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TIPS is published bimonthly
by the VA National Center for
Patient Safety. As the official
patient safety newsletter of the
Department of Veterans Affairs, it
is meant to be a source of
patient safety information for
all VA employees. Opinions of
contributors are not necessarily
those of the VA. Suggestions and
articles are always welcome.

Thanks to all contributors and
those NCPS program managers
and analysts who offered their
time and effort to review and
comment on these TIPS articles
prior to publication.

Introducing our new director, Robin Hemphill, M.D.

By Joe Murphy, M.S., A.P.R., NCPS public affairs officer



On April 25, 2011, Dr. Hemphill became the deputy chief patient safety officer and director, National Center for Patient Safety. She is also continuing her practice as an emergency medicine physician.

"I knew by the time I was in high school that I was going to be an E.R. doctor," she said. "I wanted to focus on being present when people felt they had their greatest need."

Dr. Hemphill is a graduate of George Washington University Medical School. She completed an internship in internal medicine, followed by emergency medicine, at the Joint Military Medical Centers in San Antonio, Texas.

When on active duty as an attending physician, she was asked to become the risk manager for the emergency medical department, following the reassignment of another physician.

"I became the departmental risk manager completely by accident," said Dr. Hemphill. But developing an in-depth awareness of risk management techniques and theory was to change the way she approached her practice. "It makes a difference in the way you think. So it's one of those funny things that happens to you that makes a profound difference in the way you approach things," she said.

It led her to reconsider how medical systems can affect patient care. "I would ask myself, 'Why did this happen to the patient? And did it really have to happen?'"

Sometimes, regardless of training and skill, an individual can act irresponsibly, and in those cases must be held accountable for his or her actions. But she and her colleagues on the risk management committee also took into account systems-related issues. "In some cases, we

found it was inevitable that a particular system was going to ultimately harm a patient and had to be fixed," she said. "We recognized the professional involved got caught up in a very bad system and wound up stepping on a land mine."

Her career focus, however, remained the same: "At that point in my life, I would have told you it was very clear. I was going to be a residency director, there was no doubt in my mind," she said.

Health care policy

After the completion of her military obligation, she joined the faculty at Vanderbilt University as the associate program director, Department of Emergency Medicine.

"I was not doing much in the way of risk management at that point, except for some programming and teaching of those concepts to residents," she noted, "but civilian risk programs were very different than those in the military."

While there were no opportunities to work in risk management in her new position, the differences between military and civilian health systems ultimately led her to become interested in health policy issues. She began to ask herself questions, such as: Why is civilian health policy so different? How were these systems built? How did we get here?

In an effort to learn more about these and other issues, she began to focus on earning a Robert Wood Johnson Health Policy Fellowship, but it took some time before she felt she was competitive enough to apply. "So I started to ask myself, 'What can I do to increase my value to this program so that they would accept me?'" she said.

It was during this time that she began a master's program in public health. The September 11 attack on the United States also occurred, leading to vast improvements in state disaster preparedness programs. Having served in the military, she was familiar with disaster

Patient safety fellowships: a perspective

By Joe Murphy, M.S., A.P.R., NCPS public affairs officer

The Patient Safety Fellowship program offers in-depth education in patient safety practice and leadership, as well as a chance to broaden one's exposure to a wide range of related issues that can enhance patient care.

"I am so glad that I did the fellowship because I had so many unique experiences," said Maggie Mizah, a VA pharmacist and past patient safety fellow, 2010-2011, serving at the VA Pittsburgh Healthcare System.

A number of the initiatives Mizah worked on were not directly related to her field, but offered a rich learning experience, such as work in project management. "I identified the need for a project, helped develop a project to fix the problem, and then helped implement it. It was completely invaluable," she said. "I've developed new skills I can take with me to address issues that might come up in the future at our pharmacy."

One such project involved working at the VA Pittsburgh's physical therapy clinic. "I worked with them to redesign the clinic's scheduling process so they could see more patients, increase customer service, and try to reduce their no-show rate," said Mizah.

The project was a local effort in support of the VA's National Initiative to Reduce Missed Opportunities. In this case, if a patient was a no-show or didn't call to cancel an appointment, another Veteran would miss an opportunity for that appointment. "I was given the freedom to review their program and suggest changes," she said, "with the hope that some of the ideas could be implemented nationally."

"These and other projects were of great value to my fellowship because it gave me experience in communicating and working with interdisciplinary teams," Mizah continued.

One such team, the Patient Safety Triage Committee, was developed by VA Pittsburgh's fellowship director in an effort to improve reporting. She said the director felt the previous way of reporting was cumbersome, resulting in few reports. "I think a lot of people were unaware of how to report," Mizah noted.

"You had to go to a Web site and fill out a form. He wanted to simplify this."

An email address was created that allowed staff members to easily report an issue. The committee would investigate it and bring the findings to the executive leadership board's monthly meeting.

Like many other fellows, she participated in a multidisciplinary root cause analysis (RCA) team. "I felt everyone was very committed. I was really impressed by how deep people dug and the details that we came up with," she said. "The team was very successful in uncovering a lot of issues and developing a strong action plan."

Mizah gave a presentation to residents during one of their daily noon conferences on the VA's approach to patient safety. "I gave them a baseline introduction on how we in patient safety would 'diagnose a system' and what might be an appropriate organizational response," she said.

During Pharmacy Week 2010, she also gave a presentation that concerned the importance of reporting adverse drug events, which are under reported by as much as 94 percent.¹ "The facility scheduled events that all staff members were invited to attend," she said. "I developed a poster, an educational brochure, and spoke to a number of staff members during one of the events."

In another activity related to her field, Mizah acted as a "change agent," an important aspect of a fellowship, at VA Butler Healthcare. She and other team members examined the facilitators and barriers to implementing the Patient Activated Medication Mailing initiative.

"We wanted to demonstrate that we could save money by avoiding automatically processing prescriptions. Instead, patients would have to request them," she said.

Mizah explained that in the VA's system, when a physician renews or creates new prescriptions, the orders go into an electronic pending file, which pharmacists use to fill them.

"So the patient never has to contact the pharmacist and say, 'Fill this for me,'

like you do in the private sector," she said.

Her team noted that other VA pharmacies, such as those at the VA Central Iowa Healthcare System and St. Cloud VA Healthcare System, had decided not to process prescriptions from the pending file, but only fill prescriptions that a patient requested, educating patients within their regions about the change.

"So by doing this, they found on average that 20 percent of their prescriptions were left in the pending file," Mizah continued. "So a pharmacy could cut its prescription volume by about 20 percent by not filling prescriptions that patients don't actually need."

"The cost savings can be significant," Mizah said. "If the Butler VA were to prevent a similar amount of unnecessary medication fills, and the prescriptions were filled through a consolidated mail outpatient pharmacy, the cost savings during the first quarter could be close to \$250,000, or about \$1 million annually."

"When I look back on some of my projects, I just can't believe how much I've learned," she said.

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Learn more

NCPS and the VA Office of Academic Affiliations (OAA) have partnered to offer one-year fellowships in patient safety: 36 have been selected as fellows since the program began in 2007. Funding is provided by OAA.

The fellowships offer post-residency-trained physicians and post-doctoral or post-masters-degree-trained associated health care professionals (such as nurses, psychologists, and health care administrators) in-depth education in patient safety practice and leadership.

Click to http://www.va.gov/oaa/specialfellows/programs/SF_patient_safety.asp?p=12

New surgery data indicates reduced harm to patients

By Joe Murphy, M.S., A.P.R., NCPS public affairs officer

A VA report published in the *Archives of Surgery* online edition, July 18, 2011, indicates a continued overall decrease in the number and severity of wrong site surgeries in the VA. Two hundred and thirty-seven incidents were reviewed (101 adverse events and 136 close calls) that occurred from mid-2006 to 2009.¹

“We found decreased harm to patients compared to a previous report published in 2009, which covered events from 2001 to mid-2006,” said Peter Mills, Ph.D., director of the NCPS field office, White River Junction, Vt.²

“The rate of actual adverse events per month and the severity of those events also has significantly diminished in the operating room,” noted Julia Neily, M.S., M.P.H., R.N., lead author of the report and associate director of the White River Junction field office.

The rate of reported adverse events decreased from 3.21 to 2.4 per month; reported close calls increased from 1.97 to 3.24 per month – indicating that VA surgical services continue to report and investigate adverse events and close calls.

Sometimes known as “near misses,” close calls occur when a problem is caught *before* any harm could come to a patient. Because they can occur anywhere from 3-to-300 times more often than actual adverse events,³ close calls are given the same level of scrutiny at the VA as adverse events that result in harm to a patient.

“An increase in close call reporting is a very positive sign,” Neily said. “A willingness to report problems is essential to safe care.”

The data was derived from the VA’s Patient Safety Information System, which provides a confidential, non-punitive method for users to

electronically document patient safety information. Lessons learned can benefit local care efforts or in some cases the entire health care system.

“Root cause analysis reports within the database were our primary source of data,” said James Turner, an NCPS analyst and coauthor, “though we found some useful safety reports. Nothing was taken from patient medical records.”

The root cause analysis (RCA) process is a multi-disciplinary team approach used to study adverse medical events and close calls. The goal of each RCA is to find out what happened, why it happened, and what must be done to prevent it from happening again.

Many possible reasons for the decrease in adverse events were noted, to include the implementation of the Medical Team Training (MTT) program at VA medical centers nationwide. MTT was developed to improve patient outcomes through more effective communication and teamwork among providers.

A 2010 VA study, “Association between implementation of a medical team training program and surgical mortality,” was published by the *Journal of the American Medical Association*. The study found an almost 50 percent greater decrease in the annual surgical mortality rate in groups trained in MTT methods, as opposed to untrained groups. It was also noted that the longer MTT methods had been practiced at a medical facility, the greater the decrease in mortality.⁴

The most common root cause for incorrect surgery noted in the current report was “Critical Clinical Processes not Standardized.” In these situations, a clinical process was left to the judgment of a clinician to accomplish, rather than having a specific approach the clinician could have followed.

Human factors problems were the second most common root cause, and include issues with the human-machine interface, look-alike packaging of

different implant components, and fatigue.

The VA is implementing several initiatives to prevent incorrect surgical events in collaboration with VA surgical leadership. Other efforts include providing team training for staff in non-operating room settings, such as cardiac catheterization labs, and a sustained commitment to improve communication and teamwork through programs such as MTT.

“We are going to continue to seek ways to reduce wrong site surgery,” said Neily, “It’s an essential part of the VA’s goal to reduce harm to patients as a result of their care.”

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Introducing our new director, Robin Hemphill, M.D.

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systems and disaster response. “It was an area of evolving health policy that I felt competent to speak to and to participate in,” she noted.

Dr. Hemphill became medical director for the Tennessee State Health Resources and Services Administration Hospital Bioterrorism Preparedness Program, as well as for the National Center for Emergency Preparedness at Vanderbilt. She was also involved in local planning and preparedness issues for the city of Nashville and was the medical director for the Nashville Urban Search and Rescue Team.

“It was a big leap and most people thought I was crazy,” she remarked. Her colleagues understood how it fit in with her military background, but couldn’t see the public policy angle. But for her, these new positions were a great fit: “Public policy was being driven very rapidly. A lot of money was being thrown at the problem,” she continued. “The question was how best to use the funding to build systems that would improve not just disaster responsiveness, but any response to problems of large population movements or crisis.”

Following work in these areas, she felt she had the resume and background that would make her competitive for a Robert Wood Johnson Health Policy Fellowship. She was accepted in 2005 and assigned to the office of U.S. Senator Jeff Bingaman. Dr. Hemphill was to work on a variety of issues, including health care quality, health care disparities, FDA issues, and public health preparedness legislation.

The journey to NCPS

After completion of the fellowship, Dr. Hemphill joined the Health Care Solutions Group at Vanderbilt, serving as the associate director, focusing on policy related to state-based coverage initiatives and health care quality.

She was astonished at the contrast between Washington, D.C. and Tennessee.

“After spending time in Washington, I got the sense that quality and safety was a tidal wave,” she said. “Everybody was talking about how better quality was going to improve value and services could be expanded. That was the mantra when I was in D.C. How discordant it was to come back and suddenly realize nobody was talking about it in the same way.”

She understood that leaders in Washington were becoming impatient with physicians, believing that they weren’t working quickly enough to improve quality and safety for patients. “We needed to do this ourselves,” Dr. Hemphill added, “or somebody was going to do it for us, and we probably wouldn’t like the result.”

During this time, she moved from Vanderbilt to Emory University to become the director of quality and safety for the Department of Emergency Medicine. In this position, she worked to improve the quality of health care delivery and conducted research to better inform state and federal health policy in the area of quality, value, and efficiency.

“I was really getting back down to basics, thinking ‘How are we going to create better systems and put them into operation?’” she said. “About this time, I had the opportunity and good fortune to come to NCPS.”

Looking to the future

“I think there are a lot of challenges, even though amazing work has been done in VA patient safety,” Dr. Hemphill said. “If the VA wants to continue to be the leader in safety for the nation, we really need to take a step back, not rest on our laurels, and ask ourselves, ‘What is now the cutting edge of patient safety?’”

She spoke of the array of tools created at NCPS over the years: “An extraordinary group of programs and initiatives have been created by past and current staff to help us dive deeply

into why problems have happened and why they affected a patient.”

“But I believe to get to the next level, we should partner with other professionals who have other areas of great expertise and great focus,” she continued. “For instance, we’ve got quality managers, risk managers, information technology and systems redesign people. Each brings a different set of tools to the table. So when we say we have a problem, let’s make sure that we use all the tools at our disposal to systematically, thoughtfully solve it.”

Outcome measurement is particularly important to her: “You have to actually implement solutions and make sure the intended outcome is the achieved outcome. That you made a difference. That you made it better for the patient.”

Dr. Hemphill believes that to achieve intended outcomes, NCPS staff and those in the field should work closely together. “We can come forward and say, ‘This is the problem. We have tried to understand it, put forth recommendations, and tried to help others understand the strength of each recommendation.’ But we also need to ask questions such as: ‘Did you implement the recommendations? Did you implement them correctly? Do you believe you made a difference?’ It’s got to be a two-way street.”

She is also concerned with “change fatigue,” which she defines as asking people to make one change after the next without them ever clearly seeing the result of their efforts.

“Change can be hard,” she said, “but if change comes, and people find it to be successful and their lives are better, they’re going to feel great at the end of the day. People who never see the results of their efforts can easily get burned out. That is something I really want to avoid. We need to take great care to ensure what we develop is achievable and measurable.”