Bob Panzer: Welcome everybody. I'm Bob Panzer, chief quality officer at the U of R Medical Center. And welcome to this year's Healthcare Forum. As many of you know, we have a forum annually, and the topic changes from year to year. In previous years, we had a fair amount about pandemic and leadership during the pandemic, and other consequence of pandemic, and today we're moving towards the topic of driving organizational culture change. And so I just have a few slides I'm going to share before we turn over to our presenters. But first is I want to thank my co-facilitators, Hiloni and Kristen, from Rochester Regional, and Jan and Tina, from UR Medicine.

I just wanted to show you a little bit, because we had a title, but the question is what is organizational culture? And looking at that, you can find many, many definitions and views, and our speakers will probably have some. But I thought this one was at least a nice visual, that there is the culture that is somewhat visible to our patients and other people we work with. And then there're the invisible elements of the culture, including the base of the iceberg you see here.

This is something I'm not going to read to you, but this is from one of the many articles on organizational culture. And I would just like to feature these three statements below, because I think they're highly relevant to what you're going to hear. "Organizational culture can give employees a feeling of unity and purpose, and can help a team cope with complex and dynamic changes." I think very true. Second, "A strong organizational culture can serve as an asset in achieving goals and fulfillment of people in their careers." And, "The organizational culture can be a predictor of factors, such as job satisfaction, employee commitment, and the likelihood of success of quality improvement." So it's important. No presentation on organizational culture can occur without having this statement, which I think many of you would appreciate is true.

So here's the logistics for today's session. We're going to have six speakers present rapid fire until 1 o'clock. Beginning at 1 o'clock or so, we'll move to a panel discussion and also address questions or comments. In this webinar format, attendees are muted. If there's some reason why we need to activate you, we can do that. You would want to put in the chat some reason to do that. But otherwise, we'll be monitoring the Q and A option that you had. For questions though, we'll look in the chat if some of those sneak in there as well. We do have ASL interpreters, which I believe Heidi, our meeting facilitator, will be spotlighting. But I believe you can pin them yourselves if there's some problem with that.

This session is being recorded and there will be a link to it on the GRQC website, probably by tomorrow. If you want to review parts of it or share with a colleague, some of whom couldn't make it today, I encourage you to go to the grqc.org website. Many of you, to register, went exactly there. To learn more about GRQC, which is across not just healthcare, but government education, for-profit, nonprofit organizations. And consider attending the next event in a couple of weeks on managing the age of smart machines, about artificial intelligence.

So with that, this is our speaker lineup. And I'm going to turn it over to our facilitators from RRH to introduce their speakers.

Hiloni Bhavsar: Hi. Good morning everyone. I'm Hiloni Bhavsar, I'm the medical quality officer for Rochester Regional Health. Just a quick introduction of our three speakers. First we have Dr. Tara Gellasch. Dr. Gellasch has served as the chief medical officer for UMMC or United Memorial Medical Center in Batavia since 2017. In her role, she's been able to wear many hats, including western region primary care medical director, transfer center medical director, and is a board-certified OBGYN physician, and former chief of obstetrics and gynecology at Newark-Wayne Community Hospital, both are part of the health system. In 2002, she developed the Rochester regional rural CMO network to explore common challenges and develop innovative solutions. And Dr. Gellasch's passion for rural health and experience in change management and rural healthcare delivery really give her a unique perspective on driving organizations. You'll hear about that in a minute.

Dr. Lori Paine currently serves as our vice president and patient safety officer for Rochester Regional Health. She's a native of Western New York, and joined the health system in June from John Hopkins Armstrong Institute for Patient Safety and Quality. Lori has her doctorate in public health and master's of science in applied behavioral science, in addition to her nursing degrees. And she brings a depth of knowledge on safety culture, just culture and organizational culture from numerous operational and academic perspectives.

Renee Demski joined RRH as the executive vice president of quality, safety, performance excellence officer and patient experience in May of 2023, after over 35 years at Hopkins Health System, where she served as the VP of quality and safety for the Armstrong Institute. Renee and Lori both worked together for many years, leading this work. And while at Hopkins Health System, Renee worked to develop a leadership and governance model around safety, quality, system-wide. And created and deployed an operating management system to integrate and align safety and quality principles to achieve high quality care. So you can imagine the culture change and change management that came with that. She has her MBA from Hopkins Carey Business School, and a master's in social work from University of Maryland. And her experience and expertise also give her a unique perspective on the impact on changing culture across the spectrum of healthcare. So I will hand it over to Dr. Gellasch to get us started, and then Lori and Renee, and then we'll pause for URMC interest Dr. Gellasch.

Tara Gellasch: Great. Thank you so much, Hiloni, for that introduction. And thank you Dr. Panzer and the committee here for giving me the opportunity to come and speak to you today. As Hiloni mentioned, I have been pretty passionate about rural health for the last about 10 years. Prior to that I really worked in some urban underserved communities as well. And really, there's a lot of similarities in the challenges in those populations. And as the CMO at UMMC, my focus really has been on the medical staff's role in driving quality and driving culture. And I think for a lot of us clinical people, we often learn best through stories. So I'm actually going to kick us off with a little bit of a story around some organizational change that we really needed to pursue at UMMC.

So about six years ago, we had two really very significant issues related to our maternity and newborn nursery services. In our pediatric group, we had aging community, pediatricians who were providing our newborn resuscitation and newborn care services, and they were really struggling to keep up. There were just two of them covering 365 days a year. We were seeing a high number of both patient complaints and nursing complaints, some near misses. Not really resulting in poor outcomes, but certainly a very stressed team. Additionally, on the OB side, again, we were having nursing complaints related to lack of access to the provider or delayed responses in provider. We've had New York State reportable sentinel events coming through. We had some MEDMILK cases.

And really, the talk track when I arrived there was that, "Hey, we've got a group of physicians here who just don't care." That they're not hearing the concerns of their nursing team and they're not engaged in providing solutions. And one of the things I've learned in my leadership journey is that we always need to start from a place of assuming good intent. And so when I walked into this, I met with the providers, both our OB providers and our pediatric providers, and it was pretty easy to realize the challenges that these provider teams were facing. The OB providers, there were only four of them, so that meant they were taking between seven and nine calls a month. When you're on call, you're responsible for all the patient phone calls and, of course, delivering babies at whatever time they choose to come. And they had one of their colleagues was out on a prolonged leave, and so that meant that they were up to 10 calls a month. And they were working in the office [inaudible 00:10:03]. And they were trying to do surgery and keep up with everybody's needs.

Pediatrics, a very similar story, where we had two aging pediatricians who were trying to maintain a full-time office, while also be available for every newborn resuscitation that required a provider on the maternity unit. All of these providers felt unsupported. All of these providers felt concerned about the quality of care that they were able to provide, given the circumstances that they were working with. And so that really gave us an opportunity to take a little step back and look at what should we be expecting of ourselves? What does the American College of Obstetrics and Gynecology recommend? What does the American Academy of Pediatrics recommend in terms of availability of resources, provider resources on the maternity unit and the newborn nursery unit?

And so once we were able to really define what would really be best practices around a provider care model, both in OB, as well as the nursery, I was able to meet with operational leaders and develop a team to really start to advocate for those resources, and really start to change the model of care that we are providing.

And so we did develop an OB hospitalist program. They now cover about 50% of our OB call at UMMC. This has significantly reduced the burden on our original core team. They have more time in the office, they have more time for surgery, they have more time for their family and having that time to decompress. And I think we were very pleased to be able to keep three out of our four original providers. They've been able to really adjust to this new model on a fantastic way.

Additionally, we were able to leverage being part of a larger health system, and so we were able to create some blocks in their schedules so that they could participate in educational opportunities provided by the health system. So they're able to get continuing medical education through grand rounds that are done at Rochester General, and they're able to participate in that. And they've been able to become part of a Rochester Regional peer review. So that there are multiple avenues for ongoing education, so that we make sure that our team is continuing to keep up with best practices as it relates to maternity care.

And I think similarly in pediatrics, really, we had to turn that a little bit on its head. It's extremely difficult to find community pediatricians who have the skills or interest in providing newborn nursery care. And so, again, partnering with operational leaders, we built a pediatric nurse practitioner program. And so we now have pediatric nurse practitioners who are able to provide onsite coverage for some of our most vulnerable patients, our newborns. And they're with us about two thirds of the time. We still have about a third of the time where we are relying on some assistance from our community pediatricians. But we have so significantly altered the burden of responsibility that, really, our physicians are much more engaged and able to respond and really be active participants in continuously improving the quality of the service that we're providing for our patients.

I'm going to wrap it up, my piece of this. I think the one thing I would add is what we have found this has done is it really put us in a position to better help our broader community. Many of you may be aware that Wyoming County unfortunately had to close their maternity unit earlier this year. And because we had this infrastructure available, we've been able to very quickly be able to provide care for patients in Wyoming County, which no longer now has a maternity unit. So I think overall this has been very successful. It was a huge shift for our patients and our community, in terms of being able to go from just having their one doctor that they expected, to now having OB hospitalists and that kind of thing in the mix, but it's been very successful. So with that, I'll wrap it up.

Bob Panzer: Great. Thank you. Lori.

Lori Paine: Well, first, thanks, Tara. And I wanted to just thank you also for serving Wyoming County. I was born in that Wyoming County Hospital that now doesn't have an OB service, so I'm sorry to hear that. But thank you. I'm going to shift gears a little bit in my time with you, and I'm going to share with you some of what I've learned through my career. I really had the great fortune of working with some of the great academics in the field of safety and culture, as well as have operational experience. I could have talked for two hours on this topic. I just picked out a few of the tidbits that I use in my own practice.

So I want to start... If we could go to the next slide. Thank you. So high reliability. I think we have all heard these buzzwords around high reliability and the desire to apply that to healthcare. We know high reliability organizations are those that are high risk, high volume, highly safe, but also very resilient. And through the way they organize themselves and their culture, they're able to sustain very high levels of safety, despite the hazardous environments that they work in. Nuclear power, high-speed rail, aviation, a number of those. And you can see here, they use operating management systems, much like we've tried to adopt in healthcare, to organize or, really, to integrate our quality and safety work into the work we do every day. And you can go to the next slide.

What we do know about high reliability organizations, from the work that Weick and Sutcliffe did, and drawing on some of the early academics, is that there's a unique sociocultural foundation that high reliability organizations share. Some call this the informed culture. But this is what we know is consistently present. They have a culture of reporting, where everybody in the organization understands, appreciates and values the reporting process when things go wrong. The reporting of near misses, the reporting of concerns. That is one area. I'm not going to talk about reporting culture today, but that, in and of itself is an important aspect.

The just culture, which is Weick and Sutcliffe described it as really just how we apportion blame when something goes wrong. Many of us have experience with different... There's different frameworks that can be used for just culture, that are used well beyond healthcare, they're used in other industries as well. But their processes to help standardize our approach to evaluating the role the people played when events happen. And also, to recognize when something happens, we can't just blame the person, we have to look at the system. So I'm going to talk a little bit more about that.

But the other two components of these high reliability cultures include a flexible culture. These are cultures that can easily adapt when there're sudden and radical change. They don't get so wedged into their usual way of doing things that they can't pivot when need be. I think actually, healthcare generally is pretty good. The clinicians are pretty good in this space in healthcare. I think look at what we manage to do during COVID, it was a really good example how we didn't consider ourselves manufacturers of hand sanitizer or masks or shields, but many of our organizations quickly stood up processes to fill the gap that the supply chain wasn't able to do. That was, for me, as I was sitting back in our command center at the time, I was really in awe at our organization's ability to step up into that space.

And then finally, and I think this is what all of our work is really leading us to, creating a culture of learning, where we have the ability to take the real-life experiences that are happening, quickly learn from them, and then spread. And that is a challenge, but we do it. So next slide.

So this is a quote from Lucian Leape. He's kind of the godfather of patient safety in many ways. He was quoted this probably 20-plus years ago, that the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes. Becker has recently put an article out in the last few weeks looking at, again, asking that question about healthcare and aviation, and how are we alike and how are we different. And they, again, highlight that in aviation, not that there aren't pockets of a punitive culture, I'm sure there probably still are in small pockets, but generally as an industry, they have shifted to valuing the input of everybody in the crew, not punishing people unnecessarily when error occurs. And then deeply learning from those mistakes or those events to better design the system, so that we don't perpetuate human error into future incidents. So we are currently at Rochester Regional about to embark on a large just culture initiative. I'm really excited about it. I think it is foundational to really transforming organizational culture. Next slide.

Here's another concept that I really wanted to put in here, because this, really, I tap into this concept frequently. And it comes from Heifetz work out of adaptive leadership. And understanding that problems, organizational problems come in kind of two ways. They manifest as a combination, but they really are two different things. There's technical problems, and those problems, we clearly can define them, we understand them, the solution to fix them is clear. Whose responsibility it is to fix those are very clear. Those are our technical problems. Adaptive problems in organizations require changes in attitudes, beliefs and behavior, or culture. And when that type of change is needed to fix a problem, it's oftentimes challenging to know whose responsibility is it. It's kind of everybody's responsibility.

And so Heifetz has this one quote on the next page, if you could advance, that the single biggest failure of leadership is the treating adaptive challenges like technical problems. And I think that as leaders, that's a really important distinction. There are times when a problem manifests that's both technical and adaptive. But if we expect the technical solution to fix the adaptive aspect of that, we're going to fail. And if we expect the adaptive changes to fix the technical, we're going to fail. So really, as leaders, it's just so important that we can distinguish between those two types of organizational problems. And I think that that is, and I did not plan this Bob, but I too have the iceberg on my slide that just reinforces, I think, the point that his intro slides was making, is that this cultural and adaptive stuff is what lingers below the surface, but that holds a lot of power in whether or not our technical solutions can succeed.

One example I can think of would be rolling out the new EMR. We've all done that at some point in the last 5 to 10 years. And we know that the technical solution is just part of it. Getting to adopt and adapt to that new technology is probably a bigger part of that work. I think I'm going to transition to Renee now. Renee.

Renee Demski: Yeah. Hi, everyone. Thank you so much for the opportunity. Bob, great to see you again, and thanks again for the opportunity for all of us to present. I'm really excited about this. If you can go to the next slide.

So organizational culture, we all have in our vision, we all in healthcare aim to provide the highest quality and safest care. But when you get right down to it, organizational culture is impacting all of that, but mainly, really focusing on preventing harm. And a couple of concepts I'll talk about during my presentation this afternoon is a people-centered model, leadership, governance, shared accountability and why culture matters. And I just want to say I have to work really hard because the speed presentation is almost encouraging me to oversimplify. And since Lori presented high reliability, I will try my best not to do that in my presentation. Next slide.

So the excellent care for our community, when we think about the community, it's so, so important for us to define, well, who are they? And really caring for our employees, our patients and loved ones, and the community at large. And so what is that person-centered care model? And are we truly embracing a person-centered care model in healthcare, where we know that there's an evidence-based framework? This happens to be Planetree's model. But we're really focusing on all of our community within our healthcare settings and beyond, as we think about culture and driving change. Next slide.

So when we take that model of person-centered care, that really then transcends culture and experience. And I would say experience, being employee experience or engagement, patient experience, as well as patient safety. And the literature shows, and you all are probably highly aware of this, but engaged employees provide quality healthcare, and that transcends again to a better patient experience. And then really making sure that all of the Venn diagram, they all impact each other. So culture at the very foundation of it all, when you have a really strong culture around patient safety, speaking up, speaking out, et cetera, that all of these components are interconnected and have a strong impact. And so really looking at the fundamental intrinsic drivers. Making sure when we're talking about employee engagement, and we learned this really strongly post-COVID, is wellbeing. Focusing on wellbeing of staff as part of that safety culture is critical. And that's where the CUSP teams do play a significant role in being that grassroots effort that actually identifies where they might harm the next patient, and being the solution to address that. Next slide.

So there are a couple of publications out that one is fairly recently, and it's all about trust. And gosh, someone that we work for, who's a leader in patient safety and quality, Lori and I were blessed to be mentored by him, always would say change happens at the speed of trust. And so when you look at this, it says on the left, this particular article talks about patient experience now. If patients really don't feel safe or have that experience of safety, they're less likely to recommend that hospital or healthcare system to others for care. And so it's not just that providers or clinical team members have eye contact or that they felt respected, but it's also the feeling of safety is driving patient experience. Likewise, the article on the right talks about safety culture and how that's associated with employee engagement. So do you have a culture of speaking up, of teamwork? Do employees feel safe and do they have a voice? And so how all of that's connected to the employee engagement survey, and I would even say the safety culture assessment. And we can go to the next slide.

So I'm going to transition now that core component of driving culture. I mean, we really like to look at culture and looking at the person-centered model as being driven from the board to the bedside, and it really being bi-directional. And having a very engaged board, we know and there is information in the literature around an engaged board who was really taking an active role in reviewing the data, providing feedback on whether or not you have a robust plan to drive improvement, to drive culture, those organizations have higher outcomes. And then there's also information in the literature, with the example, the article on the right, where it also shows that when the board is spending time, really looking on quality and safety, when quality and safety is truly a top priority that drives organizational change and performance improvement, that those organizations have improved or higher level of clinical outcomes and quality outcomes. Next slide.

Just a few from my perspective. The years that I've been doing this work, and the literature also supports this, is there are some best practices for quality governance. And really, organizing quality and safety work within an operating management system. And those of us who actually have DNV as our accreditation group, they follow the ISO and an operating management system. And so that's really helpful. But when we talk about an operating management system, it also has some governance and some core concepts built in.

And so if you're part of a health system, wherever cure is delivered throughout that health system, that quality reports to one board, that you're really driving transparency and performance improvement to that one board, that then reports up to the full board. And that we're declaring and communicating clear goals so that the frontline staff, and that's what I mean from the board to the bedside, are fully aware of what those goals are to drive performance improvement, as well as safety culture. That we're engaging local staff and that those initiatives are led by clinical leaders or clinical team members. That it's really that grassroots level and empowering them to drive change, but supporting them in a way that they understand the goals, they know what the expectations are. But as leaders, we're providing them with the resources necessary to get the work done, which ties into the story that Dr. Gellasch shared with us during the kickoff.

In addition, aligning quality and safety priorities. I think everyone does this. It's usually aligned with the strategic plan. We've learned a lot of this over the years. Foster and facilitate a culture of trust, respect, and psychological safety, which ties into Lori's presentation. And adopt a shared accountability model. What I mean by that is, again, that leaders hold themselves accountable first. And that we don't hold the team accountable until we clarify the expectations, we are clear on the goals, and that we ensure that they have the support that they need to really drive change and get the results we're asking them to do.

But then we also embrace that commitment to transparency, through using data that's actionable and driving performance. That we support that culture of improvement and learning organization. And, I would say, driving results through implementation science, where we're using science to help drive the culture and the work through lean human factors, design thinking, et cetera, so that we have those robust performance improvement tools to help frontline staff really improve where they're focused on driving change. Next slide.

And why culture matters. And I covered this a little bit. I think we all focused on this. It drives patient outcomes. That was actually in Bob's slides as well, the beginning, driving patient experience, infections and sepsis. When you have that culture, it impacts patient outcomes as well as staff outcomes, where you have a staff where we're focusing on wellbeing, and it's that person-centered model that really drives the culture to achieve these outcomes. And how that culture, strong culture really has that interdependency and helps foster improvement to a much greater extent as reflected here. I think that's it. Next slide. Thank you for the...

Bob Panzer: Great. Thanks a lot, Renee, and to the entire RRH team. I'm going to turn it over to our other facilitators to introduce the UR medicine presenters.

Tina Sosa: Good afternoon everyone. My name is Tina Sosa, I'm a pediatric hospitalist and I'm chief quality officer for Golisano Children's Hospital at UR Medicine. And I have the honor of introducing the speakers from UR Medicine for today's session. Thank you very much to all who just spoke from Rochester Regional, and your great presentations. First we have Rebecca Kanaley. She's a senior clinical nurse leader for quality and safety at UR Medicine Golisano Children's Hospital. Rebecca has been a pediatric nurse for over 15 years. She's a member of the pediatric nursing leadership team. And for the last nine years, she has specialized in the prevention of pediatric hospital acquired conditions, supporting a positive safety culture, and promoting employee safety and wellness. She also has a special interest in supporting pediatric nurses, through recognition efforts and continuing education.

Next we have Dr. Michael Leonard. Dr. Leonard is the chief safety officer, the associate chief medical officer, and associate vice president for healthcare safety at UR Medicine. He is certified as a professional in patient safety and as a medical review officer. Dr. Leonard also works clinically as a pediatric hospitalist and holds a master of science degree in epidemiology. Dr. Leonard leads the UR medicine enterprise in all of our safety efforts, including organizational safety culture, and was instrumental in our response to an emergence from the pandemic.

And next we have Dr. Brett Robbins. Dr. Robbins is a professor of medicine and pediatrics and the vice chair for education in the department of medicine, at UR Medicine. Clinically, Dr. Robbins caress for patients in both outpatient primary care and inpatient settings. Dr. Robbins has led organizational change in our resident and fellow training programs. Specifically, he led a pursuing excellence initiative project to instill organizational quality improvement and safety culture into our programs to train physicians to lead healthcare teams. Dr. Robbins has special interests in medical education, the transition of youth with chronic illness to adulthood, and diversity, equity and inclusion. And with that, I'll turn it over to Rebecca Kanaley, who is our first presenter.

Rebecca Kanaley: Thanks so much, Tina, for that warm welcome. And thank you to RRH, kind of setting the stage of safety culture. I'm going to go to the next slide. And trying to talk about the development and how we're able to successfully implement a positive safety culture in the children's hospital. So in my role with quality improvement, I'm really targeting a lot of [inaudible 00:36:52] specific issues and preventing hospital part conditions. But those targeted interventions can really only go so far if we don't have a mutual understanding among all team members in a supportive environment. The staff feel not only safe to speak up, but they're also encouraged to speak up. So together with the quality improvement initiatives and the culture initiatives, that we talk about them weaving together to form a strong safety culture. So you see the vertical lines on the graph of our interventions in the past seven years. We'd like to weave the quality improvement initiatives, they're going up and down. The two of them formed the positive safety culture.

As you can see, we started working on this in 2016. We started really actively working towards developing our safety culture. In 2018, we actually joined a national organization for quality and safety, specifically targeted for pediatric hospitals. And our entire quality improvement team and hospital leadership took courses specifically targeting culture work in six different domains. As you can tell from the bars, multiple interventions were identified in several culture domains. And we put those into place and continue to sustain them, which have been laying the foundation for and building our robust safety culture. So next slide.

Today, I'm going to specifically be talking about our error prevention training. This is one of our biggest safety culture domains. This is a two-hour long hybrid course that we offer for all employees who join the institution. The objectives from this course are to learn the importance of the safety culture, understand how medical errors occur through the Swiss Cheese model and through serious safety events, and then identifying each employee's role in promoting safety.

We aim to have all of our new employees, in areas where area prevention has been deployed, take the course within their first year of employment. We started training in spring of 2021, and as you can tell, to date, we have over 1,250 employees who participated in a class since inception. Our goal and kind of motto of the program is a safe day every day.

On the next slide, this is one of my favorite slides. From the course that we do teach, we tell everyone we're safer together. And we really focus on the error prevention is giving the importance of speaking up and listening up. We emphasize that everybody has a role in supporting a positive safety culture, both in speaking up, but also actively listening and catching those key phrases when someone around you is speaking up. We refer to this as the head heart voice motto. So I have, I know when to speak up, I feel that I can safely speak up, and I have the skills to effectively speak up.

On the next slide we discuss there are three expected safety behaviors that we expect all of our employees to bring to work every day. And eight related tools and techniques that are taught in the class to help implement that head heart voice motto. The first is I want to make the personal commitment to safety. So we focus on what does it mean to do the right thing, when we say that. It means we always put safety first. And since safety is a shared responsibility, we must watch out not only for ourselves, but check ourselves and our other teammates when performing tasks. It's that 200% accountability. The related tools associated that are the Name Game. CUSS, that we use from [inaudible 00:40:04]. And taking a STAR moment.

The next one is everyone is accountable for clear and complete communication. Communication is really at the core value of quality and safety. So we focus on having the three effective tools to ensure that the message that you're intending to send is also properly received, and the intended message is sent. The three tools we teach with that are SBAR, 3-way communication and a data handoff tool.

Then last, we talk about everyone supporting a questioning attitude, which is really one of the core tenets that we focus on within our safety culture transformation. Questioning attitude really needs that we think critically about the things we see and hear during our workday. We really stress this within our own safety culture, as we work towards refining it. And really being able to practice and accepting this from a team member. That someone's not questioning your clinical judgment or your skills, but really questioning information that we're hearing. And if it doesn't fit, you needed to use the related tools that silence the internal smoke alarm that might be going off as you approach a new clinical situation.

For those tools, we use QVV, which stands for qualify, validate and verify. That's just a 3-step technique for processing raw information into fact, and we really use that a lot as we're teaching, as we're reinforcing the skills. And then stop and resolve, so letting staff know it is okay to stop the line and not proceed in the face of uncertainty. If you are not comfortable, you have every right to stop, move up escalation matrix. You have other tools and techniques that you can use to make sure you don't proceed in that phase of uncertainty. This is all great.

On the next slide, we talked about how are we going to sustain this? So staff go through a 2-hour-long class. How do we positively reinforce the tools and the behaviors that we teach in the class? So we created a positive method for reinforcing, and encouraging the usage of those tools through our GCH Safety Recognition Program. We'll try to celebrate and highlight the success when people are able to take those skills and tools used in the class, and be able to implement them in their clinical area. There are two main arms that we have in this program. We have a Safety Hero award and a Clinical Moments Excellence card award. And truly, this foundation of this recognition program is rooted in our safety culture and in the eight behaviors and tools that we teach in our prevention.

On the next slide, you can see some of our recent Safety Hero winners. The recognition program, it really marries that positive proactive safety domain. I think sometimes people refer to it as safety, too. And our cultural domain of error prevention into one program. We encourage employees to not only report things in our event reporting system of when things are wrong, but also report positive events and usages of the eight expected safety tools into our event reporting system. We have a special icon for that called Clinical Moments of Excellence. So each month we score those submissions and we pick two to three events that really best highlight the eight tools, and we select the winners of that month's Safety Hero award. Quality leaders join hospital leaders at the clinical site to present the award to the winners. Along with certificate, a Safety Hero pin, and flowers. We also then post the winner and the associated safety tool that they use on our GCH quality social media accounts to further spread and reinforce these use tools.

All of our other submissions that come through, we receive a Clinical Moments of Excellence card mailed to their home, that is signed by senior leaders as well as hospital leaders. In addition, we also send thank-you cards to all of our nominators, to thank them for reporting those positive events and kind of encouraging anyone to speak up, both in a positive culture and not just when things necessarily don't go according to plan or policy.

Since we've started this award, we've had over 60 GCH employees that have been recipients of our Safety Hero award, and been able to recognize them. So this has really, I think, been a positive impact to our hospital to not only look at things in kind of that, I say negative tone, but look at things as well when things go right. When I teach new nurses about this program and all this course, I always end by saying one of my favorite quotes what I've learn from the culture way is, "You can't learn about sharks by just studying shark attacks." So we can't learn about safety culture and air prevention and all of the culture tools if we just study when things go wrong. We also have to look at when things went right, so we can help reinforce and provide opportunities for when things go right and replicate those to other areas. Thank you.

Bob Panzer: Thanks, Rebecca. Okay. Move on to our next presenter, Michael Leonard.

Michael Leonard: Good afternoon everyone. Bob, you can go to the next slide please. So I am happy to share from an organization perspective on some of the work that we're doing at UR Medicine. This first slide is really to show that we are taking a very comprehensive approach to safety, and created an integrated infrastructure. So we actually have moved from beyond talking about just patient safety, and we now talk about healthcare safety. And when we talk using that terminology, we certainly bring in the patient and all the efforts that we think about when it comes to patient safety. But we also think about workforce safety as well as psychological safety.

So in the patient safety domain, we're still working hard to reduce errors, prevent and mitigate harm like all of you are doing. From a workforce perspective, we're looking at preventing workplace injuries, mitigating exposures. And from the psychological part, which is so important and a part that's becoming more and more recognized as an area that we really need to focus on, if you think about Maslow's hierarchy, safety is just above physiologic needs. So for patients, it's that trust that Renee was talking about in the quality and safety of care that we provide. For our workforce, as Rebecca mentioned, it's that ability to speak up and also feeling safe at work. Unfortunately, we are in a world where we're seeing more and more violence being introduced in healthcare, so being able to come to work and feel that you are safe is incredibly important. Next slide please.

So I wanted to share some of the principles that we use when we look at healthcare safety. So the first is transparency. And there's several aspects to transparency. One is the data. So we have many dashboards and reports that we share across the organization. We also share a lot of our data publicly. What we're working toward is creating more interactive and actionable data using some of the new tools of the 21st century, as opposed to the static reports that many of us remember and sometimes still see in our daily work.

In addition, it's getting that information out and being transparent actively. So as an example, we send out a report of harm to thousands of employees every week. That report actually has two different aspects. One is data, looking at the different metrics that we follow from a safety perspective, but the other is what I call the datum or the N of one. It's the story about a patient. It's the story about a colleague. It's the story about a family. Where we don't have huge numbers to back up the fact that we need to make improvements, but the fact that this patient or this colleague or this family experienced something, we need to move forward on it.

The second principle is visibility. That also comes in a couple of different aspects. So one, our leaders round on a regular basis in as many clinical areas as we can reach at a time. We talk with staff, we ask them what are the safety issues? What are their concerns? How can we make things better? That's a very, very positive message and gives us fantastic feedback. We also keep safety messaging front and center across the organization. As an example, if you sit down in front of one of our workstations that's been idle for a minute or two, you will start seeing screensavers that really promote the safety efforts that we are working on.

As Lori mentioned, high reliability. Incredibly important aspect of what we do, focusing on those five principles. And making sure that our colleagues and our staff are aware of those principles and that we are working on it. And that really sets a foundation of what we're doing from all different safety aspects.

We talked about flexibility, and there's so much we learned from the pandemic. I remember vividly, December 15th, standing in our command center, and we had just received our first batch of vaccine. And we were planning on opening up the clinic on December 17th, and we were trying to get everything just right. And I remember our CEO walking over to me with his phone, handing it to me with a representative from New York State who said, "Did you receive your vaccine?" He said, "Yes." He said, "When are you planning on starting to give it?" I said, "December 17th." He said, "No, you need to give it today." And we did. And I realized in that moment that the perfectionist perspective that I always carried in my career, which is still very important when you are talking about doing direct patient care, but sometimes when we were looking at processing quality improvement, good enough is good enough, and we gave vaccine later that afternoon, and the rest is history.

Another key principle that we have really integrated and infused into our safety efforts is diversity, equity, and inclusivity. As examples, for over a year now, every root cause analysis that is performed within our organization has a DEI representative at the table or virtual table. Somebody whose sole role is to look at did anything related to diversity, equity or inclusivity impact the outcome and what could we do better to prevent those issues from contributing going forward? We've also created a policy toolkit that actually helps leaders from across our organization who are creating policy, to look at it through that DEI lens, to make sure that we are not inadvertently creating inequities within our organization.

And the final principle I'll mention this afternoon is humility. And ironically, I learned just yesterday that I need to change my thought process and some of the verbiage that I use. Many of us talk about cultural competence, and was pointed out by this very wise colleague is I will never be culturally competent in a culture that I am not part of. I can learn, I can be aware, I can be sensitive, but I will never be competent. And that I think is really a very powerful message. And you're remembering to be humble from the perspective of how we approach those types of issues, incredibly important. And a broader aspect, we also need to be humble, realizing that we don't have all the answers to all the safety issues. And being comfortable and using that high reliability principle of deference to expertise really is the approach we need to take, because again, nobody has all the answers to everything. Next slide please.

So some of the strategies that we're taking to transform our culture and really augment that culture of safety. One, is talking the walk. Nope, that's not a typo. I purposely put talk the walk, because our leaders role model and share what they do to help keep our patients and colleagues safe. And that's a slightly different approach than telling others what they should do to keep everybody safe. I use the term leading practices on purpose. And with all due respect to folks, even this morning who've mentioned best practices, I would posit that a best practice is only a best practice until something better comes along. So leading practices really is one of my strategies to really reinforce that. We talked about continually quality improvement, there's also continuous safety improvement.

Crisis prevention is a key strategy that we really emphasized over the past few years. As I mentioned, unfortunately, there is much more aggression and violence in the healthcare workplace in general. It may come from patients, it may come from families, it may come from visitors. Unfortunately, sometimes it may even come from colleagues. So teaching our staff how to deescalate those volatile situations and the reflex not being called public safety, unless that is appropriate in the moment, is really a way to actually really reinforce and create that psychological safety that's so important to everyone.

Lori mentioned just culture, again, focusing on those system-based solutions and not on individual blame. Acknowledging that when there is reckless behavior, and I'm so proud to say that is something we rarely, if ever, see, really, is again a key strategy to maintain that psychological safety.

Second victim support, a key part of just culture. But now more than ever, with our colleagues being so tired, working so hard on this marathon that we've been through for the past three and a half to four years, making sure that they feel supported and offering on that support, either on an individual or at a team level, when critical events occur. Whether they're related to error or not. Again, key strategy to keeping our workforce vitalized.

And the final thing I'll mention is scholarship. This was mentioned before about learning organizations. And with our being an academic institution, we have colleagues who actually are putting out publications who are developing their academic careers around different aspects of safety. And as much as I hate to teach to attest, I'm proud to say we actually have folks within our own organization who literally write some of the national test exam questions for physicians, so we know what the expectations are. So I think in that case, teaching to the test makes a whole lot of sense. And I think that's a perfect segue to my colleague Brett, who's speaking next, because he's really our expert on academics and scholarship in this arena. So thank you so much for your attention.

Bob Panzer: Thank you, Mike.

Brett Robbins: Thank you, Mike. It's a real honor to present to this group. I was asked by Dr. Panzer to essentially answer the question, how do you drive culture change in residency and fellowship training to focus on quality? And I'm going to tell you a story of how we walked that a little bit and were somewhat successful, using Kotter's framework for cultural and organizational change. So first, I'll just give you the developing the urgency. So in about 10, 15 years ago, the literature started to become very clear that GME trainees, residents, and fellows take the quality, safety costs and aggressive conservative nature of their clinical learning environment with them wherever they go to practice, even if they leave and move thousands of miles away. So they're imprinted with what happens around them during their training. The ACGME, Accreditation Council for Graduate Medical Education, who accredits all the GME programs, realized this. And they realized the clinical learning environment was a huge portion of training they were not addressing or even measuring.

So they created the Pursuing Excellence Initiative, the ACGME did. And the purpose of this was to integrate GME trainees into the quality, safety, and cost to mechanisms of the clinical learning environment, and it was a 4-year initiative. So they put out a call for applications across the country. In the application you had to get the sign off of your GME, Dean, your CEO, a board member, chief medical and nursing officers, and chief quality officer. And actually, required their attendance in person at some of these meetings across the country. So in echoing Renee, board engagement from board to bedside makes a big difference, and they realized that.

So we were very fortunate to be selected as one of eight sponsoring institutions in the country to participate in this. Consisted of quarterly meetings, rotating to different sponsoring institution sites as hosts. From the west coast to the east coast and everything in between.

So number two of Kotter's is we developed our guiding team, our chief medical, chief nursing, chief quality officers, educational leaders, and GME leaders. And actually, Dr. Panzer and Dr. Leonard were on that team as well. Very, very delighted that they were part of that team, and it was an amazing journey for all of us. And I was fortunate, very fortunate to be included on that team. Honestly, it's one of the highlights of my career so far. So we had monthly meetings to organize ourselves and developing our guiding team.

Third, creative vision. So our vision was to add GME trainees to the preexisting Unit-based Performance Program, our UPP teams at the University of Rochester. Our kind of activation or facilitator arm of our quality and safety initiatives. And the UPP teams consist of the medical director of that clinical setting, the nurse leader of that setting, as well as the interprofessional team members, including social workers, physical therapists, and others.

Fourth, you have to communicate for buy-in. So we started, our first go at this was a cohort of eight of our highest functioning and innovative UPP teams. And solicited volunteer GME trainees through their program directors, asking for your most innovative trainees to be assigned to each of the teams. We had a very broad communication and PR campaign, included a very large kickoff dinner with our senior leadership, the residents and the teams involved. We affectionately called that the wedding, because it was quite large. But it was a big deal and sent a huge message across the University of Rochester.

Fifth, to enable action. The teams were given performance improvement coaches, each team was. They were given resources from senior leadership. And their charge from the leadership was to essentially, to the nurse and medical director dyads, "Make your patient's care safer and of higher quality." Our motto became better teams and better care, and off we went.

So sixth, we celebrated our short-term wins. We had very regular monthly report out or quarterly report outs of the UPP teams. They included some education, as well as some team development and leadership development, and quality and safety. They presented to each other their results of their projects. And also, at an annual team-based care symposium at the University of Rochester, where the leaders of these teams actually ran the workshops, including the trainees, ran workshops for the attendees. So along short-term win lines, we discovered that when you break down silos like this across professions, giving them non-direct clinical care issues to work on together just so you can make things better, money and happiness tend to come out. So length of stay, readmissions improved. But I think more importantly, relationships and culture improved across the team members, that were incredibly helpful in a number of ways, including those middle-of-the-night care urgencies. And add these things called pandemics that arise from time to time.

Number seven, don't let up. So it was very satisfying that being on an UPP team became the place to be. So suddenly our innovator cohort, their success led to a group of early adopters becoming our cohort two. And now we have an early majority in cohorts three and four, and it just continues to roll on its own momentum.

So eighth, eighth and final is make it stick. So the vision of our senior leadership, chief medical and nursing officers was to enshrine this process into our newly minted Quality Institute, which is led by a very interprofessional team, led by our chief medical nursing officers and quality officers. And it includes an interprofessional group of URMC leaders, including our dean of GME, to continue to drive an organized change across the university in quality and safety. So we can imprint on our trainees these habits that they will carry with them, no matter where they go, for up to 20 years of their practices.

So the mission, I'll end with the mission of the Quality Institute, is to drive equitable, high value person-centered outcomes, while prioritizing safety and wellbeing. And that's a nice high and mighty thing to say, but I do believe thoroughly that we are actually doing it through the mechanisms that I've just described. Thank you all.

Bob Panzer: Thank you, Brett. So we're going to move on to our combined panel discussion and Q and A session. We have multiple Q and As in there. Would any of the facilitators like to take on these, perhaps in order? Or I could introduce the first one. So the first one is, "How do you promote a culture of equitable access to opportunities for professional growth and development among both clinical and nonclinical staff?" Anybody want-

Brett Robbins: I could take a whack at that. I'd say through our work in what I just described, you level the playing field and you put everybody on the same side of the table, looking across the table at not each other as the issue or the problem, but the problem as the problem. So you're all rowing the same direction and heading towards the same target. And that leveling of the playing field is the culture of those working groups is crucial to making that go. That's my initial answer.

Tara Gellasch: Hi. I guess I think if we think about making sure things are equitable, I think we have to be just extremely intentional about that. I think we have to be really sort of in tune with our internal biases that we might have as leaders or that others may have. And I think that, really, to get to that point where we're sort of leveling the playing field, we do have to be very intentional and make sure that when we are looking at offering different opportunities and bringing new voices to the table, that we're really having that lens on. I do think it's not accidental, I think we have to be very intentional about it.

Bob Panzer: Yeah. I'd add that you often see people talking about career ladders and intentional design of the future for many roles. But the expectation that for some roles there'll be a transition up that career ladder within that lane. And then for other people, you'll see them going off into other career ladders in nearby professions. Often we'll have people who decide to go for advanced education and training for another job, and others move up. And I think to the extent that what I described is actually known to people and available to them, we're doing great. And if we don't pay attention to it, we're not.

Next question was, "What qualities in a leader do you find best result in the capacity to affect culture in the workplace?" So leadership qualities. I think one of our panelists touched on that. One or more.

Lori Paine: Bob, I'll kick this off, because I think all of us probably have a different idea on this. But I think a leadership quality of servitude can be very helpful and powerful. Some of you have heard me tell the story, but once I had a resident with me from the military, they would do military rotation. And I asked him at the time, I'm like, "What's your experience being in the civilian, and how does it compare to being in the military?" And he said, "Well, one thing is in the military, it's everybody's job to be serving the frontline." And he was not necessarily making that same observation in the civilian hospital setting. That stuck with me for 25 years. And I always think about that, that I think it is so important as leaders that we remember every single day the work we're doing should be serving those that are providing a direct care.

Bob Panzer: Great. Thank you. Next question. "Does the group know the best pace for culture change?" I would imagine there's a dynamic tension, not to push too hard, but move improvement forward. How do you know in the moment that you're working at the optimal pace?

Lori Paine: From a pace standpoint, I was always advised, "Don't expect to see change in culture from a survey standpoint, our survey results, in any less than six months if you had an intervention." Culture change takes months and months and months, and the earliest you might see a change in your culture results might be six months. But from a pace of when you might see improvements in specific culture, I think that depends. It's so multifaceted, and depending on what aspects of the culture you're trying to affect, could take even longer. I would love to hear from other panel members and your thoughts there.

Brett Robbins: Yeah, Lori, thank you for teaching me that. What was it? The technical versus the...

Lori Paine: Adaptive.

Brett Robbins: Cultural adaptive changes. And I think the pace at which you go is the leaders need for emotional intelligence to sense that and their teams around them. And realize when they're pushing too hard or not hard enough. And that's why we need good leaders. And thank you again, Lori. That's a great way to dichotomize that. Thank you.

Tara Gellasch: I think from a practical standpoint, I think, again, going on the assumption that our colleagues are coming to work wanting to take great care of patients, I think the pace is right when you're able to bring the majority of your team with you. I think when we start, there's always going to be some skeptics and naysayers that can be a little bit more challenging to bring along with you. But if you've got the majority of your team with you, I think you're operating at the right pace.

Bob Panzer: Actually, I'm going to add something. I think the time can be shorter if it's very focused and aggressive, but for many things it takes years and years and years. Not just for the understanding of what you're trying to do to be there, but for people to believe that you're going to do it. On the just culture front, unless we can say at least for the last 10 years we have not been punitive about an individual making a mistake, then I think we can honestly say we're delivering at the leadership side and at the management side the just culture. But if it's too short, people are going to say, "I don't believe it's going to stick." And I think many of these things have stuck because we have been in this work for a long time.

Lori Paine: And I might add just, Bob, one last thing, that there are constantly new inputs to our culture. Right? So it's not like you fix it and it stays fixed. There's new people that come in, there's new regulations that come in, there's new pressures, new patient... All these factors that keep really challenging our culture. And our ability to keep up with some of that change can require... I know myself and my career, I feel like we sometimes have to go back and do what we were doing 10 years ago, and I'm like, "Didn't we already do this? This seems redundant." But it's because we have new people, and sometimes we just have to go back and you have to have the patience to recognize that sometimes we do need to take one step back to go two steps forward.

Bob Panzer: Great. "Is the leadership and training for the residents and fellows still going on? To Dr. Robbins." Dr. Robbins, I'm going to take this one since you've said it. The Unit-based Performance Program and pursuing excellence continue now years after the funding ended. So it's baked in at this point.

Next one is, "How can we join an UPP team?" I'm going to jump in on this one, but we have to give some credit here. So our Unit-based Performance Program is modeled after the CUSP, Comprehensive Unit-based Safety Program from Johns Hopkins, that Lori and Renee were highly involved in before their transition to Rochester Regional. So there's a lot of teamwork and credit there. And we've branded as UPP, given the way we've designed it here. But it's pedigree is from CUSP.

So the, "How can we join an UPP team?" So in the hospital we went big bang and have UPP teams on every inpatient unit. UPP teams are present in some ambulatory areas and some procedural areas. So if you're in one of those areas, the way to find out and join it if it exists, or find out about it or the plans for it, is to talk to the relevant physician and nurse manager, a dyad and administrative manager if there's the third person, about what's going on. Because it is deployed fully, at least in the inpatient setting. It's strong and significant parts of Highland, and to a lesser degree, elsewhere.

We have one in the chat that Dr. Leonard is going to take. "The case of RaDonda Vaught at Vanderbilt. There was a medication error that was attributed to her, rather than the system she was working in. Has this case hurt our local efforts to encourage caregivers to disclose errors? And you think we would've responded differently if it had happened here?" Michael.

Michael Leonard: Yeah. So that was a really unfortunate case. And I really hope that it's an anomaly and not setting a trend at the national level. So for those folks who may not be familiar with this case, and of course we don't have all the details, a lot of that with privilege, but what we do know is that this was a nurse who inadvertently gave a wrong medication, pulled it out of an automated dispensing cabinet, and patient had a very, very unfortunate outcome. And part of the reason that it made the national news was not only was there an error with a poor outcome for the patient, but she was actually charged criminally, I believe for negligence. I'll defer to the lawyers on the call for that. And that really sent shockwaves through the healthcare system.

As far as we know, and again, there may be details we're not aware of, there was no recklessness. This nurse certainly didn't intend to give the wrong medication to a patient. And this is the antithesis of just culture, so I think that that's the basis of the question here. I can say very confidently within our own organization, if that event was recreated here and there was no willful disregard of policy, there was no reckless behavior, this individual is doing things through the normal way we do things, our organization would 100% back this individual. The problem is we unfortunately only have limited, if any, control over what governmental agencies do, and certainly what lawyers out in the community do. But again, we do advocate for just culture.

And we actually even have a website, I can put it in the chat, at least for folks from neuro medicine who are on the call, that we speaks to just culture, not directly to this case, but how we would approach something like this or other issues where again, it's an individual who makes a simple human error, and how we as an organization respond. Again, I'd love to hear what some other folks on the call think about this. But again, based on what we know, my heart really goes out to this poor nurse. Now, fortunately, she did not wind up receiving any jail time. I don't remember what the actual verdict-

Lori Paine: Yeah, she got sentenced to probation, I think, for three years. She did license removed. But I think I had heard in the media she was actually seeking to get her license reinstated. I haven't heard the outcome of that. I was hoping to add, Mike, to your point.

Michael Leonard: Absolutely.

Lori Paine: I think one thing that case didn't help us in our journey for workplace justice systems, was it created a muddiness with the criminal justice system. And those are two very different concepts, of workplace justice and criminal justice. They're driven by very different things. Like Mike said, we can't control what the DA decides to bring forth. And I think I have heard it rumored that there were politics involved in the desire to move this case and bring charges up against RaDonda. But I think as leaders, we need to advocate against criminalization of medical error. But let's not lose sight of the lessons that we need to learn as organizations about what happened at Vanderbilt. Because I would submit that that same mistake that happened there, could happen anywhere. There were holes in that system that I submit many of us have in our own systems.

And so I think through MCIC, when I was at Hopkins, we took a deep dive into this, along with U of R, and we recognized that there were things we need to do at our own shop to make sure that same thing couldn't happen. And that type of learning is what we need to get out of these, and try not to get too distracted by the outcome, but rather do what we can to make sure it never happens here.

Bob Panzer: Thank you. Next one is, "How do we create a cultural sensitivity and humility framework, when we don't have enough people that are diverse racially and ethnically, as well as those with disabilities, as leaders in the system?"

Michael Leonard: Yeah. I can start with the response to that. It is a huge challenge. But I think one of the first things that we need to do is acknowledge the problem and address it with humility, that I cannot and should not be making decisions, creating processes without the input of those folks who would affect. So I can speak for our organization-

Speaker 10: [inaudible 01:17:43], man.

Michael Leonard: Sorry? We are actively trying to expand our pool of applicants to really create that more diverse workforce that really reflects the community and the patients that we serve. Until we get to that point, which I think we all know is going to take some time, I think reaching out to folks from that community to help guide us and provide input. So we have, I believe currently eight patient family advisory councils that really help steer us in the right direction and provide us great feedback to make sure that we are being as culturally aware as we move forward with a lot of these efforts.

Bob Panzer: Other questions?

Hiloni Bhavsar: I think there was one question about how to include other multi-professional team members into culture change. At a macro level, I think somebody made a comment relative to social work, and when we think about other support services, like our care management team members, our respiratory therapists, et cetera. And how are some ways that those professions are included in some of the culture change work is, I think, oftentimes it's focused heavily on providers and nursing, but obviously we all know we take care of patients in a much more team-based environment.

Lori Paine: We encourage the inclusion of other disciplines, other departments on our CUSP teams. I don't know if you guys do the same in your UPPs teams.

Bob Panzer: Michael, you want to take that one?

Michael Leonard: Sorry, my apologies. Can you repeat the question, Lori?

Lori Paine: Do you include other disciplines besides nursing and providers in your UPP teams?

Michael Leonard: Oh, absolutely. Absolutely. In fact, it would be rare to find an UPP teen that only has nurses and providers. We frequently engage social work, respiratory therapy, PT, OT. Again, depending on the unit, we have a lot of specialized clinical staff, they would be a part of it as well. As Brett mentioned, we certainly engage our residents who are of course part of the provider team. Our UPP teams, we want them to really reflect the population of workforce on that unit. Oftentimes, we have nonclinical folks as well, so our patient transport folks, our environmental service folks. Depending on the initiative being worked on, we actually encourage them to be participants, because they provide a very unique perspective that clinicians may not see.

Hiloni Bhavsar: And I think I'll just add, trying to scale that response a little bit broader. And I think beyond the unit level, I think some of what you're hearing and some of what the discussions have been rounding out is, really, how do you connect systems and processes to ensure behaviors and actions are consistent with the way in which that drive quality and safety, right? And so ensuring that how you design teams and systems and committees and groups have representation from an input and an impact perspective for any and all team members that are helping to facilitate that work. And so I think as you scale up from a team to a unit, to a department, to a hospital, to a health system, it's ensuring that those dots remain connected throughout when you're scaling that. So that if you're looking to implement process change or system change or decision changes, that there's appropriate up and down communication that allows people to connect the why, the rationale, for all aspects of team members that are taking care of patients.

So I think one place to start with that is at that UPP team level, because I think oftentimes that's where the work is happening and that's where people are feeling changes, decisions, seeing and interacting behaviors and actions on a day-to-day basis, that really can create that fabric and environment that you want to make sure sustains a good culture in the organization. But having that upward connection and outward connection on how decisions and information is communicated and put forward is important to maintaining a pulse on what's happening at the team level. But also, ensuring that you maintain good cultures that are there or change ones that are not.

Bob Panzer: There's a kind of a question in the form of a comment, or vice versa. "Sustaining change could be challenging." I'd like to comment on that one. I think it's true of our organization, but you've seen some elsewhere where the senior leadership team is in the territory we've been talking about, having the culture we want, high reliability, safety, et cetera, et cetera. And they get their board and other leadership together with them on that. So when there is inevitably a leadership change, things sustain. I think that's true of organizations that they're built to last and the good to great types. You occasionally see organizations where one leader changes, a new one comes in, and the, whatever, program has ended. And the people who are working on it are no longer doing that. And that's a failure to create and do the work in a way that is going to sustain itself. And I think for both of our systems in Rochester and some we work with, like Hopkins and others, I think it's true that things do sustain because it's through and through. It's not just one individual's push to do it.

Lori Paine: That's part of the resilience in the high reliability framework, is that it's resilient enough to sustain those types of leadership changes. It's an important factor.

Bob Panzer: Okay. Let's see. Okay. So it's three minutes to go. I think rather than taking another question, I'd like to put in another set of thanks to our presenters, to our facilitators, to GRQC. Dick Schroer, who helps facilitate the website and the registrations going on. Heidi Polterex Stowell for facilitating our session and this Zoom session and the administration on our subcommittee side. And again, learn more about GRQC. GRQC's long-term goal has been that Rochester be a community of excellence through quality, or quality and safety you might say. And that's a hard vision to deliver on. And obviously, we're nowhere near that on all fronts, given the current state of the world, and Rochester, particularly in the area of equity. And so we've got plenty of work to do there and plenty of good work to do in healthcare. And I think what everybody talked about today is that we're on the path together.

And I'd also like to note how good I feel, besides GRQC, that the two major systems, Rochester Regional and your medicine are together on this hardcore collaboration. So thank you. Any other comments from any of our presenters or facilitators? Okay. I would like everybody to note that we ended on time. What a magnificent thing to do. So thank you all. I'm going to stay on in the panel, if anybody wants to do any debrief for a few minutes. But thank you all and thanks to our audience for joining us. Have a great day.