Welcome to

*Mortality Reviews:
Great Learning from Our Early Journey*

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www.safetyleaders.org
Welcome

Charles Denham, MD
Chairman, TMIT
TMIT High Performer Webinar
February 16, 2017
With regard to webinar sound volume, please check:

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Surfing the Healthcare Tsunami: Bring Your Best Board™

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

High Performance 5 Rights Collaboratives

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

Surfing the Healthcare Tsunami Hospital Leaders Toolbox

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

Click here to watch the entire 53-minute documentary online.

Safety in Numbers: The Development of Leapfrog's Composite Patient Safety Score for...
February 16, 2017, 12:00 pm - 1:30 pm CT / 1:00 pm - 2:30 pm ET

Mortality Reviews: Great Learning from Our Early Journey

Session Overview

Patty Atkins, RN, MS, CNS, CPPS, is responsible for Quality, Patient Safety and Lean Six Sigma for Sharp HealthCare, the largest healthcare system in San Diego, CA. She will share the terrific learning her organization has gleaned from mortality reviews, having worked with Dr. Jeanne Huddleston from the Mayo Clinic who are the leaders in this field. Her insights are just what our surveys have told us from frontline safety leaders in our National Research Test Bed.

Dr. Huddleston’s work at the Mayo Clinic has generated one of the strongest positive reactions we have ever had in our nearly 100 monthly sequential webinars. The breakthrough work that can have enormous impact on the patient safety of healthcare institutions.

Following Patty’s presentation, a reactor panel will discuss how the insights can be applied to frontline care.

We offer these online webinars at no cost to our participants.

Webinar Video and Downloads

The webinar video will be available within five business days after the webinar airs.

Speaker Slide Sets:

Slide Sets will be available before the webinar begins.
If you wish to follow us on Twitter, go to: http://twitter.com/TMIT1 or use #safetyleaders hashtag

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

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

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

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

Patty Atkins, RN, MS, CNS, CPPS, is responsible for Quality, Patient Safety and Lean Six Sigma for Sharp HealthCare, the largest healthcare system in San Diego, CA. In 2016, Patty led a team to launch a mortality review process in collaboration with Dr. Jeanne Huddleston from the Mayo Clinic. She is a Certified Profession in Patient Safety by the National Patient Safety Foundation and has been a Critical Care Clinical Nurse Specialist. She has nothing to disclose.

Jeanne M. Huddleston, MD, FACP, FHM, is a past President of the Society of Hospital Medicine, the founder of Hospital Medicine and past Program Director of the Hospital Medicine Fellowship at Mayo Clinic, Rochester, MN. She is Chairperson of Mayo Clinic’s Mortality Review Subcommittee, a multi-disciplinary group of providers that review every death in search of where the health care delivery system may have failed the providers and/or the patient. She has nothing to disclose.

Mary E. Foley, RN, PhD, is the Director in the Center for Nursing Research and Innovation at the University of California, San Francisco (UCSF). She has worked with the Center as Associate Director since 2004 in partnership with three Bay Area academic medical centers. Mary has worked with the Collaborative Alliance for Nursing Outcomes (CALNOC) since 2004, and in 2009 was appointed Director, Education Services for CALNOC. She has nothing to disclose.

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

Patty Atkins
Jeanne Huddleston
Mary Foley
Charles Denham
Voice of the Patient and Family

Mary E. Foley, RN, PhD

Director, Center for Nursing Research and Innovation University of California, San Francisco (UCSF) San Francisco, CA

TMIT High Performer Webinar
February 16, 2017
In the News and National Survey Highlights:

News Update and

January 2017 Webinar National Survey

Charles Denham, MD
Chairman, TMIT

TMIT High Performer Webinar
February 16, 2017
A Medical-Tactical Approach undertaken by clinical and non-clinical people can have enormous impact on loss of life and harm from very common hazards:

- **High Impact Care Hazards** are frequent, severe, preventable, and measurable.
- **Lifeline Behaviors** undertaken by anyone can save lives.
It is our national responsibility to improve the likelihood of survival without disability after cardiac arrest.

Read the new report from the Institute of Medicine

www.iom.edu/cardiacarrest
FIGURE 3-1 Phases of the translational research spectrum.
An assessment of CPR skills using simulation: Are first responders prepared to save lives?

The American Heart Association’s (AHA) recommendation for biyearly recertification and annual mandatory CPR training may be suboptimal for first responders (nurses and technicians) working in outpatient clinics (American Heart Association, 2013).

To determine the efficacy of the AHA guidelines, 40 simulated sudden cardiac arrest (SCA) encounters were conducted followed by debriefing and a subsequent SCA to determine a basic level of CPR proficiency. First responders’ CPR skills were evaluated using a 19-item assessment form to quantify the event.

A comparison of scores using two different viewing modalities was performed to provide an assessment of the training program. Of the 40 sessions, group mean performance scores for the first encounter were just above the organization’s minimum required score of 24. Performance scores increased slightly (27-28) after the second encounter. Proficiency of skills was poor and frequent basic life support training may be indicated to help first responders provide high-quality CPR.

Source: Ruth Everett-Thomas a, *, Mercedes Yero-Aguayo b, Beatriz Valdes c, Guillermo Valdes d, Ilya Shekhter e, Lisa F. Rosen e, David J. Birnbach


Available at http://www.nurseeducationinpractice.com/article/S1471-5953(16)30023-3/pdf
The federal government already mandated every commercial airplane to have an AED on board. **A SCA event is 30 times more likely to occur in a school than on a plane.** Many states require schools to implement AED programs and several encourage or provide funding for school AED programs.

Kaléo, a privately-held pharmaceutical company, announced the release of its epinephrine injector last week.

AUVI-Q Auto-injector will be available by prescription starting Feb. 14, and announced AUVI-Q AffordAbility, a first-of-its-kind access program for AUVI-Q. Through this new program, patients with commercial insurance, even those with high-deductible plans, will have an out-of-pocket cost of $0.

For patients who do not have government or commercial insurance, and have a household income of less than $100,000, AUVI-Q will be available free of charge.

In addition, the cash price for AUVI-Q is $360 and will be available to those patients without government or commercial insurance. Each AUVI-Q prescription includes two auto-injectors and one trainer for AUVI-Q.

“We met with patients and physicians and listened to the very real challenges in the current healthcare environment with obtaining access to affordable medicines,” Spencer Williamson, president and CEO of kaléo said. “As a result, starting Feb. 14, for more than 200 million Americans with commercial insurance, including those with high-deductible plans, the out-of-pocket cost for AUVI-Q will be $0.”

Meaningful Use is dead. Long live something better!

High Impact Care Hazards to Patients, Students, and Employees

Major Trauma: Stop the Bleed Program

Source: CBS. American College of Surgeons website. (also available via CBS All Access)
Available at http://www.bleedingcontrol.org/about-bc/news-updates#kit
A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury

• In the initial moments after an injury occurs, **YOU AS A BYSTANDER CAN DELIVER IMMEDIATE LIFESAVING CARE** before EMS personnel arrive.

• If you have been seriously injured, **BE ENGAGED IN DECISIONS** about your care as much as possible. Patients, families, and care providers can work together, making decisions that take into account your preferences, life circumstances, and values.

• Participate in processes that work to improve trauma care, including taking part in trauma research. The public has an important role to play in **ADVOCATING FOR AND SUPPORTING TRAUMA SYSTEMS**.

• Patients, families, and other caregivers can use their firsthand experiences to identify areas in need of improvement in the trauma care system.

• **ZERO PREVENTABLE DEATHS AFTER INJURY AND BEST POSSIBLE RECOVERY IS AN ACHIEVABLE AIM**, and the benefits are clear; to protect those the nation sends into harm’s way in combat and to help save the lives of all Americans.

A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury

The Opportunity for YOU SAFETY LEADERS

In The News …DEA 2016 National Drug Threat Assessment


December 8, 2016
The suicide of a nurse who accidentally gave an infant a fatal overdose

Children’s hospital in the Northwest has closed an investigation but opened wounds for her friends and family members, as they struggle to comprehend a second tragedy.

Kimberly Hiatt, 50, a longtime critical-care nurse at Children’s, took her own life April 3. As a result, the state’s Nursing Commission last week closed its investigation of her actions with a critically ill infant who died in part from complications from an overdose of calcium chloride.

After the infant’s death, the hospital put Hiatt on administrative leave and soon dismissed her. In the months following, she battled to keep her nursing license in the hopes of continuing the work she loved, despite having made the deadly mistake, friends and family members said. Her H.R. employment record was leaked to the press of a time she hugged a co-worker giving the impression of misconduct.

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In conclusion, we found variation by a factor of more than three in rates of opioid prescribing by emergency physicians within the same hospital and increased rates of long-term opioid use among patients treated by high-intensity opioid prescribers. These results suggest that an increased likelihood of receiving an opioid for even one encounter could drive clinically significant future long-term opioid use and potentially increased adverse outcomes among the elderly. Future research may explore whether this variation reflects overprescription by some prescribers and whether it is amenable to intervention.

Ohio is ground zero for illicit fentanyl use in the United States, according to a new report documenting the deadly synthetic opioid’s flow from China to American addicts.

A report from the U.S.-China Economic and Security Review Commission details the drug’s path, primarily from China and sometimes through Mexico, creating “a fentanyl crisis in the United States, with significant increase in U.S. opioid overdoses, deaths, and addiction rates occurring over the last several years.”

Ohio had the most investigative fentanyl samples tested of any state in 2015, according to National Forensic Laboratory Information System, which collects results from state and local forensic laboratories.

Ohio documented 3,897 samples of fentanyl that year, while second-place Massachusetts had 2,556.

In one Ohio county, **the coroner has run out of space for the remains of overdose victims.**

It’s only the second week of February and a coroner in Dayton Ohio has already processed more than **150 bodies of people who have died from opioid overdoses in 2017.** Overdose deaths currently make up 60% of the cases on the medical examiner’s office January case load …

**“We’re running at full capacity,”** Kenneth M. Betz, director of the coroner’s office said in a phone interview. “We’ve never experienced this volume of accidental drug overdoses in our history. We now call funeral homes immediately” to ask if there is space available, he added.

**CDC reports that 91 people in the United States die every day from opioid overdose.** An increase in the abuse of prescription pain pills such as oxycodone, hydrocodone, hydromorphone and fentanyl has led to a crackdown on doctors who are too light handed with the prescription pad. When people who abuse prescription pain pills can’t get a hold of them, they tend to turn to heroin.

Mayo Clinic Mortality Reviews

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Chairperson of Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

TMIT High Performer Webinar
Part 1 and Part 2

Omission vs. Commission

Pareto Chart of Categories of Issues Experienced by Patients Hospitalized in Mayo Clinic Hospitals
Anonymous National Survey Questions

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

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

July 21, 2016 National Survey

The topics in Learning from Mortality Reviews I would like covered in future are:

- Are there trigger points that happen before a patient expires
- blood transfusion related mortalities.
- c. diff
- Cardiac related
- Cardiothoracic surgery mortalities blood transfusion related mortalities.
- case example.
- communication
- communication between all departments. Care of patient on Friday, Saturdays and Sundays vs the rest of the week. Respect of physician for nurses opinions.
- Delays in consulting and consulting responsiveness. Fragmented communications among specialists
- developing data for actionable changes
- Different case studies
- Do your patients become DNR's on the day of death? Is that common?
- Early Warning/Notification Systems; Basic or Preventable Errors that lead to patient deaths most often; Research Studies for applying lessons learned from mortality reviews to optimize QI/PI;
- ED mortalities
- Emotionally Difficult patients & family
- end of life pain; opioid overdose- pain protocols
- engaging physicians/nurses in review, process of forming review
- Example of preventive action taken and the resulting outcome changes
- failure to recognize issues and solutions
- Failure to Rescue
- failure to rescue
- Failure to rescue--how to increase awareness
- Focus on the omissions - how to identify them during the review.
- From review to action, sustainability
- Helping staff to deal with errors and patient deaths.
- Honestly--I thought this was a webinar about how to live longer :)
- Hospital acquired infections; c Dif
- How do you disseminate findings to physicians?
- How to conduct the review; how do you get physician engagement?
- How to disseminate info learned to coworkers
- how to exclude comfort care patients who come in and change coded to DNR/DNI?
- How to get a better grip on expected vs observed deaths especially with patients who are transitioned to end of life/palliative care after they were initially assessed and fell into the unexpected bucket.
- "How to identify omissions (not generally in the patient record). "
- How to obtain buy in from major share holders for a more change centered mortality review, as opposed to a number focused mortality review


July 21, 2016 National Survey
The topics in Learning from Mortality Reviews I would like covered in future are:

- How to recruit physicians, residents and mid-levels to participate in the mortality review process. Everyone is so busy in our organization, it's really challenging to get these clinicians involved and get face time with them (although desperately needed).
- Identifying coding inaccuracies
- Implantation of a no blame approach vs opportunity to improve
- Integrating processes for larger health systems with multiple hospitals
- Logistics of mortality review in smaller community hospitals, challenges with smaller, close medical staff
- Medication errors
- Medication errors
- Missed/misdiagnosis diagnosis
- More about committee structure, activity, etc; criteria or guidelines used if any for case reviews,
- More infections/rare as well
- More info from leaders in mortality review and patient safety.
- N/a
- Omissions
- Once again recognizing sepsis early in patients.
- Opioid overdose, transporting DNR patients to a higher acuity facility, using bipap in DNR patients.
- Peer review and mortality issues found- how to best affect peer review
- Post op respiratory failure
- RCA approach should use the same principles and glad that is being used here- makes sense
- Reporting on the issues identified, presentation methods to clinicians of the issues, action plans to prevent recurrence
- Review matrix development - guide the reviewers through a comprehensive case review and ensure standardized review of care provided.
- Same info with deep dive, forms used.....
- Second victim programs
- Sepsis
- Sepsis
- Sepsis
- Sepsis cases
- Sepsis identification & management
- Sepsis, AMI,
- Specific data collection examples
- Step by step process of setting up an effective mortality review process.
- Surgical complications - punctures, tears, etc.
- Tools used for mortality reviews
- Top issues and what was done to prevent them
- Translating data to action
- Unintentional surgical errors
- Where should we start our focus to improve our mortality review process.

Anonymous National Survey Questions

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

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

Omission vs. Commission

Pareto Chart of Categories of Issues Experienced by Patients Hospitalized in Mayo Clinic Hospitals

Mayo Clinic, Mortality Review System
I am interested in a deep dive webinar on errors of OMISSION.

98% Agreed and 71% Strongly or Very Strongly Agreed, and 58% Very Strongly Agreed

Anonymous National Survey Questions

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

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

August 18, 2017 National Survey

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

I want more information on PERFORMANCE IMPROVEMENT using MORTALITY REVIEWS

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

January 15, 2017 National Survey

Source: TMIT High Performer Webinar Series; Saving Lives Putting Mortality Reviews to Work: It does pay off! – January 15, 2017
The topics regarding PERFORMANCE IMPROVEMENT Using MORTALITY REVIEWS I would like covered include:

- A-Z in the steps she described!! We need more details to re-create.
- Any obstacles with costs and resource availability for this effort and how to overcome? Data and predictive analytics...what next? Any case examples from start to finish
- Composition and methodology of mortality review process
- Continue same presentation in form of updates and more case studies.
- Direct Relationship to Sepsis initiatives in small er community hospitals with limited personnel and other resources
- Hospital complication review form/tool
- How smaller community hospitals, with sometimes only 1 or 2 specialists in a particular specialty. How much to use benchmark information, where to find them, or should we make our own benchmarks.
- How to engage physician and nursing staff. How to deal with very limited education budgets.
- How to engage physicians
- How to help physicians understand peer review is not punitive
- How to obtain engagement from reviewers.
- how to start a program for M&M
- I would love to have a structured series on how to actually undertake the reviews - similar to how IHI has taught things like GTT
- Improving Mortality outside of sepsis. Much work surrounds that disease process and would be interested specifically in those disease with VBP
- improving nursing and MD collaboration; tying in peer review and OPPE
- key indicators to look at
- level of care
- logistics of review in a small hospital
- Meaning metrics-expand on specifics of improvement actions.
- More detail in how to do reviews, ie: forms, etc.
- Not sure specifically but would like to hear more.
- Readmission, and Case management
- RRT criteria if possible
- Severity of illness/Risk of mortality
- Sharing actual review tool would be helpful!
- Specifics regarding interventions utilized based on indicators causing response to begin with.
- stagnant mortality index despite multidisciplinary interventions
- This was a lot of information in a short period of time. How can organizations without all the resources available to Mayo actually make progress - practical advice.
- what statistical reviews and data were most helpful in determining what actions to implement
- Working with ancillaries.

January 15, 2017 National Survey

Source: TMIT High Performer Webinar Series; Saving Lives Putting Mortality Reviews to Work: It does pay off! – January 15, 2017
Julie Thao:
The nurse indicted for the death of a 16 year old mother due to an unintentional medication error.

Eric Cropp:
The pharmacist sent to prison for the death of a child due to unintentional medication error.
Editorial:

Tactics Characteristic of Sham Peer Review

Source: Tactics Characteristic of Sham Peer Review - Journal of the American ... by LR Huntoon - 2009
Real Fraud, Ethical Breach, and Crime

Sham Peer Review and Abuse of Power

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

Editorial:
Tactics Characteristic of Sham Peer Review

Source: Tactics Characteristic of Sham Peer Review - Journal of the American ...
by LR Huntoon - 2009
The pay-for-publication practices and inadequate peer review of phony journals are major sources of publication pollution but not the only sources. Misconduct is polluting the fabric of science and medicine as well.

Studies are making it into print that have been condemned by the Food and Drug Administration, other regulators, and legitimate authors and review groups. My colleague Charles Seife found in a review of Food and Drug Administration inspection reports between 1998 and 2013 that of nearly 60 clinical trials in which regulators had uncovered violations serious enough to earn the agency's most severe classification (“official action indicated”), 78 articles using data from these trials were published. Seife believes that there could well be more.

A recent analysis of the prevalence of research misconduct by Daniele Fanelli looked at “scientific behaviors that distort scientific knowledge” and found that 2% of the scientists surveyed admitted to serious misconduct (falsification or fabrication of data) at least once and nearly 34% admitted other questionable research practices. When participants were asked about their colleagues’ practices, the results were much worse: 14% for falsification of data and 72% for other questionable practices.

We are here to serve our Porpoise

Caregivers and H.R. Department

Source: Adapted from Ryan Berkley 2007
Impaired Physician, Death, and Retaliation

- An reportedly impaired physician is allowed to practice with a death related to issues of omission.
- A nurse speaks up in peer review and is targeted by falsified HR records to discredit her.
- A malpractice settlement is achieved, however the hospital refuses to correct falsified records.

Nursing Student Avoids Bullying and Losses Graduation and Career

- A student nurse is within weeks of graduating and takes her last elective.
- She tries to avoid bullying and unsafe supervision going through proper channels.
- Records of her behavior are fabricated and she is denied her credits and ability to graduate.
Anonymous National Survey Questions

I am interested in a webinar on PROFESSIONAL IDENTITY PROTECTION BEST PRACTICES after an adverse event

72% Agreed and 45% Strongly or Very Strongly Agreed, and 29% Very Strongly Agreed

January 15, 2017 National Survey

Source: TMIT High Performer Webinar Series; Saving Lives Putting Mortality Reviews to Work: It does pay off! – January 15, 2017
PROFESSIONAL IDENTITY PROTECTION
topics I would like to be covered include:

• After an adverse event we need to work together with the family. How to work with the family and providers together.
• Analyzing mortality records
• Best practices for unbiased reviews based on process focus.
• Case analysis
• Ethics of interventions in elderly
• Examples of Best Practices
• Examples of what others have done
• How do organizations handle confidentiality of RCAs. Do they release them to attorneys?
• How separate peer review process documentation from process improvement documentation
• How to handle the bad apples.
• How to identify the prevention issues
• How to operationalize
• Legislative work that is needed. Best communication
• Nurse peer review
• Physician peer review is much more protected, how that be more broadly applied
• Second victim issues; high reliability inclusion
• Sepsis Mortality Review
• Sham HR Review – Preventing it
Mayo Clinic Mortality Reviews

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Chairperson of Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

January 2017
Mortality Reviews: Great Learning from Our Early Journey

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

TMIT High Performer Webinar
February 16, 2017
Mortality Review
Great Learning from Our Early Journey
Patricia Atkins, RN MS CNS CPPS
VP Quality, Patient Safety & Lean Six Sigma
Sharp HealthCare
San Diego, CA
Feb 16, 2017
About Sharp HealthCare

Not-for-Profit Serving 3.3 Million San Diego Residents
- Largest health care system in San Diego, CA
- Baldrige Award 2007; Leapfrog: two ‘A’s, one ‘B’; CMS Star: two ‘4’s, one ‘3’

18,000+
employees

1,500+
affiliated physicians

2,084
licensed beds

4
acute care
hospitals

3
specialty
hospitals

3
skilled nursing
facilities

2
affiliated
medical
groups

• Mortality Review Committees at 3 acute care hospitals
Objectives

1. Discuss the purpose of mortality review
2. Describe the logistics of a systematic review process for discovering OFIs*
3. Discuss learning and improvements so far

*opportunities for improvement
Why Mortality Review?

Create a learning culture
• Translatable to Peer Review
• Create multi-specialty performance improvements

Prevent death
• Discover actionable insights
• Improve culture, people and processes

Help facilitate a good death
• Inform and provide choice; honor preferences
• Delay inevitable death when appropriate
• Provide palliation

Improve VBP* Metrics, CMS Star Rating
• Inpatient mortality, Medicare Spending per Beneficiary, Complications

*Value-Based Purchasing
Mortality Review Process Workflow

Q-Centrix
Screen all deaths to appropriate level of detail for:
- Complete admit source (eg SNF)

Quality Dept Reviewer
Review all deaths to appropriate level of detail for:
- Safety Event or other quality issue (eg Core Measure fallout, triage error, AIM issue)?
- SOI/ROM OFI – (in collaboration with CDI and Coding)?
- General overview to discern which Unit RN / MD to review

Specialty RN Reviewer*
Review only specialty dx cases for:
- Patient selection
- Missed or delayed dx or treatment
- EBM, System or team OFI
- Record Coding OFIs

MD Reviewer
Review for:
- Patient selection OFI
- Missed or delayed dx
- Missed, delayed, inapprop treatment
- EBM, System or team OFI

Unit RN Reviewer
Review for:
- Clinical issues and care coordination
- See 4-page Mortality Review Guidelines

Committee
Review for:
- System OFI
- Team OFI
- EBM OFI
- Reconcile and finalize OFIs
- Review aggregate reports

Feedback/Learning for:
- Physician feedback / coaching
- Dept-specific PI
- Dept team PI
- Individual feedback / coaching
- Safety Event Review Process
- CDI: MDs and Coders
- Clinical MDs and Coders
- Clinical Operations PI
- Quality: PI Project
- Lean Six Sigma Project

*Specialty RN Reviewers:
- AMI, HF, CABG
- Stroke
- Oncology
- Sepsis
- COPD, PN
- Total Joint
What Are We Learning and Improving So Far

- Teamwork and Communication
  - Chain of command; EHR challenges
- Missed or delayed diagnosis / treatment
  - Sepsis; Stroke; Known complications test
- Protocols: Abd pain, pre-op work up (Cardiac/delirium)
- Recognizing Subtle Signs of Deterioration
  - Teach graphical trending in EHR
  - Teach systematic critical thinking*
- Rapid Response Team
  - Why nurses don’t call?
  - Automate Triggers; Family initiated calls?
- Advance Illness Management (AIM)
  - Addressing needs in the ED
  - Reliable access to POLST form
  - Bioethics Team
- Clinical Documentation Improvement (CDI)

6% of the 535 cases were classified as potentially preventable, which is in line with rates published by other institutions.
Recognizing OFIs:
The Known Complications Test*

A **known complication** is an adverse outcome related to a procedure, treatment, or test that is not present before the patient care encounter and occurs as a result of patient care.

If the patient experienced a “known complication,” ask:

1. **Was the procedure, treatment, or test appropriate and warranted** based on nationally recognized standards of care?
2. **Was the complication a known risk, was it anticipated** before the procedure, and was the standard of care applied to **mitigate** the risk?
3. **Was the complication identified** in a timely manner?
4. **Was the complication treated** according to the standard of care and in a timely manner?

If the answer to **any question** is no, the event is a Safety Event.

How to Engage Physicians/Sr. Execs?

- Organizational goal / incentives
- Mayo Clinic / Dr. Huddleston Credibility – 1:1 CMO mentoring
- Best practices from published studies
- Avoid individual provider comparisons of mortality O/E unless wild outlier – instead focus on system OFIs
- Stories compel, data convinces
  - Mortality Dashboard
    - OFI Count, OFI yield
    - Imminent Death Report, etc
  - AIM Dashboard
    - # Referrals completed (to show need for additional resources)
    - POLST on discharge for 80+
    - etc
  - RRT/Code Blue Dashboard
Mortality Review
Is it Worth it?

Yes, and without it we maintain our blind spots.
Closing Thought

Remember to care for the care providers
(and reviewers)
Death is difficult for everyone
National Survey Questions

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

MORTALITY REVIEW AREAS
topics I would like to be covered first include:
National Survey Questions

The topics regarding BYSTANDER CARE I would like covered include:

I want more information on PREPARING NON-CLINICAL STAFF for emergencies and BYSTANDER CARE

Very Strongly Agree

Strongly Agree

Agree

Neutral

Neutral

Negative to Neutral

Disagree

Strongly Disagree

Very Strongly Disagree
National Survey Questions

I want more information on SHAM HUMAN RESOURCES (HR) REVIEW and Employee Fear of Retaliation after Adverse Events

The topics regarding HUMAN RESOURCES reviews and employee fear I would like covered include:
Speakers and Reactors

- Patty Atkins
- Jeanne Huddleston
- Mary Foley
- Charles Denham
Voice of the Patient and Family

Mary E. Foley, RN, PhD

Director, Center for Nursing Research and Innovation University of California, San Francisco (UCSF) San Francisco, CA

TMIT High Performer Webinar
February 16, 2017