Mortality Reviews and Patient Safety:

2019 Update

June 20, 2019
Webinar Month 127
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Welcome

Charles Denham, MD
Chairman, TMIT
TMIT High Performer Webinar
June 20, 2019
Webinar 127

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TMIT Purpose Statement

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

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

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

Jeanne M. Huddleston, MD, FACP, FHM, is a past President of the Society of Hospital Medicine, the founder of Hospital Medicine and past Program Director of the Hospital Medicine Fellowship at Mayo Clinic, Rochester, MN. She completed her residency in internal medicine and advanced general medicine fellowship at Mayo Clinic. Dr. Huddleston is a Harvard Macy Scholar (both in the Physician Educator and the Leadership Programs) and alumnus of the Health Forum/AHA Patient Safety Leadership Fellowship. Dr. Huddleston has received Masters’ Degrees in both Clinical Research and Industrial Engineering. This education equipped her scholarly translation of systems engineering to health care delivery in an effort to improve the value of the healthcare experience for patients, their families and the providers through her work in mortality reviews and patient threat safety. She has anything to disclose.

Arlene Salamendra is a former Board member and Staff Coordinator of Families Advocating Injury Reduction (FAIR). A number of years ago, she was the subject of a preventable medical error. Since that time, she has devoted a portion of her time to giving support to other patients who have been injured or have lost a loved one, and rectifying the systems errors that led to preventable medical errors. She is a member of the TMIT Patient Advocate Team. She has anything 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 with 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 including conflict of interest, healthcare fraud, and continuing professional education and consumer education including bystander care. Dr. Denham is a collaborator with Professor Christensen at Harvard Business School.

Speakers and Reactors

Jeanne M. Huddleston
Arlene Salamendra
Charles Denham

Voice of Patient and Family

Arlene Salamendra
Former Board Member and Staff Coordinator, Families Advocating Injury Reduction (FAIR)
TMIT Patient Advocate Team Member
Plano, IL
TMIT High Performer Webinar
June 20, 2019

In the News Update and April 2019 Webinar Recap

Charles Denham, MD
Chairman, TMIT
TMIT High Performer Webinar
June 20, 2019
Webinar 127
In The News …

Robocalls Overwhelm Hospitals, Threatening A New Kind Of Health Crisis

For most Americans, such robocalls represent an inevitable digital-age nuisance, resulting in constant interruptions targeting their phones each month. For hospitals, though, the spam calls amount to a literal life-or-death challenge, one that increasingly is threatening doctors and patients in a setting where every second can count.

At Tufts Medical Center, administrators registered more than 9,000 calls between about 9:30 and 11:30 a.m. on April 30, 2018, said Taylor Lehmann, the center's chief information security officer. Many of the messages seemed to be the same. Speaking in Mandarin, an unknown voice threatened deportation unless the person who picked up the phone provided their personal information.

Such calls are common, widely documented scams that seek to extort vulnerable foreigners, who may surrender their private data out of fear their families and homes are at risk. But it proved especially troubling at Tufts, which is situated amid Boston's Chinatown neighborhood, Lehmann said. Officials there couldn't block the calls through their telecom carrier, Windstream, which provides phone and web services to consumers and businesses. "There's nothing we could do," Lehmann said Windstream told them.

This is not the first time these kind of calls have affected medical teams. When Congress adopted the government's anti-robocall rule in 1991, one of the major reasons was the complaint that such calls were tying up emergency phone lines.

As lawmakers continue to debate the best course of action, hospital staffs are now being trained in the best practices to take if they receive one of these robocalls.

June 17, 2019


In The News …

Lawsuit Alleges Infections, Death Tied to Hospital Sterilization Procedures

MORE THAN 60 PATIENTS are suing a Denver hospital, alleging its failure to adequately clean surgical tools resulted in "hundreds of severe infections" and at least one death.

In April 2018, state officials and Porter Adventist Hospital announced that faulty sterilization of surgical tools may have exposed some patients who underwent orthopedic and spine procedures to infections such as hepatitis B, hepatitis C or HIV. The Denver Post reports. An investigation by state officials also identified 76 times in which surgical instruments contaminated by blood, clumps of bone, hair and other substances were taken into operating areas at the hospital between 2017 and early 2018.

The lawsuit from 67 former patients and 20 of their spouses was filed Saturday and claims the contaminated instruments were not limited to orthopedic or spine surgery patients, with patients developing hepatitis B, meningitis, urinary tract, E. coli and staph infections after procedures that occurred between January 2015 and late 2018.

As an outcome of the investigation, officials have surrendered their private data out of fear their families or spouses was filed Saturday and claims the contaminated instruments were not limited to orthopedic or spine surgery patients, with patients developing hepatitis B, meningitis, urinary tract, E. coli and staph infections after procedures that occurred between January 2015 and late 2018.

According to the Post, Dr. Tasha Ghoseh, chief medical officer for the Colorado Department of Public Health and Environment, said in a statement that the state has not confirmed a link between infections and sterilization problems at the hospital.

June 17, 2019


In The News …

20 Years Of Patient Safety

Feds on the front lines

Soon after the release of To Err Is Human, Congress passed legislation requiring the Agency for Healthcare Research and Quality (AHRQ) to issue annual reports designed to monitor progress in improving care.

The Joint Commission's safety goals

Just a few years after To Err Is Human, the Joint Commission leveraged its role as an accrediting body to identify required steps for preventing medical errors.

Goal: Save 100,000 lives

In 2004, the Institute for Healthcare Improvement (IHI), a nonprofit dedicated to improving patient care, launched its 100,000 Lives Campaign, led by Donald Berwick, MD. Its goal was to drastically reduce preventable deaths over 18 months.

The Safe Surgery Saves Lives challenge

Noting that more than 200 million operations are performed around the world each year, in 2007 the World Health Organization (WHO) set out to tackle the ambitious goal of reducing dangerous surgical errors.

Working to halt hospital infections

Health care-associated infections (HAIs) — surgical site infections, catheter-related bloodstream infections (CRBIs), and more — are common and dangerous.

The AAMC promotes quality and safety

In 2008, the AAMC created the Integrating Quality Initiative to help its member medical schools and teaching hospitals achieve safe, high-quality, and high-value care. The AAMC's safety goals put the focus on central line infections. Using IHI work product, Hopkins focused on Central Line Infections.

Healthier patient handoffs

Each day, about 4,000 patient handoffs happen at teaching hospitals across the country — and if provider communications fail during these transitions, the results can be dangerous.

The Affordable (and safer) Care Act

In 2010, the Affordable Care Act (ACA) went into effect, providing Medicaid insurance to millions of uninsured Americans. In 2008, the AAMC created the Integrating Quality Initiative to help its member medical schools and teaching hospitals achieve safe, high-quality, and high-value care. The AAMC's safety goals put the focus on central line infections.

Building on pioneering work by the Institute for Healthcare Improvement (IHI), the National Patient Safety Goals have continued to evolve their annually. Most recently, the 2019 edition added practices for preventing patient suicide.

20 Years Of Patient Safety


In The News …

20 Years Of Patient Safety

To Err is Human

In its pioneering report To Err is Human: Building a Safer Health System, the Institute of Medicine (IOM) in 1999 exposed the grim reality of preventable deaths over 18 months: The Affordable (and safer) Care Act

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In 2008, the Institute for Healthcare Improvement (IHI) released their 100,000 Lives Campaign, led by Donald Berwick, MD. Its goal was to drastically reduce preventable deaths over 18 months. It ultimately saved more than 122,000 lives.

The National Patient Safety Goals

The National Patient Safety Goals program released by the Agency for Healthcare Research and Quality (AHRQ) continues to update their annually. Most recently, the 2019 edition added practices for preventing patient suicide.

WHO Safe Surgery Saves Lives Challenge


IHI 100,000 Lives Campaign

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June 06, 2019


In The News …

20 Years Of Patient Safety

IOM 1999 Report

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WHO Safe Surgery Saves Lives Challenge 2007


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WHO Safe Surgery Saves Lives Challenge 2007


Map of the United States

Unfortunately, threats to the integrity of U.S. biomedical research exist. NIH is aware that some reviewers and to take advantage of the long tradition of trust, fairness, and excellence of NIH supported research activities. This kind of inappropriate influence is not limited to biomedical research; it has been a significant issue for defense and energy research for some time. Three

1. Diversion of intellectual property (IP) in grant applications or produced by NIH supported institutions in the U.S. and abroad, which threatens to distort decisions about the appropriate use of NIH funds.
2. Sharing of confidential information on grant applications by NIH peer reviewers with others, including foreign entities, or otherwise attempting to influence funding decisions; and
3. Failure by some researchers working at NIH-funded institutions in the U.S. or elsewhere to disclose substantial resources from other organizations, including foreign governments, which threatens to distort decisions about the appropriate use of NIH funds.

“We recently reminded the community that applicants and awardees must disclose all forms of other support and financial interests, including support coming from foreign governments or other foreign entities.”

“We also expect and encourage your institution to notify us immediately upon identifying new information that affects your institution’s applications or awards. Lastly, we encourage you to reach out to an FBI field office to schedule a briefing on this matter.”

MD Anderson Cancer Center is ousting three scientists in connection with concerns China is trying to steal U.S. scientific research, the first such publicly disclosed punishments since federal officials directed some institutions to investigate specific professors in violation of granting agency policies.

MD Anderson took the actions after receiving e-mails last year from the National Institutes of Health, the nation’s largest public funder of biomedical research, describing conflicts of interest or unreported foreign income by five faculty members. The agency, which has been assisted by the FBI, gave the cancer center 30 days to respond.

“Individuals that are being reviewed are not all of Chinese ethnicity. However, China’s Thousands of Talents Program is a known prominent player,” NIH said

“The U.S. is battling with Beijing’s growing influence on academic activities and addressing intellectual property protection in the science field. Xiao-Jiang Li and his wife Shihua Li, both professors of human genetics at Emory University School of Medicine, have been dismissed this week. The investigation on Li was prompted by a letter that the National Institutes of Health (NIH) sent to over 10,000 academic research universities last August. The letter urged institutions to work with NIH and other agencies including the FBI to crack down on foreign influence, particularly from China. Recipients of U.S. federal funds have to disclose if they are receiving funds from other countries and are not allowed to share their grant applications with foreign governments.

This is not the first time Chinese-descent researchers lost their jobs as a result of NIH investigations. In April, the top cancer research center MD Anderson Cancer Center in Houston, Texas ousted three Chinese scientist researchers after NIH notified them about their foreign ties.

MD Anderson is raising funds from China to support research and education and practice. The AAMC created the I-PASS initiative to help its students and visiting scholars to pilfer intellectual property from confidential grant applications, luring scientists to run “shadow labs” in China. Two Chinese American professors at Emory University have been fired for failing to disclose research funding’s from China and their work for Chinese universities while receiving federal grants from the U.S. government, the latest example of how the U.S. is battling with Beijing’s growing influence on academic activities and addressing intellectual property protection in the science field.

MD Anderson Ousts 3 Scientists Over Concerns About Chinese Data Theft

One Chinese American professor at Emory University have been fired for failing to disclose research funding’s from China and their work for Chinese universities while receiving federal grants from the U.S. government, the latest example of how the U.S. is battling with Beijing’s growing influence on academic activities and addressing intellectual property protection in the science field.

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MD Anderson’s action comes amid heightened concern in Washington, D.C., and around the country that China and other foreign governments are exploiting U.S.-funded research for their own benefit, enabling students and visiting scholars to pilfer intellectual property from confidential grant applications, luring scientists to run “shadow laboratorie’s” in their countries.

“As stewards of taxpayer dollars invested in biomedical research, we have an obligation to follow up” when asked to investigate grant recipients, Dr. Peter Piotter, president of MD Anderson, told the Chronicle. “This is part of a much larger issue the country is facing — trying to balance an open collaborative environment and at the same time protect proprietary information and commercial interests.”
Mit Professor Is Accused Of Claiming Others’ Scientific Discoveries As His Own

A new paper in mAbs alleges that Ram Sasisekharan, professor of biological engineering at Massachusetts Institute of Technology, claimed two previously discovered antibody therapeutics as his own.

“We looked at exactly two cases, and in both did we find irregularities,” co-author Tillman Gerngross, CEO of the private biotech firm Adimab, told STAT. “To me, if you’re sitting in the kitchen and two fat cockroaches walk across the floor, what’s the chance that there’s only two?” Gerngross and his colleagues base their argument on amino acid sequences not published in Sasisekharan’s papers but obtained through patent information and later cross-checked on GenBank.

Sasisekharan reportedly said that the paper was “inaccurate and slanderous” and that there are, for example, “fundamental differences” between the Zika antibody he and colleagues wrote about last year in Cell and the one another team of researchers shared in Nature in 2016.

MIT told STAT that “while federal regulations and MIT policy do not allow us to comment on any particular matter, research integrity at MIT is paramount. MIT has policies and confidential processes in place to assess concerns that might be raised.”

“If you look at the original [MIT] papers that reported these antibodies, they don’t give a really clear description of how they identified the epitope or how they designed the antibodies,” he said.

The implications of Adimab’s paper stretch beyond academia. Visterra was developing the flu antibody when it was acquired by the Japanese drug maker Otsuka for $430 million last year.
In The News …

**Johns Hopkins Patient Safety Crisis**

*How We Got The Story On A Surgery Program Where ‘Children Were Dying At A Stunning Rate’*

**The Pulitzer Prizes**

*Finalists for Pulitzer Prize in Investigation of the entire Johns Hopkins system.

Johns Hopkins Patient Safety Crisis

Johns Hopkins Wrote the Rules on Patient Safety But Its Hospitals Don’t Always Follow Them

Heartbroken: Despite warnings, All Children’s kept operating. Babies died.


Source: [https://www.centerforhealthjournalism.org/2019/02/14/how-tampa-bay-times-broke-story-surgery-program-where-children-were-dying-stunning-rate](https://www.centerforhealthjournalism.org/2019/02/14/how-tampa-bay-times-broke-story-surgery-program-where-children-were-dying-stunning-rate)

Patient Safety and COI Stories Being Followed

- *The New York Times*
- *The Washington Post*
- *NPR*
- *Propublica*
- *Medscape*
- *Houston Chronicle*
- *The Daily Beast*
- *USA Today*
- *The Baltimore Sun*
- *The Philadelphia Inquirer*

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**Medscape Reports**

- Duke Sedative Study Outline for $112.5 Million
- Duke Whistleblower Gains More Than $33 Million in Lawsuit for $112.5 Million
- Duke Settles Doctored Data Lawsuit for $112.5 Million
- Duke Whistleblower Gets More Than $33 Million In Lawsuit for $112.5 Million

**Tampa Bay Times Reports**

- Heartbroken: Despite warnings, All Children’s kept operating. Babies died.
- Deaths of children in 1 in 10 undergoing CV Surgery at JH All Children’s burn unit in Maryland
- Mutilation of children in cover up of harm
- Retaliation against whistleblower
- Cover up of harm
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- Cover up of harm
- Retaliation against whistleblower
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**Medical Center Reports**

- Revision of conflict of interest policies
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**Regulatory Problems**

- Oversight letting team of doctors make unannounced visits
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**Nurse Medication Error During Imaging With Patient Death**

- Nurse indicted for reckless homicide for fatal error.
- Nurse responsible for death of patient.
- Nurse paid $100,000 for 20,000 copies of her books during a period when the company was seeking a lucrative contract to provide health benefits to city employees.

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

A New Program

www.HealthcareInnocenceProject.org

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.

In The News …

Women Are Less Likely Than Men To Receive CPR

CPR mannequins are getting breasts – with the goal of saving women’s lives.

The so-called Womanikin is an attachment for flat-chested CPR dummies that aims to change the finding that women are 27% less likely than men to receive CPR if they suffer from a cardiac arrest in public.

Researchers suspect bystanders’ reluctance to touch the chest of a woman they don’t know might play a role.

So, the New York ad agency JOAN Creative, along with the organization United State of Women, created the Womanikin to try to normalize performing CPR on women.

The project, which began as a self-funded endeavor, recently won a grant that will allow it to create more Womanikins to distribute to schools across the United States, she added. It also solicits donations.

"Since survival from cardiac arrest depends on the prompt delivery of CPR by a bystander, we need to think of ways to make CPR training more accessible to everyone and for everyone," Audrey L. Blewer, epidemiologist and resuscitation scientist at the Duke University School of Medicine Department of Family Medicine and Community Health, told Campaign Live.

"We also need to consider ways to raise awareness around sudden cardiac arrest, address these known gender disparities, and empower more people to perform CPR if needed."

June 05, 2019

Source: https://www.cnn.com/2019/06/05/health/female-cpr-dummy-women-cardiac-arrest/index.html
Meaningful Use is dead. Long live something better!

YouTube Patient Safety Briefings

- Opioid Overdose Crisis
  https://www.youtube.com/watch?v=p4O4mt0BxE8

- Active Shooter Events in Healthcare
  https://www.youtube.com/watch?v=4Ss89d7u89w

- Sudden Cardiac Arrest
  https://www.youtube.com/watch?v=qWjW5464ZBE

- Med Tac Lifeguard-Surf Program
  https://www.youtube.com/watch?v=G1V88uX7m8M

- Med Tac Bystander Care Training
  https://www.youtube.com/watch?v=2MDj6uLQu8M

- Rapid Response Teams
  https://www.youtube.com/watch?v=4jVfZQXq29g

YouTube TMIT Patient Safety Briefings

- In the News: Med Tac Updates

November/December 2018 Issue

- Opioid Overdose Crisis
- Active Shooter Events in Healthcare
- Sudden Cardiac Arrest
- Med Tac Lifeguard-Surf Program
- Med Tac Bystander Care Training
- Rapid Response Teams
- In the News: Med Tac Updates

Med Tac Publication in Campus Safety Magazine: January/February Issue

Med Tac Publication in Campus Safety Magazine: In Publication

Unique Characteristics of Healthcare Facilities

Active shooter events at healthcare facilities are different from schools, shopping malls and commercial businesses for several important reasons:

1. The active shooter's motives usually are much more personal, targeted and focused.
2. Healthcare providers feel compelled to stay with their patients.
3. Certain patients will die without continued life support in ICU's and operating rooms.
4. Certain areas of hospitals are not easy to harden or evacuate.
5. Most hospitals are organized vertically and rely heavily on elevators.
6. Emergency departments may lock down or shut down during an event.
7. Violence could end in less than 10 minutes, but the healthcare delivery disruption could be prolonged.
8. Healthcare shootings occur at entrances or just outside buildings.
9. Healthcare facilities cannot easily shut down for training.

The excellent NEJM article framework is used to describe actions to be taken for healthcare facilities by safety leaders at hospitals, schools, universities, and faith-based organizations.

NOTE: See June Issue of Campus Safety Magazine at www.CampusSafetyMagazine.com

Battling Failure to Rescue With Rapid Response Teams

Applying what we have learned in hospitals to schools, higher education, and worship centers.

- Have you learned from 9/11 and the latest active shooter events?
- Can you define the current and specific risks to those you serve and those who serve?
- Can you get care to any victim within three minutes?
- Are AEDs and care supplies positioned within three minutes of victims?
- Do players from your various departments regularly practice emergency response together?

After 3 minutes without bystander care, you are counting lives lost and long term harm to victims of significant health hazards and conditions.
In The News …

Escalating Workplace Violence Rocks Hospitals

Nearly half of emergency physician respondents reported having been physically assaulted in one recent survey. Across the country, many doctors, nurses and other health care workers have remained silent about what is being called an epidemic of violence against them. The violent outbursts come from patients and patients’ families. And for years, it has been considered part of the job.

When you visit the Cleveland Clinic emergency department — whether as a patient, family member or friend — a large sign directs you toward a metal detector. According to the Occupational Safety and Health Administration, incidents of serious workplace violence are four times more common in health care than in private industry. And a poll conducted by the American College of Emergency Physicians in August found nearly half of emergency physician respondents reported having been physically assaulted. More than 60% of them said the assault occurred within the previous year.

Groups representing doctors and nurses say that, while the voluntary safety improvements that some hospitals have enacted are a good first step, more needs to be done. There is still a code of silence in health care, said Michelle Mahon, a representative of the labor group National Nurses United. “What happens if they do report it?” she said. “In some cases, unfortunately, they are treated as if they are the ones who don’t know how to do their job. Or that it’s their fault that this happened.”

“There’s a lot of focus on de-escalation techniques,” Mahon added. “Those are helpful tools, but oftentimes they are used to blame workers.”

The suicide rate in the United States continues to climb, with a rate in 2017 that was 33% higher than in 1999, new research finds. Suicide rates among people 15 to 64 increased significantly during that period, rising from 16.5 per 100,000 people in 1999 to 14 per 100,000 in 2017, the most recent year with available data, according to annual research published by the US Centers for Disease Control and Prevention’s National Center for Health Statistics on Thursday.

The report noted that America’s suicide rates are at the highest level since World War II. Those who identify as American Indian or Alaska Native had the highest increase among all race and ethnicity groups, according to the research.

Parents’ Opioid Use Increases Kids’ Suicide Risk

The rate of youth suicide has increased over the past 15 years in the United States as has the rate of death due to opioid overdose in adults of parental age. Children of parents who use opioids may be at increased risk for suicide attempts, which may be a contributing factor to the trend in adolescent suicide.

This pharmacoepidemiologic study compared rates of suicide attempts in children of parents who used opioids (>1 year of filled prescriptions) with a matched set of families in which parents did not fill opioid prescriptions. A statistically significant doubling of the rate of suicide attempts among the children of parents who used opioids was found.

Helping the families of parents with OUD depends on identifying OUD in the parents. The low rate of diagnosis of OUD in our study among parents who had been using opioids continuously for at least 1 year suggests the need for improved surveillance, recognition, and treatment of this potentially fatal condition.

Furthermore, when estimating the costs and treatment needs of families affected by opioid abuse, these results support the importance of incorporating the clinical needs and attendant costs of the assessment and care of children of affected parents.

Recognition and treatment of parents with OUD, attendance to concomitant conditions in affected parents, and screening and appropriate referral of their children may help, at least in part, to reverse the current upward trend in mortality due to the twin epidemics of suicide and opioid overdose.

The research included data on deaths in the United States from the National Vital Statistics System’s multiple cause of death files for 1999 and 2017.

The data showed that suicide deaths among girls and women rose significantly for all racial and ethnic groups except Asian or Pacific Islander, and the largest increase was among American Indian or Alaska Native girls and women, at 119%.

Among boys and men, suicide rates increased significantly for all racial and ethnic groups except for Asian or Pacific Islander, with the largest increase observed among American Indian or Alaska Native boys and men, at 71%.

The US Suicide Rate Is Up 33%

Since 1999 Research Says

Parents’ Opioid Use Increases Kids’ Suicide Risk

Using health insurance claims data from the MarketScan Commercial Claims and Encounters databases, researchers from the University of Pittsburgh and University of Chicago examined whether there was an increased risk of suicide attempts among children ages 10 to 15 whose parents ages 30 to 59 used opioids for more than a year between 2010 and 2016. The analysis included 184,142 children who had parents that used opioids and 148,395 children whose parents did not.

They found that children whose parents had used opioids long-term had a risk of 3.68 per 1,000 of attempting suicide – 1.25 times the risk of suicidal behavior for those whose parents had not filled their prescriptions.

The study, published Wednesday in the Journal of the American Medical Association’s Psychiatry, comes as rates of youth suicide, suicide attempts and ideation continue to climb across the U.S. The researchers note that all of the insurance claims examined were for families with private health insurance, so the study may underestimate the rate of suicide behavior risk. Recent surveys of opioid misuse find that the rates of opioid misuse in the past year among those with medical assistance, Children’s Health Insurance Program or with no insurance are more than double the rates among those who have private insurance," the report noted.

“When estimating the costs and treatment needs of families affected by opioid abuse, these results support the importance of incorporating the clinical needs and attendant costs of the assessment and care of children of affected parents,” the study concludes. “Recognition and treatment of parents with OUD, attendance to comorbid conditions in affected parents, and screening and appropriate referral of their children may help, at least in part, to reverse the current upward trend in mortality due to the twin epidemics of suicide and opioid overdose.”

Association Between Parental Medical Claims for Opioid Prescriptions and Risk of Suicide Attempt by Their Children

The rate of youth suicide has increased over the past 15 years in the United States as has the rate of death due to opioid overdose in adults of parental age. Children of parents who use opioids may be at increased risk for suicide attempts, which may be a contributing factor to the trend in adolescent suicide.

This pharmacoepidemiologic study compared rates of suicide attempts in children of parents who used opioids (>1 year of filled prescriptions) with a matched set of families in which parents did not fill opioid prescriptions. A statistically significant doubling of the rate of suicide attempts among the children of parents who used opioids was found.

Helping the families of parents with OUD depends on identifying OUD in the parents. The low rate of diagnosis of OUD in our study among parents who had been using opioids continuously for at least 1 year suggests the need for improved surveillance, recognition, and treatment of this potentially fatal condition.

Furthermore, when estimating the costs and treatment needs of families affected by opioid abuse, these results support the importance of incorporating the clinical needs and attendant costs of the assessment and care of children of affected parents.

Recognition and treatment of parents with OUD, attendance to concomitant conditions in affected parents, and screening and appropriate referral of their children may help, at least in part, to reverse the current upward trend in mortality due to the twin epidemics of suicide and opioid overdose.

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“When estimating the costs and treatment needs of families affected by opioid abuse, these results support the importance of incorporating the clinical needs and attendant costs of the assessment and care of children of affected parents,” the study concludes. “Recognition and treatment of parents with OUD, attendance to comorbid conditions in affected parents, and screening and appropriate referral of their children may help, at least in part, to reverse the current upward trend in mortality due to the twin epidemics of suicide and opioid overdose.”
Suicide Rate For Girls Has Been Rising Faster Than For Boys, Study Finds

The increase in suicide rates was highest for girls ages 10 to 14, rising by nearly 75% since 2007. While for boys of the same age, it rose by 7%.

The number of people dying by suicide in the U.S. has been rising, and a new study shows that the suicide rate among girls ages 10 to 14 has been increasing faster than it has for boys of the same age.

Boys are still more likely to take their own lives. But the study published Friday in JAMA Network Open finds that girls are steadily narrowing that gap.

Researchers examined more than 85,000 youth suicides that occurred between 1975 and 2016.

Donna Ruch, a researcher at Nationwide Children’s Hospital in Columbus, Ohio, who worked on the study, tells NPR that a major shift occurred after 2007.

"Girls are more often ... cyberbullied (than boys) on social media. They tend to have much more negative psychological effects to that cyberbullying," she tells NPR.

Social media has also changed how kids interact with one another, she says, noting that adolescents aren’t having as many in-person interactions, which are vital to protecting against mental health problems.

"We need to shift our thinking and evolve our culture inside the medical profession and in society," Ellison tells NPR.

Studies estimate that a doctor dies by suicide every day in the United States, Ellison said. He said the health-care industry needs programs for physicians that teach them signs of “burnout,” which is physical and emotional exhaustion that can lead to insomnia, lack of appetite and other mental health issues.

"Doctors tend to be people who never give up until they do," he said.

But Leapfrog, which has been grading hospitals since 2012, counters that some of their measurements, such as hospital infections, are risk adjusted to reflect sickness levels of patients.

Also Wednesday, the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine released its updated 2016 report on Leapfrog's grades and the increased death risk associated with them. It found some encouraging news.

"Leapfrog assigns letter grades - from A to F - to hospitals and is a tougher grader than the federal government, which doesn't issue failing marks. The latest Leapfrog rankings, released Wednesday, give failing or near-failing classifications to 168 hospitals.

"Although about 160,000 people die a year from the avoidable medical errors reflected in the Leapfrog's grades, that's still a drop from the 205,000 avoidable deaths estimated in 2016."

Some medical errors, such as leaving instruments inside patients, should never happen no matter how sick the patient is.

The researchers noted that preliminary data for 2018 indicates that rising overdose trends in these classes of drugs will continue.

Low-rated US Hospitals Are Deadlier Due To Mistakes, Botched Surgery, Infections

Patients' risk of dying from medical mistakes, deadly infections and safety lapses have gotten much worse at the lowest ranked U.S. hospitals, underscoring Americans' need to check ratings of their local hospitals, new research released Wednesday shows.

The new analysis is based on data gleaned from about 2,600 U.S. hospitals since 2016. What the findings reveal is that some of the nation's most dangerous medical centers have become even riskier for patients.

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Admit America's Opioid Crisis, Deaths From Stimulants Are Steadily Rising

Deaths from stimulants are steadily rising. In 2017, there were 23,139 overdose deaths involving cocaine and psychostimulants continued to increase. During 2015–2016, age-adjusted cocaine-involved and psychostimulant-involved death rates increased by 26.4% and 33.3%, respectively.

From 2016 to 2017, death rates involving cocaine and psychostimulants increased across age groups, racial/ethnic groups, county urbanization levels, and multiple states. Death rates involving cocaine and psychostimulants, with and without opioids, have increased. Synthetic opioids appear to be the primary driver of cocaine-involved death rate increases, and recent data point to increasing synthetic opioid involvement in psychostimulant-involved deaths.

In 2017, there were 23,139 overdose deaths involving these drugs, making up nearly a third of the 76,377 total overdose deaths that year, according to Thursday’s report. From 2016 to 2017, total overdose rates from both classes of drugs rose by about a third again.

Overdose deaths from stimulants jumped from 12,122 in 2015 to 17,258 in 2016 – an increase of 42% in just one year.

The researchers noted that preliminary data for 2018 indicates that rising overdose trends in these classes of drugs will continue.
Amid Opioid Epidemic, Report Finds More Doctors Stealing Prescriptions

In 2018, more than 47 million doses of legally prescribed opioids were stolen, an increase of 126 percent from the year before. Protenus found 34 percent of these incidents happened at hospitals or medical centers, followed by private practices, long-term care facilities and pharmacies. Only 17 percent of the cases identified a particular drug, but the most common was Oxycodone, followed by hydrocodone and fentanyl.

Sixty-seven percent of the time, doctors and nurses are responsible. Dr. Stephen Loyd of Tennessee Lollini and at least 18 others by stealing their pain medication and then leaving contaminated syringes for reuse. She's now serving 30 years in jail.

Dr. Loyd was one of them. "What I didn't realize was how quickly it would escalate. Going from that half of a five milligram Oxycodone a day. That's about 100 Vicodin," he said.

Kira Caban of Protenus said the firm's findings are likely a "tip of the iceberg" considering only a fraction of opioid diversions are uncovered because an addict admits to the behavior or a patient gets sick. The Department of Justice established an Opioid Fraud and Abuse Detection Unit to combat this issue, but it's operational in less than a third of the country.

In The News ...

Hospital technician Kristen Parker had infected Lollini and at least 18 others by stealing their pain medication and then leaving contaminated syringes for reuse. She's now serving 30 years in jail.

May 06, 2019

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Anonymous Survey Questions

I am interested in another webinar presenting

DRUG DIVERSION:

90% Agreed and 70% Strongly or Very Strongly Agreed, and 52% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Drug Diversion Scenarios & An Update on Patient Suicide – May 16, 2019

Specific DRUG DIVERSION TOPICS

I would like covered include:

- More case studies
- More case studies showing how people are able to get away with diverting drugs over a significant period of time.
- More case studies, monitoring techniques and education/research
- More examples of how people did achieve drug diversion
- More specific case
- Patient harm (infection) from drug diversion.
- Physician or outpatient clinic situations
- Prevention
- Prevention
- Recommendations for audits of staff, medications, etc. - How to carry out. Diversion policy recommendations.
- Rehabilitation and support services for diversions and proactive education for other staff
- Steps organizations need to take to investigate diversions
- Various ways of identifying a diversion as many are difficult to determine
- What happens after a caregiver is caught and follow up treatment

Source: TMIT High Performer Webinar Series; Drug Diversion Scenarios & An Update on Patient Suicide – May 16, 2019
Anonymous Survey Questions

I am interested in another webinar presenting
EMERGENCY DEPARTMENT SAFETY:

78% Agreed and 58% Strongly or Very Strongly Agreed, and 36% Very Strongly Agreed

Anonymous Survey Questions

I am interested in another webinar presenting
ERRORS OF OMISSION:

94% Agreed and 64% Strongly or Very Strongly Agreed, and 49% Very Strongly Agreed

Specific ERRORS OF OMISSION TOPICS

I would like covered include:

- ER omissions
- Held doses
- How they are being detected and where the systems are failing.
- Medical record documentation when prescribing controlled substances
- Medication misadministration doses
- Missed medical conditions, near misses in ED and or areas
- Mortality review: errors of omission - more
- Near miss and its reporting
- Nursing care
- Outcomes of those errors
- Prevention
- Prevention, priority setting underlying omissions

I am interested in another webinar presenting
EMERGENCY DEPARTMENT SAFETY:

- Communication and caring for patients in high stress, busy environment
- Communication issues
- Controlled substance over doses-emergencies
- Dealing with safety around gangs in the ed
- De-escalation strategies for violent patients/families and weapon screening
- Diverting violent behavior
- Handoff between ed MS and floor MS and handoff between ed providers and hospitalists
- Having public safety officers assigned to ed: 24/7, after hours?
- Ketamine used in ER
- Major issues of safety concerns and what are being done to address them.
- Mass casualty/trauma, best practice triaging patients
- Missed conditions and/or near misses
- Patient identification and safety
- Patient waiting time
- Preventing gaps in continuous observation of suicidal patients
- Psych patients being held awaiting transfer to mental health
- Suspicious behavior and presentations
- Team member safety
- Who sits with these 1:1s and what training do they need
- Workplace violence

Specific ERRORS OF OMISSION TOPICS

I would like covered include:

- Staff are afraid to speak up against another team member even when they know there are signs
- Ways to encourage employees to follow process and policies.
- Pre-hospital care handoffs
- Drug Diversion related errors of omission
- Missed diagnosis
- Improper Use of Imaging
- Verbal and social bullying preventing reporting of errors of omission
- How do hospitals who want to start doing mortality reviews convince their leaders to do it?
- Disruptive physicians impact on errors
- Impaired caregivers issued
- What about errors of omission of administrators
Mortality Reviews: A 2019 Update

Jeanne M. Huddleston, MD, FACP, FHM
Hospitalist
Professor of Medicine
Mayo Clinic
Rochester, MN
TMIT High Performer Webinar
June 20, 2019

Mortality Reviews and Patient Safety: A 2019 Update
Safety Learning System Collaborative

Disclosure

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

• I am a co-founder of the international SLS Collaborative & HB Healthcare Safety, SBC and nonprofit foundation

Identifying Opportunities Lurking Below the Surface
15 years of learning about process of care failures....

**Special Article**

Learning From Every Death

Jennifer M. Huddleston, MD,* Daniel A. Drohlich, MD,† Gods C. Kinsey, RN,‡
Mark J. Feider, MD,§ and Dennis M. Manning, MD,

The concepts of peer review and the value of mortality and morbidity conferences are familiar improvement approaches in healthcare providers. Since 2004, we have reviewed deaths at Mayo Clinic to acknowledge learning opportunities in our hospitals. The charge for the external collaborative evolved to reflect Dr. Santrach’s question...

Guiding principle of Mayo Clinic Mortality Review System:

“No one should ever suffer or die as the result of process of care or system failure.”

In 2014, Dr. Santrach asked the mortality review team...

“WHEN CAN WE START LEARNING FROM THE LIVING?
DON’T YOU THINK SOME PATIENTS ARE SURVIVING IN SPITE OF US?”

Mayo Clinic recognized that their review methodology could be used to learn from any “problem” patient cohort (e.g., readmissions).

Original Mortality Review Charge: Endorsed by HPS in 2004

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

2. To identify and quantify unanticipated deaths

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

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

The charge for the external collaborative evolved to reflect Dr. Santrach’s question...

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

4. To classify and quantify system level changes which will improve mortality rate.
The Next Generation Patient Safety for Healthcare Leaders

1. To create a meaningful mechanism to learn about opportunities for improvement:
   - Thoroughly understandable
   - Measurable
   - Improvable
2. To identify and quantify opportunities for improvement.
3. To identify rate of opportunities for improvement in patients.
4. To classify and quantify system level changes which will improve performance.

SLS™ is a Multidisciplinary Learning Health System Methodology

HBHS Mission:

“No one should ever suffer or die as a result of failures in our systems or processes of healthcare delivery.”

MC Mortality Review Subcommittee, May 2007

@jmhuddleston

HBHS Mission:

“No one should ever suffer or die as a result of failures in our systems or processes of healthcare delivery.”

MC Mortality Review Subcommittee, May 2007

@jmhuddleston
106 Hospitals & Counting
4394 Patients Stories

Hospital sizes: 51-2200 beds

Compare and Contrast
Peer Review or Classic M&M or Root Cause Analyses

One Patient
versus
Group of Patients

Safety Learning System

Guiding Principles for “Chart” Reviews: The Non-Negotiables

1. System review (not peer review)
2. Deference to expertise: Every case is reviewed by a practicing nurse and physician
3. Avoid over-simplification
4. Multidisciplinary, multispecialty sessions used to build consensus re: findings
5. All findings are recorded in the SLS Safeware®
6. Right size quality improvement initiatives
7. Localized implementation
Perspective: Language is Important

- Not about preventability
- Not about anticipation of death
- Not about attribution of if it caused the death
- Not only about adverse events (in the traditional sense)

Issues & Opportunities for Improvement

What is an Opportunity For Improvement?

Could I passively watch a member of my family experience this care... without wanting to intervene?

High Level Summary

- 4394 Patients with a mean age of 68
- Median length of stay = 5 days
- 2659 patients with OFIs (60.5%)
- 7756 total OFIs amongst the 2659 patients
- Average OFIs per patient: 1.76
- Average OFIs per patient with OFIs: 2.92
Contributing (human) factors

- Out of 7756 opportunities identified in 4394 case reviews, the following contributing factor categories were noted by reviewers:
  - 114 = individual provider factors
  - 228 = general care/observations factors
  - 461 = provider care factors
  - 497 = diagnosis factors
  - 643 = treatment factors
  - 315 = communication and teamwork factors
  - 719 = patient and family factors
  - 119 = organizational factors
TKA Cohort Analysis

- Average age 79.7 years
- Average LOS 6.8 days
- 14% Readmissions
- 5% Mortality
- 91% had Opportunities for Improvement (OFIs™)
- Average opportunities per patient = 4 (1-14)

Case Examples

- Documentation: Coding Opportunity
  - 84 yof with no comorbidities or HCCs listed (CRF, HF, DM2)
- Delayed Diagnosis: Pulmonary
  - 79 yof discharged on day 3, 4.5 liters positive with daily notes from PT about dyspnea limiting therapy… readmitted in less than 24 hours (readmit, 5 days)
- Treatment: Delay
  - 72 yof with unrecognized alcohol withdrawal impacting therapy (2 days)
- Transitions:
  - 52 yof needed SNF and not anticipated (3 days)

Diagnosis and Diagnostic Opportunities

Which clinical diagnosis?
Process/system breakdown?
Physiologic/severity diagnosis?
Attention to detail?
Research Collaborative Results

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

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

95-100% NOT found in existing patient safety reporting mechanisms

Getting Below the Surface: Findings for Unique Patients

Traditional Commissions
Serious Safety Events; HACs, HACIs

Omissions in Care
- OIs include:
  - End of Life
  - Communication
  - Deteriorating Patient

70 unique patients with opportunities for improvement that were otherwise hidden from existing reporting systems

Using GRAC3E™ to Facilitate Organizational Learning

- Gratitude
- Reflection
- Acceptance
- Creativity, Compassion and Consensus
- Elevation
Patient Advisory Component

• Patient advocate and advisor
• Benefactor support of Collaborative hospitals
• Bronson has adopted the Kalamazoo Fetal and Infant Mortality Review

Caution…

• Reviewing deaths does not save lives
• Reviewing readmissions does not prevent readmissions

ONLY identifying common patterns of process failures AND targeting/prioritizing those with an improvement initiative will make a meaningful (measurable) difference

ROI Depends on Your Leadership

WITHOUT action from leadership:
• Physician and nursing engagement
• Patient safety culture enhancement

WITH action from leadership
• Cost avoidance (eg, ICU days, wrongful death suits)
• Improved efficiency (eg, time-to-therapy, flow, LOS)
• Improved efficacy (eg, right provider, right place)
• Improved diagnosis (eg, accurate, timely diagnoses)
• Improved outcome (eg, decreased mortality rate)
• Improved patient experience (eg, “good” deaths)

Safety Learning System™

- Culture & Current State Assessment
- Socialization & Cultivation
- Training to Learn from Patients & Providers
- Leadership Development & Facilitation Training
- Cluster & Common Thread Analysis & Report Training
- Knowledge Dissemination Assessment & Training
- Training to Inspire and Influence Local Leadership
- Identifying & Measuring Meaningful Change
Moving beyond mortality review: additional cohorts under review in the SLS Collaborative

- Sepsis (whether they die or not)
- Heart failure (whether they die or not)
- Readmissions
- Value Based Care cohorts
  - TKA, THA, Spine and hip fractures so far
- Psychiatric outcomes (suicide, repeat hospitalizations, ER use)
- Opioid use outcomes
- Patient complaints and service recovery
- The list of possibilities is endless
National Survey Questions

I am interested in our upcoming webinar presenting WORKPLACE VIOLENCE IN HEALTHCARE:

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<th>Agree</th>
<th>Neutral</th>
<th>Negative to Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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Specific WORKPLACE VIOLENCE TOPICS
I would like covered include:

Speakers and Reactors

Jeanne M. Huddleston
Arlene Salamendra
Charles Denham

Voice of Patient and Family

Arlene Salamendra
Former Board Member and Staff Coordinator, Families Advocating Injury Reduction (FAIR)
TMIT Patient Advocate Team Member
Plano, IL
TMIT High Performer Webinar
June 20, 2019

ADDITIONAL RESOURCES
In The News …

**Johns Hopkins Articles**

1. **All Children’s deaths** December 11, 2018
   - The events described in recent news reports are unacceptable, the hospital’s parent company said.
   - After All Children’s deaths, proposal aims to catch heart surgery problems

2. **Surgeries** December 11, 2018
   - The family of a deceased 26-year-old woman is suing Johns Hopkins All Children’s Hospital, saying she died as a result of the poor care she received in the heart unit.
   - Lawsuits are common in cases where patients and their families believe their care wasn’t adequate.

3. **Oversight of pediatric heart surgery programs and institute site visits** by a system of covering up risky care; regulators for not investigating reports of problems in All Children’s Heart Institute sooner.

4. **Profit at Johns Hopkins hospitals tumbled**. All Children’s was to blame.

5. **Heart surgery bill gets new life** 04-24-19
   - Senate committee greenlights oversight of children’s heart surgery programs after Times report 03-11-19

6. **All Children’s works to restore faith, but families struggle to forgive** April 10, 2019
   - Maryland Healthcare: Johns Hopkins works to restore faith, but families struggle to forgive.
   - The Baltimore Sun; Former prosecutor to review Johns Hopkins’ heart institute in Florida after alleged complaints about unsafe care.

7. **Divided attention**
   - Many of you courageously spoke out when you happened to them
   - Senate committee greenlights oversight of children’s heart surgery programs after Times report 03-11-19

8. **All Children’s surgical mortality rates**
   - How we calculated All Children’s surgical mortality rates.
   - John Hopkins wrote the rules on patient safety. But its hospitals don’t

9. **Johns Hopkins Safety Crisis Articles**

10. **Florida Legislature 2019**: What passed and what failed May 16, 2019
   - Senate committee greenlights oversight of children’s heart surgery programs after Times report 03-11-19

11. **State, federal inspectors visit All Children’s after reports on heart surgery deaths** 01-11-19
   - Federal inspectors find unresolved problems at All Children’s 03-08-19

12. **A baby left All Children’s with a needle in her heart** 04-20-18
   - Reports: Kathy Castor, Charlie Crist repeat call for federal investigation into All Children’s Heart Institute 12-12-18

13. **How we calculated All Children’s surgical mortality rates**
   - How we calculated All Children’s surgical mortality rates.

14. **State and federal inspectors visit All Children’s after reports on heart surgery deaths** 01-11-19
   - Federal inspectors find unresolved problems at All Children’s 03-08-19

15. **Heart surgery bill gets new life** 04-24-19
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16. **Johns Hopkins Heart Institute’s operating profit dropped 10% in the first quarter of 2019, in large part because of problems in the All Children’s Heart Hospital heart surgery program, according to the system’s latest financial report.**

17. **The Baltimore Sun** April 10, 2019
   - Burn center director sues Johns Hopkins.
   - The bulk of Mitro’s compensation appears that he received starting in early 2013. Dr. Doyle Stewart’s care of six children at the pediatric unit.

18. **Florida Legislature 2019**: What passed and what failed May 16, 2019
   - Florida Legislature 2019: What passed and what failed May 16, 2019

19. **Oversight of pediatric heart surgery programs and institute site visits** by a system of covering up risky care; regulators for not investigating reports of problems in All Children’s Heart Institute sooner.

20. **Johns Hopkins Safety Crisis Articles**

   - A New York Times investigation published today details a situation that may feel familiar to readers in St. Petersburg. A well-respected children’s hospital — this one in North Carolina — was having a hard time keeping heart surgery patients alive. Cardiologists were concerned.

22. **Johns Hopkins Heart Institute’s operating profit dropped 10% in the first quarter of 2019, in large part because of problems in the All Children’s Heart Hospital heart surgery program, according to the system’s latest financial report.**

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   - After All Children’s deaths, proposal aims to catch heart surgery problems

25. **Oversight of pediatric heart surgery programs and institute site visits** by a system of covering up risky care; regulators for not investigating reports of problems in All Children’s Heart Institute sooner.

Source: [Tampa Bay Times](https://www.tampabay.com/investigations/2019/05/30/innorth-carolina-the-new-york-times-reveals-another-heart-surgery-program-in-trouble/)
In The News …

MD Anderson Ousts 3 Scientists Over Concerns About Chinese Data Theft

The cancer center gave the Chronicle copies of internal documents regarding the five cases. The names of the scientists were redacted, but Pisters said all are Asian. The Chronicle and Science magazine have confirmed at least three are ethnically Chinese.

The departures are the first to become known since Dr. Francis Collins, director of the NIH, told a Senate panel earlier this month to expect related firings at institutions across the country soon. The panel and others in Congress have raised concerns about foreign theft of intellectual property at academic institutions.

The crackdown has rolled Chinese and Chinese-American communities in the United States and particularly at MD Anderson and the Texas Medical Center. They contend the investigations involve racial profiling and targeting and claim the probes are driving out some researchers for relatively minor offenses, sometimes based on a misreading of science.

Pisters downplayed the loss of talent, arguing that those affected involve “just a handful out of MD Anderson’s 1,700 faculty.” Citing the cancer center’s demographic breakdown — 30 percent white, 29 percent Asian, 23 percent black and 17 percent Hispanic — Pisters argued “MD Anderson faculty and employees know the institution doesn’t discriminate on the basis of gender, ethnicity, race or sexual orientation.”

There is no disputing the threat is real. After a 2017 report that found intellectual-property theft by China costs the U.S. as much as $600 billion annually, FBI Director Christopher Wray called China “the broadest, most significant” threat to the nation and said its espionage is active in all 50 states.

In response to the foreign threat, MD Anderson in 2018 developed a plan to reduce risks. In an email, Pisters warned employees of the “accelerating risks” of intellectual theft and cyberattacks and announced staff traveling internationally will need to use loaner laptops and phones. Later, the center restricted the use of USB devices.

CONCLUSIONS:

A comprehensive strategy starting with civilian providers to provide care at the point of wounding along with a coordinated public safety approach to rapidly evacuate the wounded may increase survival in future events.

The Profile Of Wounding In Civilian Public Mass Shooting Fatalities

A total 139 fatalities consisting of 371 wounds from 12 CPMS events were reviewed. All wounds were due to gunshots. Victims had an average of 2.7 gunshot wounds. Relative to military reports, the case fatality rate was significantly higher, and incidence of potentially survivable injuries was significantly lower.

Overall, 58% of victims had gunshot wounds to the head and chest, and only 20% had extremity wounds. The probable site of fatal wounding was the head or chest in 77% of cases. Only 7% of victims had potentially survivable wounds. The most common site of potentially survivable injury was the chest (89%). No head injury was potentially survivable. There were no deaths due to exsanguination from an extremity.

CONCLUSION:

The overall and fatal wounding patterns following CPMS are different from those resulting from combat operations. Given that no deaths were due to extremity hemorrhage, a treatment strategy that goes beyond use of tourniquets is needed to rescue the few victims with potentially survivable injuries.

Fatal Wounding Pattern and Causes of Potentially Preventable Death Following the Pulse Night Club Shooting Event.

There were an average of 6.9 wounds per patient. Ninety percent had a gunshot to an extremity, 78% to the chest, 47% to the abdomen/pelvis, and 39% to the head. Sixteen patients (32%) had potentially survivable wounds, 9 (56%) of whom had torso injuries. Four patients had extremitiy injuries, 2 involved femoral vessels and 2 involved the axilla. No patients had documented tourniquets or wound packing prior to arrival to the hospital. One patient had an isolated C6 injury and 2 victims had uni-hemispheric gunshot wounds to the head.

CONCLUSIONS:

A comprehensive strategy starting with civilian providers to provide care at the point of wounding along with a coordinated public safety approach to rapidly evacuate the wounded may increase survival in future events.
The Orlando Fire Department had been working on a plan to respond to a mass shooting. It had even purchased vests filled with tourniquets and special needles to relieve air in the chest. But at the time of the Pulse nightclub shooting, the plan had not been fully implemented and the vests were untested.

A study published this year in the journal Prehospital Emergency Care concluded that 23 of the victims might have lived if they had gotten basic EMS care within 10 minutes and made it to a trauma hospital within an hour, the national standard. That’s nearly one third of victims that died that night.

Under the plan developed by former Orlando Assistant Fire Chief Anibal Saez, each fire district would have enough vests and gear to equip a rescue task force. Each vest carried enough medical supplies to treat 10 to 15 shooting victims.

In April 2017, the mayor stood in front of a fire engine and donned a bulletproof vest with “Fire-Rescue” written in big red letters on the front and “Orlando Fire Department” on the back.

The point of the April 2017 press conference was to show off new equipment the city had purchased to help respond to future disasters like the Pulse shooting.

Conclusion:

Autopsy reports of 232 victims from 22 events were reviewed. Seventy-three victims (31%) were shot by handguns, 105 (45%) by rifles, 22 (9%) by shotguns, and 32 (14%) by multiple firearms. Events using a handgun were associated with a higher percentage killed, and events using a rifle were associated with more people shot, although neither difference reached statistical significance. Victims shot by handguns had the highest percentage of having more than 1 fatal wound (26%); those shot by rifle had the lowest percentage (2%). Thirty-eight victims (16%) were judged to have had a PPD. The probability of having a PPD was lowest for events involving a handgun (4%) and highest for events involving a rifle (23%) (p = 0.002).

Wounding Patterns Based on Firearm Type in Civilian Public Mass Shootings in the United States.

Sources:

- Source: https://www.propublica.org/article/pulse-shooting-orlando-tragedy-response-plan
- Source: https://www.ncbi.nlm.nih.gov/pubmed/30529633

Deadly Shooting At California Synagogue

Detectives from the San Diego County Sheriff's Department along with members of several local, state and federal agencies have been working throughout the night, interviewing approximately 100 people who were victims and witnesses to the shooting that occurred at the Chabad of Poway.

Detectives also served several search warrants and processed the crime scene at the synagogue, as well as the suspect's residence in San Diego and his vehicle. The investigation is continuing as detectives process evidence and interview additional witnesses.

The suspect, 19-year-old John T. Earnest, was booked into custody on one count of murder in the first degree and three counts of attempted murder in the first degree. There is no indication at this point in the investigation that Earnest was part of an organized group. We believe he acted alone and without outside support in carrying out the attack.

We are continuing to explore every investigative avenue to bring out all the facts in the case.

The Sheriff's Department would like to acknowledge another act of courage that occurred at the synagogue yesterday. Oscar Stewart, who is fifty-one-years-old and resides in Rancho Bernardo, rushed at the shooting suspect, chasing after the suspect's vehicle. The investigation is continuing as detectives process evidence and interview additional witnesses.

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Mass Casualty Death Update

FBI Report: Active Shooter Incidents in the United States in 2018

Cassualties

- The 27 incidents resulted in 213 casualties (85 people killed and 128 people wounded, excluding the shooters).
- The highest number of casualties (17 killed and 17 wounded) occurred at Marjory Stoneman Douglas High School in Parkland, Florida.
- The second highest number of casualties (12 killed and 16 wounded) occurred at the Borderline Bar and Grill in Thousand Oaks, California.

As in past years, citizens were faced with split-second, life-and-death decisions. In 2018, citizens made their lives to safely and successfully and the shootings in five of the 27 active shooter incidents. They saved many lives. Given this reality, it is vital that citizens be afforded training so they understand the risks they face and the options they have available when active shooter incidents are unfolding. Likewise, law enforcement must remain vigilant regarding prevention efforts and aggressively train to better respond to—and help communities recover from—active shooter incidents. The FBI remains committed to assisting state, local, tribal, and campus law enforcement as its active shooter prevention, response, and recovery efforts.

By the Numbers

- 27 incidents in 16 states
- 213 casualties—excluding the shooters
- 85 killed
- 2 law enforcement officers
- 1 injured security officer
- 128 wounded
- 8 law enforcement officers
- 27 shooters—23 male, 3 female, 1 at large
- 10 committed suicide
- 11 apprehended by police
- 4 killed by police
- 1 killed by citizens
- 1 at large
- 9 incidents ended with the exchange of gunfire between the shooters and law enforcement.

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Active shooter incidents in the United States in 2018

In the News...

Cal State Long Beach Receives 'Stop the Bleed' Kits to Use in Case of Emergency

As school shootings continue to happen across the country, campuses and medical centers are taking steps to be prepared in the event of a potential emergency. St. Mary Medical Center is donating "Stop the Bleed" kits to California State University, Long Beach, and nurses will train and instruct staff how to successfully use the emergency equipment provided.

"Stop the Bleed" kits or "emergency survival kits" contain tourniquets, gloves, gauze and bandages. They will be distributed and installed across campus at nearly 40 locations.

They will be placed in every AED or Automated External Defibrillator cabinet on campus with signs on the outside so students and staff know exactly where the kits are. In addition, staff from Dignity Health will be on campus demonstrating how to apply a tourniquet to stop the bleeding.

St. Mary Medical Center received a grant from a private foundation for $7,500 to buy 100 survival kits. They will be placed at Cal State Long Beach, Long Beach City Colleges and some city buildings. The tourniquet in the kit is the same device that police and military use if they encounter a person with a life-threatening hemorrhage on an arm or a leg. The delivery of the kits to Cal State Long Beach had been planned weeks before the campus received a threat of a shooting on campus on May 9. University police investigated the threat and determined it wasn’t credible.


Professional first responders in the United States are highly trained and are the cornerstone of high-threat disaster response; however, there exists a very real operational gap between existing doctrine, public expectations, and operational capabilities.

The FCP decreases the time between point of injury and potentially lifesaving medical intervention. FCPs should be trained in the tenets of the TECC guidelines similar to their first response agencies. National planning is required to develop a means to promulgate this training and ensure ongoing competency for the population at large.

FCP programs should provide education on the following:

- Basic airway management, simple interventions for thoracic injuries, casualty movement, and psychological comfort care of the wounded;
- Improved communication between the bystander/FCP and the 911 emergency dispatch system;
- Strategies to mitigate physical and psychological risks; and
- Basic methods to interact and integrate with first response agencies, including how to signal for help and direct responders to casualties.
Man Races To Help Child Hit By Car In Iowa: ‘I Didn’t Even Realize It Was My Son’

When Timothy Mason saw a car strike a child about 15 yards from where he was parked Wednesday near an elementary school in Marshalltown, Iowa, he tried to help.

"I didn't even realize it was my son," he said. "They just said there had been an accident and I needed to get to the school; they didn't say what had happened."

Christian’s parents know he suffered head trauma, but they don’t have specifics about other injuries. They haven’t yet learned what police have discovered in their investigation.

"I do still see it from time to time," he said. "Mostly while trying to sleep."

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The majority of workers who experienced workplace violence reported injuries or side effects. More than half — 54 percent — expressed having “anxiety, fear or increased vigilance.” Eighteen percent took time off work.

The father and Fort Bend EMS administered CPR, but they were unsuccessful.

CPR BEND COUNTY, Texas — A 3-year-old girl died after she was run over by her father’s car in a Fort Bend County neighborhood, deputies said.

The incident happened Tuesday morning in the 8300 block of Logan Creek Lane not far from Sugar Land.

Deputies said the father tried to stop the car, but he was too late.

The father and Fort Bend EMS administered CPR, but they were unsuccessful.

"It could’ve been avoided,” the girl’s mother said. "And now I don’t have my little one."

Deputies believe there was confusion with the dad’s story because he was so distraught.

Deputies said they will be reviewing surveillance video from the home. They have also taken blood from the father as a precaution.

At this time, they are calling the incident a horrible accident.

"It’s a horrible incident for the family, the neighborhood out here, for the community, a deputy with the Fort Bend County Sheriff’s Office said.

In The News ...

Nurses, Health Care Care Workers Push For Better Protections From Violence

Nurses and other health care workers are now pushing legislators to take action to address the often hostile work environments faced at hospitals and other medical facilities, arguing their abuse should not be considered just “part of the job.”

In 2017, National Nurses United, a union representing more than 2,200 registered nurses in Nevada and 155,000 nationwide, surveyed 286 registered nurses. Only 17 percent reported experiencing no workplace violence within the past year. Sixty percent reported they have been verbally threatened, 36 percent have been stopped, punched or kicked, 24 percent have had objects thrown at them, and 12 percent have been groped or touched inappropriately.

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Drug Distributor And Former Execs Face First Criminal Charges In Opioid Crisis

Former Rochester Drug Co-Operative CEO Laurence Doud III, who faces criminal charges stemming from the opioid crisis, leaves the federal courthouse in Manhattan on Tuesday. A major pharmaceutical distribution company and two of its former executives are facing criminal charges for their roles in advancing the nation’s opioid crisis and profiting from it.

Rochester Drug Co-Operative, one of the nation’s 10 largest pharmaceutical distributors in the U.S., was charged with conspiracy to distribute controlled narcotics — oxycodone and fentanyl — for nonmedical reasons and conspiracy to defraud the United States. Former CEO Laurence Doud III and former chief of compliance William Pietruszewski also were charged.

RDC and Pietruszewski were also charged with willfully failing to file suspicious order reports to the Drug Enforcement Administration.

From 2012 to 2016, RDC’s sales of oxycodone tablets grew from 4.7 million to 42.2 million — an increase of approximately 850 percent — and during the same period RDC’s fentanyl sales grew from approximately 63,000 dosages in 2012 to over 1.3 million in 2016 — an increase of approximately 2,080 percent. During that same time period, Doud’s compensation increased by over 125 percent, growing to over $1.3 million in 2016.

The company has agreed to pay a $20 million fine and submitted to three years of independent compliance monitoring.

When Surgeons Are Abrasive To Co-Workers Patients’ Health May Suffer

Patients operated on by surgeons who display rude or unprofessional behavior toward colleagues tend to have higher rates of post-surgical complications.

As a group, surgeons are not well known for their bedside manner. “The stereotype of the abrasive, technically gifted ... surgeon is ubiquitous among members of the public and the medical profession,” write the authors of a 2018 article in the AMA Journal of Ethics.

While poor manners aren’t commonly accepted in most professional circles, representations of surgeons in popular culture often link technical prowess with rude behavior, and some surgeons have even argued that insensitivity can be helpful in such an emotionally strenuous profession.

Source: https://www.npr.org/sections/health-shots/2019/06/19/734044306/when-surgeons-are-abrasive-to-coworkers-patients-health-may-suffer

Association of Coworker Reports About Unprofessional Behavior by Surgeons With Surgical Complications In Their Patients

Key Points

- Do patients of surgeons with a higher number of coworker reports about unprofessional behavior experience a higher rate of postoperative complications than patients whose surgeons have no such reports?
- Findings: Among 13,651 patients in this cohort study undergoing surgery performed by 292 surgeons, patients whose surgeons had a higher number of coworker reports about unprofessional behavior in the 36 months before the patient’s operation appeared to be at increased risk of surgical and medical complications. These findings suggest that organizations interested in ensuring optimal patient outcomes should focus on addressing surgeons whose behavior toward other medical professionals may increase patients’ risk for adverse outcomes.

Conclusions and Relevance

Patients whose surgeons had higher numbers of coworker reports about unprofessional behavior in the 36 months before the patient’s operation appeared to be at increased risk of surgical and medical complications. These findings suggest that organizations interested in ensuring optimal patient outcomes should focus on addressing surgeons whose behavior toward other medical professionals may increase patients’ risk for adverse outcomes.

Source: https://jamanetwork.com/journals/jamasurgery/fullarticle/2736337

$4.5M In Settlements Over Deaths Tied To Doc In Murder Case

An Ohio hospital system has reached nearly $4.5 million in settlements so far over the deaths of patients who allegedly received excessive drug doses ordered by a doctor now charged with murder.

At least 25 wrongful-death lawsuits have been filed against the Columbus-area Mount Carmel Health System and now-fired intensive-care doctor William Husel, who pleaded not guilty to murder charges in 25 deaths that occurred between 2015 and 2018.

His lawyer has said Husel was providing comfort care to dying patients, not trying to kill them.

Mount Carmel has reached settlements in seven cases to date, plus two that didn’t involve lawsuits.

“Mount Carmel has reached settlements in seven cases to date, plus two that didn’t involve lawsuits.” Mount Carmel said in a statement. The hospital system has also publicly apologized for the patient deaths.

Mount Carmel’s settlement is one of two deals to date. The other is a $3.5 million settlement with the family of a second patient who died in 2016.

Source: https://www.modernhealthcare.com/providers/45m-settlements-over-deaths-tied-doc-murder-case

“Yet while the stereotype of the abrasive surgeon no longer applies to many modern surgeons, they write, "a continues to influence patients’ expectations and surgeons’ interactions with their clinical colleagues.'”

Source: https://www.forbes.com/sites/erica442/2019/06/19/when-surgeons-are-abrasive-to-coworkers-patients-health-may-suffer

Surgical Complications in Their Patients

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"It is our hope that these settlements will bring some measure of closure and comfort to the families." Mount Carmel said in a statement. The hospital system has also publicly apologized for the patient deaths.

Mount Carmel found that Husel ordered potentially fatal drug doses for 29 patients over the past several years. It said six more patients got doses that were excessive but did not likely cause their deaths.

Inspectors found that the doctor overcome a dispensing system to access large doses of drugs in many of the cases. Mount Carmel has since tightened its drug policies and access.
Bullying Can Cause Both Short- And Long-term Damage

Source: https://www.cnn.com/2019/05/24/health/bullying-damage-trnd/index.html

Bullied teen killed herself in front of family. Bullying is many things: teasing, name-calling, stereotyping, fighting, exclusion, spreading rumors, public shaming and aggressive intimidation. It can be in real life (IRL) or online.

During the 2017-18 school year, 7 in 50 public high school students across California said they’d experienced bullying or harassment because of their race, ethnicity or national origin over the previous 12 months, a U.S. News & World Report analysis found. The analysis used data from the California Healthy Kids Survey, an anonymous survey of school safety and student wellness managed by the state’s education department and administered at grades five, seven, nine and 11.

About 7% of students across the state said they experienced bias-related bullying based on their religion, while 6% reported the same based on their actual or perceived immigrant status, according to the analysis.

The report also showed that students who said they’d been bullied because of their race, ethnicity or nationality were twice as likely to have smoked cigarettes, and their drinking rates were higher: Four out of 10 bullied students used alcohol within the previous 12 months, compared with 3 out of 10 non-bullied students.

The analysis aligns with findings from a 2018 survey, published in the journal JAMA Pediatrics, of more than 2,500 teens. Concerns about increasing discrimination were associated with higher frequency of substance use, a greater variety of substances used, 11% higher odds of depression and 12% greater odds of attention-deficit hyperactivity disorder symptoms, the survey indicated.

May 24, 2019

With Restricted Funding, States Struggle Against Meth


The well-funded fight against opioid addiction has overshadowed another American drug problem. The number of drug overdose deaths involving meth tripled from 2011 to 2016, according to the CDC.

Mounting evidence points to a worrisome rise in methamphetamine use nationally. The presence of cheap, purer forms of meth in the drug market coupled with a decline in opioid availability has fueled the stimulant’s popularity. The number of drug overdose deaths involving meth tripled from 2011 to 2016, the CDC reported. Hospitalizations involving amphetamines—the class of stimulants that includes methamphetamine—are spiking. And it is harder to address. Treatment options for this addiction are narrower than the array available for opioids.

People addicted to a particular substance typically use other drugs as well. Controlling addiction throughout a person’s life can be akin to “whack-a-mole,” said Dr. Paul Earley, president of the American Society of Addiction Medicine, because they may stop using one substance only to abuse another. But specific addictions may also require specific treatments that cannot be addressed with tools molded for opioids, and the appropriate treatment may not be as available.