

## Lee Sacks MD - Answers to Audience Questions from March 3, 2006 CPSF Annual Scientific Meeting

1. Status of outpatient medication reconciliation
  - a. We have 3 ambulatory groups as part of the Advocate Health System. All 3 are participating in our medication reconciliation initiative and are aware of the need to carry medication reconciliation. We are working on a process to identify who is responsible for this activity and especially attempting to define the roll of the primary care physician and the consultant.
2. Strategies to engage Residents:
  - a. We are implementing a Culture of Safety within the Advocate system. All 3 sites with Residents have mandated that all Residents receive the same education we are providing for our physicians and associates. We are currently developing reinforcement strategies for all Advocate staff including Residents. We have created a CD which is a one hour review of the safety behaviors we expect from all members of the Advocate family including Residents. We will provide safety education within our new physician orientation and all Residents who rotate through an Advocate hospital will be required, at the very least, to listen to the one hour CD.
3. Medical Director's ability to effect change within unrelated medical groups:
  - a. While there is some institutional independence all of our Medical Groups and Medical Staffs relate directly to the system and are active participants in the Culture of Safety initiative. The Medical Directors of all our hospitals and our 3 medical groups have been educated as to expected behaviors and have championed this education for their medical staffs. Other physician champions have also been identified and are key to physician buy-in. 2100 of our "independent" medical staff members are part of Advocate Health Partners- our care management and managed care contracting entity. AHP has a clinical integration program with pay for performance and has included completion of the above mentioned CD and CME for OBs in fetal heart rate monitoring as criteria in the P4P program.
4. Which communication interactions cause the most communication adverse events:
  - a. Analysis of past cases has identified the handoff process and verbal telephone orders as the two most problematic areas. We have active education programs in new techniques for handoffs and have had a very effective focus on read backs and repeat backs.

### Questions directed to whole panel

1. Assumption of competency that allows for a no blame culture
  - a. We are working towards a Just Culture within Advocate. Such a culture requires that we measure competency on a continuing basis and we are doing that. Within our nascent Just Culture there is an understanding that individuals are appropriately accountable for their actions.
2. Definition of Safety:
  - a. Our definition of safety is "the absence of harm."
3. Need for Pediatric customization
  - a. Our focus is on behaviors that lead to safer performance. These behaviors, such as critical thinking or paying attention to detail are neither age nor gender specific and apply to all health care providers in all situations
4. Good CPOE system for community hospitals without Residents

Advocate is implementing a CPOE system across the system. This is difficult work and involves changing lots of processes. We are using the Cerner product in the hospitals and have now implemented at 5 sites- 3 teaching and 2 community. There are examples of problems and successes at all the hospitals, so the issues are not specific to teaching or non teaching hospitals. CPOE will be a work in progress for a long time. We have also implemented EPIC at the Dreyer Clinic and Allscripts Touchworks in parts of Advocate Medical Group.