



2016 EDUCATIONAL CONFERENCE

THE WASHINGTON STATE MEDICAL COMMISSION

Reducing Medical Error through
Understanding, Communication,
and Accountability

OCTOBER 6, 2016

Seattle Airport Marriott
3201 South 176th Street, Seattle Washington 98188



2016 EDUCATIONAL CONFERENCE

THE WASHINGTON STATE MEDICAL COMMISSION

CONTINUING MEDICAL EDUCATION

Five Continuing Medical Education (CME) credits will be available. To claim CME, please submit your signed record and evaluation as you leave for the day. Certificates will be emailed.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Washington State Medical Association and Washington State Department of Health. The WSMA is accredited by the ACCME to provide continuing medical education for physicians. The WSMA designates this live activity for a maximum of 5 AMA *PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This activity meets the criteria for up to 5 hours of Category I CME credits to satisfy the relicensure requirements of the Washington State Medical Quality Assurance Commission.

PARKING

Parking is available at the Seattle Airport Marriott for \$14 per day. Overnight parking is \$27 per night. Valet Parking is also available for \$32 per day.

USEFUL WEBSITES

- Conference website: <http://go.usa.gov/36s2e>
- [Slido.com](#): Event Code #6698
- Medical Commission Home Page: <http://go.usa.gov/xqq8x>
- Medical Commission Newsletters: <http://go.usa.gov/3z9f9>
- Speakers Bureau: <http://go.usa.gov/3z97h>
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Sli.do is a website that allows you to ask questions during a presentation without interrupting the speaker. If you think of a question, submit it on sli.do and the moderator will ask the question for you at the end. Sli.do is also a great way to ask a question if you prefer to remain anonymous. Just go to <https://www.sli.do/home>, enter #6698 into the "join event" box and submit your question.

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Reducing Medical Error through Understanding, Communication, and Accountability

Thursday October 6th 2016

8:00 AM Registration Opens

9:00 AM – 9:15 AM Opening Remarks, Message from the WA State Medical Commission
Dr. Warren Howe, Commission Chair

MULTICULTURAL HEALTH CARE AND HOW IT DRIVES QUALITY OUTCOMES

9:15 AM – 10:15 AM **Margaret O’Kane**
Founding and current president of The National Committee for Quality Assurance.

10:15 AM – 10:30 AM Networking Break

TRANSFORMING HEALTHCARE THROUGH TRANSPARENCY, COMMUNICATION, AND LEADERSHIP

10:30 AM – 11:30 AM **Gary S. Kaplan, MD, FACP, FACMPE, FACPE**
Lucian Leape Institute Chair, CEO Virginia Mason

11:30 AM – 1:00 PM Independent Lunch Break

MEDICAL, LEGAL AND ETHICAL CONSIDERATIONS IN ERROR DISCLOSURE

1:00 PM – 2:00 PM **Nathan Schlicher MD, JD, FACEP**
Former WA state Senator, Associate director for the TeamHealth National Patient Safety Organization, ER doctor at St. Joseph Medical Center

2:00 PM – 2:15 PM Break

LEARNING FROM THE PATIENT EXPERIENCE

2:15 PM – 3:15 PM A Medical Commissioner, key staff and the father who filed a report with the Medical Commission on behalf of his daughter, will discuss the practitioner regulation process and explore the lessons learned from this case.

3:15 PM – 3:30 PM Networking Break

COMMUNICATING KEY LEARNINGS FROM PATIENT SAFETY EVENTS ACROSS AN ORGANIZATION

3:30 PM – 4:30 PM **Kristina Toncray, MD**
Seattle Children’s Hospital

4:30 PM CLOSING REMARKS

Useful Medical Commission Webpages

Educational Conference Webpage

- <http://go.usa.gov/3zZqh>

Presenter Videos from Previous Educational Conferences

- <http://go.usa.gov/3z9eW>

The Medical Commission Webpage

- www.doh.wa.gov/medical

About The Medical Commission

- <http://go.usa.gov/3zWKB>

Health Equity Resources

- <http://go.usa.gov/3z9mG>

Commission Policies, Guidelines, Rules and Laws

- <http://go.usa.gov/3z9pB>

Medical Commission Newsletters

- <http://go.usa.gov/3z9f9>

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- <http://go.usa.gov/3z97h>

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**State of Washington
Medical Quality Assurance Commission**

Guideline

Title:	A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety MD2015-08	
References:	Attached	
Contact:	Daidria Pittman, Program Manager	
Phone:	(360) 236-2727	E-mail: daidria.pittman@doh.wa.gov
Effective Date:	June 26, 2015	
Supersedes:	Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery MD2011-08; Reducing Medical Errors: Developing Commission Case Studies for Hospitals and other Entities MD2012-04; Endorsement of Just Culture Principles to Increase Patient Safety and Reduce Medical Errors MD2014-06.	
Approved By:	Michelle Terry, MD (signature on file)	

“We need to quit blaming and punishing people when they make mistakes and recognize that errors are symptoms of a system that’s not working right, and go figure out and change the system so no one will make that error again, hopefully. We have to change the culture, so everyone feels safety is his or her responsibility, and identifies hazards before someone gets hurt.”

-Lucian Leape, MD

Adjunct Professor of health policy, Harvard School of Public Health
Co-Founder, National Patient Safety Foundation

Purpose

The Medical Quality Assurance Commission (Commission) adopts this policy to collaborate with the health care system to reduce medical error¹ and enhance patient safety. This policy replaces previous Commission policies to provide a more comprehensive approach to the Commission’s efforts to reduce medical error.²

Background

Medical errors continue to be a leading cause of death in the United States.^{3,4} In its seminal report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (IOM) studied other high-risk industries that have taken a systems approach to improving safety, and concluded that the most effective way to reduce error and improve patient safety is not to blame individuals, but to create an environment that encourages organizations to identify errors, evaluate causes, and take appropriate actions to prevent future errors from occurring.^{3,5,6}

Leading national patient safety advocates such as Lucian Leape, MD, have proposed going beyond the IOM's recommendations and building momentum for a "just culture" in medicine-- a culture that is open, transparent, supportive and committed to learning; a culture centered on teamwork and mutual respect, where every voice is heard and every worker is empowered to prevent system breakdowns and correct them before they occur; where patients and families are fully engaged in their care; and where caregivers share information openly about hazards, errors and adverse events.^{7, 8,9,10,11} Communication and Resolution Programs have shown great promise in providing a structure to employ these principles to reduce medical error.

Despite the efforts of many organizations across the country to develop initiatives to enhance patient safety, progress has been slow and insufficient.^{7,8} Medical errors remain vastly underreported.^{12,13,14} Traditional malpractice and disciplinary systems are thought to impede progress by discouraging the reporting of errors, contributing to a culture of blame and a "wall of silence" in health care that inhibits learning and prevents systems change that is critical to reducing error.^{14,15,16} Dr. Leape calls on regulators to become a force for error reduction rather than a force for error concealment.¹⁵

The Commission is committed to its statutory mandate to protect the public through licensing, discipline, rule-making, and education. The Commission recognizes the limitations of the traditional disciplinary process to reduce error in a rapidly evolving health care delivery system. As health care becomes more patient-centered, team-based, and transparent,¹⁷ a new regulatory model is needed, one that focuses less on punishment and more on improving systems and preventing error.¹⁸ The Commission believes that a more effective regulatory approach is to work directly with entities in the health care system to foster open communication with patients, proactively prevent or reduce medical error and increase patient safety.¹⁹

The Commission answers Dr. Leape's call to become a force for error reduction rather than concealment through the following activities:

- Endorsing just culture principles. The Commission encourages institutions, hospitals, clinics and the health care system to adopt a just culture model to reduce medical error and make systems safer. Likewise, the Commission will use just culture principles in reviewing cases of medical error.
- Entering into a Patient Safety Collaboration with the Foundation for Health Care Quality to support and develop Communication and Resolution Programs throughout the state of Washington and to develop a process to handle such cases.
- Collaborating with the Foundation for Health Care Quality to develop a state-wide system to disseminate lessons learned from unanticipated outcomes and medical errors, fostering a learning culture in our state and making the entire health care system safer.

By taking these steps, the Commission collaborates with the health care system to reduce medical error, become a more effective regulator, and better meet its mandate to protect the public. This policy replaces previous Commission policies to provide a more comprehensive and effective approach to the Commission's efforts to reduce medical errors.²⁰

The Commission Endorses a Just Culture Model for the Health Care System

“Just culture” is a term describing an approach to reducing error in high-risk and complex industries by recognizing that errors are often the result of flawed systems, and that blaming individuals for human error does not make systems safer. A just culture describes an environment where professionals believe they will be treated fairly and that adverse events will be treated as opportunities for learning. A just culture encourages open communication so that near misses can serve as learning tools to prevent future problems, and adverse events can be used to identify and correct root causes. It holds individuals accountable for the quality of their choices and for reporting errors and system vulnerabilities, and holds organizations accountable for the systems they design and how they respond to staff behaviors.^{21,22,23}

In *To Err is Human*, the IOM detailed the efforts of high-risk industries, most notably aviation, in applying these principles with remarkable success.^{3,24} The report called for applying these principles to health care, observing that health care is decades behind other high-risk industries in its attention to ensuring safety and creating safer systems.³ A just culture in healthcare recognizes that medical errors often involve competent providers in flawed systems, and encourages greater voluntary event reporting, open communication, learning and improvement of systems.^{18,21,25} A just culture has no tolerance for reckless or intentional disregard of safe practices. In those instances, discipline is required. Since the IOM report, many healthcare organizations have adopted a just culture model in their systems and have experienced the benefits of increased event reporting and decreased medical error.^{26,27,28}

The Medical Commission endorses just culture principles and encourages institutions, hospitals, and clinics to adopt these principles to improve the health care system in the state of Washington.²⁹ As the healthcare delivery system becomes more patient-centered, team-based, and transparent, the employment of a just culture model is critical to making meaningful improvement in patient safety.

The Patient Safety Collaboration to Support Communication and Resolution Programs

In 2013, the Commission and the Foundation for Health Care Quality (Foundation) signed a Statement of Understanding to form a Patient Safety Collaboration. (Attachment A) The purpose of the collaboration is for the Commission and the Foundation to work together to help the medical profession reduce medical error by supporting and promoting communication and resolution programs (CRPs). The collaboration also sets forth a process by which the Commission will handle cases that go through a CRP process.

Communication and Resolution Programs

CRPs promote a patient-centered response to unanticipated outcomes: when a patient is harmed by medical care, providers should be able to tell the patient exactly what happened, what steps will be taken to address the event, and how similar outcomes will be prevented. CRPs are a stark departure from the long-standing deny and defend posture following unanticipated outcomes.^{13,30,31}

CRPs are characterized by open and prompt communication; support for involved patients, families, and care providers; rapid investigation and closure of gaps that contributed to the unanticipated outcome; proactive resolution; and collaboration across all involved stakeholders. CRPs are based on

just culture principles, and recognize that most medical errors are caused not by incompetent providers, but rather by the interaction between competent providers who have made a simple human error and faulty healthcare systems, processes, and conditions.

A CRP involves the following steps:

- Immediate reporting of unanticipated outcomes, both to the patient and family, and to the institution;
- Immediate investigation to determine the factors that led to the event;
- Communicating the findings of the investigation to the patient and the patient's family;
- Apology to the patient and, when appropriate, an offer of compensation or non-financial resolution;
- A change to the system to prevent the event from re-occurring; and
- Shared learning.

CRPs emphasize provider accountability. Providers must report unanticipated outcomes as soon as they occur, participate in efforts to understand whether the unanticipated outcome was due to medical error or system failure, and participate in efforts to prevent recurrences. CRPs do not tolerate reckless or intentional disregard of safe practices. CRPs have been used in a number of institutions and systems across the country with early success, and have the support of the Joint Commission and the Agency for Health Care Quality and Research.^{14,30,31,32}

The Foundation for Health Care Quality

The Foundation is a non-profit organization that administers quality improvement programs. The Foundation uses clinical performance data as a tool, working with providers and hospitals to adopt evidence-based practices and improve patient safety.³³ The Foundation also houses the Washington Patient Safety Coalition, a collaboration of patient safety leaders who share best practices to improve patient safety and reduce medical errors.

In 2011, the Foundation received a grant from the Agency for Healthcare Research and Quality to form HealthPact. HealthPact is a program designed to improve communication in health care by (1) training healthcare providers to communicate better with each other and with patients, (2) working with stakeholders to create an ongoing learning community and implement best practices in their respective institutions, and (3) developing CRPs.

The CRP Certification Process

The collaboration between the Commission and the Foundation led to the creation of an additional step in the standard CRP process: the formation of a CRP Event Review Board. This Board serves as a neutral panel to review and certify CRP events. The Board is composed of individuals from across the health care spectrum, including patient safety advocates, risk managers, insurers, and physicians.

When an unanticipated outcome occurs and an institution completes a CRP process, the institution may request an independent review by submitting an application for certification to the Board. The Board reviews the application and all relevant records and documents, and determines whether all key elements of the CRP process have been satisfied, particularly that the systems changes are appropriate and effective. If all the elements are fully satisfied, and patient safety has improved as a

result, the Board will send a report back to the institution stating that the event is certified. This step provides an additional level of objective quality review of the CRP process.

The Commission's Coordination with the CRP Process

When the Commission receives a complaint against a provider, and learns that the provider is participating in a CRP process, the Commission will exercise its discretion to decide whether to place the case on hold pending timely completion of the CRP process. The Commission will not place a case on hold if the provider's continued practice presents a risk to patients or if the Commission is concerned that patient safety will not be adequately addressed by the CRP. In such a case, the Commission will conduct a prompt investigation and take appropriate action to protect the public.

If the Commission places a CRP case on hold and then receives a report that the event has been certified, the Commission will exercise its discretion to determine whether to investigate the matter or to close the case. If the Commission determines that the CRP process has timely and thoroughly enhanced patient safety, including individual and system-level improvements, the Commission may close the case as satisfactorily resolved. If not, the Commission will promptly investigate the case and take appropriate action, if warranted.

The CRP process is limited to cases of human error. The CRP Event Review Board will not certify cases involving reckless or intentional conduct, gross negligence, sexual misconduct, boundary violations, patient abuse, drug diversion, criminal activity, and other unethical or unprofessional behavior.

CRPs Benefit Patients and Families, Providers, and the Commission

The use of CRPs is a drastically different approach to medical error than the traditional system of secrecy, denial and defensiveness. CRPs provide patients with what they need after an unanticipated outcome: open and honest communication about what occurred, emotional first aid, accountability, an apology, remediation and compensation. Ultimately, CRPs have the potential to reduce medical errors and improve patient safety.

CRPs benefit providers by reducing the barriers to reporting medical errors. CRPs offer a safe environment for providers to disclose unanticipated outcomes, have an honest discussion with the patient and the patient's family, and work to improve systems, without undue fear of malpractice suits, professional discipline or personal embarrassment.³⁴ CRPs promote a non-punitive, learning culture to improve patient safety.

For the Commission, CRPs remove the limitations inherent in the traditional disciplinary process:

- Reports of medical errors to the Commission are often delayed for years by the malpractice system, limiting the effectiveness of the Commission's response to complaints.¹² The CRP process requires prompt reporting and patient-centered action allowing for early resolution of medical errors. This expedited process will allow the Commission to address errors much sooner than under the current system.

- The Commission has no jurisdiction over institutions, such as hospitals or clinics. When a medical error occurs, the Commission can discipline the individual provider but is unable to directly influence the institution to make system changes to ensure the error is not repeated. The collaboration requires the individual provider and the institution to change the system to prevent future patient harm.
- The Commission has no good mechanism for sharing lessons learned so that licensees and institutions can prevent errors from occurring. The collaboration requires shared learning across and among institutions.

The collaboration allows the Commission to have a greater effect on patient safety than the traditional disciplinary process and thereby improve its ability to protect the public.

Furthermore, medical errors that do not cause harm --"near misses"-- seldom come to the attention of the Commission. This collaboration strongly encourages reporting of near misses to help identify potential system problems and implement system fixes before patients are harmed. By promoting early reporting of all unanticipated outcomes, as well as near misses, a wider range of errors will be identified and corrected.³⁵

The Commission encourages all institutions, clinics, and practices in the state of Washington to develop a CRP program, make it available to all physicians and physician assistants, have events certified by the CRP Event Review Board, and join in the effort to foster open communication, reduce medical error and improve patient safety in our state.³⁶

The Collaboration to Develop a State-Wide System for Dissemination of Lessons Learned from Medical Error

Learning from medical errors is crucial to improving patient safety. To facilitate and enhance learning, the Commission and the Foundation have committed to collaborating to develop a state-wide system to disseminate lessons learned from medical error cases to health care providers and institutions.

The collaboration will consist of the following: The collaboration will give the Foundation two additional sets of data about medical errors: (1) the CRP Event Review Board will submit information on cases that go through the certification process, and (2) the Commission will submit de-identified reports of medical error cases that come from complaints.

The Foundation will analyze the information to determine trends in the root causes of medical errors and lessons learned from these cases, and will combine this information with data from other Foundation programs such as the Clinical Outcomes Assessment Program (COAP), the Surgical Care Outcomes Assessment Program (SCOAP), and the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) to create a comprehensive picture of medical errors, their causes, and lessons learned across the state.

On at least a bi-monthly basis, the Foundation will produce a written briefing on medical errors for distribution to healthcare workers across the state that identify key steps they can take to improve patient safety. The distribution of this briefing will be closely coordinated with the Patient Safety Coalition, another Foundation program, along with the Washington State Medical Association and the

Washington State Hospital Association. Depending on the nature of the medical errors that are highlighted in the briefing, the distribution of this material may be targeted to specific providers.

The Foundation will produce a written briefing on medical errors on a quarterly basis for distribution to healthcare institutions across the state emphasizing patterns of medical errors and lessons learned. The Foundation will closely coordinate the distribution of this briefing with the Washington State Hospital Association. In the event that a lesson learned has potential immediate impact on patient safety, the Foundation will issue an emergency briefing on the subject to both healthcare providers and institutions using the distribution channels described above.

Conclusion

Medical errors continue to pose a serious threat to patient safety. The Commission is firmly committed to its mandate to protect the public, but recognizes the limitations of the disciplinary process in the evolving health care delivery system. The Commission believes that a more effective approach is to collaborate with the health care system to develop a more patient-centered response to medical error and improve patient safety.

The Commission believes that by endorsing just culture principles, collaborating with the Foundation for Healthcare Quality to support and develop CRPs, and collaborating with the Foundation to develop a system to disseminate lessons learned from medical error statewide, the Commission will help to reduce medical errors, become a more effective regulator, and better meet its mandate to protect the public.

¹ Medical Error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Institute of Medicine 2000. Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington DC: National Academy Press; 2000.

² In 2011, the Commission adopted a policy to address wrong-site, wrong-procedure, and wrong-person surgery: Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery, MD2011-08. In 2012, the Commission adopted a policy to reduce medical error by providing case information to hospitals and other entities: Reducing Medical Errors: Developing Case Commission Case Studies for Hospitals and other Entities MD2012-04. In 2014, the Commission adopted a policy endorsing just culture principles: Endorsement of Just Culture Principles to Increase Patient Safety and Reduce Medical Errors MD2014-06.

³ Institute of Medicine 2000. Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington DC: National Academy Press; 2000.

⁴ James, John T., PhD, (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care, *Journal of Patient Safety*, 9, 122-128.

⁵ Institute of Medicine 2001. Committee on Quality of Health Care in America. *Crossing the Quality Chasm*. Washington DC: National Academy Press; 2001.

⁶ Sentinel Event Statistics Released for 2014, the Joint Commission. April 2015: "In 2014 the leading root causes and contributory factors are examples of cognitive failures. Cognitive failure is preventable and safety-critical industries take a systems view. Health care organizations must focus on factors that influence errors and operationalize strong corrective actions aimed at improving working conditions and eliminating all preventable injury, harm and death." Ronald Wyatt, M.D., M.H.A., medical director, The Joint Commission. Accessed at http://www.jointcommission.org/assets/1/23/jconline_April_29_15.pdf

⁷ Leape L, Berwick D, et al., Transforming Healthcare: a Safety Imperative, *Qual. Saf. Health Care*, 2009; 18:424-428. Waterson P, *Patient Safety Culture*. Ashgate 2014.

- ⁸ Safe Practices for Better Healthcare—2010 Update, National Quality Forum, page 7. http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx accessed 3-9-15.
- ⁹ Marx D. *Whack a Mole: The Price We Pay for Perfection*. By Your Side Studios: 2009.
- ¹⁰ Marx D. *Patient Safety and the “Just Culture”: A Primer for Health Care Executive*. New York, NY: Columbia University: 2001.
- ¹¹ Waterson P, *Patient Safety Culture*. Ashgate 2014.
- ¹² Studies show that disclosure of medical errors occurs in approximately 30% of cases. Wu A, Boyle D, Wallace G, Mazor K, Disclosure of Adverse Events in the United States and Canada: an Update and a Proposed Framework for Improvement, *J. Public Health Research*, 2013; 2:e32:186-193.
- ¹³ James J., A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *J. Patient Saf.* 2013;9(3) 122-128.
- ¹⁴ Bell SK, Smulowitz P, Woodward A, Mello M, Duva A, Boothman R, Sands K, Disclosure, Apology, and Offer Programs: Stakeholders’ Views of Barriers to and Strategies for Broad Implementation. *Millbank Quarterly* 2012;90(4): 682-705.
- ¹⁵ The Commonwealth Fund, Q&A with Lucian Leape, <http://www.commonwealthfund.org/publications/newsletters/states-in-action/2010/jan/january-february-2010/ask-the-expert/ask-the-expert> accessed 4-28-15.
- ¹⁶ Sage WM, Medical Liability and Patient Safety, *Health Law*. 2003;22(4):26-36.
- ¹⁷ In March 2015, the Robert Wood Johnson Foundation issued a report on the importance of implementing a team-based model: Lessons from the Field: Promising Interprofessional Collaboration Practices, Robert Wood Johnson Foundation report 2015, available at <http://www.rwjf.org/content/dam/farm/reports/reports/2015/rwjf418568> .
- ¹⁸ In January 2015, the National Patient Safety Foundation’s Lucian Leape Institute issued a report on the importance of transparency: Shining a Light: Safe Health Care Through Transparency, available at http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/LLI/Shining-a-Light_Transparency.pdf .
- ¹⁹ This approach is consistent with the Commonwealth Fund scorecard: “Aiming Higher: Results from a Scorecard on State Health System Performance, 2014: “The Scorecard also reminds us, however, that improvement is possible with determined, coordinated efforts. The most pervasive gains in health system performance between 2007 and 2012 occurred when policymakers and health system leaders created programs, incentives, and collaborations to raise rates of children’s immunization, improve hospital quality, and lower hospital readmissions. These gains illustrate that state health system performance reflects a confluence of national policy and state and local initiatives that together can make a difference for state residents.” <http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard>
- ²⁰ Since 2011, the Commission has adopted three policies on medical error: Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery MD2011-08; Reducing Medical Errors: Developing Commission Case Studies for Hospitals and other Entities MD2012-04; and Endorsement of Just Culture Principles to Increase Patient Safety and Reduce Medical Errors MD2014-06. The Commission rescinds these policies with the adoption of this more comprehensive policy.
- ²¹ Marx D. *Patient Safety and the “Just Culture”: A Primer for Health Care Executives* New York, NY: Columbia University; 2001. Available at <http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf>
- ²² Latter C, And Justice For All, *Prevention Strategist*, Winter 47-53.
- ²³ Griffith K, Column: The Growth of a Just Culture, *The Joint Commission Perspectives on Patient Safety*, 9(12), 8-9.
- ²⁴ The success of the Aviation Safety Reporting System is attributed to three factors: reporting is safe (pilots are not disciplined if they report promptly), simple (a one-page report is made), and worthwhile (experts analyze the reports and disseminate recommendations to the pilots and the FAA). Leape L, , Reporting of Adverse Events, *N Eng J Med*. 2002;347:1633.
- ²⁵ Boysen PG, Just Culture: A Foundation for Balanced Accountability and Patient Safety, *The Ochsner J*. 2013;13:400-406.
- ²⁶ Petschonek S, Burlison J, Development of the Just Culture Assessment Tool: Measuring the Perceptions of Health-Care Professionals in Hospitals, *J Patient Safety* 9(4): 190-197.
- ²⁷ Wachter RM, Pronovost PJ Balancing “no blame” with accountability in patient safety. *N Eng J Med*. 2009;361:1401-1406.
- ²⁸ The National Quality Forum endorsed a just culture approach as part of a patient safety program. See Safe Practices for Better Healthcare—2010 Update. https://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx
- ²⁹ The Medical Commission encourages health care systems to implement a Just Culture into their organizations by integrating the following key elements:

1. Create working health care teams with open communication among team members, recognizing that patients and their family members are active members of the health care team.
2. Encourage each member of the healthcare team to immediately internally report unanticipated outcomes, near misses, and hazardous conditions.
3. Promptly inform the patient and family of unanticipated outcomes, and keep patient and family fully apprised of the process.
4. Apply thorough analysis within facilities to identify factors that contribute to adverse events.
5. Inform the patient and family of the findings of the analysis. If the analysis reveals a medical error, notify the family of the remedial action to be taken, including apologizing for the medical error.
6. Take prompt action with adequate resources to fix system flaws and ensure individual remediation to prevent future patient harm.
7. Share improvements and learning between facilities and with pertinent specialty organizations so that other facilities can improve their systems and prevent future harm.
8. Maintain ongoing staff training to support implementation of all Just Culture elements.

³⁰ Mello M, Senecal S, Kuznetsov Y, Cohn J, Implementing Hospital-Based Communication-and-Resolution Programs: Lessons Learned in New York City. *Health Affairs* 2014; 33(1): 30-38.

³¹ Mello M, Boothman R, McDonald T, Driver J, Lembriz A, Bouwmeester D, et al., Communication-and-Resolution Programs: the Challenges and Lessons Learned from Early Adopters. *Health Affairs*. 2014; 33(1): 20-29.

³² Mello M, Gallagher T, Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers. *N. Eng. J. Med.* 2010;362(15):1353-1356.

³³ The Foundation has the following programs: 1. Clinical Outcomes Assessment Program (COAP), which collects data submitted by all 35 hospitals in the state where cardiac interventions are performed, then producing a quarterly report to the hospitals, and documenting statistically significant improvements in quality, as well as establishing standards by peer consensus and holds institutions accountable for performing to those standards. 2. Surgical Care and Outcomes Assessment program (SCOAP), which involves the surgical community working with stakeholders to create a framework which defines metrics, tracks hospital performance, and reduces variability and errors in surgical care. 3. Obstetrics Clinical Outcomes Assessment Program (OB COAP), the obstetrics version of COAP. 4. The Washington Patient Safety Coalition, which consists of diverse groups working together to improve patient safety through the sharing of best practices related to patient safety. 5. HealthPact, which seeks to transform communication in healthcare, recognizing that poor communication is a fundamental cause of most preventable injuries. 6. The Bree Collaborative, established by the Washington State Legislature, consist of stakeholders appointed by the Governor and is tasked with annually identifying three health care services with high variation in the way care is delivered, that are frequently used, and do not lead to better care or patient health, or have patient safety issues. The group then develops evidence-based recommendations to send to the Health Care Authority to guide the care provided to Medicaid enrollees, state employees and other groups. <http://www.qualityhealth.org/>

³⁴ Statement on Medical Liability Reform, Bulletin of the American College of Surgeons, March 1, 2015 (CRPs “show the most promise for promoting a culture of safety, quality and accountability; restoring financial stability to the liability system; and requiring the least political capital for implementation.”) Available at <http://bulletin.facs.org/2015/03/statement-on-medical-liability-reform/>

³⁵ Krause Ph.D., Thomas R and Hidley, M.D., John, *Taking the Lead in Patient Safety*, John Wiley & Sons, Inc. , 2009 Near-miss reporting is recognized as one of several leading indicators for healthcare safety (p. 42) “Virtually every patient injury is preceded by lower-level decisions and outcomes that increase the likelihood of a safety failure. The catastrophic outcome – a sentinel event, serious injury, or death—can be seen as the tip of an iceberg embedded in a larger architecture of behaviors, practices, and outcomes that made the greater loss predictable.” (p. 189) “. . . the companies setting the benchmark for industry safety often have the highest rates of reported near misses because they do not penalize the reporting of near misses and do not directly reward the reduction of incident rates. Instead, they welcome the information stemming from near misses, quickly digest its implications, and act immediately to reduce the likelihood of repeated exposures to hazard.” (p. 221) “When a single serious event occurs, it can be inferred with high probability that many related but less severe events have occurred previously. To prevent medical errors and adverse events, small events and their precursors must be taken as seriously as large ones.” P. 38

³⁶ The AHRQ has provided grants to other sites around the country to implement CRPs. The Collaborative for Accountability After Patient Injury consists of leading experts on medical error to exchange ideas and support the growth and spread of CRPs.



Margaret E. O'Kane

Founding and Current President
National Committee for Quality Assurance (NCQA)
Washington, D.C.

Margaret E. O'Kane is the founding and current president of the National Committee for Quality Assurance (NCQA).

She was elected a member of the Institute of Medicine in 1999 and received the 2009 Picker Institute Individual Award for Excellence in the Advancement of Patient-Centered Care. Modern Healthcare magazine has named O'Kane one of the "100 Most Influential People in Healthcare" ten times, most recently in 2015, and one of the "Top 25 Women in Healthcare" three times. She received the 2012 Gail L. Warden Leadership Excellence Award from the National Center for Healthcare Leadership.

She serves or has served as a board member of the Milbank Memorial Fund, the American Board of Medical Specialties and Chairman of the Board of Healthwise, a nonprofit organization that helps people make better health decisions.

O'Kane holds a master's degree in health administration and planning from Johns Hopkins University, where she received the Distinguished Alumnus Award, is an Associate in the Department of Health Policy and Management, and serves on the Advisory Board of the Bloomberg School of Public Health.



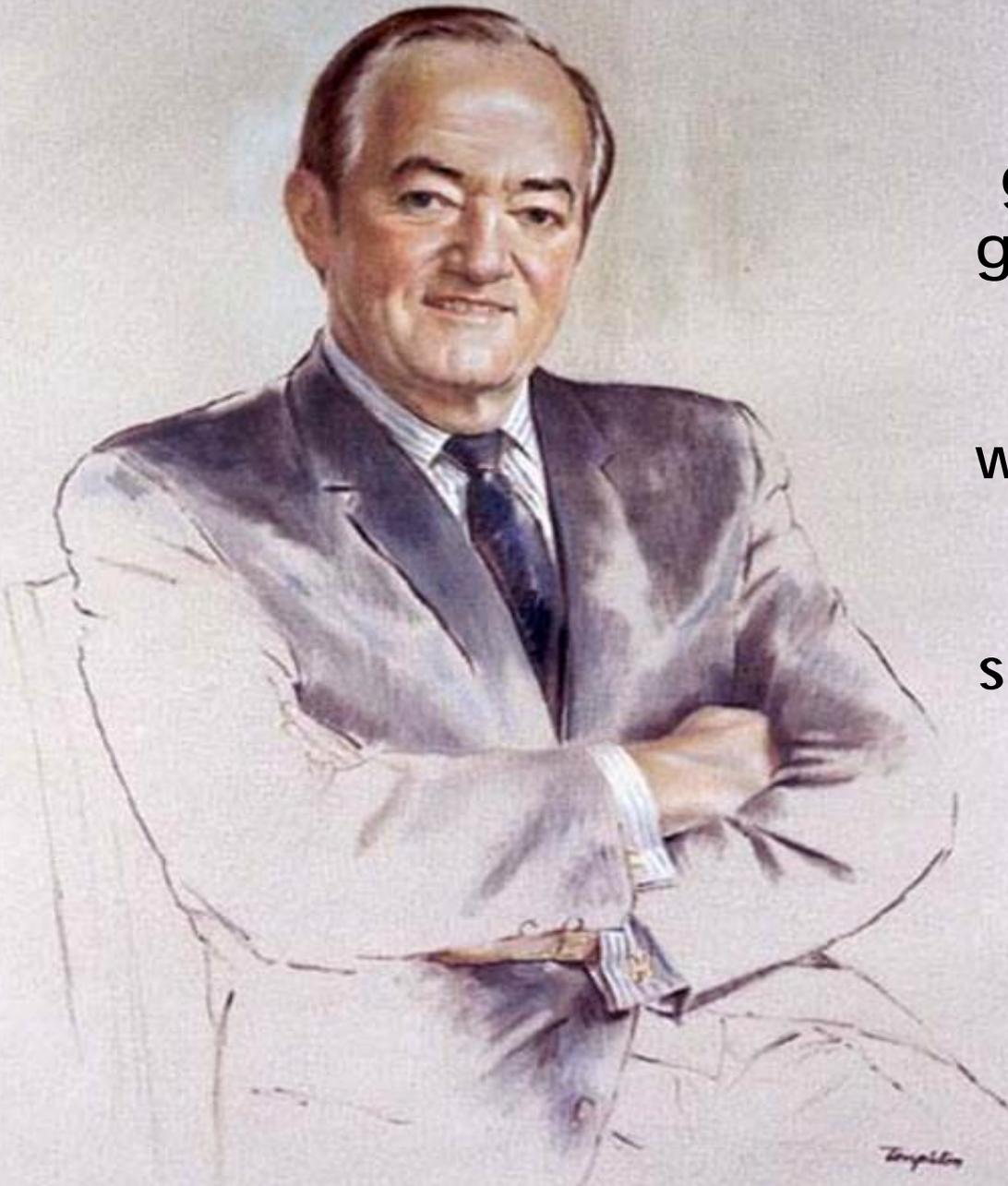
Health Care Quality and Disparities

Margaret E. O'Kane
NCQA President
Washington State Medical Commission
October 6, 2016

Everyone should have a shot at the same outcomes



ALL
LANES
OPEN



“The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.”

Hubert Humphrey

Bridging divergent definitions of care

Medical

Problem patient
presents with
during a visit

Societal

Food stamps,
SNAP, welfare,
SSI, education?

The missing middle

Predispose the
whole person for
a healthy life

Rebecca Onie, HealthLeads Why intervene upstream

“Children who experience food insecurity are 30% more likely to be hospitalized by age three”



A lesson from the Esther Project

Whole-person care
includes checking
what's in the refrigerator



Have diabetes?
We need to help you be a diabetes expert.



New York Medicaid can pay rent for this person



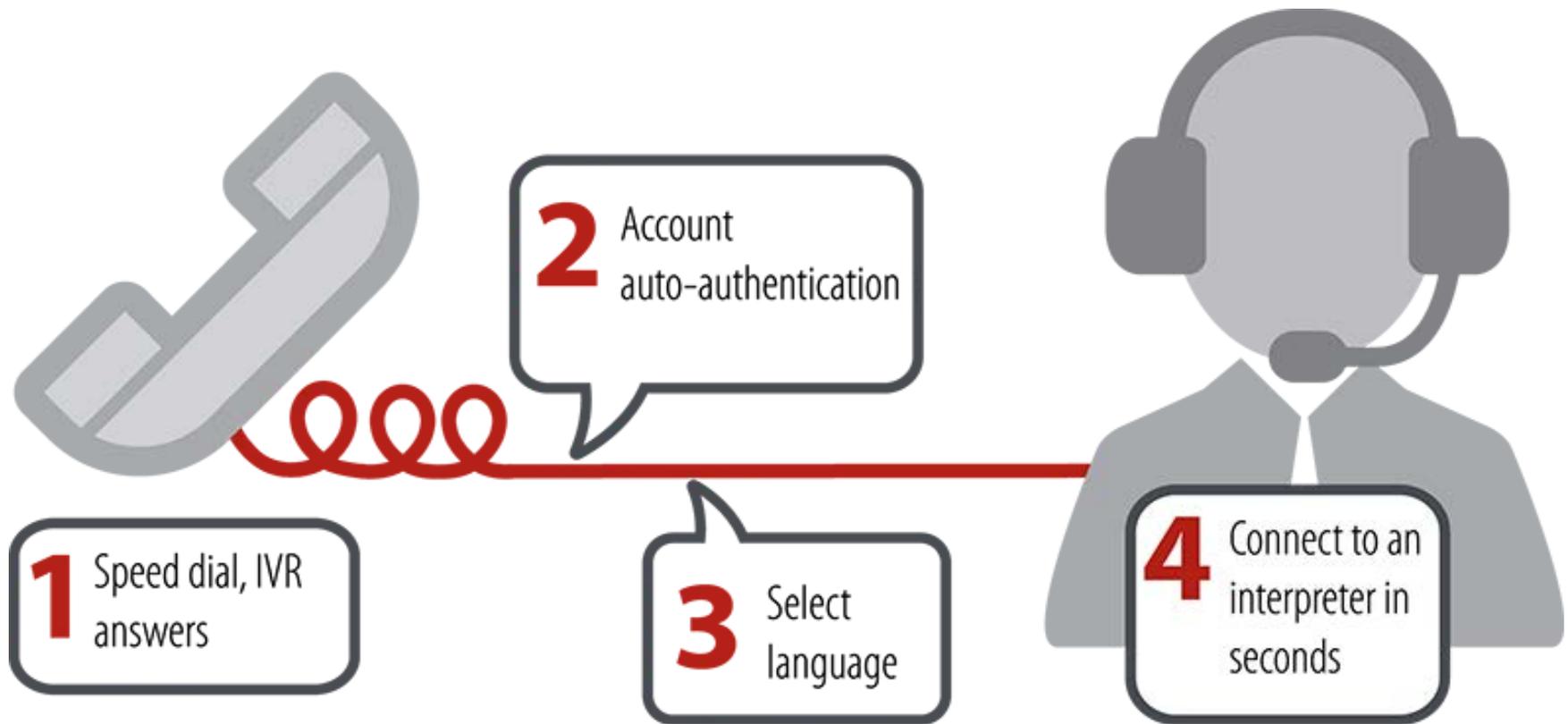
Cultural Competence

“Tourist” language skills aren’t enough

**¿Habla *de salud*
en español?**

Cultural Competence

Translation lines aren't enough, either

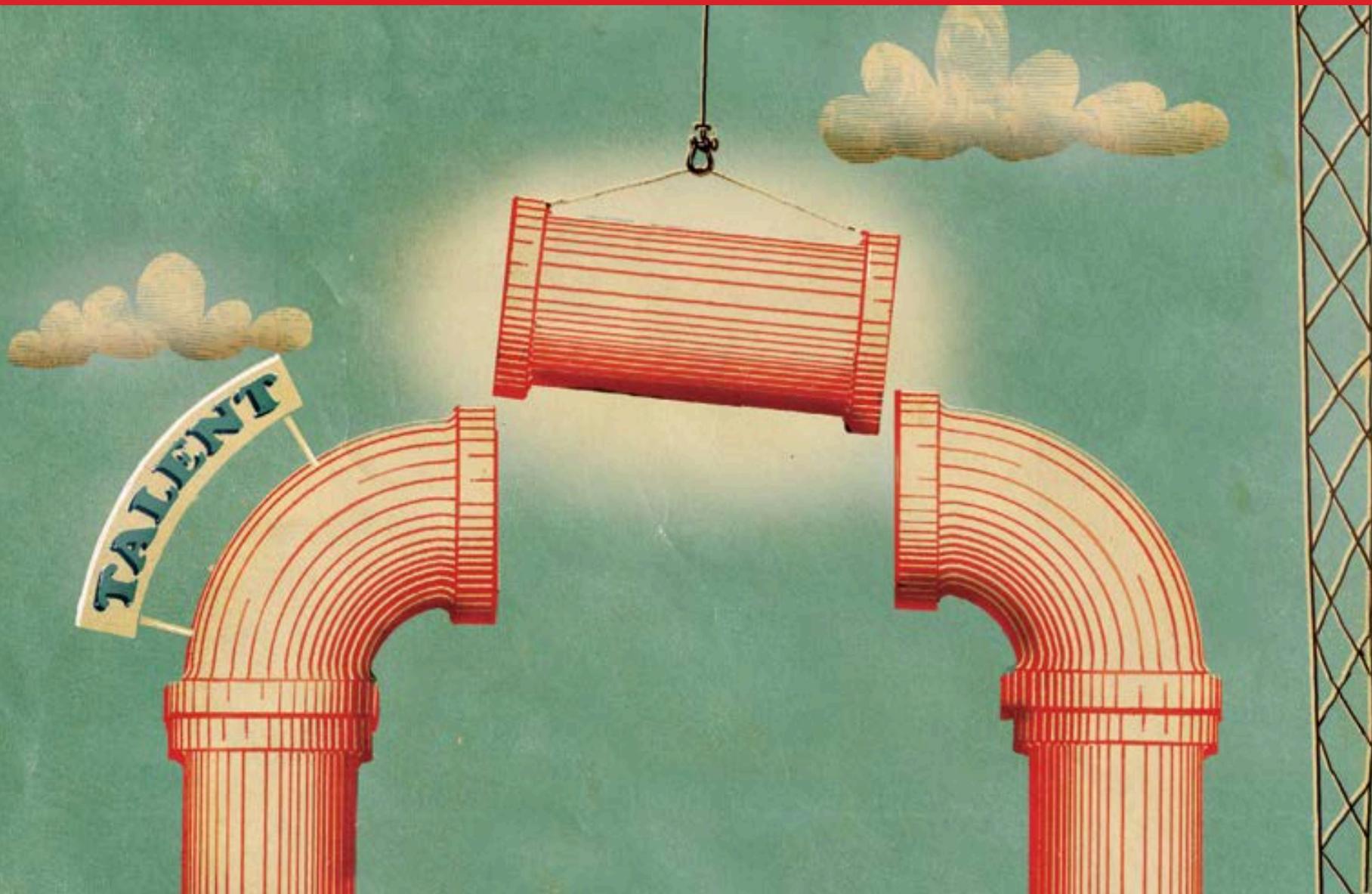


Cultural Competence
Think “conciierge”



Cultural Competence

Recruit from communities you serve



Community benefits can be more than just “check the box”



Health Affairs

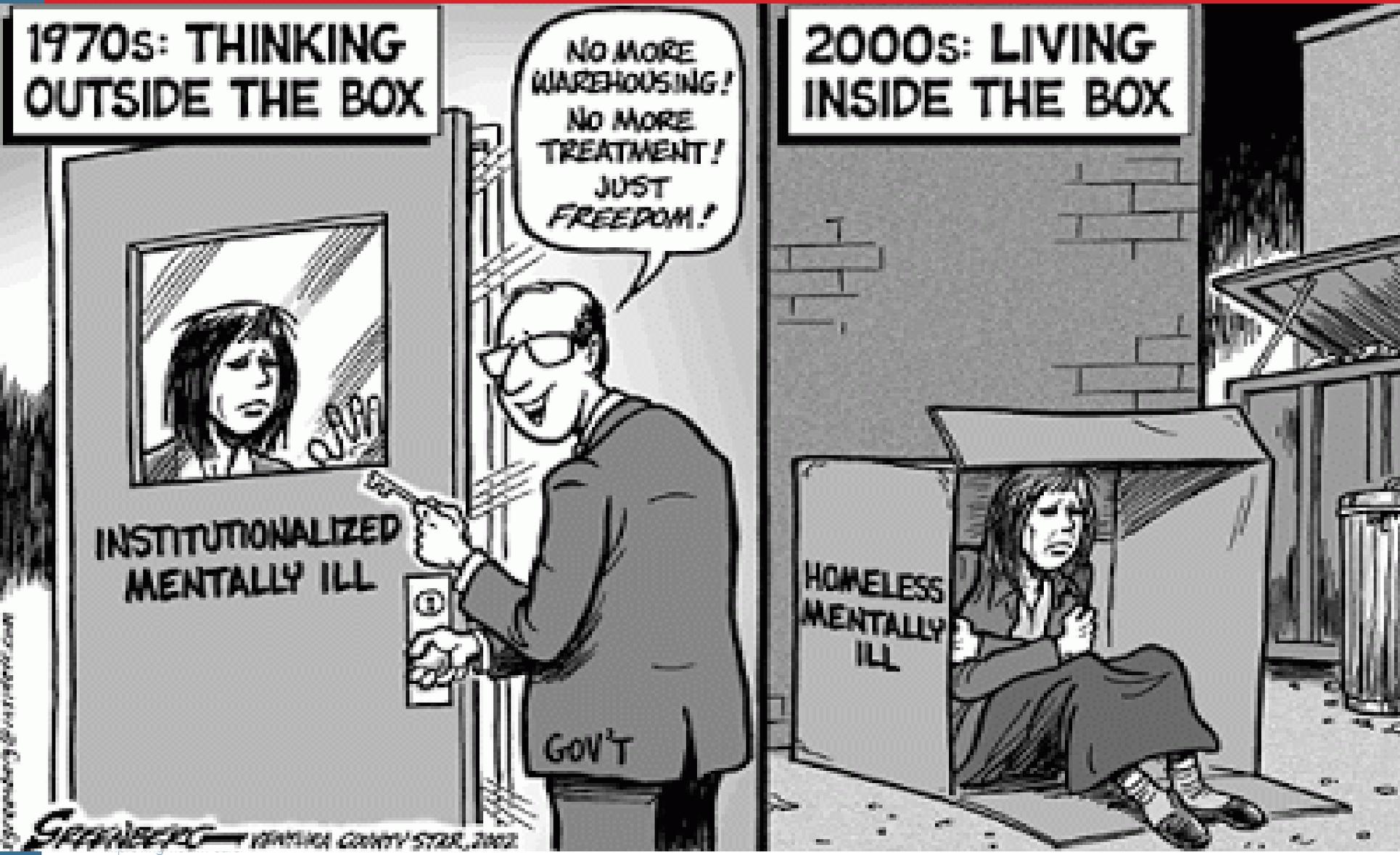
Factors Associated With High Levels of Spending For Younger Dually Eligible Beneficiaries With Mental Disorder

Richard G. Frank and Arnold M. Epstein

June 2014 vol 33 no. 6 1006-103

Nearly half of such dual eligibles have severe and persistent mental disorders... These beneficiaries were nearly twice (1.86 times) as expensive as young dual eligibles who did not have a mental disorder.

Deinstitutionalization skipped a key step



SES Risk-Adjustment

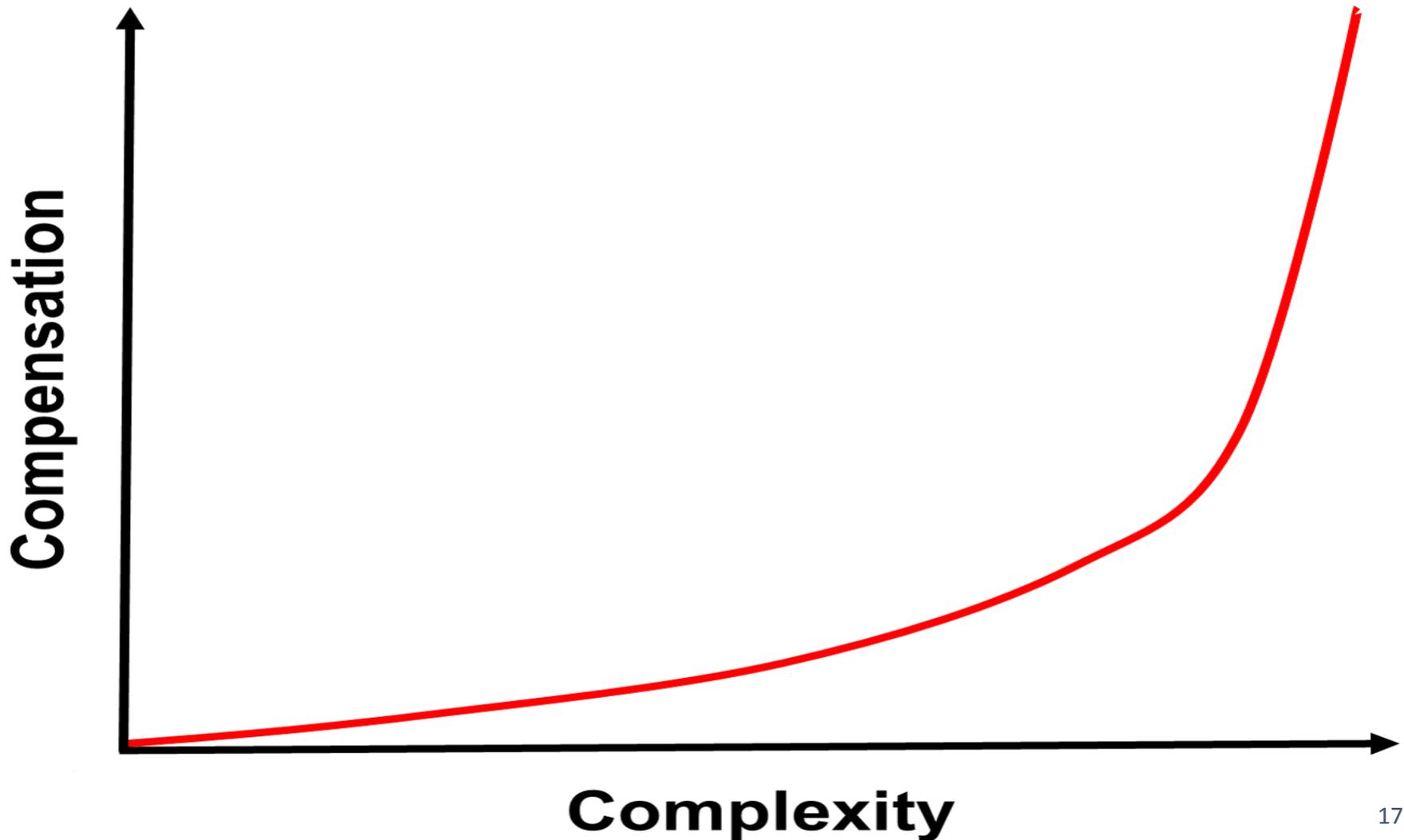
Don't do it for measures.
That sets the bar too low.



SES Risk-Adjustment

Do it to reimbursement.

Harder cases should mean higher pay.



Kate Lorig's Creation Chronic Disease Self-Management Program

**"Just in time"
help from peers**

**Using and sharing
internal resources of
patients themselves**



UW's Winning Idea

Behavioral Health Integration Program



Jürgen Unützer accepting American Psychiatric Association Certificate of Significant Achievement for BHIP.

Collaborative care model at 1,000+ clinics nationally

Holds people accountable for things they control

When Kaiser checked its data & processes

**Conventional Wisdom on
Cancer Detection**

2003-2011



For Older Adults
Use goals to improve care



A rising tide
lifts all
boats.

-Proverb

Patient-centered
care helps all
patients.

-Experience



Thank you



Gary S. Kaplan, MD

Chairman and CEO
Virginia Mason Health System
Seattle, WA

Gary S. Kaplan, MD, FACP, FACMPE, FACPE, has served as chairman and CEO of Virginia Mason Health System in Seattle since 2000. He is also a practicing, board-certified internal medicine physician at Virginia Mason.

He is chair of the Institute for Healthcare Improvement Board of Directors and the chairman of the Lucian Leape Institute. He is also the immediate past chair of the Seattle Metropolitan Chamber of Commerce Board of Directors. He was elected to membership in the Institute of Medicine in 2013.

Dr. Kaplan is also:

- A founding member of Health CEOs for Health Reform.
- A member of the National Patient Safety Foundation Board of Directors.
- A member of the American Medical Association; American Medical Group Association; American Society of Professionals in Patient Safety; and the Medical Group Management Association.
- A member of the Washington Healthcare Forum Board of Directors

Dr. Kaplan received a degree in medicine from the University Michigan Medical School. He is a Fellow of the American College of Physicians (FACP), the American College of Medical Practice Executives (FACMPE) and the American College of Physician Executives (FACPE).

With Dr. Kaplan's leadership, in 2002 Virginia Mason became the first health system in the United States to adapt the principles of the Toyota Production System as its management methodology for identifying and eliminating waste, improving quality and safety, and controlling cost. Using tools and resources of the Virginia Mason Production System, Virginia Mason has earned international recognition for innovation, quality, safety and efficiency. In 2010, Virginia Mason was named a Top Hospital of the Decade by The Leapfrog Group, a national non-profit organization representing employers and other large purchasers of health care that are driving improvements in quality, safety and transparency.

Dr. Kaplan has been on Modern Healthcare magazine's annual list of the "50 Most Influential Physician Executives and Leaders in Healthcare" for ten consecutive years. He is ranked No. 10 on the 2015 list. Additionally, Dr. Kaplan is ranked No. 15 on Modern Healthcare magazine's 2015 list of the "100 Most Influential People in Healthcare."

Updated: *October 2015*



Virginia Mason™

**Transforming Healthcare Through
Transparency, Communication and Leadership**
Gary S. Kaplan, MD

Washington State Medical Quality Assurance Commission
October 6, 2016

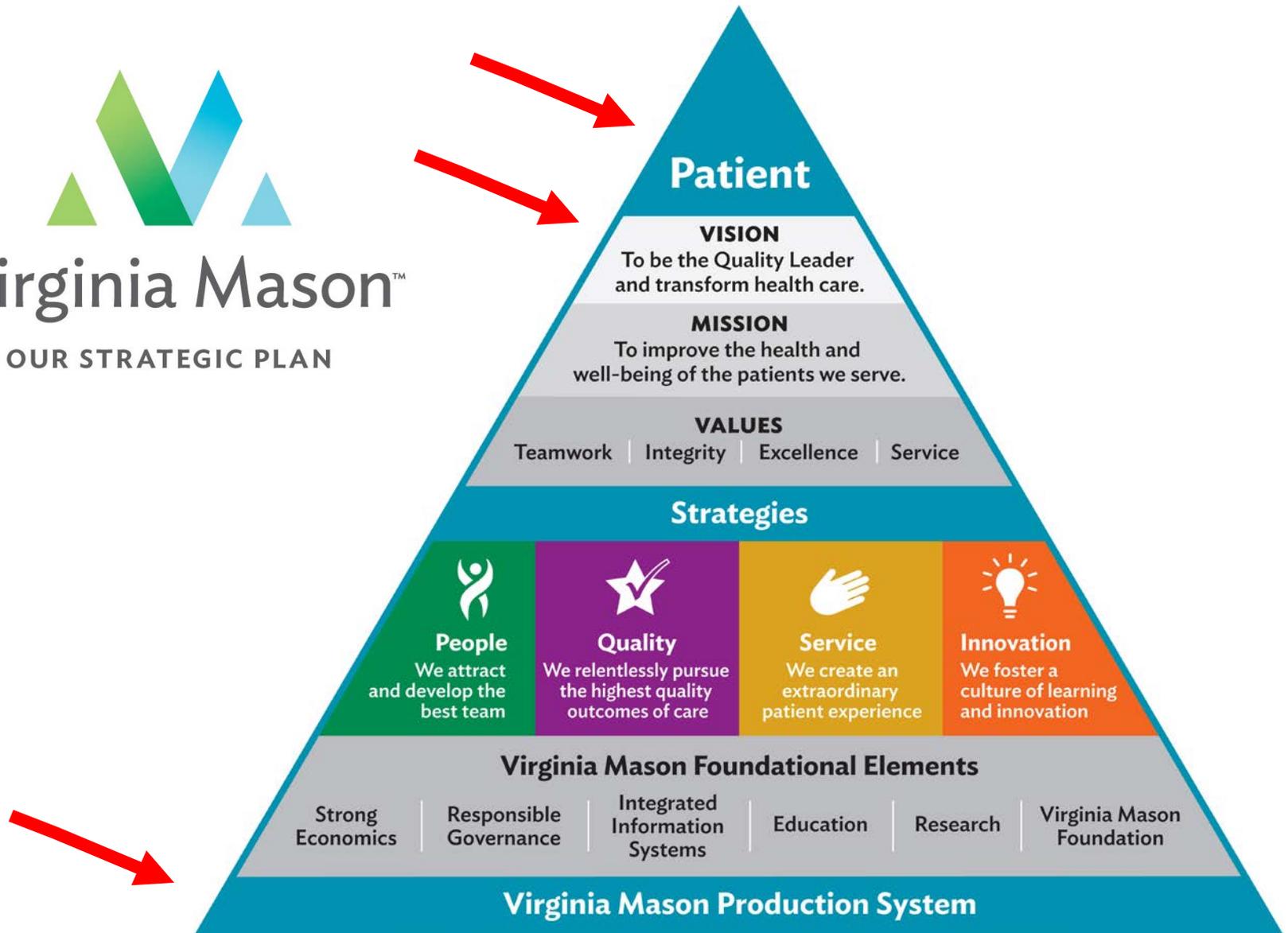
“If you are dreaming about it...
you can do it.”

Sensei Chihiro Nakao



Virginia Mason™

OUR STRATEGIC PLAN

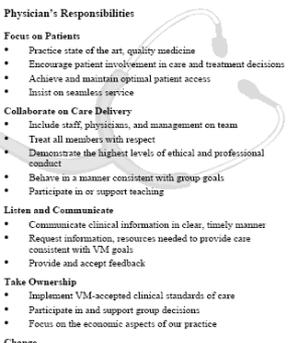


Aligned Expectations

Physician Compact

VIRGINIA MASON MEDICAL CENTER PHYSICIAN COMPACT

<p>Organization's Responsibilities</p> <p>Foster Excellence</p> <ul style="list-style-type: none"> Recruit and retain superior physicians and staff Support career development and professional satisfaction Acknowledge contributions to patient care and the organization Create opportunities to participate in or support research <p>Listen and Communicate</p> <ul style="list-style-type: none"> Share information regarding strategic intent, organizational priorities and business decisions Offer opportunities for constructive dialogue Provide regular, written evaluation and feedback <p>Educate</p> <ul style="list-style-type: none"> Support and facilitate teaching, GME and CME Provide information and tools necessary to improve practice <p>Reward</p> <ul style="list-style-type: none"> Provide clear compensation with internal and market consistency, aligned with organizational goals Create an environment that supports teams and individuals <p>Lead</p> <ul style="list-style-type: none"> Manage and lead organization with integrity and accountability 	<p>Physician's Responsibilities</p> <p>Focus on Patients</p> <ul style="list-style-type: none"> Practice state of the art, quality medicine Encourage patient involvement in care and treatment decisions Achieve and maintain optimal patient access Insist on seamless service <p>Collaborate on Care Delivery</p> <ul style="list-style-type: none"> Include staff, physicians, and management on team Treat all members with respect Demonstrate the highest levels of ethical and professional conduct Behave in a manner consistent with group goals Participate in or support teaching <p>Listen and Communicate</p> <ul style="list-style-type: none"> Communicate clinical information in clear, timely manner Request information, resources needed to provide care consistent with VM goals Provide and accept feedback <p>Take Ownership</p> <ul style="list-style-type: none"> Implement VM accepted clinical standards of care Participate in and support group decisions Focus on the economic aspects of our practice <p>Change</p> <ul style="list-style-type: none"> Embrace innovation and continuous improvement Participate in necessary organizational change
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© Virginia Mason Medical Center, 2011

Board Compact

VIRGINIA MASON MEDICAL CENTER BOARD MEMBER COMPACT

Organization's Responsibilities	Board Member's Responsibilities
<p>Foster Excellence</p> <ul style="list-style-type: none"> Facilitate the recruitment and retention of superior board members Provide a process for regular, written evaluations and feedback through annual board self-evaluation Provide a thorough assessment process for new board members Support governance excellence with adequate board resources <p>Listen and Communicate</p> <ul style="list-style-type: none"> Share information regarding strategic intent, organizational priorities and business decisions Offer opportunities for constructive dialogue Report regularly on implementation of strategic plan and achievement of specific board objectives Disclose to and inform board on risks and opportunities facing the organization Provide materials to members necessary for informed decision making sufficiently in advance of board meetings <p>Educate</p> <ul style="list-style-type: none"> Provide information and tools necessary to keep members informed and educated on local and national health care issues Provide educational and training opportunities to maintain a high level of board member effectiveness and knowledge Educate board members about organization, its structure and its guiding documents <p>Lead</p> <ul style="list-style-type: none"> Manage and lead organization with integrity and accountability Create clear goals and strategies Continuously monitor and improve patient care, service and efficiency Resolve conflict with openness and expertise Ensure safe and healthy environment and systems for patients and staff 	<p>Know the Organization</p> <ul style="list-style-type: none"> Know the organization's mission, purpose, goals, policies, programs, services, strengths and needs Keep informed on developments in the health system's areas of expertise, and on health care policy and future trends and best governance practices <p>Focus on the Future</p> <ul style="list-style-type: none"> Spent three-fourths of every meeting focused on the future Continuously maintain a current and vital strategic plan <p>Listen and Communicate</p> <ul style="list-style-type: none"> Actively participate in board discussions Participate in educational opportunities and request information and resources needed to provide responsible oversight Provide and accept feedback Represent the board to the organization and be an advocate for the organization in the community <p>Take Ownership</p> <ul style="list-style-type: none"> Attend meetings Ask timely and substantive questions at board and committee meetings consistent with your conscience and convictions Prepare for, participate in, and support group decisions Understand and participate in approving annual and longer range financial plans and Quality & Safety oversight Make no manual, personal financial contributions to the organization, according to personal assets Serve on board committees or task forces <p>Promote Effective Change</p> <ul style="list-style-type: none"> Foster innovation and continuous improvement Pursue necessary organizational change

©2004 Virginia Mason Medical Center

Leader Compact

VIRGINIA MASON MEDICAL CENTER LEADERSHIP COMPACT

Organization Responsibilities	Leader Responsibilities
<p>Foster Excellence</p> <ul style="list-style-type: none"> Recruit and retain the best people Acknowledge and reward contributions to patient care and the organization Provide opportunities for growth of leaders Continuously strive to be the quality leader in health care Create an environment of innovation and learning <p>Lead and Align</p> <ul style="list-style-type: none"> Create alignment with clear and focused goals and strategies Continuously measure and improve our patient care, service and efficiency Manage and lead organization with integrity and accountability Resolve conflict with openness and expertise Ensure safe and healthy environment and systems for patients and staff <p>Listen and Communicate</p> <ul style="list-style-type: none"> Share information regarding strategic intent, organizational priorities, business decisions and business outcomes Clarify expectations to each individual Offer opportunities for constructive open dialogue Ensure regular feedback and written evaluations are provided Encourage balance between work life and life outside of work <p>Educate</p> <ul style="list-style-type: none"> Support and facilitate leadership training Provide information and tools necessary to improve individual and staff performance <p>Recognize and Reward</p> <ul style="list-style-type: none"> Provide clear and equitable compensation aligned with organizational goals and performance Create an environment that recognizes teams and individuals 	<p>Focus on Patients</p> <ul style="list-style-type: none"> Promote a culture where the patient comes first in everything we do Continuously improve quality, safety and compliance <p>Promote Team Medicine</p> <ul style="list-style-type: none"> Devise exceptional working-together relationships that achieve results Demonstrate the highest levels of ethical and professional conduct Promote trust and accountability within the team <p>Listen and Communicate</p> <ul style="list-style-type: none"> Communicate VM values Courageously give and receive feedback Actively request information and resources to support strategic intent, organizational priorities, business decisions and business outcomes <p>Take ownership</p> <ul style="list-style-type: none"> Implement and monitor VM approved standard work Foster understanding of individual/team impact on VM outcomes Continuously develop one's ability to lead and implement the VM Production System Participate in and actively support organization/group decisions Maintain an organizational perspective when making decisions Continually develop oneself as a VM leader <p>Foster Change and Develop Others</p> <ul style="list-style-type: none"> Promote innovation and continuous improvement Coach individuals and teams to effectively manage transitions Demonstrate flexibility in accepting assignments and opportunities Evaluate, develop and expect performance daily Accept mistakes as part of learning Be enthusiastic and energize others

©Virginia Mason2011 leadership_compact_final.doc approved 10.21.13

The VMMC Quality Equation

$$Q = A \times \frac{(O + S)}{W}$$

Q: Quality

A: Appropriateness

O: Outcomes

S: Service

W: Waste

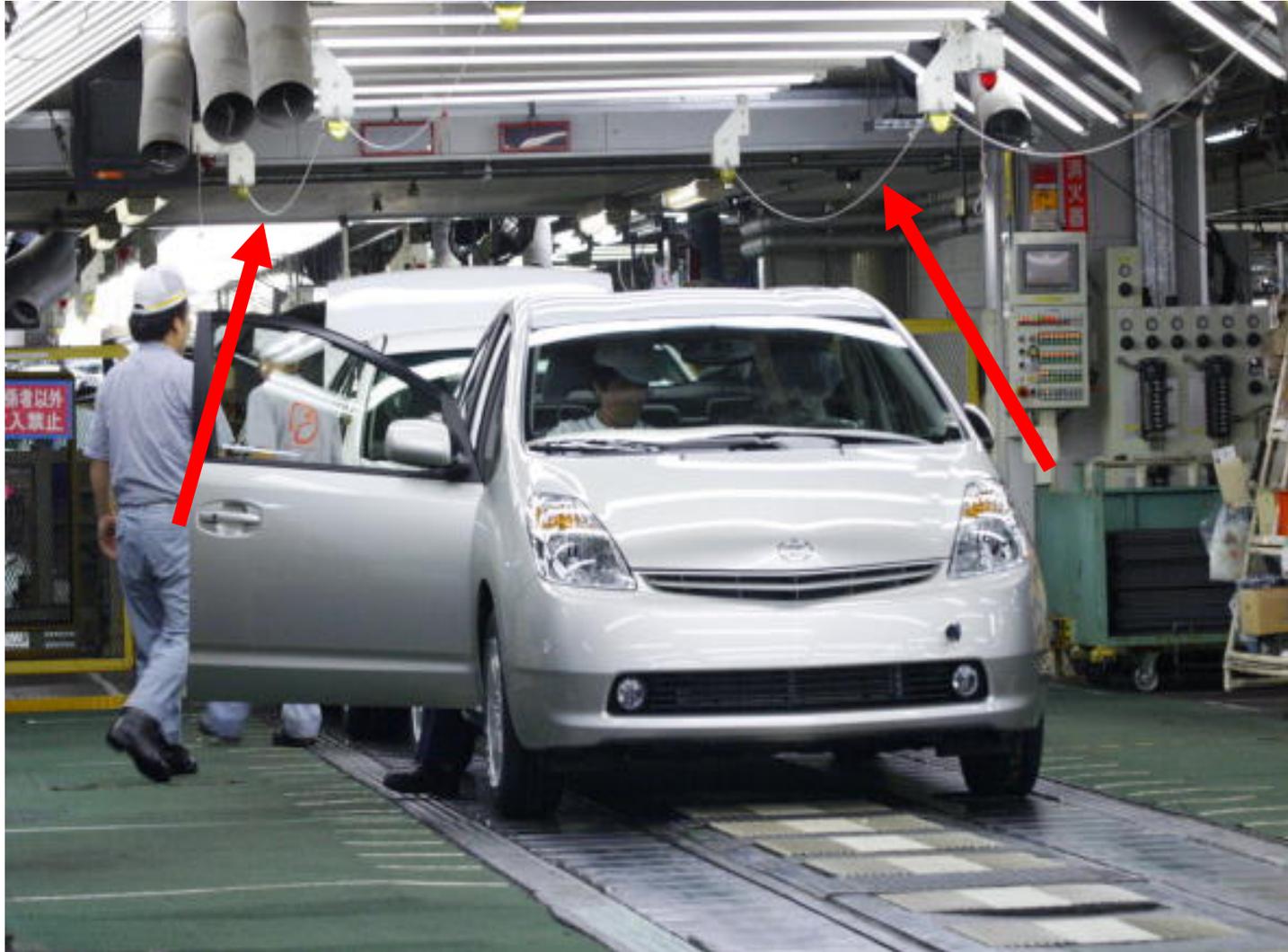
The Virginia Mason Production System

We adopted the Toyota Production System key philosophies and applied them to healthcare



1. The patient is *always* first
2. Focus on the highest quality and safety
3. Engage all employees
4. Strive for the highest satisfaction
5. Maintain a successful economic enterprise

Stopping the line



Patient Safety Alert Process TM

Created August 2002

- Leadership from the top
- “Drop and run” commitment
- 24/7 policy, procedure, staffing
- Legal and reporting safeguards



November 23, 2004 – Virginia Mason Medical Center

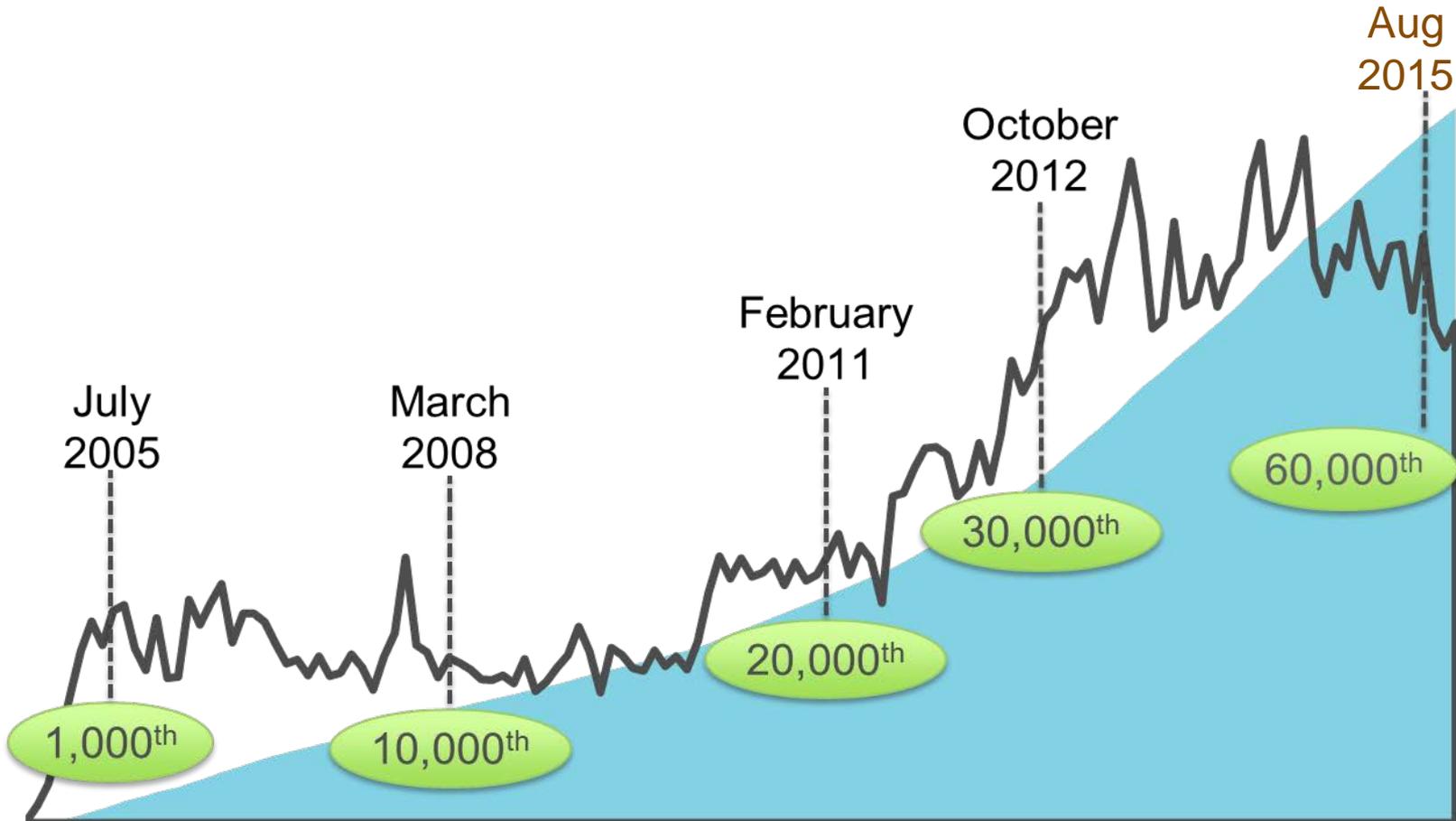
Investigators: Medical mistake kills
Everett woman



Hospital error caused death

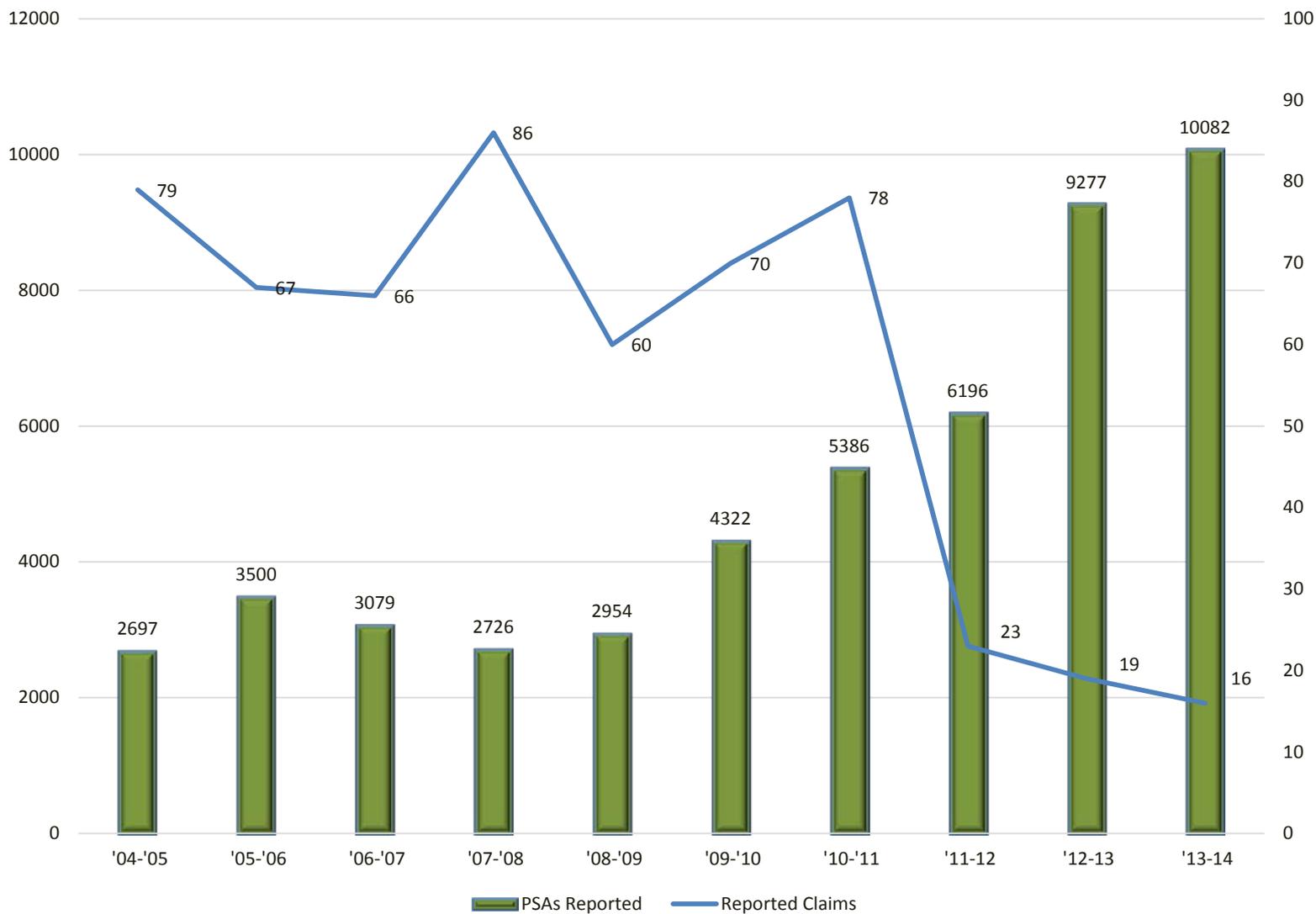


Over 60,000 PSAs

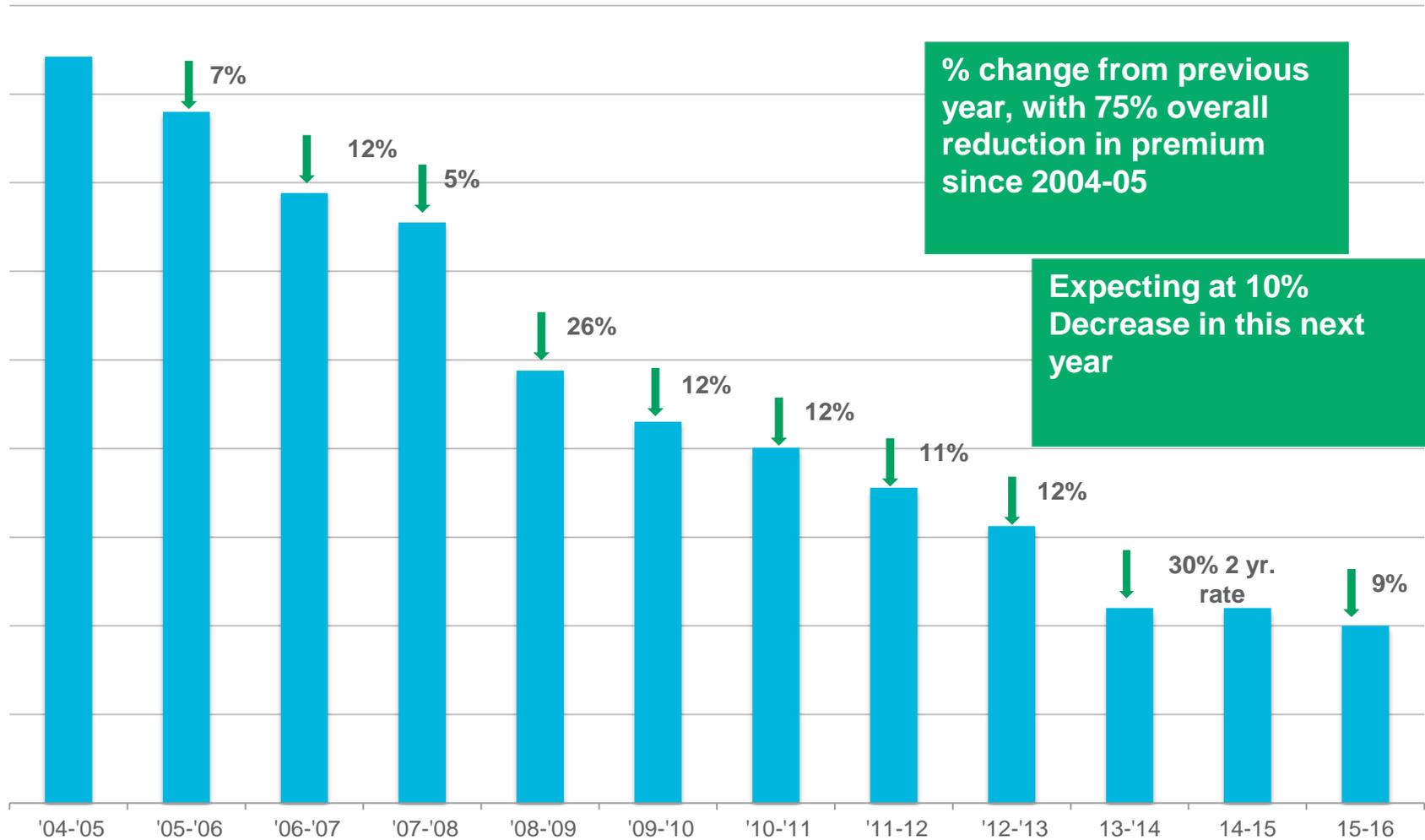


As of February 14, 2016: 64,241

Effectiveness of Safety Program



Reduction of Hospital Professional/General Liability Premiums



The NPSF Lucian Leape Institute

Mission

Mission Statement:

Creating a world where patients and those who care for them are free from harm.

The NPSF Lucian Leape Strategic Vision

Strategic Vision for Improving Patient Safety:

The NPSF Lucian Leape Institute was formed in 2007 to provide a strategic vision for improving patient safety. Composed of national thought leaders with a common interest in patient safety, the Institute functions as a think tank to identify new approaches to improving patient safety, call for the innovation necessary to expedite the work, create significant, sustainable improvements in culture, process, and outcomes, and encourage key stakeholders to assume significant roles in advancing patient safety.

Current Members of NPSF's Lucian Leape Institute



THE NATIONAL
PATIENT SAFETY
FOUNDATION'S
**LUCIAN
LEAPE**
INSTITUTE

Gary S. Kaplan, MD, FACMPE, Chair
*Chairman and CEO
Virginia Mason Health System*

Tejal K. Gandhi, MD, MPH, CPPS
*President and CEO, Lucian Leape Institute
President and CEO, NPSF*

~

Susan Edgman-Levitan, PA
*Executive Director
John D. Stoeckle Center for Primary Care
Innovation
Massachusetts General Hospital*

Amy C. Edmondson, PhD, AM
*Novartis Professor of Leadership and
Management
Harvard Business School*

Lucian L. Leape, MD, Chair
*Adjunct Professor of Health Policy
Harvard School of Public Health*

Gregg S. Meyer, MD, MSc, CPPS
*Ex-Officio Member
Chief Clinical Officer
Partners HealthCare*

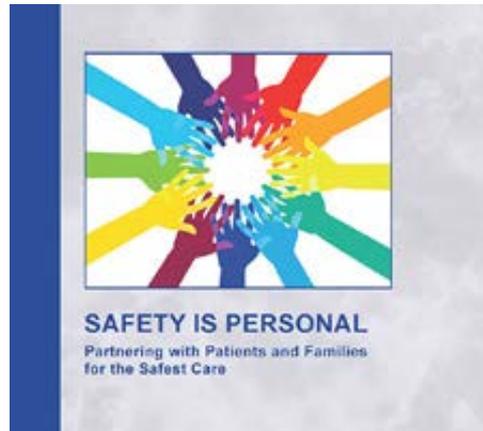
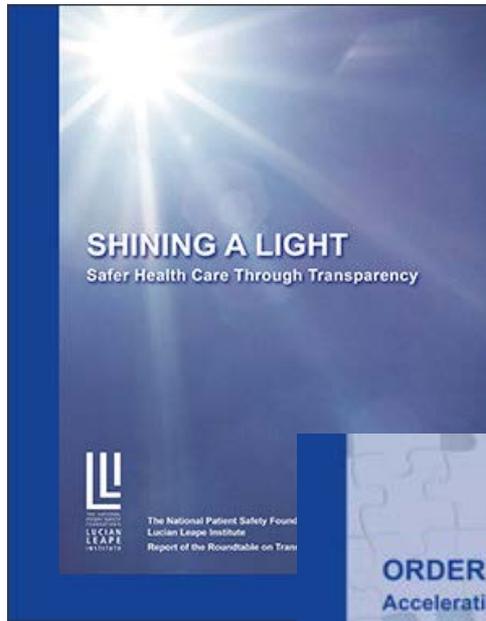
Julianne M. Morath, RN, MS
*President and CEO
Hospital Quality Institute of California*

Susan Sheridan, MBA, MIM, DHL
*Director, Patient Engagement
Patient-Centered Outcomes Research Institute*

Charles Vincent, PhD, Mphil
*Professor of Psychology
University of Oxford
Emeritus Professor of Clinical Safety Research
Imperial College, London*

Robert M. Wachter, MD
*Professor and Interim Chair, Department of Medicine
Director, Division of Hospital Medicine
University of California San Francisco*

LLI Transforming Concepts



Shining a Light: Safer Health Care Through Transparency



From the NPSF Lucian Leape Institute Roundtable on Transparency

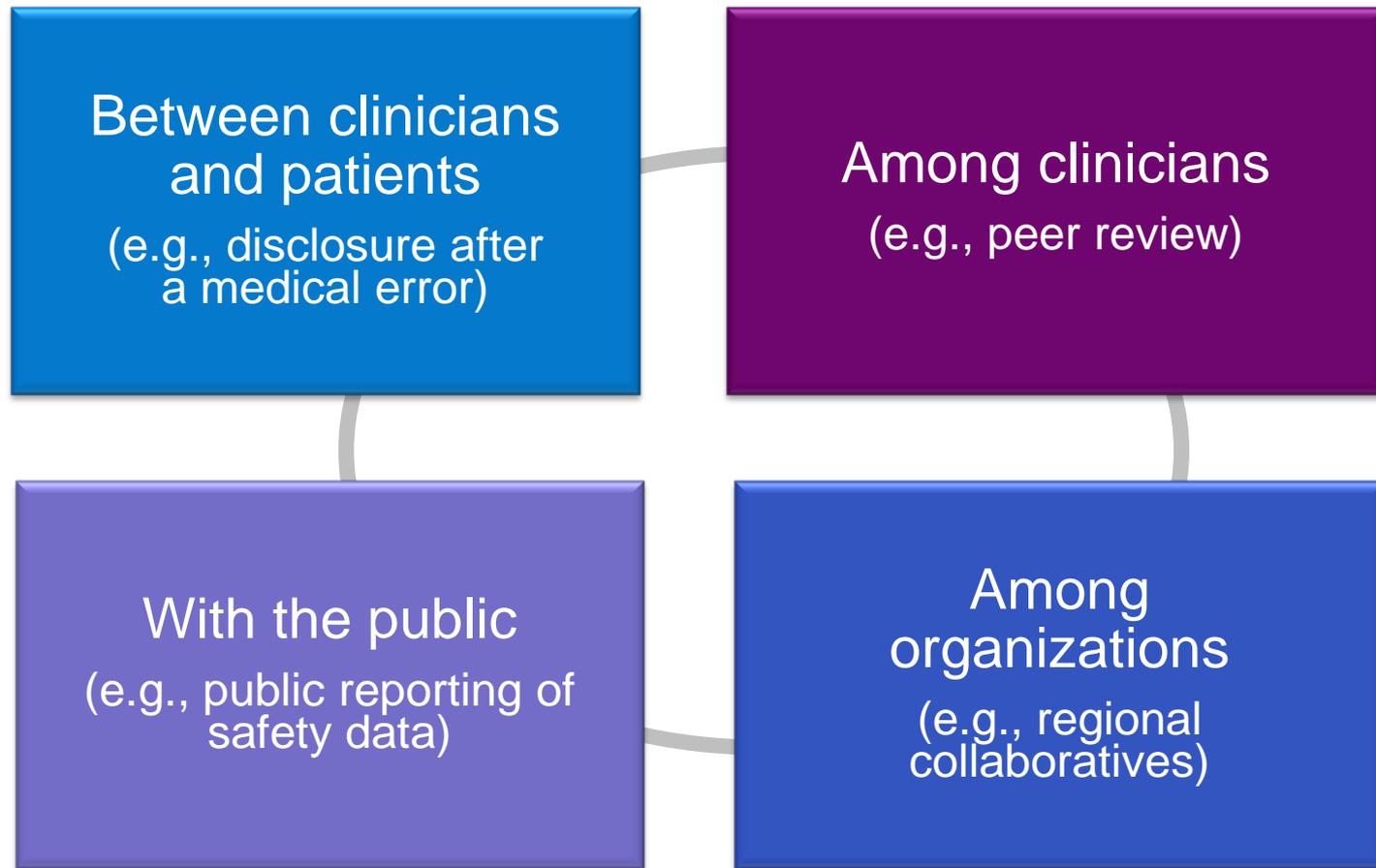
Published January 20, 2015

Available for download at <http://www.npsf.org/transparency>

What Is Transparency?

- “The free, uninhibited flow of information that is open to the scrutiny of others”
- Essential for establishing trust, accountability, ethical behavior
- Necessary first step or precondition
- Relatively inexpensive and effective tool

The Four Interrelated Domains of Transparency



Transparency Between Clinicians and Patients

Extreme honesty with patients and families, including:

- Shared decision making
- Fully informed consent before treatment
- Free and open communication during care and when things go wrong

Barriers to Transparency



Fears about conflict, disclosure, and potential negative effects on reputation and finances



Lack of a pervasive safety culture and the leadership commitment needed to create it



Stakeholders with a strong interest in maintaining the status quo



Lack of reliable data and standards for reporting and assessing clinician behavior regarding transparency

Leadership Is Essential to Achieve Transparency

Strong leadership that models honesty and prioritizes transparency is a prerequisite for effective change in this arena.



Actions for Organizational Leadership: Leaders and Boards of Health Organizations

- Prioritize transparency, safety, and continuous learning and improvement.
- Frequently and actively review comprehensive safety performance data.
- Be transparent about board membership.
- Link hiring, firing, promotion, and leader compensation to results in cultural transformation and transparency.

Communication and Resolution Programs

A commitment to patient-centered quality and safety is a prerequisite.

Communication Resolution Program Attributes

- Being transparent with patients around risks and adverse events.
- Analyzing adverse events using human factors principles and implementing action plans.
- Supporting the emotional needs of the patient, family, and care team.
- Proactively and promptly offering financial and non-financial resolution caused by unreasonable care.
- Educating patients or their families about their rights.
- Working collaboratively with other healthcare organizations.
- Assessing continuously the effectiveness of the CRP program.

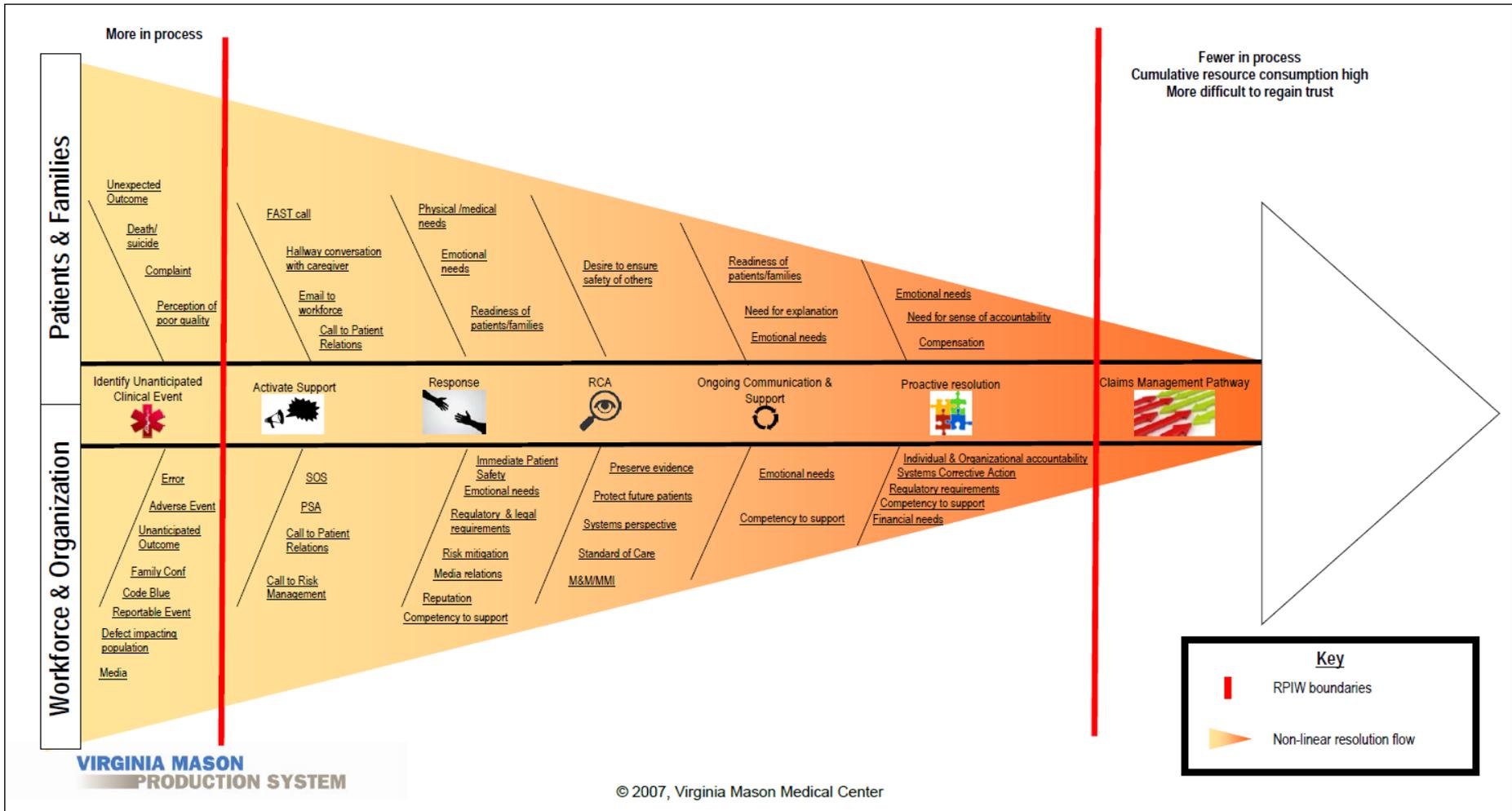
Our RPIW Areas of Focus

1. Clarify and communicate our philosophy around response
2. Develop a 24/7 team of on-site first responders
3. Clarify the role for the Administrator on Call
4. Go deeper in root cause analysis
5. Create clear standards with timelines for the first 24 hours of the response
6. Make time for healing for the care team mandatory and automatic

Experiences



Stakeholder Perspectives & Needs



Key Lessons Learned

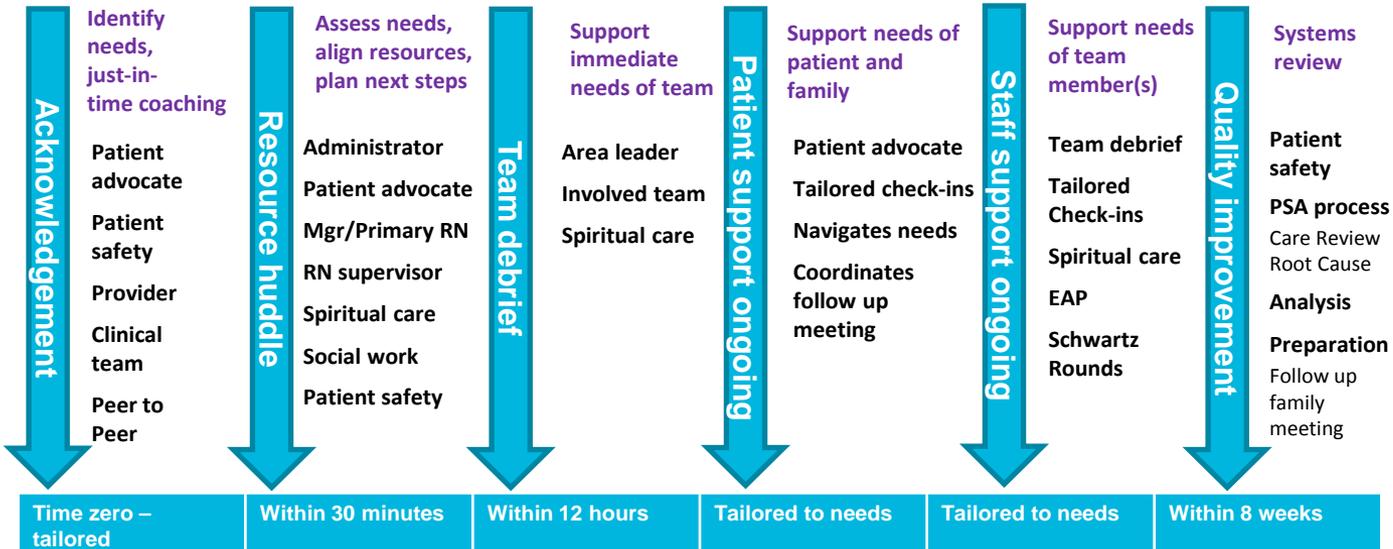
1. Patient involvement in design is required
2. Outside eyes are valuable
3. Normal for one team can be another team's abnormal
4. Reflect: Would you want to be the next patient?
5. Making something NOT OPTIONAL can be clarifying, liberating, and help us do the right thing
6. Simulation is a powerful learning method

Safety Innovation

Synchronized Ongoing Support (SOS): An Integrated Response to Unanticipated Outcomes

1. Major unexpected clinical need; or
2. Major immediate family need; or
3. Urgent non-clinical support need

Dial '0' for
Patient Safety
& Patient
Relations



SOS – A standard response that is transparent, individualized and phased to promote restoration and growth for all touched by the event.

Respect for People
refers to how we treat each
other as we work together to
create the perfect patient
experience.

Respect for People

FOUNDATIONAL BEHAVIORS OF RESPECT



Top 10 Ways to Show Respect to People

1. **Listen to understand.** Good listening means giving the speaker your full attention. Non-verbal cues like eye contact and nodding let others know you are paying attention and are fully present for the conversation. Avoid interrupting or cutting others off when they are speaking.
2. **Keep your promises.** When you keep your word you show you are honest and you let others know you value them. Follow through on commitments and if you run into problems, let others know. Be reliable and expect reliability from others.
3. **Be encouraging.** Giving encouragement shows you care about others and their success. It is essential that everyone at VM understand their contributions have value. Encourage your co-workers to share their ideas, opinions and perspectives.
4. **Connect with others.** Notice those around you and smile. This acknowledgement, combined with a few sincere words of greeting, creates a powerful connection. Practice courtesy and kindness in all interactions.
5. **Express gratitude.** A heartfelt “thank you” can often make a person’s day and show them you notice and appreciate their work. Use the VM Applause system, a handwritten note, verbal praise, or share a story of “going above and beyond” at your next team meeting.
6. **Share information.** When people know what is going on, they feel valued and included. Be sure everyone has the information they need to do their work and know about things that affect their work environment. Sharing information and communicating openly signals you trust and respect others.
7. **Speak up.** It is our responsibility to ensure a safe environment for everyone at VM; not just physical safety but also mental and emotional safety. Create an environment where we all feel comfortable to speak up if we see something unsafe or feel unsafe.
8. **Walk in their shoes.** Empathize with others; understand their point of view, and their contributions. Be considerate of their time, job responsibilities and workload. Ask before you assume your priorities are their priorities.
9. **Grow and develop.** Value your own potential by committing to continuous learning. Take advantage of opportunities to gain knowledge and learn new skills. Share your knowledge and expertise with others. Ask for and be open to feedback to grow both personally and professionally.
10. **Be a team player.** Great teams are great because team members support each other. Create a work environment where help is happily offered, asked for and received. Trust that teammates have good intentions. Anticipate other team members’ needs and clearly communicate priorities and expectations to be sure the work load is level loaded.

Flu Vaccination “Fitness for Duty”

Do we put patient first?

Compelling science

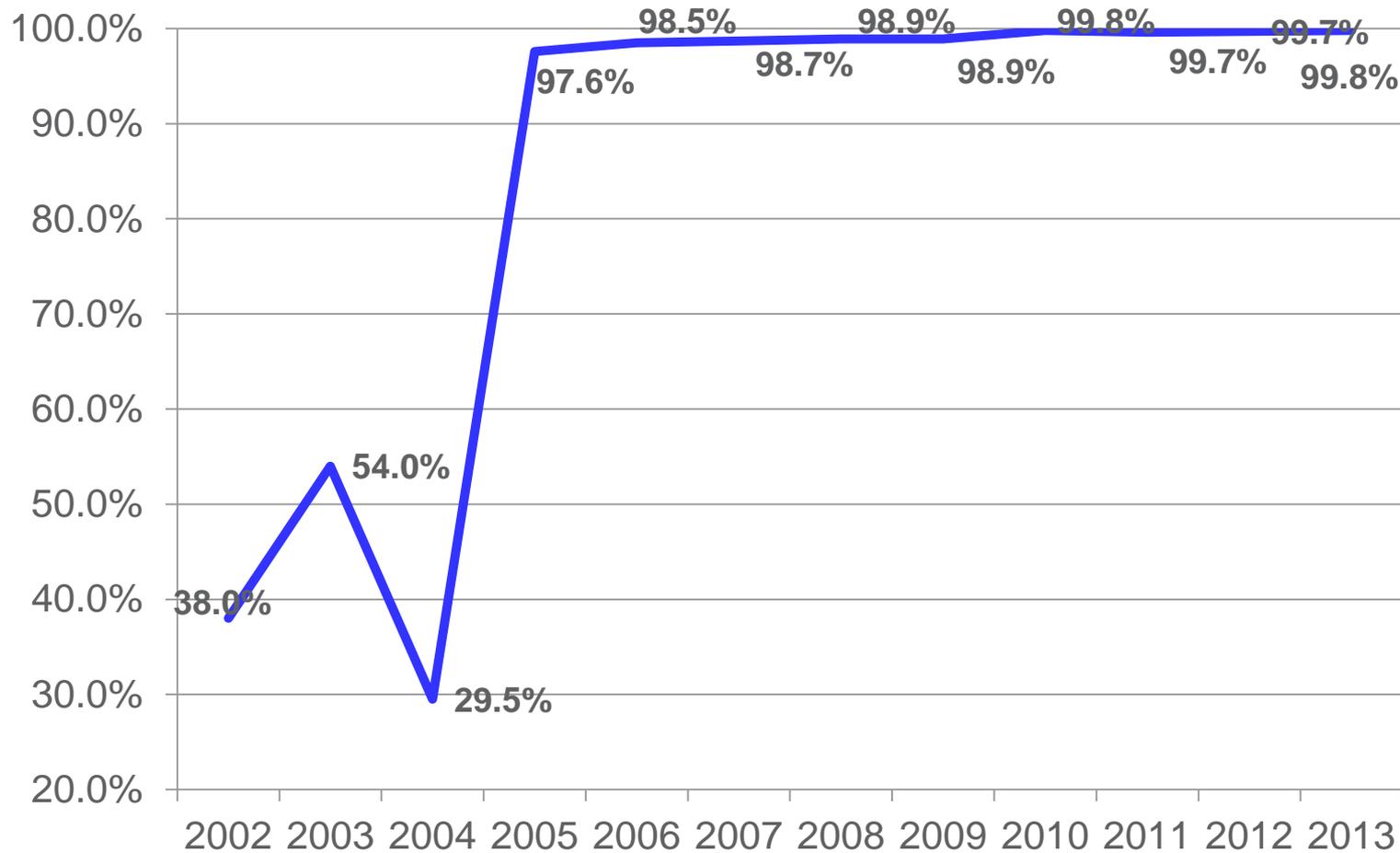
Staff resistance

Staying the course

Organizational Pride



VMMC Influenza Vaccination Rates



Mary L. McClinton Patient Safety Award

The Mary L. McClinton Patient Safety Award
For Outstanding Teamwork in Making Patient Care Safer

Hands That Make Dreams Come True

Virginia Mason Medical Center, Seattle, Washington

2006 Honorees: CCU Breakthrough Coordinating Group

A tireless volunteer and civic activist, Mary Louise McClinton devoted her life to helping others. She was a steadfast advocate for the disabled, poor and disadvantaged.

She earned adoption by the Tlingit tribe of Juneau, Alaska, and the name "Jin-Koo-See'e" or in English, "Hands That Make Dreams Come True."

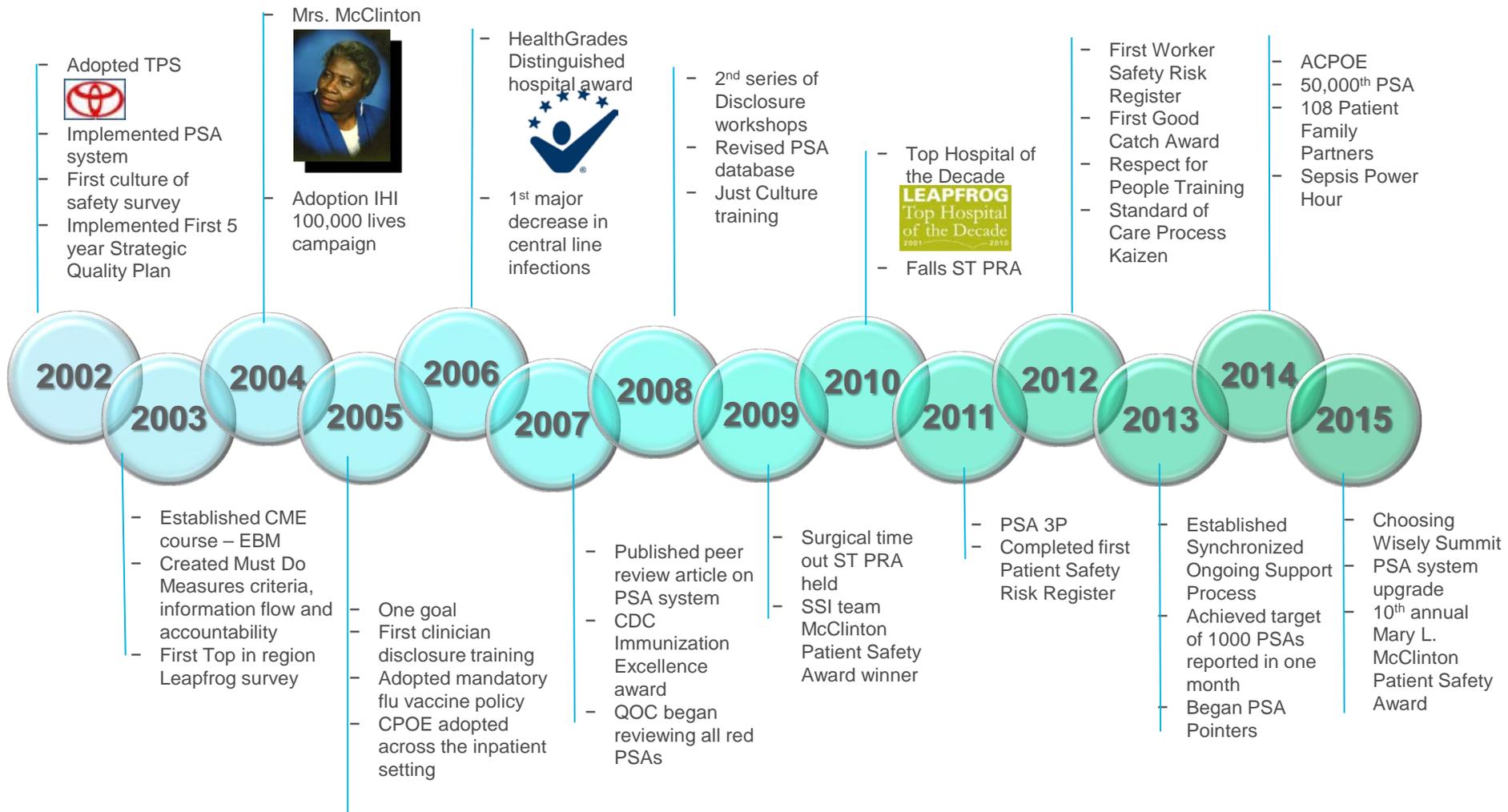
Mrs. McClinton died on November 23, 2004 while she was a patient at Virginia Mason, due to an avoidable medical error.

To honor her life, Virginia Mason has committed itself to eliminating avoidable death and injury.

This award is given annually to a team that has shown extraordinary effort and devotion to that goal.

TEAM VIRGINIA MASON
MEDICINE™

Where We Have Been





“In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

- Eric Hoffer



Nathan Schlicher, MD, JD, FACEP

Associate Director, TeamHealth Patient Safety
Organization

Attending Emergency Room Physician, St. Joseph's
Medical Center
Tacoma, WA

Dr. Nathan Schlicher currently works at St. Joseph's Medical Center, and lives in Gig Harbor with his wife Dr. Jessica Schlicher, and his three children (David, Juliette, and Henry). He serves as the Regional Director of Quality for the emergency departments of the Franciscan Health System and the Associate Director of the TeamHealth Patient Safety Organization. He attended Law School and then

Medical School at the University of Washington before completing an EM residency at Wright State in Dayton Ohio. He is board certified in Emergency Medicine.

As Legislative Affairs Chairman of the Washington State Chapter of Emergency Physicians, Nathan spearheaded the "ER for Emergencies" program to replace the State's plan to deny ER services to Medicaid Patients. Nathan's leadership in this effort will lead the state to save \$31 million per year by making better health care. He has edited three editions of a textbook on the importance of advocacy by physicians, "The Emergency Medicine Advocacy Handbook." He currently serves as a Board Member with the Washington State Medical Association and the Washington Chapter of the American College of Emergency Physicians where he is also the President-Elect. He has previously served as the Legislative Advisor on the Board of Directors of the Emergency Medicine Residents' Association. He also served for a year in the Washington State Senate, representing the 26th District, where he continued his work on health care advocacy.

He has been recognized for his leadership multiple times including the South Sound Business Journal's 40 under 40 Award, Washington State Chapter of the American College of Emergency Physicians Guardian of Emergency Medicine Award, Pacific Lutheran University Outstanding Recent Alumni Award, and the American Medical Associations Leadership in Excellence Award.

Medical, Legal, and Ethical Considerations in Error Disclosure

Hon. Nathaniel Schlicher, MD, JD, FACEP

My Background / Conflicts

- Regional Director of Quality Assurance, TeamHealth NW
- Associate Director, TeamHealth Patient Safety Organization
- President, Northwest Emergency Physicians CQIP
- ER Physician at St. Joseph's Medical Center, Tacoma, WA
- President, Washington Chapter American College of Emergency Physicians
- Asst Secretary Treasurer, Washington State Medical Association
- Health law attorney doing medical malpractice defense

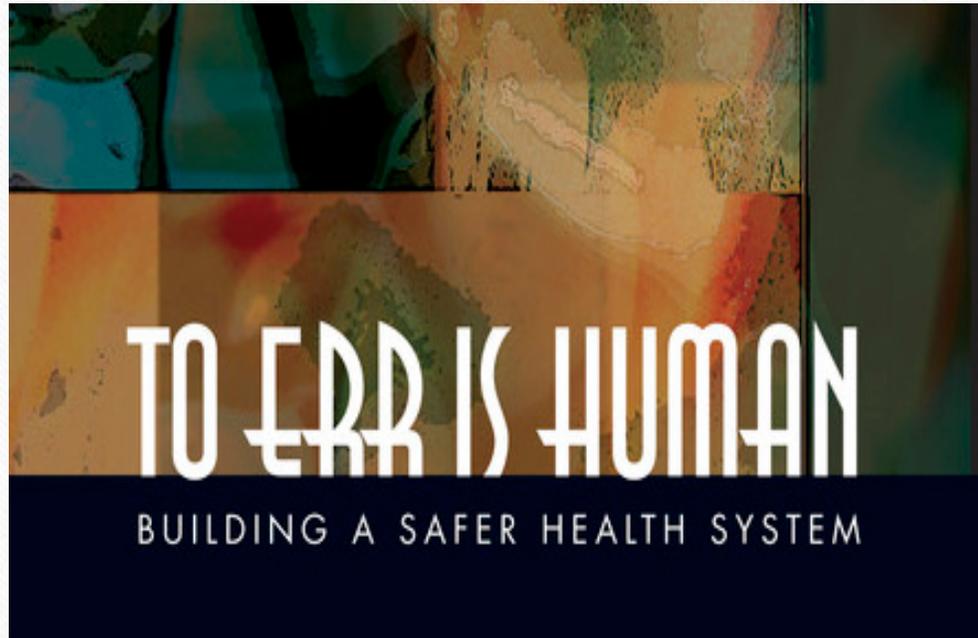
Agenda

- Errors Defined
- Medicine
- Law
- Ethics
- Cases



Defining Errors

Why We Talk About Errors (or Don't)



“Errors” in Medicine

- Extrapolation from two studies
 - 44,000 people die per year if we treat them like CO
 - 98,000 people die per year if we treat them like NY
- 8th leading cause of death
- \$17-29 Billion dollars in expense



Defining Medical Error

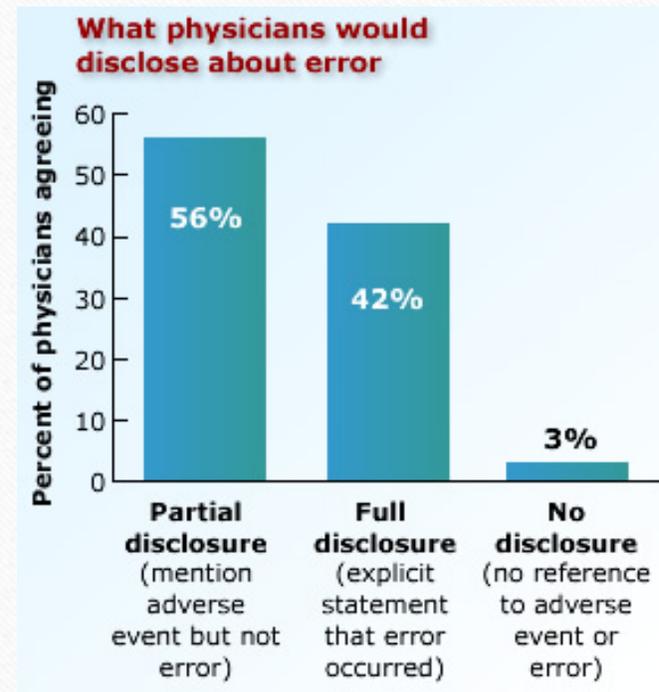
- **Outcome dependent** – patients that experience an adverse outcome or injury as a consequence of medical care
- **Noxious episode** – all untoward events, complications, and mishaps that result from acceptable diagnostic therapeutic measures
- **Adverse Event** – unintended injury to patients caused by medical management (rather than underlying condition of the patient) that results in measurable disability, prolonged hospitalization, or both
- **Preventable adverse event** – when there is a failure to follow accepted practice
- **Negligent preventable adverse events** – failure to meet the standard of care reasonably expected of an average physician qualified to take care of the patient

Error in a Real Case?

- 65yo male with chest pain
 - Sudden onset, L sided, radiating to his shoulder 1 hour prior while watching TV
 - SOB, diaphoresis, lightheaded
 - Anxious and diaphoretic
- EKG – Evolving ST segments
- CXR – NAD, normal mediastinum
- Labs – NI CBC, CMP, Trop, Lactic Acid
- DX – STEMI Field Activation
- **Final Outcome:** Bilateral pneumonia diagnosed 24 hours later on subsequent chest x-ray after patient spiked a fever
- **Cardiologist Note:** The patient presented with atypical chest pain that is not cardiac in origin.

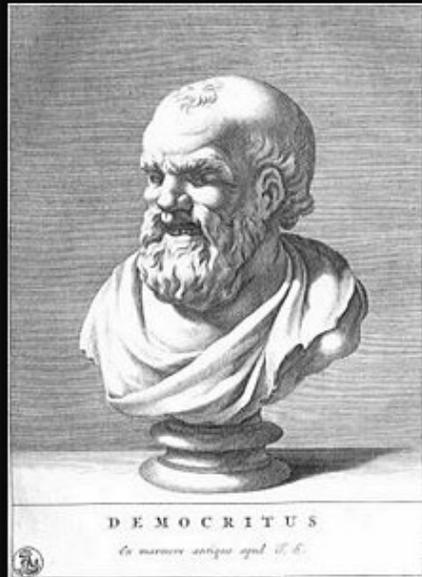
Do You Disclose Errors?

What would you do?
2006 Study



The Medicine

Who's Errors Do You Find?



It is better to destroy one's own errors than those
of others.

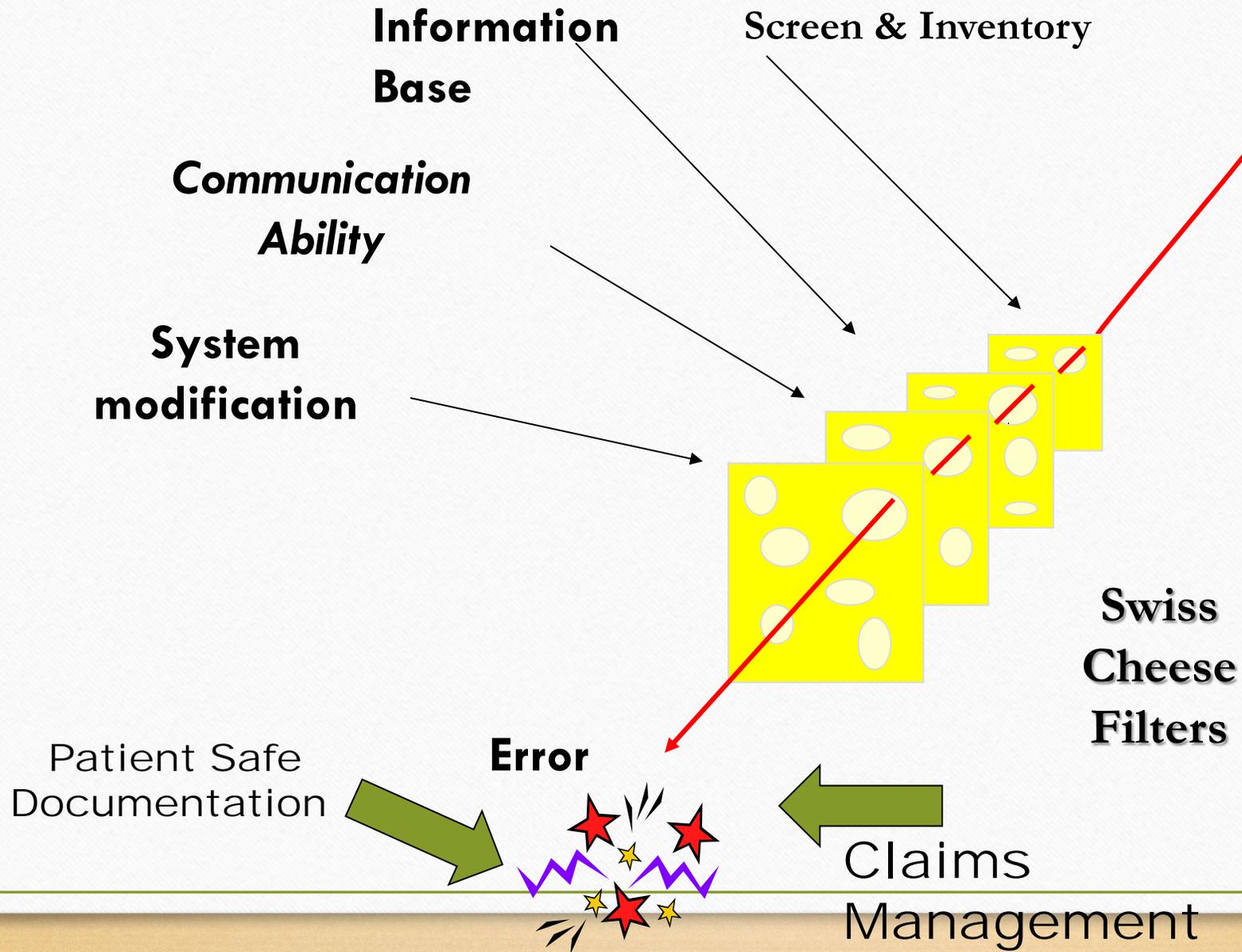
(Democritus)

Errors

- Omission – You forgot to do something
 - Insulin orders in a diabetic admitted patient
 - Postoperative pain medication orders
- Commission – You did something that hurt
 - Gave an antibiotic that the patient was allergic to
 - Left a sponge in the patient



Risk Loaded Activity



Finding Errors

- Formal review process
 - 72 hour returns
 - 24 hour deaths
- Peer review cases
- M&M conferences
- Case follow ups



Changing Practices

- Review the literature
- Attend conferences
- Attend M&M Cases
- Formal quality improvement processes

	Dec	July	Absolute Decrease	% Decrease	Average
TH	17.2	12.4	-4.8	-28.1%	-20.1%
	23.5	19.0	-4.5	-19.0%	
	17.4	14.1	-3.3	-18.8%	
	22.4	19.1	-3.3	-14.6%	
Non-TH	22.8	22.2	-0.6	-2.8%	-3.9%
	22.1	23.1	1.0	+4.5%	
	16.2	14.0	-2.1	-13.2%	

Be Certain on the Medicine

- Assigning errors is easy to do, but hard to take back
- Be short to judge others without all of the facts
- Empathize with both patient and provider when assigning error



The Law

Say Your Sorry at Least! (RCW 5.64.010)

- Statement, affirmation, gesture or conduct that:
 - Within 30 days of occurrence or discovery of the issue
 - Relates to discomfort, pain, suffering, injury or death
 - Expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence OR
 - If it pertains to remedial actions



Say Your Sorry at Least! (RCW 5.64.010)

- Offer to pay medical, hospital, or similar expenses occasioned by an injury is not admissible



Testify As An Expert

- You can be called to testify against your colleagues
 - Think about what you say to them, it can be used against both us in a court of law
- Legal Rule: Doctors pointing fingers equals verdict for the plaintiff



Lawyer's Rule: You can be an idiot
or an ass, you just can be both.

Nathan's Corollary: I choose to hedge my bets by being nice.

What to Say?

- What happened
- Sympathy / condolence
- Working to address the cost of your care
- Address questions
- Don't get defensive



Anesthesia Case

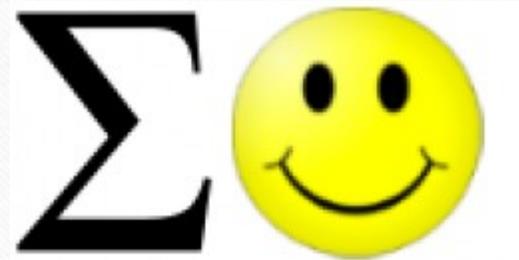
University of Michigan Model

- Disclose with offer program to address errors
- Studied from 1995 to 2007 (implemented program in 2001)
- Caveat – All claims went down in study period across Michigan
- Decreased claims from 7.03 to 4.52 per 100K patients
- Time to claim reduced from 1.36 to 0.95 years
- Costs went down:
 - 0.41RR patient compensation
 - 0.39 RR non-compensation

The Ethics

Consequentialism

- Ethical theory of looking at the outcome to guide the decision
- Utilitarianism – The greatest good for the greatest number



Deontological Thinking: Categorical Imperative

- Categorical Imperative from Kant
- Act as though your actions were to become universal law and evaluate the appropriateness
- Example: If I lie now, is it always okay to lie to a patient?



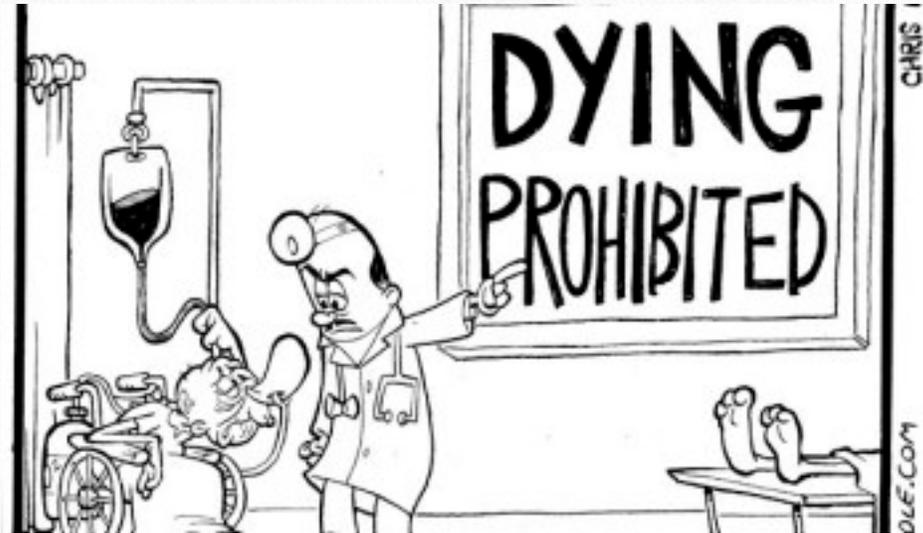
Deontological Thinking: Veil of Ignorance

- From Rawls
- Assume that everyone is ignorant as to their position in the world and their role, decide what is most fair for everyone



Bioethics

- Four Part Test of Tom Beauchamp and James Childress:
 - Autonomy
 - Beneficence
 - Non-maleficence
 - Justice

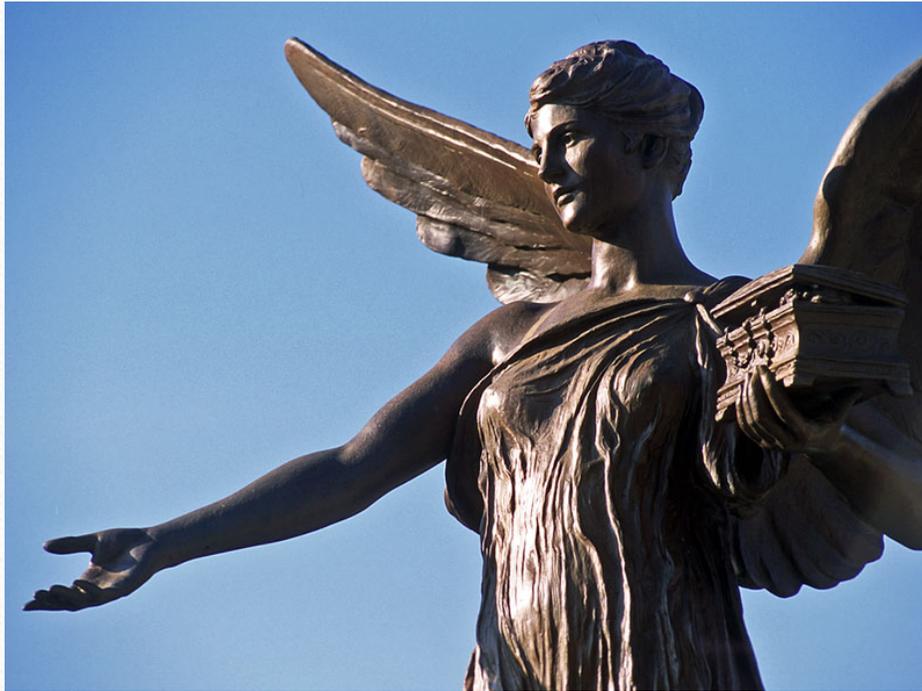


Autonomy

- Defined as the right of individual self-determination
- Social reaction to paternalism of medicine in the past



Beneficence



- Actions to promote the well being of others; taking actions that serve the best interest of the patient
- Some argue that this is the only ethic theory that matters

Non-Maleficence

- *Primum non nocere*
- Doing no harm is more important than doing good to many scholars



Justice

- Distribution of scarce health resources and the decision of who gets what treatment
 - Fairness
 - Equality



Cases

The Lung

- Case: 3rd Year resident causes a pneumothorax during a Subclavian Line Placement in a DKA patient with tachypnea
 - Requires chest tube
 - No lasting complication
- What do you disclose?
- How do you disclose it?

Disclosing Your Own Errors

- Always easier to do yourself than waiting for someone else
- Be open, honest, and discuss the issue
- Address what you are doing to fix the issue
- If there are system problems, identify with the patient and follow up



Arm

- 48yo male presents with pain in his right from his cast
 - Cast placed two weeks ago for forearm fracture by ortho
 - Saw ortho PA 3 days ago for pain and weakness, documents weakness in fingers and grip, one sided valve done
 - Called the day before for worsening pain and flaccid, told to call back
- **Outcome:**
 - Essentially no strength in hand for grip or dexterity
 - Works as a chef, right hand dominant
 - Cast removed and splint applied
 - Remains weak at this time

Disclosing Errors of Others with Relationship

- Gather the facts
- Reach out first and give them a chance to do it themselves
- Encourage disclosure
- Offer support
- Balance the patient harm, certainty, and provider opportunity

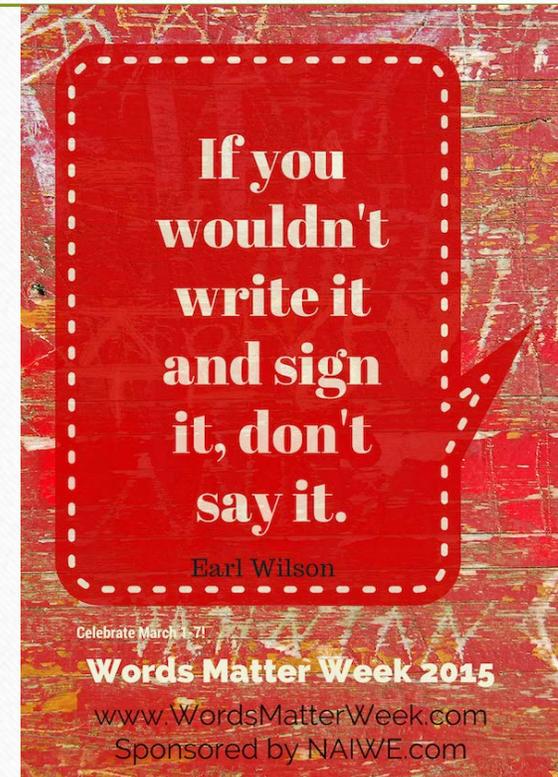


Airway

- 32yo micrognathic Pierre Robin Syndrome, respiratory distress, picked up by medics, sats high 80s
- ‘Elective’ intubation with etomidate and succinylcholine
- **Outcome:**
 - Failed intubation, placed King LT airway in the mouth
 - Cardiac arrest on arrival
 - Neurologically devastated
 - Care withdrawn

Disclosing Others Errors with No Relationship

- Be mindful of what you say
 - Stick to the facts
 - Don't throw the other provider under the bus unnecessarily
- Recognize families (and providers) will live with what you say, so be certain



Make Your Case™



Conclusion

- Follow the golden rule in all things
 - It's easy to point out someone else's flaw
 - Imagine what you would want done for your family
- Consider the medical, legal, and ethical aspects of disclosure
 - Not simple, but the important things never are

Learning From Experience of the Patient and their Family

Micah Matthews, MPA
Moderator

Mr. Bruce McClelland
Filed a report with the Medical Commission on behalf of his
daughter

Dr. Peter Marsh
Reviewing Commission Member

Kristin Brewer, JD
Assistant Attorney General

Case Review

- The Respondent assumed treatment and responsibility for managing pain medications for 29 year old Patient A in late 2008.
- Respondent failed to obtain an adequate medical history – didn't review prior toxicology records or speak with providers.
- Aug 2008 Prescribed Percocet – and patient informed him she was taking double the dose placing her at risk for Tylenol toxicity. Respondent continued to prescribe Percocet.
- By October 08 had added Dilaudid and noted Patient's ongoing Methadone (previously started by a different provider). No referral to mental health or close monitoring.

Case Review Continued

- February 2011: The Patient attempted Suicide by placing 12 fentanyl patches on herself.
- The patient entered in patient drug treatment in Nevada after her suicide attempt
- After treatment, the Respondent prescribed Oxycodone and Fentanyl without contacting the patient's treatment center, her parents or other providers to verify patient's statements that her medications were continued even during in patient treatment
- Patient passed away on August 27th, 2011 from an overdose of the prescriptions from Respondent filled at Nevada pharmacy

September 2008 to 2011 Red flags ignored:

- The patient did not experience any relief of pain, even after disclosing to the respondent that she was taking twice the prescribed dosage;
- The respondent provided the patient with numerous early refills on all of her pain medications due to various excuses by patient 8 different times such as meds fell in toilet, meds stolen, etc.;

Red Flags Cont.

- Patient reported combining alcohol, benzodiazepines and high dose opioids;
- Call from pharmacy re high dose and combinations dangerous;
- Letter from insurer to Respondent notifying of multiple providers of controlled substances;
- UA inconsistent;

Case Review- Family Involvement

- January 2010: Mr. McClelland left a message for the respondent outlining his daughters history of drug addiction and expressed concern that she was receiving excessive medication
- April 2010: Mrs. McClelland expressed concern with her daughter's care to the rheumatologist at the respondents clinic.
- The patient and her parents met with the respondent after her suicide attempt to discuss detoxification and inpatient treatment.

Assistant Attorney General Perspective

Kristen Brewer, JD

The Agreed Order, June 2014

- Permanent Restriction on Prescribed Substance Prescribing and Prescription of Psychotropic Medications
- Surrender of DEA Registration
- Mandatory referral for patient needing psychotropic medications to psychiatrist to manage prescription
- Personal appearance, practice reviews
- No modification of practice review or compliance appearance requirements for 3 years
- Fine

Patient & Family Perspective

Mr. Bruce McClelland

Clinical Perspective

Dr. Peter Marsh

Common Themes in Pain Mgmt.

- Inadequate screening techniques
- Failure to monitor changes in patient status
- Failure to consult the PMP and other providers
- No treatment/tapering plan developed
- Did not maintain patient's (and family's) expectations

“8P” Risk Assessment

- Prior hospitalization
- Problem medications
- Psychological
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Palliative Care

- 1) Identify
- 2) Mitigate
- 3) Communicate

Help is Available

- **Communicate with the Medical Commission**
 - Report providers posing a risk
 - Communicate earlier so that adverse effects are mediated
- **Effective Communication in Children's Hospitals: a Handbook of Resources for Parents, Patients and Practitioners**
- **WA Recovery Helpline: Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups.**

Questions?

- Please submit all questions via SLI.DO
 - www.sli.do/home
 - Event Code 6698



Kristina Ai Toncray, M.D.

Seattle Children's Hospital
Seattle, WA

Kristina Toncray, MD, has served as the Physician Director for the patient safety events at Seattle Children's Hospital in Seattle since 2011. She is also a practicing, board-certified pediatric physician at Seattle Children's. Dr. Toncray is also a clinical assistant professor of pediatrics at the University of Washington.

Dr. Toncray's position as the physician director of patient safety events includes:

- Providing medical direction to the Patient Safety Cause Analysis program;
- Serve as a resource to faculty, trainees, staff in prevention of and response to safety events;
- Provide education related to Patient Safety, including coordination of monthly hospital-wide Patient Safety Conference;

Dr. Toncray received a degree in medicine from Washington University in St. Louis. At Washington University she was the recipient of the Women in Medicine Award. She then took a pediatric residency at the University of Washington and then went on to become the chief resident at Seattle Children's.

She is the instructor of various courses at Seattle Children's and University of Washington including:

- Apparent Cause Analysis;
- Pediatric Intern Error Prevention;
- Introduction to Reliability;
- High Reliability Organizations;
- Root Cause Analysis;

Dr. Toncray has been a champion for improvements for patient safety since 2009. She has filled the roll of patient safety representative, reviewer for patient safety events and is a physician leader for Seattle Children's continuous performance improvement.

Communicating Key Learnings From Patient Safety Events Across an Organization

Kristina A. Toncray, MD

Seattle Children's Hospital /University of Washington

6 October 2016

Washington Medical Commission Educational Conference



stART with Safety

At Seattle Children's we start every meeting with a "Safety Story."

Here is mine, an example of how we can prevent future safety events via dissemination of learnings from those of the past.

Seattle Children's Hospital

- 371 licensed beds
- Free-standing pediatric teaching hospital affiliated with the University of Washington
- WA, ID, WY, MT, AK coverage
- Largely non-employed physician staff
- ~19 years into Lean Journey



Why I “Speak Safety”

- Seattle Children’s Hospital/University of Washington
 - Pediatric Hospitalist and Assistant Professor of Pediatrics
 - Medical Director, Patient Safety Cause Analysis Program
- Interests in
 - Safety event analysis and the use of novel tools
 - Diagnostic error analysis and education
 - Improvements in the M&M process
 - General patient safety and QI education for trainees

Contact: Kristina.Toncraay@seattlechildrens.org



Objectives

- Recognize that communication of Lessons Learned is integral for prevention of safety events in healthcare
- Appreciate the need to share lessons in multiple directions, to leadership and to those on the front lines
- Understand the need to include the patient/family member perspective in learning from errors
- Identify the unique attributes of the classic physician learning model
- Leverage the Seattle Children's experience to identify next steps in your Lessons Learned journey

Tools for Learning from Errors

M&M

Root
Cause
Analysis

Failure Mode
and Effect
Analysis

HR Review

Peer
Review

Simulation

Risk
Management
Review

Tools for Learning from Errors

How do these learnings translate into practice change?

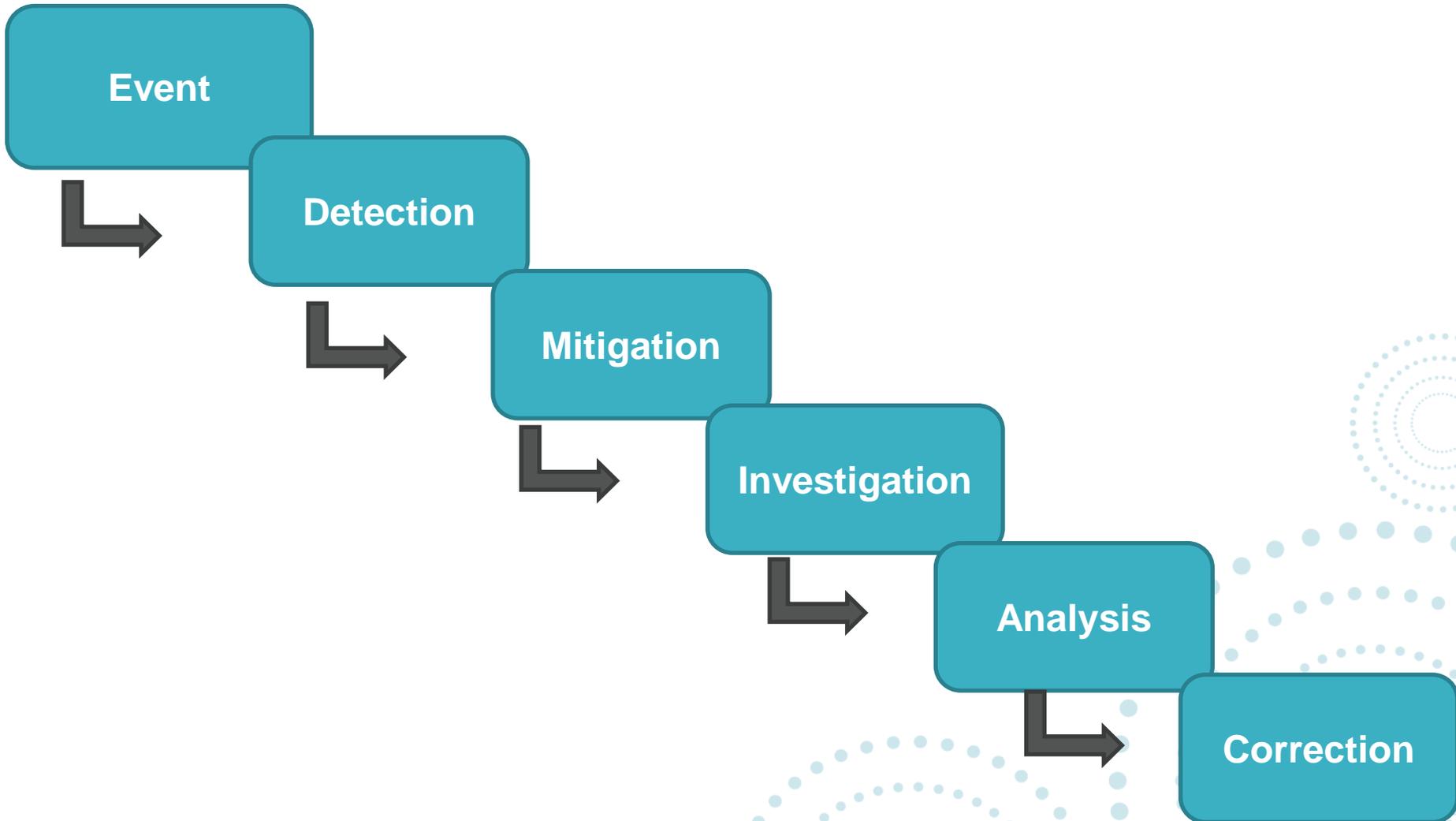
M&M

Failure Mode
and Effect
Analysis

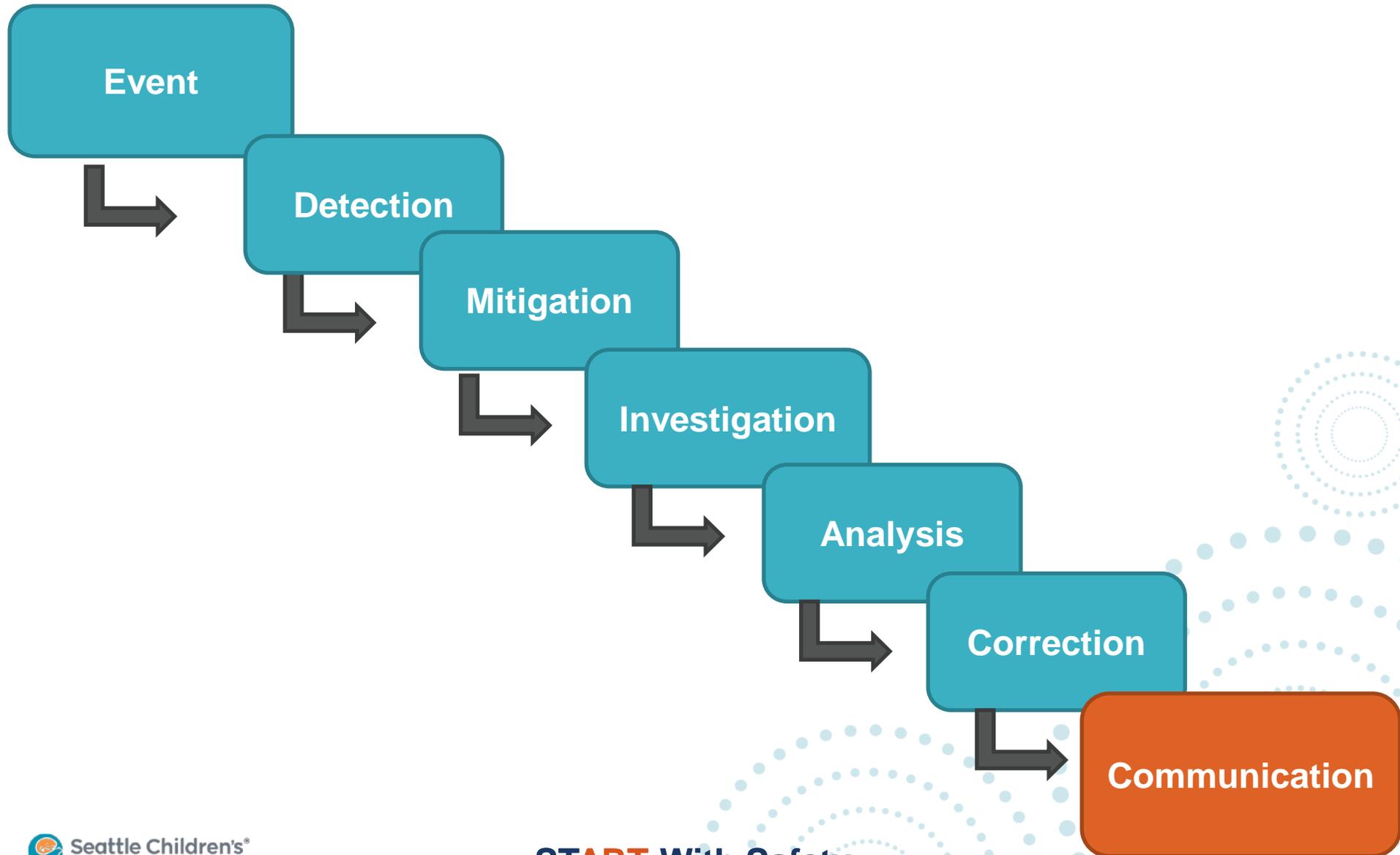
HR Review

Management
Review

Learning from Event Reviews



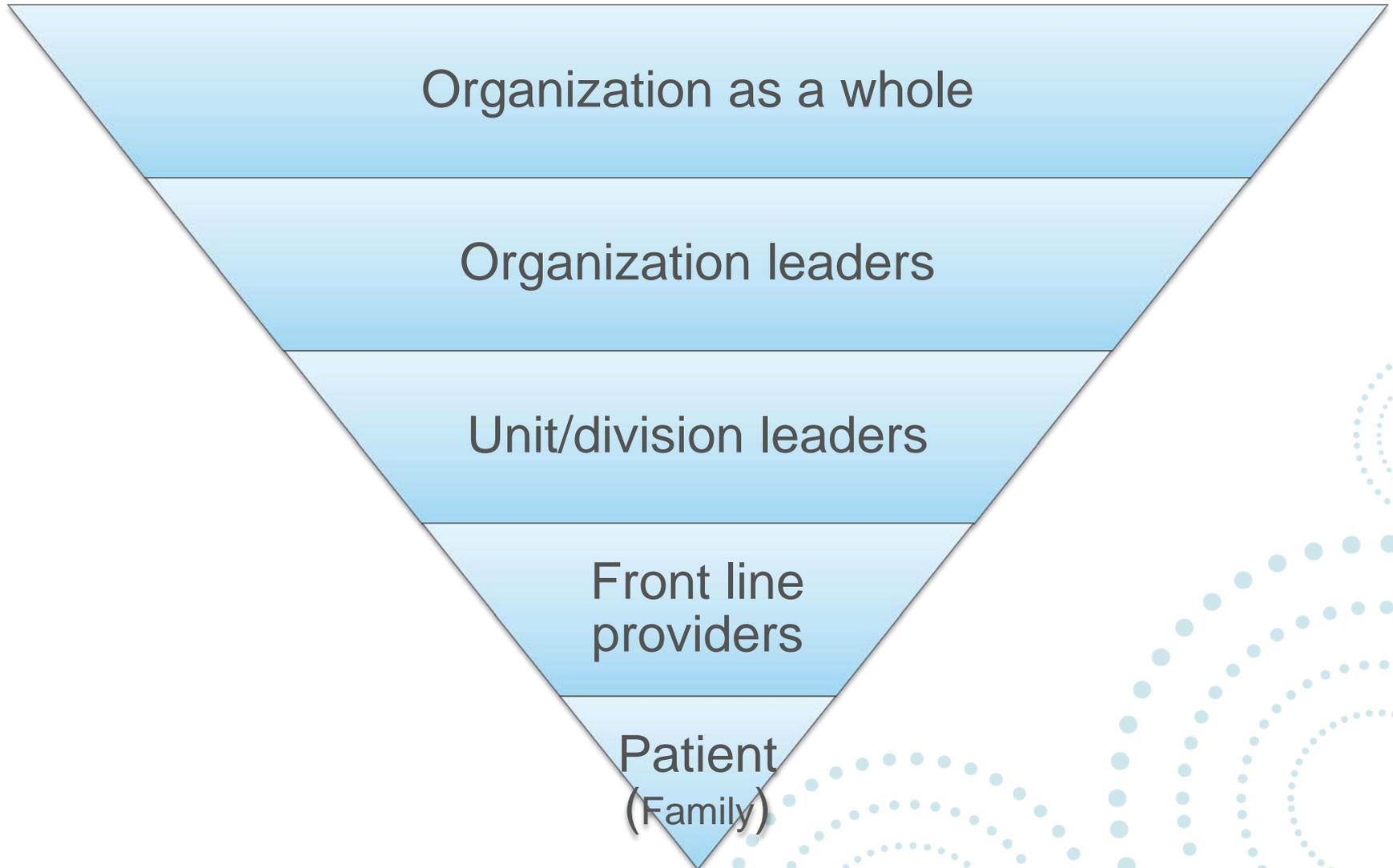
Learning from Event Reviews



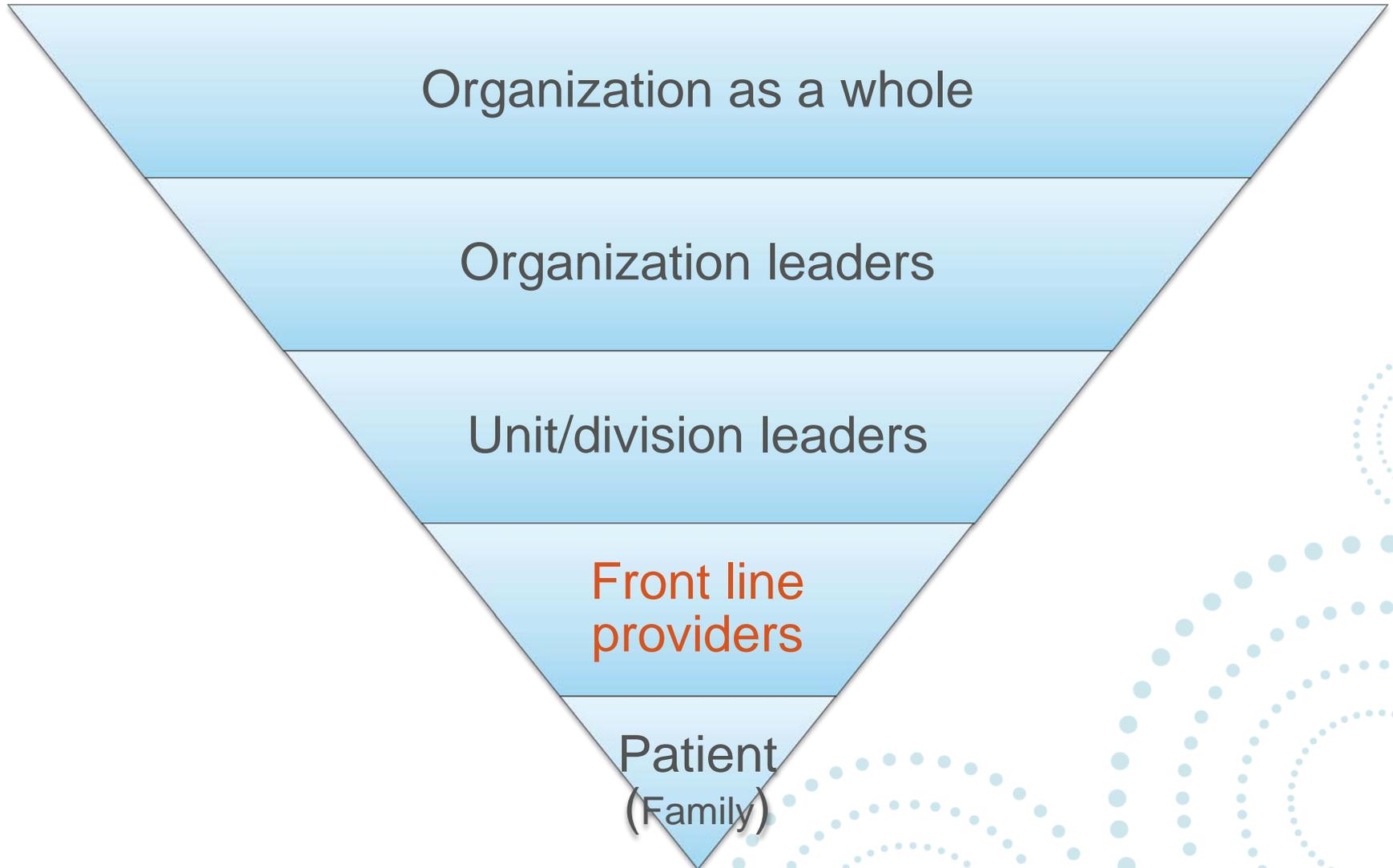
Why Communicate Learnings?

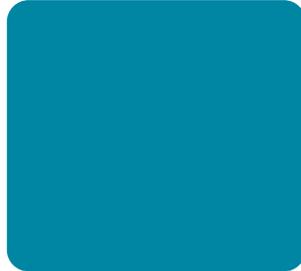
- Provide feedback and closure to those involved in an event
- Respect the time and expertise of those who participated in the review process
- Provide education and closure to those who know the patient
- Provide education to those who perform a similar job as those involved in an event
- Increase the chance of future reporting of safety events and overall morale
- **PREVENT DÉJÀ VU EVENTS**

The Audience

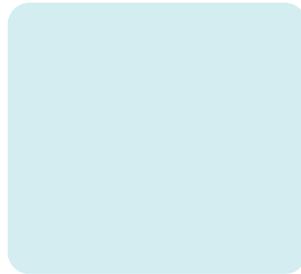
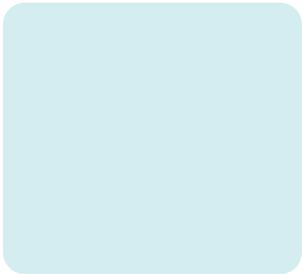


The Audience





Closing the Loop with the Front Line



Front Line Staff/Providers



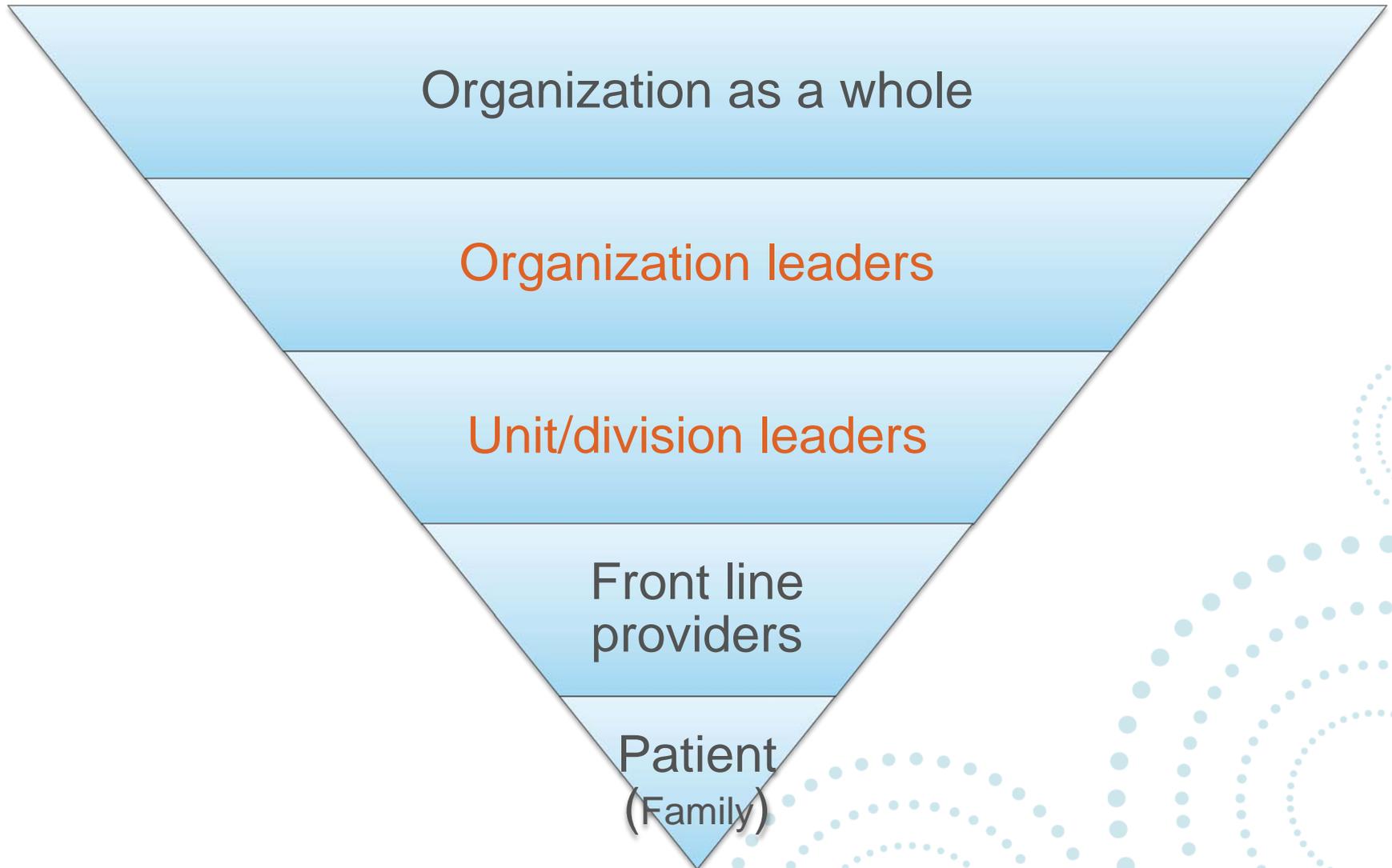
Suggestions for Communication with the Front Lines

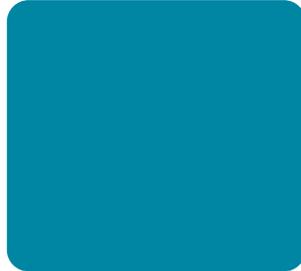
- Interviews
- Post-interview follow-up
- Pilot: Post-RCA debrief meeting
 - Invite Executive Sponsor, Process Owners, those involved in the event, those who knew the patient as invited by area leadership
 - Review Root Causes and Action Plans
- Role of the Root Cause Analysis role representative
- Role of the Root Cause Analysis Process Owner

Nursing Quality Practice Councils

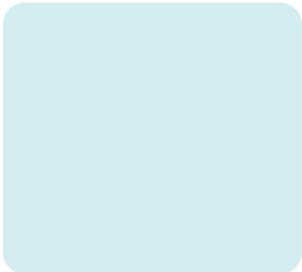
- Monthly sharing of stories at hospital-wide Quality Practice Council
- Presentation by Unit Clinical Nurse Specialists
 - Pre-work done with Patient Safety Consultant
- Stories alternate between Root Cause Analysis and “Severe Clinical Deterioration” Lessons Learned

The Audience

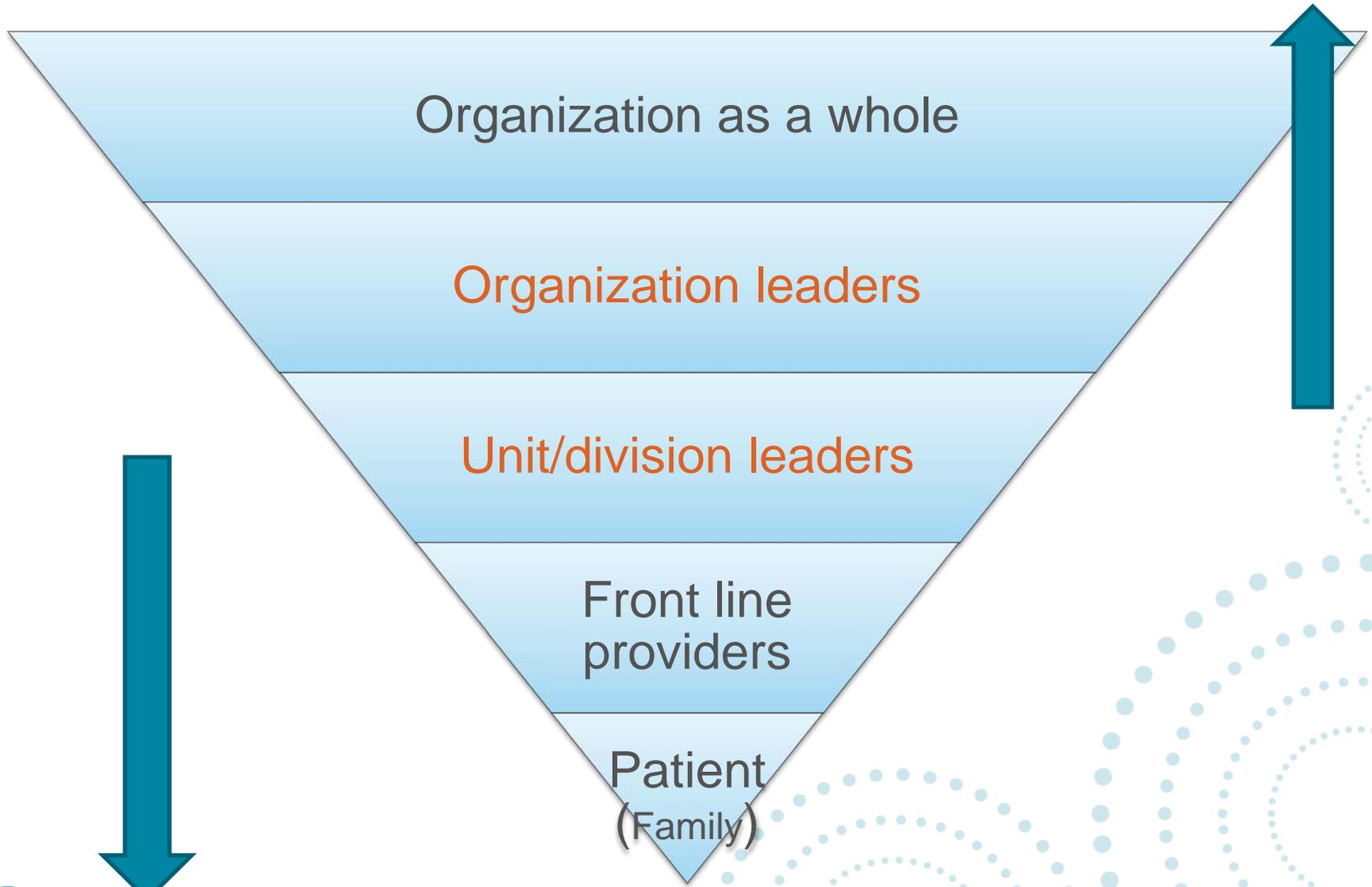




The Role of the Leader in Lessons Learned



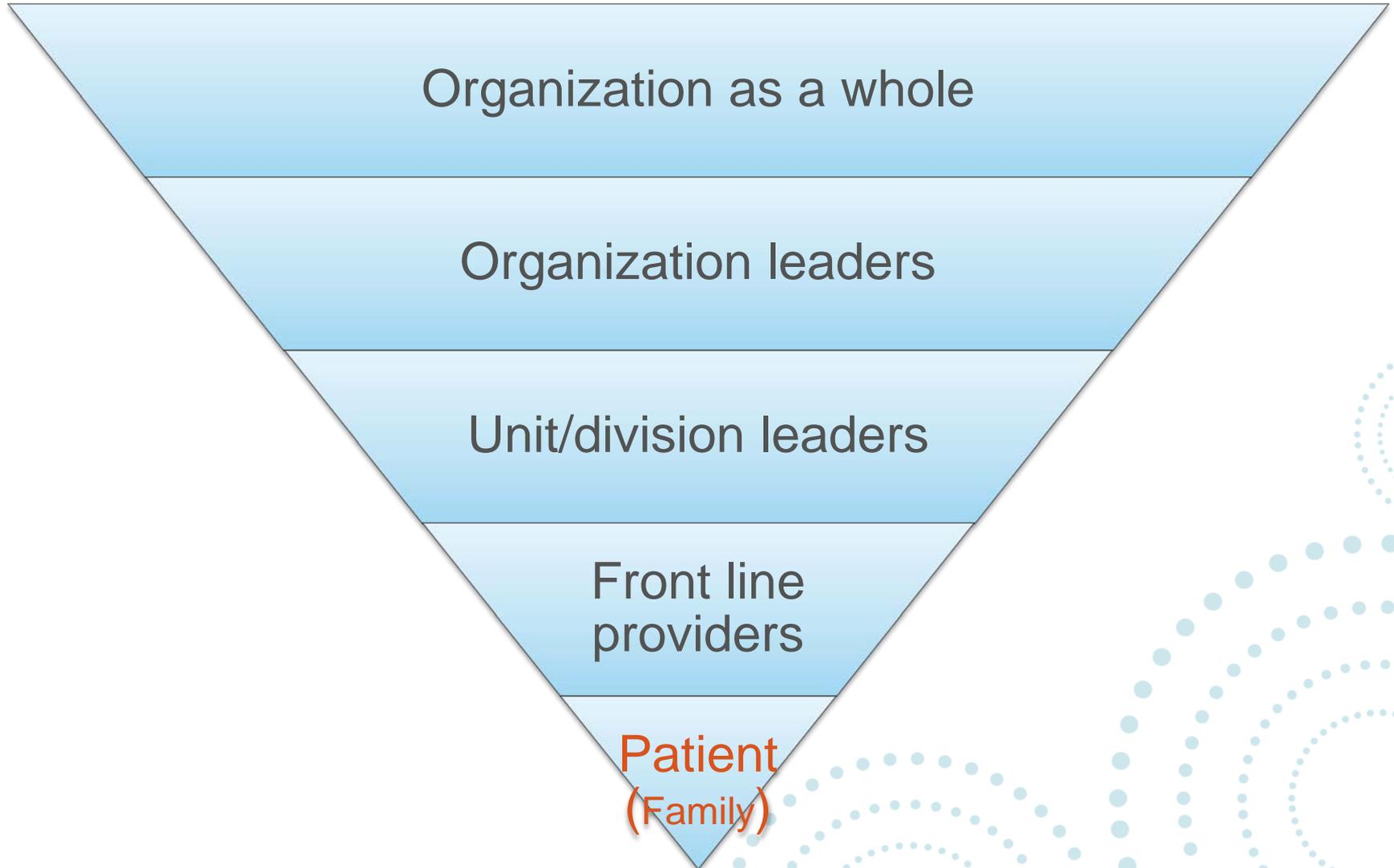
The Dual Role of Leaders



Communicating Lessons via Existing Leadership Structures

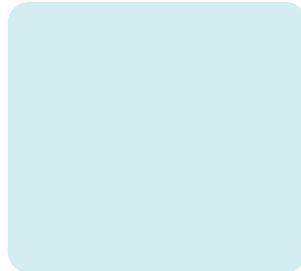
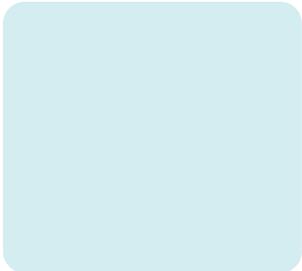
- Root Cause Analyses presented monthly to hospital Patient Safety Subcommittee
- Aggregate data on RCAs presented to various committees annually
 - Quality Improvement Steering Committee
 - Hospital Steering Committee
 - Executive Operations Committee
 - Board Quality and Safety Committee
- Data from Patient Safety available for specific areas/roles

The Audience

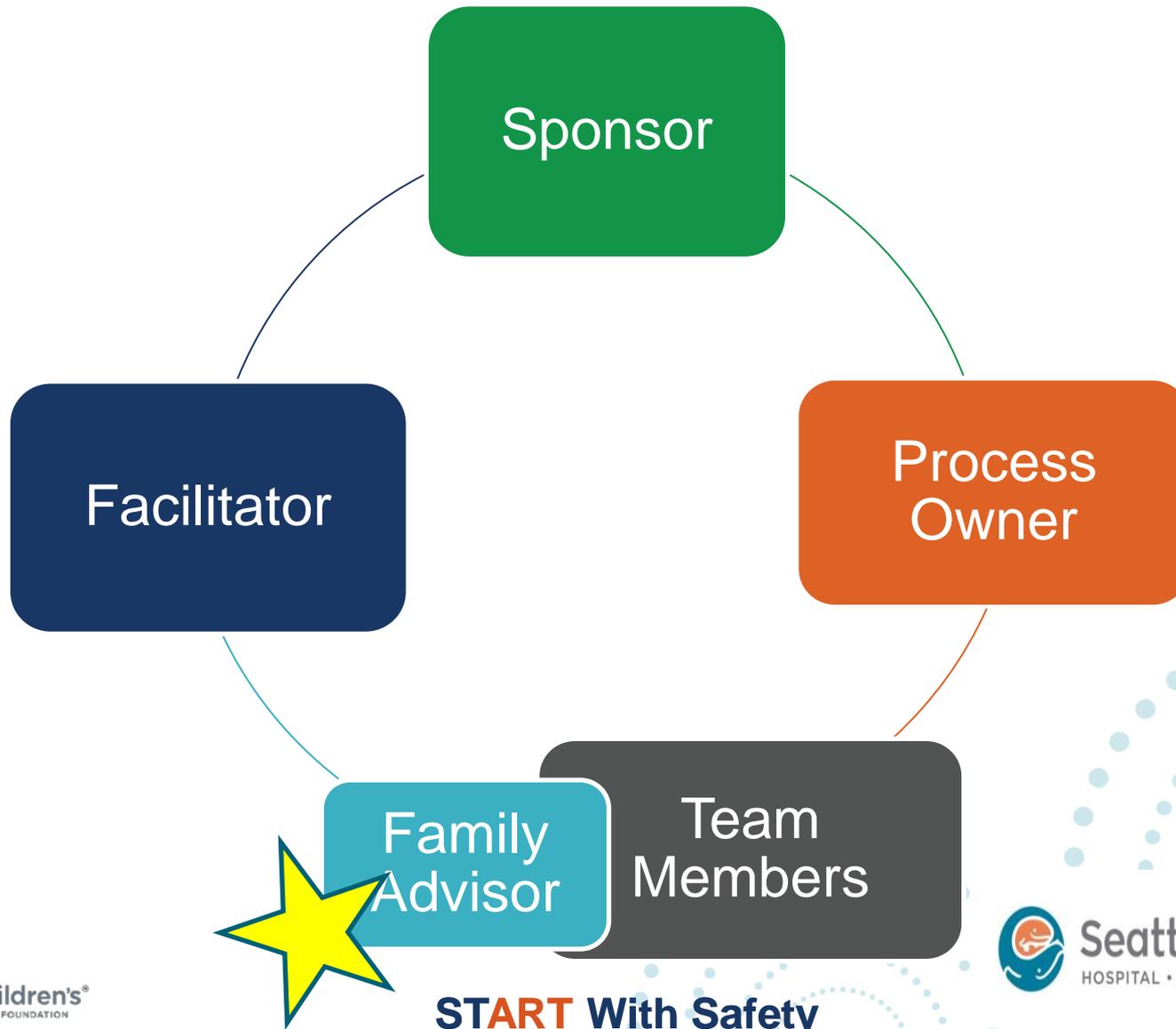




The Unique Perspective of the Patient & Family Advisor



The Root Cause Analysis Team



The Audience

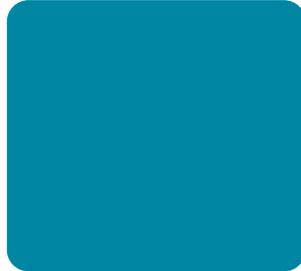
Organization as a whole

Organization leaders

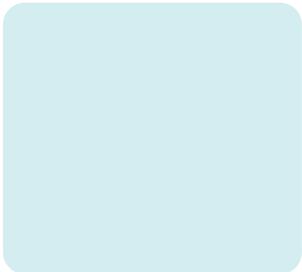
Unit/division leaders

Front line
providers

Patient
(Family)



Hospital-Wide Communication



Patient Safety Conference

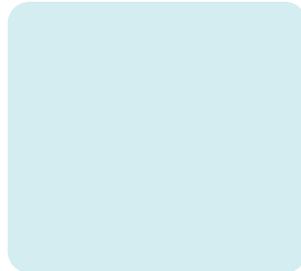
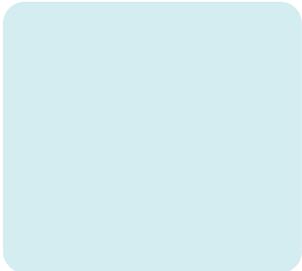
- Monthly institutional conference with all invited
- Topics this year include:
 - Family Involvement in Root Cause Analyses
 - Analysis of Cognitive Errors by Pediatric Trainees
 - Cognitive Psychology:
 - Impact of Fatigue
 - Human Factors in Patient Safety
 - Proactive assessments:
 - Disaster Planning
 - Simulation of Medical Fire Evacuation

Lessons Learned Page

- Safety Stories and Good Catches posted regularly on “CHILD” (hospital intranet)
 - ~2/3 Good Catches
- Populated by
 - Safety Stories submitted by safety coaches once/month
 - Root Cause Analyses
 - Ad hoc stories
- Goal of 8 per month
 - One always reflects a provider Good Catch
 - One always reflects a Root Cause Analysis



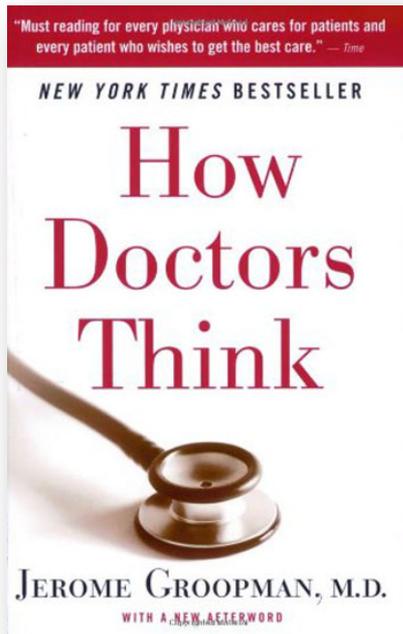
Thoughts on the Physician Role



We All Make Mistakes

“Of course, no one can expect a physician to be infallible...Every doctor makes mistakes... But the frequency of those mistakes, and their severity, can be reduced by understanding how a doctor thinks and how he or she can think better.”

-Jerome Groopman

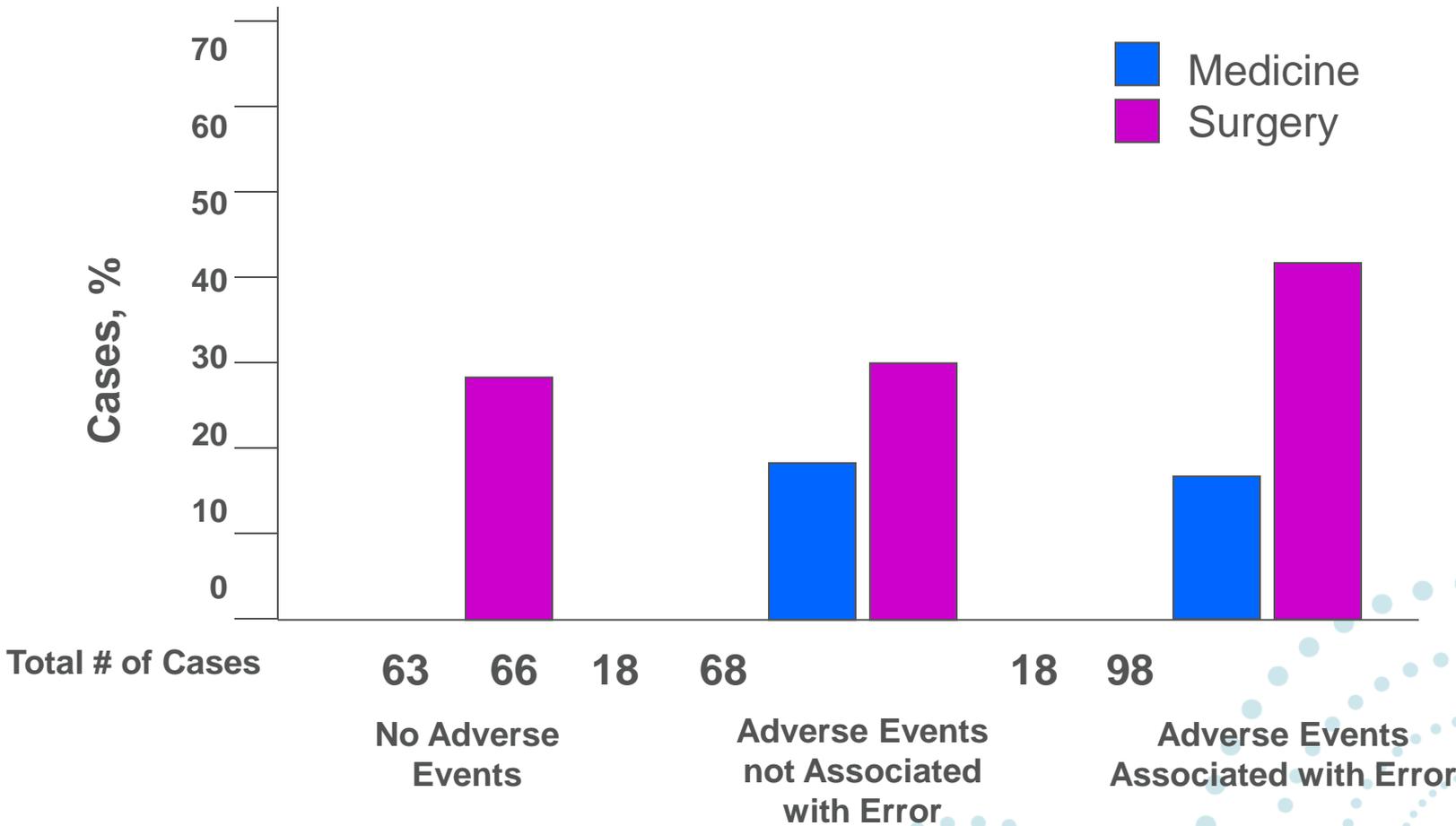




Morbidity & Mortality Review

- Origin in surgical community
- Widely varied format and content
- Common objectives
 - Learning from complications
 - Modification of clinician judgment & behavior
 - Prevention of repetition of errors
- Inherent drawbacks
 - Traditionally closed door (physician only)
 - Often a risky environment and disincentive to reporting/investigating error

Discussion at M&Ms



Pierluissi, et al; *JAMA* 2003;290:2838-2842

Courtesy D. Brownstein, MD

The Challenge: Transforming the M&M

- Creation of action items
- Sharing of information with individuals not present
- Sharing learnings with other organizational support services
- Including those of other disciplines (nurses, trainees, etc)
- Aggregating lessons

What Can YOU Do?

- If you're a front-line staff member involved in an event...
- If you're a front-line staff member who hears about an event...
- If you hold a leadership position...
- If you're a patient/family member...

Acknowledgments/References

- Seattle Children's Hospital Patient Safety Department
- Seattle Children's Hospital Physician Leader Standard Work Group
 - Lynn Martin, MD, and Kris Lukkarila
- Seattle Children's Hospital Family Advisory Group
 - Jennifer Davidson, Jen Faultner, Sheryl Kalbach
- Seattle Children's Hospital Patient/Family Relations
 - Mark Mendelow and Amanda Mogg
- Seattle Children's Hospital RISK group
 - Joan Roberts, MD
- Seattle Children's Hospital/UQ Risk Management
 - David Stallings, Caity Morray, Marcia Rhodes
- David Higgins, MD—Former SCH resident



Tell me and I forget,
teach me and I may remember,
involve me and I learn.

Benjamin Franklin

Questions?



Seattle Children's[®]
HOSPITAL • RESEARCH • FOUNDATION

