MHA
MISSOURI HOSPITAL ASSOCIATION

MHA Clinical Quality Quarterly Webinar

Safety Across the Board, Part I

Dial-in #: 855/427-9512
Conference ID# 74225907

Objectives

- The safety landscape in health care today
- Review The Partnership for Patients Campaign Guide to Safety Across the Board imperatives
- Define safety across the board and what it means for strategizing harm reduction
- Leadership and staff: perspectives, re-engagement, re-energize
- How to count all harms-the “new” metric

Movement in a Time of Great Change

- 2010: Affordable Care Act
- Beginning implementation of health care reform actions
  - payment reform
  - improvement incentives
  - Federal, state-level, private partner program changes
    - Partnership for Patients

Strategic Goal 1: Strengthen Health Care

Objective A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured

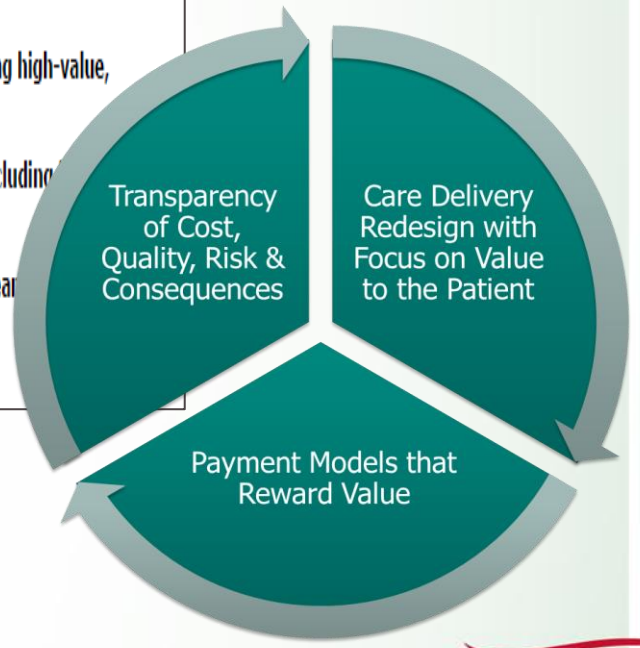
Objective B: Improve health care quality and patient safety

Objective C: Emphasize primary and preventive care, linked with community prevention services

Objective D: Reduce the growth of health care costs while promoting high-value, effective care

Objective E: Ensure access to quality, culturally competent care, includin services and supports, for vulnerable populations

Objective F: Improve health care and population health through mea health information technology



The Hospital Safety Landscape-2015

- HEN sunset December 8, 2014
  - AHRQ National Scorecard Report
    - 17% reduction in hospital safety events (2010-2013)
    - 1.3 million events prevented
    - $12 billion saved
    - 50,000 lives saved
- New QIO-QIN program
- Measure reporting burden
- Variable denominators-comparison issues
- Harm Across the Board--*a start*

A Call to Action

Sylvia Burwell

"I need your help in accelerating the pace of progress."

"This is a start."

Secretary of Health & Human Services
Sylvia Burwell

17% Reduction

40% Reduction

0 Harm

Achieve Safety Across the Board

HHS.gov

- January 2015 release
  - CMS set BOLD AIMS
    - 30% of Medicare provider payments to be in alternative payment models tied to value—by 2016; 50% by 2018
      - Examples: ACO, PCMH, "bundled payment" model
    - By 2016, at least **85%** of Medicare fee-for-service payments will be tied to quality and value; **90%** in 2018
    - Created a Health Care Payment Learning & Action Network
      - Facilitation of public-private sector partnerships
      - Streamline costs, business models, improve coordination and safety

Safety Across the Board

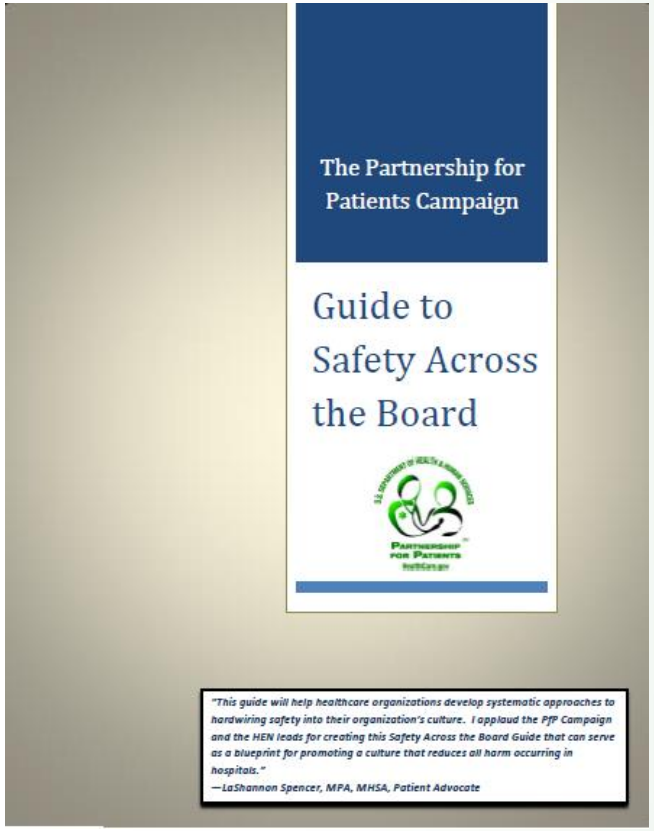
- Systemic approach: measuring, monitoring, continuous improvement
- Focus shift: not about projects or units—systems thinking
- Measured as “Total Harm”
- Gives hospitals a single safety metric to track over time
- Engages hospital boards, executives, and staff to action

Partnership for Patients Campaign: Guide to Safety Across the Board

- Four Imperatives
  - Establish a Culture of Safety
  - Count all harms
  - Engage the patient and their family
  - Create safety across the board

Leadership & Staff together

Transparency



Guide to Safety Across the Board

Safety Across the Board happens when the hospital has a ***culture of safety*** and a ***sensitivity to operations*** that makes it **"difficult to the do the wrong thing"** and easy **"to do the right thing"** to prevent harm and *keep care providers safe*.

Achieving Safety Across the Board

A Culture Focused on Safety

Leadership Role

Top down strategy

Hold Accountable

ZERO PATIENT HARM

Engaged employees

Safety assurance

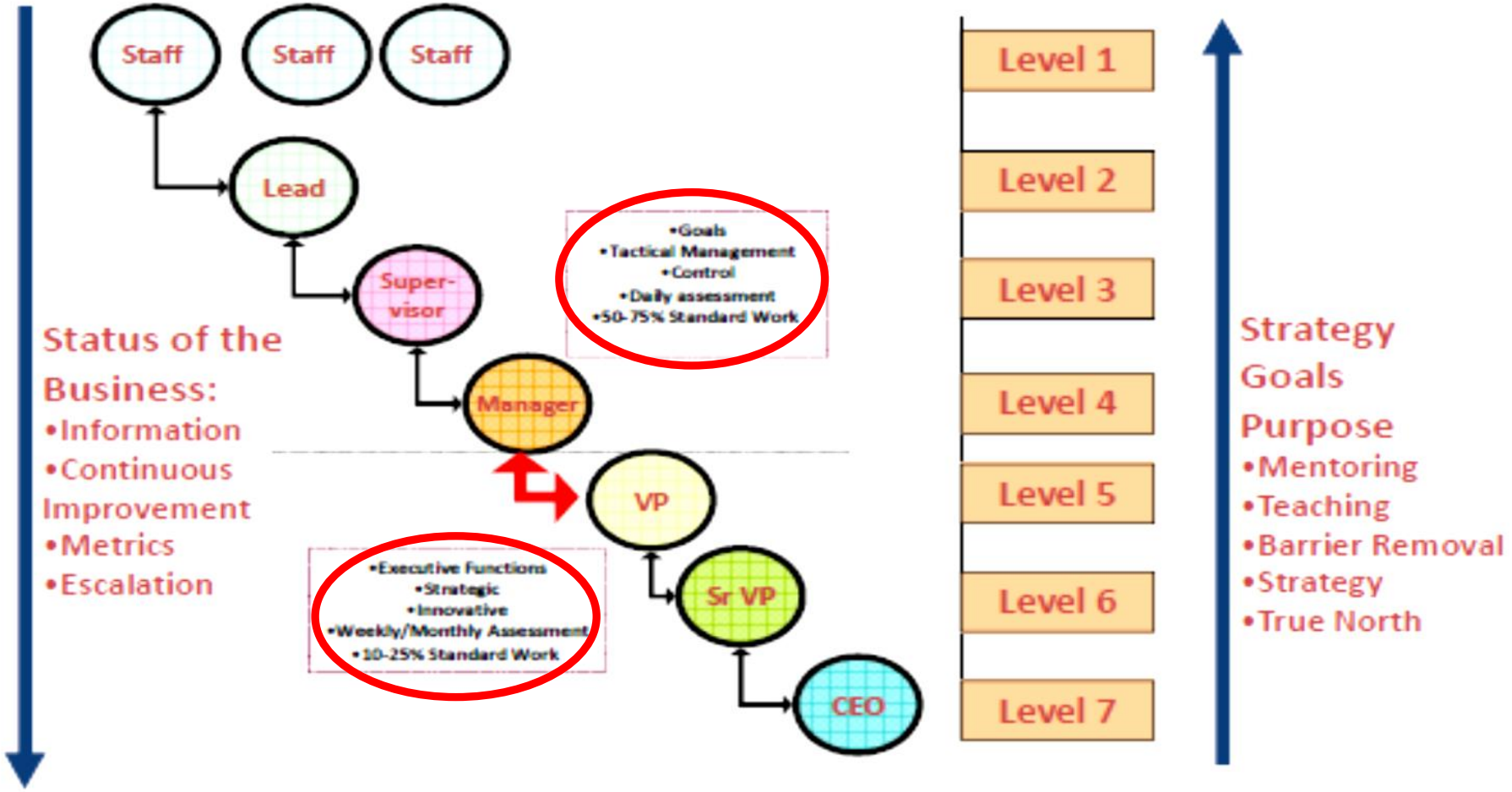
Staff Role

Learnings from Visits to 142 Health Care Organizations in 15 Countries-Dr. John Toussaint

ThedaCare Center for Healthcare Value

- Most work processes are in chaos
- Very little standard work is in practice
- There is no way to identify and solve problems immediately when they occur
- Leadership is autocratic and not engaged at the frontline
- Most leaders can't see waste

Management Process



THEDACARE

"Most of what we call management consists of making it difficult for people to get their work done."

-Peter Drucker

White Coat Leadership	Improvement Leadership
Exhibits an "all knowing" attitude	Demonstrates humility
Adopts an "in charge" posture	Exhibits curiosity
Demonstrates autocratic tendencies	Facilitates improvement efforts
Adopts a "buck stops here" approach	Teaches others
Shows impatience	Learns from others
Blames others	Communicates effectively
Controls others	Perseveres

Role Models

High-Impact Leadership Behaviors
What Leaders Do to Make a Difference—Culture Building

1. Person-centeredness	Be consistently person-centered in word and deed
2. Front Line Engagement	Be a regular authentic presence at the front line and a visible champion of improvement
3. Relentless Focus	Remain focused on the vision and strategy
4. Transparency	Require transparency about results, progress, aims, and defects
5. Boundarilessness	Encourage and practice systems thinking and collaboration across boundaries

Swensen S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. Cambridge, MA: Institute for Healthcare Improvement; 2013. Available on www.ihi.org.

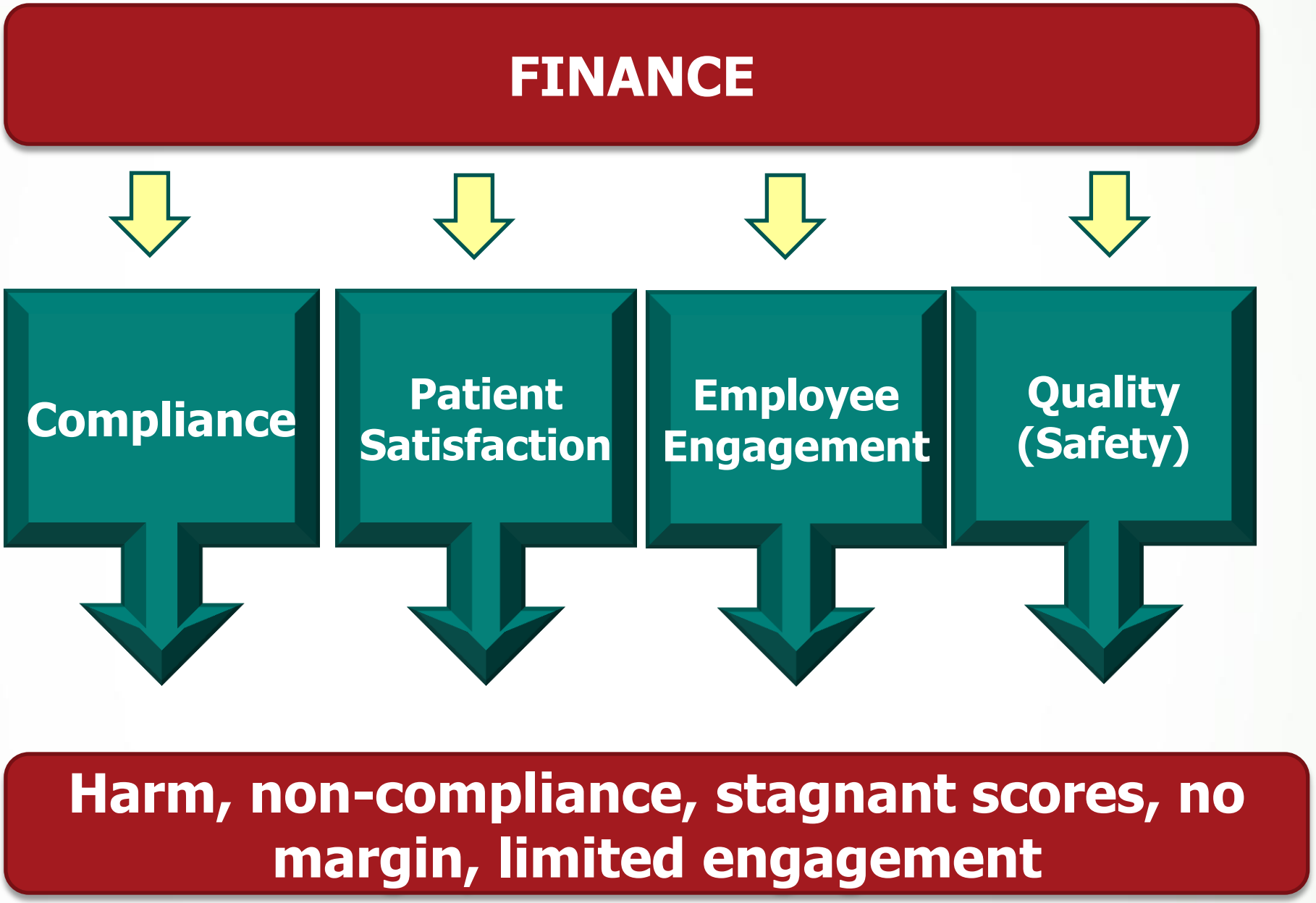
Social Change

- Improvement requires social change and that people are more likely to act if they ***believe***.

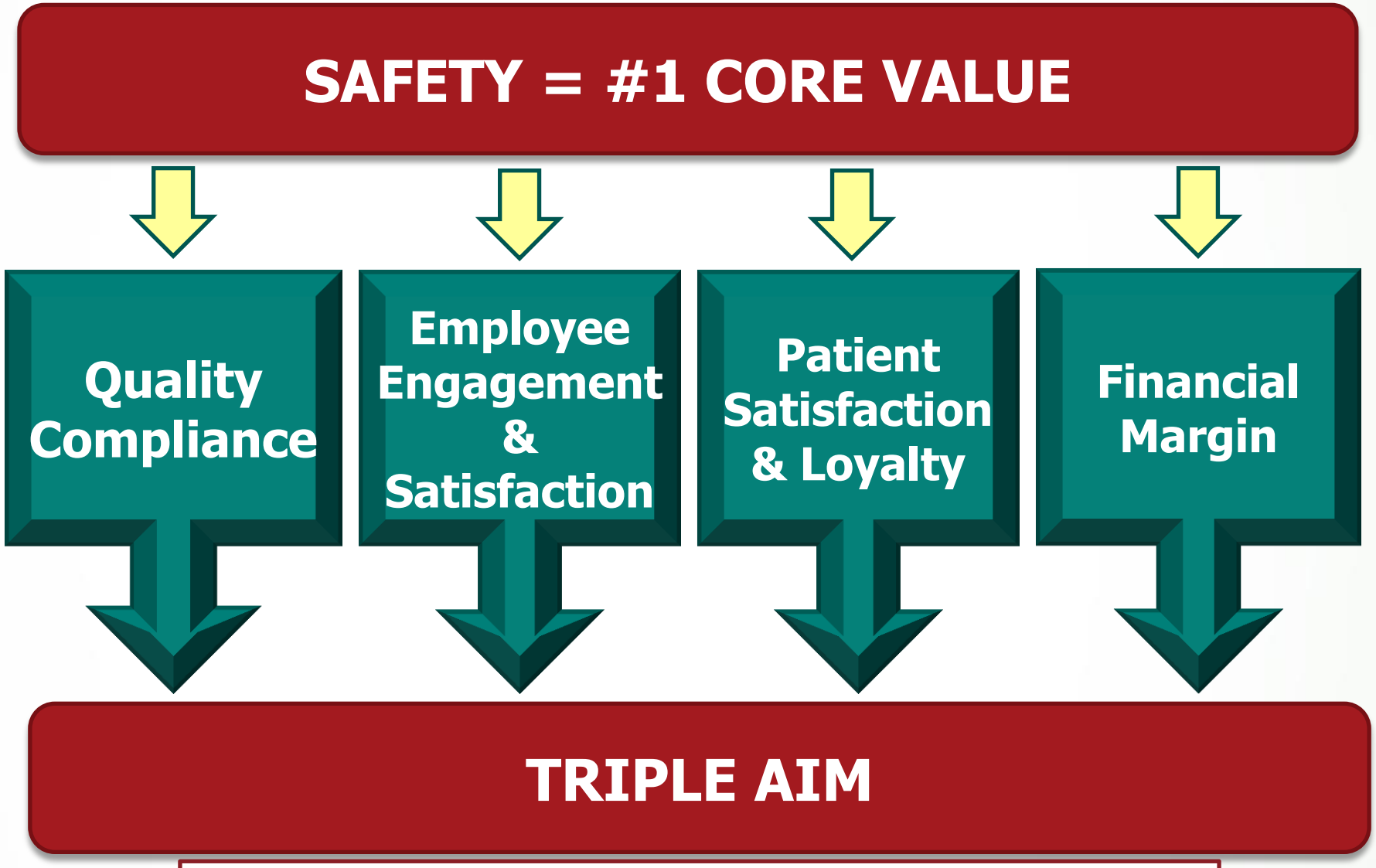
"If you want to harvest, go to the fields."

Goren Henriks

Perspectives

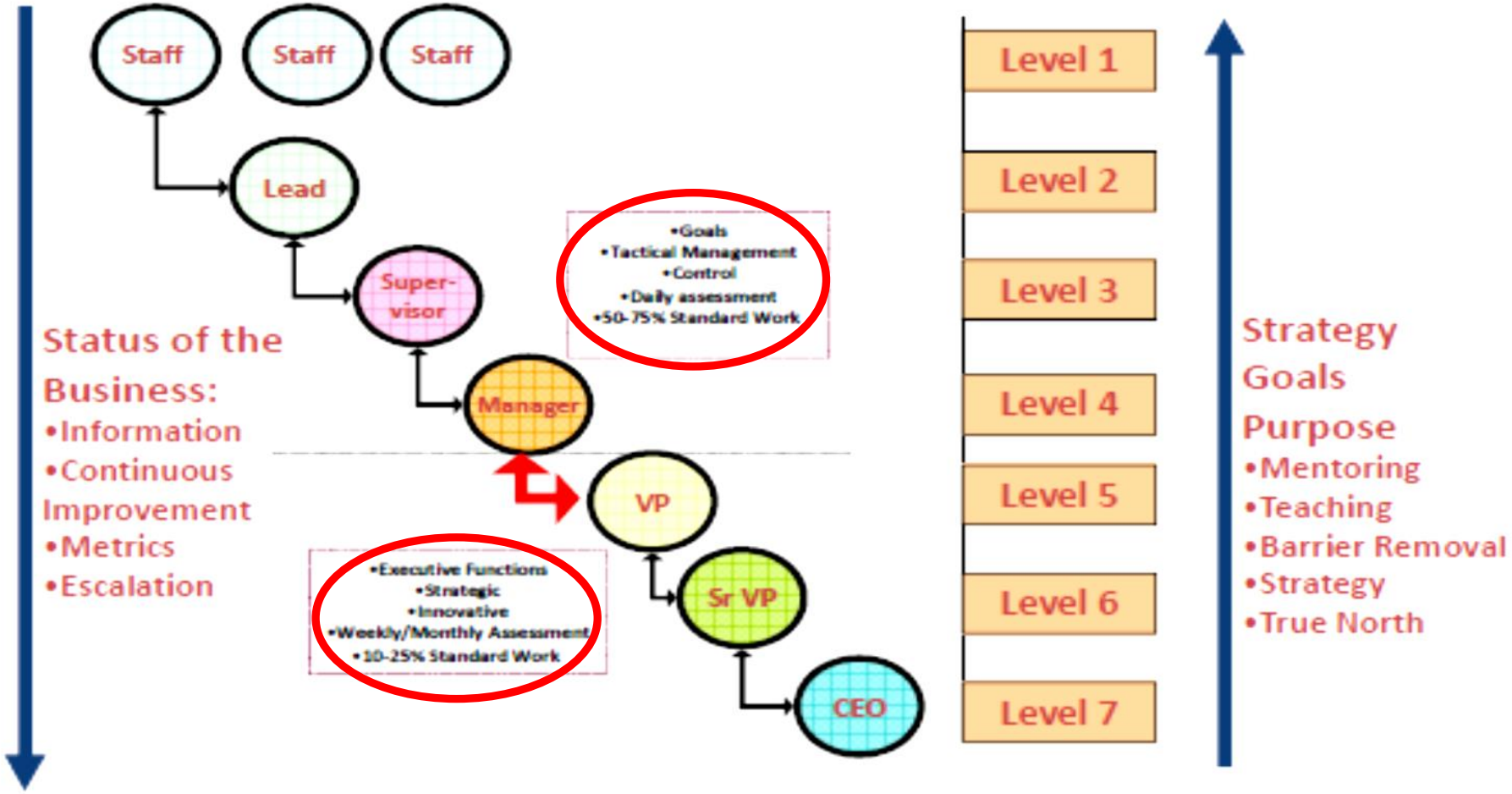

FINANCE
Compliance
Patient Satisfaction
Employee Engagement
Quality (Safety)
Harm, non-compliance, stagnant scores, no margin, limited engagement

The Shift



Because if people are safe…the rest will follow

Management Process



THEDACARE

Culture Shift-Staff

Frontline Management Expectations (50-75% of work)

- Goals
  - Knowing my risks
  - Designing safe systems
  - Facilitating safe choices
- Tactical Management & Control
  - Investigating the source of errors and at-risk behaviors
  - Turning events into an understanding of risk
- Daily Assessment

Staff Expectations

- Looking for the risks around me
- Reporting errors and hazards
- Helping to design safe systems
- Making safe choices
  - Following procedure
  - Making choices that align with organizational values
  - Never signing for something that was not done

The Start of HRO…

Just Culture

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	*A Choice: Risk Believed Insignificant or Justified* Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	*Conscious Disregard of Substantial and Unjustifiable Risk* Manage through: • Remedial action • Punitive action
Console	**Coach**	**Punish**

Culture Defined:

Set Expectations Explicitly: MGH Credo

- ***As a member of the MGH community and in service of our mission, I believe that:***
  - The first priority at MGH is the well-being of our patients, and all our work, including research, teaching and improving the health of the community, should contribute to that goal.
  - Our primary focus is to give the highest quality of care to each patient delivered in a culturally sensitive, compassionate and respectful manner.
  - My colleagues and I are MGH's greatest assets.
  - Teamwork and clear communication are essential to providing exceptional care.

As a member of the MGH community and in service of our mission, I will:

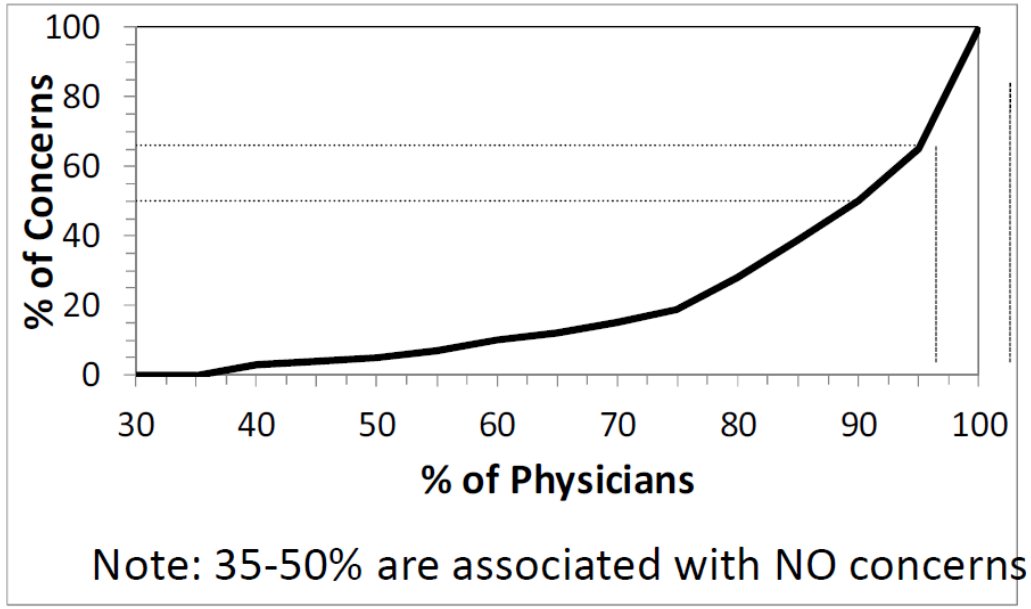
- Listen and respond to patients, patients' families, my colleagues and community members.
- Ensure that the MGH is safe, accessible, clean and welcoming to everyone.
- **Share my successes and errors with my colleagues so we can all learn from one another.**
- Waste no one's time.
- Make wise use of the hospital's human, financial and environmental resources.
- Be accountable for my actions.
- Uphold professional and ethical standards.

n of Population Health Management

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Focused Physician Engagement

9% of MDs Accounted for 50% of Recorded Concerns (and 5% for 33% over 6 year study period)



Hickson et al, JAMA 2002;287:1583-87

The 3 Duties

The duty to avoid causing unjustified risk or harm
The duty to produce an outcome
The duty to follow a procedural rule

High Reliability Organizations

Weick & Sutcliffe 2007

Anticipation has three elements:

1. **Preoccupation with failure**: to avoid failure - look for early signs
2. **Reluctance to simplify interpretations**: critical thinking and looking past easy explanations provides situational awareness
3. **Sensitivity to operations**: systems are dynamic and non-linear – provide direct oversight to adjust to unpredicted interactions

Containment has two elements:

4. **Commitment to resilience**: the organization maintains function(s) during high demands. Resilience has three components:
   - Absorb demands and preserve functions
   - Maintain the ability to return to service after untoward events
   - Learn and grow from untoward events
5. **Deference to expertise**: decision-making seeks those with knowledge and experience regardless of rank or status

Strategies to Engage Staff in Safety Across the Board

- Safety is the #1 job (patients & staff)
- Align evaluation metrics, strategy, and accountability to follow-through on safety improvements
- Follow the outcomes-harms saved, quotes from staff, $
- BE TRANSPARENT (aka-follow-up, closing the loop, etc.)—keep it simple
- Assign high value to those who report errors, near misses, etc.
- Consider non-regular time not as something to cut, but as an opportunity to save money through safety improvement (ROI)

- Schedule time with your staff
  - Have a purpose
- Limit organizational meetings…find new ways
  - Suggestions:
    - Designate a few days a month for priority business reviews, team meetings, etc. with a strategic agenda—meeting facilitation is key!
    - All other "meetings" are stand-ups/huddles—at the Gemba
      - Data, problem review, prioritization, communication plan, key take-aways, accountability assignments
    - Technology: in-house videos from executives, private social media groups, Apps-Trello…even faxes work! Caution-avoid email with staff

Recognize this seems daunting and is a complete shift in the business model…but just pick a day and start!

Strategy: HRO + Develop Staff Resiliency

- Staffs need to be enabled and empowered to design innovative solutions to the problems and headaches they see every day
  - Human resources account for the largest expense—put this resource to work outside their traditional roles
- While there is a top down approach that says "Zero Harm," it is the staff who should design it
- Raise staff up to level of process designers and let them own it
- Management is a support, a guide, a facilitator
- RECOGNIZE and PROMOTE achievements—walls of fame, award ceremonies, invite family, meet and greet with patient who was saved the harm—meaningful!

- And the most important and worthwhile strategy to engage staff in safety across the board…

Leave your office…go to the GEMBA

Gemba is a Japanese word which means "at the site". When **gemba** is used in conjunction with process improvement methodologies, it refers to the act of making observations of the process in action.

Counting Harms

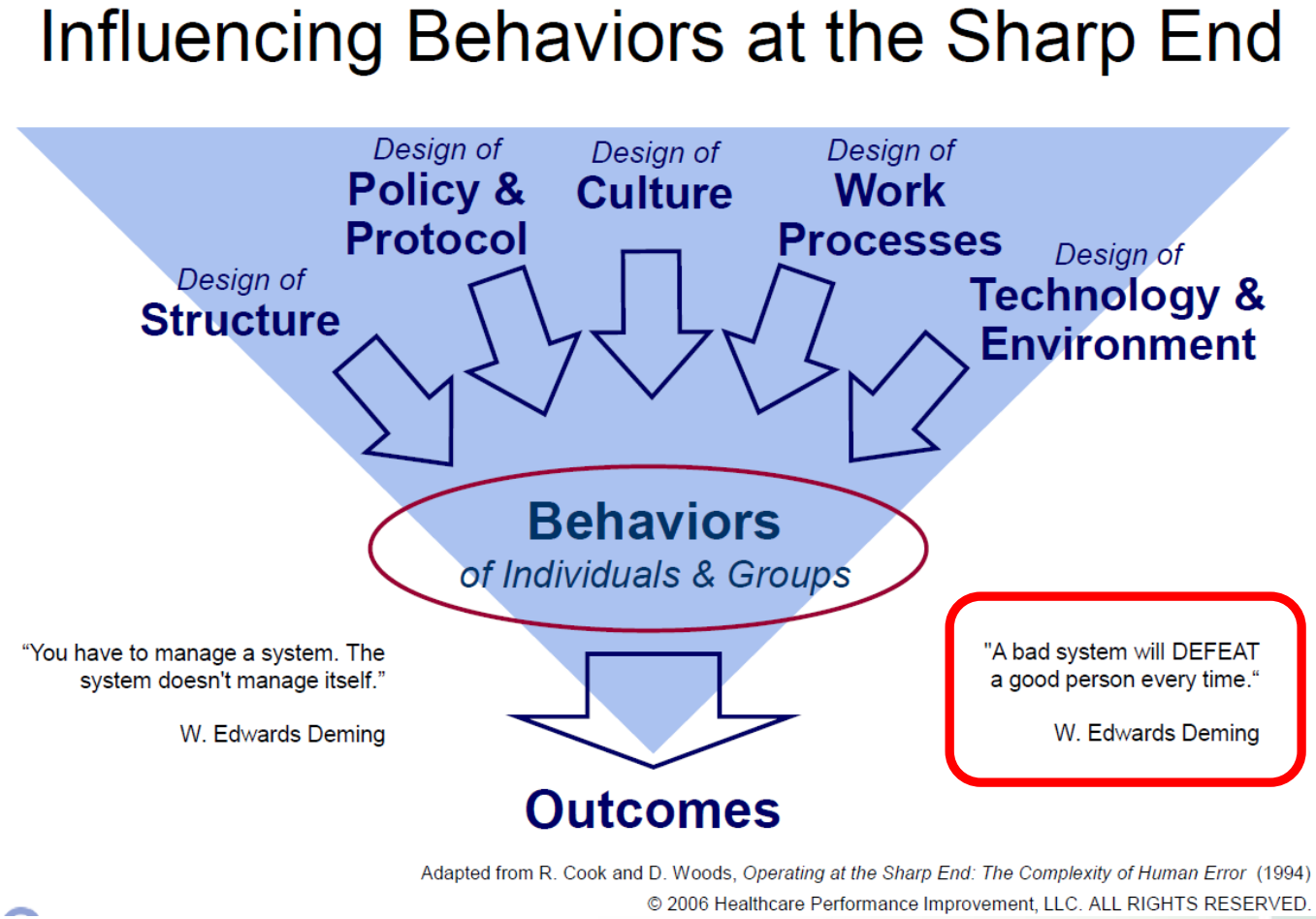
Approach & Impact

Safety Across the Board: Error vs. Harm

- Only 10-20% of errors are ever reported
- Of those, some 90 to 95 percent cause no harm to patients
- The inadequacy of the error-reporting system stems from limitations in the process itself
  - it is voluntary and highly subjective
  - often a cumbersome process, based on time-consuming paperwork required of over-burdened providers
  - there is a punitive element that hinders reporting: we naturally look to blame individuals for errors, but harm is typically caused by system flaws or failures

New Ways to See Harm

- Errors of commission
- Errors of omission
- Errors of communication
- Errors of context
- Diagnostic errors
- *Errors in failing to care across the continuum*



James, JT. "A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care." *J Patient Saf*. 9:3, Sep, 2013.

Errors, Near Misses, & Good Catches

- SIMPLIFY
- Batch errors system-wide: themes, common causality
- Near misses are **freebies**-don't waste them
- Good catches are **freebies**-don't waste those either
- Re-education is not a fix! (common final causality from RCAs)
  - System fix-what can be built into the system to prevent this from occurring?
  - Just Culture algorithm-professional responsibility/accountability
- PI Tools
- Competition—who can submit the most?? (This is a good thing)

Engaging Staff in Safety Across the Board: Harm & Systems Engineering

- Daily identification of potential safety risks, opportunities for system failures, at-risk behaviors, raised awareness
  - Through huddles, leadership presence on units—you have to ask the questions!
- In the moment solutions *and* implementation
- Spread-what's your mechanism?
- Accountability
  - Who is designing the fix?
  - When is it due?
  - What is expected?

Errors, Near Misses, & Good Catches (cont)

- DEBRIEF-an underutilized tool
  - Real-time discussion
  - Immediate fix
  - Items to turf to the PI team
  - Platform to spread the lessons learned-quickly-to fix the system
- Andon-what's yours?
  - **The idea:** Workers pull the cord to alert co-workers when a problem crops up so they can get help. If the glitch persists, workers may even stop the line to troubleshoot.
  - The cords are essential to Toyota's concept of built-in quality, or catching problems before they head down the line and are cemented in place in a completed vehicle.

Safety I vs. Safety II

A Shift in Approach

	Safety I	Safety II
Definition of safety	As few things as possible should go wrong.	As many things as possible should go right.
Safety management principle	Reactive, respond when something happens, or is categorized an unacceptable risk.	Proactive, continuously trying to anticipate developments and events.
Explanation of accidents	Accidents are caused by failures and malfunctions. The purpose of investigation is to identify causes and contributing factors.	Things basically happen in the same way regardless of outcome. The purpose of an investigation is to understand how things usually go right as a basis for explaining how things occasionally go wrong.
Attitude to the human factor	Humans are predominately seen as a liability or a hazard.	Humans are seen as a resource necessary for system flexibility and resilience.
Role of performance variability	Harmful – should be prevented as far as possible.	Inevitable but also useful. Should be monitored and managed.

Hollnagel, E. (2014). Safety-I and Safety-II: The Past and Future of Safety Management.

Don't forget…

- Communication-key to success
- HR Opportunities
  - Align skill set building with safety improvement/project opportunities
  - Consider how projects can serve as annual competency achievements
- Engage stakeholders-not just the "normal" ones
  - Finance
  - Coding/abstracters
  - PR/marketing
  - Patient & Family

Count All Harms

- Create a performance improvement measurement system to track and reduce all-cause harm
  - Use consistent, standardized measures if possible—but don't get lost in the measure!!

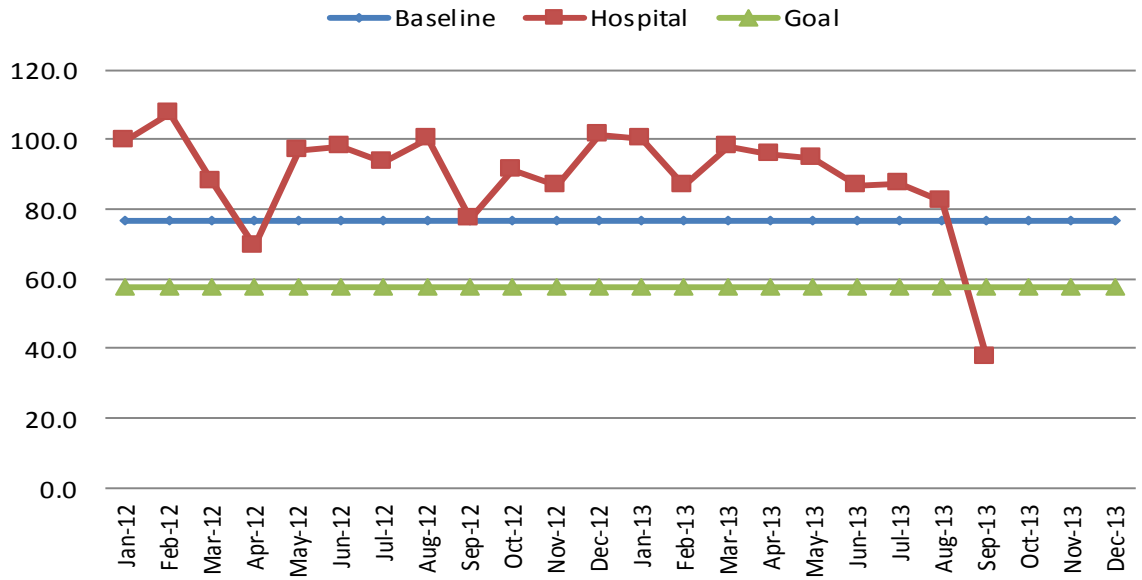
This is about people…

"What really matters…is the *harm* that patients suffer — some of it due to errors, but most of it resulting from flawed systems within which highly skilled providers operate." --IHI

Organization Name

Most Recent 3-Months Total Harm Rate (% Change from Baseline)	69.9 (-8.8%) Sep-13
Number of Total Harm Prevented To-Date	64
Cost Savings To-Date	$ 237,250
Estimated Number of Total Harms to Prevent in Order to be at Goal Rate by Next Month	20

Total Harm



Input for calculations

	Harm	Patient Days
Baseline	1,485.40	19,372
Goal	25%	reduction
Jan-12	158	1,586
Feb-12	170	1,586
Mar-12	158	1,803
Apr-12	110	1,588
May-12	152	1,570
Jun-12	158	1,613
Jul-12	144	1,542
Aug-12	161	1,611
Sep-12	115	1,486
Oct-12	144	1,577
Nov-12	134	1,545
Dec-12	159	1,570
Jan-13	157	1,566
Feb-13	125	1,440
Mar-13	147	1,500
Apr-13	135	1,414
May-13	148	1,569
Jun-13	130	1,495
Jul-13	135	1,547
Aug-13	125	1,516
Sep-13	53	1,412
Oct-13		
Nov-13		
Dec-13		
Total	2,918	32,536
# of Months	21	21
Mthly Avg	139.0	1,549

Baseline Considerations

Goal Rate

Slide 5

Improving Harm Rates (/ Discharge)

HACs	Baseline Time Period	Baseline Rate	Target Rate	Current Rate [time period – last 3 months]	Improvement Status (scale)
ADE	1/1/11 – 12/31/11	.0001	.0000	.0000	Ideal
CAUTI	1/1/11 – 12/31/11				Progress
CLABSI	1/1/11 – 12/31/11				Progress
EED	1/1/11 – 12/31/11	.0011	.0007	.0000	Ideal
OB	1/1/11 – 12/31/11	.0002	.0001	.0010	Opportunity
Falls	1/1/11 – 12/31/11				Opportunity
PU	1/1/11 – 12/31/11				Ideal
SSI	1/1/11 – 12/31/11	.0003	.0002	.0008	Opportunity
VAP	1/1/11 – 12/31/11	.0000	.0000	.0000	Ideal
VTE	12/1/11 – 12/31/11	.0001	.0000	.0010	Opportunity
Total	1/1/11 – 12/31/11	.0101	.0060	.0110	Opportunity
Readmissions	1/1/11 – 12/31/11	.1096	.0877	.1312	Opportunity

What does this mean to managers and staff??

How does this information drive improvement? How do you know?

Example Executive Dashboard

NO HARM CAMPAIGN RESULTS

for Calendar Year 2014 as of September 30

% Change from Target

- Blue square = >=0
- Green check -.01 to -.10
- Yellow triangle -.11 to -.20
- Red dot > -.20

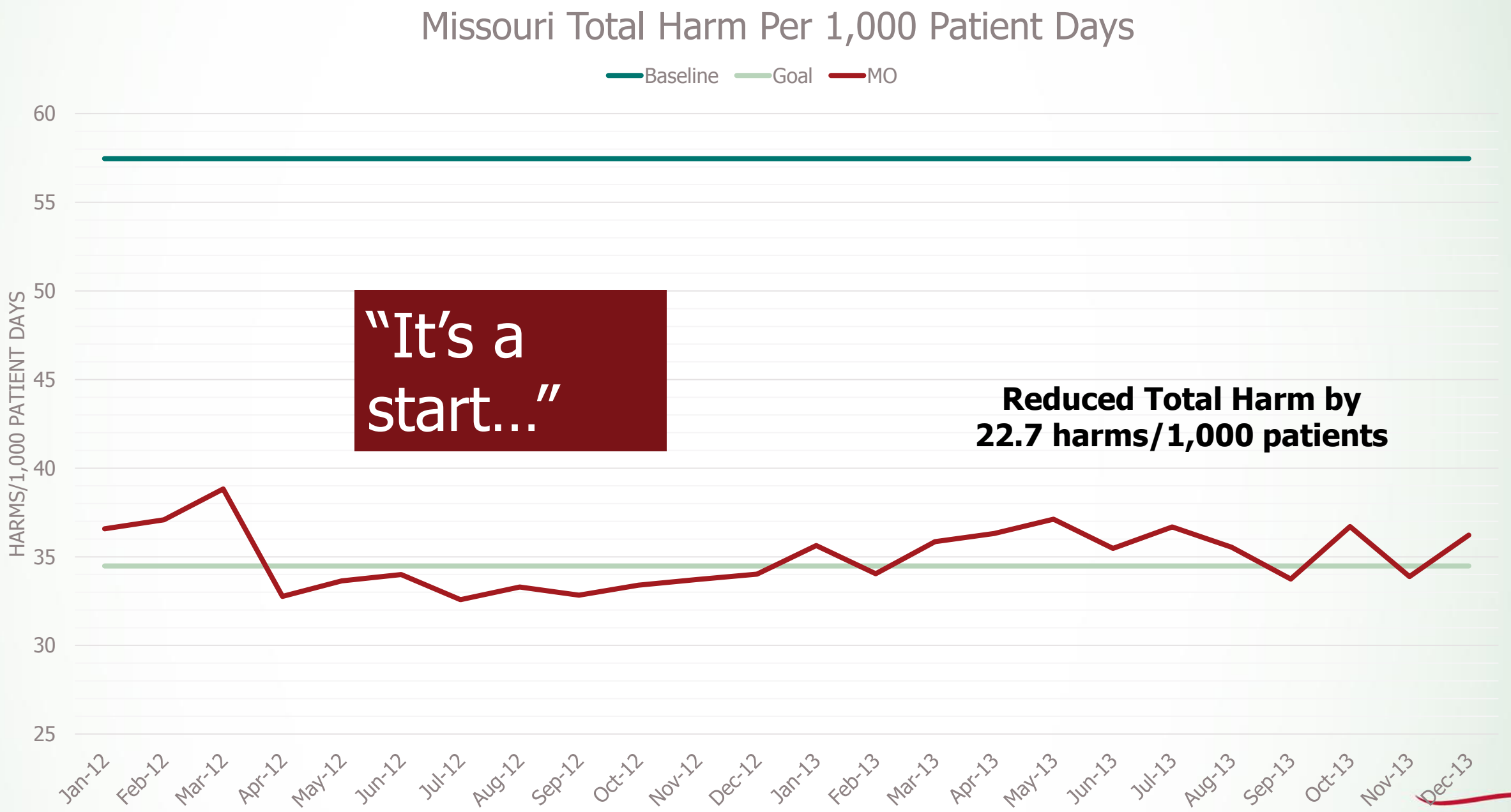
Area of Focus	Target CYTD Status	Baseline	Target	CYTD Numerator	CYTD Denominator	CYTD Actual	Progess to Goal (% Change from Target)	CYTD % Change From Baseline	CYTD % Change From Target
#1 Hypoglycemic Rate	↑	0.29%	0.17%	1,283	1,663,111	0.08%	Blue square	73.40%	54.62%
#2 Catheter Associated Urinary Tract Infections	↑	1.89	1.13	282	250,314	1.13	Blue square	40.39%	0.30%
#3 Central Line Associated Blood Stream Infections	↑	0.81	0.49	76	223,354	0.34	Blue square	58.10%	30.16%
#4 Falls	↑	0.11	0.06	65	1,183,670	0.05	Blue square	48.68%	14.99%
#5 Perinatal Safety - Early Elective Deliveries	↑	7%	0.01	13	10,730	0.1%	Blue square	98.22%	87.76%
#5 Perinatal Safety - Oxytocin	↑	63.0%	85.0%	3,758	4,097	91.7%	Blue square	45.60%	7.91%
#6 Hospital Acquired Pressure Ulcers	↑	2.13	1.28	246	210,436	1.17	Blue square	45.06%	8.43%
#7 Surgical Site Infections	↓	0.84	0.50	184	23,649	0.78	Red dot	7.38%	-55.61%
#8 Venous Thromboembolism & Pulmonary Embolism	↓	4.24	2.54	811	210,692	3.85	Red dot	9.17%	-51.39%
#9 Ventilator Associated Pneumonia	↑	1.63	0.98	47	64,396	0.73	Blue square	55.15%	25.26%
#10 Readmissions within 30 Days	↓	7.33%	5.86%	21,567	307,933	7.00%	Yellow triangle	4.45%	-19.52%
#11 ED Holds and Facility Decompression	↓	394	295	69,461,107	168,085	413	Red dot	-4.93%	-39.90%
#12 Culture of Safety - Just Culture	↑	43%	80%	0.93		93%	Blue square	116.66%	16.08%
#12 Culture of Safety - Safety Attitude Questionnaire	↓	65	72	66		66	Green check	1.95%	-8.51%

Put a Face on the Data

- Total harm is compelling data with an emotional impact
- Creates urgency to do what is right
- Has applicability to every person
- No rates, No denominators…ONLY numerators

"When organizations stop looking at harm rates and denominators, and begin to focus on only the numerators or numbers of patients harmed, this changes the focus of the staff from data to people and it becomes a personal crusade to keep those numbers to a minimum."

—Cathleen Krsek, MSN, MBA, RN, FAAN Senior Director, UHC


Missouri Total Harm Per 1,000 Patient Days
Baseline
Goal
MO
HARMS/1,000 PATIENT DAYS
60
55
50
45
40
35
30
25
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
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Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
"It's a start…"
Reduced Total Harm by
22.7 harms/1,000 patients

For every 1,000 patients, 35 are harmed in Missouri

Create Safety Across the Board

"An organization's cultural commitment to applying the scientific method to designing, performing, and continuously improving the work delivered by teams of people leading to measurably better value for patients and other stakeholders."

Mayo Clinic Proceedings
January 2013; 88(1):74-82

Hospital First Action Steps

- Publicly commit to eliminate harm in your organization
- Use SAB during Board/Executive planning exercises
- Use the guide as a self-assessment tool
- Redesign daily work processes to get to the Gemba (50-75%)
- Align safety with daily staff work-across the organization
- Charter a clinical committee-*frontline staff to C-suite*
  - Data/measurement oversight
  - Performance management
  - Focus is safety

7 Things to Start Next Week

- Adopt new mental models about patients and your job as a leader
- Personal Leadership—get in front of the improvement efforts in your organization or department/section
- Make sure that you are working on important issues—what matters to the patients and families
- Intentionally shape culture—Practice the High Impact Behaviors
- Think and lead across boundaries
- Make staff leaders of system design
- Be transparent-start telling patient stories

Think Link graphics

QUESTIONS & DIALOGUE

Upcoming Events

- February
  - What's Up Wednesday? Lunch & Learn: Feb. 4, from 12-1 p.m.
  - HEN End of Project Report released
  - Falls Toolkit released
- Next Quarterly Quality Topic Webinar: March 26, 12-1 pm, Safety Across the Board, Part II: Transparency Use, Taking PDCA further, Patient and Family Engagement
- Spring Regional Quality Workshops in April: "Readmissions & Care Coordination: Aim Towards Outcomes"
- Strategic Quality 101 Conference, Columbia, MO, May 20-21
- MHA website: http://web.mhanet.com/strategic-quality/

Center for Patient Safety Upcoming Events

- Annual Patient Safety Conference, March 13th, 2015
- Patient Safety Awareness Toolkit-March is Patient Safety Awareness Month

Spring Regional Workshops

- Call for speakers
  - Macon
  - St. Louis
  - Independence
  - Cape Girardeau
  - Springfield
- Topics: readmissions, care coordination innovations, successes, lessons learned, collaborations; strategies for hip/knee replacement readmissions reductions
- MHA website: http://web.mhanet.com/strategic-quality/

MHA Quality Staff

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Triple Aim
Population Health
Oversight of division (Quality Improvement, Quality Works, Emergency Preparedness)
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Cheryl Eads

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Coordinates webinars, conference calls and meetings
Distributes correspondence and communication
Assists in maintaining reports

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