2015

Communication: The Way to Patient Safety

Washington State

Medical Commission

Educational Conference

September 30th and October 1st 2015

Washington State Department of Health

Washington State Medical Commission
2015 Educational Conference
"Communication: The Way to Patient Safety"

WEDNESDAY – SEPTEMBER 30TH, 2015	
DOUBLETREE SOUTHCENTER – TUKWILA/SEATTLE	
8:00 A.M.	Registration Opens
9:15 A.M.	Welcome: Michelle Terry, MD Chair, Washington State Medical Commission
9:30 A.M.	Dr. Thomas Gallagher University of Washington **Promoting Patient-Centered Accountability and Learning** Introduction by: Mark L. Johnson, MD. 1st Vice Chair of the Medical Commission 10 minute Q&A
10:30 A.M.	Larry Mauksch M.Ed Clinical Professor Department of Family Medicine, University of Washington **Making the Best use of Time: Communication Skills for Patients and Providers** Introduction by: Mimi Winslow, JD. Public Commission Member 10 minute Q&A
11:30 A.M.	**Independent Lunch Break**
12:30 P.M.	Dr. Joseph Hwang Clinical Associate Professor, Department of Obstetrics & Gynecology, University of Washington School of Medicine and Valley Medical Center **Focus on Maternal Well-Being: A Guideline for Clinicians** Introduction by: Charlotte Lewis, MD. Congressional District 7 10 minute Q&A
1:30 P.M.	**Networking Break**
2:00 P.M.	Bonnie Bizzell MBA, M.Ed Foundation for Health Care Quality **Communication: A Patient's Perspective** Introduction by: John Maldon, Public Commission Member 10 minute Q&A
3:00 P.M.	Panel Presentation Melanie de Leon, JD, MPA: Executive Director of the Medical Commission Tracy Bahm, JD: Assistant Attorney General, Government Compliance and Enforcement Bruce F. Cullen, MD: Medical Quality Assurance Commission Pro Tem Member **Process Transparencies: The Role of the Commission Member in Complaint Assessment and Administrative Hearings**
4:00 P.M.	**Wrap Up and Discussion**

Download the e-book at: http://go.usa.gov/3z5GR

Washington State Medical Commission
2015 Educational Conference
"Communication: The Way to Patient Safety"

Thursday – October 1st, 2015	
DOUBLETREE SOUTHCENTER – TUKWILA/SEATTLE	
8:00 A.M.	Registration Opens
9:15 A.M.	Welcome: Michelle Terry, MD Chair, Washington State Medical Commission
9:30 A.M.	Dr. Mimi Pattison Medical Director for Franciscan Hospice and Palliative Care, Commission Member **A Model for Communication in Relationship Centered Care** Introduction by: Melanie de Leon, JD, MPA. Executive Director of the Medical Commission 10 minute Q&A
10:30 A.M.	Carol Wagner RN, MBA Senior Vice President Patient Safety, Washington State Hospital Association **Transformational Culture: Engagement Leadership, Clinicians and Patients** Introduction By: Toni Borlas. Commission Public Member
11:30 A.M.	**Independent Lunch Break**
12:30 P.M.	Dr. Robert Arnold Director, Institute for Doctor-Patient Communication **"Why Can't We All Get Along?"** **Handling Conflict with Seriously Ill Patients and Their Families** Introduction by: Mimi Pattison, MD. Congressional District 6 10 minute Q&A
1:30 P.M.	**Networking Break**
2:00 P.M.	Dr. Sam Mandell Assistant Professor in the Division of Trauma and Critical Care, University of Washington **Communicating with the Burn Center** Introduction by: Theresa Schimmels, PA-C 10 minute Q&A
3:00 P.M.	Dr. John Scott Associate Professor, University of Washington. Medical Director, Telehealth **Telemedicine Update** Introduction by: William Gotthold, MD. Congressional District 8 10 minute Q&A
4:00 P.M.	**Closing: MQAC Strategic Direction Discussion and Conference Debriefing**

Download the e-book at: http://go.usa.gov/3z5GR

State of Washington

Medical Quality Assurance Commission

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

Speakers Bureau

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

Twitter

- https://twitter.com/WAMedBoard

Facebook

- Like us at : Washington State Medical Quality Assurance Commission
- https://www.facebook.com/Washington-State-Medical-Quality-Assurance-Commission-1548354572107042/timeline/

Comments/ Suggestions
Jimi Bush
Performance and Outreach Manager
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360-236-2738

Patient-centered accountability and learning after medical injury

Thomas H. Gallagher, MD
Professor and Associate Chair, Department of Medicine
University of Washington

ELLE > HAIR & BEAUTY > HEALTH & FITNESS

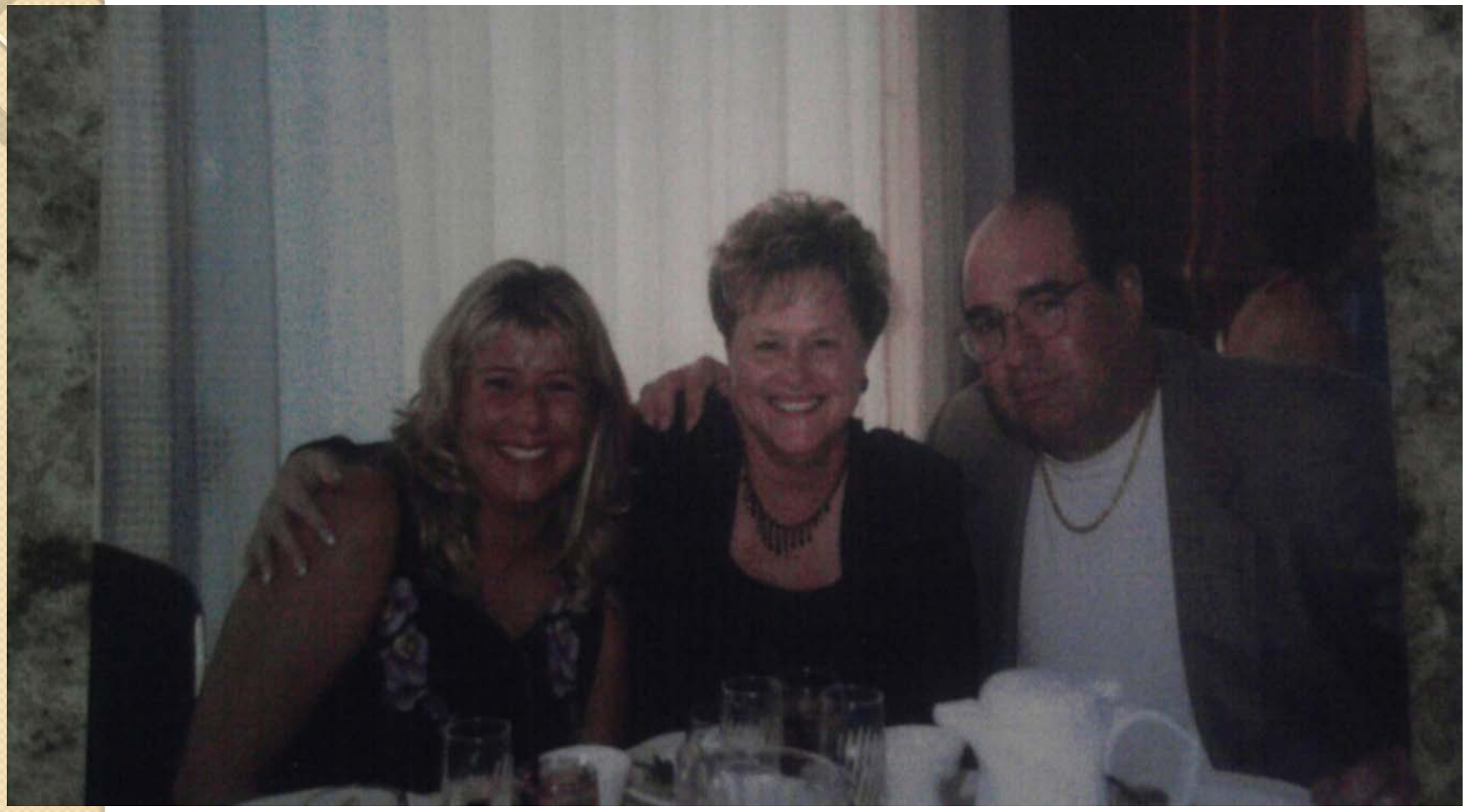
CAN A SINCERE "I'M SORRY" MAKE UP FOR MEDICAL MALPRACTICE?

In light of all this, is Dr. P's apology still enough? Sometimes yes. Often no.

for it profusely—should that be enough?

So now I've got a clot, just like I did the first day I walked into Dr. P's office. My right arm often gets achy and swollen when I use it, because the clot blocks the blood from draining effectively. In addition, my upper arm is numb because nerves were cut during surgery. The scars in my chest wall hurt when I take a deep breath. A surgery to remove this clot isn't an option, I've been told, so I inject myself with blood thinners each night, which leaves my stomach mottled with bruises. I face the possibility of lifelong damage from the blood thinners, and who knows what from the blood transfusions. And I have less money in the bank to cover it all.

Michelle Malizzo-Ballog



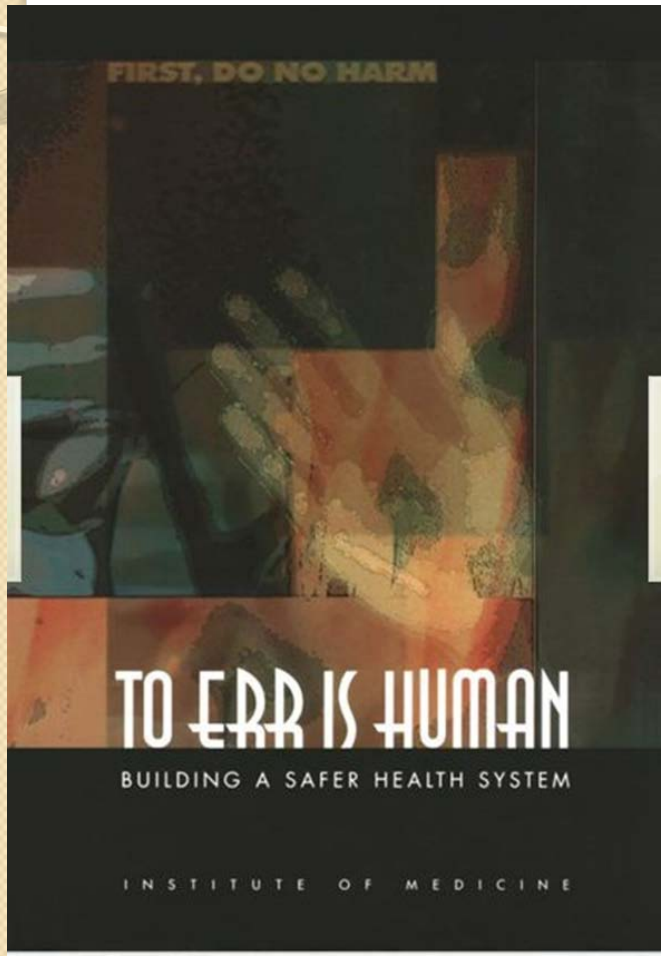
Story of Michelle Malizzo Ballog

- 39 year old presents for endoscopic GI procedure under heavy moderate sedation
  - Had failed stent placement two weeks prior due to discomfort despite large amounts of narcotics.
  - Repeat scheduled for 1 pm with anesthesia present
  - GI physician delayed. Arrives at 4pm, at which point anesthesia not available for elective case
  - Twice the dose of fentanyl, midazolam used
- Standard monitors for HR, BP, O2 Sat used
- Dark room, patient on side, unable to auscultate
- Physician asks monitoring nurse to get different stent. Nurse leaves room

(case continued)

- Upon return, patient found to be in respiratory distress
- Code called
- No response to reversal agents
- Team assumes allergic reaction to medication as etiology of arrest
- Michelle resuscitated but brain dead

Patient Safety Background



- 2010 data from Medicare:
  - 13.5% of hospitalized beneficiaries experience an adverse event
  - 1.5% experienced harm that contributed to death
  - 44% of adverse events were preventable

Levinson D, et al. OIG Report, Nov 2010

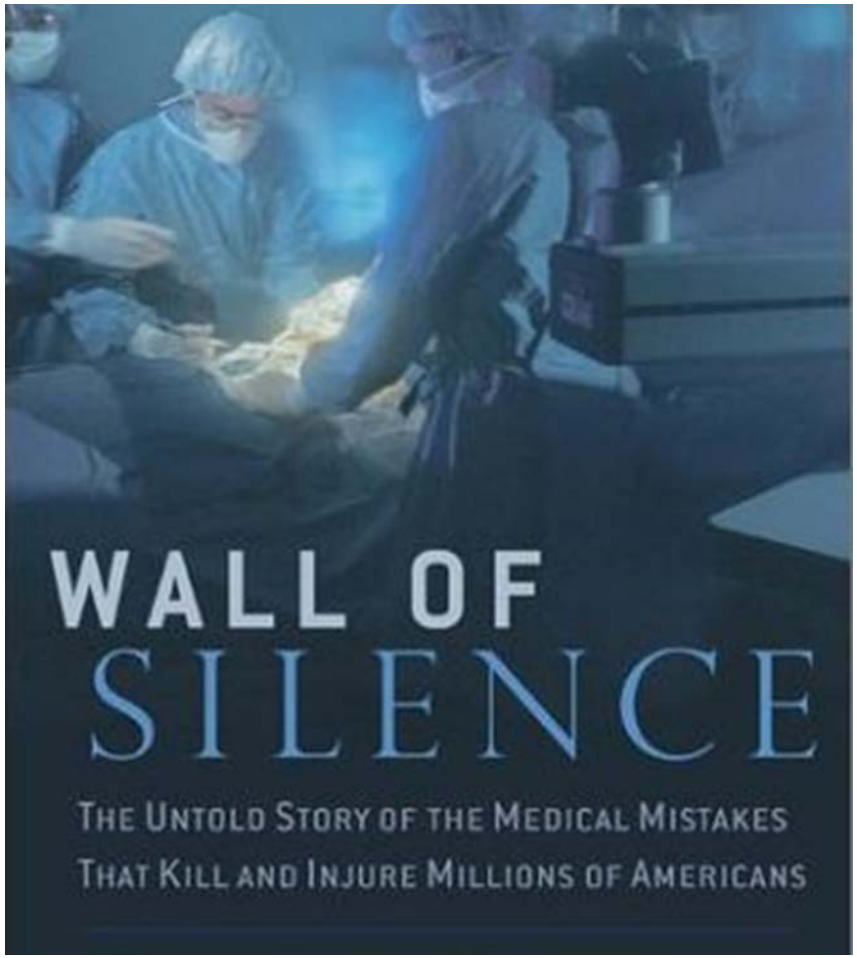
Following Harm: Not Always Transparent, Not Always Learning

Health Affairs

February 2012

Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients

Lisa I. Iezzoni[1,*], Sowmya R. Rao[2], Catherine M. DesRoches[3], Christine Vogeli[4] and Eric G. Campbell[5]



Consequences of Failed Response to Adverse Events

- Compounds suffering of patients and family
- Heightens distress of clinicians
- Increases likelihood of litigation
- Lost opportunity for learning within and across institutions
- Degrades institutional culture/climate
- Reduces public trust in healthcare

The CRP Vision

- Healthcare institutions and providers:
  - Report adverse event immediately to the institution
  - Disclose adverse events effectively to the patient and family
  - Involve patients in timely investigations
  - Proactively make patients and families whole
  - Learn from what happened
- in a healthcare delivery environment that:
  - Remains patient-centered after injury occurs
  - Proactively monitors quality of care
  - Identifies unsafe providers and takes action
  - Spreads learning across institutions
- in a cultural/legal/regulatory environment that supports providers in "doing the right thing"

A Paradigm Shift

	Traditional Response	Open Accountability
Incident reporting by clinicians	Delayed, often absent	Immediate
Communication with patient, family	Deny/defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on Just Culture, system, human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails on a malpractice claim	Proactively address patient/family needs
Care for the caregivers	None	Offered immediately
Patient, family involvement	Little to none	Extensive and ongoing

The changing landscape

- Current regulatory models developed when medicine was largely cottage industry
- Now
  - Increasing number of physicians employed
  - Complex teams deliver care
  - Better understanding of the causes and prevention of medical error
  - ACOs
  - Greater societal expectations for transparency

History of the CRP Field

- Pioneering Programs
  - VA
  - U. of Michigan
- Proof of concept
  - U. of Illinois
  - Stanford
  - MACRMI
  - Oregon
- AHRQ Demonstration Projects to test and refine model
- AHRQ funding for CANDOR toolkit for spread
- Collaborative for CRP innovation and support of spread

CRP Key Elements

1. Change readiness/gap analysis
2. Adverse event reporting coupled with human-factors based event analysis
3. Transparent communication between patients, providers, and institutions after adverse events
4. Peer support
5. Proactive and fair offers of financial or non-financial compensation

SURGEONS AND MEDICAL LIABILITY:

A GUIDE TO UNDERSTANDING MEDICAL LIABILITY REFORM

DECEMBER 2014

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100+years

AMERICAN COLLEGE OF SURGEONS | DIVISION OF ADVOCACY AND HEALTH POLICY

TABLE 4: SUMMARY OF EXISTING SYSTEM, TORT REFORM AND ALTERNATIVES

	Current System	Tort Reform	Alternative Dispute Resolution	Health Courts	Enterprise Liability	Safe Harbors	Communication and Resolution Programs
Cost Control	✗		✓	✓			✓
Just Culture	✗		✓	✓	✓		✓
Patient Safety	✗				✓		✓
Feasibility			✓				✓
							YES

On balance, however, communication and resolution programs may represent the most attractive reform solution, best encapsulating ACS principles of a "just culture" while also restoring financial stability to the liability system. Multiple pilot

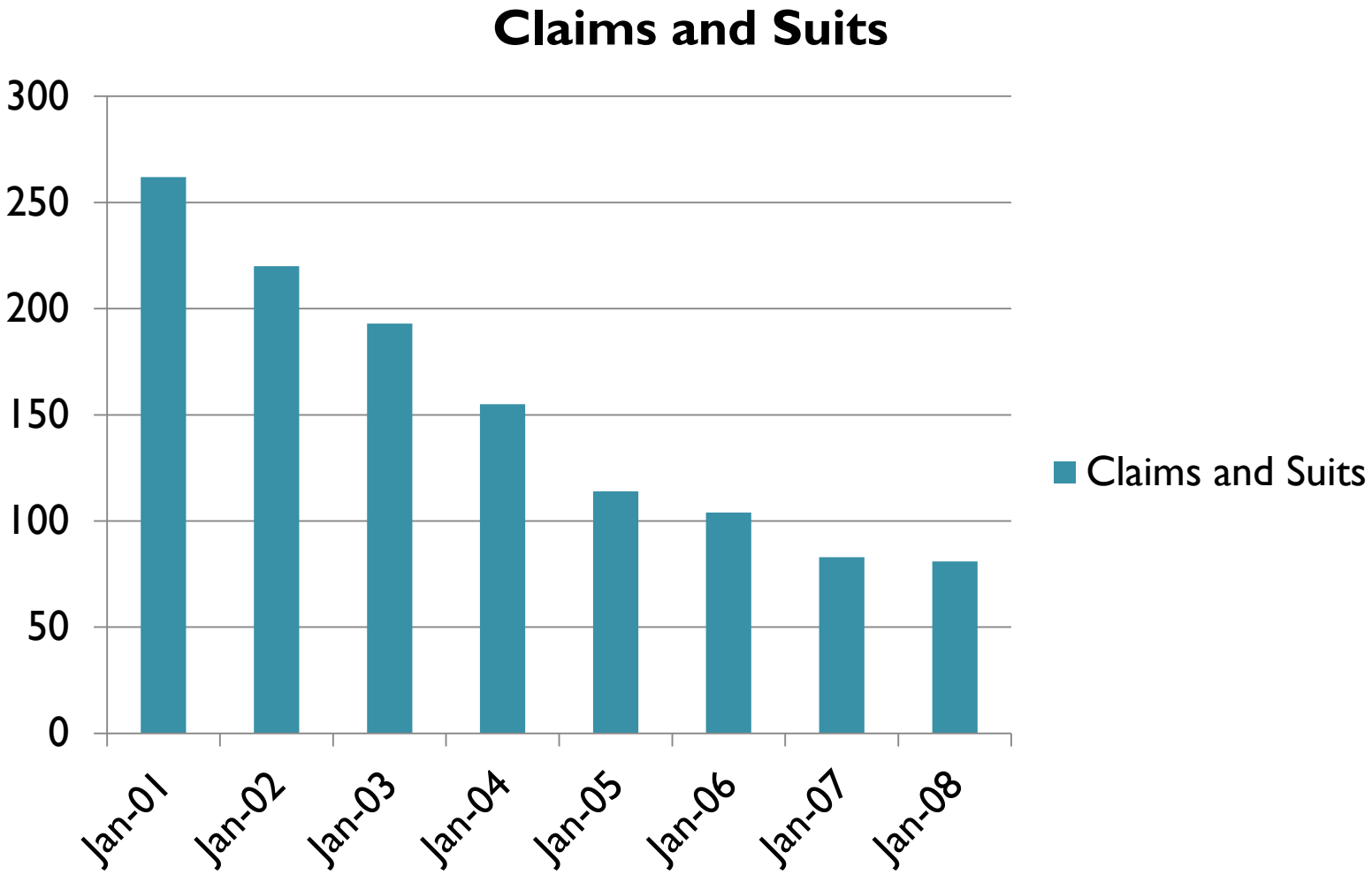
CRP Proven Success

- U. Michigan
  - Average monthly rate of new claims decreased
  - Median time from claim reporting to resolution decreased
  - Average patient compensation costs decreased
  - Legal expenses decreased

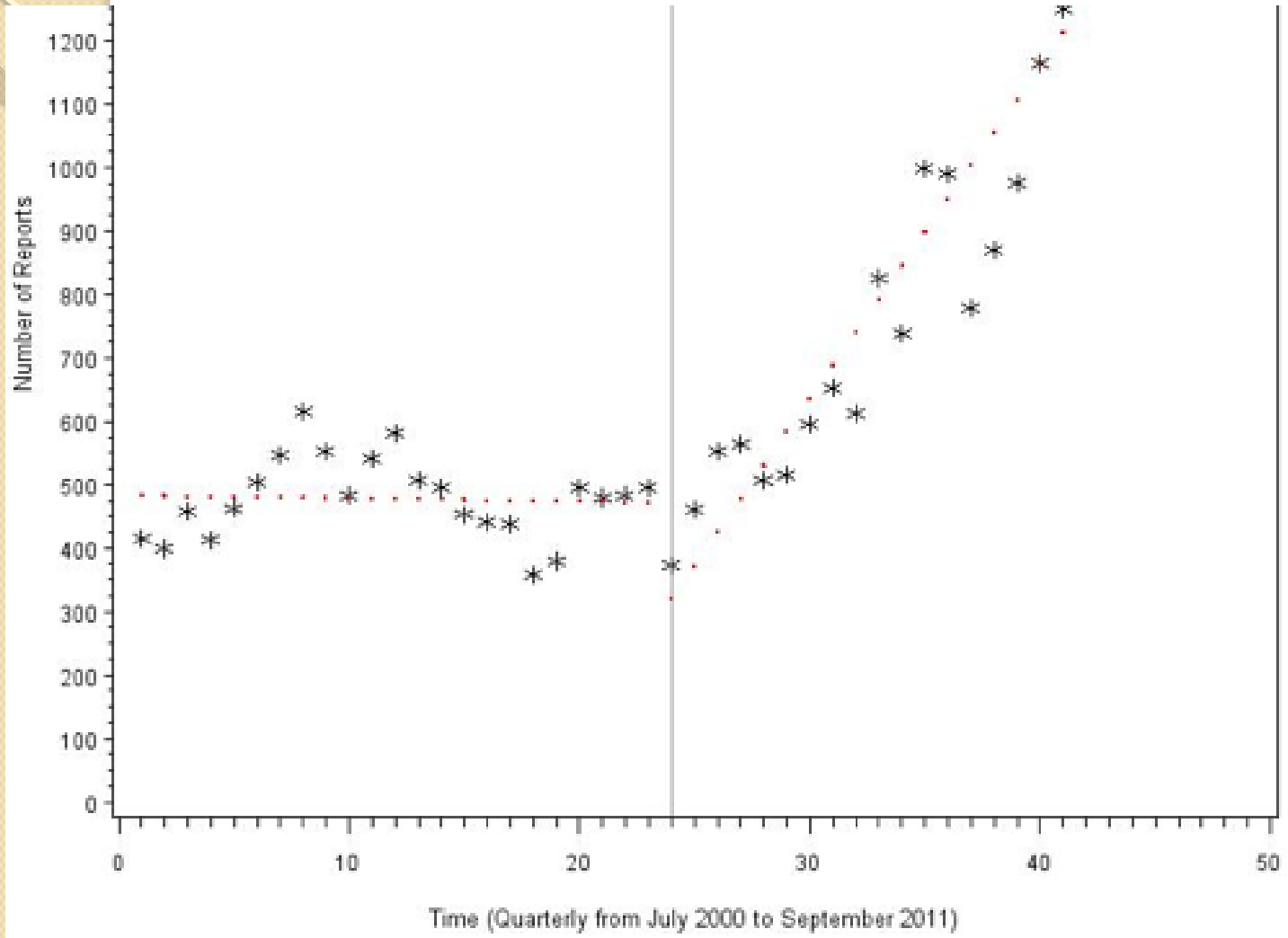
- University of Illinois Chicago:
  - Event reporting increased from 1,500 to 7,500 per year
  - New claims dropped 50%
  - Median time to resolution dropped from 55 to 12 months

- Stanford University Medical Indemnity and Trust
  - Frequency of lawsuits nearly 50% lower
  - Indemnity costs in paid cases 40% lower
  - Defense costs 20% lower for cases handled through the CRP

University of Michigan: Claim Trends



Impact of CRP on Adverse Event Reports: UIC Experience



Where's the Patient?

- Only modest efforts to involve families as partners in preventing and resolving injuries
- Reform debates heavily driven by providers' and insurers' concerns
- Little understanding of what accountability actually means to patients

This story is part of WHEN HEALTHCARE MAKES YOU SICK
Doctors perform thousands of unnecessary surgeries
Why you should get a second opinion before getting surgery
Advice for patients considering surgery

Thousands of doctors practicing despite errors, misconduct

DANGEROUS DOCTORS ALLOWED TO KEEP PRACTICING

Thousands of doctors are able to continue practicing despite records of serious misconduct that puts patients at risk. Many of those doctors have had their clinical privileges restricted or taken away by hospitals, HMOs and other health care institutions, but their state medical boards have taken no action against their licenses to practice.

1 2 3 4 5

TROUBLED DOCTOR IMPLICATED IN WOMAN'S DEATH

JENNIFER CHANEY DIED FROM A TOXIC MIX OF DRUGS PRESCRIBED BY DR. GREGGORY K. PHILLIPS. PHILLIPS, HAD A LONG HISTORY OF MISHANDLING DANGEROUS DRUGS, BUT HE WAS ABLE TO KEEP PRACTICING FOR YEARS AFTER CHANEY'S DEATH.

USA TODAY analysis of the U.S. government's National Practitioner Data Bank public use file; data include reports filed from Sept. 1, 1990-March 31, 2013
Frank Pompa, Alex Gonzalez and Barbara Hansen, USA TODAY

Conflict Of Interest Under The Microscope — Again

BY LINDA KOCO

20 HOURS AGO

One could argue that virtually everything one does, and does not do, influences thinking and decisions, so where are the boundaries?

These Agencies Gained New Clients Via Social Media
Linda Koco

Brother, Can You Spare A Million?
Susan Rupe

Most Popular Articles

- Guaranteed Lifetime Income Benefits - Part 2: Positioning
- Recession Took Bite Of Gen X Retirement
- Investor Advocate Says User Fees Would Not Increase Deficit

Public Citizen Applauds HHS Decision to Address Loopholes Created by Oregon, Massachusetts Laws That Threaten Integrity of National Practitioner Data...

Targeted News Service

Public Citizen Applauds HHS Decision to Address Loopholes Created by Oregon, Massachusetts Laws That Threaten Integrity of National Practitioner Data Bank: The Next Step is Now Required

WASHINGTON, Aug. 12 -- Public Citizen issued the following news release:

In a letter today, (http://www.citizen.org/hrg2211) Public Citizen applauds a recent decision by the U.S. Department of Health and Human Services (HHS) to address dangerous loopholes resulting from recent state laws that hinder the ability of hospitals, medical boards, health maintenance organizations and similar entities to detect doctors and other health care providers who have a history of medical malpractice payments.

But to implement and give force to the decision, Public Citizen is urging HHS to immediately notify appropriate state officials about the decision and ensure state

SafePatientProject.org

SEARCH

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Doctor Accountability

When physicians provide poor quality care, their patients are typically the last to know. Some physician backgrounds may be available in your state, but can you tell which ones have the most complaints, malpractice claims or disciplinary actions? Knowing the background information on your doctor could save your life.

- **Consumers Union April 28, 2014 Letter Regarding Opposition AB 2346 (Gonzales)**
  Source: Consumers Union (Monday April 28, 2014)
  Consumers Union opposes AB 2346 (Gonzales) which would create a program that secretly diverts drug and alcohol addicted physicians from a public disciplinary track into a voluntary monitoring program, where physician participation and possible impairment are kept secret from both the CA medical board and patients.
- **Consumers Union Letter to Susan Bonilla, Chair of Assembly Business, Professions and Consumer Protection Committee on AB 1886**
  Source: Consumers Union (Wednesday March 26, 2014)
  Consumers Union urges the chair to vote yes on A.B. 1886 (Eggman), which would remove arbitrary and unwarranted time limits on the availability to patients of important information regarding California physicians.

unnecessary brain surgery. Due to medical error caused by negligence and incompetence, routine expectations of our healthcare system proved ineffective in providing quality medical care and patient safety for 22 year old Michael Skolnik."

Patty of Denver, ColoradoNational

Where do we stand now?

- Profession has lost public's trust in ability to self-regulate
  - Regaining that trust will require profession take uncomfortable steps
- Enormous interest in CRPs and their transformative potential
- Implementation experience mixed at best
  - Emphasis on communication over resolution
- Evidence base is thin

What's needed?

- Trusted source of best practices and training
- Patient-centered vision of accountability
- Stronger evidence base
- Incentives
- Innovation
- Supportive state, federal policy environment

Safety Attitudes

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

--Dr. Lucian Leape, Professor, Harvard School of Public Health
Testimony to congress

"Fallibility is part of the human condition. We *cannot* change the human condition. But we *can* change the conditions under which people work"

--James Reason, Ph.D.

Just Culture

- Seeks middle ground between historical "shame/blame-bad apple" approach and "blame-free" model after medical injury
- Distinguish between "human error" (console), "at-risk behavior" (coach), reckless behavior (punish)
- Conceptually appealing, hard to implement
  - In a recent survey of 500,000 health care workers, half felt their mistakes were held against them.

Major CRP Challenge: Provider Fear of Reporting

- Providers worry that reporting unanticipated outcome may lead to punitive consequences from institution, regulators
  - Mandatory reporting to Medical Quality Assurance Commission required when patient receives compensation >$20K in response to medical error
  - Providing fast, fair financial resolution to patients when care was not reasonable is central tenet of CRP process
- Absence of event reporting by providers preventing analysis, learning

Most Adverse Events Are Not Caused By Incompetent Providers

- Oftentimes, adverse events happen despite high quality care
- When adverse events are associated with care that was not reasonable, usually involve competent provider caught in system failure or who made simple human error

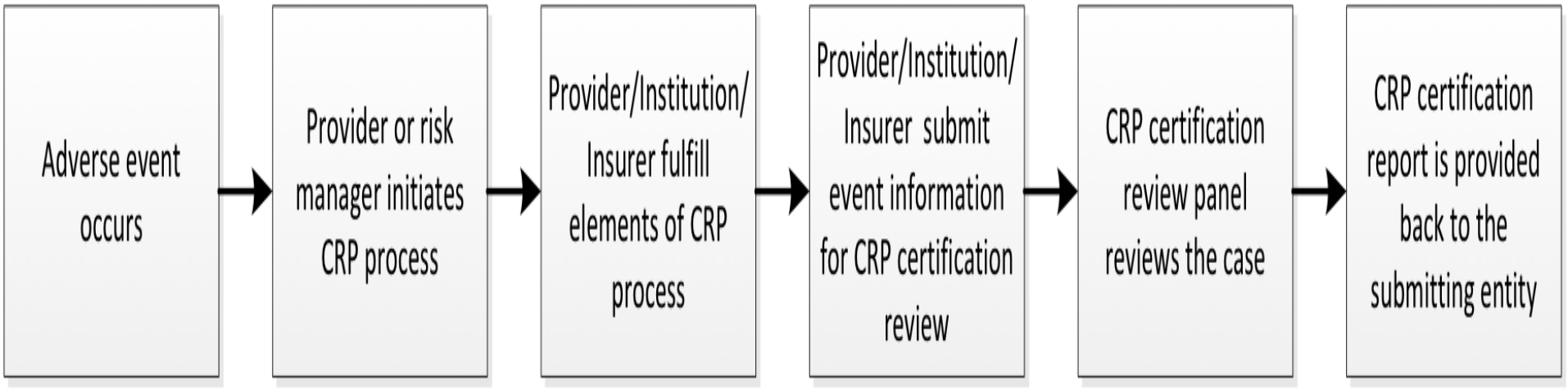
Collaboration between HealthPact and Regulators

- 3-pronged collaboration with MQAC
  - CRP Certification Pilot
  - Align internal policies on medical error with Just Culture: New MQAC Medical Error Guideline
  - Over time, new legislation/formal rulemaking to enhance regulatory response to adverse event

CRP Certification Goals

- Promote learning through early adverse event reporting by providers to their institution/insurer, comprehensive event analysis, and implementation of prevention plans
- Enhance patient-centered accountability

CRP Certification Overview



CRP Certification Basics

- Important exclusions: Gross provider negligence, provider impairment, boundary violations
- Certification process based at Foundation for Healthcare Quality
- MQAC retains all current authority.
- All mandatory reporting requirements remain in effect
  - Responsibility of institution, insurer
- Process is voluntary, open to all Washington physicians
- CRP Certification group will not perform independent investigations

CRP Certification Review

- Case reviewed by multi-disciplinary group including patient advocate, risk/claims specialists, physician leaders, individual with regulatory experience.
  - Reviewers can not be affiliated with institution where event occurred
- Review addresses whether key elements of CRP were met
- Institutions/insurers can resolve CRP deficiencies and resubmit

What Does the Ideal CRP Event Look Like?

- Early event reporting by provider
- Careful analysis by institution-was unanticipated outcome caused by medical error? If so, how can recurrences be prevented?
- Prompt, compassionate disclosure to patient
- Fast, fair resolution for patient
- Learning at individual and institutional level

Dissemination of Lessons Learned

- FHCQ will produce bi-monthly learning briefs for providers and institutions across the state based on information from CRP Certification cases, MQAC cases, other Foundation sources (SCOAP, COAP, etc.)
- Briefings will be produced in collaboration with WSMA and WSHA

CRP Certification: Current Status

- Grant from Greenwall Foundation to pilot, evaluate CRP Certification
- MQAC passed overarching medical error guideline
- CRP Certification Process designed
- DOH-approved CQIP in place
- Reviewers recruited, trained
- Ready to go live
- CRP Certification Working Group

Domains of Needs

- Support for CRPs, CRP Certification, and Just Culture model
- Interprofessional approach to regulation following medical error
- Improved balance between QI protections and information sharing
- More flexible array of tools for regulators
- Stronger mechanisms to share lessons learned

Collaborative

FOR ACCOUNTABILITY AND IMPROVEMENT

Reaching resolution after patient harm

Collaborative Goals

- Strengthen and spread CRPs by providing guidance on best practices and implementation strategies.
- Create a policy environment that supports, rather than inhibits, CRPs.
- Cultivate the growing community of CRP experts to share ideas and collaborate on innovations.

Supporting spread of CRPs

- National
  - Identify, disseminate best practices, tools
  - Fellowship program
  - Internship program
  - Learning community/meetings
- Regional
  - 7 regional CRP implementation nodes across country
- Local
  - Subscription service

Creating a supportive policy environment

- NPDB reform
- Certification
  - Event-level certification
  - Institution-level certification
- Model state legislation
- Close collaboration with patient advocates, regulators

Supporting innovation

- CRP event registry
- Network for research
- Learning community

Summary

- Washington state is poised to become a national leader in patient-centered accountability following medical injury
- CRPs and CRP Certification represent critical steps towards this goal
- Support from all stakeholders is needed to smooth the way

Making the best use of time: Communication skills for patients and providers

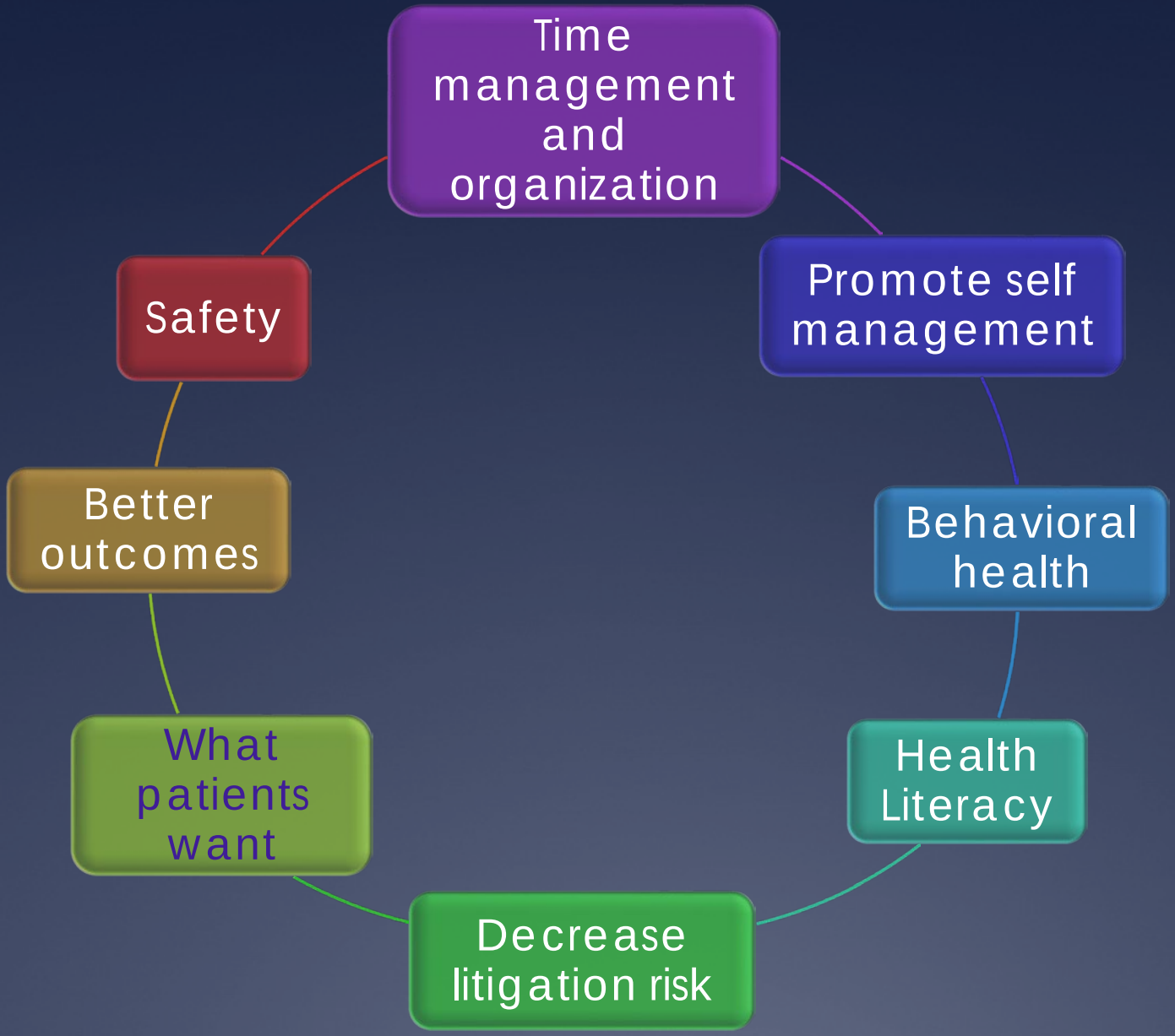
Larry Mauksch, M.Ed
Consultant and Trainer
Clinical Professor Emeritus,
Department of Family Medicine
University of Washington
Editor, Families, Systems, and Health

Objectives

Name and demonstrate skills in a medical encounter that help manage time and maximize quality

Apply these skills for provider and patient use

Why Learn Communication Skills?



Observation Form Purpose and Training

The value

- Structures vision
- Creates and standardizes vocabulary

Primarily for formative assessment and to strengthen the “observer self” (mindfulness)

Online training:
http://uwfamilymedicine.org/pcof

PCOF Use

Behavior in either of the columns to the right of thick vertical line is in the competent range

Observers mark accurately and avoid giving the benefit of the doubt

Feedback is best:

- When solicited
- Specific, rather than general
- Curious, not judgmental

Relationship Communication and Efficiency: Creating a Clinical Model from a Lit Review

Mauksch et al, 2008, Arch of Intern Med, 168 (13) 1387-1395

Ongoing influence

- Rapport and Relationship
- Mindfulness
- Topic Tracking
- Empathic response to cues

Sequential

1. Upfront collaborative agenda setting
2. Understand the patient perspective
3. Co-creating a plan

SMS: problem solving

EEE: Polite Interruption

Excuse yourself (acknowledge and/or apologize)

Empathize with the problem that is being cut off

Explain why you are interrupting

- Planning time use
- Finishing an important topic (topic tracking)
- Stopping to explore an important cue

When to Interrupt

Providers

- When patient repeatedly dives into a story before planning the agenda
- When the patient gives a cue worth exploring
- When the patient changes topics prematurely
- When the patient talks too long and /or become repetitive

Patients

- When providers move too quickly into a diagnostic interrogation before you have listed all concerns
- When the provider is talking too fast or using words you do not understand
- When the provider is creating a plan too fast without knowing your concerns

Relationship Communication and Efficiency

Mauksch et al, July 14 2008, Arch of Intern Med

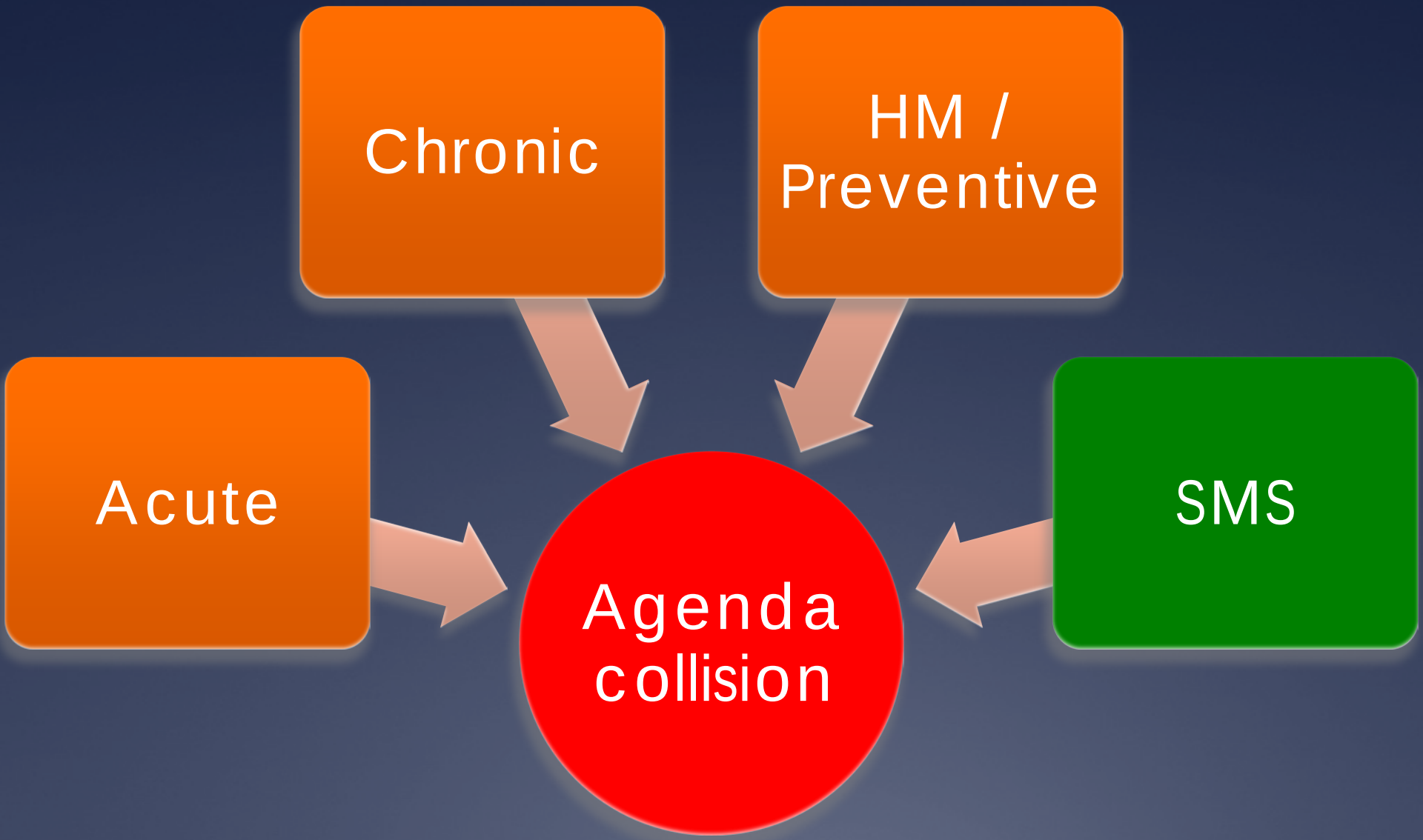
Ongoing influence

- Rapport and Relationship
- Mindfulness
- Topic Tracking
- Empathic response to cues

Sequential

1. Upfront collaborative agenda setting

Visit Organization



Providers: Diving or Agenda Setting

Old	New
What are we doing today?	What is on your list of concerns today?
How are you?	
What can I do for you?	In addition to your ear pain is there something else?
What is going on?	
Tell me about your ear pain.	Let's make a list of your concerns and then figure out how to make the best use of our time?

Agenda Creation

Orient the patient:

"I know you are here to talk about ____. Before we get into_____ is there *something else* important to addresses today? Making a list will help us make the best use of time".

If the list is greater than three items,

the patient is *screen* positive for depression or anxiety

Ask, "what is most important"

- Listen (feel) for the most important concern

Avoid premature diving by patient or yourself

When needed interrupt the patient or yourself:	Acknowledge, Empathize Share reasoning

Patients: Agenda Setting

Bring a prioritized list and give it to the medical assistant or provider

Name:

- Major concerns
- Questions
- Needed refills
- Paperwork

Relationship Communication and Efficiency

Mauksch et al, July 14 2008, Arch of Intern Med

Ongoing influence

- Rapport and Relationship
- Mindfulness
- Topic Tracking
- Empathic response to cues

Sequential

1. Upfront collaborative agenda setting
2. Hypothesis testing and understanding the patient perspective

Explore the Patient Perspective When:

- Promoting self management and behavior change
- Detecting clues about thoughts or feelings
- Family or cultural influences are suspected
- Psychosocial factors may be present
- There are unexplained medical symptoms
- You sense distrust in the health system
- Desired change does not occur
- Contemplating a major health care decision

Empathy

Empathy: The Human Connection to Patient Care (Cleveland Clinic)

Action:

- To label emotional states and attempt to convey what it might feel like to experience this emotion in context
- Be specific and accurate and let the patient edit

Empathy Vs Sympathy

Reference: What is Clinical Empathy, by Halpern (free access)

Relationship Communication and Efficiency

Mauksch et al, July 14 2008, Arch of Intern Med

Ongoing influence

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1. Upfront collaborative agenda setting
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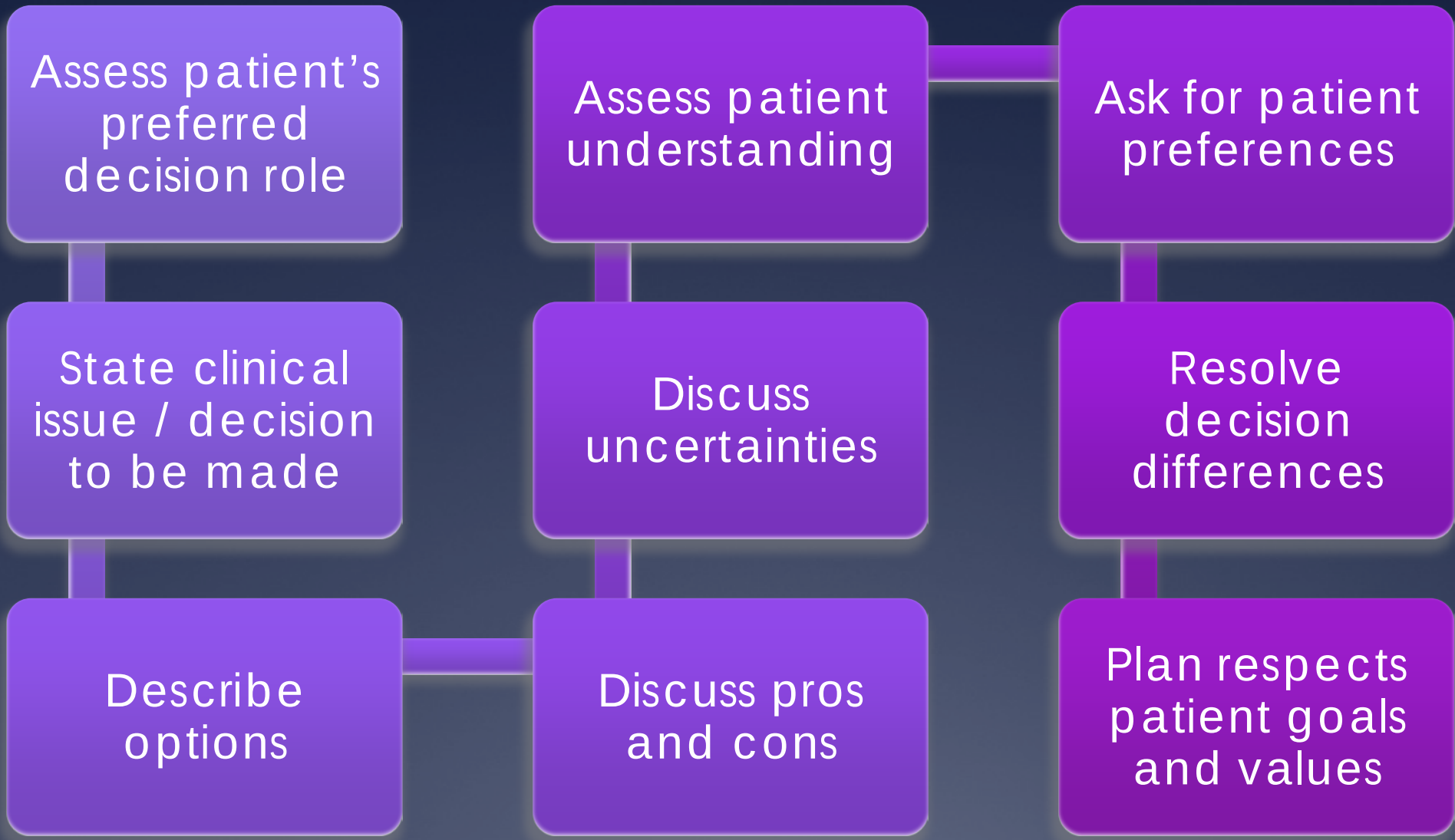
3. Co-creating a plan

Co-creating a Plan



Teachback

Goals:

- To confirm shared understanding between provider and patient
- To refine the plan, when needed
- To deepen the understanding for both patient and provider
- To improve probability of success

Teachback

What teachback is not:

- A way to embarrass the patient or provider
- A way to purposively lengthen the visit
- A gimmick with no evidence
- The sole province of one discipline or provider
- An abnormal communication technique

Sample Text: Provider

"We have discussed a lot today and sometimes I am not clear or complete. Would you mind telling me what you understand the plan to be"

Sample Text: Patient

May I say the plan back to you to make sure I understand?

Closing the visit

- Questions
- Teachback
- After visit summary
- Combine Teachback and AVS and share the screen

Patient Centered Observation Form:
MA/Nurse

Trainee name_____ Observer_____Obsrvn#____Date_____

Directions: *Directions; Track behaviors in left column. Then, mark one box per row: a, b or c. Competent skill use is in one of the right two columns. Record important MA/ Nurse or patient comments and verbal / non-verbal cues in the notes. Use form to enhance your learning, vocabulary, and self-awareness. Ratings can be for individual interviews or to summarize several interactions. If requested, use this form to guide verbal feedback to someone you observe.*

Element	MA/Nurse Centered Biomedical Focus ⟷ Patient Centered Biopsychosocial Focus		
Establishes Rapport ☐ Introduces self ☐ Warm greeting ☐ Acknowledges all in the room by name ☐ Uses eye contact ☐ Humor or non medical interaction	☐ 1a.Uses 0-2 elements	☐ 1b.Uses 3 elements	☐ 1c.Uses ≥ 4 elements
Maintaining Relationship Through the Interaction ☐ Uses verbal or non-verbal empathy, including during vitals ☐ Listens well using continuer phrases ("um hmm") ☐ Paraphrases important verbal content; ☐ *Demonstrates mindfulness through curiosity, intent focus, not seeming "rushed" or by acknowledging distractions*	☐ 2a. Uses 0-1 elements	☐ 2b. Uses 2 elements	☐ 2c. Uses 3 or more elements
Collaborative upfront agenda setting ☐ Additional elicitation- "something else?"- <u>each elicitation counts as a new element</u> ☐ Acknowledges agenda items from other team member (eg receptionist), from form, or from EMR. ☐ Confirms what is most important to patient?	☐ 3a. Uses 0-1 elements	☐ 3b. Uses 2 elements	☐ 3c. Uses ≥ 3 elements **NAME THE PROBLEMS RAISED BY PATIENT OR MA/Nurse:**
Maintains Efficiency through transparent (out loud) thinking: ☐ *about visit MA/Nurse time use* ☐ *about entire visit organization* ☐ *about problem solving strategies* ☐ *Respectful interruption/redirection using EEE: **E**xcuse your self, **E**mpathize/validate issue being interrupted, **E**xplain the reason for interruption (eg, for Agenda setting, Topic tracking)*	☐ 4a. Uses 0 elements	☐ 4b. Uses 1 element	☐ 4c. Uses 2 or more elements
Basics: Vitals, Checks Meds and Paperwork ☐ Prepares patient and shares vital findings ≥ 2 times ☐ Asks about paperwork ☐ Asks about refills ☐ Medication reconcilliation	☐ 5a. Uses 0-1 elements	☐ 5b. Uses 2 elements	☐ 5c. Uses 3 elements
Patient Activation and Engagement **(encourages pt to bring up important issues)** ____ # of clues ☐ Explores patient verbal cue about psychosocial or physical concern ☐ Explores patient non-verbal cue about underlying concern ☐ Asks if patient has questions ☐ Encourages patient to address concerns with provider ☐ Explores contextual influences: family, cultural, spiritual	☐ 6a. Uses 0-1 elements	☐ 6b. Uses 2 elements	☐ 6c. Uses ≥ 3 elements

University of Washington Department of Family Medicine

Patient Centered Observation Form:
MA/Nurse

Trainee name_____ Observer_____Obsrvn#____Date_____

Element	MA/Nurse Centered Biomedical Focus ◄——► Patient Centered Biopsychosocial Focus		
Electronic Medical Record Use ☐ *Regularly describes use of EMR to patient* ☐ *Maintains eye contact with patient during majority of time while using EMR.* ☐ *Positions monitor to be viewed by patient* ☐ *Points to screen*	☐ 7a. Uses 0 or 1 5elements.	☐ 7b. Uses 2 elements	☐ 7c. Uses 3 or 4 elements
Gathering Information ☐ *Collects focused history per problem* X____ ☐ *Uses reflecting statement* X____ ☐ *Uses summary/clarifying statement* X____ *Count each time the skill is used as one element_*	☐ 8a. Uses 0 elements	☐ 8b. Uses 1-2 elements	☐ 8c. Uses 3 or more elements
Notes:			
Self management support: Goal setting and action plan development NOT PRESENT IN EVERY INTERVIEW ☐ Asks if patient wants to create a health goal ☐ Asks patient to brainstorm activities to reach goal ☐ Asks patient to chose one activity ☐ Asks patient to name activity frequency ☐ Asks patient to identify time for activity ☐ Assesses patient confidence (1 through 10) ☐ Assesses patient barriers	☐ 9a. Uses 0-2 elements.	☐ 9b. Uses 3-5 elements	☐ 9c. Uses ≥ 6 elements
Self management Follow-up: Checking on progress, revision ☐ Assesses progress on prior goals ☐ Problem solves with patient to revise action plan ☐ Celebrates patient successes ☐ "Normalizes" struggles with self management ☐ Ask about including action plan in today's agenda	☐ 10a. Uses 0-1 elements	☐ 10b. Uses 1-3 elements	☐ 10c. Use ≥ 4 elements
Closure and System Navigation ☐ Asks for questions about today's topics. ☐ Assesses patient comfort with system navigation ☐ Provides system navigation aid ☐ Uses Teachback. = Asking the patient to explain his/her understanding of the plan ☐ Prints After Visit Summary ☐ *Combines Teachback and AVS creation while sharing the screen. (Counts for 3 elements)*	☐ 11a. Uses 0-1 elements	☐ 11.b Uses 2-3 elements	☐ 11c. Use ≥ 4 elements

Patient Centered Observation Form- Clinician version

Trainee name_____ Observer_____Obsrvn#____Date_____

Directions; Track behaviors in left column. Then, mark one box per row: a, b or c. Competent skill use is in one of the right two right side columns. Record important provider / patient comments and verbal / non-verbal cues in the notes. Use form to enhance your learning, vocabulary, and self-awareness. Ratings can be for individual interviews or to summarize several interactions. If requested, use this form to guide verbal feedback to someone you observe.

Skill Set and elements ***Check only what you see or hear.*** ***Avoid giving the benefit of the doubt.***	*Provider Centered Biomedical Focus* ⟷ *Patient Centered Biopsychosocial Focus*		
Establishes Rapport ☐ *Introduces self* ☐ *Warm greeting* ☐ *Acknowledges all in the room by name* ☐ *Uses eye contact* ☐ *Humor or non medical interaction*	☐ 1a. Uses 0-2 elements	☐ 1b.Uses 3 elements.	☐ 1c.Uses ≥ 4 elements
Notes:			
Maintains Relationship Throughout the Visit ☐ *Uses verbal or non-verbal empathy during discussions or during the exam* ☐ *Uses continuer phrases ("um hmm")* ☐ *Repeats important verbal content* ☐ *Demonstrates mindfulness through presence, curiosity, intent focus, not seeming "rushed" or acknowledging distractions*	☐ 2a. Uses 0-1 elements	☐ 2b. Uses 2 elements	☐ 2c. Uses 3 or more elements
Notes:			
Collaborative upfront agenda setting ☐ *Additional elicitation- "something else?" * X_____* ** each elicitation counts as a new element* ☐ *Acknowledges agenda items from other team member (eg MA) or from EMR.* ☐ *Asks or confirms what is most important to patient.*	☐ 3a. Uses 0-1 elements	☐ 3b. Uses 2 elements	☐ 3c. Uses ≥ 3 elements
Note patient concerns here:			
Maintains Efficiency using transparent (out loud) thinking and respectful interruption: ☐ *Talks about visit time use / visit organization* ☐ *Talks about problem priorities* ☐ *Talks about problem solving strategies* ☐ *Respectful interruption/redirection using EEE: **E**xcuse your self, **E**mpathize/validate issue being interrupted, **E**xplain the reason for interruption (eg, for Topic tracking)*	☐ 4a. Uses 0 elements	☐ 4b. Uses 1 element	☐ 4c. Uses 2 or more elements
Notes:			
Gathering Information ☐ *Uses open-ended question* X____ ☐ *Uses reflecting statement* X____ ☐ *Uses summary/clarifying statement* X____ *Count each time the skill is used as one element*	☐ 5a. Uses 0-1 elements	☐ 5b. Uses 2 elements	☐ 5c. Uses 3 or more elements
Notes:			
Assessing Patient or Family Perspective on Health ☐ *Acknowledges patient verbal or non-verbal cues.* ☐ *Explores patient beliefs or feelings* ☐ *Explores contextual influences: family, cultural, spiritual.* *Number of patient verbal / non-verbal cues___*	☐ 6a. Uses 0 elements	☐ 6b. Uses 1 element	☐ 6c. Uses 2 or more elements
Notes:			

Contact Larry Mauksch for further information <Mauksch@uw.edu>

Patient Centered Observation Form- Clinician version

Trainee name_____ Observer_____Obsrvn#____Date_____

Skill Set and elements ***Check only what you see or hear.*** ***Avoid giving the benefit of the doubt.***	*Provider Centered* *Biomedical Focus* ⟷		*Patient Centered* *Biopsychosocial Focus*
Electronic Medical Record Use ☐ *Regularly describes use of EMR to patient* ☐ *Maintains eye contact with patient during majority of time while using EMR.* ☐ *Positions monitor to be viewed by patient* ☐ *Points to screen*	☐ 7a. Uses 0 or 1 elements.	☐ 7b. Uses 2 elements	☐ 7c. Uses 3 or 4 elements
Notes:			
Physical Exam ☐ *Prepares patient before physical exam actions **and** describes exam findings during the exam* *("I am going to ___ " then "your lungs sound healthy")*	☐ 8a. 0-1 exam elements (eg., lungs)	☐ 8b. 2 exam elements (eg, heart, lung)	☐ 8c. > 2 exam elements (eg, heart, lung, ears)
Notes:			
Sharing Information ☐ *Avoids or explains medical jargon* ☐ Summaries cover biomedical concerns ☐ *Summaries cover psychosocial concerns.* ☐ *Invites Q/A*	☐ 9a. Uses 0-1 elements	☐ 9b. Uses 2 elements	☐ 9c. Uses 3 or more elements
Notes:			
Behavior Change Discussions ☐ *Explores pt knowledge about behaviors* ☐ *Explores pros and cons of behavior change* ☐ *Scales importance of or confidence in change (1- 10)* ☐ *Asks permission to give advice* ☐ *Reflects comments about: desire, ability, reason, need, or commitment to change (respects ambivalence)* ☐ *Creates a plan aligned with patient's readiness (see MA/nurse version of PCOF* ☐ *Affirms behavior change effort or success*	☐ 10c. Uses 0-1 elements or lectures patient	☐ 10b. Uses 2-3 elements	☐ 10c. Uses 4 or more elements
Notes:			
Co-creating a plan ☐ *Assesses patient preferred decision making role* ☐ *States the clinical issue or decision to be made* ☐ *Describes options* ☐ *Discusses pros and cons* ☐ *Discusses uncertainties with the decision* ☐ *Assesses patient understanding* ☐ *Asks for patient preferences* ☐ *Identifies and resolves decisional differences* ☐ *Plan respects patients goals and values*	☐ 11a. Use 0-2 element	☐ 11b. Uses 3-4 elements	☐ 11c. Uses ≥ 5 elements
Notes:			
Closure ☐ *Asks for questions about today's topics.* ☐ *Co-creates and prints a readable After Visit Summary* ☐ *Uses Teachback. = Asking the patient to explain his/her understanding of the plan* ☐ *Combines Teachback and AVS creation while sharing the screen or notepad. (Counts for 3 elements)*	☐ 12a. Uses 0-1 element	☐ 12b. Uses 2 elements	☐ 12c. Uses 3 elements
Notes:			

Contact Larry Mauksch for further information <Mauksch@uw.edu>

Communication: The Way to Patient Safety

Focus on Maternal Well-Being: A Guideline for Clinicians

Washington State Medical Commission Annual Conference

Joseph Hwang, MD FACOG
Maternal Fetal Medicine
University of Washington
Seattle, WA

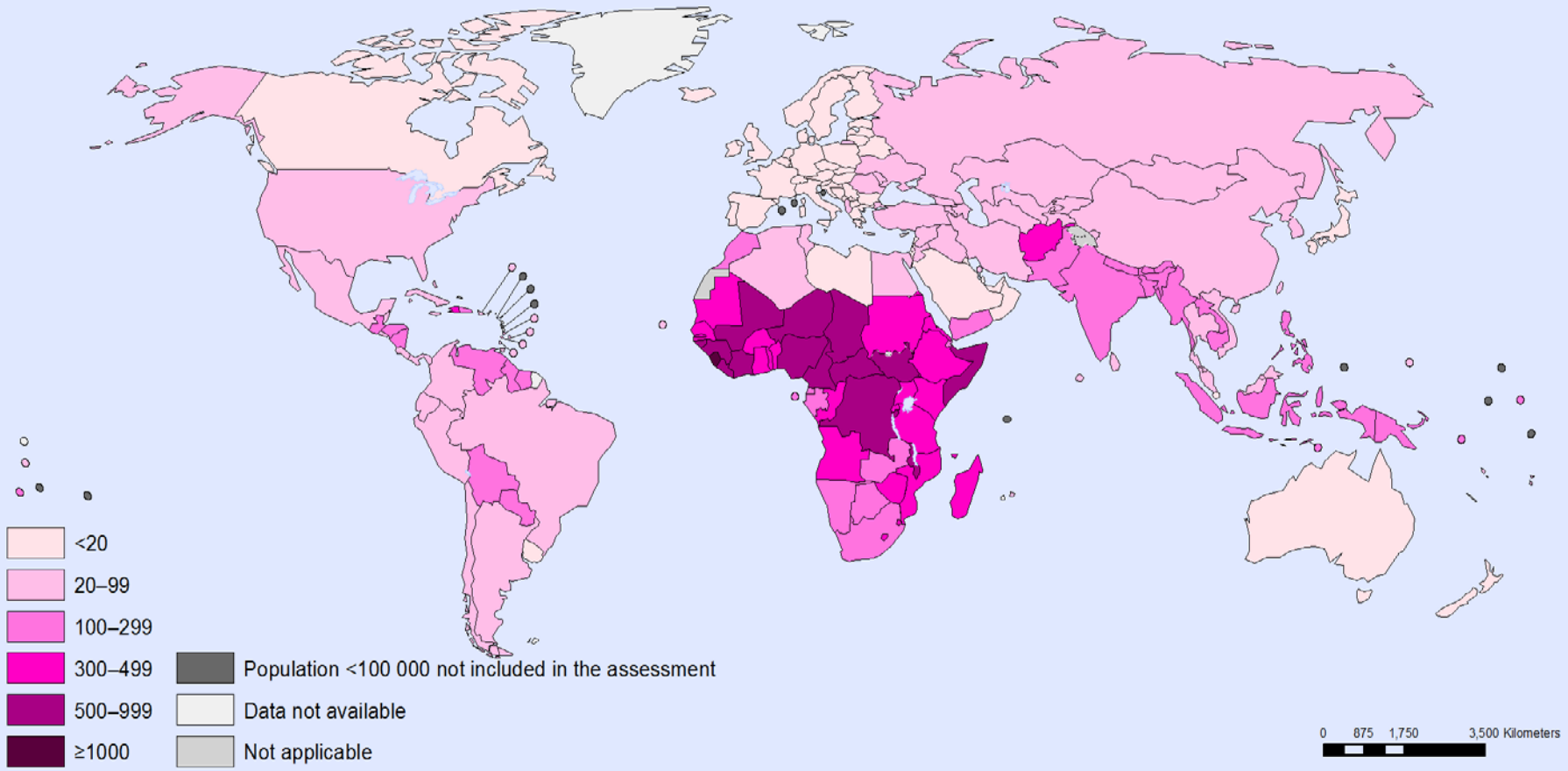
Disclosure

No conflict

Objectives

- New epidemiology on maternal morbidity and mortality.
- Common conditions associated with adverse maternal outcomes.
- Strategies to reduce maternal complications.
- Guidelines in the literature.
- Algorithm for practicing clinicians.

Maternal mortality ratio (per 100 000 live births), 2013



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

SAVING MOTHERS' LIVES

World Health Organization

Almost **800 women** die every day due to complications in pregnancy and childbirth.

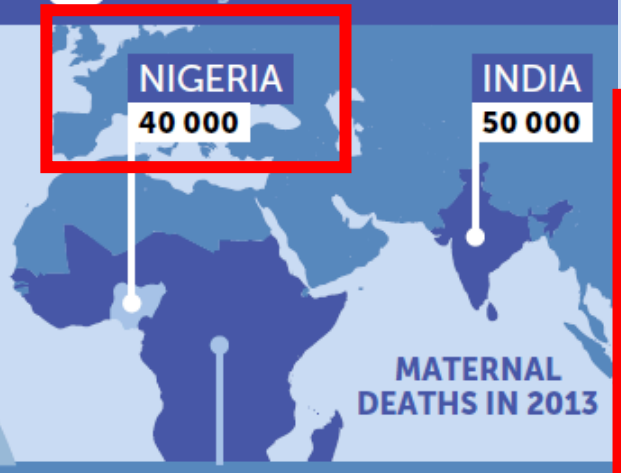
YEAR	DEATHS
1990	523 000
2013	289 000

Lifetime risk of dying during pregnancy and childbirth

- 1 in 3300 — EUROPE
- 1 in 40 — AFRICA

World Health Organization

ONE THIRD of total global deaths are in two countries



The most dangerous place for a woman to have a baby is in sub-Saharan Africa.

WHAT IS NEEDED TO **SAVE** MORE LIVES?

- Quality care before, during & after childbirth
- Safe blood supplies
- Essential medicines such as antibiotics and oxytocin
- Contraception & safe abortion services
- Every death is counted & its cause recorded

Global causes of maternal death: a WHO systematic analysis

Lale Say, Doris Chou, Alison Gemmill, Özge Tunçalp, Ann-Beth Moller, Jane Daniels, A Metin Gülmezoglu, Marleen Temmerman, Leontine Alkema

CAUSES	Developing Countries	Developed Countries
Abortion	7.9	7.5
Embolism	3.1	13.8
Hemorrhage	27.1	16.3
Hypertension	14.0	12.9
Sepsis	10.7	4.7
Other direct causes	9.6	20
Indirect causes	27.5	24.7

Lancet Glob Health 2014; 2: e323–33

Maternal Mortality: WHO Definition

"the death of a woman whilst pregnant or within 42 days of delivery or termination of pregnancy, from any cause related to, or aggravated by pregnancy or its management, but excluding deaths from incidental or accidental causes"

WHO. International Classifi cation of Diseases and Related Health Problems. Geneva: World Health Organization, 1992

CDC Definition: within 1 year

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

SEARCH

A-Z Index A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

Reproductive Health

- **Reproductive Health**
- About Us
- Data and Statistics
- Emergency Preparedness
- Maternal and Child Health Epidemiology Program
- Pregnancy Risk Assessment Monitoring System
- Infertility
- Assisted Reproductive Technology
- Depression and Postpartum Depression
- Maternal and Infant Health
  - Pregnancy Complications

Reproductive Health > Maternal and Infant Health > Pregnancy-Related Deaths

Pregnancy Mortality Surveillance System

When did CDC start conducting national surveillance of pregnancy-related deaths?

CDC initiated national surveillance of pregnancy-related deaths in 1986 because more clinical information was needed to fill data gaps about causes of maternal death.

How does CDC define pregnancy-related deaths?

For reporting purposes, a pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of pregnancy termination—regardless of the duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

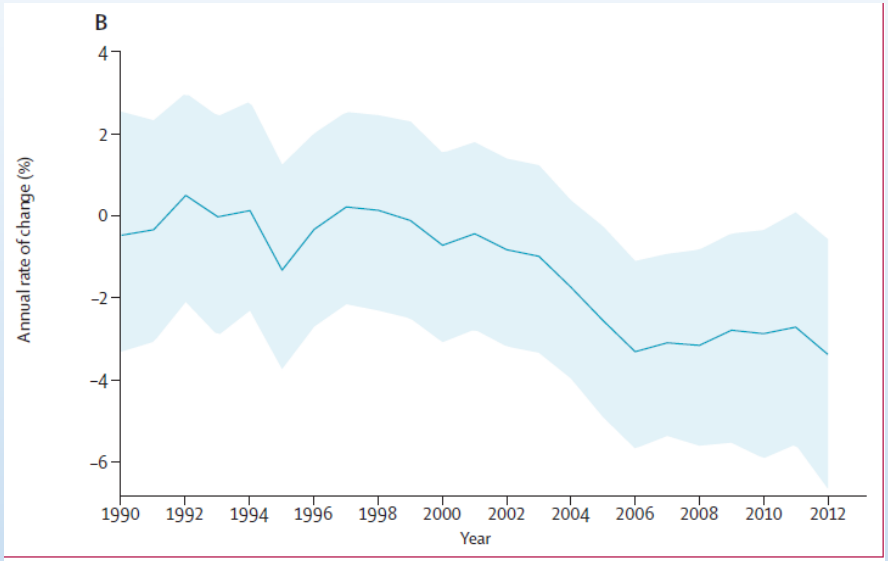
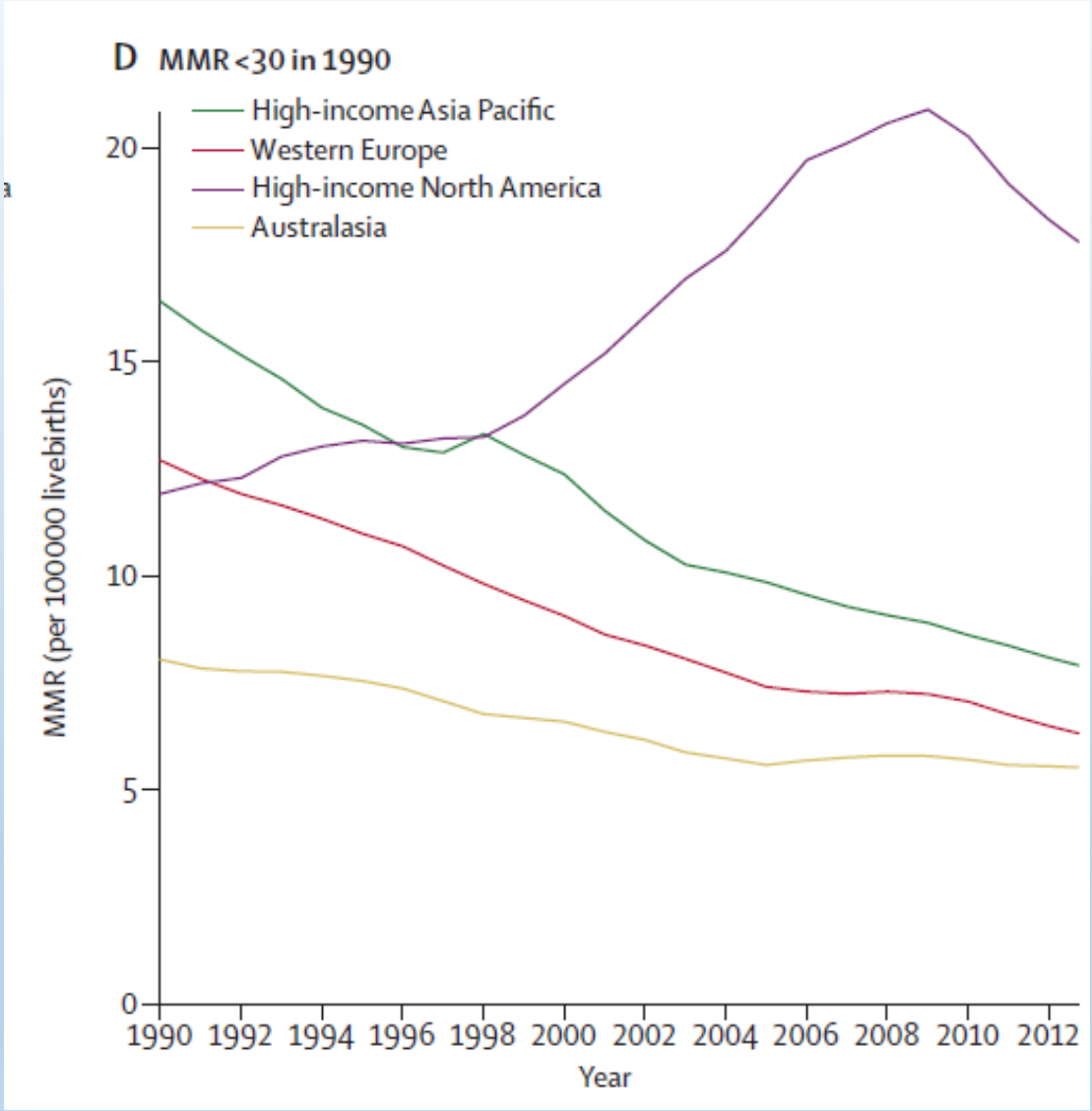


Figure 3: Global maternal deaths (A) and annualised rate of change in maternal mortality ratio (B), 1990–2013
Shaded areas show 95% uncertainty intervals.

While Global MMR is trending down,

	Maternal mortality ratio (per 100 000 livebirths)			Number of maternal deaths			Annualised rate of change in maternal mortality ratio (%)		
	1990	2003	2013	1990	2003	2013	1990–2003	2003–13	1990–2013
High-income North America	11·9 (10·7 to 13·3)	17·0 (15·1 to 18·8)	17·6 (14·3 to 21·6)	555 (499 to 621)	784 (697 to 867)	829 (672 to 1016)	2·7% (1·5 to 3·8)	0·3% (–1·8 to 2·6)	1·7% (0·7 to 2·6)
Canada	7·1 (6·0 to 8·3)	9·2 (7·6 to 10·7)	8·2 (6·3 to 10·3)	28 (24 to 33)	32 (27 to 37)	33 (25 to 42)	2·0% (0·2 to 3·6)	–1·2% (–3·7 to 1·3)	0·6% (–0·7 to 1·9)
USA	12·4 (11·1 to 13·9)	17·6 (15·7 to 19·5)	18·5 (14·8 to 22·9)	527 (472 to 592)	752 (669 to 833)	796 (638 to 985)	2·7% (1·4 to 3·8)	0·5% (–1·8 to 2·8)	1·7% (0·8 to 2·7)

www.thelancet.com Published online May 2, 2014



USA

USA MMR has gone up by 2.7% in the last 13 years.

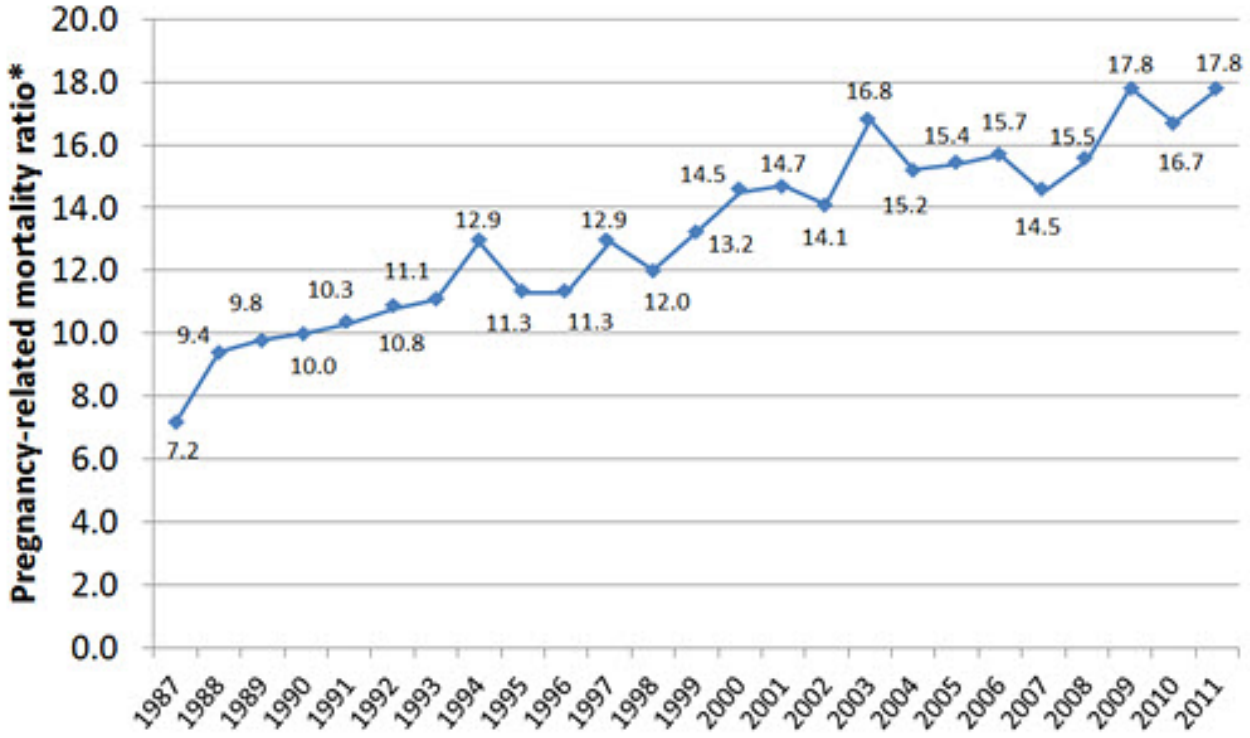
ASIA

Europe

Australia

www.thelancet.com Published online May 2, 2014

Trends in pregnancy-related mortality in the United States: 1987–2011



**Note:* Number of pregnancy-related deaths per 100,000 live births per year.

Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

Maternal Age and MMR

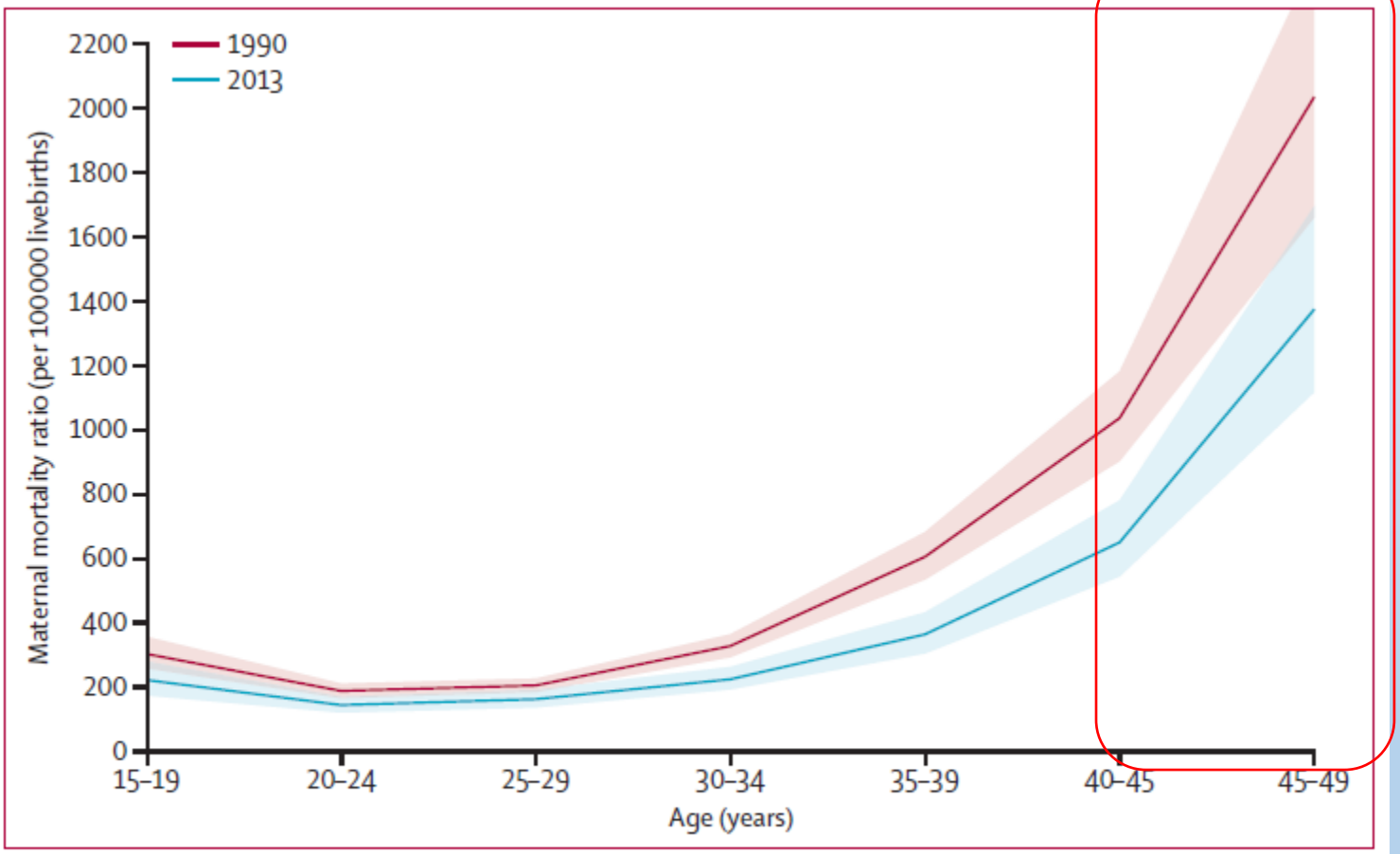


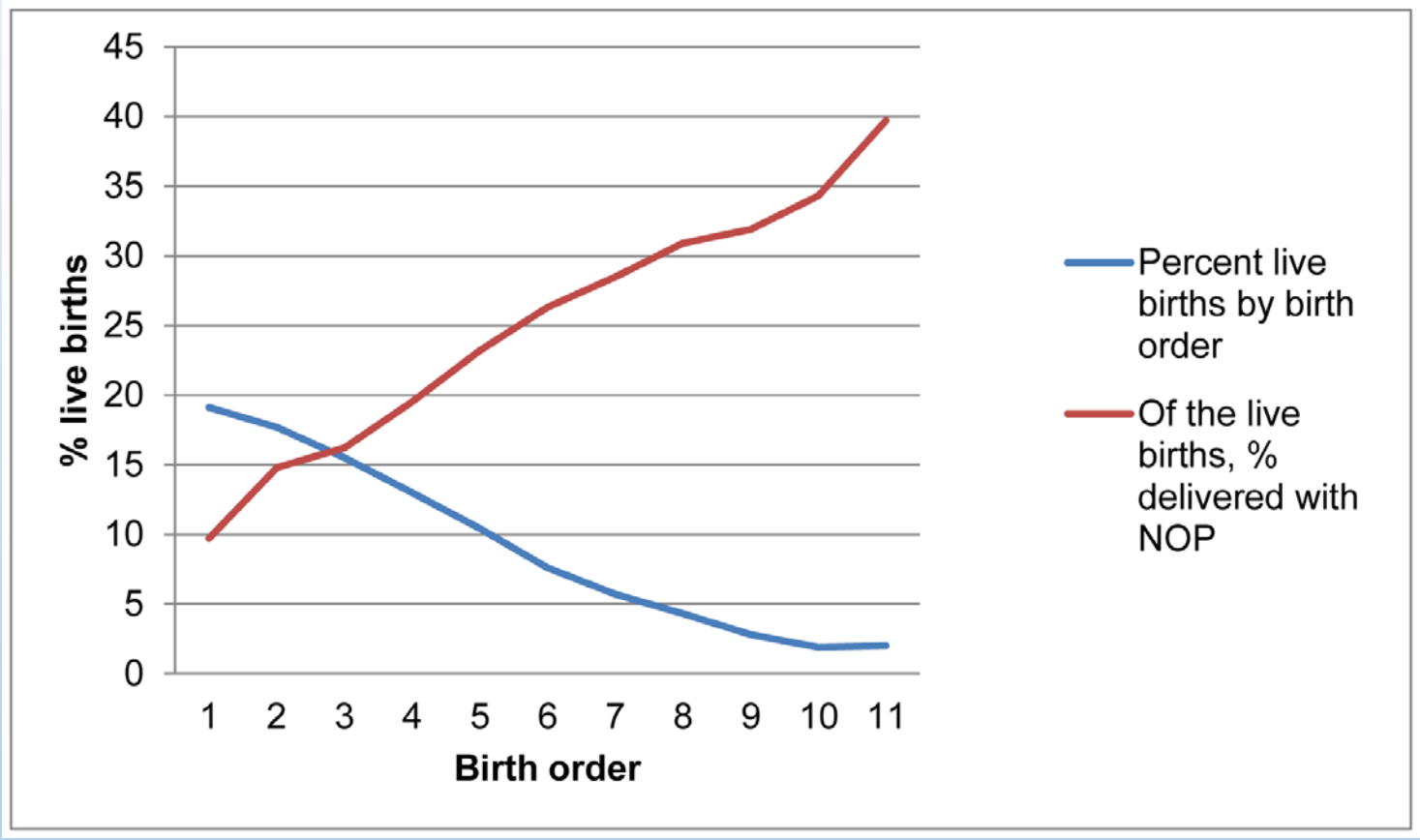
Figure 4: Global maternal mortality ratio in 1990 and 2013, by age
Shaded areas show 95% uncertainty intervals.

www.thelancet.com Published online May 2, 2014

Global Perspective

- More birth attendants
- Basic medical necessity
- Blood banks
- Contraception

NOP Delivery in Nigeria



Fapohunda BM, Orobaton NG (2013) When Women Deliver with No One Present in Nigeria: Who, What, Where and So What? PLoS ONE 8(7): e69569.

MMR in the USA

- Older gravida.
- Co-existing medical conditions.
- Obesity.
- Is there anything else?

"Most deaths occur in women who are classified as being at low risk for death at the beginning of pregnancy."

JULY 2008 American Journal of Obstetrics & Gynecology 37

Maternal Mortality

INDIRECT CAUSES

27.5%

DIRECT OBSTETRICAL CAUSES

73%

What is dangerous to moms?

	Developed countries	Africa	Asia	Latin America and the Caribbean
Number of datasets	5	8	11	10
Number of maternal deaths	2823	[illegible]	[illegible]	11 777
Haemorrhage	13·4% (4·7–24·4)	[illegible]	[illegible]9–48·5)	20·8% (1·1–46·9)
Hypertensive disorders	16·1% (6·7–24·3)	9·1% (3·9–21·9)	9·1% (2·0–34·3)	25·7% (7·9–52·4)
Sepsis/infections	2·1% (0·0–5·9)	9·7% (6·3–12·6)	11·6% (0·0–13·0)	7·7% (0·0–15·1)
Abortion	8·2% (0·0–48·6)	3·9% (0·0–23·8)	5·7% (0·0–13·0)	12·0% (0·0–32·9)
Obstructed labour	[illegible]	[illegible]	[illegible]12·0)	13·4% (0·0–38·9)
Anaemia	[illegible]	[illegible]	[illegible]17·3)	0·1% (0·0–3·9)
HIV/AIDS	0·0%* (0·0–0·0)	6·2% (0·0–13·3)	0·0%* (0·0–0·0)	0·0%* (0·0–0·0)
Ectopic pregnancy	4·9% (0·4–7·4)	0·5% (0·0–3·3)	0·1% (0·0–3·9)	0·5% (0·0–4·5)
Embolism	14·9% (0·0–21·2)	2·0% (0·0–5·6)	0·4% (0·0–51·0)	0·6% (0·0–8·4)
Other direct causes	21·3% (0·0–33·9)	4·9% (0·0–10·[illegible])	1·6% (0·0–25·9)	3·8% (0·0–27·9)
Other indirect causes	14·4% (0·0–51·[illegible])	[illegible]	2·5% (0·0–29·2)	3·9% (0·0–25·3)
Unclassified deaths	4·8% (0·0–22·[illegible])	3·4% (0·0–21·8)	6·1% (0·0–16·2)	11·7% (0·0–20·4)

Hemorrhage

Hypertension

Embolism

Data are pooled percentages (range), unless stated otherwise. *Zero indicates that the condition is not reported as a cause of death. Deaths from that cause could have occurred but listed under other or unclassified deaths.

Table 1: Joint distribution of causes of maternal deaths

Maternal Deaths in the USA

- Hospital Corporation of America (HCA).
- 1.5 million deliveries in 125 hospitals over 7 year period.
  - 16% Preeclampsia related.
  - 14% amniotic fluid embolism.
  - 12% obstetrical hemorrhage
  - 11% cardiac disease
  - 9% pulmonary embolism
  - 15% Preexisting medical conditions.

Maternal death in the 21st century: causes, prevention, and relationship to cesarean delivery

Steven L. Clark, MD; Michael A. Belfort, MD; Gary A. Dildy, MD; Melissa A. Herbst, MD; Janet A. Meyers, RN; Gary D. Hankins, MD

Maternal Deaths in the USA

- 18% "Preventable" with more appropriate care.
- 4 deaths directly from C/S.
  - 3 deaths from vessel injury on primary C/S.
  - 1 death from bowel injury.
- 2 deaths from vaginal deliveries.
  - 1 Uterine inversion.
  - 1 Berry aneurysm.

Maternal death in the 21st century: causes, prevention, and relationship to cesarean delivery

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Maternal Deaths in the USA

- Retrospective review of a large system.

TABLE

Causal relationship between route of delivery and maternal death

Delivery type	Number of procedures	Number of deaths causally related to route of delivery	Frequency of deaths causally related to route of delivery (per 100,000 procedures)
Vaginal	1,003,173	2	0.20
Primary cesarean	282,632	7	2.5
Repeat cesarean	175,465	2	1.1
Total cesarean	458,097	9	2.0
Total	1,461,270	20	1.4

For vaginal birth vs total cesarean and vaginal birth vs primary cesarean, $P < .001$. For vaginal birth vs repeat cesarean, $P = 0.12$. For primary cesarean vs repeat cesarean, $P = .50$. For vaginal delivery vs primary, repeat, and total cesarean delivery, excluding pulmonary embolism deaths preventable with universal prophylaxis, $P = .07$, $P = .38$, $P = .08$.

Clark. Maternal death in the 21st century. Am J Obstet Gynecol 2008.

Maternal death in the 21st century: causes, prevention, and relationship to cesarean delivery

Steven L. Clark, MD; Michael A. Belfort, MD; Gary A. Dildy, MD; Melissa A. Herbst, MD; Janet A. Meyers, RN; Gary D. Hankins, MD

What Can We Do as Clinicians?

- Pre-conceptional counseling
- Antenatal Management
- Intrapartum Management
- Medical Management
- System Optimization
- More Research

Preconceptional Counseling

- Unplanned pregnancy
  - Contraceptive nonuse and misuse
- Teenage pregnancy
- Co-existing medical conditions
  - Pulmonary hypertension
  - Severe cardiac anomalies/dysfunction

Antenatal Management

- Early warning
- Do not prolong pregnancy more than necessary.
- Be aware of protocols
- 98% Neonatal survival after 34 weeks.

Intrapartum Management

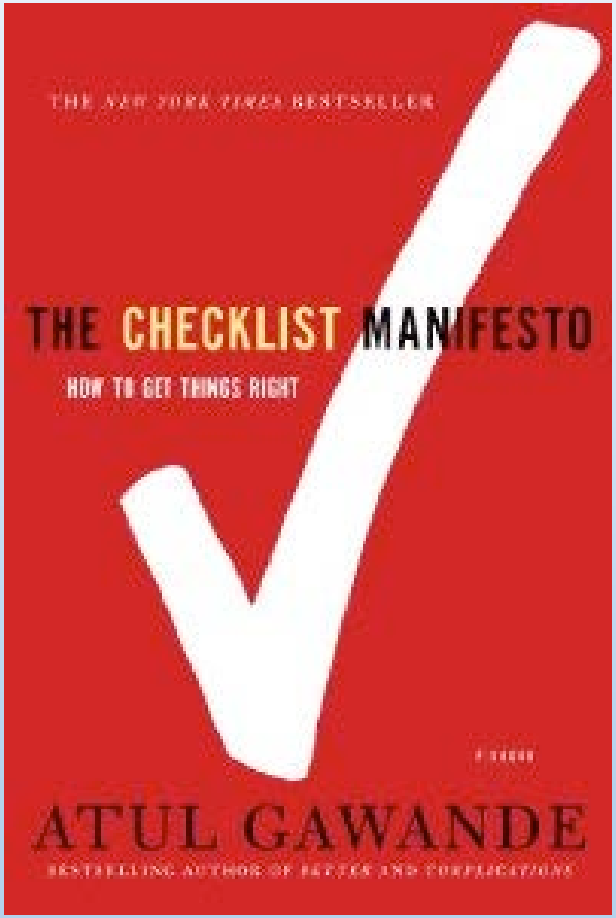
- Appropriate use of anti-hypertensives
- MgSO4 seizure prophylaxis
- DVT prophylaxis
- Massive Transfusion Protocol
- Transfer to tertiary centers
- Mock drills

System Optimization

- Checklists & Protocols.
  - PPH, HTN, DVT
- Appropriate Triage & Regionalization.
  - Not just fetal, but for maternal.
- Experts in the care of complicated pregnant patients.
  - Cross-field communication.

Checklist

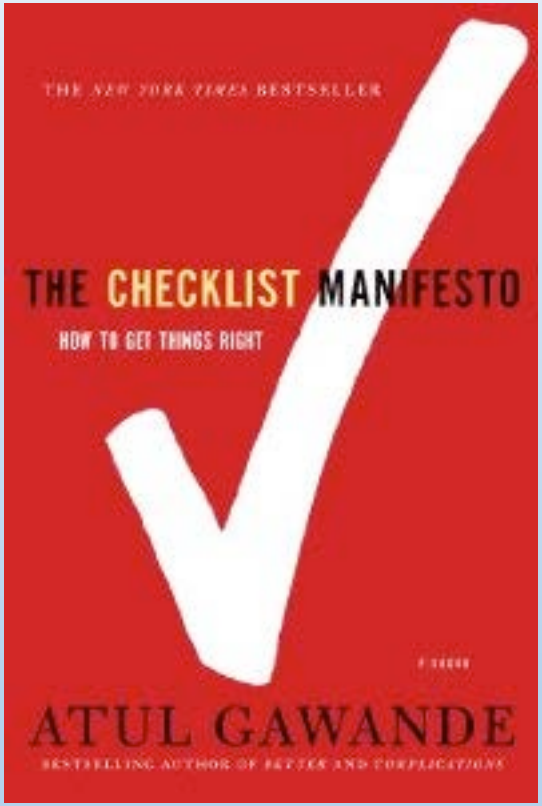
- Precise and efficient.
- Makes priority clearer.
- Make people to function better as team.
- Cannot make anyone follow them.



Algorithms in the literature

- Protocols and Checklist can help in dire situations.
- HCA instituted protocols in:
  - Hypertension management.
  - SCD in all C/S.

JULY 2014 **American Journal of Obstetrics & Gynecology**



OBSTETRICS

Maternal mortality in the United States: predictability and the impact of protocols on fatal postcesarean pulmonary embolism and hypertension-related intracranial hemorrhage

Steven L. Clark, MD; James T. Christmas, MD; Donna R. Frye, RN; Janet A. Meyers, RN; Jonathan B. Perlin, MD, PhD

IMPLEMENTATION OF SPECIFIC PROTOCOLS

- SCD IN ALL C/S.
- AGGRESSIVE HTN MANAGEMENT
- AGGRESSIVE HEMORRHAGE MANAGEMENT.

Hypertension Management Protocol

FIGURE 1
Blood pressure management of severe intrapartum or postpartum hypertension with hydralazine

HCA WOMEN'S AND CHILDREN'S CLINICAL SERVICES

Blood Pressure Management of Severe Intrapartum or Postpartum Hypertension using Hydralazine

FIGURE 2
Blood pressure management of severe intrapartum or postpartum hypertension with labetalol

HCA WOMEN'S AND CHILDREN' CLINICAL SERVICES RECOMMENDED

Blood Pressure Management of Severe Intrapartum or Postpartum Hypertension using Labetalol

Hypertension Management Protocol

- If SBP >160 mmHg OR DBP >110 mmHg,
  - Notify Physician
  - Administer hydralazine 5 mg IV over 2 min.
  - Repeat BP in 15 min.
  - Repeat hydralazine 5 mg IV again over 2 min.
  - Administer Labetalol 20 mg IV over 2 min.
  - Administer Labetalol 40 mg IV over 2 min.
  - Consult stat MFM or internal medicine, or anesthesia

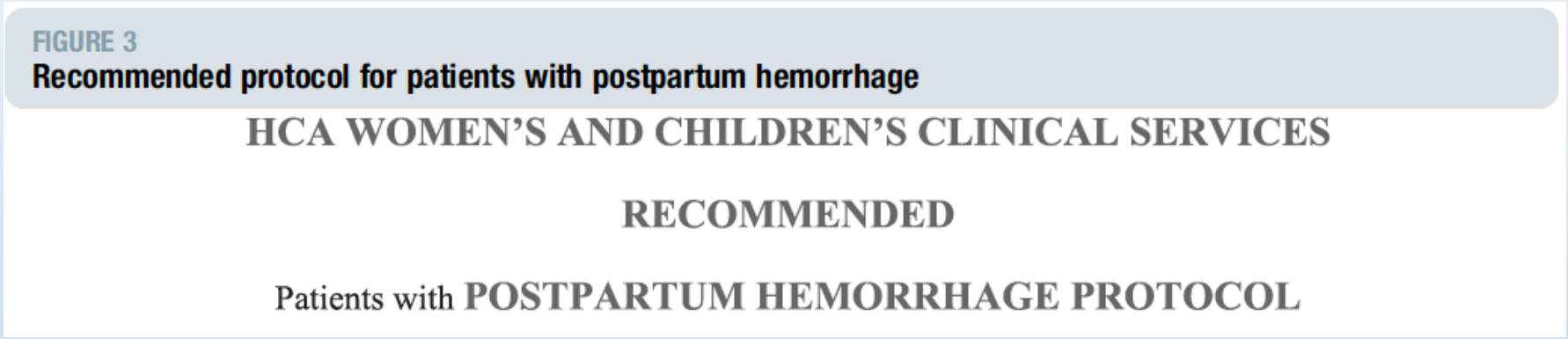
JULY 2014 American Journal of Obstetrics & Gynecology 32.e4

PP Hemorrhage

- Declare and Mobilize team.
- Activate Blood Bank.
- Look for etiology.
- Have Pharmacological agents available.
- Prepare for Surgical exploration.
- ICU management

PP Hemorrhage Protocol

FIGURE 3
Recommended protocol for patients with postpartum hemorrhage



- LEVEL 1 – EBL >500 CC
  - Bring hemorrhage cart to room.
  - Weigh all sponges and laps to quantify losses.

PP Hemorrhage Protocol

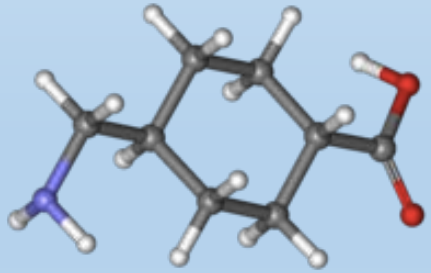
- LEVEL 2 – EBL > 1000 CC
  - Call OB doc stat for bedside examination.
  - Notify anesthesia and OR.
  - Start second IV with 16G catheter.
  - 30 U pitocin to 500 cc NS wide open.
  - Firm fundal massage, vaginal exam, weigh clots.
  - Vital signs Q15 min.
  - O2 via tight face mask at 10 L/min.
  - Foot of bed elevated.
  - Stat labs: CBC, T&S, PTT, fibrinogen.
  - T&C 2 u pRBC
  - Foley catheter w/ urimeter.
  - RN asks OB to define the cause of bleeding.
  - Cont spO2 monitoring

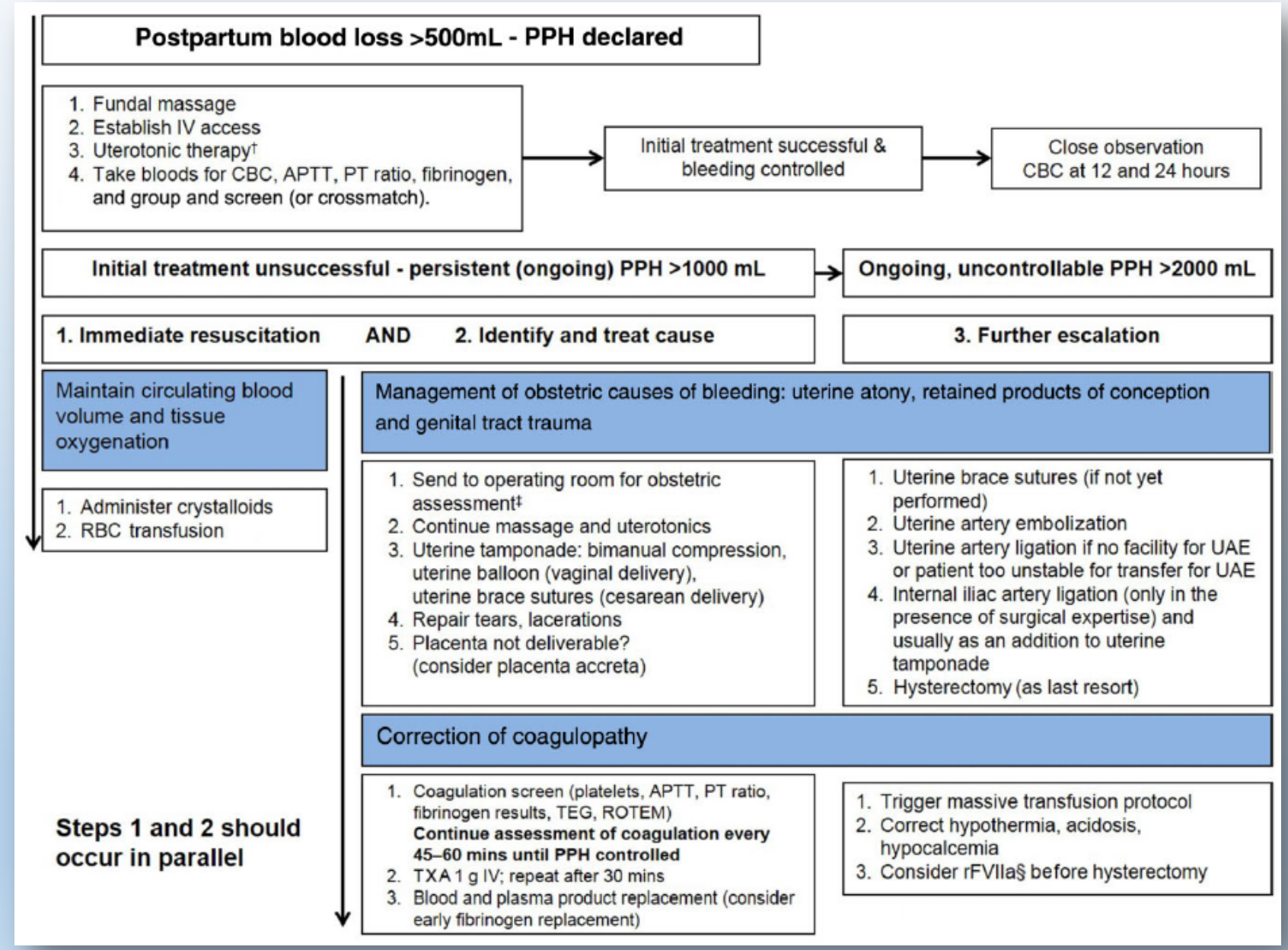
PP Hemorrhage Protocol

- LEVEL 3 – EBL >1500 CC or SBP <90 mmHg or DBP <50 mmHg
  - 2 OB docs evaluate the patient personally.
  - All Level 2 procedures instituted.
  - Initiate rapid transfusion protocol, where available.

Tranexamic Acid (TA)

- Synthetic derivative of lysine.
- Anti-fibrinolytic effect.
- Proven efficacy in ortho, cardiac, & trauma cases.
- Evidences are mounting on efficacy and safety in obstetrical population.
- No increased risk of VTE.




Postpartum blood loss >500mL - PPH declared
1. Fundal massage
2. Establish IV access
3. Uterotonic therapy†
4. Take bloods for CBC, APTT, PT ratio, fibrinogen, and group and screen (or crossmatch).
Initial treatment successful & bleeding controlled
Close observation CBC at 12 and 24 hours
Initial treatment unsuccessful - persistent (ongoing) PPH >1000 mL
Ongoing, uncontrollable PPH >2000 mL
1. Immediate resuscitation AND 2. Identify and treat cause
3. Further escalation
Maintain circulating blood volume and tissue oxygenation
1. Administer crystalloids
2. RBC transfusion
Management of obstetric causes of bleeding: uterine atony, retained products of conception and genital tract trauma
1. Send to operating room for obstetric assessment‡
2. Continue massage and uterotonics
3. Uterine tamponade: bimanual compression, uterine balloon (vaginal delivery), uterine brace sutures (cesarean delivery)
4. Repair tears, lacerations
5. Placenta not deliverable? (consider placenta accreta)
1. Uterine brace sutures (if not yet performed)
2. Uterine artery embolization
3. Uterine artery ligation if no facility for UAE or patient too unstable for transfer for UAE
4. Internal iliac artery ligation (only in the presence of surgical expertise) and usually as an addition to uterine tamponade
5. Hysterectomy (as last resort)
Correction of coagulopathy
1. Coagulation screen (platelets, APTT, PT ratio, fibrinogen results, TEG, ROTEM) Continue assessment of coagulation every 45–60 mins until PPH controlled
2. TXA 1 g IV; repeat after 30 mins
3. Blood and plasma product replacement (consider early fibrinogen replacement)
1. Trigger massive transfusion protocol
2. Correct hypothermia, acidosis, hypocalcemia
3. Consider rFVIIa§ before hysterectomy
Steps 1 and 2 should occur in parallel

A Multidisciplinary C of Suspected Placent

Amira El-Messidi, MD, FRCSC,[1] Angela Ma
Lawrence Oppenheimer, MD, FRCSC, FRC

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Montreal QC

[2]Division of Maternal-Fetal Medicine, Department Obstetrics, G
Ottawa ON

Multidisciplinary Checklist for Suspected Placenta Accreta

Date:					
Patient's name:					
Medical record number:					
Most responsible physician/contacts:					
Pertinent clinical history:					
Age:					
GTPAL:					
Estimated due date:					
Blood type and antibody screen:					
Dates of Rh immunoglobulin administration:					
BMI:					
Number of prior CS:					
Type of other prior uterine surgery:					
Desire for future fertility:					
Number of APH episodes to date:					
ULTRASOUND	Not applicable	To do	Pending	Complete: Present	Complete: Absent
Details of placentation:					
Anterior					
Posterior					
LLP or previa					
Loss of echolucency between uterus and placenta					
Lacunae					
Interruption of bladder–uterine interface					
Placental mass protrudes into bladder					
Suspected accreta by colour Doppler					
DESIGNATED DELIVERY CENTRE:					
MRI					
CONSULTATIONS					
MFM team					
Anaesthesia					
Interventional radiology					
Most experienced surgeons (e.g., gyn-oncology)					
Urology					
Neonatal ICU					
LABORATORY Most recent date:					
2 to 4 units PRBCs currently on hold					
CBC					
Coagulation profile					
INTRAOPERATIVE PLANS					
Notification of the main OR					
Consent form					
Preoperative internal iliac stents					
4 units PRBC on hold (or as requested)					
Hysterectomy tray available					
Cystoscopy set available/urology team					
CellSaver					
Neonatal team present					
Experienced surgeons on site					

GTPAL: gravida term preterm aborta living; APH: antepartum hemorrhage; LLP: low-lying placenta; MFM: maternal–fetal medicine; PRBC: packed red blood cells; CBC: complete blood count.

DESIGNATED DELIVERY CENTRE:
MRI
CONSULTATIONS
MFM team
Anaesthesia
Interventional radiology
Most experienced surgeons (e.g., gyn-oncology)
Urology
Neonatal ICU
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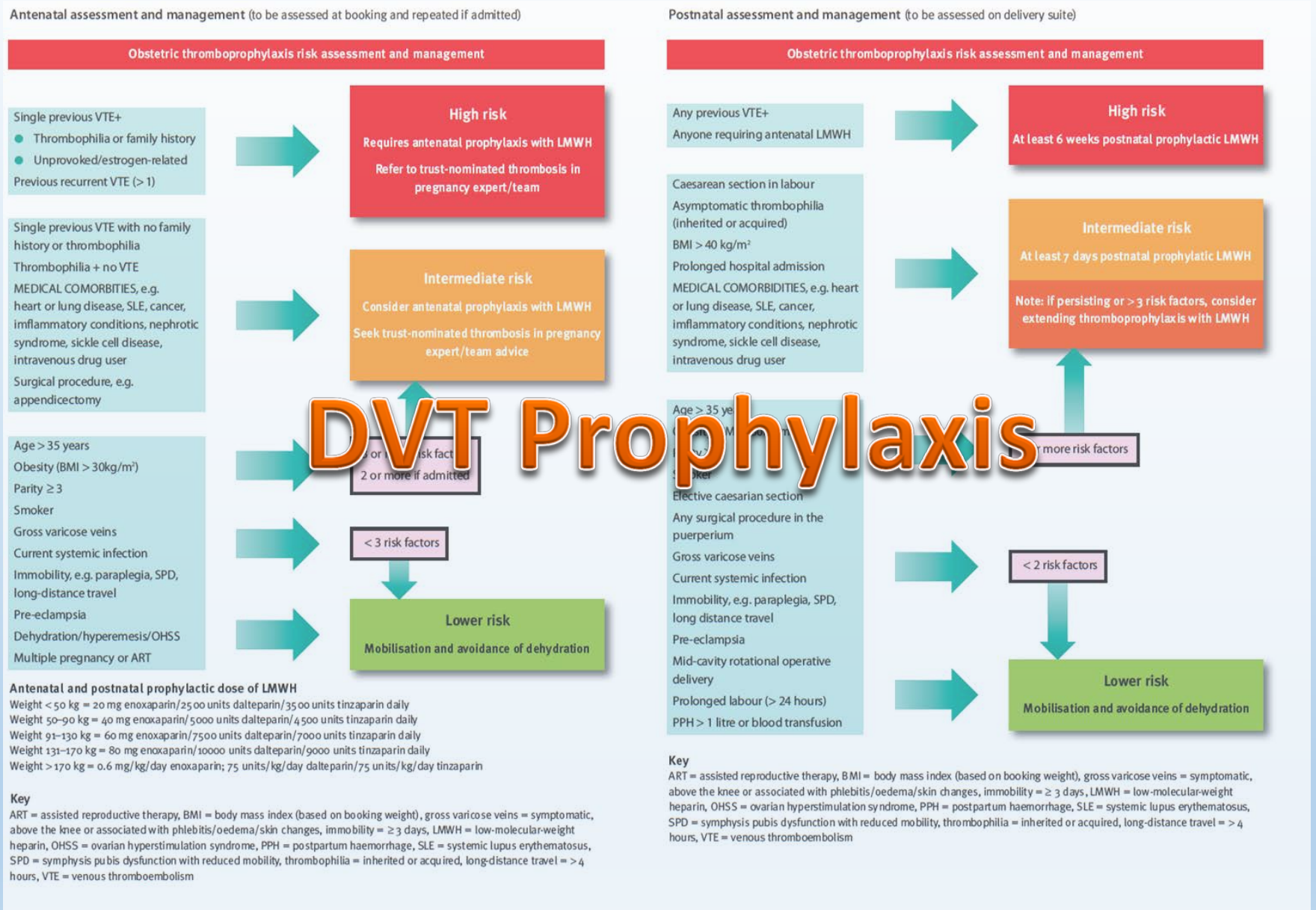


DVT Prophylaxis

RCOG Green-top Guideline No. 37a

Current Commentary

Preventing Maternal Death

10 Clinical Diamonds

Steven L. Clark, MD, and Gary D. V. Hankins, MD

VOL. 119, NO. 2, PART 1, FEBRUARY 2012

Any Hospitalized Patient With Preeclampsia Experiencing Either a Systolic Blood Pressure of 160 or a Diastolic Pressure of 110 Should Receive an Intravenous Antihypertensive Agent Within 15 Minutes

VOL. 119, NO. 2, PART 1, FEBRUARY 2012

- **A Pregnant Patient Reporting Acute Chest Pain Always Should Undergo an Immediate Computed Tomography Angiogram**
- **A Patient With Preeclampsia Reporting Shortness of Breath Should Undergo a Chest X-ray Immediately**
- **Any Patient With Identified Structural or Functional Cardiac Disease Gets a Maternal–Fetal Medicine Consultation**

VOL. 119, NO. 2, PART 1, FEBRUARY 2012

- **Never Treat "Postpartum Hemorrhage" Without Simultaneously Pursuing an Actual Clinical Diagnosis**
- **If Your Labor and Delivery Unit Does Not Have a Recently Updated Massive Transfusion Protocol Based on Established Trauma Protocols, Get One Today**
- **If More Than A Single Dose of Medication Is Necessary to Treat Uterine Atony, Go to the Patient's Bedside Until the Atony Has Resolved**

VOL. 119, NO. 2, PART 1, FEBRUARY 2012

Angiographic Embolization Is Not Meant to Be Used for Acute, Massive Postpartum Hemorrhage

In the Postpartum Patient Who Is Bleeding or Who Recently Has Stopped Bleeding and Is Oliguric, Furosamide Is Not the Answer

VOL. 119, NO. 2, PART 1, FEBRUARY 2012

Any Woman With Placental Previa and One or More Cesarean Deliveries Should Be Evaluated and Delivered in a Tertiary Care Medical Center

"10 Clinical Diamonds"

- Hemorrhage 7
- Preeclampsia 1
- Embolism 1
- Maternal Cardiac disease 1

VOL. 119, NO. 2, PART 1, FEBRUARY 2012

Hwang's Pearls

- Know thyself.
- Know your colleagues.
- Know your unit.
- Know your help outside.

Protocols Make Difference!

- Automatic and prompt treatment of hypertension.
  - Death from HTN went from #1 to #11.
- C/S DVT Prophylaxis
  - Death went down from 7 to 1.
- PPH protocols.
  - No difference


OBSTETRICS

Maternal mortality in the United States: predictability and the impact of protocols on fatal postcesarean pulmonary embolism and hypertension-related intracranial hemorrhage

Steven L. Clark, MD; James T. Christmas, MD; Donna R. Frye, RN; Janet A. Meyers, RN; Jonathan B. Perlin, MD, PhD

32.e1 American Journal of Obstetrics & Gynecology JULY 2014

TABLE 2

Cause of death

Category of death	2000-2006 (n = 1,461,270)	2007-2012 (n = 1,256,020)	*P* value
Hemorrhage	11	19	NS .07
Amniotic fluid embolism	13	11	NS 1.0
Nonobstetric ID	7	10	NS .81
Other	11	8	NS .72
Postcesarean pulmonary embolism	7	1	.038
Other pulmonary embolism	2	7	NS .09
Cardiovascular	10	8	NS .48
End-stage medical disease	1	5	NS .10
Obstetric ID	7	3	NS .36
Trauma/overdose	6	3	NS .52
Hypertension	15	3	.02
Asthma	0	2	NS .21
Medication error/reaction	5	1	NS .23
Total	95	81	NS 1.0

ID, infectious disease; *NS*, not significant.

Clark. Maternal mortality in the United States. Am J Obstet Gynecol 2014.

Summary

- MMR is higher than acceptable in the US.
- Most patients started as low risk.
- Our main focus should be in three areas.
  - Hemorrhage, Embolism, & Hypertension.
- Standard checklists and protocols are helpful.
- Active management saves lives.
- Always call for help.

Thank You for your attention

UNIVERSITY of WASHINGTON

Communication: A Patient's Perspective

Developed by Stephen Lovell
Presented by Bonnie Bizzell

Goals & Agenda

- Background
  - How and why I became involved
- Obstacles to effective communication
  - Generational
  - Cultural
  - Emotional
- Ideas to move us forward
  - Patient education
  - Shared decision-making
  - Patient and family-centered care environment
- Final Thoughts/Q&A

Background:
How & Why I Became Involved in Patient & Family Issues

Obstacles to Effective Communication

Generational Challenges & Opportunities

The “White Coat” Effect

Generational Challenges & Opportunities

Older patients:

- May be overly deferential
- Are less likely to question providers
- Avoid asking for clarification; do not ask “why?”
- Will wait without following up – even if the provider’s office promised to connect and the date has passed
- Refrain from complaining about the illness or ineffective treatment
- Might not ask for help from family or friends

Generational Challenges & Opportunities

"Dr. 

"

Generational Challenges & Opportunities

Younger patients:

- Can be very different than older ones
- Tend to “own” responsibility for their healthcare
- Research symptoms, may arrive at appointments with in-depth questions or even “answers”
- May be insistent for “action,” that something be done
- Open to seeking a second opinion
- But still: Might not ask for help from family or friends

Cultural
Challenges & Opportunities

"It's Impossible Right Now"

Cultural Challenges & Opportunities

Different cultural and life experiences mean alternative:

- Frames of reference or how we see the world
- Rules about proper behavior, including the role of authority
- Appropriate emotional reactions
- Languages and literacy levels

Emotional Challenges & Opportunities

The “Downward Spiral”

Emotional Challenges & Opportunities

Previous healthcare experiences embed in a person's memory and can lead to:

- Immediate discomfort or distrust
- Second-guessing the diagnosis and the situation
- Unrealistic expectations – bad *or* good

Ideas to
Move Us Forward

Patient Education

Limited health literacy is associated with poor health behaviors, inadequate self-management of chronic diseases, increased hospitalization, and higher health care costs.[1]

- Since patients must help in managing their own health, they should have as much accurate knowledge
  - Assist patients with finding (useful) resources to understand their situation
- The medical community needs to evaluate a patients understanding to provide relevant resources for additional assistance
  - http://www.wapatientsafety.org/for-patients-families/preparing-for-a-health-care-visit

[1]DeWalt, D. A., N. D. Berkman, S. L. Sheridan, K. N. Lohr, and M. Pignone. 2004. Literacy and health outcomes: A systematic review of the literature. Journal of General Internal Medicine 19:1228-1239.

Shared Decision-Making

What, ideally, it would look like:[2]

- Clinician(s) share information about relevant testing/treatment options
  - Including severity and probability of potential harms as well as benefits and alternative options (within context of patient's situation)
- The patient explores/shares preferences regarding harms, benefits, and potential outcomes
- Through an interactive process of reflection/discussion, clinician(s) and patient reach a mutual decision about the subsequent testing or treatment plan
  - http://www.informedmedicaldecisions.org/patient-resources/

[2]Alston, Chuck, et. Al, "Shared Decision-Making Strategies for Best Care: Patient Decision Aids", September 2014, Institute of Medicine

Patient- & Family-Centered Care

Principles:

- Dignity and Respect
  - providers listen to and honor patient & family perspectives and choices
- Information Sharing
  - providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful
- Participation
  - patients and families are encouraged and supported in participating in care and decision-making at the level they choose

Patient- & Family-Centered Care

Principles (cont):

- Collaboration
  - patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care

Patient- & Family-Centered Care

Driving forces:

- System Centered
  - priorities of the system (and those within) drive delivery
- Patient Focused
  - focus on patient: interventions are done to/for instead of with; patient not viewed in context of family/community
- Family Focused
  - focus on family: interventions are done to/for instead of with
- Patient- and Family- Centered
  - priorities of patients & their families drive delivery (with)

Adapted from: Schwab, B. MD. (2014, March 31). Recognizing patient- and family-centered care. *Moving Forward with Patient- and Family-Centered Care: Partnerships for Quality and Safety.* Lecture conducted at the Institute for Family- and Patient-Centered Care, Burlingame, CA

Patient- & Family-Centered Care

Creating the environment:

- Learn about patient- and family-centered care; encourage others to do so as well
- Engage with patients and families; listen and seek feedback and advice; build trust
- Ask questions to yourself and others; honesty assess
- Set priorities for high visibility and impact improvements; involve patients and families
- Create actions plans; ensure infrastructural support

Adapted from: Institute of Patient- and Family-Centered Care (2011, April). *Advancing the Practice of Patient- and Family-Centered Care: How to Get Started.*

Patient- & Family-Centered Care

Creating the environment (cont):

- Educate patients, families, staff, leaders, etc.; provide meaningful support to those learning, leading, and exploring
- Celebrate changes; address roadblocks; allow time

Adapted from: Institute of Patient- and Family-Centered Care (2011, April). *Advancing the Practice of Patient- and Family-Centered Care: How to Get Started.*

Final Thoughts/
Q & A

CATHOLIC HEALTH INITIATIVES
Franciscan Health System

A Model of Communication in Relationship Centered Care

Washington State Medical Commission
Educational Conference

October 1, 2015

Mimi Pattison, MD, FAAHPM
Commission Member
Medical Director Franciscan Hospice and Palliative Care
mimipattison@chifranciscan.org

Background

- By 2030 the number of people in WA State >65 will be close to 1.5 million (currently approx. 784,000)
- >80% will suffer from at least one chronic illness and 20% from more than one chronic illness with resultant pain, debility and suffering

- Washington State Plan on Aging 2010-2014
- CDC, 2012, Chronic Diseases and Health Promotion. Retrieved from http://www.cdc.gov/chronicdisease/overview/index.htm

Background

- Advance chronic illness causes increased symptom burden, pain, fatigue and breathlessness
- 70% of people with advanced chronic illness admitted to hospital in last 6 mos. of life and estimated that ¼ receive inadequate symptom management

- Solano, J. P., Gomes, B., & Higginson, I. J. (2006). A Comparison of Symptom Prevalence in Far Advanced Cancer, AIDS, Heart Disease, Chronic Obstructive Pulmonary Disease and Renal Disease. *Journal of Pain and Symptom Management,* 31(1), 58-69.
- Morrison, R. S., & Meier, D. E. (2004). Palliative Care. *New England Journal of Medicine, 3*50(25),2582-2590.

- Historically, medical education has focused on curing and prolonging life rather than relieving suffering and improving QOL
- Most clinicians lack the necessary communication skills needed to elicit care preferences or to effectively manage symptoms

- Anderson, W., Kools, S., & Lyndon, A. (2012). Dancing Around Death: Hospitalist-Patient Communication About Serious Illness. *Qualitative Health Research.*

- Once clinicians have completed their training there is little opportunity to gain these skills
- Most clinicians have large panels of patients and are not incentivized to provide time-intensive care

- Bodenheimer, T. (2008). Coordinating care-a perilous journey through the health care system. *New England Journal of Medicine, 358(10), 1064-1071.*

- There are not enough and will not be enough palliative specialists to meet the growing need
- There is one cardiologist for every 73 people experiencing heart attack and only one palliative specialist for every 1,700 people with severe advanced illness
-

- Meier, D. E., & Morrison, R. S. (2011) America's Care of Serious Illness: A State by State Report Care on Access to Palliative Care in Our Nation's Hospitals: National Palliative Care Research Center.

Definition of Palliative Care

Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of doctors, nurses, and other specialists together with a patient's other doctors to provide an extra layer of support , appropriate at any age and at any stage in a serious illness and can be given with curative treatment.

Diane Meier, MD

CAPC 2012

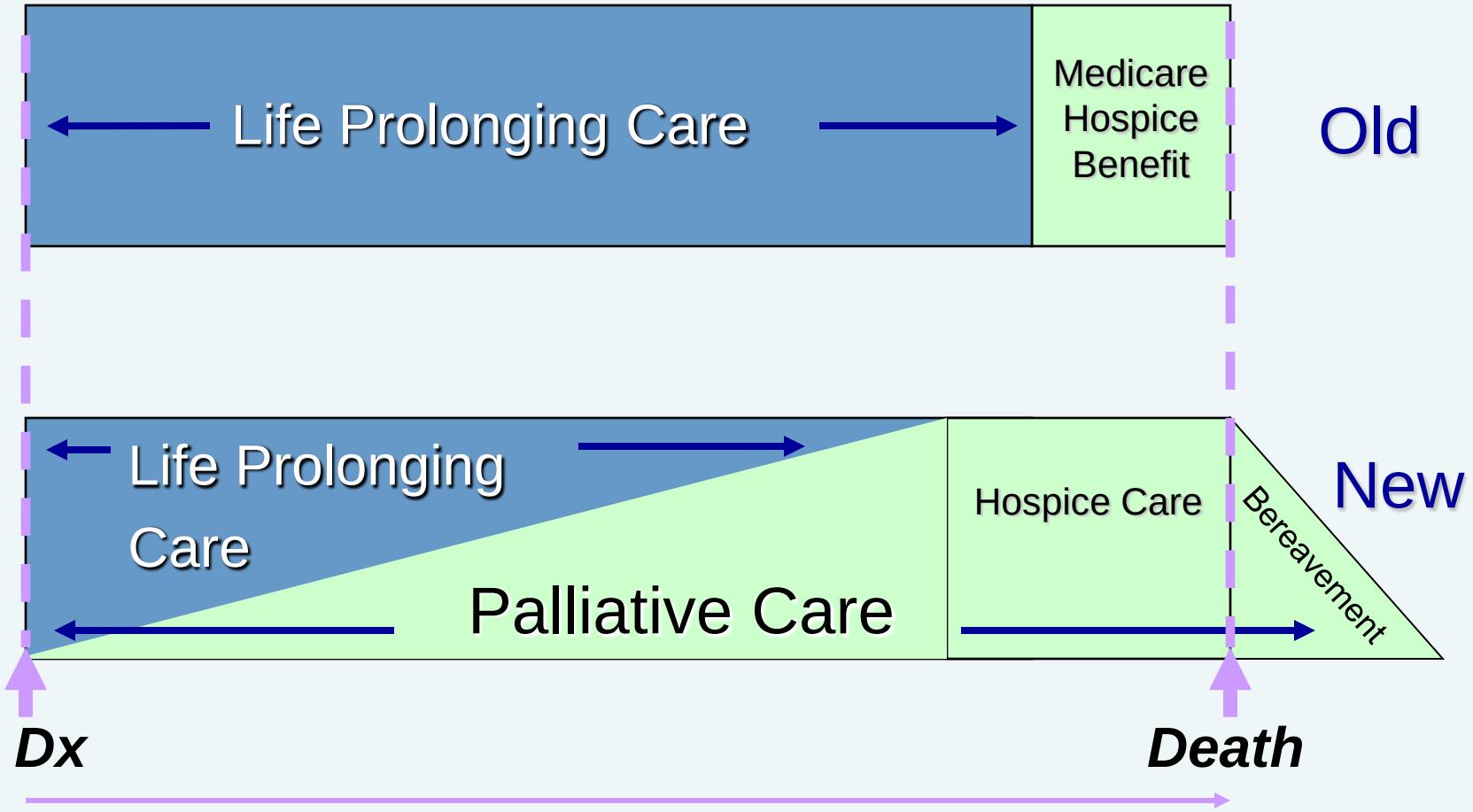
The Best Care Possible

Ira Byock, MD

"We've had a 50-year experiment with medicalizing mortality, treating it as just another problem to be solved…and it has failed"

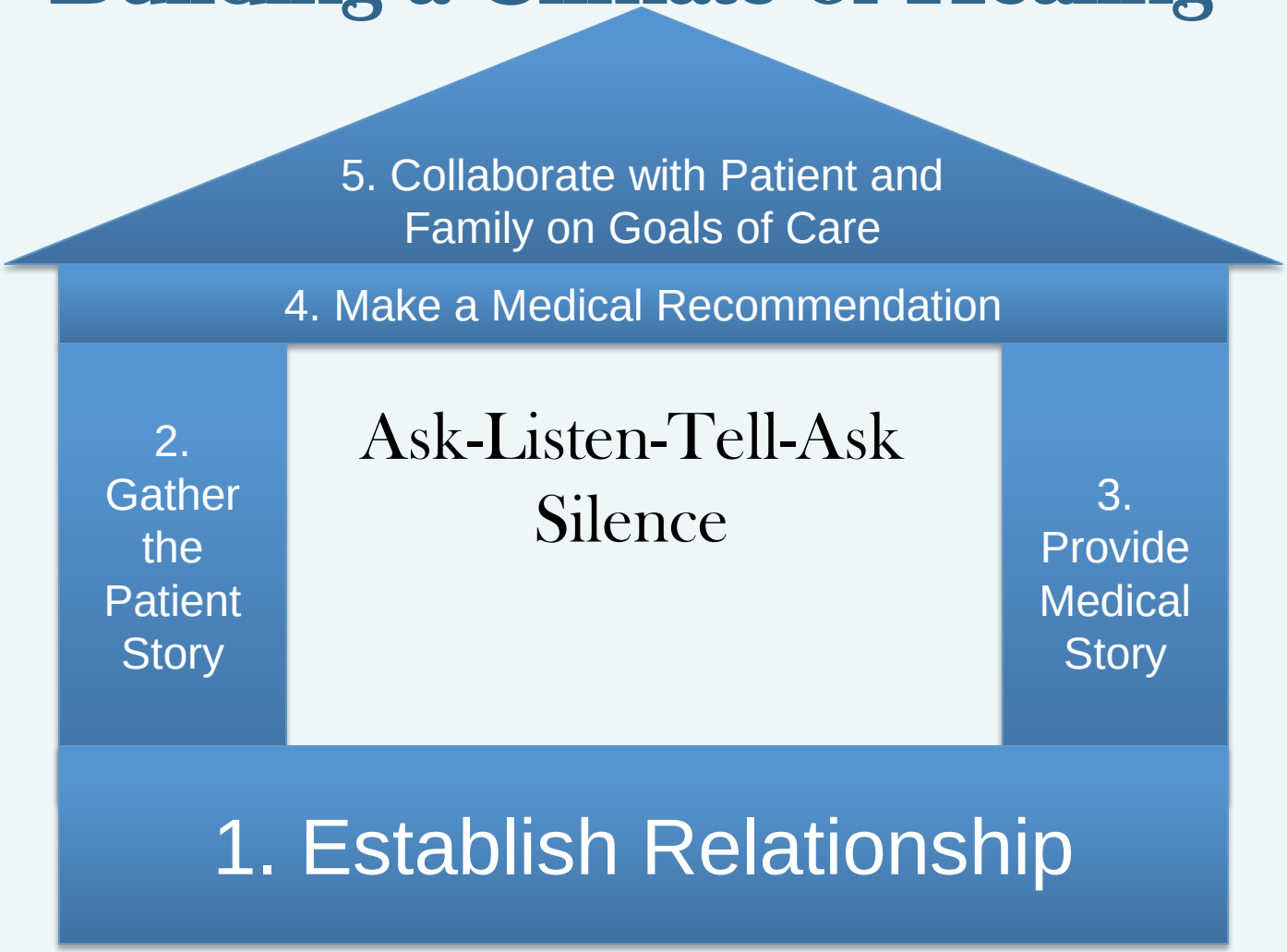
Dr. Atul Gawande

Conceptual Shift for Palliative Care Goals



Curing	Healing
Elimination of disease Back to normal Limited number of disease that we heal	Managing chronic disease The new normal Progressive decline in function
Medications Surgery Specific treatments	Symptom management Whole person care Family Spiritual care
Medicine (we) have the power	Patient has the power

Building a Climate of Healing



Words That Work

- In your own words please share with me…..
- So that I understand…..
- I am concerned…..
- Always talk about the care we can provide

Palliative Care and Hospice

- Both focus on symptom management and quality of life
- All hospice care IS palliative care
- All palliative care IS NOT hospice care

Palliative Care

- Referral based on unmet need, e.g. symptom management, advance care planning
- Often consultative, primary clinician continues to be managing clinician
- Maybe short-term or long-term depending on the service available

Palliative Care

- Appropriate any age, any diagnosis, any time in the course of serious progressive illness

- IS NOT just for persons at end of life

Hospice Referral

- Referral based on prognosis
- Life expectancy of less than 6 months if the condition takes a usual course
- Care until death occurs and for family for 13 months after death

We all must…

- Have effective communication skills
- Know resources in our communities
- Give *THE BEST CARE POSSIBLE*

A Model of Communication in Relationship Centered Care

WA State Medical Commission Educational Conference

October 1, 2015

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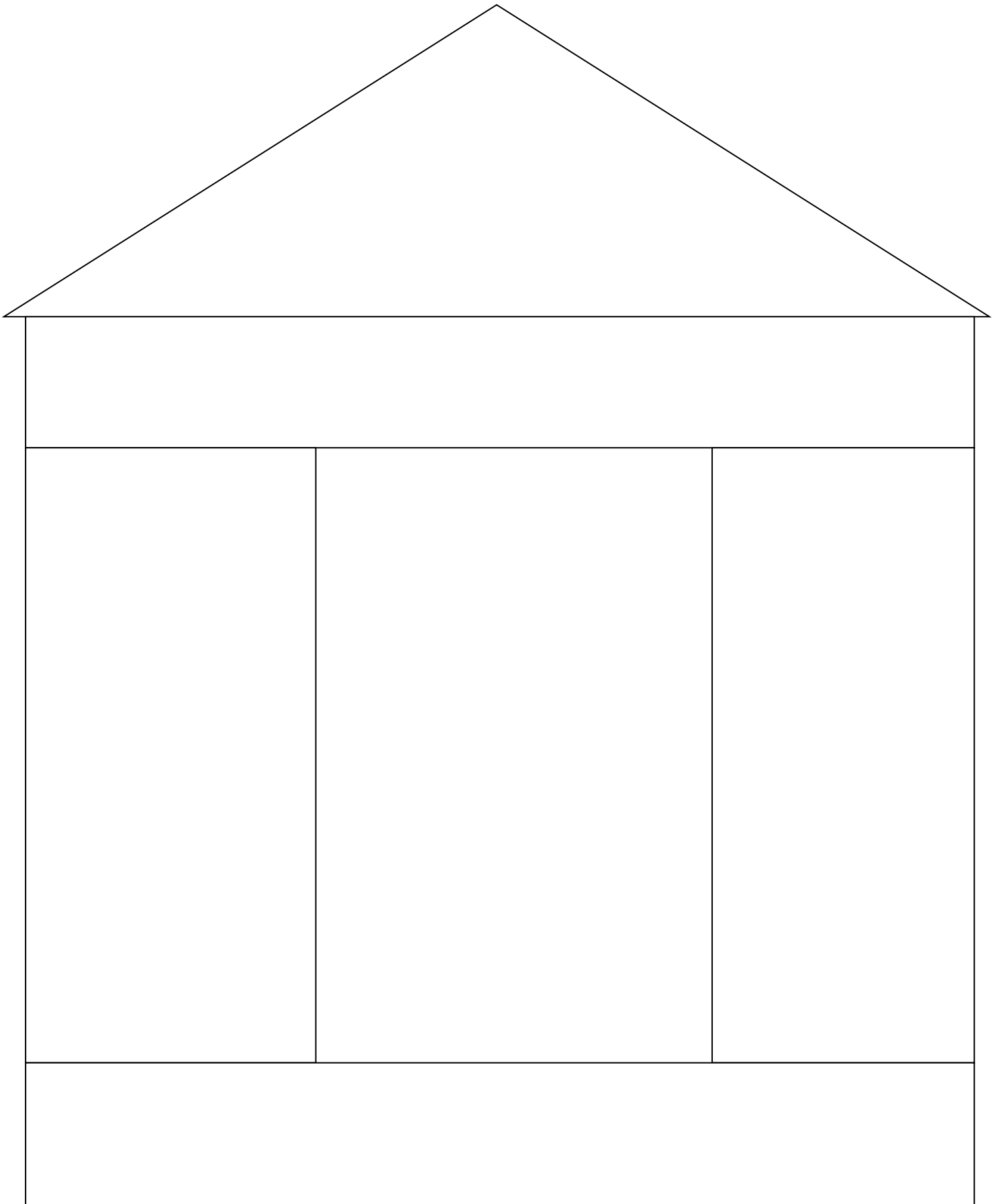
Curing	Healing

Building a Climate of Healing



Washington State Hospital Association

Washington State Hospital Association Partnership for Patients

Transformational Culture: Engagement Leadership, Clinicians and Patients

Medical Quality Assurance Commission

Carol Wagner
Senior Vice President Patient Safety
October 1, 2015

Partnership for Patients

- 40 – Percent reduction in harm
- 20 – Percent reduction in readmissions

Saving Lives

2015 and Beyond

Infections

- Catheter Associated Urinary Tract Infections
- Central Line Associated Blood Stream Infections
- Surgical Site Infections
- Ventilator Associated Pneumonia
- Sepsis
- C. Diff

Nursing and Staff Care

- Falls
- Pressure Ulcers
- Venous Thromboembolism
- Worker Safety

Safe Delivery Roadmap

- C-Section Rate
- Early Elective Delivery
- Episiotomy
- Inductions

Medications

- Antibiotic Stewardship
- Anticoagulants
- Hyperglycemic
- Opioid

General Care

- Blood Usage
- Honoring Choices
- Radiation
- Readmissions

Population Health

Washington State Hospital Association

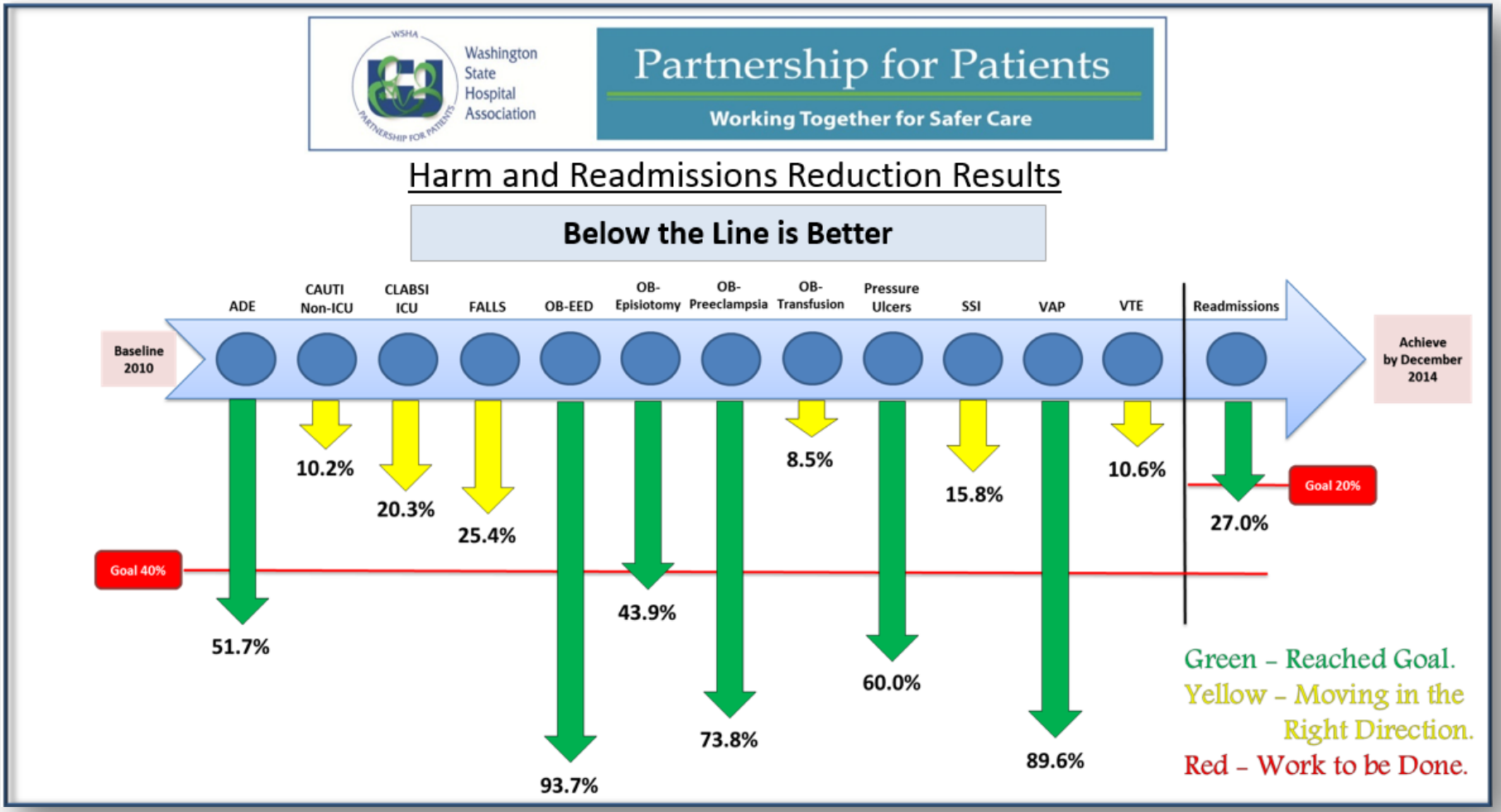
- Early Intervention Mental Health
- First Three Months of Pregnancy
- Diabetes - Rural

WSHA PARTNERSHIP FOR PATIENTS

AMERICA'S BEST CARE

Washington State
Hospital Association

Washington State Hospital Association



23,000 fewer harm events!

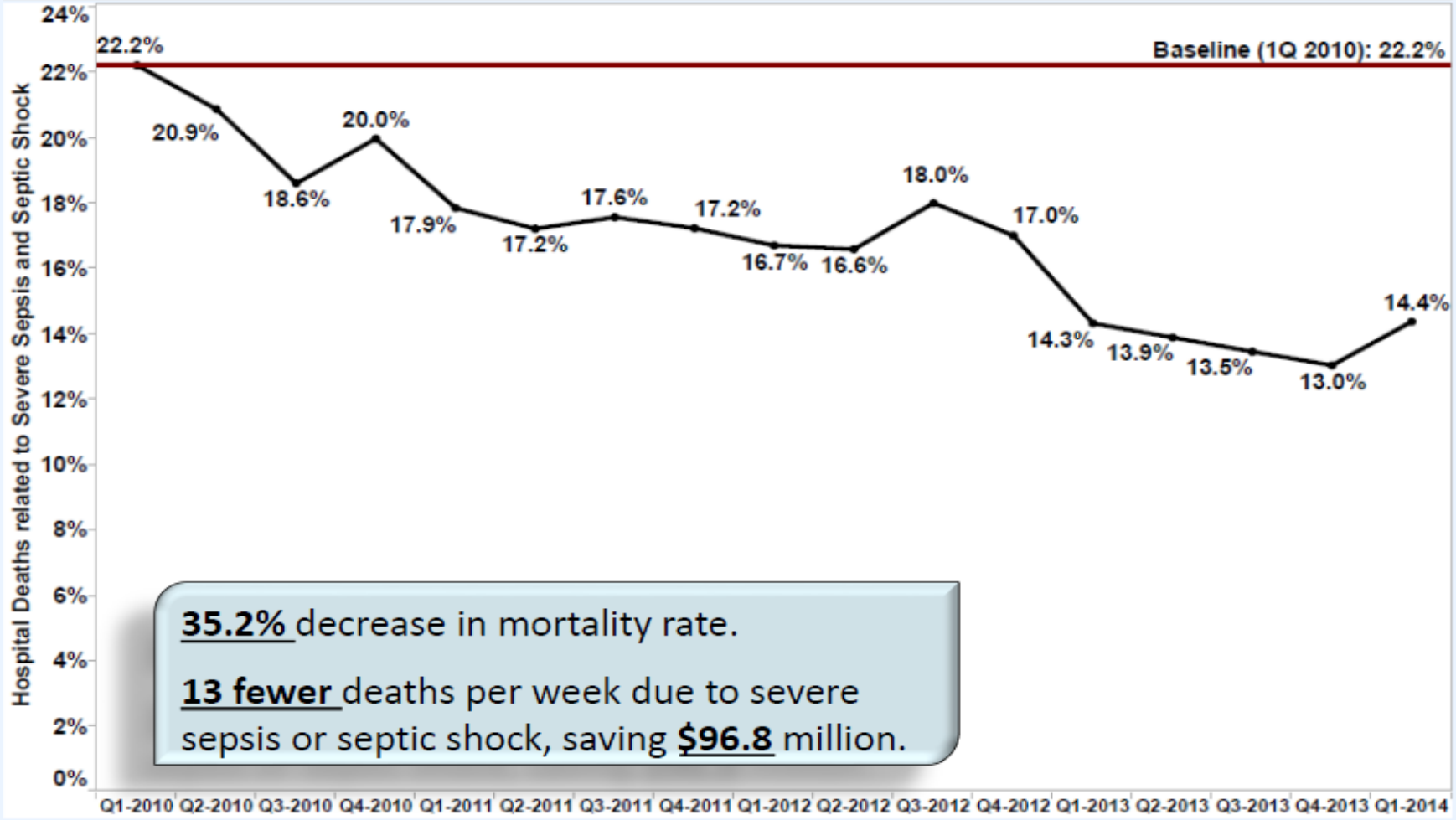
$235 million savings!

Washington State Hospital Association

Partnership for Patients

Working Together for Safer Care

Severe Sepsis and Septic Shock Mortality Rate



35.2% decrease in mortality rate.

13 fewer deaths per week due to severe sepsis or septic shock, saving **$96.8** million.

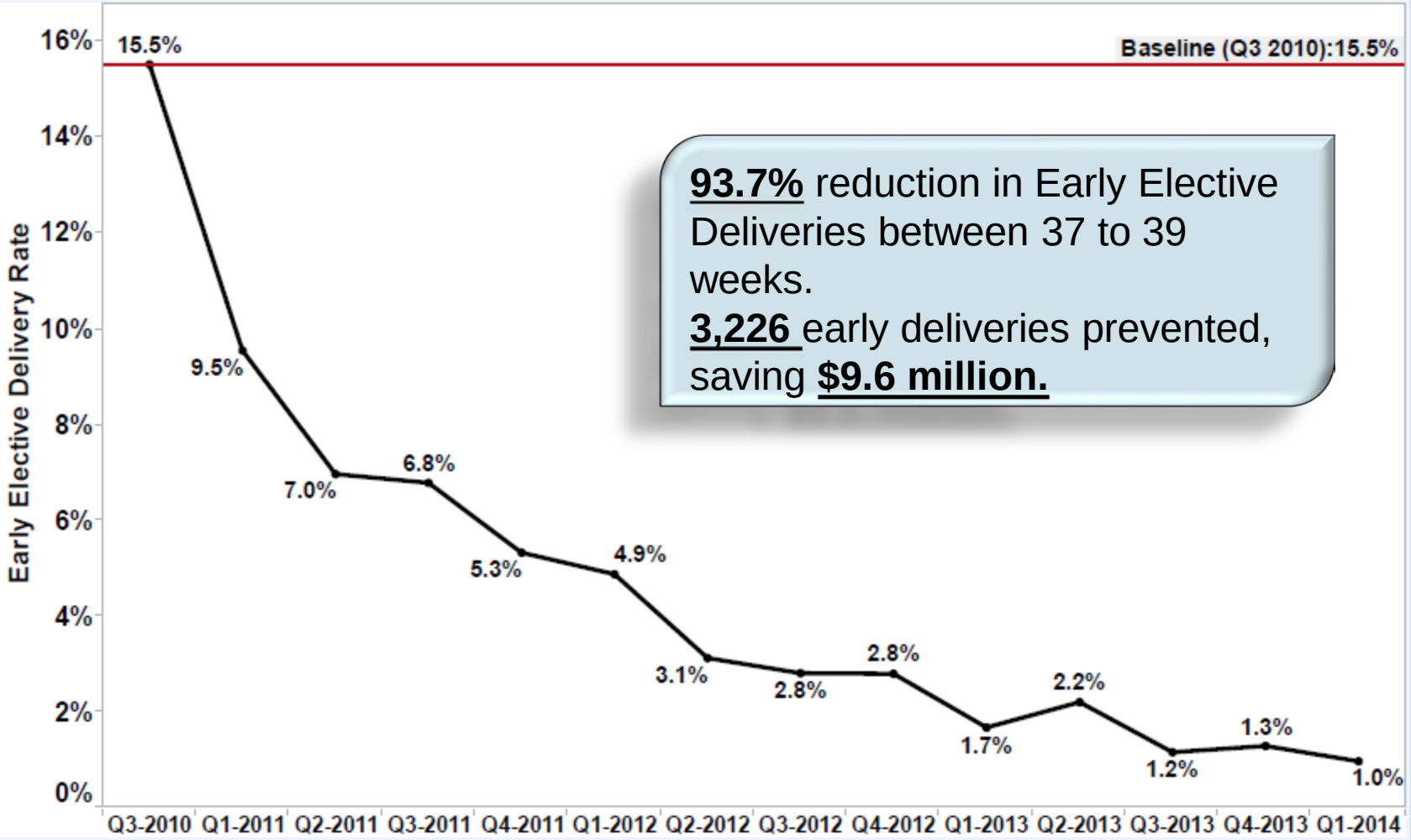
Definition: Hospital deaths related to Severe Sepsis (995.92) and Septic Shock (785.52) (All Ages) from the number of patients diagnosed with Severe Sepsis (995.92) and Septic Shock (785.52) (Excludes Comfort Care Patients)

Data Source:Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS)

Washington State Hospital Association

Partnership for Patients
Working Together for Safer Care

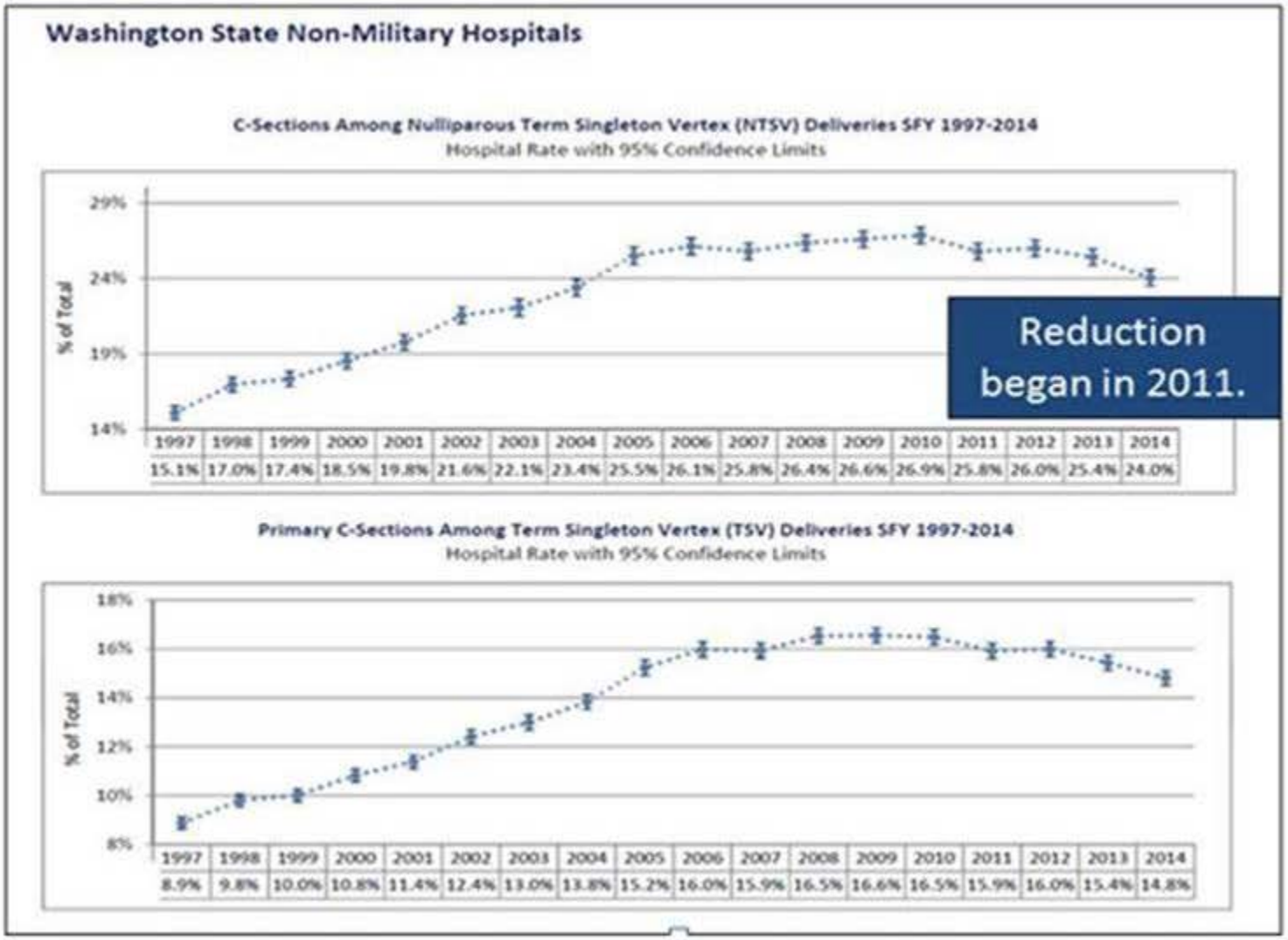
Early Elective Delivery Rate



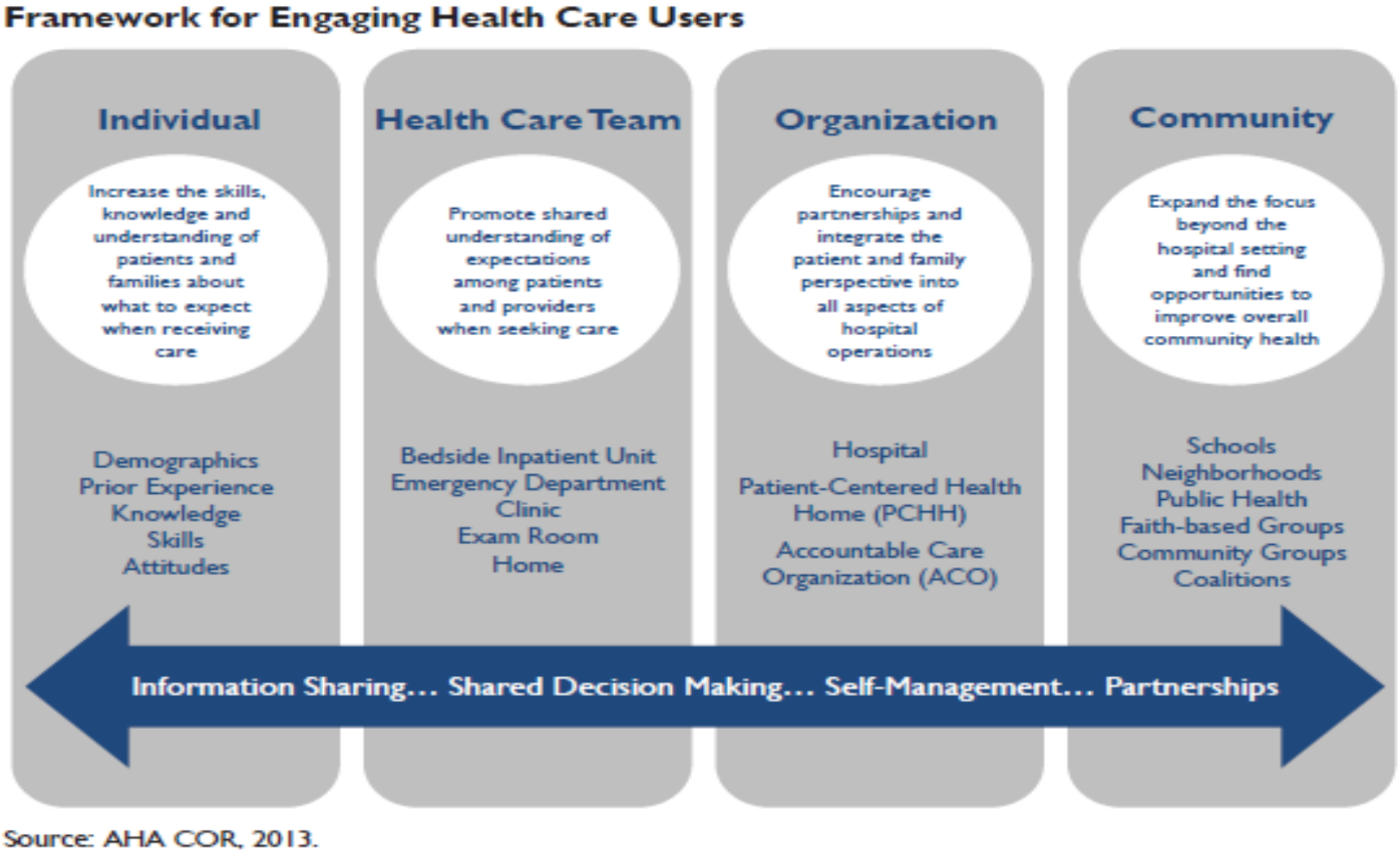
93.7% reduction in Early Elective Deliveries between 37 to 39 weeks.
3,226 early deliveries prevented, saving **$9.6 million.**

Definition: The Joint Commission, PC-01 Elective Delivery, patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

WA State NTSV and Primary TSV



HRET's Framework



One Culture, One Process for All Members of Team

Difficult Clinician-Patient Communication

By Maysel Kemp White, PhD, and Vaughn F. Keller, EdD, Yale

Related to: Communication, Emergency Medicine, General Medicine, General Surgery, Nursing, Obstetrics, Surgical Specialties, Medical Specialties

WSHA

PARTNERSHIP FOR PATIENTS

Systems Driven

Set Aside Competition to Make Care Safer for Patients

Partnership for Patients (CMS) Goals

Planning check list for patients known to be coming to the hospital.

- Conduct **shift change huddles** and **bedside reporting** with patients and families.
- Designation of an **accountable leader** in the hospital who is responsible for patient and family engagement.
- Active **Patient and Family Engagement Committee** (PFEC) or other committees where patients are represented.
- One or more **patient representatives serving on board of directors**.

WSHA Website

http://www.wsha.org/files/177/Resources_for_PFE_metrics_updated.pdf

PATIENT AND FAMILY ENGAGEMENT

Safety is a Partnership

REVISED: JUNE 2014

WASHINGTON STATE HOSPITAL ASSOCIATION
300 Elliott Avenue West, Suite 300, Seattle, WA, 98119

Patient and Family Engagement

- Assessment
  - Orientation
  - Planning
- Recruiting and Selection
- Training and Role
- Partnership Council in Action
  - Purpose
  - Team Building
  - Communication
  - Results

In Action

- Applications and interviews
  - Solicitation of applications with future oriented questions
  - Team interviews
- Recruit patients and family members who
  - Are users of care
  - Have accomplished something as part of a team
  - See themselves as future-oriented change agents
  - Will help hospitals achieve their safety and quality mission and goals
- Recruit hospital staff eager to learn with patients and families and contribute

Patient and Family Advisory Council (PFAC)

Questionnaire

Please tell us about your experience at _____

1. Have you ever been hospitalized at _____ for more than 24 hours? ❑ Yes ❑ No

If your answer is YES, how long was your longest hospitalization? _____

2. Have you ever been a care-giver for a patient who was hospitalized at _____ for more than 24 hours? ❑ Yes ❑ No

If your answer is YES, how long was the longest hospital stay of the person you were caring for? _____

3. How many times have you or a person you take care of has been hospitalized at _____ in the last three years? _____

4. How would you describe your hospital experience at _____?

_____

_____

_____

_____

5. What did the hospital do well during your stay or your loved one's stay?

_____

_____

_____

_____

6. What could the hospital have done better during your stay or your loved one's stay?

_____

_____

_____

_____

7. What would you like the hospital to learn from your stay or your loved one's stay?

_____

_____

_____

_____

If you have more to say, please feel free to use additional pages.

Please tell us more about you

1. Please tell us your name and the best ways to reach you?

Name: _____

Address: _____

_____

Email: _____ Phone: _____

2. Do you volunteer in your community? If so, for which organizations?

_____

_____

_____

_____

3. Do you feel comfortable working in groups, speaking up and providing input?

_____

_____

4. Is English the language you primarily use when communicating?

❑ Yes ❑ No

If your answer is no, what is your primary language? _____

5. Are you able to attend meetings at _____ during weekday evenings?

❑ Yes ❑ No

6. Are you willing to take the necessary immunizations to serve on the Patient Family Advisory Council?

❑ Yes ❑ No

7. Are you willing to sign an agreement promising not to disclose confidential information given to you in your role as a member of the Patient Family Advisory Council?

❑ Yes ❑ No

8. Are you willing to undergo a background check?

❑ Yes ❑ No

Thank you!

Review Form

Please rate the candidate across all categories below and give this form to _____ following your interview. All reviews will be kept confidential. Your feedback is important to me.

Name of Applicant:			Interviewer:		
Core Questions	Excellent answer (5 pts)	Good answer (4pts)	OK answer (2pts)	Not a strong answer (1pts)	Total Points
1. Top reasons for wanting to be on the PFAC?	Comments:				
2. Affiliations with other groups in the community?	Comments:				
3. Success working as part of a team?	Comments:				
4. How do you reach agreement in a group where others disagree?	Comments:				
5. Issues/concerns, particular populations important to you?	Comments:				
6. Willing to undergo training re privacy and confidentiality?	Comments:				
7. Unresolved issues with [H]? Or other provider?	Comments:				
8. Conflicts of Interest?	Comments:				
9. OVERALL ASSESSMENT Ability to articulate and generalize from own experience to others	Comments:				
TOTAL SCORE					

Note to reviewers: MAXIMUM SCORE = 45

θ I highly recommend and will support the candidate for this position.

Comments:

θ I recommend and will support the candidate for this position

Comments:

θ I do not recommend the candidate for this position (please explain).

Comments:

Thank you for your participation in the interview process for this key role

Patient Family Councils Culture & Covenants

- We’re all in this together.
- Listening without being judgmental
- Active participation
- Embracing change
- Personal commitment to mission
- Regular attendance at Council meetings

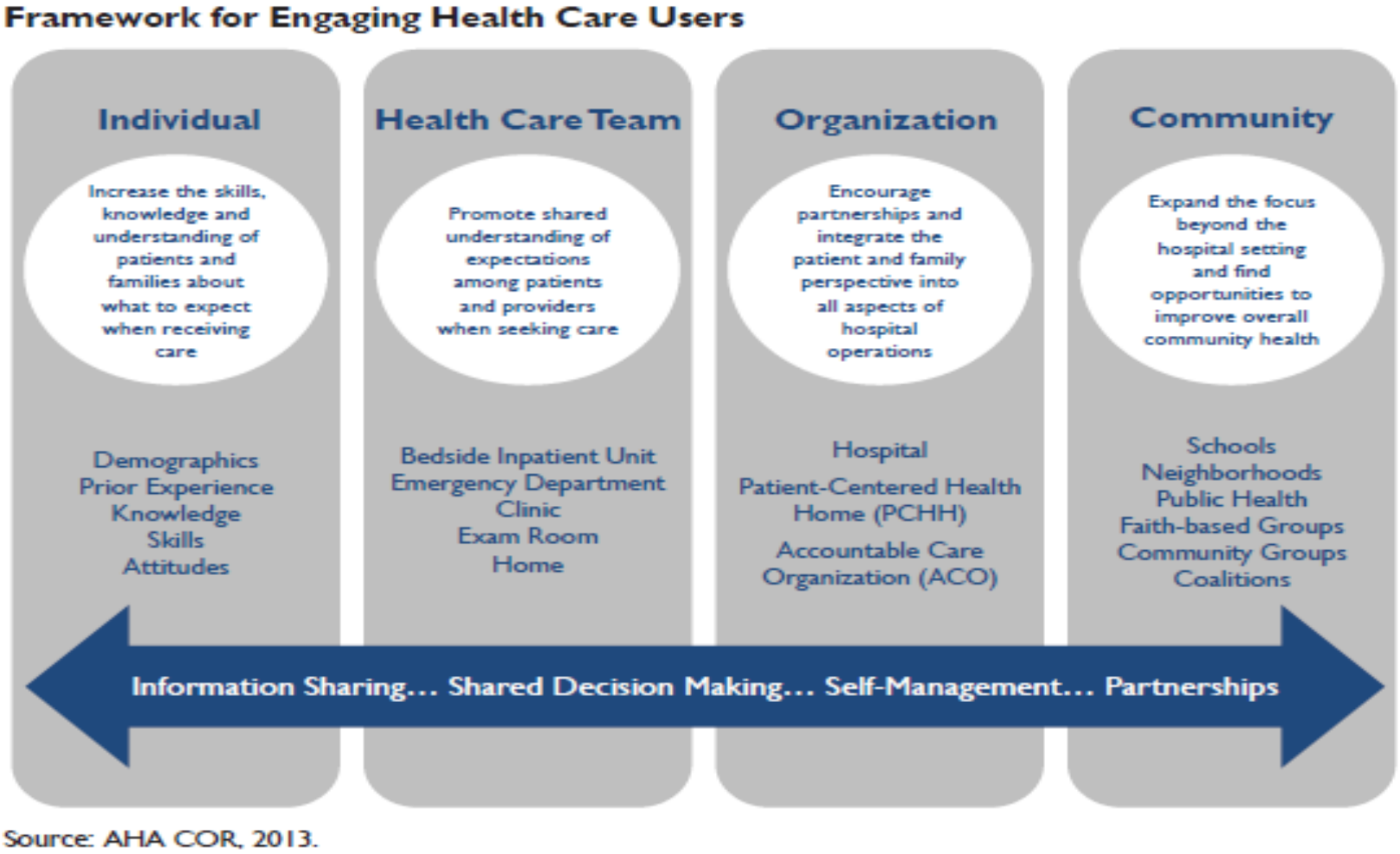
What do Patient Family Advisory Councils (PFAC) work on?

- Outcomes improvement
- Communicating effectively
- Transitions of Care
- Patient, family & hospital staff/associate education
- Environment of care
- Care for the caregiver
  - Supporting family caregivers
  - Supporting associate wellness
- Care for the community hospitals serve

Patient Family Advisory Councils: Lessons Learned

- Personal commitment is extremely important to success
- Development/implementation is a journey
  - Comfort, trust, confidence, development of shared mental model, openness to evolution
- Screening is crucial
- Orientation, training and coaching are useful for all audiences

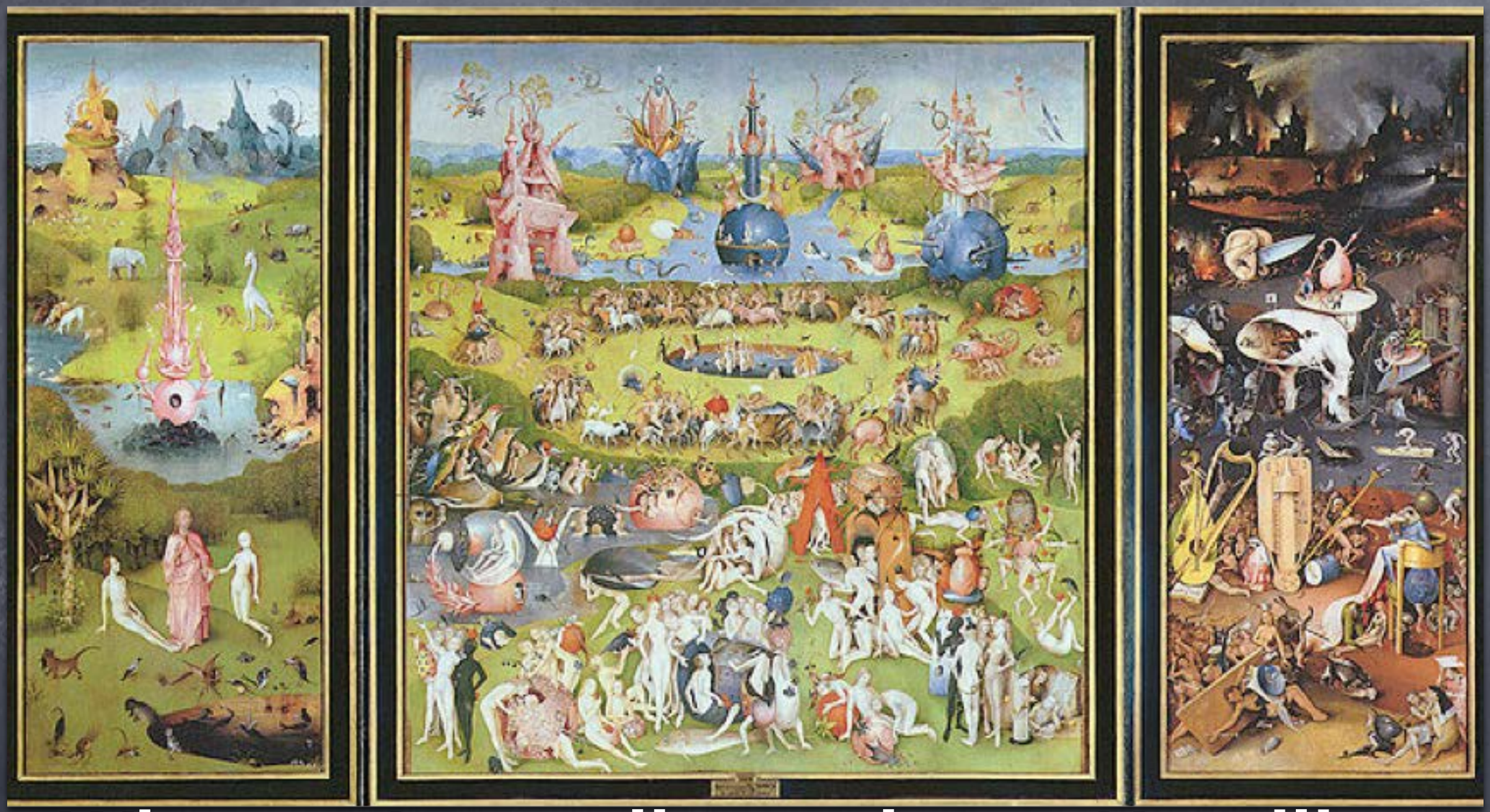
HRET's Framework



One Culture, One Process for All Members of Team

Thank you

Questions



Why can’t we all get along: Handling conflict with seriously ill patients and their families

Goals of this talk

- Be able to come up with better reasons why families/patients ask for things that you think are unreasonable
- Explain why conflicts often arise using a three pronged model
- To provide some practical hints for communicating about conflicts

Caveats

- I am an internist
- Thanks Drs. Tulsky/Back
- Modified from psychology and business literature
- Tested on patients and teen-agers

Myths & realities about conflict

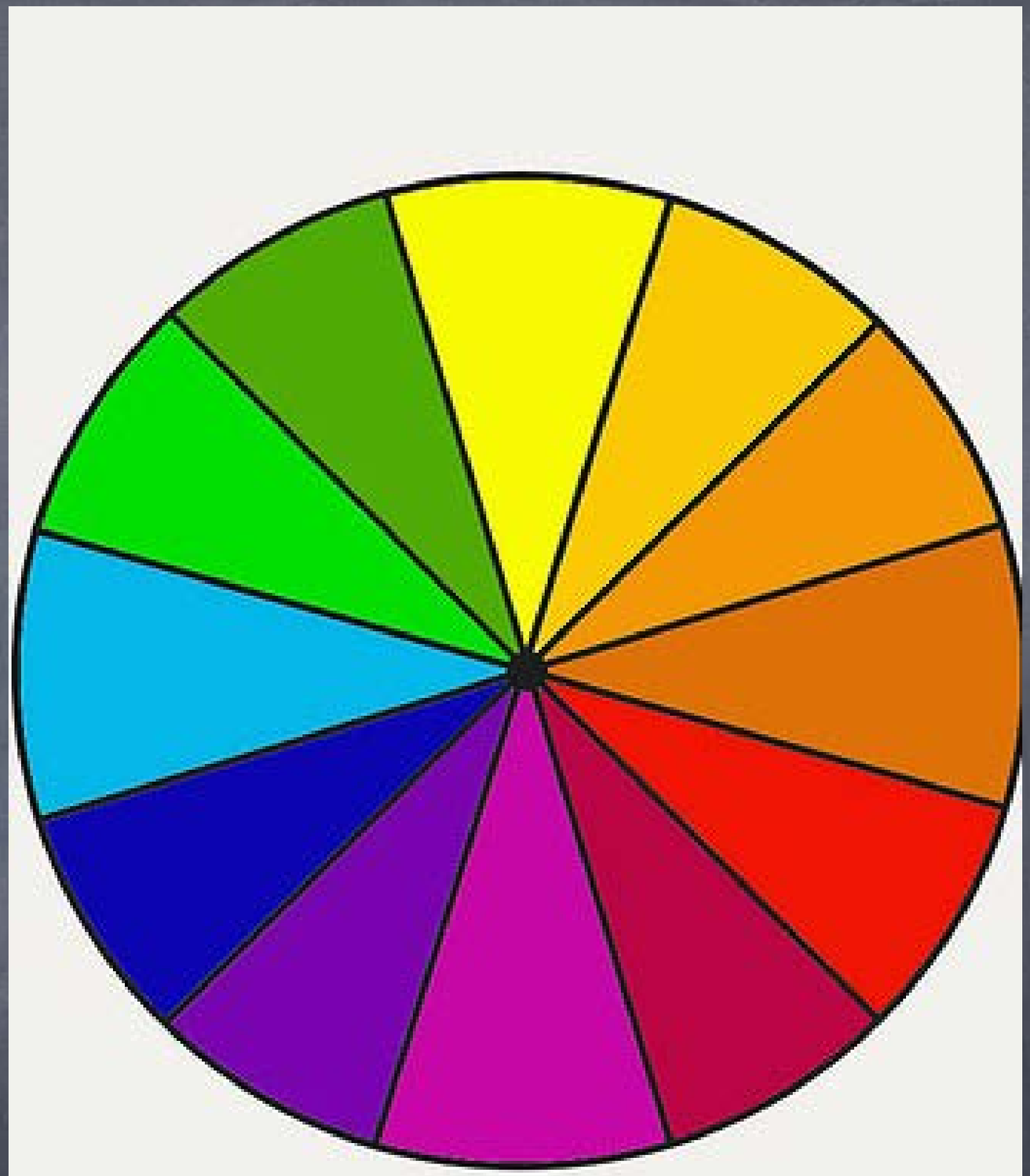
- It’s better not talk about conflict
- Focus on facts not feelings
- The other party must change

Insanity is doing the same thing over and over again and expecting a different result

Convince and persuade

And if that doesn’t work?

- Blame
- Give up and walk away

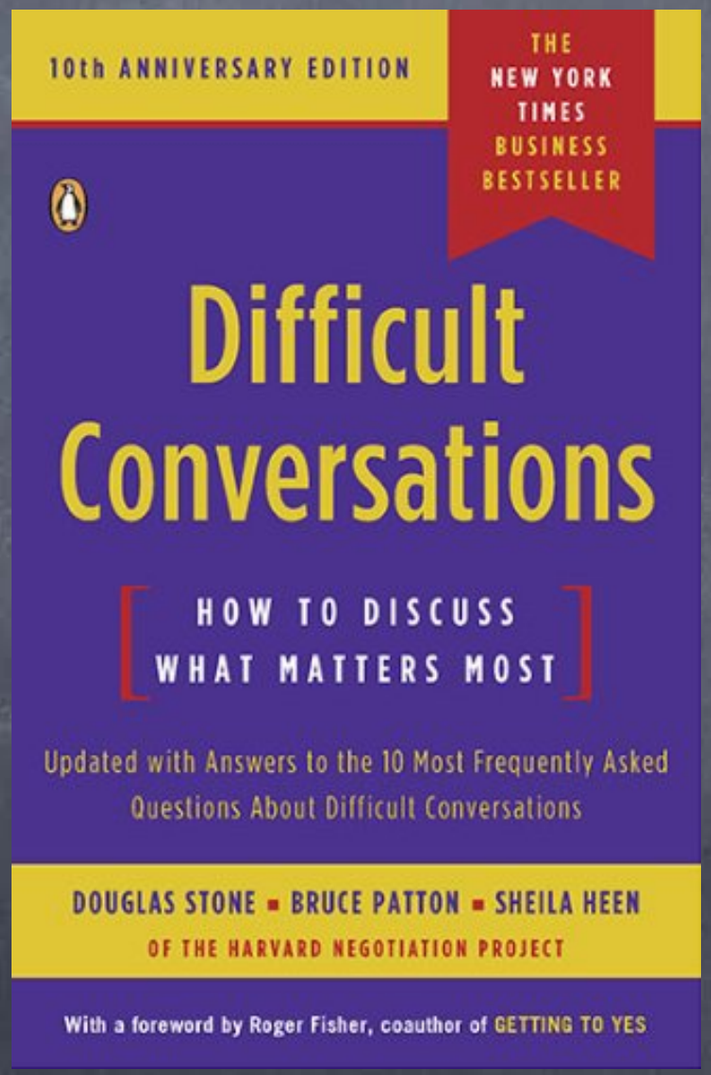


YOU ARE THE YELLOW TO MY PURPLE

Where to start

- Use the conflict as an opportunity
- Why might this caring family be making a decision that we think is unreasonable??

Each difficult conversation is really three conversations



Difficult conversation=3 conversations

- General structure (Stone et al):
  - The “what happened” conversation
  - The feelings conversation
  - The identity conversation
- In each of these three areas we make predictable errors that distort the conversation

Stone R, Patton, B, Heen, S Difficult conversations 1999

We Talk talk talk...

McDonagh, Crit Care Med, 2004

Family don’t understand our story

- 102 families with a pt in an ICU for >2 day
  - interviewed 76 family members
  - Mean age 54+/-17, APACHE 40 +/-20
  - Duration of first visit 10+/-6 min
  - **54% did not know the dx (major organ involved), prognosis (grave or not grave) or tx (at least one of 10 possible treatments)**
  - **34% understood the prognosis**

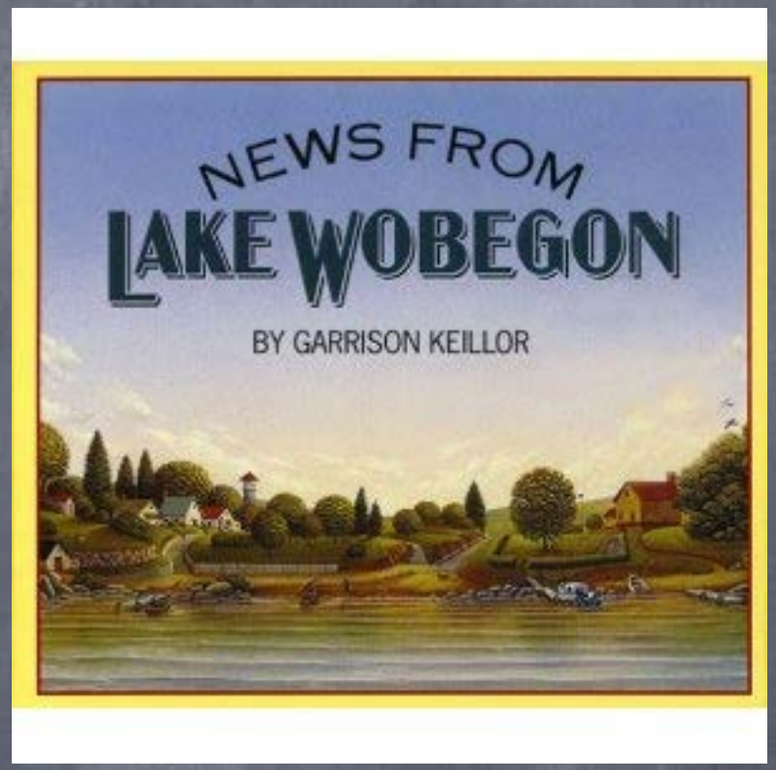
Why a family might not hear our story

- Clinician factors
  - Jargon
  - Hedging
  - Conflicting information from different people

Families ability to hear is limited

- Listening is an inefficient way to obtain information (15-25%)
- One can not process more than 3-7 pieces of information

Families filter what they hear

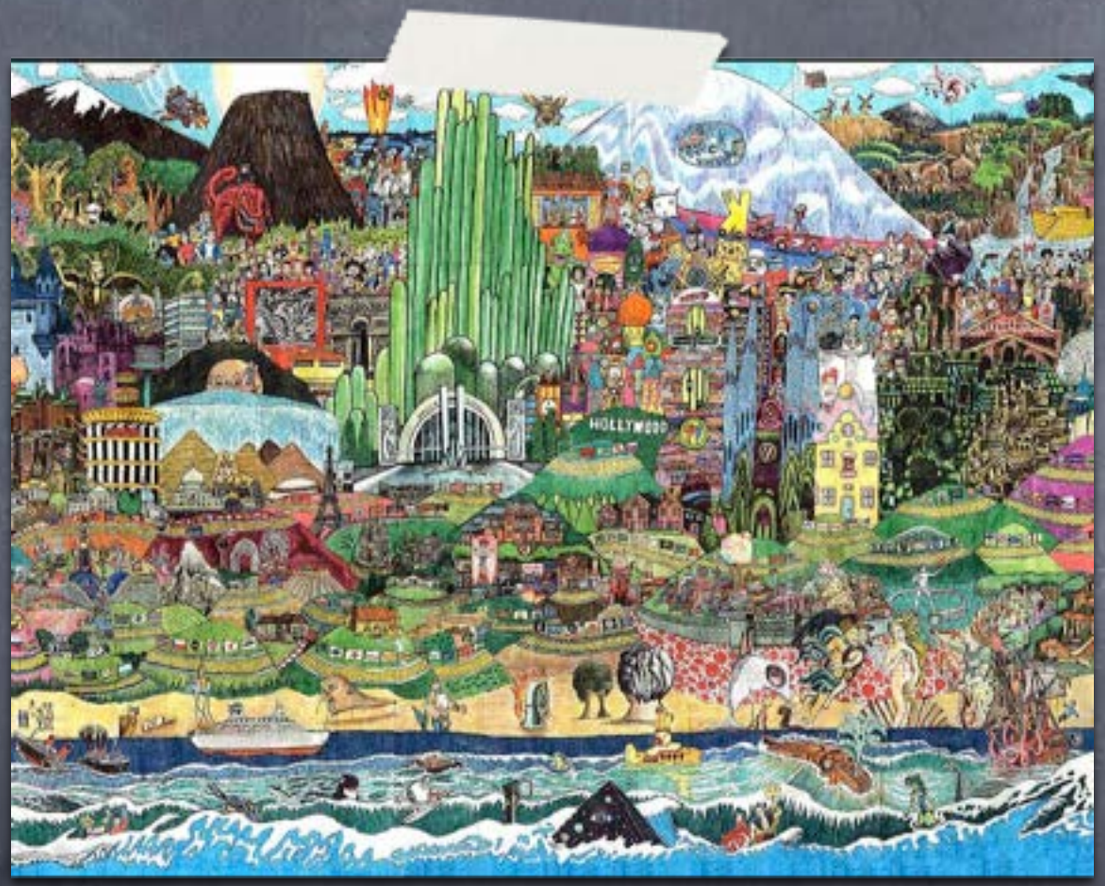


- Family want our info
- But filter it thru their own beliefs
- Our loved one will do better than average

What happens when they do not “get it”

- The “False Consensus Effect”
  - People tend to see their own views as more common than they actually are…
- “Naïve Realism”
  - A persons’ unshakeable conviction that they know the truth and others will perceive it, provided they are reasonable and rational

Communication skills



Attitude first

- Be curious
- Listen rather than talk
- Listen rather than try to convince
- Roll with resistance

Ask-tell-ask

- “Ask-tell-ask” involves
  - Checking patient expectations
  - Sharing information
  - Inquiring explicitly about the patient’s reaction
- Provides important data for you about comprehension, coping that helps you tailor what you say next

Different ways of asking

- Asking permission to explore topic
- Asking regarding their knowledge/beliefs
- Asking to share your view
- Asking about concerns/questions

"Which do you want first, the good news that sounds better than it is or the bad news that seems worse than you expected?"

Telling

- Simple language
- 3 take home points
- Find the common story
- Be careful of “but”
- Chunk and check in

Asking again

- What questions do you have ?
- Keep asking until no more questions
- What will you tell X about our conversation when you go home

The feeling conversation

The power of emotions

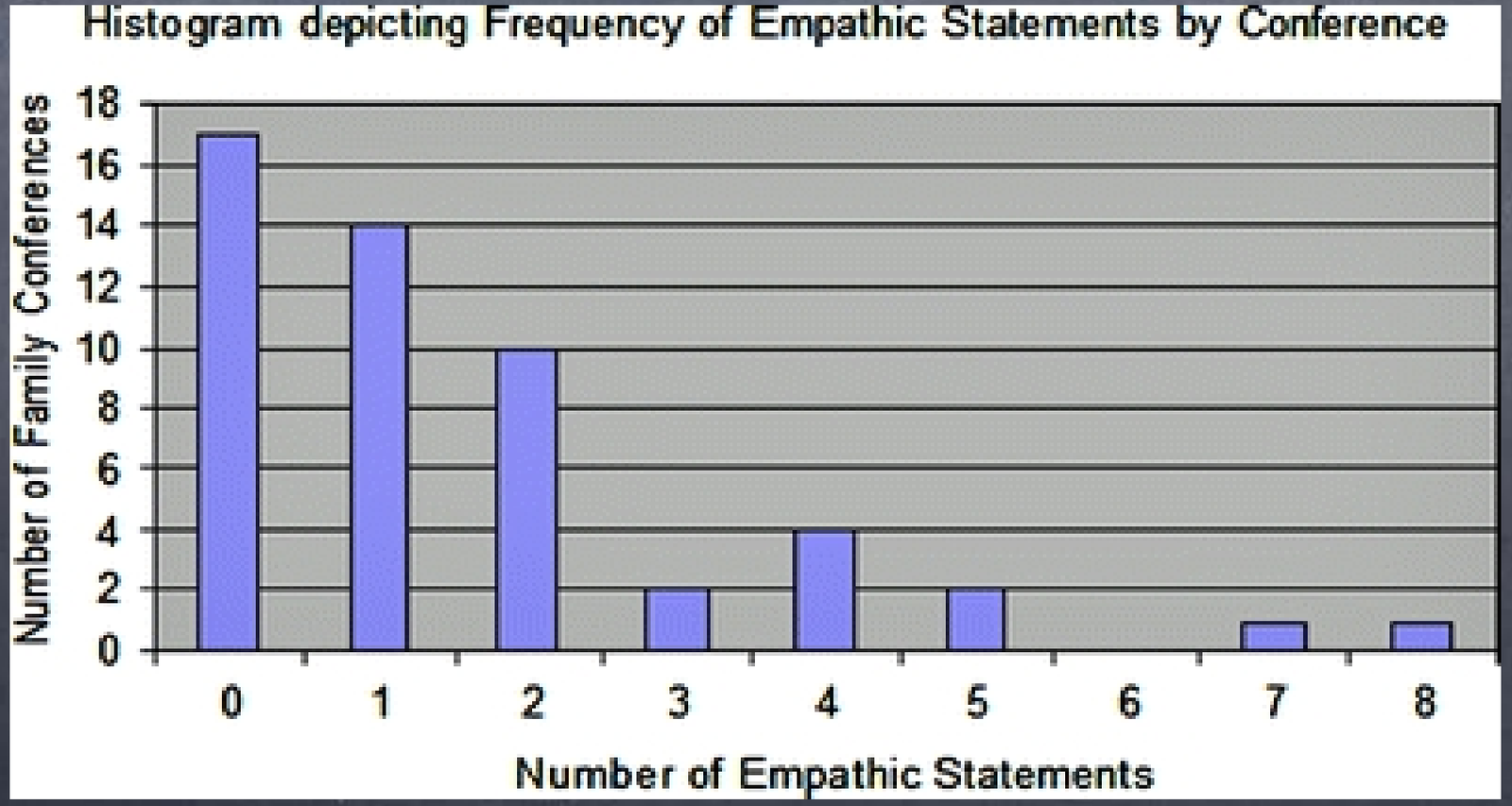
- Emotions act faster than cognition
- Emotions shut down cognition
- Talking about emotions helps most people

The patient/family feelings are central

- Feelings are at the heart of difficult conversations.
  - Loss, frustration, sadness
  - Anxiety about the unknown future
  - When one is emotional they can not reason
  - Family evaluation of doctors is based on gestalt

Physicians and emotion

- Blocking behaviors are 2x as common as empathic behaviors



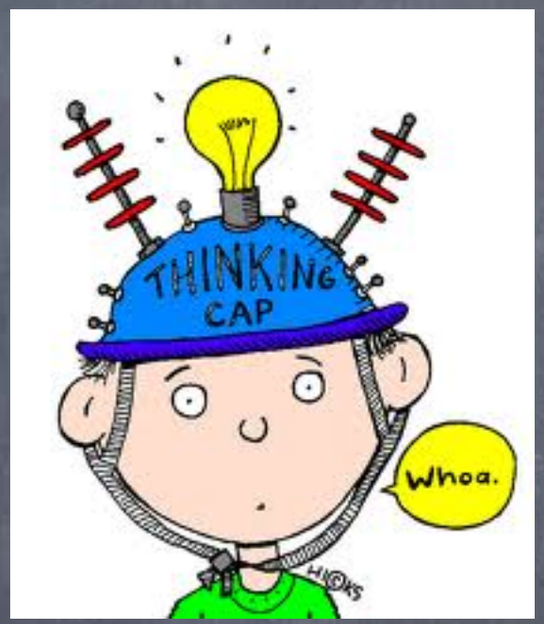
Recognizing emotions

- Emotion words
- Paralinguistic cues
- When facts do not work
- After bad news

Verbalize empathy

- Naming “It sounds like…”
- Understanding “I’m hearing you say…”
- Respecting “I am impressed that…”
- Supporting “I’ll be available for you…”
- Exploring “It would help me to know more about…”

Let’s practice



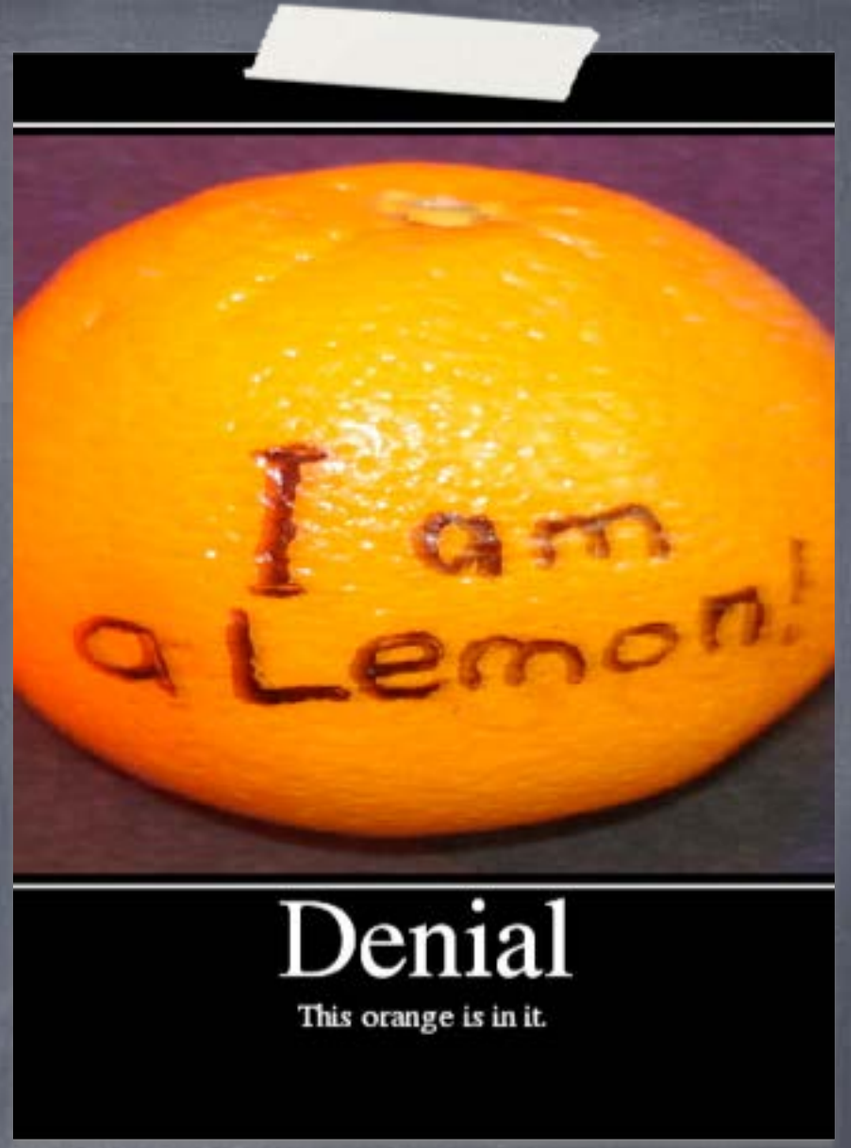
How long do you have to do this?

- 40 seconds

When can you stop?

- Let the family lead
- Check in and ask

Denial



- Families who do “not get it”
- Our job is to help them “get it”
- Unfortunately these conversations usually go badly


Don't quit
before your
miracle

Dealing with “push-back”

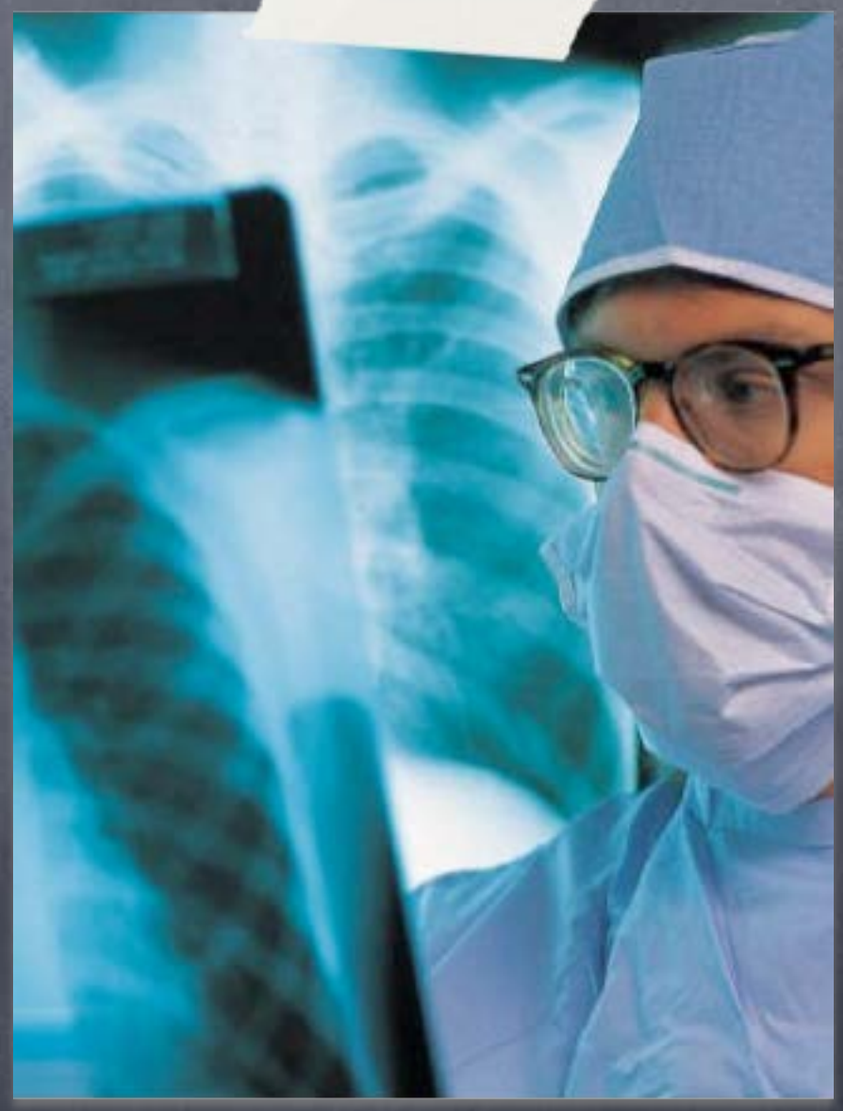
- Naming the ambiguity
  - Reflect what you are hearing
- Acknowledge their hopes
- Use wish statements
- Ask permission before giving advice

Your feelings are important

- Unrecognized feelings
  - Interfere with your speaking clearly
  - Make it difficult to listen
  - Leak into conversation
  - Are a rich source of clinical data
  - Lead to stress

What if you are overwhelmed

The identity conversation



The identity conversation

- Who are we and how do we see ourselves
  - Sets up what we think our role is
    - Keys frustration and satisfaction
    - A good intern gets the DNR order
    - Family -Son’s do not give up on their dad

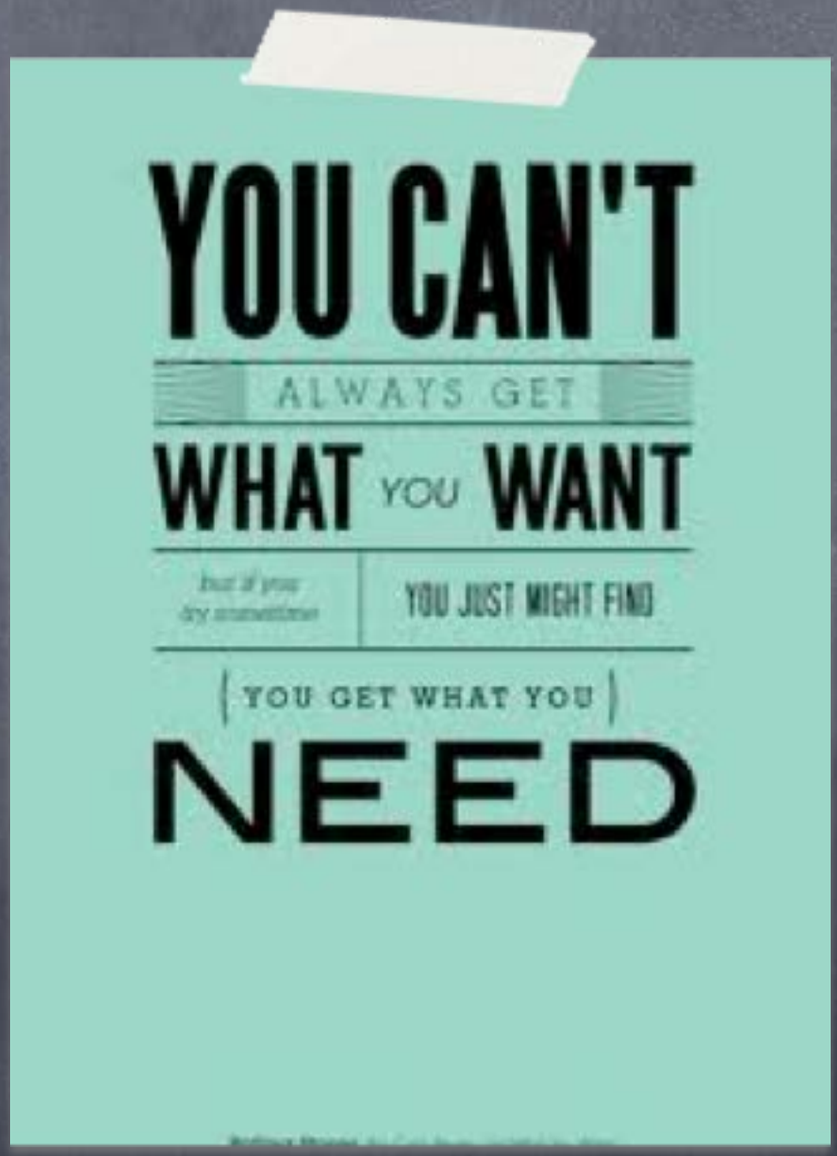
Tool : As yourself why this one's getting to you

- Rule: Ask yourself these questions
  - Am I making assumptions about the other person's intentions?
  - Am I acting as if I know all I need to know to understand what happened?
  - Do I think my feelings are the other person's fault
  - Which buttons is this pushing in me?

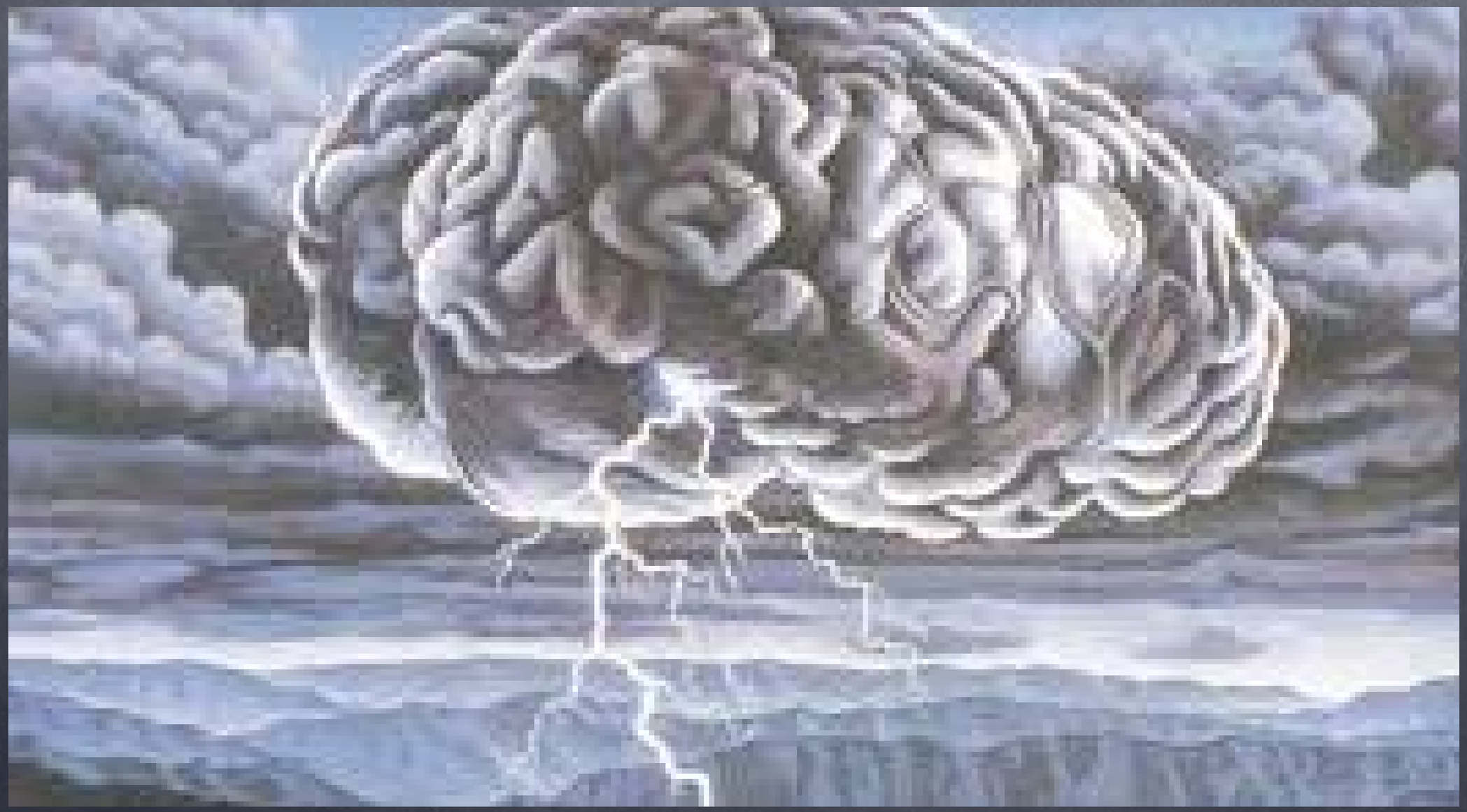
Step back and focus on goals

Talking with surrogates

- Focus on the patient
- Avoiding “wanting”
- Patient goals/fears



Brainstorm….. (their brain)



Offer a plan

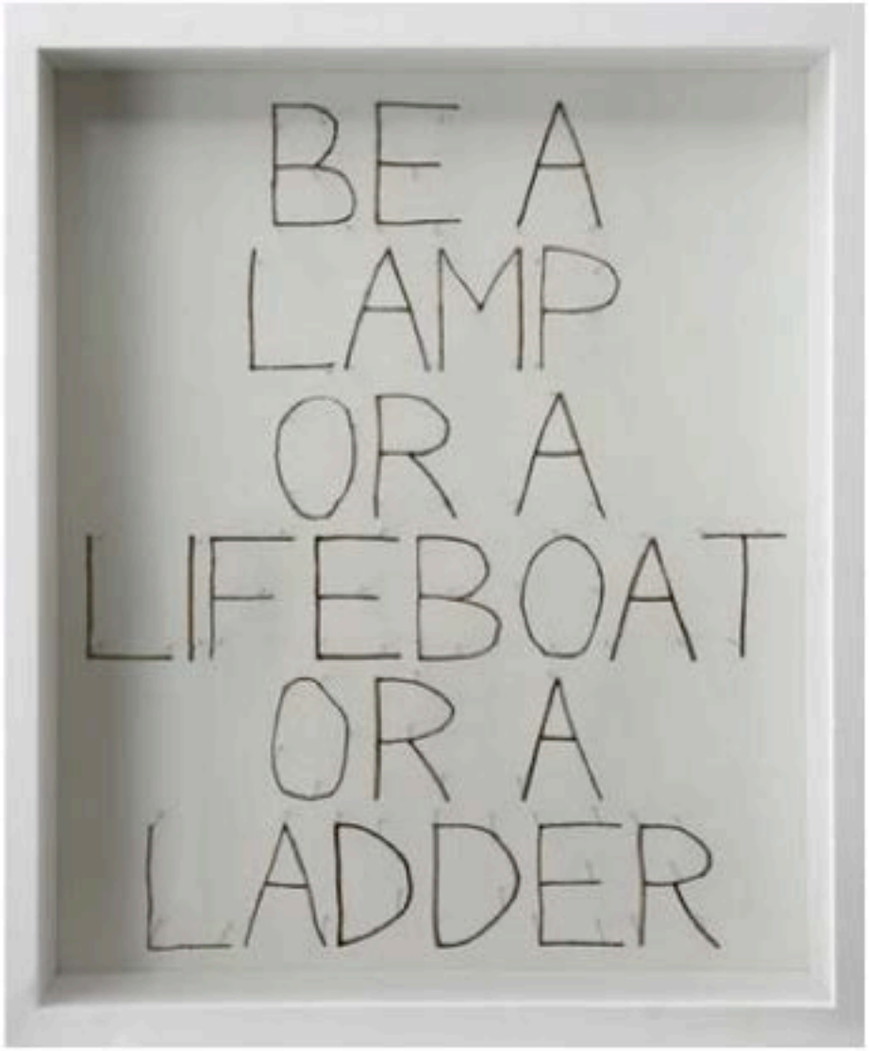
- Ask if you can give recommendations
- Offer recommendations
- Show your work- patient values and goals
- Reinforce what you WILL do
- Reinforce what it doesn’t make sense to do

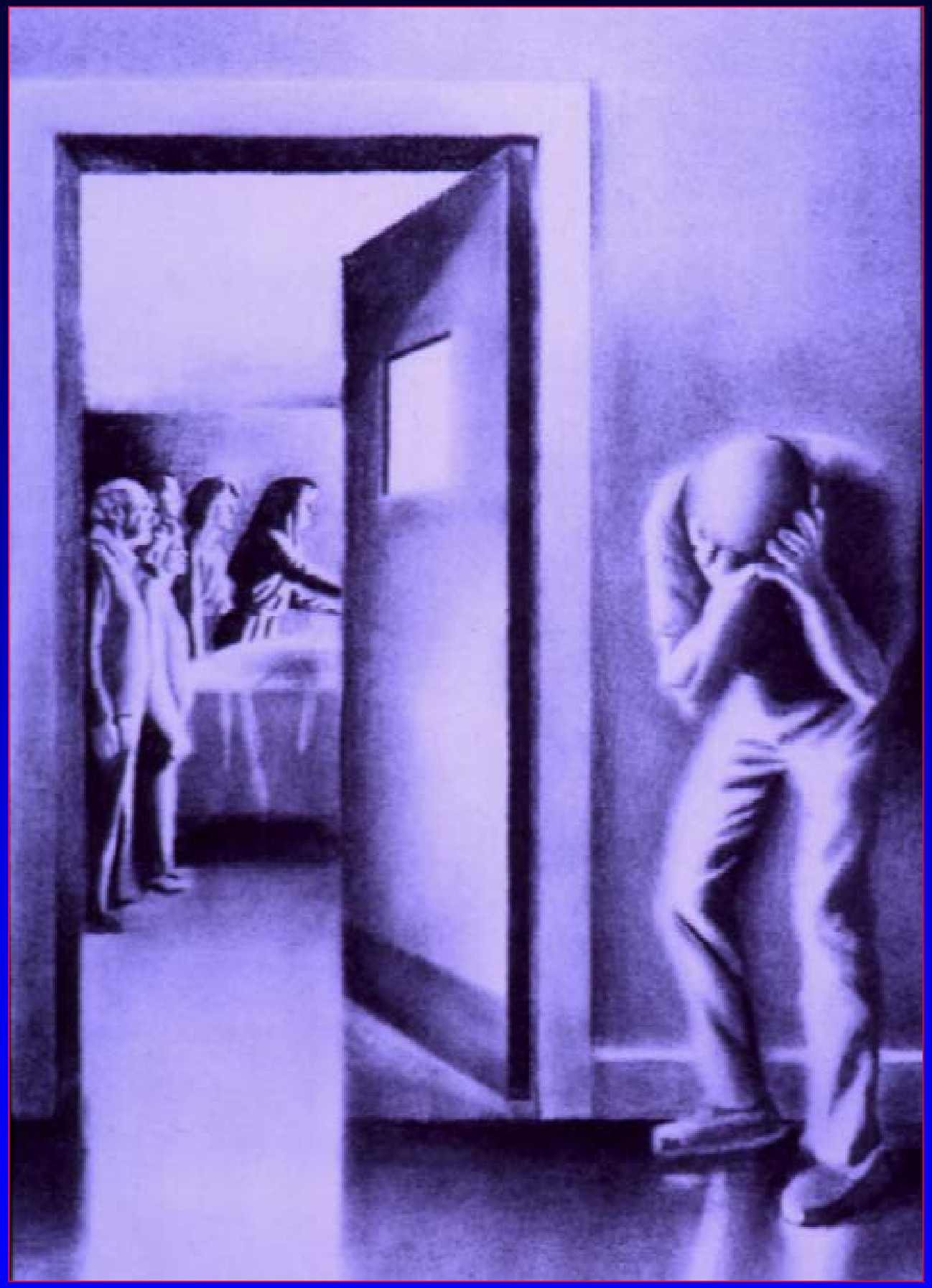
Time limited trial

- Give them time
- Time-limited trial
  - Be clear about what counts as success
  - Be clear about how long
  - Hope for best, prepare for the worst

Conclusion

- Recognize conflict early
- Seek to understand their side: facts, emotions and identity issues
- Find shared common ground and purpose
- Devise a strategy
- Reflect on your role in the conflict





COMMUNICATING WITH THE BURN CENTER

SAMUEL P. MANDELL, MD, MPH
ASSISTANT PROFESSOR OF SURGERY
HARBORVIEW MEDICAL CENTER
OCTOBER 1, 2015

UW Medicine
HARBORVIEW
MEDICAL CENTER

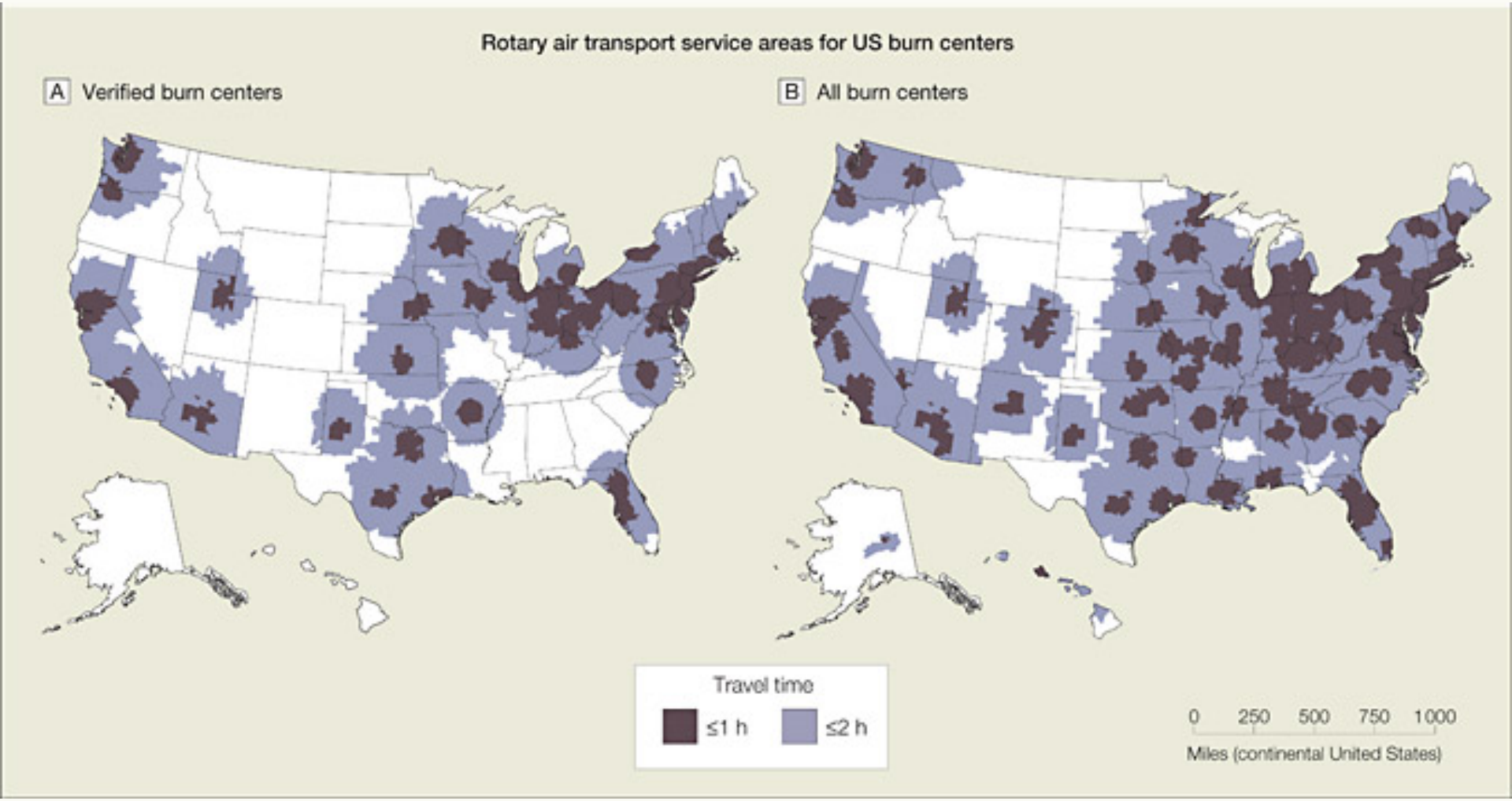
I HAVE NO DISCLOSURES

ALL IDENTIFIABLE PHOTOS ARE USED WITH PERMISSION

OBJECTIVES

1. Why is this important
2. Who and What we can help with
3. Patient Stories
4. Future Opportunities

A GALAXY FAR, FAR AWAY…



Klein, JAMA 2009

OVERTRIAGE

17.7 %

of patients airlifted to a regional burn center were discharge within 24 hours

Kashefi, JBCR 2015

UNDERTRAIGE

50%

Of patients that met referral criteria that were not treated at a burn center.

Carter, JBCR 2010 and Davis, JBCR 2012

CRITERIA

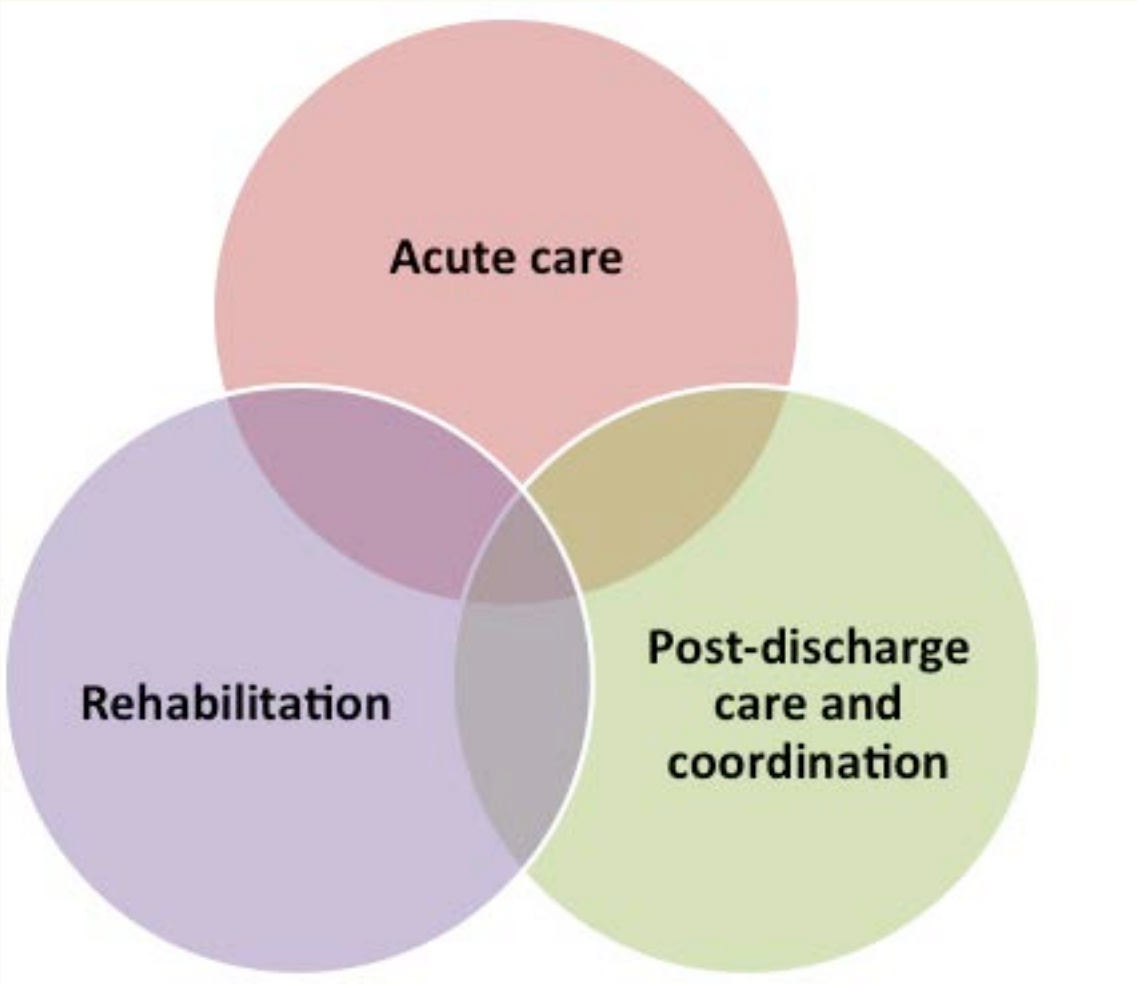
1. Partial thickness burns > 10%
2. Third degree burns in any age group
3. Children in hospitals without qualified personnel or equipment for the care of children
4. Burns to hands, face, feet or perineum
5. Electrical burns
6. Chemical burns
7. Other associated injuries
8. Inhalation injury
9. Co-morbidities or systemic disease
10. Psycho - social, emotional issues, or rehabilitation needs

CALL EARLY

- Talk directly to a burn expert
- Send Pictures
- We can help with:
  - Determining severity
  - Resuscitation formula Y/N
  - Intubation Y/N
  - Ventilator Management
  - Wound Care
  - Who needs transfer
  - Timing / method of transport

UW REGIONAL BURN CENTER CARE MODEL

- **PROVIDERS**
  - ICU/BURN
  - PLASTICS
  - ANESTHESIA
  - PEDIATRICS
  - REHABILITATION MEDICINE
  - PSYCHOLOGISTS
- **SPECIALIZED NURSES**
  - ARNP
  - ICU
  - OR
  - CLINIC
- **PHARMACISTS**
- **DIETICIAN**
- **THERAPISTS/COUNSELORS**
  - OT
  - PT
  - CHILD LIFE
  - SOCIAL WORK
  - SPIRITUAL CARE
  - VOCATIONAL REHABILITATION



SMALL BURNS CAN CAUSE BIG PROBLEMS

Electrical worker

One month later

PEDIATRIC HAND BURN

No Big Deal

Potentially Devastating

MINOR BURN

Does not require specialty care

A burn that will not…

- Leave a scar in an aesthetically important area
- Compromise joint function or mobility
- Lead to functional or psychological sequelae

DEVASTATING BURN INJURIES

- Factors to Consider
  - Extent of burn
  - Depth of burn
  - Patient co-morbidities
  - Likely outcome

MR. W

MR. X

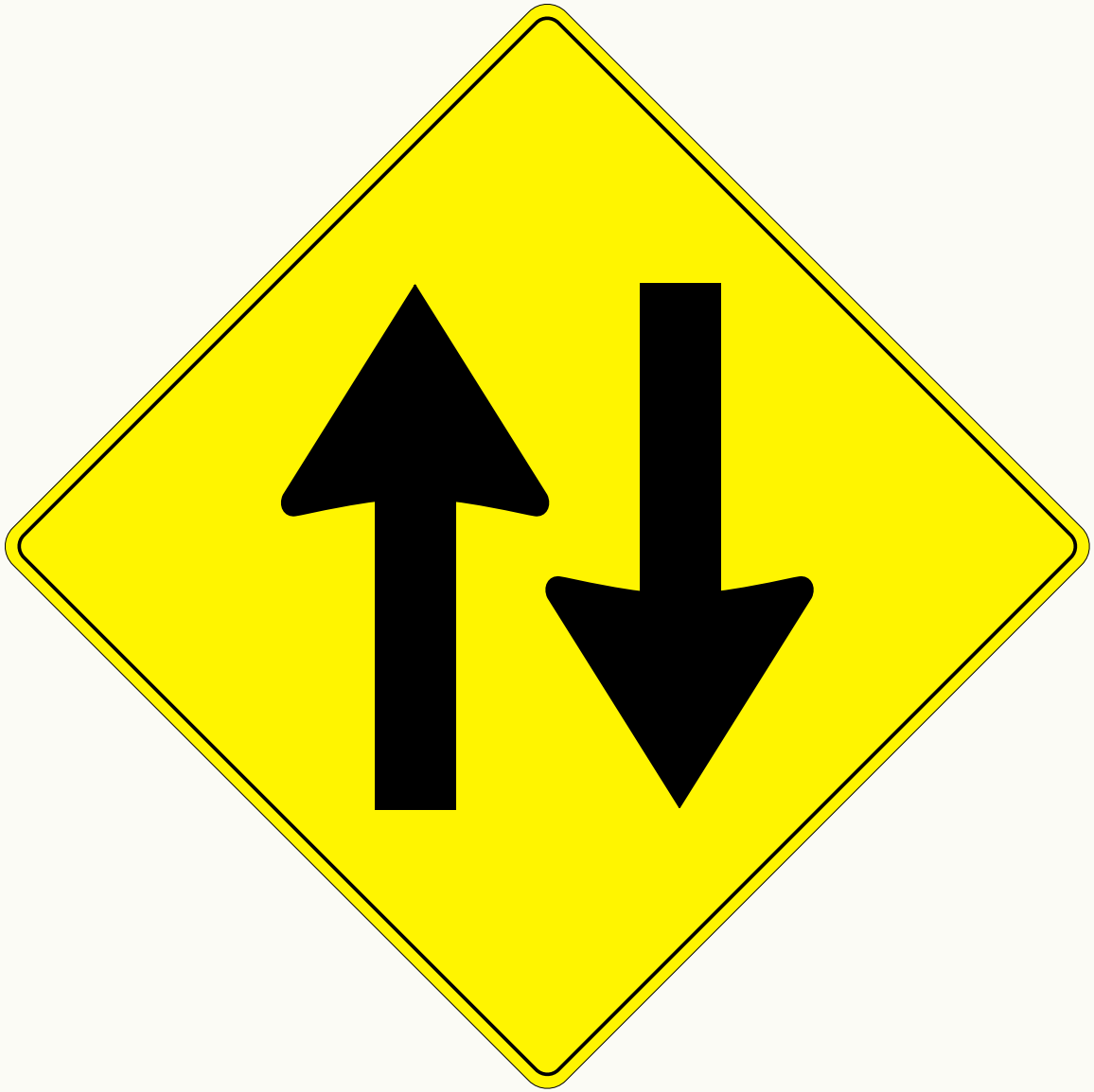
- 60 year old man with 35% TBSA burn
  - History of Enbrel Use
  - Colonic pseudobstruction
  - Pneumonia
  - Excised and Grafted
  - Discharged after 35 days

MR. X

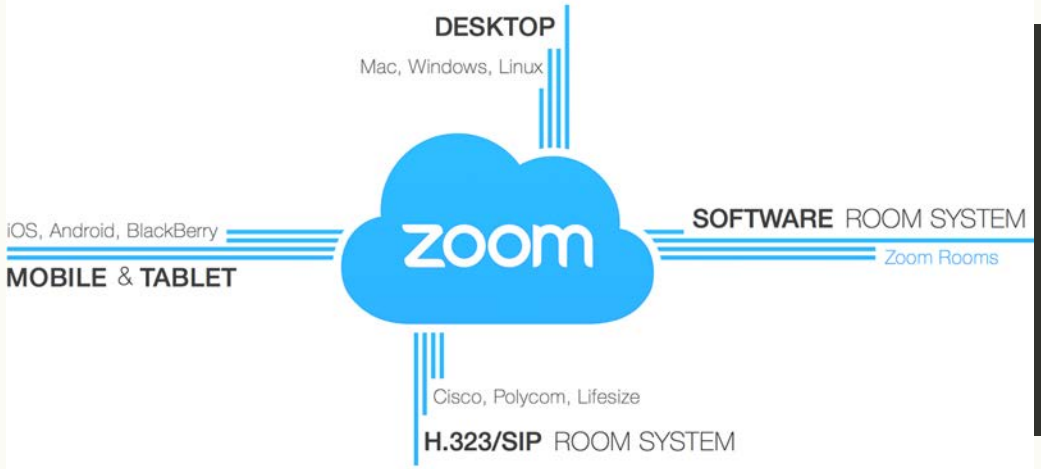
- ED for day after discharge → Zpack
- 2 days later PCP
- 3 days later collapses at home

Death due to acute organizing pneumonia.

COMMUNICATION



http://ulink.uwmedicine.org



YouTube

THE FUTURE OF COMMUNICATION

BURN CENTER
UNIVERSITY of WASHINGTON

iTUNES

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UW Surgery

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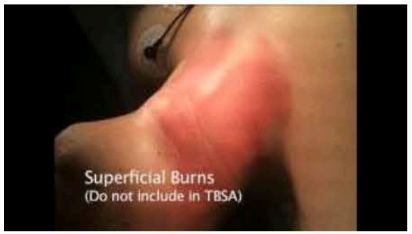
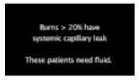


Burn Educational Videos

by UW Surgery • 15 videos • 321 views • Last updated on Jul 28, 2015

Play all | Share | Save

1		**Burns 101 Assessment** by UW Surgery	6:49
2		**Burns 101 Triage** by UW Surgery	3:16
3		**Burns 101 Initial Management** by UW Surgery	4:30
4		**Burns 101 Treatment** by UW Surgery	5:15

BURNS 102

Escharotomy for 3rd degree (full-thickness) burns

Gabriel Wallace, MD, Pirko Maguiña, MD,
Samuel Mandell, MD, MPH, Gary Fudem, MD,
Tam Pham, MD

UW Medicine
HARBORVIEW MEDICAL CENTER

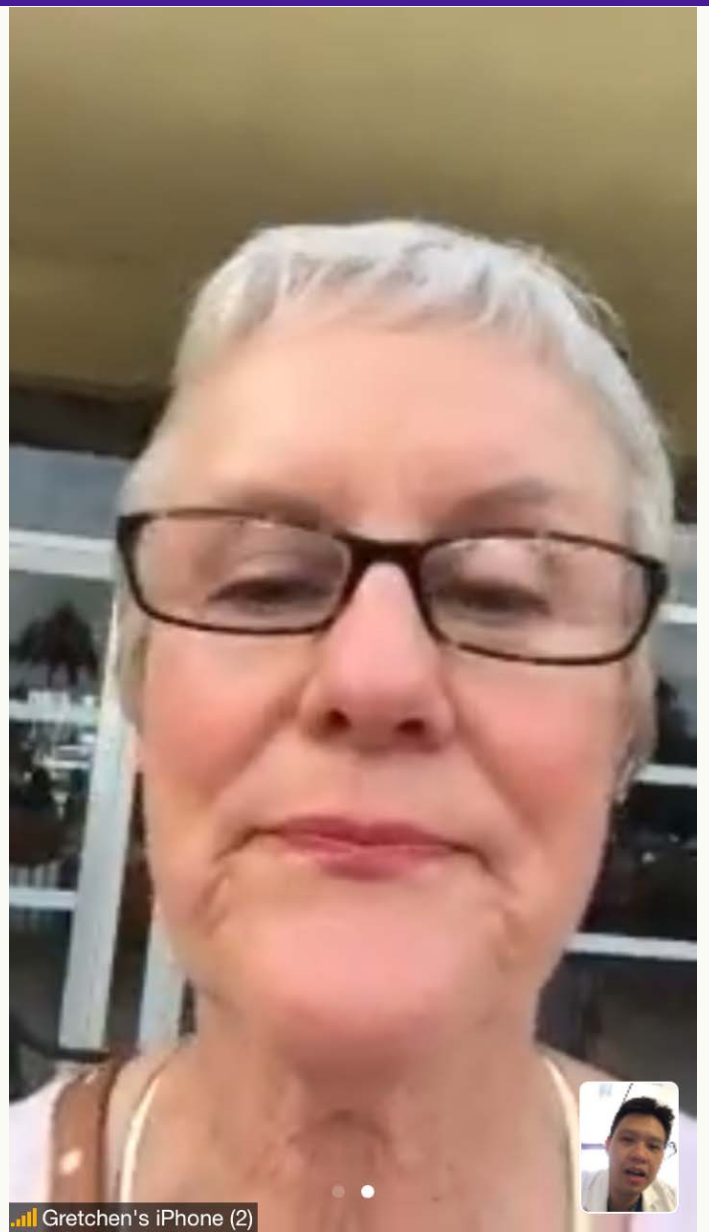
ReSurge INTERNATIONAL

Shriners Hospitals for Children™

TELEMEDICINE

Live from…

Timbuktu



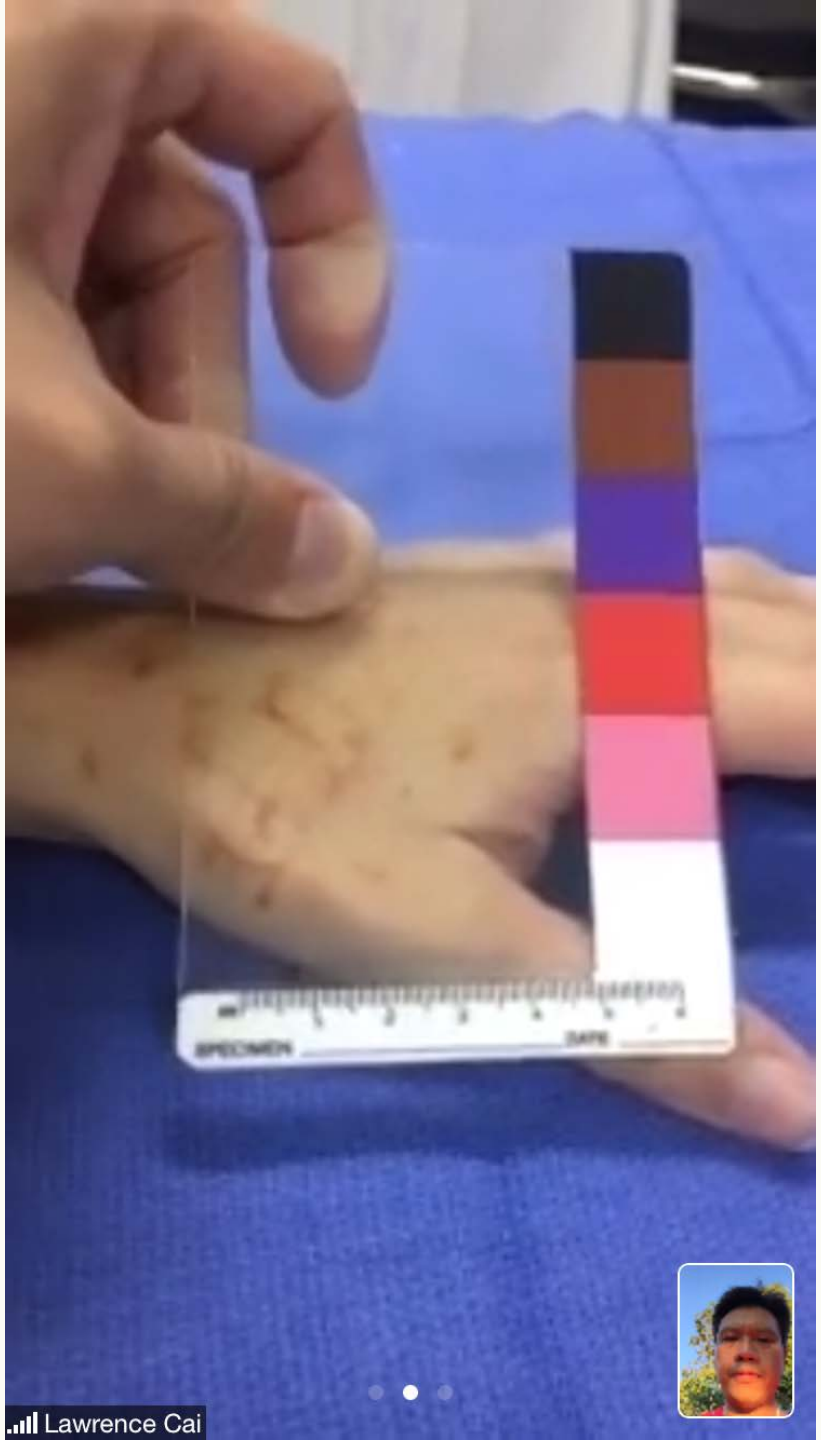
EVALUATING ACUTE BURNS

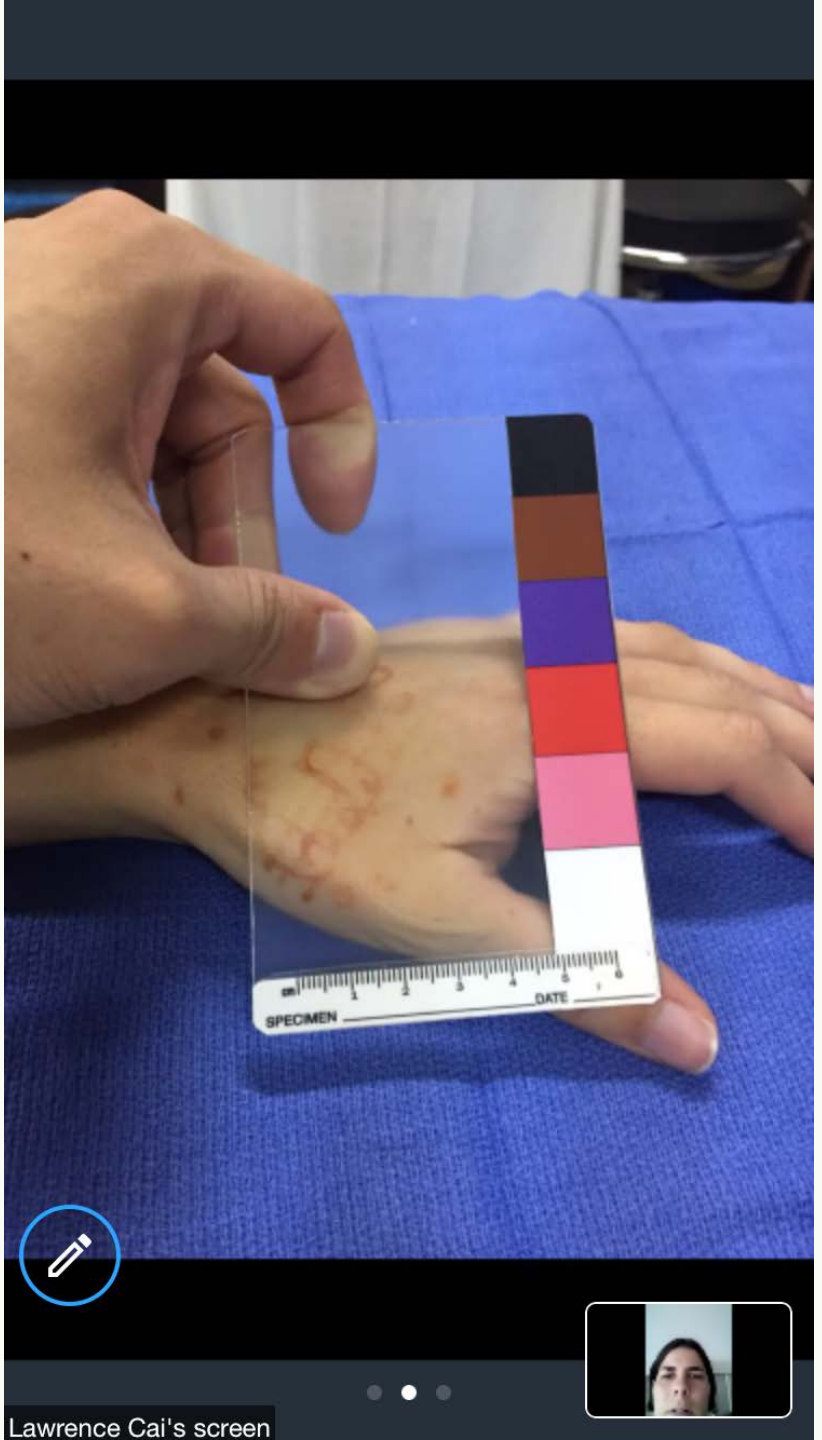
Elisha's iPhone

ACROSS TOWN

AROUND THE WORLD

Lawrence Cai


SPECIMEN
DATE
Lawrence Cai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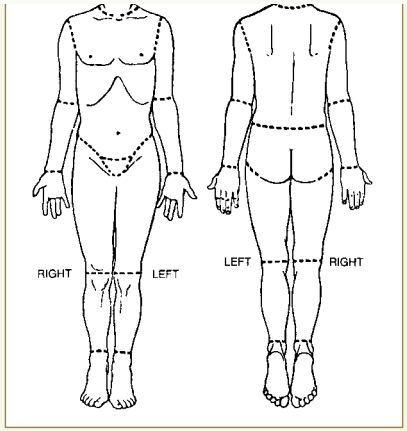
TRANSFER CENTER WEBSITE

UW Transfer Center: 1-888-731-4791

http://www.uwmedicine.org/referrals/transfer-center



COMPLETED BY

SHALLOW + INTERMEDIATE OR DEEP = ____ %

SHALLOW (PINK, PAINFUL, MOIST)

INDETERMINATE OR DEEP (DRY, LESS SENSATION, WHITE, MOTTLED, DARK RED, BROWN OR BLACK, LEATHERY)

Percent Surface Area Burned
(Berkow Formula)

AREA	1 YEAR	1-4 YEARS	5-9 YEARS	10-14 YEARS	Y 15 YEARS	ADULT	SHALLOW	INDETERMINATE OR DEEP
Head	19	17	13	11	9	7		
Neck	2	2	2	2	2	2		
Ant. Trunk	13	13	13	13	13	13		
Post. Trunk	13	13	13	13	13	13		
R. Buttock	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2		
L. Buttock	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2		
Genitalia	1	1	1	1	1	1		
R. U. Arm	4	4	4	4	4	4		
L. U. Arm	4	4	4	4	4	4		
R. L. Arm	3	3	3	3	3	3		
L. L. Arm	3	3	3	3	3	3		
R. Hand	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2		
L. Hand	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2	2-1/2		
R. Thigh	5-1/2	6-1/2	8	8-1/2	9	9-1/2		
L. Thigh	5-1/2	6-1/2	8	8-1/2	9	9-1/2		
R. Leg	5	5	5-1/2	6	6-1/2	7		
L. Leg	5	5	5-1/2	6	6-1/2	7		

Harborview Medical Center

BURN STABILIZATION PROTOCOL

Burn physicians are available to consult 24 hours a day.
To speak with the Transfer Center, phone: 1.888.731.4791
or email: www.uwmedicine.org/facilities/harborview/clinicsandservice.burn/

MINIMAL CRITERIA FOR TRANSFER TO A BURN CENTER
AMERICAN BURN ASSOCIATION

Burn injuries that should be referred to a burn unit include the following:

- Partial thickness burns greater than 10% total body surface area (TBSA)
- Third-degree burns in any age group
- Electrical burns, including lightning injury
- Chemical burns
- Inhalation injury
- Burn injury in a patient with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality
- Any patient with burns and concomitant trauma

Thank You

TELEMEDICINE UPDATE

MQAC Meeting

Oct 1, 2015

John Scott, MD, MSc

Medical Director, Telehealth Services

UW Medicine

OUTLINE

- ✓ Definition and examples of telehealth
- ✓ Gaps in care
- ✓ Tele-ICU
- ✓ SB 5175 Telehealth legislation
- ✓ Best practices in telehealth
- ✓ Barriers to wider adoption of telehealth

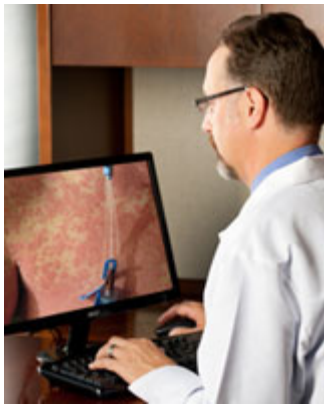
WHAT IS TELEHEALTH?

- ✓ "**Telehealth** is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."
- ✓ Often used interchangeably with **telemedicine**, but telemedicine is technically focused on clinical aspects of care.

www.hrsa.gov/**telehealth**/

DIFFERENT METHODS OF TELEHEALTH

1. Live, face-to-face consultation



2. Store and forward

3. Remote monitoring

4. Case-based teleconferencing

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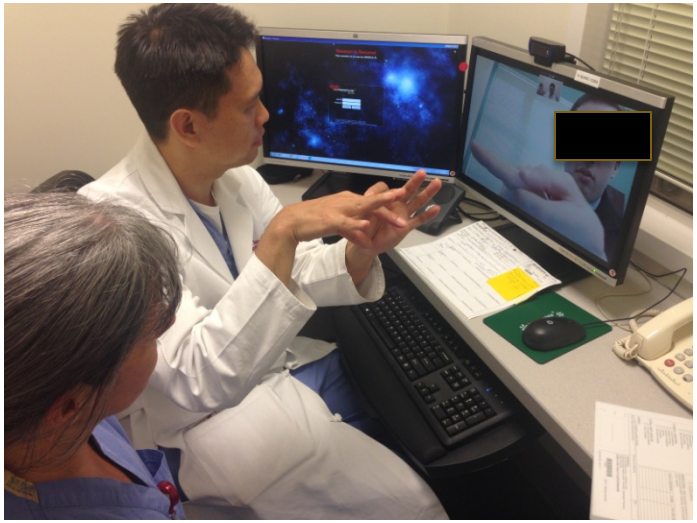
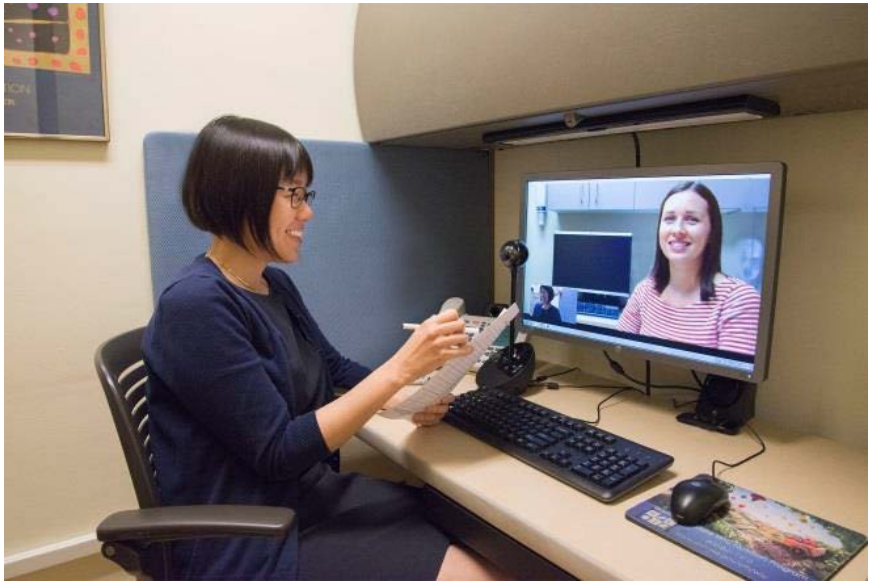
TELEMEDICINE LAUNCHES





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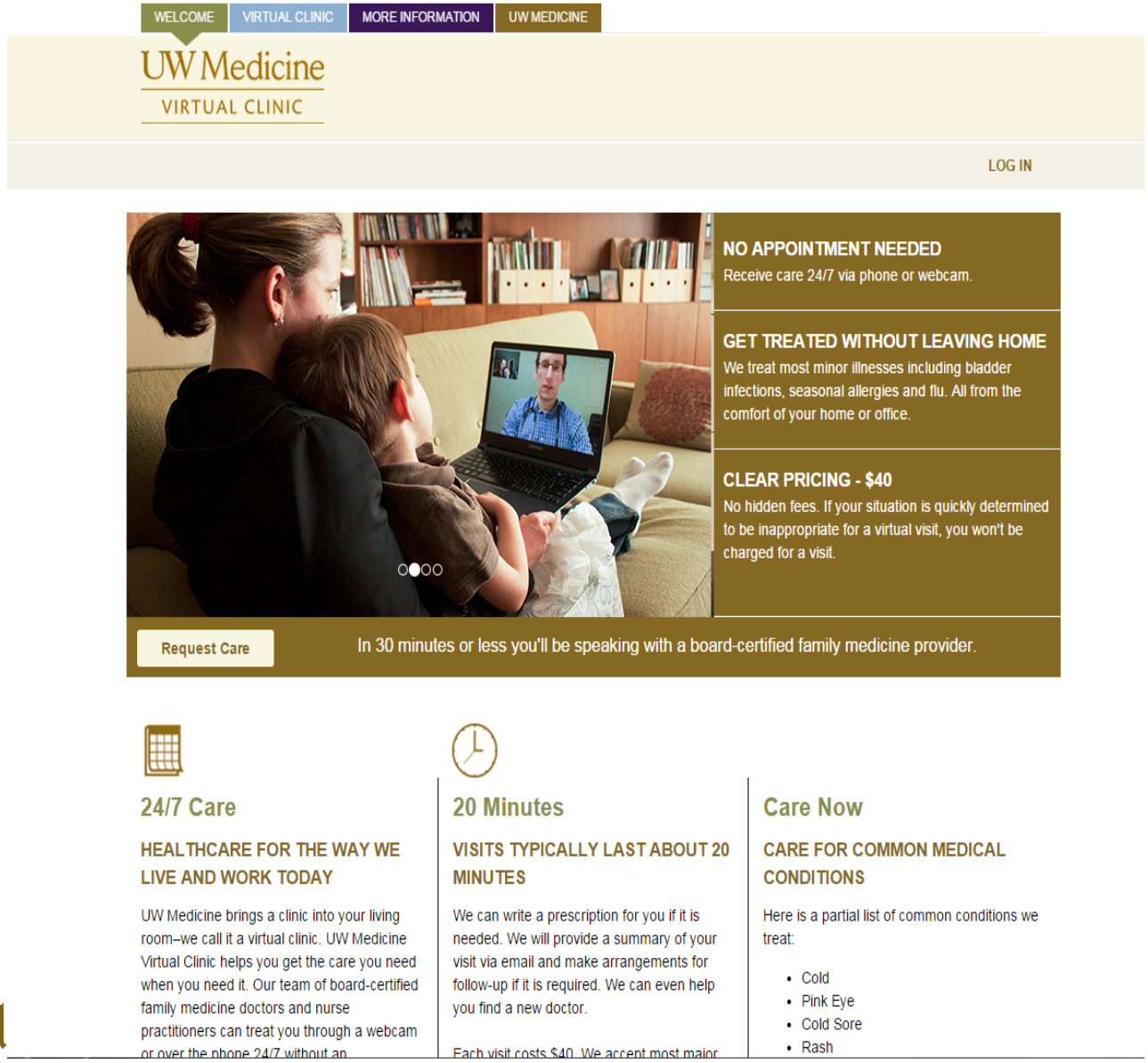
VIRTUAL CLINIC: TELE-URGENT CARE

VIRTUAL CLINIC



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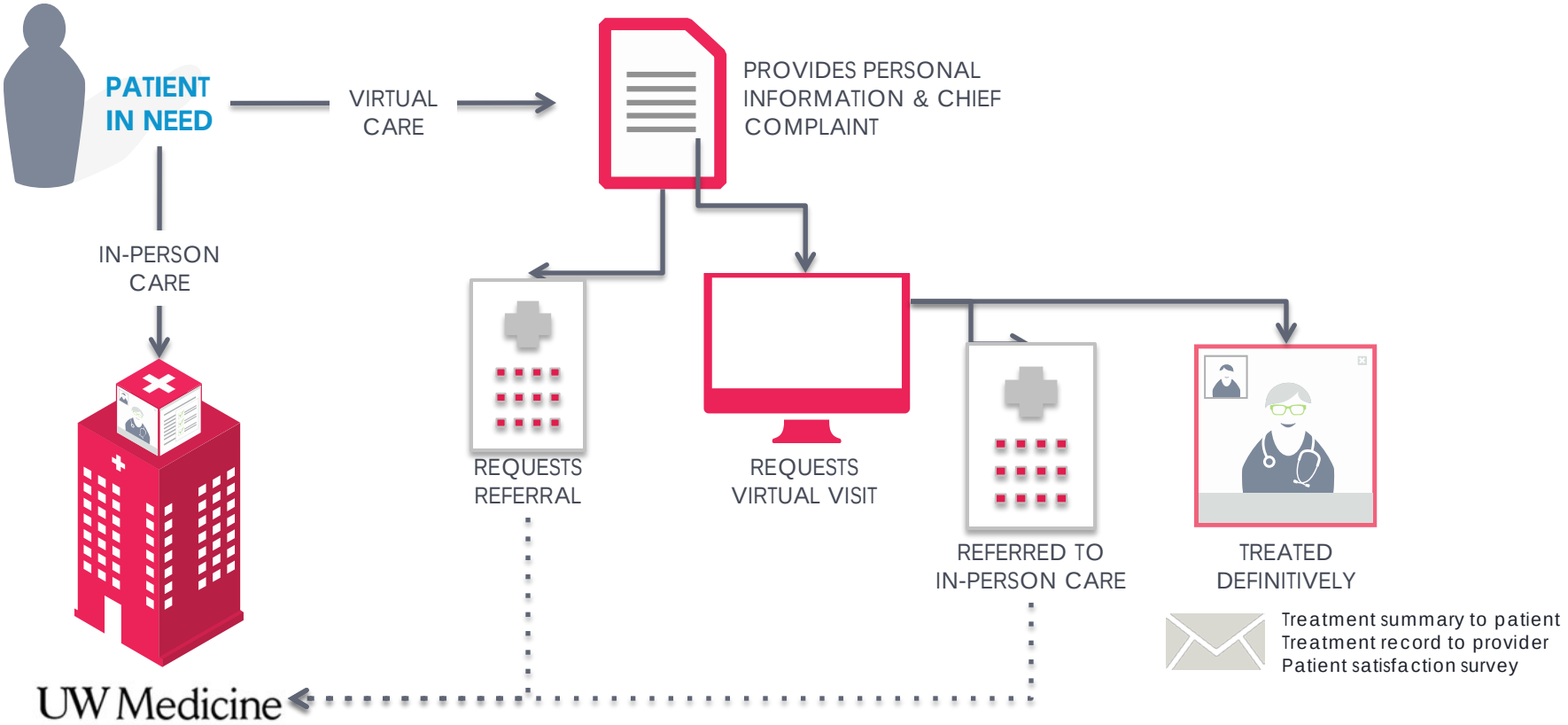
HOW IT WORKS

Aligning the Patient & the Health System



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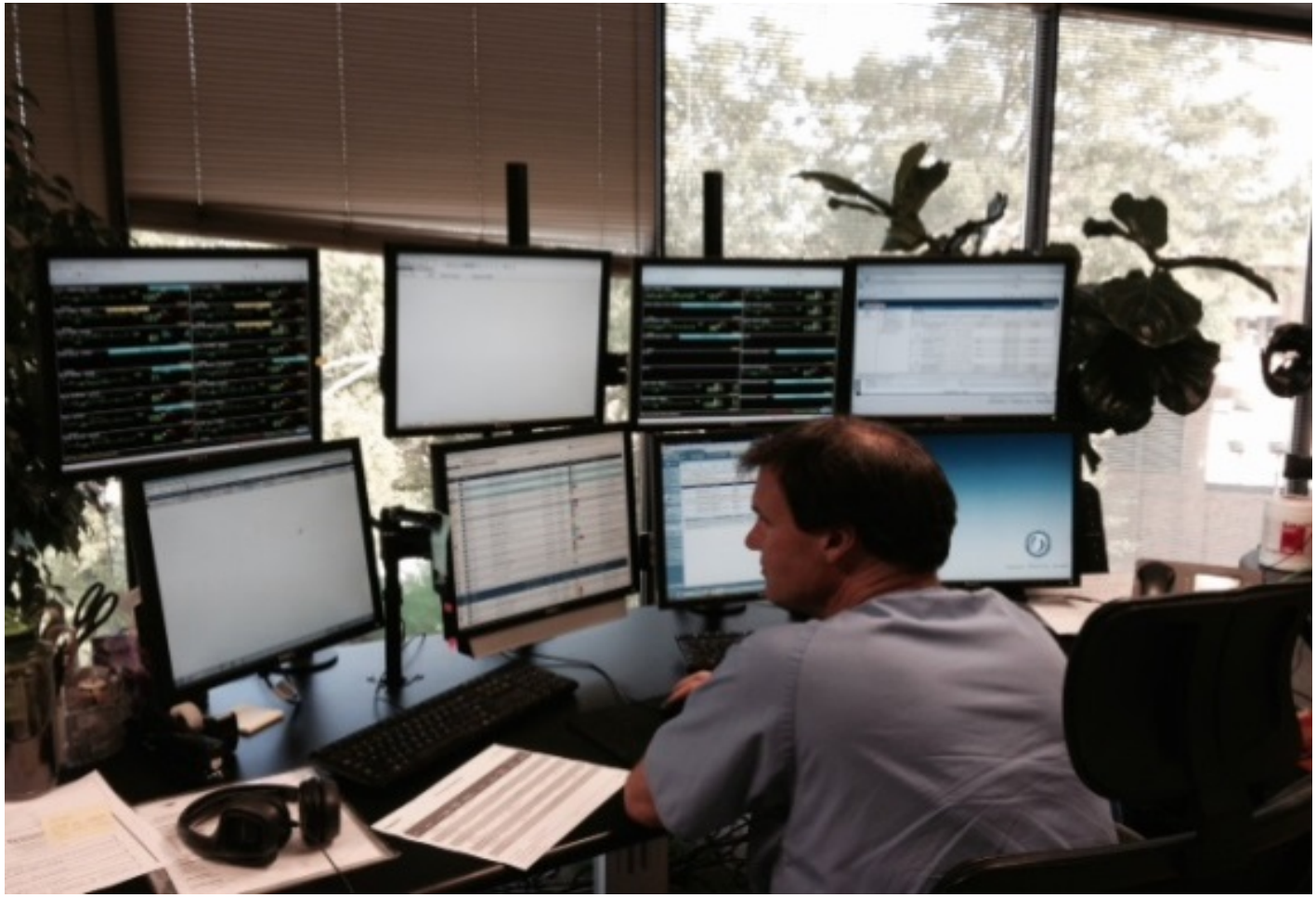
GAPS IN CARE

- ✓ Psychiatry
- ✓ Complicated specialty care

TELE-ICU



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THE NEED

- Aging population
- Smaller or critical access hospitals without 24/7 hospitalist or intensivist
- Standardization of clinical pathways and procedures across care networks (ACO)
- Fewer training positions at AMCs, possibly fewer specialists in future

BUSINESS CASE

- ATA estimates that >550,000 patients in ICU are monitored through tele-ICU
  - 11% of all US pts in ICU
- 10-25% growth annually in # monitored by tele-ICU
- Among the most expensive patients in an ACN
- Mean cost of $31,500 for LOS and 14 d stay if ventilated
- Mean cost of $13,000 for LOS and 8.5 d stay if not ventilated
- Best practices developed for tele-ICU by ATA

Source: Dasta JF[1], McLaughlin TP, Mody SH, Piech CT. Daily cost of an intensive care unit day: the contribution of mechanical ventilation. Crit Care Med. 2005 Jun;33(6):1266-71.

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HOW IT WORKS

Centralized:

- 24/7 tele-monitoring in a central hub
- Use custom technology and health system's EMR
- Best practices, care pathways
- eCare Manager allows for documentation, vitals, bedside monitors, alerts

Decentralized:

- Intensivists around the country
- Come in for AM, PM and Qhs rounds
- Plus consults + emergencies
- QI checklists, care pathways
- "Smart nurses, not smart alerts"

EVIDENCE BASE

- Mixed results in terms of safety and efficacy

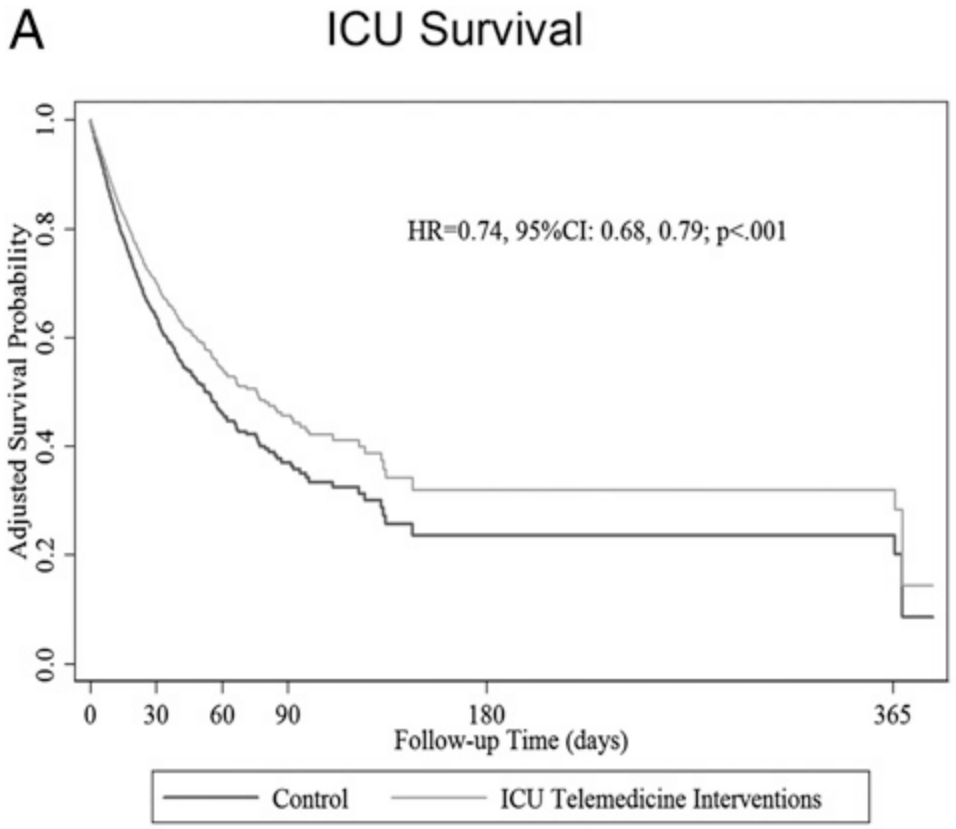
FAVORABLE RESULTS

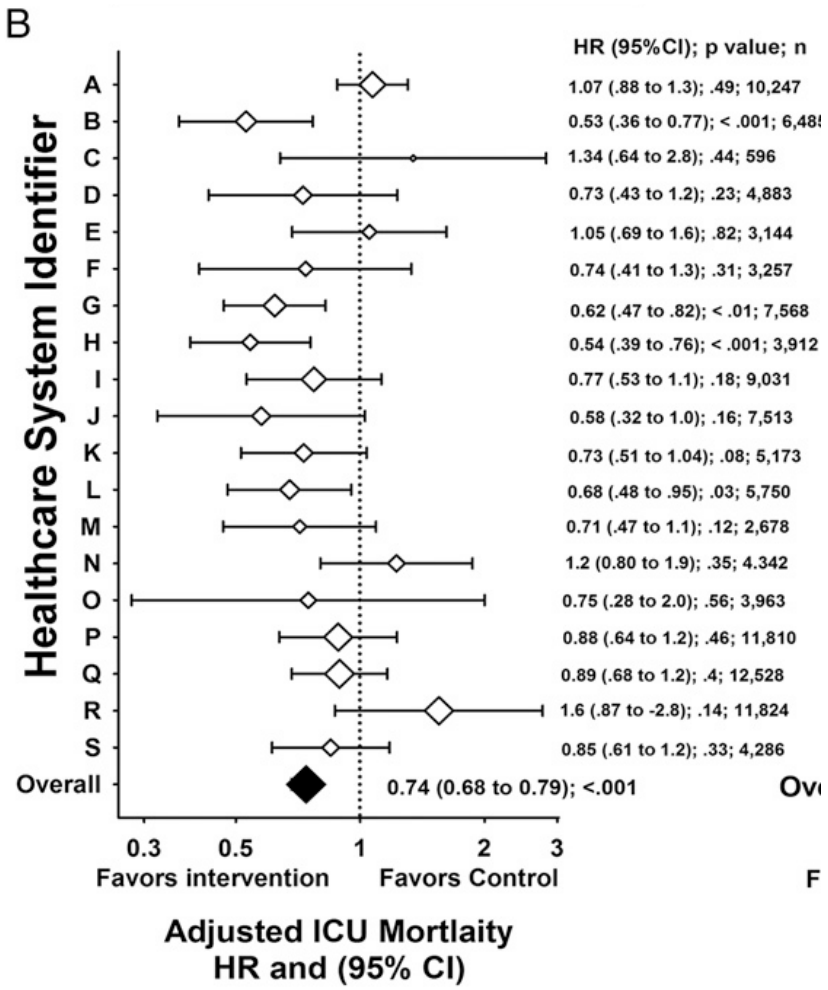
- Lilly CM, et al. A multicenter study of ICU telemedicine reengineering of adult critical care. Chest 2014; 145:500-507.
- Deslich S, et al. Expanding technology in the ICU: the case for the utilization of telemedicine. Telemed J E Health. 2014 May;20(5):485-92.
- **Limitations**: done in AMCs, short period of outcome (30d), lack of concurrent controls

FAVORABLE RESULTS: LILLY

- Non-randomized, unblinded study
- Pre- and post-tele-ICU program
- 56 US ICUs in 15 states
- 2003-08
- Powered to detect 4.5% difference in mortality at 0.05 significance
- Large study: 11,588 control ICU admissions vs. 107,432 Tele-ICU admissions

ICU SURVIVAL





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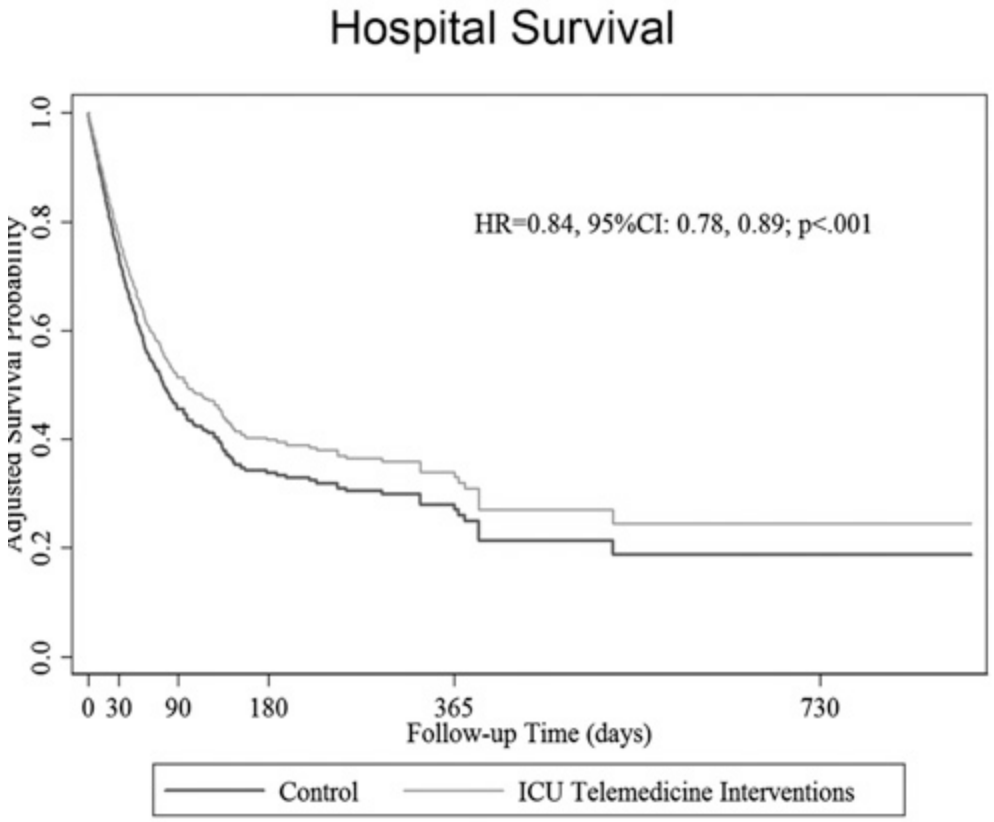
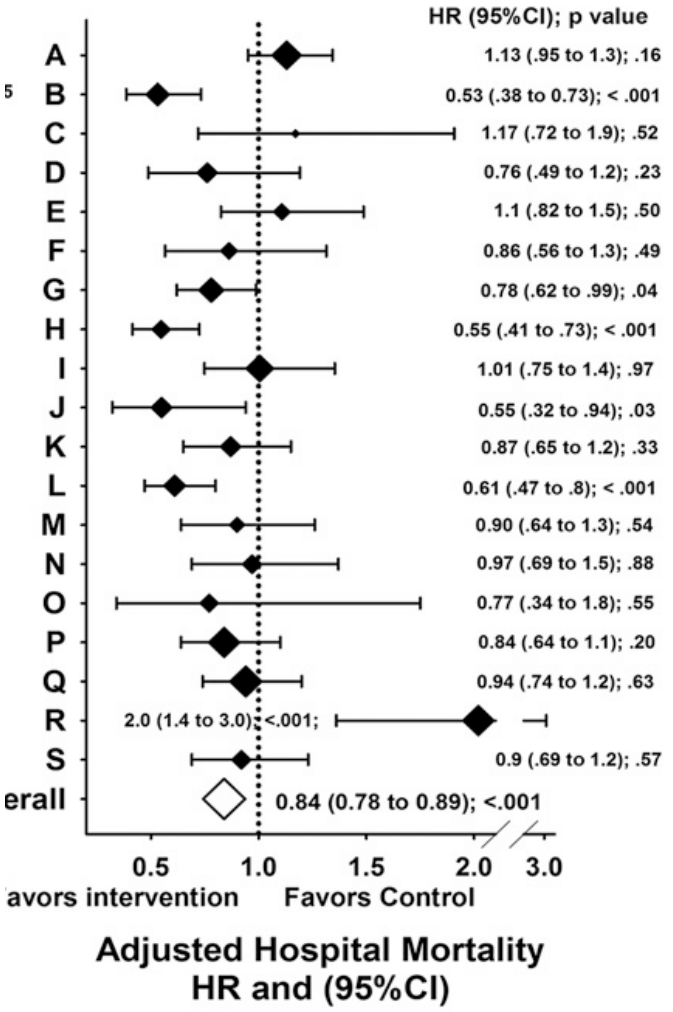
HOSPITAL SURVIVAL





Adjusted Hospital Mortality HR and (95%CI)

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FAVORABLE RESULTS: DESLICH

- Meta-analysis of 55 studies
- Startup costs were significant: $100k per bed
- LOS reduced by 24%
- “The findings …suggest that the implementation of tele-ICU may have been more beneficial than costly, and it may…increase quality of care and decrease mortality”

UNFAVORABLE RESULTS

- Nassar BS, et al. Impact of an intensive care unit telemedicine program on patient outcomes in an integrated health care system. JAMA Intern Med. 2014;174:1160-7.
- Young LB, et al. Impact of telemedicine intensive care unit coverage on patient outcomes: a systematic review and meta-analysis. Arch Intern Med. 2011; 171:498-506.

NASSAR

- Compared patients in Tele-ICU vs. control ICUs
- Eight ICUs in upper Midwest, all were VAMC, mix of urban and rural (N=6654)
- Centralized model
- Staffed 21 hrs/d, 7 d/wk
- Intensivist + 2 critical care nurses
- 2011-12
- Control patients came from ICU matched by ICU type, volume, racial mix

RESULTS

Table 2. Unadjusted Mortality and LOS Outcomes for 6939 Patients in Intervention and Control ICUs

Outcome	Intervention ICUs			Control ICUs			
	Pre-TM Period (n = 1708)	Post-TM Period (n = 1647)	*P* Value[a]	Pre-TM Period (n = 1664)	Post-TM Period (n = 1920)	*P* Value[a]	*P* Value[b]
Mortality, No. (%)							
ICU	49 (2.9)	46 (2.8)	.89	67 (4.0)	65 (3.4)	.31	.58
Hospital	62 (3.6)	70 (4.3)	.36	115 (6.9)	111 (5.8)	.17	.11
30-d	132 (7.7)	129 (7.8)	.91	200 (12.0)	195 (10.2)	.08	.22
LOS, mean (SD), d							
ICU	2.6 (3.6)	2.8 (4.7)	.15	2.9 (3.7)	2.9 (3.4)	.72	.18
Hospital	6.9 (8.5)	7.3 (6.9)	.18	6.8 (7.9)	6.5 (8.2)	.35	.11

Abbreviations: ICU, intensive care unit; LOS, length of stay; TM, telemedicine.

[a] *P* values comparing differences in outcomes during pre-TM vs post-TM periods.

[b] *P* values comparing the magnitude of change in outcomes between periods for intervention vs control ICU patients (significant at $P < .05$).

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RESULTS

Table 3. Risk-Adjusted Odds Ratio for Mortality and Relative LOS for Patients in Intervention and Control ICUs[a]

	Post-TM (vs Pre-TM) ICUs				Change in Intervention (vs Control) ICUs (in Pre-TM vs Post-TM Periods) (n = 6939)	
	Intervention ICUs (n = 3355)		Control ICUs (n = 3584)			
Outcome	OR (95% CI)	*P* Value	OR (95% CI)	*P* Value	OR (95% CI)	*P* Value
Mortality						
ICU	1.07 (0.60-1.90)	.82	0.88 (0.52-1.49)	.65	1.21 (0.56-2.63)	.63
Hospital	1.33 (0.86-2.07)	.20	0.82 (0.57-1.19)	.30	1.62 (0.91-2.87)	.10
30-d	1.10 (0.82-1.47)	.52	0.79 (0.62-1.01)	.06	1.39 (0.95-2.04)	.09
Relative LOS						
ICU	1.02 (0.95-1.11)	.58	1.00 (0.93-1.08)	.99	1.02 (0.92-1.14)	.68
Hospital	1.03 (0.96-1.11)	.43	0.93 (0.86-1.00)	.05	1.11 (1.00-1.23)	.05

Abbreviations: ICU, intensive care unit; LOS, length of stay; OR, odds ratio; TM, telemedicine.

[a] Models adjusted for patient demographics, comorbid illness, primary conditions at ICU admission (based on Clinical Classifications Software categories for ICU admission diagnosis), and the most abnormal laboratory values during the 24 h surrounding ICU admission, categorized according to the Acute Physiology and Chronic Health Evaluation (APACHE) III scoring method. Full details for all models are available on request. C statistics for mortality models ranged from 0.823 to 0.843.

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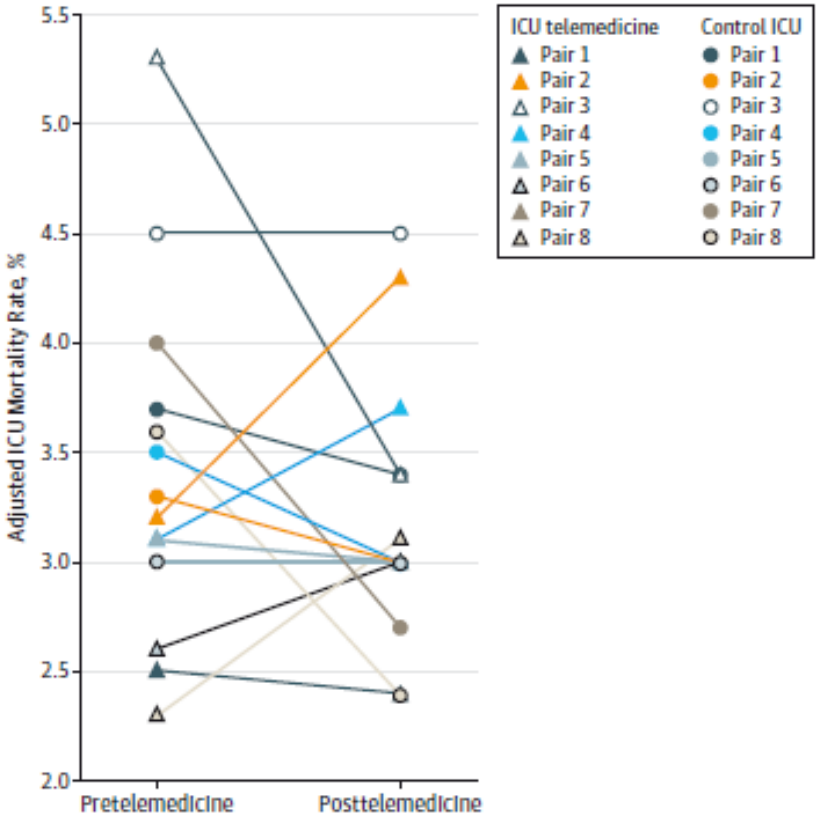
RESULTS

Figure 2. Adjusted Intensive Care Unit (ICU) Mortality Rates for Intervention and Control ICUs During Pretelemedicine and Posttelemedicine Periods



Colors and pairs correspond to individual ICU-level data provided in eTable 2 in the Supplement.

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TAKE HOME MESSAGE

- It’s not just telemedicine that drives impact
- Protocols, culture of collaboration are important
- Implementation and buy-in is critical!
- Have modest expectations of short-term benefits

WA SB 5175/ HB 1403

It passed!!

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SUBSTANCE OF BILL

Health plans (commercial insurance and Medicaid) will reimburse for telemedicine:

1) live face to face, videoconsultation

2) plan covers for benefit if provided in person

3) recognized as an essential health benefit

4) occurs at one of seven designated facilities

SUBSTANCE OF BILL

7 designated facilities are:

1) Hospital
2) Rural health clinic
3) Federally qualified health center
4) Physician's or other health care provider's office
5) Community mental health center
6) Skilled nursing facility
7) Renal dialysis center

ADDITIONAL INFO

- ✓ Pays for "**store-and-forward" teledermatology** so long as there is an associated office visit between patient and referring clinician
- ✓ Requesting ("originating") site may charge a facility fee for infrastructure and preparation of patient
- ✓ Provider must be licensed in State of Washington, be fully privileged at distant site hospital
- ✓ The originating hospital must show evidence of review of telemedicine providers and report regularly to MQAC about any adverse events or complaints
- ✓ "The legislature encourages health plans to adopt requirements prior to Jan 1, 2017"

BEST PRACTICES IN TELEHEALTH

- ✓ ATA guidelines!
  -general and specialty specific
- ✓ Etiquette
  -introductions, sign on door, etc
- ✓ Documentation
- ✓ Proxy credentialing and licensing
- ✓ Technology setup and support

BARRIERS TO TELEHEALTH EXPANSION

- ✓ Reimbursement/funding model
- ✓ Credentialing and licensing
- ✓ Physician acceptance
- ✓ Workflow
- ✓ Technology
- ✓ Relationship management

Second only to reimbursement, what is the largest hurdle to Telemedicine today?

- Licensure Portability

STATE REGULATORY AUTHORITY

States generally agree that physicians treating patients through telemedicine are practicing medicine in the location of…

- The Patient

But they do not agree when licensure is required, and when it is exempt

WHAT'S THE BIG DEAL?

- Criminal Prosecution - Unlicensed practice of medicine is a crime in most states
- Licensure - Unlicensed practice is professional misconduct in the state of the patient
    - Once that state takes action, Washington can reciprocate
- Medical Malpractice - In Idaho the burden switches to an unlicensed physician defendant to prove her/his services were within the standard of care

WASHINGTON LAW

Practice of Medicine defined broadly:

"A person is practicing medicine if he or she… offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality…."

RCW 18.71.011(1)

WASHINGTON LAW

- Licensure Required

"No person may practice or represent himself or herself as practicing medicine without first having a valid license to do so." RCW 18.71.021

- Express Exemption to Licensure

"The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state…."

MQAC CONSTRUES EXEMPTION NARROWLY

- Rules of statutory construction require exemptions to be narrowly construed
- MQAC construction *very* narrow:

  > "The licensure exemption in RCW 18.71.030(6) does not apply to Telemedicine practice."

MQAC TELEMEDICINE POLICY

- Effective 10/4/2014
- Appears to not apply to *pro bono* consultations
- Practice of medicine occurs at location of the patient

  Except when treated patient in Washington and conducting a brief follow-up through Telemedicine to patient in other state

Beware: Only protected if patient's home state law agrees!

FEDERAL PORTABILITY ATTEMPTS

- Attempts to date have been limited to Medicare or VA
- Attempts to generalize to the states basically doomed to failure

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INTERSTATE MEDICAL LICENSURE COMPACT

- "Expected to significantly reduce barriers to the process of gaining licensure in multiple states, helping facilitate licensure portability and telemedicine while expanding access to health care by physicians, particularly in underserved areas of the nation." --FSMB 9-5-14
- Contains elements of both contract and statutory law
- MQAC asked Gov. Inslee to request its adoption
- Several medical boards from other states have expressed written or verbal support

COMPACT CORE PRINCIPLES

- Participation strictly voluntary for both physicians and state boards
- Participation creates another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act
- Requires the physician be licensed by and under the jurisdiction of the laws and board of the state where the patient is located
- Regulatory authority will remain with the participating state medical boards, not national compact staff
- State boards participating in an interstate compact are required to share complaint / investigative information with each other

CONTRACTING

ISSUES TO CONSIDER AND ADDRESS

- Scope of services
  - Provider-patient relationships
- Definitions
- Billing issues
- Licensing requirements
  - Who pays?
- To BA or not to BA?
- “Free” equipment or tech support
- Credentialing/privileging

CREDENTIALING/PRIVILEGING

PROXY CREDENTIALING

- Historically, CMA and TJC required full PSV credentialing for any medical staff member.
  - Threshold question: Is there a need for originating site medical staff membership in a given telemedicine setting?
- TJC began to allow “proxy credentialing” around 2003.
  - CMS disagreed until 2011, then issued its proxy credentialing rule
  - TJC standard now conforms
    - DNV/NIAHO?
  - State law gap: RCW 70.41.230 still required PSV
    - Addressed in recent WA telemedicine bill

42 CFR 482.22

When telemedicine services are furnished to the hospital's patients through an agreement with a distant site hospital, the governing body of the originating site hospital may choose to have its medical staff rely upon the credentialing and privileging decisions made by the distant site hospital when making recommendations on privileges for the individual distant site healthcare professionals providing such services.

42 CFR 482.22

- Conditions (include in agreement)
  - Distant site hospital is a Medicare participating hospital.
  - Distant site hospital provides a current list of the distant-site healthcare professional's privileges.
  - Distant site healthcare professional holds a license issued or recognized by the State in which the originating site hospital is located.
  - Originating site hospital sends the distant site hospital performance information for use in the periodic appraisal of the distant site healthcare professional.
    - At a minimum, all adverse events that result from the telemedicine services by the healthcare professional and all complaints the hospital has received about the healthcare professional.

VISION

"By the next five years, 70% of outpatient visits will be virtual."

To achieve the "triple aim":

-Improving the patient experience of care (including quality and satisfaction);

-Improving the health of populations; and

-Reducing the per capita cost of health care

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CONTACT INFO

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206-598-9076 (UWMC)

www.uwmedicine.org/Patient-Care/Referrals/Pages/Telehealth-Services.aspx

Thomas H. Gallagher, M.D.

Thomas H. Gallagher, M.D., is a general internist who is Professor in the Department of Medicine at the University of Washington, where he is Associate Chair for Patient Care Quality, Safety, and Value. He is also a Professor in the Department of Bioethics and Humanities. Dr. Gallagher received his medical degree from Harvard University, Cambridge, Massachusetts, completed his residency in Internal Medicine at Barnes Hospital, Washington University, St. Louis, and completed a fellowship in the Robert Wood Johnson Clinical Scholars Program, UCSF.

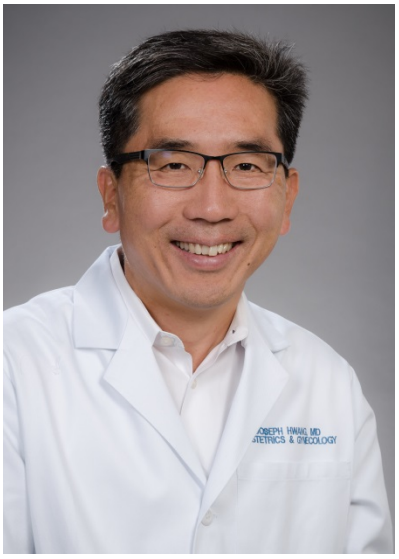
Dr. Gallagher's research addresses the interfaces between healthcare quality, communication, and transparency. Dr. Gallagher has published over 85 articles and book chapters on patient safety and error disclosure, which have appeared in leading journals including *JAMA, New England Journal of Medicine, Health Affairs, Surgery, Journal of Clinical Oncology, Archives of Internal Medicine, Archives of Pediatric and Adolescent Medicine, and the Joint Commission Journal.* His work in error disclosure received the 2004 Best Published Research Paper of the Year award from the Society of General Internal Medicine, as well as the 2012 MITSS Hope Award. He also received a Robert Wood Johnson Foundation Investigator Award in Health Policy Research. He is the principal investigator on two grants from the Agency for Healthcare Research and Quality, including an AHRQ patient safety and medical liability demonstration project entitled "Communication to Prevent and Respond to Medical Injuries: WA State Collaborative." He also is principal investigator on grants from the National Cancer Institute, the Robert Wood Johnson Foundation, and the Greenwall Foundation. He is senior author of the book Talking with Patients and Families About Medical Errors: A Guide for Education and Practice, published in 2011 by The Johns Hopkins University Press. At the University of Washington, he directs the UW Medicine Center for Scholarship in Patient Care Quality and Safety, and also directs the UW Program in Hospital Medicine. He currently serves on the Institute of Medicine Committee on Diagnostic Error in Healthcare, and was an appointed Commissioner on the National Commission on Physician Payment Reform.

Dr. Gallagher is an active member of many professional organizations, including the American College of Physicians (Fellow), the Society for General Internal Medicine, and the American Society of Bioethics and Humanities.

Larry Mauksch, M.Ed

Larry Mauksch is a Clinical Professor in the Department of Family Medicine, University of Washington School of Medicine in Seattle and a national recognized speaker, consultant and trainer for health care system transformation. He has spent 30 years training medical students, residents, mental health professionals, practicing physicians and nurses in interviewing skills, team development, and the diagnosis and management of mental disorders. He is the co-editor of Families, Systems and Health: The Journal of Collaborative Family Health Care and is the past chair of the Collaborative Family Health Care Association. He was member of the board, Society of Teachers of Family Medicine (STFM) and former chair of the STFM program committee, as well as a member of Council of Academic Family Medicine Competency Measurement Task Force He continues to serve as an STFM “On the Road” faculty. He was a core faculty in the Washington State Department of Health, Medical Home Collaborative. Mr. Mauksch designs training that combines the use of role models, peer coaching, video applications, and team based exercises for academic and community health care organizations.

Mr. Mauksch's areas of research include examining educational strategies to enhance the value of team and clinician communication on patient satisfaction, health outcomes and efficiency. He was the co—principal investigator of a 2009-2010 Picker Residency Education Challenge Grant studying the development and use of a patient centered care plan. He was the principal investigator of the Paired Observation and Video Editing (POVE) project to disseminate innovative training in communication skills to 7 medical schools. Mr. Mauksch developed the Patient Centered Observation Form (PCOF) to help trainees learn the skills, concepts and language of medical communication while observing provider patient interactions. Between 1998 and 2007 Mr. Mauksch designed and studied quality of care transformation and the integration of behavioral health in a primary care clinic serving only uninsured, low income adults in Grand Junction, Colorado.



Joseph K. Hwang, M.D., FACOG

Joseph K. Hwang, M.D., is a obstetrician and gynecologist who is a clinical associate professor at the University of Washington School of Medicine. Dr. Hwang also holds appointments at the University of Washington Medical Center, where he is a Maternal Fetal Medicine Specialist, and Valley Medical Center where he is the medical Director of the maternal fetal medicine clinic Dr. Hwang received his medical degree from Loyola University of the Chicago Stritch School of Medicine and has been in practice for 23 years. He completed his residency in Obstetrics and Gynecology from the Georgetown University School of Medicine in Washington D.C. and completed his fellowship in maternal-fetal medicine from Yale University School of Medicine in New Haven, CT.

Dr. Hwang's clinical focus addresses the interface between prenatal diagnosis and preterm birth prevention. His research interests have focuses on Micorobiome in preterm birth prevention and perinatal quality assessment

Dr. Hwang is an active member of many professional organizations, including: the American Congress of Obstetricians and Gynecologists, The Society for Maternal-Fetal Medicine and the International Society of Ultrasound in Obstetrics and Gynecology

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

PATIENT & FAMILY ADVISORY COUNCIL

Biographies

Bonnie Bizzell, MBA, MEd

Family Advisor

In three short consecutive years, each of Bonnie Bizzell's close family members experienced a traumatic medical event. Her brother, at age 34 and diagnosed with Crohn's, had part of his intestine removed. Her father suffered a heart-attack which resulted in an emergency quadruple bypass surgery. And, in 2006, her mother's biopsied brain tumor was identified as non-Hodgkin lymphoma. Experiences in the different hospitals varied greatly for the family: sometimes there was disregard for their needs; sometimes there was incredible attention and responsiveness. Often the two ends of the spectrum occurred within hours of each other in the same hospital. But, when care and caring happened simultaneously, the results were powerful.

Inspired by her personal encounters and family's history, Bonnie joined the University of Washington (UW), Medicine's Inpatient Patient and Family Centered Care (IPFCC) Advisory Council in 2007 as a family advisor. During her tenure, the IPFCC council's accomplishments include ensuring documents are patient and family friendly, participating in charge nurse education, transforming the meal delivery system to include on-demand menu options, and creating a staff training video about the voice of the patient.

In addition to her work at UW, Bonnie is a family panel member for the innovative Communication and Resolution Program (promoting collaboration and transparency after adverse events), a patient partner for CERTAIN's PCORI-funded random-control appendicitis study, and a member of the Foundation for Health Care Quality's Patient and Family Advisory Council. She has presented at the Medical Quality Assurance Commission Educational Conference (2014) and has attended multiple health conferences, including those hosted by the Institute for Patient– and Family– Centered Care and the Washington Patient Safety Coalition.

Professionally, Bonnie brings to over twelve years of operations management experience with expertise in process evaluation, continuous improvement, organizational development, team building, communications, and strategic and event planning. She holds a MBA in Change Management as well as a Master of Education. For fun, she likes to throw glamorous dinner parties, listen to old radio detective shows, and watch cartoons with her husband.

Mimi Pattison, M.D., FAAHPM

Dr. Pattison is a palliative medicine physician at CHI Franciscan Health, with more than two decades of clinical experience. Dr. Pattison is the Medical director of Franciscan Hospice House. She received her medical degree from the University of Washington and completed her internship with Tucson Hospitals Internal Medicine Education Program. She completed her residency from the University of Arizona and completed a fellowship with the University of Arizona Nephrology Medical Center. She is certified by ABMS in Hospice and Palliative medicine.

Dr. Pattison was the first hospice and palliative care physician to practice in a Washington hospital. She originated a question "would you be surprised if the patient you are examining died in the next year?" that is used nationally for palliative care referrals and used by the U.K. General Medical Council as a standard for referrals in their health system. In recognition of her work in this area, the Regence Foundation recognized her with the Sojourns Award including a grant in 2010. Additionally, Dr. Pattison helped launch the Franciscan Palliative Care Outreach program which won the American Hospital Association's Circle of Life Award in 2000.

Dr. Pattison is a champion for hospice and palliative care in Washington and her expertise has influenced the practice of medicine nationally and internationally. She was appointed by Governor Christine Gregoire to the Medical Quality Assurance Commission in 2008. She became the chair of the Medical Commission in 2011 and served in this role through June 2012. With her terms as commission Chair completed, Dr. Pattison continues to serve the commission with expert advice and guidance.

Dr. Pattison's medical interests include ethical issues at end of life, incorporating palliative medicine in Intensive Care Units, and educating medical students about palliative care.

Carol Wagner, RN, MBA

Carol Wagner is the Vice President, Patient Safety with the Washington State Hospital Association. Carol is an RN with an MBA focusing on finance and operations. She studied management and system change at Wharton and trained with Dr. Brent James at Intermountain Health Care and Dr. W. Edwards Deming. She has worked in the profit and not-for-profit environments, including Huntington Memorial Hospital in Pasadena, California and Tenet Healthcare.

Carol provides leadership for the WSHA Patient Safety Program. She works closely with national and state regulatory agencies, professional societies, and associations to design and implement programs on quality and safety such as the 5 Million Lives Campaign. She is the editor for the Patient Safety and Patient Safety for Trustees and CEOs newsletters.

She can be contacted at carolw@wsha.org and 206-577-1831

Robert M. Arnold, M.D.

Robert M. Arnold, MD, is a Professor in the Division of General Internal Medicine, Department of Medicine at the University of Pittsburgh and in the University of Pittsburgh Center for Bioethics and Health Law. He completed his medical school training at the University of Missouri-Kansas City and residency at Rhode Island Hospital. Subsequently he has been on the faculty at the University of Pittsburgh. In 2000, Dr. Arnold was named the first Leo H. Creip Chair of Patient Care. The chair emphasizes the importance of the doctor-patient relationship, particularly at the end of life. He is the Director of the Institute for Doctor-Patient Communication and the Medical Director of the UPMC Palliative and Supportive Institute. He is clinically active in palliative care.

Dr. Arnold has published on end-of-life care, hospice and palliative care, doctor-patient communication and ethics education. His work regarding palliative care has been published in *JAMA, Journal of Palliative Medicine, Clinical Journal of the American Society of Nephrology, Harvard Review of Psychiatry* and the *American Journal of Health Promotion.* His current research interests are focused on educational interventions to improve communication in life-limiting illnesses and better understanding how ethical precepts are operationalized in clinical practice. He is currently working with the UPMC Health System to develop system-wide, integrative palliative services throughout the health system. He is the Past-President of the American Society of Bioethics and Humanities as well as the American Academy of Hospice and Palliative Medicine.

Samuel P. Mandell M.D., M.P.H.

Dr. Mandell is a UW assistant professor in the Division of Trauma, Critical Care, and Burn Surgery. He practices at Harborview Medical Center, where he works with a multidisciplinary team to care for critically injured trauma and burn patients. He also cares for patients with a variety of general and emergency surgery needs.

Dr. Mandell earned his medical degree from the University of Massachusetts Medical School. Following medical school he moved to Seattle and the University of Washington where he completed his general surgery residency, fellowship in burn surgery, and fellowship in trauma and critical care. During residency, he also completed a trauma research fellowship and earned a master's in public health from the University of Washington School of Public Health and Community Medicine.

John Scott, MD, MSc

John Scott, M.D.is an Associate Professor of Medicine (Division of Allergy and Infectious Diseases) and the first Medical Director of Telehealth at the University of Washington. He graduated from Stanford University with a degree in Human Biology, attended Georgetown University School of Medicine *cum laude*, completed a residency in Internal Medicine at Stanford University Hospitals, and then obtained sub-specialty training in Infectious Diseases at the University of Washington. He has an active research program in viral hepatitis, which is supported by federal, foundation and pharmaceutical grants. He has published in *JAMA, Hepatology, Clinical Infectious Diseases, Annals of Internal Medicine, Nature Medicine* and the *Journal of Infectious Diseases.*

In 2013, Dr. Scott spent 4 months at the University of Queensland, Centre for Online Health, learning about the Australian health care system and how telehealth can be used to increase specialty care access and to improve health outcomes. He was awarded the Best Paper at the 2012 Global Telehealth Conference in Sydney, Australia.

In 2009, he launched Project ECHO (Extension for Community Health Outcomes) in Washington State, the first place to replicate the ECHO model outside of New Mexico. This innovative telehealth program helps clinicians serving in rural and underserved areas with the evaluation and treatment of hepatitis C and has since expanded into the areas of HIV/AIDS, chronic pain, addictions and psychiatry, multiple sclerosis and complex care. Project ECHO uses case-based learning to increase the capacity of primary care clinicians to care for common, complex diseases. Treatment of patients with hepatitis C through Project ECHO is as safe and effective as in person care (Arora S, et al. NEJM 2011) and is cost-effective. The Project ECHO model has spread throughout the United States and the world.

State of Washington
Medical Quality Assurance Commission

Just Culture Selected Resources

1.
Frank-Cooper, M.
The justice behind a just culture.
Nephrol Nurs J. 2014;41(1):87-8.
Medline
AN 24689270

2.
Martin G, Ozieranski P, Willars J, Charles K, Minion J, McKee L, et al.
Walkrounds in practice: Corrupting or enhancing a quality improvement intervention? A qualitative study.
Jt Comm J Qual Patient Saf. 2014;40(7):303-10.

BACKGROUND: Walkrounds, introduced as Leadership (or Executive) WalkRounds, are a widely advocated model for increasing leadership engagement in patient safety to improve safety culture, but evidence for their effectiveness is mixed. In the English National Health Service (NHS), hospitals have been strongly encouraged to make use of methods closely based on the walkrounds approach. A study was conducted to explore how walkrounds are used in practice and to identify variations in implementation that might mediate their impact on safety and culture. METHODS: The data, collected from 82 semistructured interviews in the English NHS, were drawn from two components of a wider study of culture and behavior around quality and safety in the English system. Analysis was based on the constant comparative method. FINDINGS: Our analysis highlights how local, pragmatic adjustments to the walkrounds approach could radically alter its character and the way in which it is received by those at the front line. The modification and expansion of walkrounds to increase the scope of knowledge produced could increase the value that executives draw from them. However, it risks replacing the main objectives of walkrounds--specific, actionable knowledge about safety issues, and a more positive safety culture and relationship between ward and board--with a form of surveillance that could alienate frontline staff and produce fallible insights. CONCLUSION: The studys findings suggest some plausible explanations for the mixed evidence for walkrounds' effectiveness in creating a safety culture. On a practical level, they point to critical questions that executives must ask themselves in practicing interventions of this nature to ensure that adaptations align rather than conflict with the intervention's model of change.
Medline
AN 25130013

3.
Bush, H.
Creating a culture of safety.
Trustee. 2013;66(7):8-12.
Trustees and CEOs from several hospitals share strategies for organization wide reductions in harm.
Medline
AN 23926860

4.
Morello RT, Lowthian JA, Barker AL, McGinnes R, Dunt D and Brand C.
Strategies for improving patient safety culture in hospitals: A systematic review.
BMJ Qual Saf. 2013;22(1):11-8.

PURPOSE: To determine the effectiveness of patient safety culture strategies to improve hospital patient safety climate. DATA SOURCES: Electronic search of the Cochrane Library, OVID Medline, Embase, CINAHL, proQuest and psychinfo databases, with manual searches of quality and safety websites, bibliographies of included articles and key journals. STUDY SELECTION: English language studies published between January 1996 and April 2011 that measured the effectiveness of patient safety culture strategies using a quantitative measure of patient safety climate in a hospital setting. Studies included were randomised controlled trials (RCTs), non-RCTs, controlled before and after studies, interrupted time series and historically controlled studies. DATA EXTRACTION: Data extraction and critical appraisal were conducted by two independent reviewers. Study design, intervention, level of application, setting, study participants, safety climate outcome measures and implementation lessons were extracted from each article. RESULTS OF DATA SYNTHESIS: Over 2000 articles were screened, with 21 studies meeting the inclusion criteria, one cluster RCT, seven controlled before and after studies, and 13 historically controlled studies. There was marked methodological heterogeneity amongst studies. Impacts of 11 different strategies were reported. There was some evidence to support that leadership walk rounds ($p=0.02$) and multi-faceted unit-based programmes ($p < 0.05$) may have a positive impact on patient safety climate. CONCLUSIONS: Despite strong face validity for a variety of patient safety culture strategies, there is limited evidence to support definitive impacts on patient safety climate outcomes. Organisations are advised to consider robust evaluation designs when implementing these potentially resource intensive strategies.
Medline
AN 22849965

5.
Petschonek S, Burlison J, Cross C, Martin K, Laver J, Landis RS, et al.
Development of the just culture assessment tool: Measuring the perceptions of health-care professionals in hospitals.
J Patient Saf. 2013;9(4):190-7.

OBJECTIVES: Given the growing support for establishing a just patient safety culture in health-care settings, a valid tool is needed to assess and improve just patient safety culture. The purpose of this study was to develop a measure of individual perceptions of just culture for a hospital setting. METHODS: The 27-item survey was administered to 998 members of a health-care staff in a pediatric research hospital as part of the hospital's ongoing patient safety culture assessment process. Subscales included balancing a blame-free approach with accountability, feedback and communication, openness of communication, quality of the event reporting process, continuous improvement, and trust. The final sample of 404 participants (40% response rate) included nurses, physicians, pharmacists, and other hospital staff members involved in patient care. RESULTS: Moderate support for the factor structure was established with confirmatory factor analysis. After modifications were made to improve statistical fit, the final version of the measure included 6 subscales loading onto one higher-order dimension. CONCLUSIONS: The instrument designed and tested in this study demonstrated adequate structure and reliability. Given the uniqueness of the current sample, further verification of the JCAT is needed from hospitals that serve broader populations. A validated tool could also be used to evaluate the relation between just culture and patient safety outcomes.
Medline
AN 24263549

6.
Rideout, D.
'Just culture' encourages error reporting, improves patient safety.
OR Manager. 2013;29(7):13-5.
Medline
AN 23926642

7.
Singer SJ and Vogus TJ.
Reducing hospital errors: Interventions that build safety culture.
Annu Rev Public Health. 2013;34:373-96.

Hospital errors are a seemingly intractable problem and continuing threat to public health. Errors resist intervention because too often the interventions deployed fail to address the fundamental source of errors: weak organizational safety culture. This review applies and extends a theoretical model of safety culture that suggests it is a function of interrelated processes of enabling, enacting, and elaborating that can reduce hospital errors over time. In this model, enabling activities help shape perceptions of safety climate, which promotes enactment of safety culture. We then classify a broad array of interventions as enabling, enacting, or elaborating a culture of safety. Our analysis, which is intended to guide future attempts to both study and more effectively create and sustain a safety culture, emphasizes that isolated interventions are unlikely to reduce the underlying causes of hospital errors. Instead, reducing errors requires systemic interventions that address the interrelated processes of safety culture in a balanced manner.
Medline
AN 23330698

8.
Thomas L and Galla C.
Building a culture of safety through team training and engagement.
BMJ Qual Saf. 2013;22(5):425-34.

Medical errors continue to occur despite multiple strategies devised for their prevention. Although many safety initiatives lead to improvement, they are often short lived and unsustainable. Our goal was to build a culture of patient safety within a structure that optimised teamwork and ongoing engagement of the healthcare team. Teamwork impacts the effectiveness of care, patient safety and clinical outcomes, and team training has been identified as a strategy for enhancing teamwork, reducing medical errors and building a culture of safety in healthcare. Therefore, we implemented Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS), an evidence-based framework which was used for team training to create transformational and/or incremental changes; facilitating transformation of organisational culture, or solving specific problems. To date, TeamSTEPPS (TS) has been implemented in 14 hospitals, two Long Term Care Facilities, and outpatient areas across the North Shore LIJ Health System. 32 150 members of the healthcare team have been trained. TeamSTEPPS was piloted at a community hospital within the framework of the health system's organisational care delivery model, the Collaborative Care Model to facilitate sustainment. AHRQ's Hospital Survey on Patient Safety Culture, (HSOPSC), was administered before and after implementation of TeamSTEPPS, comparing the perception of patient safety by the heathcare team. Pilot hospital results of HSOPSC show significant improvement from 2007 (pre-TeamSTEPPS) to 2010.
Medline
AN 23211280

9.
Bashaw ES and Lounsbury K.
Forging a new culture: Blending magnet principles with just culture.
Nurs Manage. 2012;43(10):49-53.
Medline
AN 22992692

10.
Raghunathan, K.
Checklists, safety, my culture and me.
BMJ Qual Saf. 2012;21(7):617-20.

The world is not flat. Hierarchy is a fact of life in society and in healthcare institutions. National, specialty-specific and institutional cultures may play an important role in shaping today's patient-safety climate. The influence of power distance on safety interventions is under-studied. Checklists may make power distance-hampered negotiations easier by providing a standardised aviation-like framework for communications and by democratising the environment. By using surveys and simulation, we might discover patterns of potentially hidden yet problematic interactions that might foster maintenance of the error swamp. We need to understand how people interact as members of a group as this is crucial for the development of generalisable safety interventions.
Medline
AN 22491530

11.
Barnsteiner, J.
Teaching the culture of safety.
Online J Issues Nurs. 2011;16(3):5.

Although a healthcare culture of safety has been a practice priority for many years, there has been less attention to incorporating culture of safety content into the education of healthcare professionals. Students need to become knowledgeable about system vulnerabilities and understand how knowledge, skills, and attitudes promoting utilization of safety science will lead to safer care for patients and families. Learning about both patient safety and system vulnerabilities needs to begin in pre-licensure programs and become an integral part of learning in all phases of nursing education and practice. In this article the author will begin by reviewing the essential elements of a culture of safety and considering what students need to know about a culture of safety. She will describe activities that promote safety, high reliability organizations, and external drivers of safety, and conclude by offering strategies for integrating a culture of safety into the curriculum.
Medline
AN 22324571

12.
Bell SK, Delbanco T, Anderson-Shaw L, McDonald TB and Gallagher TH.
Accountability for medical error: Moving beyond blame to advocacy.
Chest. 2011;140(2):519-26.

Accountability in medicine, once assigned primarily to individual doctors, is today increasingly shared by groups of health-care providers. Because patient safety experts emphasize that most errors are caused not by individual providers, but rather by system breakdowns in complex health-care teams,

individual doctors are left to wonder where their accountability lies. Increasingly, teams deliver care. But patients and doctors alike still think of accountability in individual terms, and the law often measures it that way. Drawing on an example of delayed lung cancer diagnosis, we describe the mismatch between how we view errors (systems) and how we apportion blame (individuals). We discuss "collective accountability," suggesting that this construct may offer a way to balance a "just culture" and a doctor's specific responsibilities within the framework of team delivery of care. The concept of collective accountability requires doctors to adopt transparent behaviors, learn new skills for improving team performance, and participate in institutional safety initiatives to evaluate errors and implement plans for preventing recurrences. It also means that institutions need to prioritize team training, develop robust, nonpunitive reporting systems, support clinicians after adverse events and medical error, and develop ways to compensate patients who are harmed by errors. A conceptual leap to collective accountability may help overcome longstanding professional and societal norms that not only reinforce individual blame and impede patient safety but may also leave the patient and family without a true advocate.
Medline
AN 21813531

13.
Halligan M and Zecevic A.
Safety culture in healthcare: A review of concepts, dimensions, measures and progress.
BMJ Qual Saf. 2011;20(4):338-43.

BACKGROUND: A growing body of peer-reviewed studies demonstrate the importance of safety culture in healthcare safety improvement, but little attention has focused on developing a common set of definitions, dimensions and measures. OBJECTIVES: Specific objectives of this literature review include: summarising definitions of safety culture and safety climate, identifying theories, dimensions and measures of safety culture in healthcare, and reviewing progress in improving safety culture. METHODS: Peer-reviewed, English-language articles published from 1980 to 2009 pertaining to safety culture in healthcare were reviewed. One hundred and thirty-nine studies were included in this review. RESULTS: Results suggest that there is disagreement among researchers as to how safety culture should be defined, as well as whether or not safety culture is intrinsically diverse from the concept of safety climate. This variance extends into the dimensions and measurement of safety culture, and interventions to influence culture change. DISCUSSION: Most studies utilise quantitative surveys to measure safety culture, and propose improvements in safety by implementing multifaceted interventions targeting several dimensions. Conversely, very few studies made their theoretical underpinnings explicit. Moving forward, a common set of definitions and dimensions will enable researchers to better share information and strategies to improve safety culture in healthcare, building momentum in this rapidly expanding field. Advancing the measurement of safety culture to include both quantitative and qualitative methods should be further explored. Using the expertise of traditional culture experts, anthropologists, more in-depth observational and longitudinal research is needed to move research in this area forward.
Medline
AN 21303770

14.
Lazarus, I. R.
On the road to find out...transparency and just culture offer significant return on investment.
J Healthc Manag. 2011;56(4):223-7.
Medline
AN 21838020

15.
Morris, S.
Just culture-changing the environment of healthcare delivery.
Clin Lab Sci. 2011;24(2):120-4.

Although errors cannot be totally eliminated, they can be reduced by adopting a system of accountability that requires employees to self-report errors in the interest of patient safety. Traditional laboratory accountability systems are based on a culture of blame, focusing on punishing individuals, and with little emphasis on learning lessons from the errors. Under a just culture laboratory accountability system, if factors in the environment or process contributed to an error, the individual should not be punished. Rather, they and the system can both identify improvements for processes so that this type of error does not reoccur. Using this approach, laboratory services can be made safer for current and future patients.
Medline
AN 21657146

16.
Ohrn A, Rutberg H and Nilsen P.
Patient safety dialogue: Evaluation of an intervention aimed at achieving an improved patient safety culture.
J Patient Saf. 2011;7(4):185-92.

OBJECTIVES: Patient Safety Dialogue, a local intervention inspired by walk round-style approaches, was implemented in 2005 in a Swedish county council to achieve a positive patient safety culture in health care. This paper evaluates the results and changes after 5 years of the Patient Safety Dialogue in 50 departments (37 medical and 13 psychiatric) in 3 hospitals. METHODS: The patient safety culture maturity was rated on 5 levels that correspond with the Manchester Patient Safety Assessment Framework. The assessment was based on information supplied by the departments and discussions between clinical leaders and staff members with special patient safety assignments and representatives from a patient safety unit. Three patient safety areas were assessed: hospital-acquired infections, outcome measurements, and general patient safety. Each department was assessed 3 times: at baseline and at follow-ups at 18 and 36 months. Average scores were calculated for each of the 3 safety areas on all occasions. The departments were classified into 3 types of trajectories on the basis of the development of their scores over time. RESULTS: More than two-thirds of the departments attained higher scores in round 3 than in round 1. Seventy-eight percent of the departments in the general patient safety area were categorized as continuously improving or developing, compared with 68% for outcome measurement and 50% for hospital-acquired infection. Approximately one-third was categorized as nonimproving, with scores in round 3 lower than or equal to the scores in round 1. The medical departments had higher scores than the psychiatric departments in all rounds. CONCLUSIONS: Most of the 50 departments were evaluated to have improved their patient safety culture during the 5 years of the Patient Safety Dialogue, suggesting that the intervention is effective in supporting an improved patient safety culture. However, one-third of the departments did not improve during the 5-year study period.
Medline
AN 21952549

17.
Pepe J and Cataldo PJ.
Manage risk, build a just culture.
Health Prog. 2011;92(4):56-60.
Medline
AN 21838115

18.
Shepard, L. H.
Creating a foundation for a just culture workplace.
Nursing. 2011;41(8):46-8.
Medline
AN 21765329

19.
Bohne P and Peruzzi W.
A just culture supports patient safety.
Trustee. 2010;63(4):32-3.
When an error occurs, a just culture supports clinicians and patients.
Medline
AN 20481257

20.
Gluck, P. A.
Physician leadership: Essential in creating a culture of safety.
Clin Obstet Gynecol. 2010;53(3):473-81.

Advances in patient safety require a receptive culture that values transparency, communication, and mutual respect. The Safety Attitude Questionnaire is an effective tool that can be used to assess the safety culture in a variety of clinical settings. Transformational leadership is essential in promoting a culture of safety. There are several strategies available to these leaders that will improve patient safety including Patient Safety Leadership Walkrounds, briefings, huddles, debriefings, and conflict resolution. Finally, leaders must maintain a "just culture" that recognizes most errors involve system deficiencies not human error and that disruptive behavior cannot be tolerated.
Medline
AN 20661033

21.
Szekendi MK, Barnard C, Creamer J and Noskin GA.
Using patient safety morbidity and mortality conferences to promote transparency and a culture of safety.
Jt Comm J Qual Patient Saf. 2010;36(1):3-9.

BACKGROUND: Although creating a culture of safety to support clinicians and improve the quality of patient care is a common goal among health care organizations, it can be difficult to envision specific efforts to directly influence organizational culture. To promote transparency and reinforce a nonpunitive attitude throughout the organization, a forum for the open, interdisciplinary discussion of patient safety problems--the Patient Safety Morbidity and Mortality (M&M) Conference--was created at Northwestern Memorial Hospital (Chicago). The intent of the M&M conference was to inform frontline providers about adverse events that occur at the hospital and to engage their input in root

cause analysis, thereby encouraging reporting and promoting systems-based thinking among clinicians. METHODS: Convened under the purview of the organization's quality program, and modeled on the traditional M&M conferences historically used by physicians, the conference is a monthly live meeting at which case studies are presented for retrospective (root cause) analysis by an interdisciplinary audience. RESULTS: Since its start in 2003, approximately 60 patient safety M&M programs have been presented. Audiences typically represent a mix of physicians, nurses, pharmacists, management, therapists, and administrative and support staff. Staff perceptions of culture, as measured by the Hospital Survey on Patient Safety Culture, showed statistically significant improvements over time. DISCUSSION: Ensuring the patient safety M&M conference program's sustained success requires an ongoing commitment to identifying events of clinical importance and to pursuing the productive discussion of these events in an open and safe forum. Patient safety M&M conferences are a valued opportunity to engage staff in exploring adverse events and to promote transparency and a nonpunitive culture.
Medline
AN 20112658

22.
Vogelsmeier A, Scott-Cawiezell J, Miller B and Griffith S.
Influencing leadership perceptions of patient safety through just culture training.
J Nurs Care Qual. 2010;25(4):288-94.

There are differences in perceptions of safety culture between healthcare leaders and staff. Evidence suggests that an organization's actual safety performance is more closely reflected in staff perceptions suggesting that frontline staff may be more aware than the leadership of actual patient safety challenges within their organization. Closing the perception gap between healthcare leaders and staff is critical to aligning the resources and strategies required to create a true culture of safety.
Medline
AN 20220531

23.
Khatri N, Brown GD and Hicks LL.
From a blame culture to a just culture in health care.
Health Care Manage Rev. 2009;34(4):312-22.

BACKGROUND: A prevailing blame culture in health care has been suggested as a major source of an unacceptably high number of medical errors. A just culture has emerged as an imperative for improving the quality and safety of patient care. However, health care organizations are finding it hard to move from a culture of blame to a just culture. PURPOSE: We argue that moving from a blame culture to a just culture requires a comprehensive understanding of organizational attributes or antecedents that cause blame or just cultures. Health care organizations need to build organizational capacity in the form of human resource (HR) management capabilities to achieve a just culture. METHODOLOGY: This is a conceptual article. Health care management literature was reviewed with twin objectives: (a) to ascertain if a consistent pattern existed in organizational attributes that lead to either blame or just cultures and (2) to find out ways to reform a blame culture. CONCLUSIONS: On the basis of the review of related literature, we conclude that (a) a blame culture is more likely to occur in health care organizations that rely predominantly on hierarchical, compliance-based functional management systems; (b) a just or learning culture is more likely to occur in health organizations that elicit greater employee involvement in decision making; and (c) human resource management capabilities play an important role in moving from a blame culture to a just culture. PRACTICE IMPLICATIONS: Organizational culture or human resource management practices play a critical role

in the health care delivery process. Health care organizations need to develop a culture that harnesses the ideas and ingenuity of health care professional by employing a commitment-based management philosophy rather than strangling them by overregulating their behaviors using a control-based philosophy. They cannot simply wish away the deeply entrenched culture of blame nor can they outsource their way out of it. Health care organizations need to build internal human resource management capabilities to bring about the necessary changes in their culture and management systems and to become learning organizations. [References: 70]
Medline
AN 19858916

24.
Leape, L. L.
Errors in medicine.
Clin Chim Acta. 2009;404(1):2-5.

Modern awareness of the problem of medical injury--complications of treatment--can be fairly dated to the publication in 1991 of the results of the Harvard Medical Practice Study, but it was not until the publication of the 2000 Institute of Medicine (IOM) report, To Err is Human that patient safety really came to medical and public attention. Medical injury is a serious problem, affecting, as multiple studies have now shown, approximately 10% of hospitalized patients, and causing hundreds of thousands of preventable deaths each year. The organizing principle is that the cause is not bad people, it is bad systems. This concept is transforming; it replaces the previous exclusive focus on individual error with a focus on defective systems. Although the major focus on patient safety has been on implementing safe practices, it has become increasingly apparent that achieving a high level of safety in our health care organizations requires much more: several streams have emerged. One of these is the recognition of the importance of engaging patients more fully in their care. Another is the need for transparency. In the current health care organizational environment in most hospitals, at least six major changes are required to begin the journey to a culture of safety: 1. We need to move from looking at errors as individual failures to realizing they are caused by system failures; 2. We must move from a punitive environment to a just culture; 3. We move from secrecy to transparency; 4. Care changes from being provider (doctors) centered to being patient-centered; 5. We move our models of care from reliance on independent, individual performance excellence to interdependent, collaborative, interprofessional teamwork; 6. Accountability is universal and reciprocal, not top-down.
Medline
AN 19302989

25.
Ovretveit, J.
Understanding and improving patient safety: The psychological, social and cultural dimensions.
J Health Organ Manag. 2009;23(6):581-96.

PURPOSE: This paper aims to provide researchers and practitioners with an overview of how organisation behaviour research (OBR) helps to understand and resolve patient safety problems in health care. DESIGN/METHODOLOGY/APPROACH: The paper describes psychological, sociological and other social science theories and research which help to understand the causes of patient safety problems, how to implement change effectively and how to create an organisational culture of safety. FINDINGS: Social science perspectives and organisational behaviour research are beginning to show why improvements in patient safety are slow, and how to make lasting and effective change. RESEARCH LIMITATIONS/IMPLICATIONS: Social sciences and OBR have already helped make healthcare safer, but could make a greater contribution. Progress could be faster with

greater awareness of the findings of this research and understanding of social science research paradigms. PRACTICAL IMPLICATIONS: Better implementation and safer care could result from providing implementers and decision makers with more knowledge and access to social science research. More useful social science research could be developed by research funders and proposal reviewers gaining a greater understanding of social science methods and potential, and by including this research in a field made up largely of traditional experimental medical research methods. ORIGINALITY/VALUE: This paper provides an overview of the scientific and practical contributions of social sciences to patient safety and shows where future studies could assist understanding of current challenges and speed implementation of change.
Medline
AN 20020593

26.
Singer SJ, Falwell A, Gaba DM, Meterko M, Rosen A, Hartmann CW, et al.
Identifying organizational cultures that promote patient safety.
Health Care Manage Rev. 2009;34(4):300-11.

BACKGROUND: Safety climate refers to shared perceptions of what an organization is like with regard to safety, whereas safety culture refers to employees' fundamental ideology and orientation and explains why safety is pursued in the manner exhibited within a particular organization. Although research has sought to identify opportunities for improving safety outcomes by studying patterns of variation in safety climate, few empirical studies have examined the impact of organizational characteristics such as culture on hospital safety climate. PURPOSE: This study explored how aspects of general organizational culture relate to hospital patient safety climate. METHODOLOGY: In a stratified sample of 92 U.S. hospitals, we sampled 100% of senior managers and physicians and 10% of other hospital workers. The Patient Safety Climate in Healthcare Organizations and the Zammuto and Krakower organizational culture surveys measured safety climate and group, entrepreneurial, hierarchical, and production orientation of hospitals' culture, respectively. We administered safety climate surveys to 18,361 personnel and organizational culture surveys to a 5,894 random subsample between March 2004 and May 2005. Secondary data came from the 2004 American Hospital Association Annual Hospital Survey and Dun & Bradstreet. Hierarchical linear regressions assessed relationships between organizational culture and safety climate measures. FINDINGS: Aspects of general organizational culture were strongly related to safety climate. A higher level of group culture correlated with a higher level of safety climate, but more hierarchical culture was associated with lower safety climate. Aspects of organizational culture accounted for more than threefold improvement in measures of model fit compared with models with controls alone. A mix of culture types, emphasizing group culture, seemed optimal for safety climate. PRACTICE IMPLICATIONS: Safety climate and organizational culture are positively related. Results support strategies that promote group orientation and reduced hierarchy, including use of multidisciplinary team training, continuous quality improvement tools, and human resource practices and policies.
Medline
AN 19858915

27.
Wachter RM and Pronovost PJ.
Balancing "no blame" with accountability in patient safety.
N Engl J Med. 2009;361(14):1401-6.
Medline
AN 19797289

28.
Wesley, K.
To err is human. creating a 'just culture' to alter behavior & reduce medical errors.
J Emerg Med Serv JEMS. 2009;34(7):44.
Medline
AN 19596296

29.
Yee PL, Edwards ML, Dixon J and Gleason NS.
Implementation of patient safety rounds in a children's hospital.
Nurs Adm Q. 2009;33(1):48-53.

Many healthcare organizations have implemented patient safety initiatives aimed at creating a safer healthcare environment. At North Carolina Children's Hospital at University of North Carolina Hospitals, patient safety rounds were established in the fall of 2005. Rounds are held weekly and involve all members of the healthcare team. Senior leadership actively participates and helps staff seek out solutions for the identified issues. Within the first year of operation, 191 issues were identified, of which 58% were resolved. Rounds continue to occur and have expanded over to the Women's services. Other initiatives such as Just Culture and Six Sigma have been established and help further cultivate a climate that strives toward optimizing patient safety.
Medline
AN 19092523

30.
Fleming M and Wentzell N.
Patient safety culture improvement tool: Development and guidelines for use.
Healthc Q. 2008;11(3 Spec):10-5.

The Patient Safety Culture Improvement Tool (PSCIT) was developed to assist healthcare organizations in identifying practical actions to improve their culture. This article describes the development process of the PSCIT and provides a guide to using the PSCIT. The tool is based on a safety culture maturity model, which describes five stages of cultural evolution, from pathological to generative. The PSCIT consists of nine elements that cover five patient safety culture dimensions, namely, leadership, risk analysis, workload management, sharing and learning and resource management. Each element describes the systems in place at each level of maturity, enabling organizations to identify their current level of maturity and actions to move to the next level. The PSCIT should be used with caution as there is currently a lack of reliability and validity data.
Medline
AN 18382154

31.
Gorzeman, J.
Balancing just culture with regulatory standards.
Nurs Adm Q. 2008;32(4):308-11.
Over the past decade, there has been much attention called to the reality of errors occurring in healthcare that jeopardize patient safety. Not only has this attention and reality caused angst and concern for persons and families that may require healthcare but it also causes significant angst and concern among care providers themselves. In response to the reality that 44,000 to 98,000 deaths occur annually because of medical error, regulatory organizations developed standards to achieve compliance with safe practice and delivery of care and to increase accountability. To promote more open,

consistent, and reporting without fear of retribution, Just Culture philosophies are increasingly evident in healthcare organizations. These Just Culture organizations are described as taking a fair and balanced approach to event reporting, learning from mistakes, and holding persons and the organization accountable.
Medline
AN 18813088

32.
Reid Ponte P and Peterson K.
A patient- and family-centered care model paves the way for a culture of quality and safety.
Crit Care Nurs Clin North Am. 2008;20(4):451-64.

Over the past 13 years, the Dana-Farber Cancer Institute has embraced a patient- and family-centered model of care and culture of quality and safety. The authors discuss how their care delivery model and quality and safety efforts reinforce one another, and how they have shaped the organization's practice environment, governance structures, and systems and processes that support care delivery. The authors also discuss key values, structures, and processes that must be upheld to assure the advancement of patient- and family-centered care and quality and safety efforts within an institution.
Medline
AN 19007711

33.
Weiner BJ, Hobgood C and Lewis MA.
The meaning of justice in safety incident reporting.
Soc Sci Med. 2008;66(2):403-13.

Safety experts contend that to make incident reporting work, healthcare organizations must establish a "just" culture-that is, an organizational context in which health professionals feel assured that they will receive fair treatment when they report safety incidents. Although healthcare leaders have expressed keen interest in establishing a just culture in their institutions, the patient safety literature offers little guidance as to what the term "just culture" really means or how one goes about creating a just culture. Moreover, the safety literature does not indicate what constitutes a just incident reporting process in the eyes of the health professionals who provide direct patient care. This gap is unfortunate, for knowing what constitutes a just incident reporting process in the eyes of front-line health professionals is essential for designing useful information systems to detect, monitor, and correct safety problems. In this article, we seek to clarify the conceptual meaning of just culture and identify the attributes of incident reporting processes that make such systems just in the eyes of health professionals. To accomplish these aims, we draw upon organizational justice theory and research to develop a conceptual model of perceived justice in incident reporting processes. This model could assist those healthcare leaders interested in creating a just culture by clarifying the multiple meanings, antecedents, and consequences of justice.
Medline
AN 17949876

34.
Campbell DA Jr and Thompson M.
Patient safety rounds: Description of an inexpensive but important strategy to improve the safety culture.
Am J Med Qual. 2007;22(1):26-33.

Patient safety rounds (PSRs) were established at the University of Michigan Medical Center to improve patient safety by opening a new line of communication between the chief of staff and frontline caregivers. Patient safety rounds are biweekly, hour long meetings between the chief of staff and care givers on individual patient care units. In the past 4 years (2002 to 2006), 70 PSRs have been conducted, and more than 900 area staff members have participated. Staff attendance averages 8 to 10 unit or area staff members per session. Patient safety rounds have proven to be a concrete, inexpensive mechanism to enhance patient safety. Benefits have been documented in the improvement in the safety culture and development and implementation of preventive strategies to solve patient safety issues. Key components in the success of PSRs are active medical staff leadership and the engagement of physicians and senior management in the process improvements the PSRs have directed.
Medline
AN 17227875

35.
Connor M, Duncombe D, Barclay E, Bartel S, Borden C, Gross E, et al.
Creating a fair and just culture: One institution's pat toward organizational change.
Jt Comm J Qual Patient Saf. 2007;33(10):617-24.

BACKGROUND: Health care organizations have begun to move toward a nonpunitive, or "blame-free," process when analyzing medical errors and near misses. The Dana-Farber Cancer Institute's (Boston) "Principles of a Fair and Just Culture," define for staff and managers behavioral expectations when an error occurs. CREATING THE PRINCIPLES OF A FAIR AND JUST CULTURE: The principles focus not just on patient safety but on a culture of safety and transparency in all the organization's functional areas, including nonclinical departments such as information services, administration, and research. INCORPORATING THE PRINCIPLES INTO PRACTICE: Introducing the principles is a gradual process, one that requires continual education and discussion among staff at all levels and a commitment to examining and changing many of the systems, policies, and procedures that guide the organization's work. A survey conducted in January 2007 revealed that the clinical areas had sustained higher-than-average scores and that the nonclinical areas showed improvement. DISCUSSION: Changing a long-standing culture of blame, control, and disrespect to one that embraces principles of fairness and justice and standards of respectful behavior is a major undertaking. Educating and involving clinical and administrative leaders, who work directly with staff and play a pivotal role in translating the principles into practice, is especially important.
Medline
AN 18030864

36.
Schneck, L. H.
The good, the bad and the equitable. patient safety and the just culture.
MGMA Connex. 2007;7(8):27-8.
Medline
AN 17910211

37.
Apold J, Daniels T and Sonneborn M.
Promoting collaboration and transparency in patient safety.
Jt Comm J Qual Patient Saf. 2006;32(12):672-5.

BACKGROUND: The Minnesota Alliance for Patient Safety (MAPS) collaborative was founded in 2000 by the Minnesota Hospital Association (MHA), the Minnesota Medical Association, and the Minnesota Department of Health. CREATING A CULTURE OF LEARNING, JUSTICE, AND ACCOUNTABILITY: MAPS made it a priority to make the health care workplace one that encourages learning from adverse events. MAPS is pioneering a statewide model of a "just" culture--one that supports learning yet holds individuals accountable for errors. LEGISLATIVE CHANGES: In 2001, MAPS helped revise the Minnesota peer review law to allow hospitals to share key safety information through electronic databases such as the MHA Patient Safety Registry. The revisions paved the way for the 2003 landmark Minnesota Adverse Health Care Event Reporting Act, which encourages reporting of root cause investigations and steps taken by facilities to prevent recurrence. In 2003 the Patient Safety Registry, an electronic database, was expanded to serve as a confidential clearinghouse for facilities' reporting of adverse events. PATIENT SAFETY TOPICS: MAPS serves as catalyst for developing and disseminating best practices on topics such as health literacy, falls prevention, culture of safety, engaging patients, and consumers' medication tracking. CONCLUSION: The six-year collaborative effort by the many organizations comprising MAPS has led to a transformation in Minnesota's health care safety culture.
Medline
AN 17220155

38.
Frankel AS, Leonard MW and Denham CR.
Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability.
Health Serv Res. 2006;41(4 Pt 2):1690-709.

BACKGROUND: Disparate health care provider attitudes about autonomy, teamwork, and administrative operations have added to the complexity of health care delivery and are a central factor in medicine's unacceptably high rate of errors. Other industries have improved their reliability by applying innovative concepts to interpersonal relationships and administrative hierarchical structures (Chandler 1962). In the last 10 years the science of patient safety has become more sophisticated, with practical concepts identified and tested to improve the safety and reliability of care. OBJECTIVE: Three initiatives stand out as worthy regarding interpersonal relationships and the application of provider concerns to shape operational change: The development and implementation of Fair and Just Culture principles, the broad use of Teamwork Training and Communication, and tools like WalkRounds that promote the alignment of leadership and frontline provider perspectives through effective use of adverse event data and provider comments. METHODS: Fair and Just Culture, Teamwork Training, and WalkRounds are described, and implementation examples provided. The argument is made that they must be systematically and consistently implemented in an integrated fashion. CONCLUSIONS: There are excellent examples of institutions applying Just Culture principles, Teamwork Training, and Leadership WalkRounds--but to date, they have not been comprehensively instituted in health care organizations in a cohesive and interdependent manner. To achieve reliability, organizations need to begin thinking about the relationship between these efforts and linking them conceptually.
Medline
AN 16898986

39.
Hoff T, Jameson L, Hannan E and Flink E.
A review of the literature examining linkages between organizational factors, medical errors, and patient safety.
Med Care Res Rev. 2004;61(1):3-37.

The potential role of organizational factors in enhanced patient safety and medical error prevention is highlighted in the systems approach advocated for by the Institute of Medicine and others. However, little is known about the extent to which these factors have been shown empirically to be associated with these favorable outcomes. The present study conducted an intensive review of the clinical and health services literatures in order to explore this issue. The results of this review support the general conclusion that there is little evidence for asserting the importance of any individual, group, or structural variable in error prevention or enhanced patient safety at the present time. Two major issues bearing on the development of future research in this area involve strengthening the theoretical foundations of organizational research on patient safety and overcoming definitional and observability problems associated with error-focused dependent variables. [References: 42]
Medline
AN 15035855

40.
Meaney, M. E.
Error reduction, patient safety and institutional ethics committees.
J Law Med Ethics. 2004;32(2):358-64.

Institutional ethics committees remain largely absent from the literature on error reduction and patient safety. In this paper, the author endeavors to fill the gap. As noted in the Hastings Center's recent report, "Promoting Patient Safety," the occurrence of medical error involves complex web of multiple factors. Human misstep is certainly one such factor, but not the only one. This paper builds on the Hastings Center's report in arguing that institutional ethics committees ought to play an integral role in the transformation of a "culture of blame" to a "culture of safety" in healthcare delivery.
Medline
AN 15301200

41.
Ruchlin HS, Dubbs NL and Callahan MA.
The role of leadership in instilling a culture of safety: Lessons from the literature.
J Healthc Manag. 2004;49(1):47-58.

The publication of To Err Is Human has highlighted concern for patient safety. Attention to date has focused primarily on micro issues such as minimizing medication errors and adverse drug reactions, improving select aspects of care, and reducing diagnostic and treatment errors. However, attention is also required to a macro issue--an organization's culture and the level of leadership required to create a culture. This article discusses the concepts of culture and leadership and summarizes two paradigms that are useful in understanding the precursors of medical errors and developing interventions to prevent them: normal accident theory and high-reliability organization theory. It also delineates approaches to instilling a safety culture. Normal accident theory asserts that errors result from system failures. An important element of this perspective is the need for a system that collects, analyzes, and disseminates information from incidents and near misses as well as regular proactive checks on the system's vital signs. Four subcultures are necessary to support such an environment: a reporting

culture, a just culture, a flexible culture, and a learning culture. High-reliability organization theory posits that accidents occur because individuals who operate and manage complex systems are themselves not sufficiently complex to sense and anticipate the problems generated by the system. Lessons learned from high-reliability organizations indicate that a safety culture is supported by migrated distributed decision making, management by exception or negotiation, and fostering a sense of the "big picture." Lessons from other industries are also shared in this article. [References: 60]
Medline
AN 14768428

42.
Marx, D.
How building a 'just culture' helps an organization learn from errors.
OR Manager. 2003;19(5):1,5, 20.
Medline
AN 12762162

Washington State Medical Commission 2015 Educational Conference Evaluation

Please select the choice that best fits your answer.

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
1. How satisfied were you with the conference materials provided?	○	○	○	○	○
2. Overall, how satisfied were you with the speakers/ presenters?	○	○	○	○	○
3. Overall, how satisfied were you with the conference facilities?	○	○	○	○	○

4. How many sessions did you attend?

- ○ 1-3
- ○ 4-6
- ○ 6-10
- ○ All Day September 30th
- ○ All Day October 1st

5. Were the sessions?

- ○ Too Short
- ○ Too Long
- ○ Right Amount of Time

6. Approximately how many conferences of this type do you attend annually?

- ○ 1-2
- ○ 3-4
- ○ 5-6
- ○ More than 6
- ○ I do not usually attend these types of conferences

7. How would you rate this conference compared to other conferences that you have attended?

- ◯ Excellent
- ◯ Very Good
- ◯ Average
- ◯ Poor
- ◯ Very Poor

Please tell us how much you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
8. The content of the conference sessions is appropriate and informative.	◯	◯	◯	◯	◯
9. The conference is well organized.	◯	◯	◯	◯	◯
10. Conference and Commission staffs are helpful and courteous.	◯	◯	◯	◯	◯

11. In what ways could we improve this conference?

12. What did you like most about the conference?

13. What did you like least about the conference?

14. Do you plan on attending the conference again?

- ◯ Yes
- ◯ No
- ◯ I do not know

15. What kinds of sessions would you like to see included at future conferences?

16. If the conference required registration would you attend?

- ◯ Yes
- ◯ No
- ◯ I do not know

17. If the conference required a fee but granted CME, would you attend?

- ☐ Yes
- ☐ No
- ☐ I do not know

Thank you for completing this survey of the 2015 educational conference. Please place the completed survey in the basket on the registration table or send the completed electronic version to jimi.bush@doh.wa.gov