Resiliency, Where Are We in 2025?

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Objectives

- Understand components of high reliability organizations
- Understand three components of professional fulfillment
- Understand solutions being worked on in Virginia

About the MSV

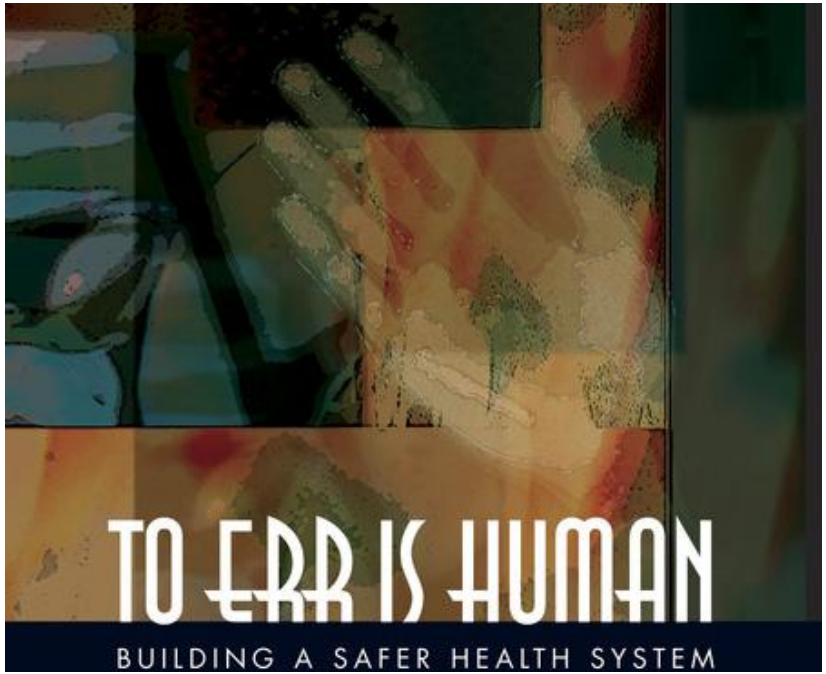
Founded in 1820, the Medical Society of Virginia (MSV) has been responsible for the creation of Virginia's Board of Health, Board of Medical Examiners, Board of Medicine and the MSV Review Organization (which evolved into the Virginia Health Quality Center). Each of these now-independent entities had their beginnings within the MSV.

- Headquartered in Richmond, Virginia
- Advancing high-quality healthcare and making Virginia the best place to receive care and practice medicine

To Err is Human

- 44,000 to 98,000 people die every year from medical errors
- Imagine a Boeing 747 crashing every day…

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To err is human*. National Academies Press.



- **Are our systems resilient?**
- **Do we learn and improve?**

Start with Why… Josie King

Harvard Medical Practice Studies I and II

- Troyen Brennan
- **3.7%** of hospitalized patients experience an adverse event
- 27.6% are from negligence

Brennan, T. A., Leape, L. L., Laird, N. M., Hebert, L., Localio, A., Lawthers, A. G., Newhouse, J. P., Weiler, P. C., & Hiatt, H. H. (1991). Incidence of adverse events and negligence in hospitalized patients. *New England Journal of Medicine*, *324*(6), 370–376.

- Lucian Leape
- **58% of adverse events** due to errors in **management**

Leape, L. L., Brennan, T. A., Laird, N., Lawthers, A. G., Localio, A., Barnes, B. A., Hebert, L., Newhouse, J. P., Weiler, P. C., & Hiatt, H. (1991). The nature of adverse events in hospitalized patients. *New England Journal of Medicine*, *324*(6), 377–384.

Have We Improved?

- John James
- Patient deaths from preventable harm is between **210,000 and 400,000 per year**
- Serious harm 10-20X more likely than preventable death

James, J. T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, *9*(3), 122–128.

- Martin Makary
- Medical **error** is the **third leading cause of death** in the U.S.

Makary, M.A., & Daniel, M. (2016,May 3). Medical error – the third leading cause of death in the US. *BMJ* 3(1), 1-5.

STILL NOT SAFE

PATIENT SAFETY
AND THE MIDDLE-MANAGING OF
AMERICAN MEDICINE

Robert L. Wears & Kathleen M. Sutcliffe

Are High Reliability Organizations the Solution?

- Nuclear Power Plants
- U.S. Navy aircraft carriers
- Air traffic control
- “Effective management of innately risk technologies through organizational control of both hazard and probability”.

Rochlin, G. L. (1993). Defining high reliability organizations in practice: a taxonomic prologue. In *New challenges to understanding organizations* (pp. 11–32). Macmillan.

What is an HRO?

HROs, or High Reliability Organizations, are defined as those where accidents are expected to occur normally due to operational risk and task complexity, but do not…

USS *Boise* (SSN-764)

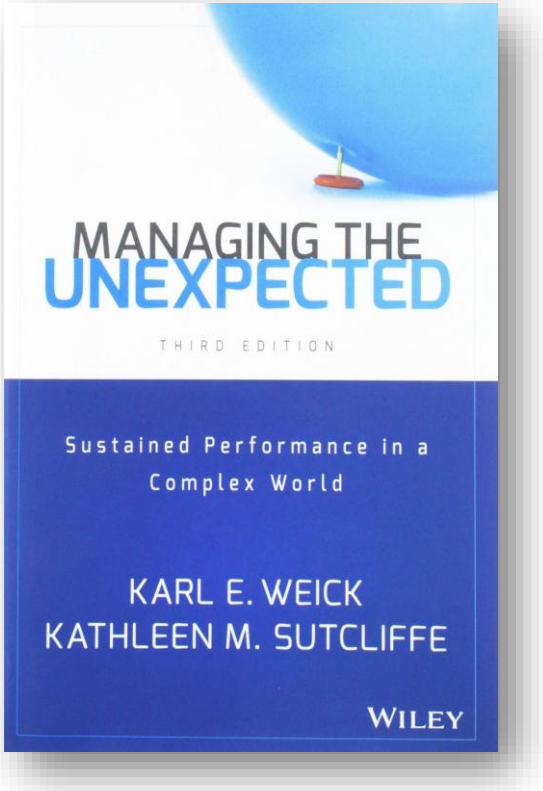
Five HRO Principles

Prevention of Errors:

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations

Organizational Resilience:

- Commitment to resilience
- Deference to expertise



Weick, K. E., & Sutcliffe, K. M. (2015). *Managing the unexpected: Sustained performance in a complex world* (3rd ed.). Jossey-Bass.

Organizational Resilience

Resilience: “Developing capabilities to cope with, contain, and bounce back from mishaps that have already occurred, before they worsen and cause more serious harm.”

“Resilience involves an ability to learn and grow…”

Sutcliffe KM. High reliability organizations (HROs). *Best Pract Res Clin Anaesthesiol*. 2011 Jun;25(2):133-44.

Wait, There's More…

- Building guardrails
- Reducing professional autonomy through teamwork
- Embracing evidence-based practices
- Optimizing safety strategies across the organization
- Simplify burdensome and complex rules

Amalberti, R., Auroy, Y., Berwick, D., & Barach, P. (2005). Five system barriers to achieving ultrasafe health care. *Annals of Internal Medicine*, *142*(9), 756.

HRO Safety Management System Inputs

- Safety culture survey
- Engagement index
- Malpractice claims
- Leadership rounding
- Physician peer review
- Nursing peer review
- Cause analysis from harm events
- Consultant external eyes
- Patient satisfaction scores
- Trigger tools
- Outcome data
- Patient reported measures
- Internal audits
- Pro-active risk assessments
- Grievances and complaints

Execution of HRO Principles

- **Leadership Bundles**

- Message on mission
- Ensure safe operations
- Accountability

- **Staff Universal Skills**

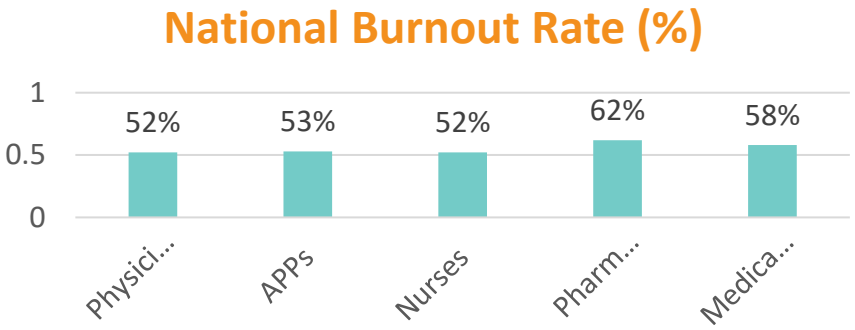
- Attention on task
- Communicating clearly
- Thinking critically
- Adhering to protocols
- Speaking up

Clapper, C., Merlino, J., & Stockmeier, C. (2019). *Zero harm: how to achieve patient and workforce safety in healthcare*. McGraw-Hill.

Physician Well-being & Resiliency

The State of Clinician Well-being

- Prior to the COVID-19 pandemic, physician burnout was already a major challenge
- Burnout, is a syndrome comprising emotional exhaustion, depersonalization and reduced personal accomplishment, and is **considered as an "occupational phenomenon"**



- Highest consistent rates in ED, critical care
- Primary care – from 4th lowest to 4th highest in 4 years-PRE-COVID

Causes of Burnout & Decreased Well-Being

62%

Too many **bureaucratic tasks** (e.g. charting, paperwork)

41%

Too many hours at work

40%

Lack of respect from administrators, employers, staff, etc.

38%

Insufficient compensation

32%

Lack of control/autonomy

24%

Increasing computerization of practice (EHRs)

Abbreviated Maslach Burnout Inventory

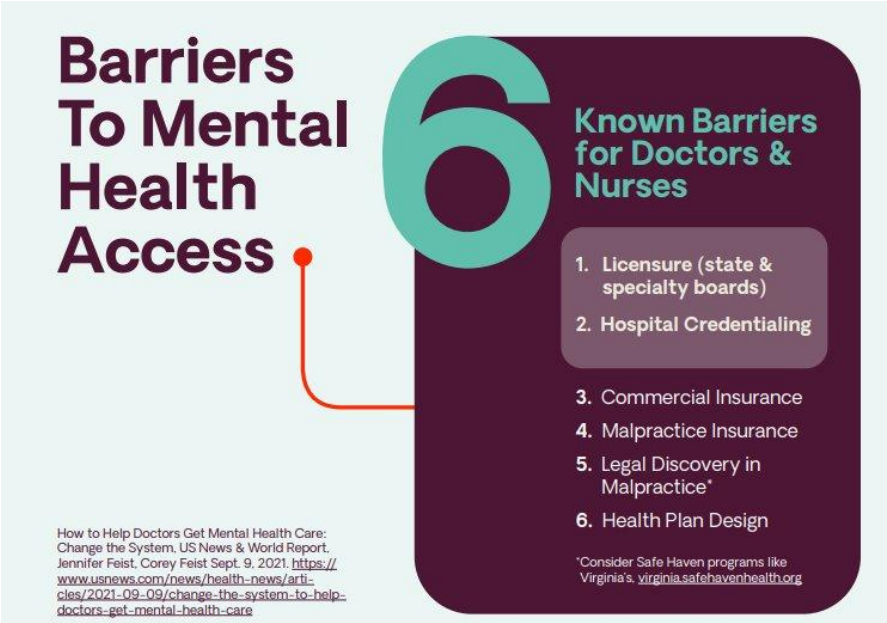
1 out of 3 in healthcare experience burnout

- Emotional Exhaustion
- Depersonalization
- Perceived Lack of Personal Accomplishment

Invasive Questions

Nearly 4 in 10 physicians were either afraid, or knew another physician fearful of, seeking mental health care because of questions asked in medical licensure, credentialing, or insurance applications.

The Physicians Foundation 2022 Physician Survey: Part 2 | The Physicians



The Cost of Burnout

Burnout is independently associated with job dissatisfaction and more than

200%

increased odds of **intent to leave.**

It costs approximately

$500K

to $2M and

12-14 mos.

to replace a clinician

Doctors who report signs of burnout are

Twice as likely

to have **made a medical error in the past 3 months.**

The Cost of Nurse Burnout

Using 2006 data* on 161 Pennsylvania hospitals, researchers measured an association between nurse burnout and rates of two common patient infections. They then projected the total annual impact of reducing the proportion of burned-out nurses statewide.

	Urinary tract infections		Surgical site infections	
Reduction in burnout	Infections prevented	Cost savings	Infections prevented	Cost savings
-10%	1,335	$1,055,640	744	$15,082,953
-20%	2,671	$2,111,280	1,489	$30,165,906
-30%	4,006	$3,166,920	2,233	$45,248,859

*Responses to questionnaires indicated that more than one-third of the nurses met a standard definition for high burnout. Infection data for 2006 were collected by the Pennsylvania Health Care Cost Containment Council (and was posted for each hospital at www.phc4.org). Average savings were based on federal estimates of per-patient cost for each infection.

SOURCE: Jeannie P. Cimiotti, American Journal of Infection Control

The Philadelphia Inquirer

Solution: A Culture of Care

- Building a culture of care is the responsibility of the employer and leadership
- Psychological safety **refers to an environment where individuals feel comfortable speaking up, expressing their thoughts, and seeking support without fear of reprisal or judgment**
- Psychological safety within the healthcare workplace is essential for addressing burnout, moral injury and promoting overall well-being
- When healthcare professionals feel secure seeking help and admitting vulnerability, **a more supportive and collaborative work environment is reinforced**

Stanford Model of Professional Fulfillment

This Is How I Look at Physician Well-Being…

Physician Well-Being: The Reciprocity of Practice Efficiency, Culture of Wellness, and Personal Resilience

Think of physician well-being as a three-legged stool. Improvement efforts should focus on all three domains to achieve best results.

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NEJM Catalyst | August 7, 2017

ALL IN: Caring for Virginia's Caregivers

A PARTNERSHIP MODEL TO IMPLEMENT "SYSTEMS CHANGE"

Caring for Virginia's Caregivers Taskforce 2021

- Strategies to address staffing and healthcare workforce challenges
- Remove intrusive language regarding mental health treatment
- Address burden created by third-party payment requirements
- Shared learning regarding electronic health records improvement
- Statewide learning and sharing of best practices
  - Virginia Patient Safety Summit
  - Duke well-bring webinar series
  - Caring for Virginia's Caregivers webpage
  - Collaboration between MSV, VNA and Hospitals/systems

All In: Caring for Virginia's Caregivers

Steering Committee

Typical Agenda 2023-2025

- Workplace Violence
- Licensure and Credentialing Challenge
- Curriculum Development- Wellbeing 101
- Sharing across the state
- Dr. Lorna Breen Heroes' Foundation update
- MSV SafeHaven

SafeHaven (since 2020 and expanding)

Confidentiality

Legislation allowed for the creation of the MSV SafeHaven™ Program, which is a confidential resource for clinicians seeking help to address career fatigue and other mental health issues

Reporting Protections

Clinicians participating in the SafeHaven™ program will not be reported to the Virginia Board of Medicine unless they are not competent to practice or are a danger to themselves

Privilege

Consultations which take place under the scope of the Medical Society of Virginia SafeHaven™ Program are considered privileged communications

SafeHaven Program Components

What's Included?

Clinician Peer Coaching — talk with someone like you who can help you grow both personally and professionally

Counseling — available in either face-to-face or virtual sessions

In-the-moment telephonic support — available 24/7

Legal and financial consultations and resources

WorkLife Concierge — a virtual assistant to help with every day and special occasion tasks

VITAL WorkLife App — mobile access to resources, well being assessments, Insights, videos and more

To date more than 2,000 physicians & PAs have engaged with SafeHaven, and more than 2,400 nurses.

“ The foundations for safety within healthcare exist. With aligned, focused and personally engaged leadership we can move closer to the goal that remains at once essential, noble and elusive – zero harm.”

Gary Yates, MD