Ann & Robert H. Lurie Children's Hospital of Chicago®
Center for Quality and Safety

Beyond Blame: Designing Improvement-Focused Morbidity & Mortality Conferences Across Your Institution

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Disclosures

The facilitators of this session have no conflicts of interest to disclose.

Agenda

Timing	Activity
0-10 min	Introduction and Icebreaker
10-15 min	Framework for MMI
15-25 min	MMI Design- Small Group Breakout
25-35 min	MMI Design- Large Group Report Out
35-50 min	MMI in Detail
50-70 min	MMI Case Application- Small Group Breakout
70-85 min	MMI Case Application- Large Group Report Out
85-90 min	Wrap up

Objectives

1. Describe the role of M&M conferences in promoting a culture of safety and identify key components of a restructured Morbidity, Mortality, and Improvement (MMI) conference

2. Design an MMI conference plan for a specific audience, including consideration of cases, audience members, stakeholders, learning objectives, discussion points, and associated institutional improvement work

3. Apply MMI design principles to a mock case using the developed framework

Introduction & Icebreaker

Kate Lucey, MD, MS

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Manager, Improvement Consulting, Center for Quality and Safety

Ann & Robert H. Lurie Children's Hospital of Chicago

Please Share:

- ❑ Your name
- ❑ Home institution
- ❑ Role
- ❑ Favorite snack!

Transforming M&M into MMI

CQS

OLD: M&M
Morbidity & Mortality

- Shame and blame culture
- Emphasizes individual accountability and mistakes made
- Focuses on detailed event synopsis
- Division specific, siloed

Applying Safety Science

NEW: MMI
Morbidity, Mortality, and Improvement

- Culture of safety
- Emphasizes failure modes and opportunities for improvement
- Focuses on system vulnerabilities
- Institution wide and audience appropriate

MMI Framework

MMI Across the Institution

Case Selection

Content

Structure

Psychological Safety

Protected Status

MMI Across the Institution

CQS

Institution

- Focus on multidisciplinary care
- Intradisciplinary discussion and points of view
- Highlighting communication and how patients transition between different teams within the hospital

Division

- Building on basics of MMI
- Focus on content and trends in area-specific diagnoses
- Colleague collaboration and discussion, fostering culture of accountability and safety
- Generating improvement ideas, emphasis on prevention

Trainee

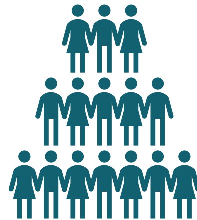
- MMI fundamental concepts
- Identifying system issues and core teaching points
- Alignment with hospital safety and improvement work
- Emphasis on psychological safety

MMI Design- Small Group Breakout

Who is your audience?

Choose an audience for your MMI design:

Group 1: Trainees

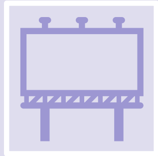


Group 2: Division

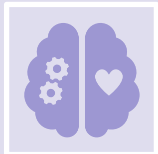
Group 3: Institution

In your small group, use Worksheet #1 as a guide to discuss how you would design MMI at your institution for your selected audience.

MMI Design- Large Group Report Out



How did your intended audience influence your design choices?



How will you maintain psychological safety with your participants?

Case Selection

Common Cases:

- Deaths and resuscitations
- Emergency events
- Escalation of care shortly after admission
- Unexpected events: readmissions, service changes, change in diagnosis
- Patient & family grievances
- **Patient or staff safety events**
- Surgical/procedural complications
- **Faculty nomination of cases**: challenging cases, ethical issues, multidisciplinary coordination

How to Find Cases:

- Automated reports
- Safety event reports
- Word of mouth

Case Review Content

Case Review

Description of case, event details, and outcome

Discussion

- Systems, logistical, or technical issues
- Health equity factors
- Variation from standard of care
- Failure modes
- Cognitive bias

Improvement

- Six aims for healthcare quality
- Ideas for improvement
- Ongoing or completed improvement projects in the hospital

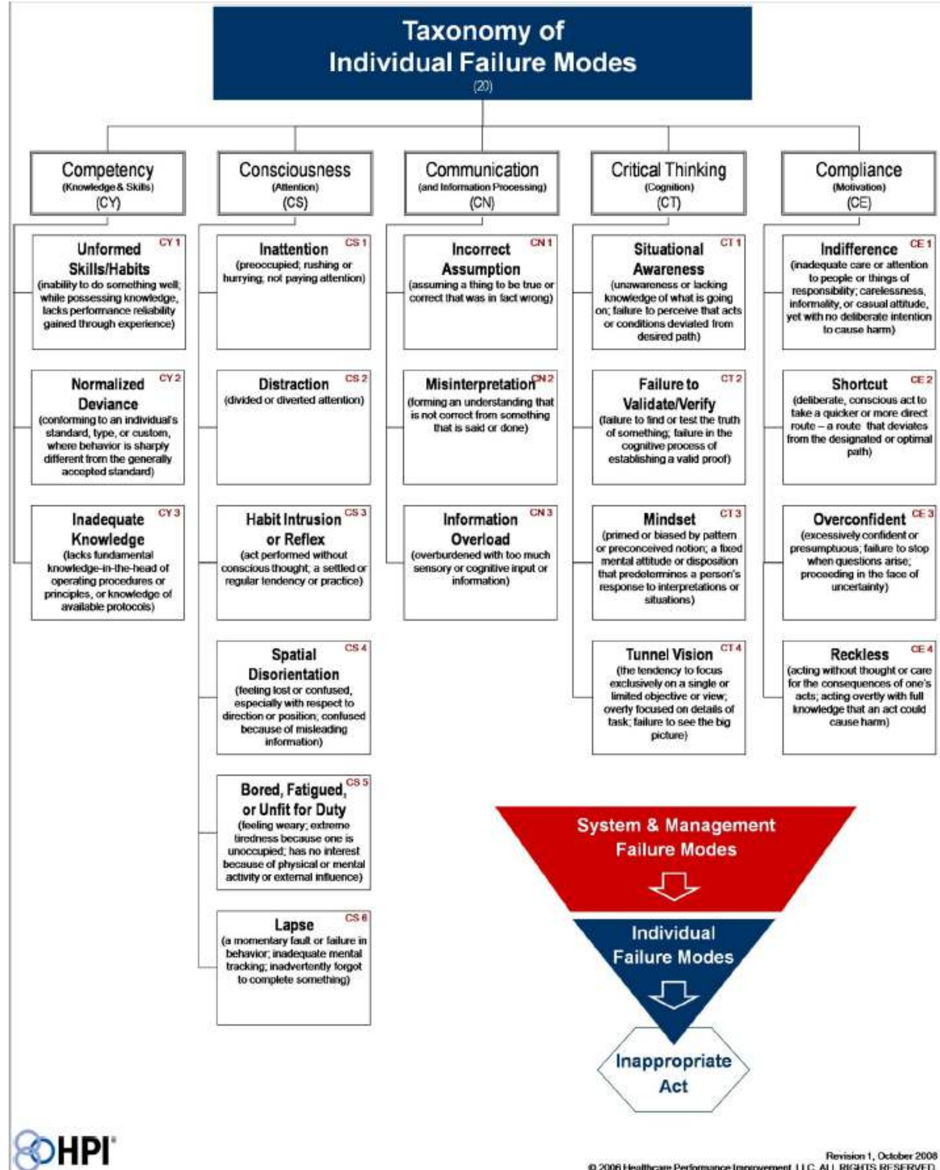
Teaching

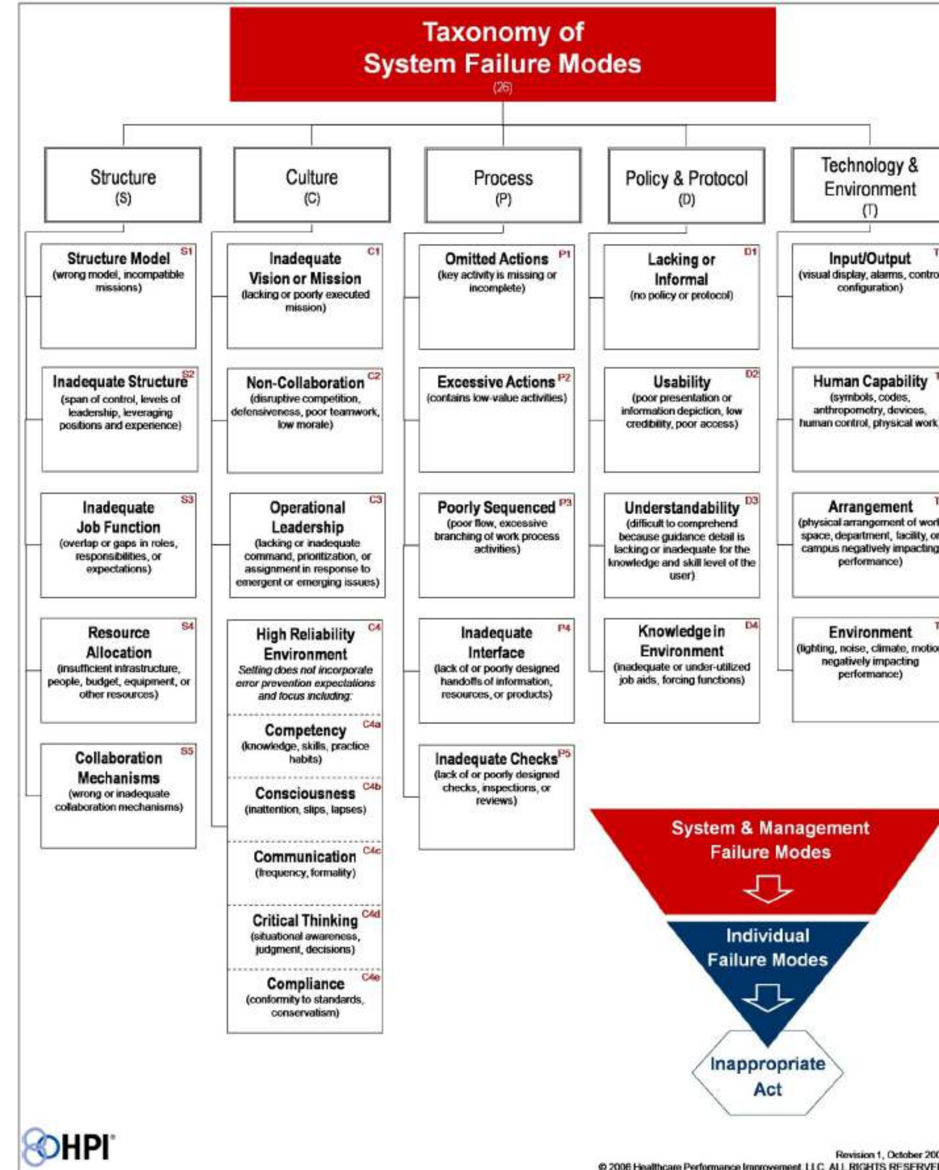
Aligning teaching points and teaching style to your audience

Topics We Often Discuss

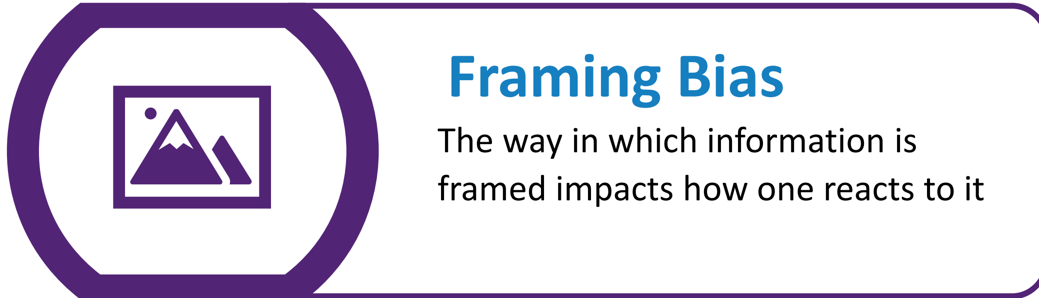
- **Failure modes**
- **Cognitive bias**
- **Diagnostic error**
- **New or active improvement work**
- Situational awareness
- High Reliability Organization principles
- Pathways for escalation of care, chain of command
- Safety analyses
- Communication challenges
- Shared mental models for patient diagnosis and treatment

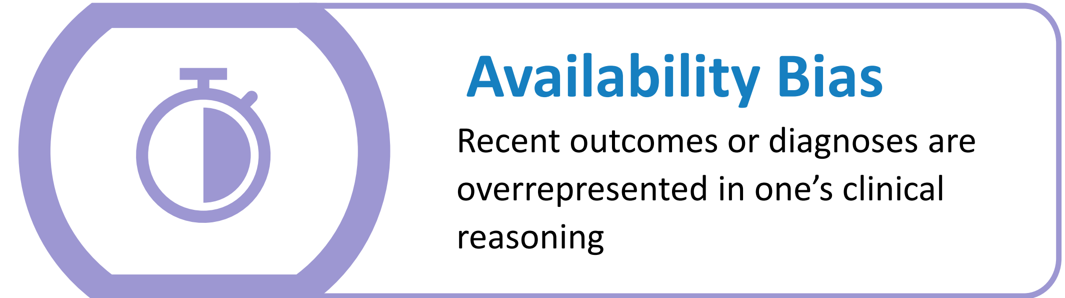
Failure Mode Taxonomies

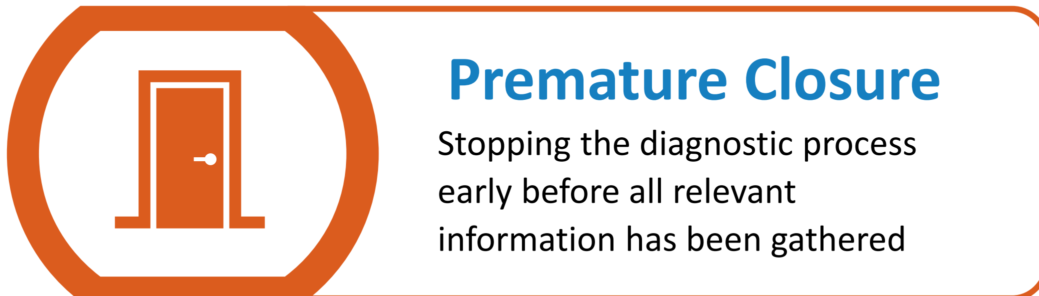


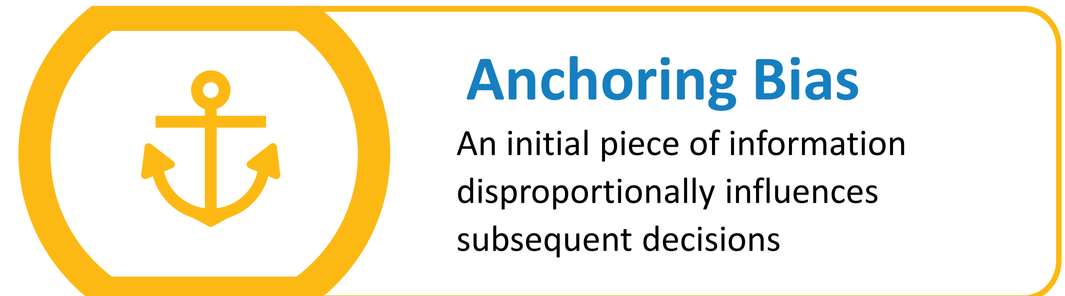


Types of Cognitive Bias









Diagnostic Error

Delayed Diagnosis

Missed Diagnosis

Wrong Diagnosis

Using MMI to Highlight Improvement Work

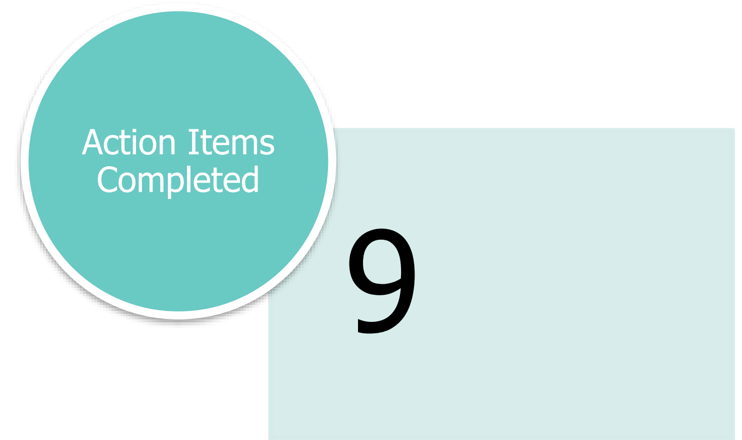
Are there potential areas for improvement that this case highlights?

…and/or…

Is there ongoing or completed improvement work at your institution that you can highlight with this case?

Tracking Improvements

MMI Date	Event Type	Identified Opportunity	Action Type	Action Item	Person Responsible	Status	Completed Date



Conference Structure Considerations

Facilitators

Audience Members

Format

Cadence

Outside Attendees

Psychological Safety

CQS

Setting Goals & Establishing the Why

- Forum for collaboration
- Focus on lessons learned, opportunities for improvement, and psychologically safe discussion
- Establish culture of practice-based learning
- Promote transparency

Laying Ground Rules

- Respect for providers, patients, and families
- Confidentiality
- Constructive discussion
- Emphasis on systems issues, not individual performance or blame

Attendees

- Who will attend?
- Who will present?

Care Team Considerations

- Deidentifying the care team
- Soliciting input of the care team in advance

Protected Status

Consult with your risk and legal teams to ensure your discussions are privileged and exempt from discovery in legal proceedings. Many states have laws that protect the proceedings in morbidity and mortality meetings.

An example of a statement to include in all communication and at the start of your conference might look like this:

"This material was prepared pursuant to the specific directive of the Morbidity, Mortality, and Improvement Committee for the purpose of investigating and discussing matters concerning improvement in patient care or reducing morbidity or mortality"

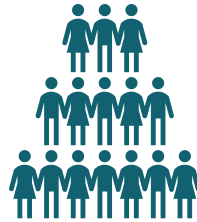
At Lurie, we often include the Illinois Medical Studies Act in our communication and presentations.

MMI Case Application- Small Group Breakout

Read your assigned case. Using Worksheet #2 as a guide, discuss how you would design an MMI session about your case.

Group 1: Trainees

Sepsis



Group 2: Division

Button Battery Ingestion

Group 3: Institution

Post-T&A Tylenol Overdose

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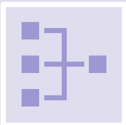
MMI Case Application- Large Group Report Out

Share a 1-2 sentence summary of the case

What key failure modes, biases, or diagnostic challenges did you identify?



What system-level improvement opportunities did you identify?
How will you ensure these are communicated and escalated?

How will you know your MMI was effective?

Wrap Up

How can MMI fit within the Q&S framework at your institution?

What is one thing you will take away from this session?

Session Evaluation