: 51
- Jun: 81
- Jul: 90
- Aug: 110
- Sep: 115
- Oct: 108
- Nov: 89
- Dec: 93
2017 In Review

• In CY2016, AIM saw a total of 2,696 patients
  – 901 patients were seen in the ED (33%)

• In CY2017, AIM saw a total 2,788 patients
  – 1,463 patients were seen in the ED (53%)
    • 63% increase from CY2016
Accountability

We are not only responsible for the acute outcomes of our patients, but for the long term consequences of that same care.
End of Life Care
Our Journey at EMMC

Vikram Kumar, MD

Eastern Maine Medical Center
University College of Medical Sciences
Medical College of Wisconsin
American Board of Anesthesiology
Maine, USA

TMIT High Performer Webinar
April 19, 2018
End of Life Care
Our Journey at EMMC

Vikram Kumar
Eastern Maine Medical Center

• 400 bed tertiary hospital
• Wide referral area covering northern two-thirds of the state
• Part of the Eastern Maine Healthcare system
• Cardiac/Vascular/Trauma/Thoracic/Neurosurgical
• Level II trauma center
Our Journey with mortality review

• Started in the surgical group
• Committed surgeons
• NSQIP database
• Data on PSI 04 metric and NSQIP performance: a call to action
• Mortality review group with surgeons initially and then quickly expanded based on SLS methodology
Thank you to the team!

- Bach, MD, Robert
- Briggs, MD, Dana
- Call, Joanna
- Cambria, MD, Robert
- Carmack, MD, David
- Clarke, MD, James L
- Fenwick-MD, Amy
- Foster-Woolley, Joani
- Hand, MD, Robert
- Hartman, MD, Karen
- Jawed, Ali
- Kumar, MD Vikram
- Lebowitz, MD, Murray
- Lundy, Erin B
- Pedersen, PAC Craig
- Requena Armas, MD Carlos
- Robichaud, Nicole
- Saunders, Lisa
- Sharrow, Amy
- Small, Patricia
- Spittler, Karl-Heinz
- Staley, MD, Charles
- Waddell, MD Brad
- Wilson, Tami
- Closson, Tina
- Feero, Kristina
- Hanson, Jaime E
- Hartman, MD, Karen
- Houp, Susan
- Karnabi, MD, Eddy
- Klemperer - MD, John
- Kumar, MD Vikram
- Sharrow, Amy
- Sherpa, MD Chheki
- Sherpa, MD Lakpa
- Staley, MD, Charles
- Syed, MD Toyiba
- Ushakumari, Deepu
- Ver Lee, MD, Peter
- Wiseman, MD, Alan
- Tagaram MD, Sandhya D
- Turner MD, James
- VanKirk MD, James
Problem magnitude

Results from 118 reviews
Results for End of Life Care

Results from 118 reviews

- Palliative care team could have assisted (earlier/at all)
- Symptom management
- Family's/patient's expectation management
- Goals of care uncertain or discussion delayed
- Excessive/Futile care

End of Life Opportunities
Cumulative OFI Count
Process evolution so far

- NSQIP risk calculations in surgical navigation/Frailty scores
- High risk charts are reviewed
- Trigger tool development
- Trigger tool is primarily directed at inpatients for now but we expect it to help us in outpatient decision making
- Referrals from surgical navigation to supportive care
Literature Review

Pitfalls in Communication That Lead to Nonbeneficial Emergency Surgery in Elderly Patients With Serious Illness

*Description of the Problem and Elements of a Solution*

Zara Cooper, MD, MSc, FACS,*† Andrew Courtwright, MD, PhD,‡ Ami Karlage, BA,†§
Atul Gawande, MD, MPH,*†§ and Susan Block, MD†¶

Recommendations for Best Communication Practices to Facilitate Goal-concordant Care for Seriously Ill Older Patients With Emergency Surgical Conditions

Zara Cooper, MD, MSc,*†‡ Luca A. Koritsanszky, MPH,* Christy E. Cauley, MD,*§ Julia L. Frydman, BA,*†
Rachelle E. Bernacki, MD, MS,*|| Anne C. Mosenthal, MD,** Atul A. Gawande, MD, MPH,*†
and Susan D. Block, MD*†||††‡‡
Possible criteria for prompting supportive care consult/ goals of care discussion in surgical patients

a. Permanent nursing home resident
b. Cancer
   i. Worsening symptoms of performance status
   ii. No longer a candidate for chemotherapy
c. Class III or IV heart failure
   i. Failing maximal medical therapy
   ii. Cardiac cachexia
d. Pulmonary disease
   i. Long-term oxygen therapy
   ii. Cachexia
   iii. ≥ three emergency hospital visit in 12 months
e. End-stage liver disease
   i. Ascites
   ii. Encephalopathy
   iii. Coagulopathy
   iv. Hepato-renal syndrome
f. End-stage renal disease
   i. Worsening on hemodialysis a refused further dialysis
g. Neurologic disease
   i. Deterioration despite maximal therapy
   ii. Progressive dysarthria or dysphagia, recurrent aspiration pneumonia
h. Dementia
   i. Complete functional dependence
   ii. Unable to communicate meaningfully
   iii. Worsening aspiration
i. Stay in the ICU for more than 7-10 days
j. Poor family/social support system/ decision making
k. Diagnosis with significant mortality such as ischemic bowel/necrotizing fasciitis etc
Presentations
- Surgical/Anesthesia Service
- EMIC/ Cardiology presentation
- Nephrology/ Intensivists

Trigger Tools
- Surgical Trigger tool
- Trigger tool for all patients

Training
- Initial training leadership/ surgery/EMIC
- Repeat training (Consider RN/case managers)

Data Measures
- Goals of care discussion documentation
- Prevalence of OFI - palliative care could have been called earlier
- Time to consult in inpatients
- Supportive care consult in the same admission as death
- Outcome measures Mortality/Readmissions/LOS/Cost of care per episode/Pt Experience
THANK YOU
Teaching Primary Palliative Care to Physicians

Tim Jessick, DO
Palliative Medicine
timjessick90@gmail.com
• Aurora Healthcare
  – Largest health system in Wisconsin/Northern Illinois
  – 15 hospitals
  – >13 hospitals w/ palliative care clinicians/programs

• Aurora West Allis Medical Center (AWAMC)
  – Second largest system hospital - 350 beds
  – Community focused Med/Surg – 140 beds
  – Specialty Palliative Care since 2010
What was Broken?

– Preventable ICU deaths
– Lack of goals of care discussions
– DNR order confusion
– Clinicians calling Palliative Medicine for simple communication encounters
– Pain and symptom management not optimal
– Difficult to change doctors practice(culture change)
Guiding Principle

- Education
- System Changes

→ Improved Outcomes
Key Conversations

Healthy
Category 1
- ACP/surrogate

Chronic Disease
Category 2
- ACP/Surrogate
  - Values
  - Early GOC
  - DNR

Last Year
Category 3
- ACP/Surrogate
  - DNR
  - Late GOC
  - Hospice
Training Principles

• Small group learning environment (< 20)
• Time to discuss personal attitudes that impede communication; cognitive re-framing
• Time to practice different words using role playing
  – Focus on microskills
• Didactic information:
  – ethics and legal issues, advance directives, prognostication.
• Utilized Dr. David Weissman’s Communication training
# Training Agenda

<table>
<thead>
<tr>
<th>Giving Bad News</th>
<th>Role Play</th>
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<tbody>
<tr>
<td>Prognostication: cancer and non-cancer factors</td>
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<tr>
<td>Decision Making Capacity</td>
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<tr>
<td>Advance Directives: clinical responsibilities/protections</td>
<td>Readings/Group discussion</td>
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<tr>
<td>Informed consent: emergency exception</td>
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<tr>
<td>Hospital policies</td>
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<tr>
<td>Family Goal Setting meeting-Part 1</td>
<td>Group Discussion</td>
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<tr>
<td>Family Goal Setting meeting-Part 2</td>
<td></td>
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<tr>
<td>Conflict management</td>
<td>Role Play</td>
</tr>
<tr>
<td>DNR/CPR</td>
<td>Role Play</td>
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</tbody>
</table>
Teaching Generalists

• Getting Buy-In
  – Trained the Medical Executive Committee
    • Internists, Surgeons, ED, Cardiology, Ortho

• Roll-Out
  – >200 hospitalists, ED physicians, specialists
  – CNO, CMO, Director of Quality
  – Physician leaders

• Request for training: System CMO, Director of Hospitalist(140 hospitalists) and ED service lines(>100 physicians)
Physician Follow-Up

• Two, one hour mentoring sessions
  – Observed goals of care discussions
• Assistance in documentation
  – Implemented goals of care template
• Chart review
  – Looked for presence of and quality of the goals of care notes
• Mortality review
Goals of Care Template

*Does the patient have an AD?*

*Is the patient decisional?*

*What is the patient’s code status and rationale?*

*What are the Goals of Care?*
Embedding the GOCC into Practice

- Standard of Care
- Who/When GOCC
- Documentation/EMR
- Quality Monitoring
January 2014 to June 2015 Analysis

Early Effective *Goals of Care* Discussion Improves patient centered care & In-Hospital Mortality at AWAMC
## AWAMC Outcomes: 2013-2015

<table>
<thead>
<tr>
<th>Outcome Metrics</th>
<th>Outcome</th>
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<tbody>
<tr>
<td># Inpatient Deaths</td>
<td>↓</td>
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<tr>
<td># and % of ICU deaths</td>
<td>↓</td>
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<tr>
<td>LOS Inpatient deaths</td>
<td>↓</td>
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<tr>
<td>SNF to Hospital Readmissions</td>
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<tr>
<td>Code 4 Calls</td>
<td>↓</td>
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<tr>
<td>Admission within 30 days of terminal admission</td>
<td>↓</td>
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<tr>
<td>ED visits within 30 days of terminal admission</td>
<td>↓</td>
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<tr>
<td>Hospice Referrals</td>
<td>↑</td>
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<tr>
<td>HCAHPS Scores</td>
<td>↑</td>
</tr>
<tr>
<td>Documentation of GOC discussion</td>
<td>↑</td>
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<tr>
<td># Completed Adv. Directives</td>
<td>↑</td>
</tr>
<tr>
<td>Comfort care orders within 24 hrs of admission</td>
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</tbody>
</table>
Future Goals

• Screening all patients admitted for unmet needs
• Follow-up training (Reinforcement) for the hospitalists, other docs
• ALL Aurora hospitals adopting mortality review/training/systems changes
• Statewide interest through Palliative Care Network of Wisconsin (PCNOW)
• Apply system change to all settings
• System leadership looking at GOCC as a quality metric for all hospitals in the metro area
• Randomized Control Trial with MIT regarding goals of care training of physicians and measurable outcomes (readmissions, LOS, mortality)
National Survey Questions

I am interested in ADDITIONAL INFORMATION on:

End of Life Issues

Very Strongly Agree
Strongly Agree
Agree
Neutral
Neutral
Negative to Neutral
Disagree
Strongly Disagree
Very Strongly Disagree

End of Life Issues
Specific Topics I would like covered includes:
National Survey Questions

I am interested in webinar on PATIENT SAFETY CASE STUDIES regarding: HUMAN RESOURCES “JUST” BEST PRACTICES

10 9 8 7 6 5 4 3 2 1
Very Strongly Agree Strongly Agree Agree Neutral Neutral Negative to Neutral Disagree Strongly Disagree Very Strongly Disagree

Specific HUMAN RESOURCES Topics I would like covered include:
Example: Handling Patient Safety Accidents and Just Culture
National Survey Questions

I am interested in AN UPDATE on:
Central Line-associated Bloodstream Infections

Specific Central Line-associated Bloodstream Infections
Topics I would like covered includes:
Speakers and Reactors

Jeanne M. Huddleston
Patty Atkins
Vikram Kumar
Timothy Jessick
Dan Ford
Charles Denham
Voice of Patient and Family

Dan Ford

Voluntary Patient Safety Advocate
Voluntary Spectrum Health EPFAC and Hospital Group
Board Quality & Safety Committee
Voluntary TMIT Patient Advocate Team Member
Retired Healthcare Executive Search Consultant
Rockford, MI

TMIT High Performer Webinar
April 19, 2018