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INSIDE

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High Reliability Organizations Aim High, Strive for Zero

Hospitals and health systems are always striving to improve quality and become more reliable providers of healthcare, but some are setting even higher goals by striving to become high reliability organizations (HROs). With the HRO concept, these hospitals are aiming not to just improve and reduce errors, but to completely eliminate them.

That may sound like a recipe for failure, but hospitals are showing that it can be done as they achieve HRO status. Cincinnati Children's Hospital in Ohio and Memorial Hermann Health System in Houston are both HROs that have eliminated many risks entirely and are on the way to zero with others.

Memorial Hermann's mission to zero was prompted in part by two blood transfusion errors in 2006 that left one patient dead and another in critical condition. A new protocol was established that requires more thorough identification and cross-checking at each stage of the process, but reducing transfusion errors would not be enough. The goal was to eliminate them altogether, and from 2007 to today, more than 1.1 million transfusions were performed in Memorial Hermann facilities without a single transfusion adverse event. That first effort at reaching zero evolved into Memorial Hermann's crusade to become an HRO.

> "THAT FIRST EFFORT AT REACHING ZERO EVOLVED INTO MEMORIAL HERMANN'S CRUSADE TO BECOME AN HRO."

Memorial Hermann was among the earliest healthcare providers to strive for HRO status, but the industry is adopting the concept more readily now, says Chief Medical Officer **M. Michael Shabot**, MD, FACS, FCCM, FACMI, at Memorial Hermann.

"Applying the high reliability concept had a slow start, but it is picking up some momentum," Shabot says. "The usual

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hindrance is a cultural belief that accidents and errors can't be prevented, especially in healthcare, due to the non-perfectibility of man. While it is true that man is non-perfectible, high reliability organizations don't count on perfect employees and perfect users to achieve high reliability."

Cincinnati Children's Hospital has been striving for high reliability for 10 years and **Stephen E. Muething**, MD, vice president for safety and an attending physician, has come to realize that there is no end point for an HRO. The philosophy at Cincinnati Children's is that the good comes from always striving for more. "High reliability is not something you achieve," he says. "We believe the important thing is to relentlessly be on the journey to try to achieve high reliability. The more we improve, the more we feel that we have to improve."

Minimizing errors not enough

The HRO concept was first developed through studies of the air traffic control system, naval aircraft carriers, nuclear power operations, and other systems that must operate with zero defects where minimizing errors is just not enough. HROs have many feature in common, including risky and complex technologies that present the potential for error and complex processes. They also have highly trained personnel, ongoing training, process audits, and continuous improvement efforts. One of the main traits of an HRO is that they can't afford to learn through trial and error; the scale of the potential harm is too great. *(See the story on page 4 for more on the theory of high reliability.)*

In HROs, senior leaders are conducting frequent walk-rounds to reinforce safety behaviors and find and fix critical safety issues, Muething notes. Senior leaders also meet in daily operational briefs where they look back to learn from failures and look forward to predict and lessen risk or harm. At Cincinnati Children's, frontline leaders such as unit charge nurses round with staff every day, giving 5:1 positive to negative feedback, conduct daily huddles, and model the expected safety behaviors. HRO leaders also manage by anticipation and prediction rather than reaction, Muething notes. They focus on predicting events in the next 24 hours and making real-time adjustments.

Support from the highest levels of administration and the C-suite are crucial to achieving high reliability, Muething says. Transparency is a critical element in high reliability, he says, and that cannot happen without support from top leaders. "You can't be on this high reliability journey if you aren't willing to talk about what went wrong every single day," he says. "If you have a culture of fear and uncertainty, you can't do this."

Impressive results for HROs

Shabot emphasizes that HRO is about making a cultural change in the organization, which takes time. It is about establishing the belief that measurable adverse events can be prevented for long periods of time, he says. Once that concept is accepted, the hospital can focus on developing systems to reach that goal. Three hospitals in the Memorial Hermann system have gone for more than five years without a retained foreign object, Shabot says, which he says is a testament to how an HRO achieves what previously would have been called an unrealistic goal.

"Is it because we found a whole crop

of perfect surgeons and nurses? No, we have the same surgeons and nurses, but five years ago they developed new processes for what to do when a sponge count is off and the actions taken before the patient is closed," he says. One of the process improvements was the implementation of radio frequency identification (RFID) scanning of sponges in addition to the radiopaque marker.

"The healthcare organizations that are moving toward high reliability are seeing very dramatic results," Shabot says. Memorial Hermann worked with the Joint Commission Center for Transforming Healthcare to target hand hygiene and saw the average across all 12 hospitals in the system go from a baseline of 44% hand hygiene compliance to 92%. As a result, the rate of central line-associated bloodstream infections and ventilator-associated pneumonia decreased to essentially zero across the system, Shabot says.

Memorial Hermann also began a program called "Board to the Bedside," intended to engage all 21,500 health system employees in high reliability. To achieve that goal, the health system centralized its quality departments, trained all employees off-site in the principles of high reliability, and emphasized the use of evidence-based protocols. It also documented performance on quality measures with data dashboards. *(See the story on page 4 for more Memorial Hermann initiatives to promote high reliability.)*

Striving for high reliability also has led Cincinnati Children's to broaden its view on what constitutes patient harm, Muething says. What might previously have been regarded as a complication or just an inevitable part of the medical process can now be classified as patient harm.

"It might be slowness in making a diagnosis or managing a situation, or a complication that was considered just a risk that came with the treatment," Muething says. "Now we look at that and say, 'No, that is unacceptable harm.' We keep raising our standards about what we consider preventable. Instead of debating whether a harm was preventable or not, now we're moving toward thinking that all harm is preventable and we just don't know how to prevent some if it yet."

Muething notes that at Cincinnati Children's, little distinction is made between patient safety and employee safety. Metrics for both are intertwined, so any discussion of patient safety metrics will be accompanied by similar data on employee lost work time injuries and similar measures.

No one gets in trouble

Shabot notes that while safety is the primary goal of high reliability, reaching zero risks in a particular area also has the added benefit of improving the work experience for many people in the system.

"No one gets in trouble. Our physicians and nurses don't get in trouble because a patient was harmed, and nobody goes to peer review," he says. "We don't have lawsuits. Everybody wins, and we're proving that hospitals can do it. It's not just airlines and nuclear power plants."

Memorial Hermann recognizes hospitals with a Certified Zero Award for eliminating risks. One hospital received a Certified Zero Award for having no central line-associated bloodstream infections for 12 months, for instance, and five hospitals eliminated ventilator-associated pneumonia. Others have received the award for eliminating retained foreign objects, serious pressure ulcers, hospital-associated injuries, deaths among surgical inpatients with serious treatable complications, birth traumas, accidental punctures and lacerations, deep vein thrombosis, and many other risks. Two hospitals have now gone longer than a year without a catheter-associated urinary tract infection, "something we thought was impossible as recently as two years ago," Shabot says.

Memorial Hermann recently assisted the Hospital Association of South Carolina with implementing the HRO concept for its member hospitals, and the association included the Certified Zero Award.

"They have now given out 188 Certified Zero Awards to hospitals in South Carolina," Shabot says. "That is remarkable because before they did this they had no hospitals going a year without these kinds of adverse events. It's not because they made people perfect, but because they put in processes and systems that catch errors before they ever get close to patients. That's how well it works."

Muething endorses a word of advice he was given years ago when first considering high reliability: Start before you're ready.

"Because you're never going to be ready," he says. "It's a journey you just have to get started on. There is so much to learn from other organizations that have taken this step, and I have been so impressed by how much people from other industries are willing to share their insights if you just ask."

SOURCES

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Preoccupied with Failure, HROs Constantly Ask Why

Cincinnati Children's Hospital in Ohio provides the following summary of the five key characteristics of a high reliability organization:

1. Preoccupation with Failure: Everyone is focused on errors and near-misses, learning from them and figuring out how to prevent them from happening again. Attention to detail is crucial. Finding and fixing problems is everyone's responsibility and is encouraged and supported by leadership.

2. Reluctance to Simplify Interpretations: Requires constantly asking the "why" question and inviting others with diverse experience to express their opinions. The belief is that the more you're immersed in something, the harder it is for you to objectively observe and question things that need questioning.

3. Sensitivity to Operations: An ongoing concern with the unexpected. Hallmark actions include closing loopholes in processes where there is potential for patient harm, maintaining situational awareness, developing teams that speak up and paying attention to the frontline — which in hospitals is primarily nurses, patient care attendants, techs, and support staff.

4. Commitment to Resilience: The concept that things will go wrong that we can't predict; mistakes will be made, and we will get into trouble. But we will quickly identify issues and have structures in place so we can immediately respond and minimize the harm. Errors won't disable us.

5. Deference to Expertise: Finding and using experts for the given problem in the given time. More specifically, it means recognizing that those closest to the frontline are the experts and empowering them to make decisions when a critical issue arises results in quicker mitigation of harm.

(Cincinnati Children's developed these five key characteristics from research published in 2001. An abstract of that research is available online at http://tinyurl.com/hy3dxmt.) ■

STAR, CUSS, Secret Shoppers Promote Reliability

Memorial Hermann Health System in Houston adopted several programs to promote high reliability among its employees. The following are four of the most successful initiatives:

• **STAR**: Employees are encouraged to Stop, Think, Act, and Review. Research has shown that the chance of an error decreases logarithmically with the amount of time spent in thought before taking an action, notes Chief Medical Officer **M. Michael Shabot**, MD, FACS, FCCM, FACMI, at Memorial Hermann. The health system encourages healthcare providers to stop for one second.

"It's not like on TV where the doctor barks out an order, the nurse(s) measures out the injection and plunges it in," he explains. "We take a one second stop before the patient gets the med, so the nurse can ask if this is the right patient, right dose, right medication. We have hundreds of patient safety reports in which a patient was saved from harm by that one second stop."

In one case, a neonatal intensive care unit nurse had a proper computerized order for a medication, went to the pharmacy where it was entered into the computerized dispensing machine, and took the med back to the unit. She did a one second stop and realized that although all of the outer packaging was marked for pediatric use, the actual vial of medication inside was the adult concentration of the drug, which would have killed the child.

• **CUSS words**: Physicians and staff are trained to use particular phrases when they are concerned, and to respond appropriately when they hear those phrases. They were crafted to be specific, easily recognizable statements that raise a red flag to other clinicians but which can be said in front of patients and family members without causing alarm. They are:

- I am Concerned.
- I am Uncomfortable.
- This is for Safety.

In addition, the final S comes from the promise to "Stand up and stand together" when a colleague raises a concern. Memorial Hermann staff are assured that raising a concern in this way will never result in discipline or any negative

consequences, no matter who is objecting or disagreeing. "They are absolutely backed up, and when someone speaks up for safety we bring them into the boardroom to tell us about it and so we can honor them for their actions," Shabot says. "Even if they turn out to be wrong, they are honored for speaking up." Two nurses recently told the board about how they were worried that a patient had a pulmonary embolism after surgery, but the attending physician disagreed. They took their concerns to the surgeon who performed the procedure, who determined that the patient did not have a pulmonary embolism, but rather a dissecting aorta.

• **Red rules**: Memorial Hermann has three rules that require absolute compliance. The patient identification must be checked and verified before any treatment, medication administration, or moving the patient from one place to another. The health system makes a point of not including the room number in the identification verification process, to avoid the too easy assumption that you have the right patient if you're in the right room. The other rules require a formal time out before procedures, even procedures performed in a patient room, and a two-provider check for high-risk medications and blood transfusions. The computer system requires that, for high-risk medications and transfusions, two licensed providers must individually sign into the system with their own passwords.

• **Hand hygiene secret shoppers**: Memorial Hermann has hospital personnel who discreetly watch for proper hand hygiene and record what they see. Failure to comply with hand hygiene is noted but only by the type of employee, such as a nurse or technician, not by name. Memorial Hermann reached 90% compliance in 2012 and is now at 95%. ■

Protect Your Peer Review Privilege or Lose Major Protection

Quality peer review depends on people being able to openly discuss issues without fear that the information will be made public, so the law provides a shield that keeps lawyers and others from demanding access. Healthcare systems rely on that peer review privilege to ensure quality and safety, but they sometimes inadvertently relinquish that protection by breaking the rules that keep that information private.

State laws regarding peer review will vary, but California's protection under Evidence Code sec 1157 is typical of most states, says **Sara Hersh**, JD, an attorney with the law firm of Nelson Hardiman in Los Angeles. Peer review proceedings and the records of peer review committees are protected from discovery primarily to encourage the free exchange of ideas and opinions among healthcare providers regarding care and treatment rendered to patients by members of a medical staff without fear of public scrutiny and to ensure safe and competent delivery of care. Participants in the peer review meetings cannot be compelled to testify in a civil lawsuit as to what happened or said in the meeting, Hersh explains. The protection, however, is not absolute.

Hersh outlines these limitations to the peer review privilege in California:

• Although the member of a committee cannot be compelled to testify, any member can do so voluntarily because the privilege against testifying is held by each individual and not by the committee.

• The protection does not apply to statements made by the physician, present at the meeting, who is the subject of the peer review discussion.

• The protection against discovery of the proceedings of a peer review committee does not apply to lawsuits brought by physicians claiming wrongful denial of hospital privileges.

• The protection could arguably not apply if the committee was not in conformity with the facility's bylaws.

• The protection does not apply to criminal proceedings.

• The Medical Board of California can inspect and copy certain documents (statement of charges, documents in evidence, any opinion, finding or conclusion for use in a subsequent disciplinary hearing or investigation by law enforcement).

Though there are common themes, courts will look to the specific and usually very strict language of your particular state when determining if material is protected, cautions **Kenneth N. Rashbaum**, JD, partner with the Barton law firm in New York City. Knowing the details of your own state's peer review statute is the foundation of any effort to protect

the privilege, he says.

"People go astray when they write something that says at the top, 'For peer review and quality control purposes,' and think that's going to do it. That doesn't do anything by itself," Rashbaum says. "They also distribute the records to places they shouldn't go. They'll CC or BCC it, just flat-out hand it to somebody, or discuss it with somebody. The privilege is waived at that point."

Rashbaum also has seen instances in which someone makes negative comments about a physician or other clinician, assuming it will be protected by the peer review privilege. But if it is never used in a peer review proceeding, there is no protection, he says. Physicians participating in peer review often are insufficiently educated about the law regarding the process, he notes.

Don't assume records are protected

Physicians attending peer review meetings must be reminded of the confidentiality of the proceedings, Hersh notes. Many hospitals require a written affirmation signed by each attendee. In the event of civil litigation such as a medical malpractice claim, in order to prepare for deposition, defense counsel should meet with witnesses and participants in any peer review committee in which the care of the patient was discussed.

"In my experience, the protection is often lost when a physician participant in a peer review committee discussion takes it upon himself or herself to reveal peer review discussions outside of the committee meeting," Hersh says. "The protection also is lost when committee documents are distributed to persons who are outside the committee, when participants leave the meeting room with documents in hand, or when a protected document is filed in a personnel, administrative or other unprotected location in lieu of the medical staff office."

It is common to see hospitals and other healthcare organizations fail in their attempts to exercise their peer review privilege, says **Delphine O'Rourke**, JD, managing partner of the Philadelphia office of Hall, Render, Killian, Heath & Lyman, who also works as in-house general counsel and chief advocacy officer of Our Lady of Lourdes Memorial Hospital in Binghamton, NY. A common scenario is a hospital trying to retroactively benefit from the privilege while investigating an issue that did not start out as a peer review matter, she says. Perhaps human resources is researching an issue and eventually finds that a physician is involved and must be interviewed.

"They say, 'Oh, this must be peer review protected because we're investigating a physician's behavior,'" O'Rourke says. "At that point it's too late. They've been investigating this issue for three months and just now put it on the peer review committee's agenda, thinking it's protected now. That's not the case."

The reason is that peer review analysis focuses on the purpose of the document, and the purpose must be peer review or quality improvement, she explains. Courts historically have asked whether the document was created for those purposes, whether it was created by the peer review committee or at its direction, and whether it was created by following the hospital's processes for peer review. If so, the document is protected. But O'Rourke says there is a trend now for courts to be especially stringent and decline peer review protection if the document could have been created for other purposes.

"Even if there is no evidence that it was created for other purposes, if there is a possibility that the document could have been used in insurance claims or a malpractice defense, the courts are arguing that there could have been more than one purpose for creating the document," she explains.

The difficulty for hospitals is knowing when to initiate an investigation or documentation process as a peer review function, O'Rourke says. Running every physician-related matter through the peer review committee is not practical, so hospitals need a trigger mechanism to determine which issues must go through the committee. Once the peer review process is triggered, follow all procedures carefully. *(See the story on page 8 for more on how to follow peer review procedures carefully.)*

Committee minutes released online

Industry interest in centralization, information collection, and transparency is making protection of state law peer review confidentiality much more difficult, says **Karen Owens**, JD, an attorney with the law firm of Coppersmith Brockelman in Phoenix. Administrators sometimes don't consider confidentiality as they centralize peer review-related processes and work to increase transparency across the hospital system. While acknowledging that these approaches help protect patients and improve care, Owens urges hospital clients to be intentional and inclusive in their

decisions to give up confidentiality. For example, she worked with one hospital that decided to put certain medical staff committee minutes on its system-wide intranet, available to all employees. The fact that protected peer review information appeared in those minutes was not considered until they were sought by a plaintiff's attorneys in discovery.

"It was only then that we — and the medical staff leaders — learned about the placement of the minutes online," she recalls. "Ultimately, the decision was made to keep the general minutes online but create separate 'executive session' minutes for confidentiality activities. In the meantime, though, the plaintiffs won the discovery dispute."

Owens recommends a strong focus on educating physicians and others about the purpose, and the limitations, of peer review protection. *(For more on creating a "culture of confidentiality," see the story below. For advice on how to protect peer review documents in court, see the story on page 8.)*

One other increasingly common worry about losing peer review confidentiality protections involves employed physicians, Owens says. The rate of hospital employment of physicians is skyrocketing, of course, and employed medical staff members then face two kinds of oversight: by the medical staff and by the hospital employers. Hospital administrators understandably want to make decisions about continuing physician employment with all information in hand, she says, including information about quality, and administrators may see employment decisions as a more efficient means of addressing quality problems than traditional peer review. But if hospitals do not prospectively put structures in place to determine to what extent and how quality information gets into non-confidential employment processes, courts are very likely to refuse to protect such information in discovery disputes, Owens explains.

"And those disputes may take place not just in malpractice cases, but in employment cases as well," she says. "Whether the court finds a formal waiver of confidentiality or decides that the hospital never intended the information to be confidential, the result is the same: The information is in the public realm, and physicians are less likely to want to put time and energy into reviewing their colleagues."

SOURCES

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Create Culture of Confidentiality Through Education

The best way to protect physician-related materials from discovery under state peer review statutes is to develop what might be called a "culture of confidentiality" in peer review proceedings, suggests **Karen Owens**, JD, an attorney with the law firm of Coppersmith Brockelman in Phoenix. To expedite the development of such a culture, she recommends the following steps:

• Make sure an expectation of confidentiality is present in medical staff governance documents, from the medical staff bylaws to committee charters to departmental rules and regulations.

• Educate the medical staff leadership. Every orientation and workshop should include a section on confidentiality, and there should be periodic reminders during meetings over the course of the medical staff year. The key to this education making a difference is to explain the purpose of peer review confidentiality: to maximize the ability of peer reviewers to improve patient care by facilitating open discussion and appropriate action without fear of retaliation or legal action.

• Explain the limits of confidentiality. For example, many medical staff leaders don't understand that peer review materials typically are discoverable in federal court proceedings; peer review is not a license to discriminate in violation of federal law. Finally, education should explain the medical staff mechanisms that protect peer

review and stress the importance of complying with them. Peer review work should take place in committee and the medical staff office; the privilege typically will not protect "off-the-record," hallway, or golf course conversations.

• Enforce peer review confidentiality. Physicians and leaders who ignore confidentiality and talk in the doctors' lounge should be sent through the peer review process themselves; repeat offenders should not be in leadership. ■

Don't Overreach, and Argue for Broad Interpretation in Court

Courts typically see confidentiality issues arise in the context of discovery disputes in medical malpractice cases, says **Karen Owens**, JD, an attorney with the law firm of Coppersmith Brockelman in Phoenix. Naturally, plaintiffs' counsel would like nothing better than to get into the peer review files they think will prove their case, so they will look hard for ways to squeeze past the statutory protections, she says.

"We've found that the judges who decide discovery disputes are accustomed to seeing other privileges, like the attorney/client privilege, which is interpreted narrowly," Owens says. "Using prior court opinions and public policy reasoning, a hospital attorney must convince the judge that peer review confidentiality should be interpreted broadly because of its critical importance in protecting patient safety."

Owens says that, in her experience, courts are more likely to agree to protect medical staff documents when hospitals do not "overreach." For example, rather than making a blanket objection against production of the entire credentials file, Owens will produce documents that the plaintiff could obtain elsewhere — things like CME certification, copies of professional licenses, or information pulled from public Internet sites.

"We also freely provide medical staff governance documents like bylaws, rules and regulations, and policies. Then we can honestly and accurately argue to the judge that we have disclosed every item we possibly can and are prohibited by law from doing more," she says. "Courts may not find the peer review privilege intuitively clear, but they certainly will defer to the will of the state legislature."

Owens and her colleagues have had good success with this approach. In one case when a plaintiffs' lawyer fought hard to get into a root cause analysis file, they showed the judge the medical staff policy stating that the root cause analysis (RCA) was confidential.

"We explained that the many emails setting up meetings and addressing matters between meeting were 'in connection' with the confidential process and therefore covered under our statute," Owens says. "We explained the critical public process reason for including the RCA process as a core peer review activity. The court agreed, and medical staff members still participate in RCAs as a result." ■

Follow Peer Review Procedures Rigorously to Protect Privilege

The peer review committee meets at 7 a.m., followed by a tumor board and then four administration meetings back to back. None of the physicians really want to be in the room at that moment, and one has showed up early for the next meeting and wants to stay there with her coffee and donut instead of coming back later. There's also a human resources representative still hanging around after a prior meeting.

Those two extra people aren't on the peer review committee, but no one wants to confront them and everyone wants to just get on with the meeting. So you figure it's fine for them to stay while the committee meets.

Wrong decision. You've just

lost your peer review protection, says **Delphine O'Rourke**, JD, managing partner of the Philadelphia office of Hall, Render, Killian, Heath & Lyman, who also works as in-house general counsel and chief advocacy officer of Our Lady of Lourdes Memorial Hospital in Binghamton, NY.

"I'm amazed at how often that happens. You cannot have non-peer review committee people present during these discussions," O'Rourke says. "The information discussed in that committee must stay within the committee. Not only are you violating the promise of confidentiality, but you are losing your protection because you allowed that information outside the protected confines of the committee."

Any issue addressed by the peer review committee must be handled exactly as prescribed in your bylaws and policies, she says. Any deviation can jeopardize the protection afforded to peer review.

"Whatever your process is around peer review, quality improvement, notifying physicians, follow that process to the letter," she says. "The legal system generally favors discoverability, so if there is an opportunity to waive that privilege there is a high likelihood that it will be. Particularly if the case is egregious, the court is not going to want to protect that physician's information from discovery."

Some of the challenges are administrative. For instance, O'Rourke cautions against having multiple files on the same physician under investigation. Keep all the information in one file rather than splitting it into files for the credentialing aspect of the matter, the personnel and human resources part of the investigation, and so on. If the information was gathered at the direction of the peer review committee, make that explicit in the file. Include a clearly stated memo or other documentation from the peer review committee that this document is being created as part of the peer review process — this document, not a vague reference to an investigation regarding the physician. The goal is to contemporaneously provide a link between peer review and the document, so that the hospital is not left with the burden of demonstrating later that it was, in fact, created at the direction of the committee.

Remember that courts will look for any chance that the document had any additional purpose. Never create multipurpose documents because the same information is needed in peer review and also for another administrative need.

"You're asking the court to give you special protection because quality improvement depends on this information being kept private," she explains. "But if you can't be bothered to protect it, why should the court? If you were sloppy with it and didn't take this seriously, the court's not going to deny that information to the other party." ■

Hospital Culture Must Be Measured, Not Just Improved

Hospitals strive to have the right culture, particularly when it comes to patient safety, but measuring improvement can be challenging. It's not enough to strive for a health culture, says one expert. You also have to know if you're getting any closer to your goal.

The idea of a hospital's culture is challenging enough for many people, but the idea of measuring it can be even more difficult, says **Catherine Miller**, RN, JD, senior risk management and patient safety specialist for the Cooperative of American Physicians in Los Angeles.

"All of the major patient safety leaders really think that culture most significantly impacts patient safety, worker happiness, and patient outcomes," Miller says. "It's nebulous, it's hard to get your arms around it and define it, but you can see it and feel it. And you can measure it."

A working definition of hospital culture is the attitudes, behaviors, beliefs, and expectations of an organization, Miller says. A more folksy definition is "the way we do things around here," she adds. In hospitals with a good safety culture, people feel supported, that they have tools to do the job, that they are listened to, and they can escalate patient safety concerns without fears of retaliation,

she says. A good safety culture correlates with fewer infections, fewer readmissions, and overall better patient outcomes.

A multi-pronged approach is best when measuring culture, Miller says. The Joint Commission requires that hospitals annually survey and assess their safety culture, and there are several tools available. One that Miller recommends is the Hospital Survey on Patient Safety, created by the Agency for Healthcare Research and Quality, available online at *http://tinyurl.com/pzm62sn*. The survey asks questions of hospital staff such as whether they have enough staff to handle the workload, whether people treat each other with respect, and if the respondent can escalate a patient safety concern without fear of reprisal.

"Surveying your folks is a good way to start improving your culture because you get a baseline," Miller says. "Another thing to consider doing is conducting patient safety rounds and interviewing staff. Maybe when you get the survey results that is a good time to go out on the floor and try to drill down deeper into any issues that were identified there."

Interviewing patients and family members also can yield great insight, Miller says. The most useful information can come from long-term and frequent flier patients because they have the most exposure to the hospital, she notes.

A common mistake when trying to improve hospital culture is to underestimate how long the process will take, Miller says. She likens it to a political campaign — long and arduous, but you should be able to tell if you're winning or not.

"It's easy to think that if you get out there and promote your mission statement, staff will align themselves with it. Then that's it and after a while you have a culture of safety," Miller says. "That's not enough. It's very much dependent on leadership guiding this from the top down, having a presence at new employee orientation, every chance they get to be seen advocating for a culture of safety."

Periodically, you should reassess the culture by surveying staff at least annually as required by the Joint Commission, but perhaps more often to explore specific areas that you are trying to improve. Also, don't underestimate the value of face-to-face discussions with managers and frontline staff, Miller says. Data from surveys and other tools is essential, but sometimes your best assessment of progress will come from the few minutes you spend chatting with a nurse who happened to be walking by. You may hear that he or she has noticed real improvements in the way staff feel about the culture of safety, and you may hear that there are still particular issues that need more attention.

"Leadership can get so bogged down with meetings and other distractions that they find it hard to get out on the unit and connect. Just getting out there and introducing themselves is one way they show their commitment to the culture of safety, so you can't downplay the importance of just walking onto a unit and saying hello," Miller says.

SOURCE

- **Catherine Miller**, RN, JD, Senior Risk Management and Patient Safety Specialist, Cooperative of American Physicians, Los Angeles, CA. Telephone: (800) 252-7706. ■

CMS Proposes Access to information for Quality, Patient Care Improvement

The Centers for Medicare & Medicaid Services (CMS) has proposed rules that will expand access to analyses and data that will help providers, employers, and others make more informed decisions about care delivery.

The new rules, as required by the Medicare Access and CHIP Reauthorization Act (MACRA), will allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers, and other groups who can use the data to support improved care. In addition, qualified entities will be allowed to provide or sell claims data to providers. The rule also includes strict privacy and security requirements for all entities receiving Medicare analyses or data, as well as new annual reporting requirements.

The initiative is part of a broader effort by the Obama Administration to create a healthcare system that delivers better care, spends dollars more wisely, and results in healthier people, CMS said in its announcement.

The qualified entity program was authorized by Section 10332 of the Affordable Care Act and allows organizations that meet certain qualifications to access to patient-protected Medicare data to produce public reports. Qualified entities must combine the Medicare data with other claims data (e.g., private payer data) to produce quality reports that are representative of how providers and suppliers are performing across multiple payers; for example, Medicare, Medicaid, or various commercial payers. Thirteen organizations have applied and received approval to be a qualified entity. Of these organizations, two have completed public reporting while the other 11 are preparing for public reporting.

The rules seek to enhance the current qualified entity program to allow innovative use of Medicare data for non-public uses while ensuring the privacy and security of beneficiary information. Comments are welcome on this set of proposed rules. You can submit your comments until March 29, 2016, here: *http://www.regulations.gov*. The proposed rule is available online at *http://tinyurl.com/goj7xjx*. ■

CMS Releases Guide to Preventing Readmissions Among Diverse Beneficiaries

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) has released a new Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries.

The guide was developed in collaboration with the Disparities Solutions Center at Massachusetts General Hospital and the National Opinion Research Center (NORC) at the University of Chicago as part of the CMS Equity Plan for Improving Quality in Medicare, and is designed to assist hospital leaders and stakeholders focused on quality, safety, and care redesign in identifying root causes and solutions for preventing avoidable readmissions among racially and ethnically diverse Medicare beneficiaries.

"CMS has an important opportunity and a critical role in preventing hospital readmissions while promoting health equity among diverse Medicare beneficiaries," said **Cara James**, director of CMS's Office of Minority Health. "This guide encourages action-oriented steps and solutions in achieving health equity, addresses reducing readmissions, and focuses on our initiative of achieving better care, smarter spending, and healthier people throughout our healthcare system."

Racial and ethnic minority populations are more likely than their white counterparts to be readmitted within 30 days of discharge for certain chronic conditions, such as heart failure, heart attack, and pneumonia, among others. Social, cultural, and linguistic barriers contribute to these higher readmission rates.

The guide provides new, action-oriented guidance for addressing avoidable readmissions in this population by providing an overview of the issues related to readmissions for diverse Medicare beneficiaries; a set of seven key recommendations that hospital leaders can take to prevent avoidable readmissions in this population; and concrete examples of initiatives and strategies that may be applied to reduce readmissions in diverse populations.

To learn more about the guide and key recommendations, visit *http://tinyurl.com/zvga2mz.* ■

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CNE QUESTIONS

1. What was the result of protocols established at Memorial Hermann Health System after two transfusion-related incidents in 2006?

A. From 2007 to today, more than 1.1 million transfusions were performed in Memorial Hermann facilities without a single transfusion adverse event.
B. From 2007 to today, more than 1.1 million transfusions were performed in Memorial Hermann facilities with only six transfusion adverse events.
C. The rate of transfusion-related adverse events was brought down to the average found in other American facilities.
D. The rate of transfusion-related adverse events did not decrease because compliance with the protocols was not sufficient.

2. What is the current compliance rate with hand hygiene at Memorial Hermann?

A. 67%
B. 81%
C. 88%
D. 95%

3. What is one way to lose the protection of peer review privilege?

A. Committee documents are distributed to persons who are outside the committee.
B. Committee documents are not reviewed and approved by legal counsel.
C. The document does not have the signatures of all members of the committee.
D. At least one member of the committee was absent during creation of the document.

4. What must be clear about a document for it to retain protection under the peer review privilege?

A. It addresses a matter involving civil litigation.
B. It was created originally as part of the peer review process.
C. It concerns a matter considered sensitive by the parties involved.
D. It addresses a matter regarding physician performance.