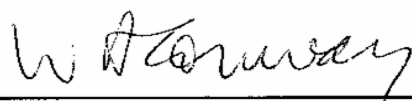


State Commission on Patient Safety
Demographic Information

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I am providing testimony as a patient safety expert.



Signature

A dedicated leader and committed researcher, William A. Conway, M.D., has given more than 30 years of service to Henry Ford Health System. Dr. Conway serves as Senior Vice President and Chief Quality Officer for Henry Ford Health System. Dr. Conway also serves as Chief Medical Officer, he is responsible for the clinical operations at the Detroit Campus.

Dr. Conway has championed many quality innovations for Henry Ford, most recently our award-winning Pursuing Perfection projects which have gained national attention. He received grants for six major research projects, which have studied issues ranging from the effectiveness of inhaled corticosteroids in chronic obstructive pulmonary disease to nocturnal oxygen therapy to Pursuing Perfection in Health Care Services.

A graduate of Creighton University Medical School in Omaha, Neb., Dr. Conway joined Henry Ford Hospital as a resident in 1973. He became chief medical resident in 1975 and maintains an active clinical practice in Pulmonary and Critical Care Medicine.

Dr. Conway is a member of the professional organizations Leadership Detroit Alumni Association and American Medical Group Association, where he is a past president. He is also past chairman and founding member of the Group Practice Improvement Network.

Active in the community, Dr. Conway is on the Board of Directors for the Southeastern Michigan Chapter of the American Red Cross and sits on the Board of Directors of the University of Detroit Jesuit High School and Academy.

Dr. Conway has been published over 40 times in his professional career and was invited to participate in National Outcomes Congress in April 2003 where he presented Henry Ford Hospital's effective model of Surgical Infection Prevention and in September 2004 he was the featured speaker at the Quality Expo sponsored by the Michigan Peer Review Organization and Michigan Association for Healthcare Quality.

Henry Ford Health System Response for Request for Testimony

Executive Summary

The IOM's landmark report To Err Is Human (1999) sent shock waves across the health care industry. It gave voice to the silent but growing concerns of thousands in the health care workforce and catalyzed a national effort by all key stakeholders to make radical improvements in safety. For Henry Ford Hospital and health system leaders, nothing less than the highest degree of patient safety meets the standard of "care and comfort we would want for our families and ourselves." In the past three years, hospital leaders and staff have made a substantial personal and organizational commitment to safety improvement.

Examples include:

- Establishment of a systemwide Patient Safety Steering Committee to oversee the safety agenda and execution.
- Institution of senior leader safety walkarounds in the hospital and staff safety huddles on hospital nursing units.
- Revision of the adverse event action planning process to permit participation by senior leaders in decision-making and follow-up.
- Revision of the error reporting policy to promote a non-punitive approach to staff reporting of errors and risks.
- Implementation of electronic technology to log reports of errors and other safety concerns and permit anonymous reporting.
- Inclusion of patient safety improvement as a core element in new employee orientation and the multi-year culture-shaping initiative called Organization Renewal, which began with senior leaders and will enroll all employees in the next two years.
- Participation in national collaboratives focused on safety improvement--Quantum Leaps in Patient Safety, Improving ICU Care, and Surgical Infection Prevention.

Testimony: Evidence of Success and Recommendations

I. Building leadership and knowledge to improve patient safety in the state

Recommendation:

The identification of a state focal point for patient safety to set goals for patient safety, track progress in meeting goals, and the issuance of an annual report is supported by Henry Ford Health System. It is recommended however, that statewide goals/initiatives be aligned and coordinated with any current or future national goals/initiatives. Such alignment would minimize the burden of organizations trying to meet varied "measure sets" or goals from multiple agencies with similar charges. Additionally, it is recommended that resources and funding be available at the state level to assist organizations with the implementation of safety programs.

II. Identifying and Learning from Errors

Mandatory Public Reporting

Evidence of Success:

HFH defines a culture of safety as a culture that recognizes that errors are almost always systems failures and encourages continuous examination and improvement of processes and systems in order to deliver ever-increasing quality and value to patients and communities served. A culture of safety is “blame-free” and actively promotes employee self-disclosure to uncover and address system issues that put patients and staff at risk so that future errors can be prevented.

An important *new policy* implemented in 2002 supports a culture of safety at HFH. The Disclosure of Safety Events policy articulates the hospital’s philosophy that unsafe care is almost always the product of poorly designed systems. (A safety event is any variance not consistent with the desired, normal, or usual operations of the organization. An injury need not occur.) This policy encourages and supports employee reporting of actual and potential safety events as a mean to monitor and improve current processes through tracking, trending and analysis of events and concerns. Leaders commit to non-punitive analysis and action to find out what happened, why it happened and what can be done to prevent it from happening again. Senior leader safety walkarounds in the hospital and staff huddles on the units occur to proactively identify and address issues that may lead to an adverse event.

HFHS has had a long-standing approach to *disclosing unanticipated outcomes* to patients and families. The patient and family are informed by the attending physician or senior staff physician responsible for the care of the patient in collaboration with other members of the health care team, as appropriate. The disclosure includes information about how the error occurred, its short and long term effects and remedies available to the patient. Staff involved in the adverse event is offered counseling and support from the organization.

Good data and information are essential to identify safety improvement opportunities and track progress on improving performance as priorities are addressed. In 2002, HFH launched an innovative web-based incident reporting system. This system, which replaces multiple paper forms,

- Makes data entry simpler and more accessible (from virtually any hospital computer)
- Standardizes definitions and risk categories
- Captures data in a consistent format
- Facilitate information sharing and follow-up electronically across departments and levels
- Identifies issues requiring immediate action
- Builds a database for pattern analysis to identify systemic issues

Recommendation:

Mandatory, public reporting for the collection of standardized information about preventable adverse events is supported if legal protection is provided both to the organization and the provider(s). Lack of patient safety legislation to provide such protection will be detrimental to the sharing of standardized information within and across health care organizations and/or between health care professionals. Additionally, transparency across organizations is critical to identify persistent safety issues that require more intensive analysis and/or a broader-based response. Health care institutions would also benefit from a coordinated reporting system to document issues with equipment, medications, etc. This would eliminate redundant reporting and minimize the burden of multiple reporting requirements for organizations.

II. Setting Performance Standards and Expectations for Safety

Education and Training Curriculums

Evidence of Success:

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics. This requires a common vision across the professions centered on a commitment to meeting the patient's needs as envisioned in the Quality Chasm.

At HFHS, a systemwide, multidisciplinary Patient Safety Steering Committee reviews safety results and initiatives; serves as a "think tank" on current research and best practices; and oversees the patient safety curriculum.

Creating and fostering a culture of patient safety is addressed in

- New employee orientation (mandatory)
- New physician orientation (mandatory)
- New house officer orientation (mandatory)
- One-day all-employee Organization Renewal workshops (to reach all employees by 2004)

Hospital employees may attend an in-depth half-day safety workshop, designed to address the learning needs of physicians and nurses identified in a 2002 National Patient Safety Foundation survey. Topics include human factors analysis, failure modes and effects analysis, proper prescription writing, and health literacy.

Effective *communication* is essential in changing the culture and building new knowledge and skills. But the size and complexity of a large urban teaching hospital make communication difficult. Our approach is to use multiple channels and formats—CD ROM, "live workshops," web-based tools, even games, as well as existing employee meetings and publications.

A variety of methods make learning efficient, effective, and even fun. Three *innovations in safety education* were deployed in 2003.

1. Henry Ford Hospital launched a new approach to house officer education, using CD Rom technology. This self-paced, interactive, digital format offers two modules on patient safety: (1) the medical resident's role in patient safety, including patient transfer to other caregivers, writing orders, and the physical and cognitive hazards of fatigue; (2) the hospital's commitment to a culture of patient safety, with relevant policies and approaches.
2. Patient Safety "Jeopardy" is an internally designed interactive learning tool, modeled on the television game show. Safety questions are organized into single, double and final jeopardy rounds, and there are multiple levels of difficulty. To assess learning, participant knowledge is tested before and after the game. First designed for use with internal medicine residents, Patient Safety "Jeopardy" is now part of the hospital staff curriculum as well.
3. A quarterly Patient Safety Newsletter, aimed at all staff, debuted online. Distributed to email boxes hospital wide, it can also be printed for posting or discussion in staff meetings. Each issue contains a safety message from leadership. Objectives include:
 - Increase the safety awareness of all employees.
 - Serve as a communication tool for leadership
 - Share new knowledge about patient safety.
 - Share successful approaches used by employees, and their results
 - Build skills

Recommendation:

The state should serve as the forum to align the various professional societies and organizations to promote standardization across education and training curriculums. This alignment would serve to enhance interdisciplinary education and collaboration; accelerate process improvements; share competencies; set common standards. This coordination would minimize duplicative efforts, ensure better use of limited resources, and assist all organizations in trying to achieve the same goal.

Standards for the safe use of drugs

Recommendation:

Part of FDA approval for the safe use of drugs must include the implementation of a process to address the problem of look alike and sound alike drugs and appropriate labeling of medication. This will necessitate the continued study of human factors engineering in other industries with an application to the health care industry.

Consumer Involvement

Evidence of Success:

HFH embraces *patients (and families) as partners* in safe care. Patients and families are encouraged to “speak up.” An innovation in Medical Critical Care keeps families informed so they can “speak up” knowledgeably. Family members have access 24 x 7 to a daily message from the health care team about their loved one’s plan of care and progress. Open visitation is supported and encouraged since family involvement promotes better patient outcomes. Patient advisory committees have recently joined focus groups as tools to uncover patient needs and preferences for use in process design and redesign, in oncology, behavioral health, and diabetes, for example. Safety videos are offered on the hospital TV system for patient and family viewing. The hospital also uses patient satisfaction survey data and comments as a source for patient input about safety, and a full-time Customer Feedback Coordinator is responsible for responding to patient/family concerns and making appropriate referrals to resolve issues.

III. Implementing Safety Systems in Health Care Organizations

Safety as an explicit organizational goal

Evidence of Success:

A *culture of safety* is a fundamental building block to achieve the vision and goals. A pioneer in quality improvement, Henry Ford Health System, and its flagship Henry Ford Hospital (HFH), embraced quality as a core business strategy in 1989. Trustees and top leaders reaffirmed that commitment a decade later, revising the organization’s Mission, Vision, and Values to set the direction for the 21st century—a focus on patient-centered, safe, evidence-based care, delivered to every patient every time, or “Each Patient First.”

Based on this leadership vision and policy, they defined a set of ten 5-year goals, long-term strategic objectives for the system and its entities. The 5-year *goals for quality and safety* include:

- To be recognized by each of our patients, our community, and our professions as the Best Health Care Provider, and also the Best Health Care Plan, in southeastern Michigan.
- To be recognized among the safest health care systems in the U.S.A.

HFH uses multiple methods to *engage caregivers and other staff* in patient safety improvement. The hospital has a long history of using multidisciplinary teams to redesign care. Members represent appropriate disciplines and functions. The hospital’s closed medical staff of salaried physicians and the emphasis on safety in the quality plans of physician leaders ensure physician involvement and leadership. Three examples of physician-led improvements are

- redesign of oral anticoagulation therapy management and establishment of protocol-driven, nurse- and pharmacist-managed virtual clinics
- implementation of evidence-based strategies to reduce surgical site infections, including improving antibiotic selection and timing and perioperative glucose management and eliminating shaving
- implementation of an electronic discharge process that consolidates necessary information from multiple caregivers electronically into a single discharge plan to prevent gaps, redundancies, or other hand-off failures as the patient transfers to the next level of care.

Through such approaches the hospital embeds safer practices into the daily work to improve safety for all patients and for staff. The hospital also supports its multidisciplinary teams in benchmarking with other organizations on safety improvement through national initiatives, such as IHI’s learning collaboratives Quantum Leaps in Medication Safety and Improving ICU Care and the CMS-CDC- sponsored Surgical Infection Prevention Collaborative. Such collaboratives have proven to be successful because they promote the sharing of information; promote learning from other “innovative” organizations, and foster the “spread” of evidence-based best practices throughout the organization.

One key learning from our experiences is understanding that traditional *physician culture* honors autonomy and expert knowledge. As a result, it is often difficult to engage physicians in leading and making practice changes, even in a hospital with a closed staff of group-practice physicians. Our approach is to involve physicians as leaders, to focus on defining and communicating the evidence that supports change, and to support our improvement efforts with ongoing measurement to demonstrate progress in process and outcome improvement. The success of the Surgical Infection Prevention Collaborative and Glycemic Control Initiative can be attributed in large part to this approach.

Recommendation:

The state could provide financial incentives to organizations who design “safe” facilities and who implement meaningful patient safety programs and support “evidence-based” collaboratives. Additionally, ongoing, state-funded, state sponsored safety education programs that focus on innovative approaches to teaching patient safety and effective team functioning including Crew Resource Management, especially in the ER, ICU, and OR settings; simulation training; and medication safety practices would further advance the cause. Effective multidisciplinary team functioning and communication are critical to preventing adverse events. Much can be learned from other industries, notably Aviation, and transferred to the health care setting.

Medication Safety Practices

Recommendation:

With regard to safe medication practices, we support the following National Quality Forum practices:

- Active participation by Pharmacists in the medication-use process

-Dispensing medications in unit-dose or unit-of-use form

These practices add another layer of defense in the medication use process. The state could offer incentives/funding for organizations to utilize more Pharmacists on patient care units.

Pharmacists, based on their educational backgrounds, are in a unique role to intercept potential medication errors at the medication ordering phase; are better skilled to admix high-risk medications; add value by monitoring the patient's response to drug therapy; and can provide ongoing education for staff and patients.

Additionally, all organizations should be required to maintain ongoing lists of patients' medications. Such lists should be maintained in an electronic registry and printed for patients to carry to facilitate their movement throughout the delivery system and ensure safe medication practices amongst multiple providers and settings. This integrated medication list should be reconciled at each patient admission and discharge. Ideally, the state should support some sort of state registry to support the transfer/exchange of medication information across all health care organizations and pharmacies. Patients, in many cases, do not exclusively receive care at one organization. Any means to provide medication information and potentially medical history information across organizations (in an easily retrievable format but well protected) can only enhance patient safety efforts.

Conclusion:

At HFHS, we believe we have laid the foundation for a culture of safety and deployed useful methods and tools for leaders and staff to make improvements. The challenge ahead is to focus and apply knowledge, energy, and resources to make rapid and real safety improvements and demonstrate that we can deliver—every time—the level of safe care that “we would want for our families and for ourselves.” Joining efforts with the state and other health care organizations across Michigan can only advance our state as one of the safest in the nation. We can accomplish much more as a “team” rather than independently working in “silos” for the same cause.

