



Chasing Zero: Behind the Scenes May 20, 2010 Webinar Transcript

Charles Denham: Good day. We are very delighted to welcome you to the TMIT High Performer Webinar, *Chasing Zero: Behind the Scenes*. This is Charles Denham, chairman of TMIT. And for those [who] are logging on, safetyleaders.org is our website where you can attend.

We are very delighted to have a terrific group of speakers and panelists today. We will ask Sue Sheridan, who is one of the – we say stars of the *Chasing Zero* movie, *Winning the War on Healthcare Harm* – to open us, as is our typical fashion. We like to open and close our webinars with a patient family representative, and I can't think of a better one than Sue Sheridan, who will also be a panelist. Sue, go ahead.

Susan Sheridan: As a patient, as a mom of a little boy who suffered brain damage, and as a widow due to failures in our healthcare system, one might say that I'm passionate about patient safety. I'm excited about patient safety, although over the last decade, some have said we've seen little progress. I've had the opportunity to see progress, primarily because of dedicated, gutsy, courageous, passionate people. So I thank all of you for taking the time today to attend this webinar, to listen to the message, and look at the Behind the Scenes of *Chasing Zero*. So welcome, thank you for your time, your resolve, your energy, and please, after this webinar, share the message with others in your institution that there's incredible opportunity to create a safer healthcare system and partnership with patients. I'll pass it back to you, Chuck.

Charles Denham: And before we start, I'd just like to let everybody know that we are in full support of Dr. Don Berwick, the recently nominated head of the Centers for Medicare & Medicaid. And Dr. Berwick will be up for very, very careful review before he would be confirmed. And we'd like to recommend that you all contact Senator Chuck Grassley of Iowa either by phone call or by e-mail. And the e-mail addresses are on this slide. And we'll have Hayley Burgess, our director of performance improvement, and our staff people on these webinars, make sure that this slide is available. There won't be slides to be downloaded today. Many are pictures, there are personal pictures of Dennis Quaid and his family, and they were just too large to be able to be downloaded, but we'll have her whittle down the deck and make sure that this slide is available for those [who] want to respond. I think it's really important that we contact both Senator Grassley and Senator Baucus. This really isn't about partisan issues, it's really about principle. And as a political independent myself, you know I – and a military brat – I was always taught you support your government and you support what's going on for the betterment of the whole. And so TMIT is taking an independent position – a nonpartisan position, but we really believe that based on principle that Dr. Don Berwick would be a terrific leader of CMS, and we are in full support, and we know that our public servants look at these e-mails, they look at the letters that are sent, and they look at e-mails. And so we'd just like to start that off as well.

I'm only gonna take a few minutes to click through a series of slides. This is the flash screen or the landing page of safetyleaders.org. You can watch the trailer on the first page by clicking on the video or going to the Discovery Channel section and click on that. Also, there are some assets that you'll be able to download, and you'll be able to download the slide with the e-mail addresses and addresses to be able to contact the two senators [who] are most important regarding the confirmation of Dr. Berwick and contact them as well, and that'll be posted for you later today.

The article, "Story Power: The Secret Weapon," is an article written by Dennis Quaid, myself, and Julie Thao; and there'll be other assets that'll be available to you.

Our disclosure statement is that TMIT did have an educational grant from CareFusion for the movie *Chasing Zero* and coproduced this with Discovery Channel and funded – TMIT was the third funder of *Chasing Zero*, and AORN was a small funder as well as CareFusion; and the financial relationship with

the Discovery Channel was one of providing funding to Discovery Channel for the portion of production that they undertook. Dennis Quaid has no relevant financial interest; Dr. Henderson and Dr. Phillips are employed by the Cleveland Clinic; and Sue Sheridan has no relevant financial interest.

So our roundtable includes Dennis Quaid, the movie actor, who is now our partner at TMIT. We wish that he could be in attendance today and comment. However, he's gonna be giving about a 20-minute speech. We have a recording for you that is also available on SafetyLeaders (<http://nice.safetyleaders.org/index.jsp>), and then we'll have reactions and comments and the process and principles provided to us by Sue Sheridan. Sue is the leader of the Patients for Patient Safety program for the World Health Organization, a wonderful champion for patient safety, co-author with us on a number of articles; and she'll be participating with us in our future documentaries and really championing the cause for patients. Dr. Michael Henderson, the chief quality officer for the Cleveland Clinic, has been a leading surgeon in the country and has been developing the safety programs for the Cleveland Clinic; and Shannon Phillips, the safety officer for the Cleveland Clinic; both terrific quality champions, and I think will share with us some very practical insight regarding patient safety and the content in *Chasing Zero*, both have been involved in it, and you can see both of them on our website, Behind the Scenes.

Our harmonization effort was these six organizations: AHRQ, NQF, [the] Joint Commission, Leapfrog, the IHI, and CMS. This expanded to a much larger group of about ten harmonization partners and then [the] 2010 Safe Practices were released April 12 at a National Press Club event with Dennis Quaid in Washington, and are available now (http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%932010_Update.aspx). They're organized by the same seven categories that the prior versions have been, but there is a major upgrade to the entire set, not the specifications, but the background information. And we worked very closely with the National Quality Forum. They did a fabulous job getting that book out for us, and for all of us nationally.

If you're on our main landing page (www.safetyleaders.org) and scroll down, you can see the "click here" button, which is demarcated in red, and if you click on that button it will take you to the NQF, and you'll be able to order that report of approximately 500 pages. We had 500 subject matter experts [who] participated, and it is the most harmonized set of national standards actually ever created.

Back to our landing page, you can watch the *Chasing Zero* trailer by clicking on the icon for the movie that you see in the left upper portion of the page, and then we also have been collecting the video clips and support information that has been available to us as we've gone through a number of media telecasts. The Global Patient Safety Summit, a GPS for Leaders, in the upper right hand corner of your screen was a meeting that we had in Nice, France, that was wiped out by the volcanic ash. And I'd like to say when they yell tsunami, grab your surfboards; when they yell volcano, grabbed the internet. We've now been able to capture about 70 percent of the content that was to be delivered then. The satellite telecast of the speech that Dennis and I gave is available streaming from our website, and Dr. Henderson and other leaders around the world have participated in webinars which we will be screening or broadcasting in the months to come.

If you click on the area where you see the red box for "related articles and coverage," you can understand Dennis's commitment to safety, and how he's joined TMIT. And also in the news, video clips, which we actually will be providing shortly as a media reel that helps leaders understand how consumers have now been activated by this work.

I'm clicking forward quickly, and you'll see that you can now watch in pretty high resolution on our website by clicking on the area to watch the movie from our landing page. You can watch the entire movie from our website. You can also watch it from the Discovery Channel. However, we have it streaming at pretty high resolution taking up, you know, a half to three-quarters of your screen.

If you want to move around our website (www.safetyleaders.org/discovery/) and hear about the themes of the movie, you can do so, and we have the who, what, when, where, how, and why the movie was put together.

Under "Progress to Date" [tab], you'll see a number of clips: those [who] were in the movie including Dr. Henderson and Dr. Phillips and other physicians and leaders and nurses from Cleveland Clinic, Mayo Clinic, and Vanderbilt, the Brigham and Women's Hospital, and Johns Hopkins.

The airings, there's one more airing, which will be July 31st and the other networks, now it's being seen all over the world through the World Health Organization and other organizations that are distributing it. We'll have DVDs available for hospitals. We'll be giving it to all 5,700 hospitals and also developing a toolbox for boards and for retreats and quality retreats that will likely be released in the next six weeks, but there's still one more airing on Discovery. We have a number of behind-the-scenes video clips. You'll see Dr. Nicholas Smedira from Cleveland Clinic, and Julie Morath from Vanderbilt, and we have a number of clips behind the scenes that many caregivers have really enjoyed.

And finally, we are collecting viewer responses on the movie, and responses from board members, clinicians, caregivers, purchasers, and a host of other folks. You'll also be able to get CME, CEU, continuing legal education credit, administrative credits, and credits for pharmacy, for pharmacists through Discovery Channel's CME website. And then the Global Patient Safety Summit that I referred to, we'll have streaming audio and video from this conference (<http://nice.safetyleaders.org/indexPresentationMaterials.jsp>) that was to be held in Nice. We had 1 of 40 speakers [who] made it, and that one of them is Dr. Henderson, who's in this webinar. And we'll have a number of assets that will be able to be downloaded from this virtual set of global sessions.

So starting next month, we will start having recordings of webinars that we undertook in the middle of the night with leaders from Scotland, from Germany, from France, from all over the world, that we did immediately after the Nice meeting was wiped out by the volcanic ash. And the assets: video, audio, and also articles, proceedings – a supplement will be produced by the British Medical Journal Group and their quality and patient safety journal [*Quality & Safety in Health Care (QSHC)*] that we will be producing in the next six months. It will be approximately 80 pages, and it will capture the essence of those webinars. They'll be highly referenced, and there will be scholarly articles that will capture the essence of what the messages were.

I'm going to stop there and hand the ball over to our team in Austin, who will now play Dennis Quaid's speech, and Hayley Burgess will advance slides tied to his speech. And then I'll end that with just a couple of comments of Dennis's wishes for you and then we'll open things up to our panel.

[Pre-recorded excerpts from April 22, 2010, keynote presentation via satellite to 2010 International Forum on Quality and Safety in Healthcare held in Nice, France (full version at <http://nice.safetyleaders.org/index.jsp>):

Dennis Quaid: Hello, everybody. It is both humbling and exciting to give the keynote speech to such an incredible group of safety leaders from around the world. You know, as an actor, I get to play action heroes. However, you who lead hospitals and healthcare organizations will now get to be heroes.

Now that we know so much about reducing preventable harm, it is your time in history to make an enormous difference. In the journey that brought me here today, I have found out two shocking truths: first, the staggering magnitude of healthcare harm that occurs in healthcare; and second, how much of that harm is absolutely preventable. Dr. Lucian Leape, the father of patient safety in the United States, taught us that up to 100,000 deaths occur each year in America due to healthcare harm, making it the eighth leading cause of death, and that was in 1999. That is the equivalent to more than ten 747 jumbo jets full of Americans going down every week. Now when you add in the infections patients get in United States hospitals, it doubles that number, which means that now more than 20 jumbo jets are going down each week, making healthcare harm the third leading cause of death in America. Yet this epidemic is invisible. It has spread over more than 5,000 hospitals and happens quietly and insidiously. The public is

unaware, and many of our healthcare leaders are unaware of this in our country. And I understand the same problem exists in many countries around the world. Now, that's the bad news.

The good news is even more shocking. In my journey I have found that we have the means to dramatically reduce preventable harm to almost zero. However, the general public, policy makers, and many healthcare leaders are unaware of this, which I find absolutely amazing. So my mission today is to drive awareness. Awareness of the shocking amount of harm we have and that we can prevent a huge majority of this harm. My message is a call to action.

I have found a role that I can play, and it is to partner with the best experts and drive awareness of what we can do if we act now. I will succeed today if I help you drive action of our leaders through awareness: awareness of both the harm and the opportunity to save countless lives.

Stories. Stories have power, and you, as leaders, must become storytellers. We need you. We need you to both embrace and tell the stories of success, not just the dramatic stories of harm. Awareness is more than just knowing. It is about feeling, feeling the pain and suffering of the victims and their families, for they are more than just statistics; feeling the inspiration from great stories of great role models who can inspire us to action.

You likely have heard a lot about the evolving healthcare reform in our country. Full care reform is impossible without dramatically cutting preventable harm. It will save lives, save money, and restore the sacred trust between patients and caregivers. Zero harm is the number, and now is the time. All of the leading experts are teaching it.

My story, the story that brought me here today, was the near-catastrophic medical accident of our twins, T. Boone and Z.G., as my wife Kimberly and I call them. Until then I had heard my share of medical horror stories, but they were mostly secondhand. I, myself, had my portion of typical hospital stays, but I had faith that I was in a safe place, faith that the doctors, nurses, and pharmacists knew what they were doing and never made mistakes. I had confidence that I would live to see another day because, after all, the reason I was in the hospital to begin with wasn't life-threatening.

Well, little did I know how dangerous any hospital can be. Now, I'm not here to denigrate doctors, nurses, pharmacists, or any other caregivers. I revere them. They have dedicated their lives to curing the sick and easing human suffering. They are overworked and underappreciated. They are also human, and all humans make mistakes. I have now learned that the overwhelming majority of healthcare harm is due to failure of the systems that support them. We don't have bad people, we have bad systems. Our support systems have just not caught up with the complexity of care. The good news is, we can fix them.

On their tenth day of life, our twins were admitted to hospital with infections requiring intravenous antibiotics. While my wife and I were in the room, a nurse unintentionally gave our children 1,000 times the dosage of a dangerous blood thinner called heparin. Unaware of what had just happened, Kimberly and I were exhausted, and our children appeared to be safe and sound. So we went home to get some rest. We had no way of knowing that the potentially lethal quantity of heparin in their tiny bodies was turning their blood to the consistency of water. That night, another injection [of] 1,000 times the intended dose was administered to our precious children. At about 9:00 that night Kimberly was suddenly struck with a hammer blow of overwhelming dread. She became inconsolable, crying out with a mother's intuitive certainty that our babies were in trouble. "They're passing," she said. So I called the nurse's station. We were told that the twins were fine. The twins were not fine. In fact, they were fighting for their lives. They were bleeding out of every place they had been poked or prodded, and their now water-thin blood had the real possibility of hemorrhaging through a vein or an artery, causing massive brain damage or failure to one of their vital organs. Our babies could have died that night and we would not have been there for them.

The next day was the most frightening day of our lives. It was spent caring for our infants who were still bleeding profusely and severely bruised from internal bleeding. They were both screaming in pain, and God only knows what they were feeling. At one point, as the doctors tried to clamp a bleeding wound in

the remnant of T. Boone's umbilical cord, blood spurted six feet across the room and splattered on the wall. The twins bled all day, and although they were given an antidote for heparin, their bleeding and lab tests remained off the charts all day and well into the night. Kimberly and I did a lot of praying. Finally, after 41 hours, their coagulation levels dropped into the normal range. T. Boone and Z.G. had survived, apparently with no damage.

Now, how had this happened? The answer became all too apparent. After interviewing the doctors and team nurses, we discovered that the similar labeling of the vials of high-dose and low-dose medication is what led to the overdose of our twins. Further, the same error happened in Indianapolis the year before, causing three tragic deaths and injuries to a number of children. Now I am pleased to report that the twins are doing fine. I firmly believe this was due to a lot of praying by a lot of people who had heard of our twins' plight in the media. I have to believe a few of you were right there in that room, and I thank you for that.

I believe that there was a reason this near-tragic incident happened to us. Through these precious children and their story was the opportunity to turn lemons into lemonade by helping prevent something similar [from] happening to someone else's kids and loved ones. After the event, Kimberly and I started The Quaid Foundation and carefully began to learn about patient safety. Along this journey, I met Dr. Charles Denham, the founder of TMIT, who introduced me to leading experts in safety and helped us understand that the real sweet spot for safety envelope for high-performance care is at the intersection of three systems: leadership, safe practices, and technology. If these support systems are functioning within the right organizational culture, we get great care, and we get safe care. So if the job is to accelerate the development of great leadership, adopt safe practices, and implement technologies, as well as creating an organizational culture that will support these systems, how are we going to do this? What role must you and I play?

Let's talk about leaders. What if we had consensus around the practices that leaders could implement at all U.S. hospitals that could even be embraced by you around the world? Well, we do. The National Quality Forum has a special designation by the United States Congress to develop measures, standards, and practices. I was honored to be with Janet Corrigan, the NQF CEO, and be involved last week in the release of the *2010 Safe Practices for Better Healthcare*, which is a blueprint for leaders. These Practices address the most common areas of preventable harm, including medications, infections, and testing. Many are the same as the World Health Organization's safety solutions so many of you are adopting. They include adoption of technologies like computerized prescriber order entry, or CPOE. In a flight simulator, to measure its effectiveness, they target harmful events our government calls "hospital-acquired conditions" that we understand are already built into the new United States healthcare reform incentives. Immediate action, however will require courageous leadership.

Safe practices: Safe practices are standardized methods, with predictable results. All humans make mistakes. Human error combined with systems failures causes the majority of harm due to medical accidents. Now, I'm an actor. If I make a mistake, it's called Take 2 or 3 or 4 or 37, and believe me, I've been there. But if a caregiver makes a mistake, it could mean somebody's life. Hospital staff, more often than not, are working without a safety net, working sometimes double shifts; they are expected to make crucial decisions with clarity and sound judgment for every patient in their care, often without any backup except for maybe the overworked caregiver working beside them. Practices like checklists reduce the probability of error and harm. Now, once you have engaged leaders and introduced standardized practices, enormous power can be delivered through innovative technologies.

Healthcare needs more of what the airline industry figured out long ago. Safety-centered design is technological backup for human factors-related error. The innovative instruments in modern airplanes are essentially a safety net that aid a pilot in flying the airplane safely, even when conditions are zero-visibility, and to alert him if he makes a mistake. Even the pilots with the right stuff (a little personal career thing). Things happen when they operate an aircraft outside of the safety performance envelope. Now, that envelope is defined by their own human performance in the airplane's technology. Technologies like bar-code systems, smart infusion pumps, electronic medical records, automated infection tracking systems, and CPOE all require investment and safe adoption, but they can have a huge impact on safety.

A full-scale approach at getting to zero healthcare harm will have to involve all stakeholders, and they are getting involved. Dr. Allan Korn is the Chief Medical Officer of our largest insurer in America, representing 100 million covered lives. He is leading National Blue Cross Blue Shield safety programs to activate hospital boards to invest in developing leaders and pursuing programs to reduce central-line infection. Dr. Don Wright, our deputy assistant secretary of health, is leading the charge on healthcare-associated infections for the entire United States government. His goal is elimination of infections we give patients in hospitals.

So I am at a waypoint in my journey. We have merged our Quaid Foundation into TMIT in order that I can more effectively play my role of helping drive awareness of the opportunity to truly chase zero harm. We will do so with the more than 3,100 hospitals and 500 experts that work with us in the United States and groups we are starting to work with around the world. It is time to make a call to action to encourage policy leaders to tie safe practices to healthcare reform, challenge hospital leaders to adopt them, and ask the public to demand them.

Chasing Zero: Winning the War on Healthcare Harm, coproduced by the Discovery Channel and TMIT. We are thankful for the educational financial sponsorship by CareFusion and David Schlotterbeck, its chairman and CEO, and the AORN, the Association of periOperative Registered Nurses, who were financial sponsors and actually play a role in our film. Our documentary uses patient and caregiver stories to demonstrate that zero harm is within reach. It provides examples of chasing zero role models that will inspire and encourage others. We even have stories of some of the unsung heroes of patient safety like cleaning staff who have developed checklists to reduce infections and medical students around the world who through their "Check a Box. Save a Life" program are already saving lives even before they get their MD. Some of their student leaders are like Dan Henderson.

After the documentary airs on the Discovery Channel, we will give it to every hospital board of directors in the United States, and it will become a continuing education program for caregivers. We hope the international audience will want to use it as well. It will be available free of charge streaming from our website, safetyleaders.org.

Great quality leaders, like Dr. Mike Henderson from the Cleveland Clinic, Dr. Steve Swensen from the Mayo Clinic, Dr. David Bates from the Brigham and Women's Hospital, and Julie Morath from Vanderbilt University, are all in the documentary and represent great organizations. They are great role models who can help us blaze a trail to a new level of safety.

Looking forward to the future, we envision engaging those from industries like the aviation industry, interested in helping us accelerate the development of our leadership, safe practices, and technology to speed our learning curve. People like John Nance, an aviation and media expert who, like many other experts, believes we can learn a great deal about patient safety by applying the disciplines of safety in the aviation industry, such as the creation of the National Transportation Safety Board or the NTSB. This national program studies U.S. transportation accidents with real scientific rigor. We need a similar approach in healthcare. If an NTSB investigation of the heparin accident in Indianapolis had been done, and a report generated, perhaps our twins would not have suffered their accident, and I would not be speaking to you today.

Other safe practices from aviation, such as simulation and teamwork training, as well as the use of technologies that protect us from human error, have great value and application in healthcare. Stories can unify the head and the heart of our leaders to put their hands to work. In our recently published article entitled "Story Power: The Secret Weapon," we address how stories can have an impact in activating the inner David of our healthcare leaders to attack their Goliath: fear. Fear of malpractice. Fear of failure. Fear of shame. That they might indeed have a bigger problem than they realized. At first glance, the worlds of reason and that of emotion would seem to collide, yet the research in almost any industry reveal that they coexist in great leaders. It turns out that both leadership and storytelling are what business experts consider performance arts. Leadership is essentially a task of persuasion, of winning people's hearts and minds. A story expresses how and why life changes. It begins with a situation in which life is

relatively in balance. Then there is an event called, in screenwriting, the inciting incident that throws life out of balance. The hero or protagonist has to deal with the challenge, discover a truth, go into the darkness, and ultimately rise to the occasion. Every story has a hero, a victim, a villain, a crisis, and a resolution.

We clearly have a patient safety crisis. Our villain is an enemy that never sleeps and that is systems failure. Both our patients and our caregivers are victims. We need heroes to step up, at a time when resources are in short supply, and invest their minds, their hearts, and their dollars in patient safety. Heroes take personal risk to help someone else. There has never been a more urgent time for our leaders to become action heroes, and the action that they must take is to face their fear of short-term financial pain in order to protect their patients and caregivers. They must have the faith that good care is safe care. And safe care is good business. The most powerful stories today are those of great caregivers and organizations who live in that high-performance envelope of leadership, safe practices, and technology dedicated to safe, high-performance care.

I want you to think about your own story. Every story has a hero, a victim, a villain, a crisis, and a resolution. I want you to see yourself as a hero. It is time to write your own story. Your villain is the status quo, the way we have always done it, now fueled by cost pressures. The crisis is happening right now at your facility. We are harming patients, putting our own caregivers at risk. They both are future victims. As your friend and champion, I am asking you to embrace new safe practices like the NQF Leadership Practice. Look for ordinary things that can have extraordinary impact. Look for training opportunities to equip your people and become a storyteller to the troops.

The great organizations of people who will help us push the envelope and make the zone of safe care bigger for all of us and our families will prove to be those who truly have the right stuff. My request of those of you who have not yet stepped up and made safety Job 1: please do so now. Don't be the last action hero in your community. Zero is the number and now is time. It is time for you to play your role. Here is your cue. The cameras are rolling. So as we say in the movie business: action!

Charles Denham: But I would like to turn to Sue Sheridan. Sue, you were one of the major stories that was in the *Chasing Zero* movie, and had the opportunity actually of telling your story and having that impact; but also have the story unfold of this new reunion with the hospital that was involved in your son's accident. And we would like to turn things to you and have you react to Dennis's speech and also your role in the movie of *Chasing Zero*.

Susan Sheridan: Well, thanks, Chuck. First of all, hearing Dennis's speech, I've heard it several times and it still moves me. As a mother, you know, Dennis, I think as a father, and – can totally relate to his determination, his emotion, and I'm so thankful for him for embracing this initiative. You know my reactions to being a part of this, first of all, it provided, like Dennis said, and like Chuck has said, the importance of storytelling.

Often when harm occurs in healthcare, to the family it often feels like it simply didn't matter. So to hear Cal's story and Pat's story to the public made me feel like it did matter, and that the listeners and the viewers and those who watched the movie, I hope that they ask themselves, if they are institutions, it's safe when it comes to jaundice? And does their institution have appropriate mechanisms in place to ensure that pathologies don't get lost? So as a patient it was very powerful for me to share just a very human story in the hopes that those stories would touch people's lives and make sure that they implemented changes in their institutions to prevent what happened to my family.

And you know, another reflection I have about being part of it was the redeeming moment and a very unique moment, that by the simple virtue of filming this, it provided a mechanism to unite a hospital, the hospital where Cal was born, and myself, who for over a decade have been separated by fear. You know, in our separate corners, really not knowing each other, I think wanting to reach out to each other, but never really having that pathway. And so just by filming this it gave us this remarkably powerfully human opportunity to sit and talk about it. And of course I applaud the hospital for stepping up and for having the courage, as Dennis referred to the inner David, to step up, visit with me on film, and to agree to go

forward together, a patient and a hospital, to improve patient safety, to chase zero, and to create a patient advisory council that currently does not exist, but a patient advisory council that is robust in the patient safety area that will indeed help change policy, that will be involved in all levels of teaching, of implementation, of working directly with the community to drive safety.

So that was just an incredible opportunity for the two of us, the hospital and myself, and my family. So we're right now at the planning stage. We have a whole series of meetings planned where we're gonna look at how do we take our energy that we both have and combine that energy and bring in our communities, the mothers, the dads, the sisters, the soccer moms, the grandmas, to drive change at the hospital.

So those were, you know, powerful reflections, powerful opportunities for me, you know as a mom, as a widow, and as a community member of Boise, Idaho.

Charles Denham: Great. Thank you so much, Sue. I'd just like to ask you, what did it feel like to be filmed as your own story unfolded? It was so exciting to be in Boise and to hear the honest and genuine and authentic desire, as you later said, and move forward and be captured in the movie, but we got so many other clips of real commitment to move forward and question this concept of collateral damage or the cost of doing business aside and to look forward and to see, to team up with you and your community, what did that feel like as we were shooting that?

Susan Sheridan: Well, honestly, it was initially surreal. You know, I never imagined sitting with a Chief Medical Officer of the hospital where my son was born, and subsequently he suffered from brain damage from jaundice. So it was initially walking into the hospital, I think I was anxious, I was nervous, I was excited, I didn't believe it. But once we got to sit down and talk, it became very human. And I think so often hospitals and patients get, you know, separated by this chasm of fear, and sitting there with the Chief Medical Officer, neither of us were [*sic*] afraid. And it was human, it was exciting, I was nervous. But I think we both left jazzed and excited about our future opportunity.

Charles Denham: Fantastic, and we're so excited that you will now be actively involved in building the 10- to 15-minute digital short and toolbox that we'll be adding to the video, to the 53-minute movie. It will be in a DVD that we'll be distributing in about six weeks that teams can use to engage patients and families. We'll come back to that during the QA session. But I'd like to –

Susan Sheridan: Right.

Charles Denham: - advance the slide forward and ask Dr. Shannon Phillips to provide her reflections. Dr. Phillips is – and also ask her to describe what they're doing at the Cleveland Clinic tonight as they go forward. I was so impressed with Dr. Phillips and her energy, desire, her heartfelt desire, to really see performance improvement, and also her reflection of the power of stories at one of our highest performing organizations in the country. Dr. Phillips?

Shannon Phillips: You know, I think we spend a lot of time as healthcare providers talking amongst ourselves, and I think, too, the point of listening to patients and families and their stories is incredibly important because that adds a different dimension that we don't always take into consideration every day. You know their – I think they both, you know, talk about culture. A culture of always getting better, a culture of talking about things that don't work all the time well, you know. Healthcare is no more perfect than anything else. We are a group of humans trying to do our best. And you know, Dennis alluded to the simple things that we can translate from other industries that are just so important. And one of the things we took on as a call to action was the safety checklist. And the World Health Organization had put out a safety checklist to be used in surgical areas to cover those things you would never want to miss. And you know medicine is increasingly incredibly technical. There's a lot of things to remember. We can't ask every single person in the room to know everything. But we can ask people to work as a team and to collect together before they get started and make sure they have everything they need and let everybody own their piece of the puzzle and bring us together to make a picture.

So this is, on the screen now, a copy of the checklist that we put into place over the course of last year and made sort of an official date at the beginning of 2010 where we really expected it everywhere. But it was driven, I think very importantly, by our providers, by our surgeons and our proceduralists, who said, "You know what, we need this. We'll be better at what we do if we all talk to each other." So that kind of drive from the ground troops, but tremendous support from our leadership at the top, has made this incredibly successful.

So our teams meet now before every case and sign in, as we call it, or huddle and have a discussion about those things that we need to be sure we have lined up for the case. They do their timeouts; and then at the end of the procedure, they come back together and talk about key things, such as concerns for the recovery of the patient, but also an interest and important initiative for our hospital, is blood conservation. So we take a moment to kind of check out, do we have any blood products left and what should we do to disposition those. So it's a combination of regulatory things, the right things for the patient just as basic communication things, and then key quality initiatives that are important to us here at the clinic. And while, you know, I would say we continue to work at it, it has had a great impact here and it's a real culture changer. It's not just about putting a list up on the wall of things to do, but it's actually started some very good discussions and conversations about how to raise the bar and how to do this better. And so I challenge people, if they have not thought about this, to take it on because it's been a very powerful culture builder for us.

Charles Denham: Fantastic.

Shannon Phillips: So Chuck alluded to my evening tonight, and we round at the Cleveland Clinic quarterly, we walk the halls all night. So I will spend the night here with some of our executive leadership and leadership of major support areas in the organization to do safety walk-rounds. And I'm sure a number of you, if not all of you, do some form of these, where you connect the senior leadership of your hospital to front-line staff and make sure that they know that safety matters, and it develops often an ongoing relationship if an executive adopts the unit and they come back over and over again and help the unit catalyze change and improve what they do. It also facilitates a culture of speaking up, which is incredibly important. If we wait for tragedies like what happened to the Quaid family or to Sue's family to happen, you know we're learning that's true, but why can't we learn before it becomes something so tragic? So having a non-punitive approach that says, "Thank you for bringing that up; how can we make our system better?" Safety walk-rounds really brings that home, I think, incredibly powerfully. And so people see the things that happen as opportunities to make us better.

It's classically been – we've emphasized an executive adopting a unit and that has not been what we have done exclusively. We've really said that rounds don't have to be a one-size-fits-all. And there are a couple of ways to do this. So the classic executive adopting a unit is a very powerful model, and month after month the same person goes to the same place, and they act on the themes and the things that make it harder for that unit.

But we have a couple other ways that we're doing this, trying to find the right fit for the right area. An example would be in our children's hospital. We have a children's hospital within a larger facility for adults, and we've found it to be very effective for that group to round actually weekly for about 60 to 90 minutes. And that group goes not just through the children's hospital *per se*, but any place children are cared for. So we get the opportunity to interact with adult providers or areas that see a majority of adults and a little bit [*sic*] of children to make sure they feel like they have champions who will help them do the right thing for the children they care for. So that model of rounding has been very effective. And we also are trialing a model where an executive is adopting an institute here, which is kind of a structure, for instance, the Heart and Vascular, Neurologic Institute. In that setting, an executive is going to walk the inpatient and outpatient areas of a single clinical group, and again, help their executive leadership drive improvement.

And then lastly, the night walk-rounds are really, really fun. We take a group – we literally walk the 54 inpatient units here, the emergency department, and the ORs that happen to be running at night, and we ask people what they think could harm the next patient, what we could do to help make the job they

do safer for the patients they care for. And very often we can change things in the moment because we bring the right people to tackle the problem. But if we can't, the next morning our CEO and those who didn't walk, whoever didn't walk that night, gets a copy of what we found and they do move the world. And so they're very powerful, and if you don't use executive walk-rounds in your area, your hospital, I really encourage it. It's been a very powerful tool for us. Walking nights and weekends also is incredibly powerful.

Charles Denham: Great. Thank you so much, Dr. Phillips. And I clicked rapidly through your slides. Do you want to add anything at the end, who on the rounds?

Shannon Phillips: No, thanks. I think the thing to keep in mind is be flexible. Your executives can be any number of people. Our CFO, our – you know somebody who manages contracts for your organization. Lots of different people can fill that role and have the flexibility, if it's a culture to have these sorts of walk-rounds, you can "ad hoc" all sorts of people to round, to increase the effectiveness of them. And one of the biggest ones for us I think is ITD [Information Technology Division] coming with us when we have connectivity issues. And it's very hard for us to use the technology that we talked about – you know, leadership technology and safe practices. If any one of those things doesn't work well for you, we can deliver what you want. And so ad hoc involvement of people who really make a difference in the ability to do front-line work is helpful. So they've been a real big asset in particular. Thanks, Chuck.

Charles Denham: Great. Thank you so much. And so now we'll move to Dr. Henderson, the Chief Quality Officer of the Cleveland Clinic. Dr. Henderson is a leading surgeon and will describe a little bit of his background and has been weaving together institutes focused on quality across the Cleveland Clinic, and has really impressed us with the insights of both how important data is [*sic*] and for us to get back to the basics. Mike, go ahead.

Michael Henderson: Thanks, Chuck. I think, you know, some people say, well, why is the surgeon doing this? I think the surgeon's doing this because I think physicians need to really help lead the improvement as we do chase zero around these harms and our infection rate. And as I have said to you many times before, I think this should be data-driven. We are dealing with docs. We are dealing with the healthcare professionals. We give them the data and initially they look at the data. I don't believe that. I can give you an example here of how we look at some of our infection rates across and in our ICUs. It's not about the details. It's about the fact that you get data out in front of people on a regular basis. And I think it's challenging the groups, and this is just an example of what our ICUs are advocating. Just to show that it is about looking and seeing who's doing best. Who can keep the infections out of their intensive care unit and the one my staff put on this happens to be a heart failure unit where they hadn't had a line infection for close to a year. It's driving these people to be thinking about on a daily basis: front-line needs and where the opportunities lie.

And then you go to the next slide you will see that there's a slight difference in the way of looking at that for that particular unit. They were kind of – they were having infections over the map; but you can see towards the end of this control chart that they are down to zero for the last couple of quarters here, and I think that's what's important: that people know what they're doing, how they're performing, and that really does help drive them toward improvement. I think projects that you put together for quality and safety improvement projects around hospitals need to be data-driven. It's all about the data. Without good reliable data they don't get there. I think that's one of the things that certainly we push here and trying to get people on the same page and focusing on common projects and safe picture goals is part of our culture now. But I don't think it was part of the culture five, ten years ago.

These are some of my favorite themes, Chuck, these are just some examples. As you said, I'm a surgeon, but these are the things we don't like to talk about but that we need to talk about. These are really just about the basic things we don't do well. Everyone knows that central venous catheter infections are a problem. Do we take proper care in placing these and managing our central lines when we put them in? We know that the risk of pneumothorax is there as we do more and more invasive procedures around patients. Are we doing the checks, checks, and double checks we should go do? You know we love doing the complex operations, but do we always do the very basic things that make them safe and better for

patients at the end of the day? VTE, deep venous thrombosis, pulmonary embolism, are we doing everything we can do, should do to try and prevent it from happening? Do we assess our patients properly? Are we using the right prophylactics? Are these things on our radar screens? I have seen the changes. I've been around a bit and I have seen us going from doing the basics well, when I started, to doing the fancy things well now, and forget the basics. So this is one of my big peeves is, let's keep the pressure on to the basics. (We'll give pressure, pressure ulcers at the bottom corner here.) This is about good basic nursing care, and physicians have a responsibility too, of knowing their patients, knowing they have other risk factors that can lead to this. So you know, when I talk about quality and safety with our medical staff, there are two themes I really push on. One is about standardization and simplification. Keep it simple and standardize our practices. The other is get back to the basics. Let's avoid the simple things that we should be doing every day to make it better and safer for our patients.

Charles Denham: Thank you, Mike. What we'd like to do now is open things up for Q & A. The first question really is to both Dr. Henderson and Dr. Phillips. How hard was it to introduce checklists into the OR at the Cleveland Clinic? And can you walk us through from the very beginning? I know, you know, at first that there was some reluctance, and then, can you just kind of take us through the process from starting from zero?

Michael Henderson: I'll let Shannon go at you first. As a non-proceduralist, I made her do this. So I'll have her talk to that first.

Shannon Phillips: Yeah, well, there's the first lesson for anyone, that is, you know, it is always easier, I think, to bring something to your healthcare facility when you do what you're trying to change. So, but that said, I mentioned that checklists are actually one of the biggest things that made this a game-changer for us was that there were front-line surgeons and proceduralists who just felt it was time, that our communication was not where it could be. They actually were looking for safety, but they were also looking for some efficiencies. Wow, I'd like to come down to make sure all the right equipment is here, and how frustrating it is to get some place and not have what you need to do the right care for the patient. So we really had a ground swell. Additionally, I think we're not different than a lot of other hospitals, that the rules, the regulations keep changing, and so there's a subtle change here or there and what's expected in a National Patient Safety Goal or by CMS and making the subtle changes year to year. Also it doesn't feel very value-added for the patients, albeit they're there for the right reasons. We wanted to step back and say not – this isn't about the bottom basics of what's required, but how can we really put the patient at the center of this and build the right peri-procedural process with a checklist that would serve the patient well? And then the regulation pieces aren't such a big deal, because you've already taken care of providing the best. So starting with that ground troop, finding those champions among the people that do this every day and the physicians, the nurses, the technical staff, I think, is a real key element. And then, because it is a big culture shift, bringing that to the top leadership to say, "Here's what we've done, here's what we've been piloting, it looks like it's promising," and gaining their support so that when you do find them, small, the minority objectors who can sometimes be as loud as the chorus who's singing, "This is a great thing to do," you have a great top-level leadership to help rally the troops and get everybody back in place. So I think the ground support, and bringing it up from the bottom with leadership support, was a real key element to starting to move the culture. But that said, Mike is a surgeon, so he might have something to add.

Michael Henderson: I think people were more apprehensive before we did it than when we did it. I think a strong procedural surgical culture clinic here, we go, "What's Dr. So-and-so going to do with it," and getting, in terms of a great job of finding the right people to help lead the charge of the challenge in radiology. And quite honestly, the first week or two there was some rumbling, and you listen to the rumbling, you respond to the rumbling. But they weren't in a hurry. I keep saying to people it's about two things, it's about team building, number one, and it's about communication, number two. And that is the visible difference we saw over the first two or three months. But I think it has very much become part of the culture now, that this is the expectation; and we weren't good, the surgeons, and I can say this as Surgeon B. Well, that's something the anesthesiologist deals with. The patients love it. They love it that the full team is there, the surgeon, anesthesiologist, the nurse; and the patient is the center of that team, talking about, "This is what we're going to do this morning. This is what we're going to do this afternoon."

So it has been a culture change and we reach a point: “When can we do this too?” So it’s rolling out across them in fairly short order afterwards.

Shannon Phillips: And Chuck, I’d add, one of the things that’s really helped us, since we sort of said you have to, here’s the date where we start, is storytelling. And so, you know, we started this conference with stories and those are really the things that sustained people’s excitement and enthusiasm about it. In fact – and we try to get those messages out and I would say we can even do a better job but, you know, this last week, an example of a story in one of our ORs is, we had a patient going down, you know, in the OR for a procedure. The team was around the patient, and whenever possible we do our sign-in huddle when they’re awake. And the team was talking about the case and the equipment, and, you know, had seemingly completed it. But they always turn to the patient and ask them *[sic]* if they have any questions or anything to add, and the patient said, “I didn’t hear anyone say that I have a fistula in my arm and I can’t have any procedures or lines or anything on that side.” And the whole team was thrilled. The patient was thrilled that they’d *[sic]* been able to participate, and it was what we call now, we’re trying to call “Save.” But really giving a story that tells when the patient, or the equipment tech, or the nurse, whoever, spoke up and made a difference in the case so that the outcome was better than anyone was going to anticipate. So those sorts of stories, I think, reinforce to people why we change the culture of this.

Charles Denham: Fantastic. Let’s shift gears just for a moment to Sue. We know that the World Health Organization checklist is important. It was brought forth. We have actually these students [who] have worked on this nationally through the Open School with the Institute for Healthcare Improvement -- probably the organization that has the greatest impact in the world on quality – such a small organization but huge impact in bringing forth the World Health Organization checklist and actually having students bringing them in. Are there any initiatives, Sue, that are being undertaken, with you and with your leadership through the Patients for Patient Safety with the World Health Organization, tied to the checklist, and can you give us a picture of what the major focus areas are going to be over the next year?

Susan Sheridan: Absolutely, and you know at the time that you are asking the question is perfect, Chuck, because you know this morning I checked my e-mail. And just to give you a little background for those of you who don’t know the structure at WHO, but there is a patient safety program with about ten programs under that, one of them being called Patients for Patient Safety. It’s based on the premise that the collective wisdom of the patients will contribute to the learning and contribute to a safer healthcare system. So we do workshops all over the world where we’ve met hundreds of patients who’ve experienced bad outcomes but really want to contribute to improving the system.

So we now have a network of what we call champions. One of our champions is in Mexico. She e-mailed me this morning saying she’s giving a big presentation for the Minister of Health on the checklist. And she’s sharing three patient stories where the checklist could have prevented harm. But all the patients are there calling for implementation of this checklist and also just distributing the checklist to patients actually.

We did a survey a year ago throughout the world, got 750 responses from 59 countries, and we asked the patient populations, we sent the survey through patient organizations, through every patient network we could find in the world. And we asked them, “Do they want to know about this checklist, do they want to participate, when they can in, as much of the checklist as possible? Well, do they want to help advocate in their country for the implementation of the checklist?” And the unanimous response from 59 countries was, “Absolutely.” And so it was exciting to get this response. A woman in Argentina partnered with the Surgical Association and campaigned together at the Ministry of Health in Buenos Aires and it has been adopted – that the checklist will be used in every hospital in Buenos Aires. So patients, in partnership with clinicians, with institutions, with organizations, are helping at the policymaking level driving this, and also educating the patient population. This is out there. Ask for it and contribute what you can to the pieces of the checklist. So it’s really exciting to see how a patient partnered with clinicians can ignite action.

Charles Denham: What I’d like to do now is open up to our audience. For any questions anyone would like to ask, you can open the pane in the lower right-hand corner of the WebEx screen and type in your questions, and I’ll read them off and help shape them. But some of the questions I’m getting by e-mail pertain to patients and consumers and families who have seen *Chasing Zero* and want to positively

approach their hospitals, to go to their hospitals and say, "Listen, I'd like to help financially support or donate time to your safety program." Some even have suggested, "Hey, I'd like to help support and ask board members if they're using the checklist and if they're adopting the safe practices."

Mike, you first, then maybe Shannon. You know, what do you think the reaction's gonna be of hospitals if soccer moms, soccer grandmas, business people, moms, and dads start contacting their local hospitals and say, "Hey, are you using these? Are you adopting these practices? What can I do to help?" You know, who should they contact and what do you think the reaction's gonna be?

Michael Henderson: I think they'll get very mixed reactions, but I think it's the right thing to do at this stage and I think it is persistence along these lines and these messages. I think in most hospitals these things are on or getting on the radar screen. I think it is important to encourage it to happen. I think it is a growing swell of the medical profession [that] is realizing that we are way behind in taking these steps compared to all other industries. So I think the time is right and I think there's been so much talk about safety, and patient involvement in it, that we should be continuing to encourage that. I say that because we were slow getting going. And when I first got into this, Shannon had to keep pushing me left, right, and center. So I'll let her kick it off from here and tell you a bit of what our journey has been to get there and what her recommendations would be for other hospitals facing those issues.

Shannon Phillips: You know, Chuck, I agree with Mike in that I think any given hospital knows when a patient makes that call how it will go, but I think a simple thing, you know, is to just say, "Do you have a patient advisory council, family advisory council?" much like the one Sue is describing getting involved in forming. Not every hospital does and that is the way to start to have a voice. You say, "I want to be involved. This matters to me."

And then the other piece is a patient, simply by walking in the door and being an activated patient, is somebody who takes an active role in asking questions, in reviewing their medication list and reviewing their allergies and problem lists and asking who gave them that conversation, is also a very powerful method to the hospital. Those will be game changers. You know, for us increasingly, involving the voice of the patient and how we develop clinical programs and serve the patient and deliver care, has been very important and it changes, as I think Sue and others will talk to, is, if you involve patients, you will develop something differently than you would if you just did it with the front-line clinical staff. And so an activated patient and a patient getting involved in the structure that exists, in terms of councils, is very powerful. And the last thing I want to say is our board is full of a number of patients and people who have family members or are patients themselves, and they are a great catalyst. They have asked them very hard questions and they push on us. They walk with us, you know. They're taking the board members on walk-rounds and allowing them to ask, you know, not allowing, but just letting them loose to ask the front-line staff, "What's going to hurt a patient? What do you have to work around in your daily life?" informs them, and they bring that to decision-making and presentations we give to them and those hard questions I think drive us and really catalyze us to do better.

Charles Denham: Great. I'll just make a couple comments and frame a couple of the questions back to the panel. Y'all can see, the audience, why we picked this wonderful trio of great panelists. One comment was that another story that could be powerful would be that of Sorrel King. And this person probably hasn't seen the movie yet even though the Sorrel King story actually is in most story-power movies and *Chasing Zero*, and we're just so honored to have worked with Sorrel over the last, I guess, nine years. We videotaped her nine-minute story. Her nine-minute story is now in 2,000 hospitals and part of our TMIT Pay-It-Forward program where we'll give away three videos for every donation that's made to Sorrel's Center. So Sorrel and the Josie King Center, in honor of her 18-month-old [who] passed away, and for every donation of \$250 we will pay for and distribute three more DVDs, and ask them to make a donation, and for each of them we'll distribute three more. So there's a geometric progression that's now caused 2,000 hospitals to be using it in three languages, and has raised \$200,000 for Sorrel's program, and it's also in the *Chasing Zero* movie. And a little more of it will be in the next one.

And I will mention that we featured more air time in the last documentary and the current one, *Chasing Zero*, at Mayo Clinic. We're looking forward to featuring more of the Cleveland Clinic in the next one and

we're very excited about this. We'll be focusing on the human fallibility and human error that honest, conscientious people make and the technologies that can provide the safety net to support it. And we'll be focused on the sweet spot of leadership, practices, and technologies: engage leaders in practices, and deliver predictable outcomes like the checklist and the technologies that enable us.

Another question is regarding formal education for patient safety officers [who] are not MDs. The greatest and best patient safety officer program in the world is run by IHI, "Nine Days." I've had the honor of being a faculty member of it. You don't have to be an MD or an RN. You can be an administrator to do so. And we're also developing a fellowship, in partnership actually with Mayo Clinic. And we'll also have input from our Greenlight partners of our Greenlight program, including Cleveland Clinic, to a fellowship program that TMIT will be running for Fellows in high-performance care; and the title of it is LEAD, L-E-A-D caps, that's Leadership Engagement And Development of healthcare, which will be a two-year fellowship.

One question and I'll throw this back to all three of you, maybe starting with Sue, and then to Mike, and then to Shannon. How do you encourage disclosure and transparency? Some find that leaders appear to be strongly opposed to this. We see this in our test bed. So Sue, then Mike, then Shannon.

Susan Sheridan: Chuck, your question is, how do you encourage disclosure? Do you mean the disclosure of bad outcomes for the patients and families?

Charles Denham: I'm presuming adverse events and the concept of transparency, but disclosure after a serious adverse event, and transparency.

Susan Sheridan: Sure. Well, not working within the healthcare industry and not being a nurse or doctor or inside of the hospital, you know, from a patient's point of view it should be an absolute given that disclosure is practiced 100 percent of the time when there is an adverse event. You know, I've always said that disclosure is just a different way of saying the word honesty. And honesty should never be compromised in any profession or any industry. You know, I felt as a patient when the harm in my family that occurred, when it wasn't that harm was not disclosed to us and like I say on *Chasing Zero*, it felt like a hit and run. And so I think that the implementation of disclosure will come from very courageous leadership who won't tolerate anything but disclosure. And, of course, provide the support and the training for the staff to learn how to do it and to not be afraid to do it. And that's part of the culture within a healthcare system.

Charles Denham: Mike, how do you, in a typical front-line hospital that is facing so many of the fears of malpractice and so many of these, there's so many myths out there that actually "disclosure will cause more claims and more awards." And we know people like, one of my heroes, Tim McDonald, at University of Illinois says that disclosure is the Trojan horse of cultural transformation. We are just being, so many of the myths about disclosure itself. It's a very real problem at the front line. Mike, any advice for those out at the front line that have resistant leaders?

Michael Henderson: Yeah, I think it is being persistent and don't be scared to change. This is one area where I have seen the greatest change in my career where we've gone through, you know, "how much do you really tell the patient," period, to the deny and defend attitude when things did go wrong, to where we are now over the last few years. And where the open, honest discussion at the personal level is one of the things I always really struggled with, where the institutions wanted to deny and defend and I really found that very difficult. I think it's great that the honesty and straightforwardness is the way that we practice now. I think getting the front line to understand that, as many of your people who have grown up in some of the older cultures, is not easy. When we first looked at more open disclosure at the Clinic, you know, some of our lead people we've talked about, "But we've always done that!" And when you actually sat down and someone talked about it, "Well, not really." Sue's points are well on target. There's also educating and training your healthcare team. This needs to be done. Yeah, I've made mistakes. You get caught in the emotions at the moment. With the right person to be talking to the patient and all the families at those points in time and it's having a right overall approach to it. But the truth is the right actions are taken and everyone understands exactly what is happening and hopefully we're on its way. From my career perspective it is having that willingness to be open about it and it is recognizing that I do

believe the medical profession has changed enormously over the last five years, decade and a half, and that we should be encouraging it even more so. Shannon has strong feelings about this one, too.

Shannon Phillips: And you know, Mike had summed it up by Tim McDonald and then other groups and the University of Michigan and so forth have some really nice, I think, early data that is [*sic*] getting, you know, I think there's more and more of it that suggests just that you'd expect, that being honest is really what people want and it's not about lawsuits and financial punishment. It's about being honest, and assuring them that we learned from what goes wrong, and that the same thing couldn't happen with someone else again because we are in a different place. I see us personally having really moved on this, and having the privilege to work with families from time to time, very early when we are stepping up to do the right thing is very powerful. It's certainly reinforcing to me. I think it's reinforcing to the front-line caregiver [who's] been involved in those situations, and it's very powerful to the family at a time when they are in crisis. And supporting both the family, and as was alluded to earlier, supporting the caregivers who are victims in this as well, has really, I think, proven to be a very successful strategy for us. We're all learning; healthcare has not been good at this, but I think we, along with other institutions around the country, get better at this every year.

Charles Denham: Great. I've got a couple of just quick answers to some of the questions that are popping up in the Q&A as we are coming over the next five to ten minutes to close. A question is how can you get a copy of the *Chasing Zero* video? We will actually be getting thousands made. We've had so much, the doors are getting beat down by people [who] want it right away even before the toolbox. So there will be a big run of this made very shortly, with articles that we'll use for the education materials. And it'll be distributed through AORN, through CareFusion, through TMIT, to many hospitals, and we'll give you a mechanism to get that off of safetyleaders.org. And within six weeks we'll have a toolbox with another hour to an hour and a half of specific 10-minute digital shorts that could be viewed regarding specific areas. So for instance, disclosure. We'll be providing the DVD as a ready-made retreat package for boards, for quality teams or safety teams where you could watch a 53-minute video. You could have facilitated questions for a Q&A, over – let's say – a lunch, and then a number of 10-minute videos. And the reason we picked 10 minutes is actually the attention span of a typical older adult is about 9 minutes with attention breaks in television broadcasts and sports events. So the 10-minute shorts will tee up the concepts, the tools, the resources for a specific area like in this case, disclosure. So we'll have the safe practice of disclosure, some of the concepts and some of the articles and tools that'll be available right on the disc so that one can have a 10-minute briefing and then spend the next 20 or 30 minutes discussing how you might implement that in your organization.

Sue will have one that she'll lead regarding starting a program with patients and families and we'll have a number of topics that will be covered.

And then there've been a couple questions regarding a checklist regarding suicide and behavioral health facilities that may be an issue and one of our answers is from Hayley Burgess from our High Performer Resource Center (see www.sprc.org). And we will be transcribing this entire webinar, so if we go by very quickly to answer your questions, we'll give you resources. What I always do on our transcripts is if I want to hear what Dr. Henderson said, I would use Ctrl H in Word or use the search function on a PDF.

Let me come back to all three panelists. One of the people on the Q&A panel had requested some information regarding what's the process or processes that have been most instrumental in supporting these initiatives in safety quality, and this is coming from an environmental services director, I presume from a hospital. What key processes would you all say? Maybe starting with Dr. Henderson and then going to Sue. What processes have been most instrumental in the transformation of a safe surgical culture?

Michael Henderson: If you go specifically around the environmental thing, it's all about involvement and then having good leadership, good standardized practices, and then accountability. We had environmental issues four or five years ago. We've got a fantastic leader of that group now who knows exactly how to communicate with them, who has changed the way they practice in a much more standardized way and it's unbelievable that it's resolved the gap. So it is about the leadership, the

standardization of practices in that particular example. The same applies for so many of the important support workhorses within a hospital and within the healthcare environment. It's all about involving them and then finding the right leadership and practices to make it work well, I think.

Shannon Phillips: I would just add that one of the things that's been successful with environmental services has been ownership and teamwork. And they were given a tool, really a checklist, by their leader, as Mike was describing. They really felt, they feel a sense of ownership to the geography where they work. And then they also feel part of the team, so when they partner with the nursing leadership in the area that they are geographically responsible for and they work together as a team. So leadership from environmental services, a checklist to guide what they're responsible for, a sense of ownership, their performance is evaluated with that, and they feel a sense of ownership for the team that geographically works there and cares for patients. So they really feel that patient safety starts with them because their role is about safe environment, and that has been incredibly successful.

Charles Denham: Sue, comments regarding transformation? You circulate so broadly and widely. I know you swap stories about hearing great success stories, anything you'd like to add?

Susan Sheridan: Well, I think, just in general, I think what I've been able to witness over the past decade is what gets me excited, is including patients in processes, you know, re-engineering, patient safety process where patients can, if they choose, play a role. And so I, you know, just witnessing at the WHO, and here also in the United States, with consumers advancing patient safety where patients are involved at all levels, and bringing in a patient perspective is fresh. Patients see healthcare through a different lens. So I think that that is just a tremendous enhancement to what is being done for patient safety.

Charles Denham: Great. I'm just gonna rotate back through our group with one more question and then allow Sue Sheridan to close us. I do wanna add, before people drop off, that transcriptions of this webinar will be entirely available. Dennis's speech will be streaming from our website and studio as well, and folks can be watching that. The DVD will be available. We're sending them for free to all U.S. hospitals. We're sending this to every board chair in the U.S. I know that AORN will be distributing them. I think it will be put on so that will be put on so people can screen the video. We are going to develop CME for docs, CNE for nurses, continuing education credits for pharmacists and for lawyers whom we think we really can have some impact on by sharing some of the stories that we'd like to cover. So all of those will be available.

We would love, in the Q&A and then as people sign off, they'll be given a survey and we'd like to have you e-mail us, e-mail to our webmaster, any suggestions you might have for any of the panelists that we have going forward.

And then also our next video will actually be addressing human performance and the fallibility that occurs with well-intentioned, well-trained, highly competent people. So it'll be very practical, but I think it will be bringing in a lot of high-performance aviation, aircraft carriers, as well as maritime learning.

As we come back with the last questions, the model that we'll be using for a lot of what we drive going forward will be the 4A model of awareness, accountability, ability, and action – that we need to be aware of the performance gaps that we have. If you wanted to ask us what models for adoption do we find the most powerful, we used them for 25 years in developing products for some of the biggest corporations in the world; you need to be aware of your performance gaps, and that means you have to have good measurements. Have awareness the first day of the performance gaps. Secondly, accountability. That's what we do. The third A is you can be aware and accountable, but you may not be able. You may not have the knowledge, the skill, for the soft green dollars of the past to change. For ability we know it's all about adjustment. And finally action. Line of sight action that real human beings are engaged in dialogue, but that real people take that are line of sight actions. I'll give you any one of the four As. Mike, we'll go from Mike down, Shannon, if any of the four As that jump out at you or all of them.

Michael Henderson: I think it's a great sequence and I think it is recognizing that there is always an opportunity to improve, and one of the things that always bothers me most is when people say, "We're

perfect, we're 100 percent complying with everything." No one is, so you're aware of where your opportunities lie and then building off them. I think we work a lot around it, absolutely, and it's developing a good team that can also take the action around driving good projects. So I think it's a bit of all of these, and I think that's a great model, Chuck.

Shannon Phillips: You know, I'd add, we make strategic or hospitals make goals at a big level, a leadership level, and then when you, you know, the action happens, the ability to do things happens through leadership catalyzing things, and that can be front-line or executive, but the action is really local; and I think that's where we've developed the meat of what really changes how we deliver care. So the action part is exciting to me. We ought to clear the way of safety quality leaders in our organization, 'cause to make action be able to happen gives people the ability, but being action at the front line is where I think the most impact for the patient happens.

Sue Sheridan: Well, just to add to what Dr. Henderson and Shannon said, I agree with everything they said. The only thing that I would just layer on top of what Shannon just said was the action piece, you know, from the patient's perspective we want to see action. There has been, you know, we've been building a lot of awareness just about patient safety. But the action piece, I think action can accelerate and be catapulted with more patient engagement, patient involvement, and patient partnership. So action gets me excited.

Charles Denham: Fantastic, and I'll assure everyone [who] has not had enough volume, I'm an old guy, I always kind of blame it on the fact that I'm a jet pilot and I ruined my ears. I'd just like to give a shout-out to Catholic Healthcare Partners. I think they're an example of one of our Greenlight collaborators in Dr. Henderson and leaders at Harvard and Vanderbilt and Yale are all teammates on our Greenlight program where we're coming up with HIPAA-validated given assumptions variables for infections, but broadening it much broader, and Catholic Healthcare Partners. And today and while this webinar is going on they are showing *Chasing Zero* to their 25 CEOs, and I'll be going on the phone with them to field questions and that kind of thing from them. So that's the intention of the movie, and I am so grateful to Mike and Shannon for allowing us to film at Cleveland Clinic. We're so grateful to you. You live these dramatic events day after day after day, you're, I think, the greatest heroes.

Sue Sheridan: All right, and thank you, Chuck, for those kind words and, you know, in closing I would like to actually use the closing words that my husband shared when he was dying from his cancer, when his days were limited, and you'll see this on the film, but it was a precious conversation, a privilege to be with my husband when he died and, you know, Pat said to me – we were talking about our children -- and the one thing he said to me was to never give up, he said to never give up on patient safety, and honestly those are some of the most powerful words I've heard in my life. So I'm asking the listeners [who] are still on this conference call to – I ask the same of you. Never give up on patient safety. This is hard, but I ask you to see this with relentless passion. I ask you to act with unstoppable courage. I ask that you create partnerships never imagined before. And I ask you to ask yourself right now, how are you and your team and your institution going to chase zero harm? So those are my parting words. I thank you to TMIT, and to Dennis Quaid and his family. I'm impressed and thankful to AORN and CareFusion for their courage and in trusting in the creation of *Chasing Zero*. And so one of the greatest assets that we all need to, resources that we all have at our fingertips is to believe. And we all need to leave believing that we can all make a difference. So those are my parting words.

Charles Denham: Well, thank you, Sue. And we do thank Dennis. He wished he could be on. This is his big day for his premiere. We're going to it tonight, of his new movie depicting President Clinton and his relationship with Tony Blair. And of any of the people that I have met in the safety movement, it is an honor to work with Dennis. He truly does have what my favorite movie, *The Right Stuff*, this is the guy that has the right stuff. He is authentic and really dedicated to help all of us. So we are so grateful for him. And as Sue has said, for the support and the belief by AORN and CareFusion, because they didn't see the movie, had no influence over it, and saw it for the first time you all did on April 22nd. So thank you all and this ends our webinar, and we thank you all.