2015 ACHE-SETC Conference on Healthcare Leadership

Navigating Change to Achieve High Reliability: The Role of Leadership

(An ACHE Qualified Category II Education)

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Joint Commission Center for Transforming Healthcare

Anne-Claire France, PhD, FACHE
President, Houston Health Innovations, LLC

INSIGHTS FOR HEALTHCARE PROFESSIONALS
(A partnership with Medical World Americas)

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Learning Objectives

- Articulate the need for high reliability in healthcare.
- Understand that healthcare management and clinical leadership are key to successful change to high reliability.
- Describe leadership commitment action to navigate change.

Biography

***Erin S. DuPree, M.D., FACOG*,** is the Chief Medical Officer and Vice President for the Joint Commission Center for Transforming Healthcare. She leads the efforts of the Center to transform the health care industry into a high reliability industry. She has expertise in performance improvement and information technology.

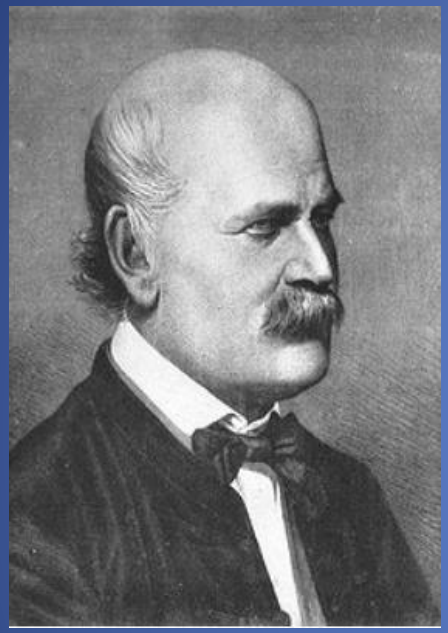
Prior to assuming her role, Dr. DuPree practiced obstetrics/gynecology and was Chief Medical Officer and Senior Vice President for Medical Affairs at The Mount Sinai Medical Center in New York City. During her eight years at Mount Sinai in a progression of leadership roles, she steered efforts to improve safety culture, evidence-based care, and critical processes that impact patient care.

Dr. DuPree has a bachelor of arts in biochemistry and molecular biology from the University of California, Berkeley, and received her M.D. from Columbia University, College of Physicians and Surgeons in New York City.

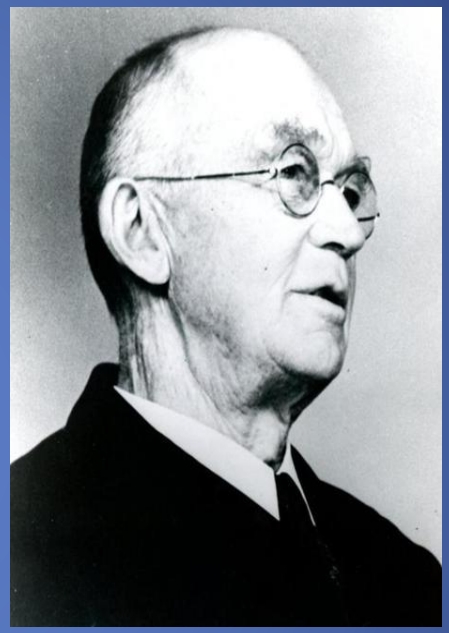
Biography

Anne-Claire France, PhD, CPHQ, FACHE, is President/Owner of Houston Health Innovations, LLC (HHI), an organization specializing in improving performance in healthcare systems using Robust Process Improvement methodologies. Dr. France has trained and coached over 150 Master Black Belts, Black Belts and Green Belts in Lean Six Sigma. Before becoming a Lean Six Sigma professional, she served as Director of the Center for Healthcare Improvement at Memorial Hermann Health System, where she actualized the process improvement ideas of front line clinical staff. Her focus within the healthcare system was the improvement of patient safety, clinical outcomes, customer and staff satisfaction and significant cost savings. Anne-Claire's twenty-five years of healthcare experience include twenty years in applied research and process improvement. Her primary clients include the pharmaceutical industry, small rural hospitals, multi-hospital healthcare systems, physician organizations and group practices. Before founding Houston Health Innovations LLC in 2001, Anne-Claire held a number of leadership positions in healthcare organizations. She has taught applied research, statistics, and psychology. She served as Adjunct Faculty at the Center for Health Studies, Houston Baptist University as well as academic appointments at the University of Texas Health Science Center at Houston Schools of Medicine and Nursing and Northern Illinois University. In addition to certification as a Six Sigma Master Black Belt, in Health Care Administration, and as a Healthcare Quality Professional, Anne-Claire holds a B.A. from the University of Colorado (Boulder), a M.A. and a Ph.D. from Vanderbilt University, and a Post Doctoral Fellowship from the University of Texas Health Science Center at Houston Medical School.

CHANGE AGENTS



Ignaz Philipp Semmelweis



Ernest Amory Codman

CHANGE AGENTS

"Change is good.
You go first."

— Dilbert

55°
Rain
H: 63° L: 52°
Traffic

Monday, May 6, 2013

The Atlanta Journal-Constitution

Credible. Compelling. Complete.

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HOME / NEWS

456 Piedmont patients warned about improperly cleaned devices

Posted: 6:06 p.m. Tuesday, April 30, 2013

456 patients notified

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SSM Health Care apologizes for brain-surgery error

Recommend 283 Tweet 9 +1 7

May 01, 2013 3:15 am • By JIM DOYLE jdoyle@post-

SSM Health Care acknowledged Tuesday that its neurosurgeon and medical staff recently operated on the wrong side of a St. Louis-area woman's brain and skull.

The admission — and a lengthy public apology — followed a Post-Dispatch story in Tuesday's paper about a lawsuit filed Friday on behalf of Regina Turner of St. Ann.

"SSM Health Care and SSM St. Clare Health Center sincerely apologize for the wrong-site surgery in our operating room," Chris Howard, president and chief executive of SSM Health Care-St. Louis, said in a written statement.

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Serving Moore County, NC | August 15, 2013

Operating-Room Fire at Hospital Burns Patient, Prompts Changes

Posted: Friday, August 9, 2013 11:45 am | *Updated: 12:17 pm, Mon Aug 12, 2013.*

Ted M. Natt Jr., staff writer | **26 comments**

FirstHealth of the Carolinas officials should know by the end of the month whether they have taken adequate corrective steps to prevent operating room fires like the one recently that burned the neck and shoulders of a patient during an emergency surgery at Moore Regional Hospital.

The N.C. Division of Health Service Regulation placed Moore Regional on "immediate jeopardy" status following an

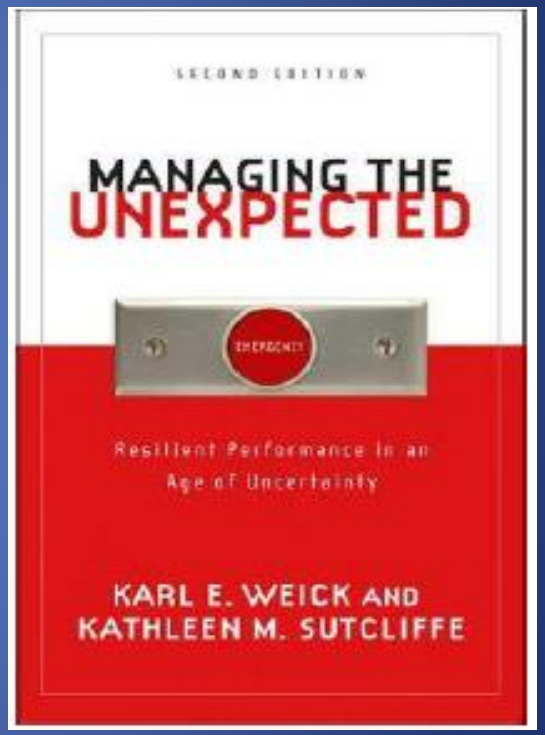
Five Principles of High Reliability Organizations

Anticipation - "Stay Out of Trouble"

- *1. Preoccupation with failure*
- *2. Sensitivity to operations*
- *3. Reluctance to simplify*

Containment - "Get Out of Trouble"

- *4. Commitment to resilience*
- *5. Deference to expertise*



Is Health Care Different?

- Patients, not machines
- One person at a time
- Workforce mobility
- Definition of harm

Reliability is failure free operation over time from the viewpoint of the patient.

-R. Resar, Institute for Healthcare Improvement

THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

High-Reliability Health Care: Getting There from Here

MARK R. CHASSIN and JEROD M. LOEB

The Joint Commission

Context: Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day. Hospitals find improvement difficult to sustain, and they suffer "project fatigue" because so many problems need attention. No hospitals or health systems have achieved consistent excellence throughout their institutions. High-reliability science is

Milbank Q 2013;91(3):459-90

RELIABILITY

Leadership

Safety Culture

Robust Process Improvement®

MANAGING CHANGE

VS

LEADING CHANGE

EXPERTS

LEADERS

US Safety Board Determines D
Crash Was Failure of Both Trac
an Safety Culture

By Robert Charette
Posted 29 Jul 2010 | 16:07 GMT

Share

IEEE SPECTRUM

VITERBI JOINS WITH METROLINK TO CREATE SAFETY CULTURE

USC professors help 50 high-level Southern California commuter rail leaders study the histories of past rail disasters to prevent future ones

ERIC MANKIN
September 02, 2011 —

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Metro-North railroad has 'deficient safety culture,' government says after fatal derailment

BP Oil Spill: Engineering Experts Attack Industry Safety Culture

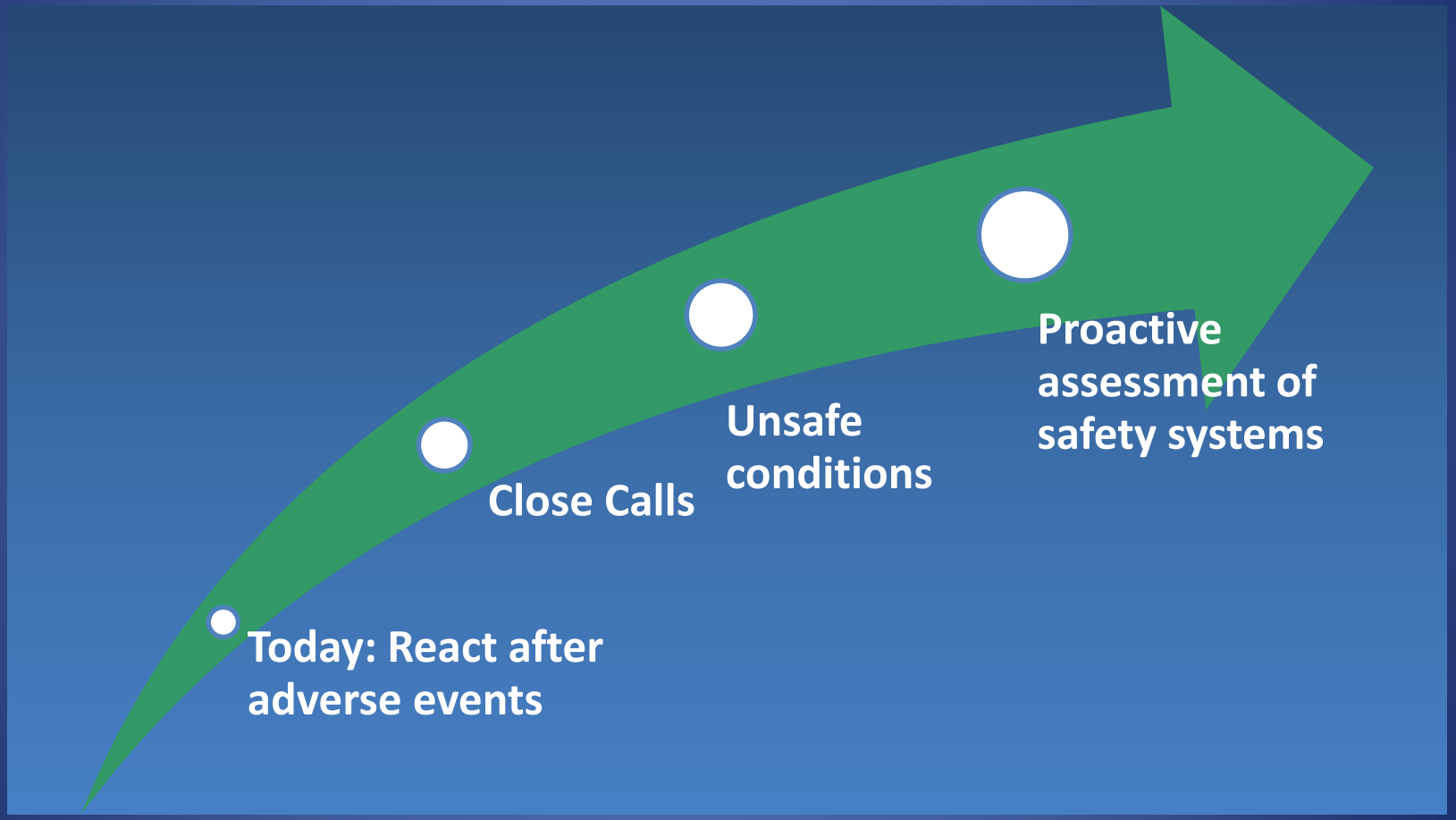
By SETH BORENSTEIN | 12/14/11 01:35 PM ET | AP

Culture is Predictive: *A Leading Indicator*

1. Medication errors
2. Back injuries
3. Patient satisfaction
4. Nurse turnover
5. AHRQ Patient Safety Indicators
6. Nurse satisfaction
7. Urinary tract infections
8. Malpractice claims

- Hofmann & Mark (2006) • Katz-Navon et al. (2005)
- Mark et al. (2007) • Naveh et al. (2005) • Singer et al (2008).
- Vogus & Sutcliffe (2007)

Evolution of Safety Culture



INTIMIDATING BEHAVIORS

The Joint Commission

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- Advisory Group
- Forms and Tools
- Policy and Procedures
- Reporting Alternatives
- Sentinel Event Alert
- Statistics

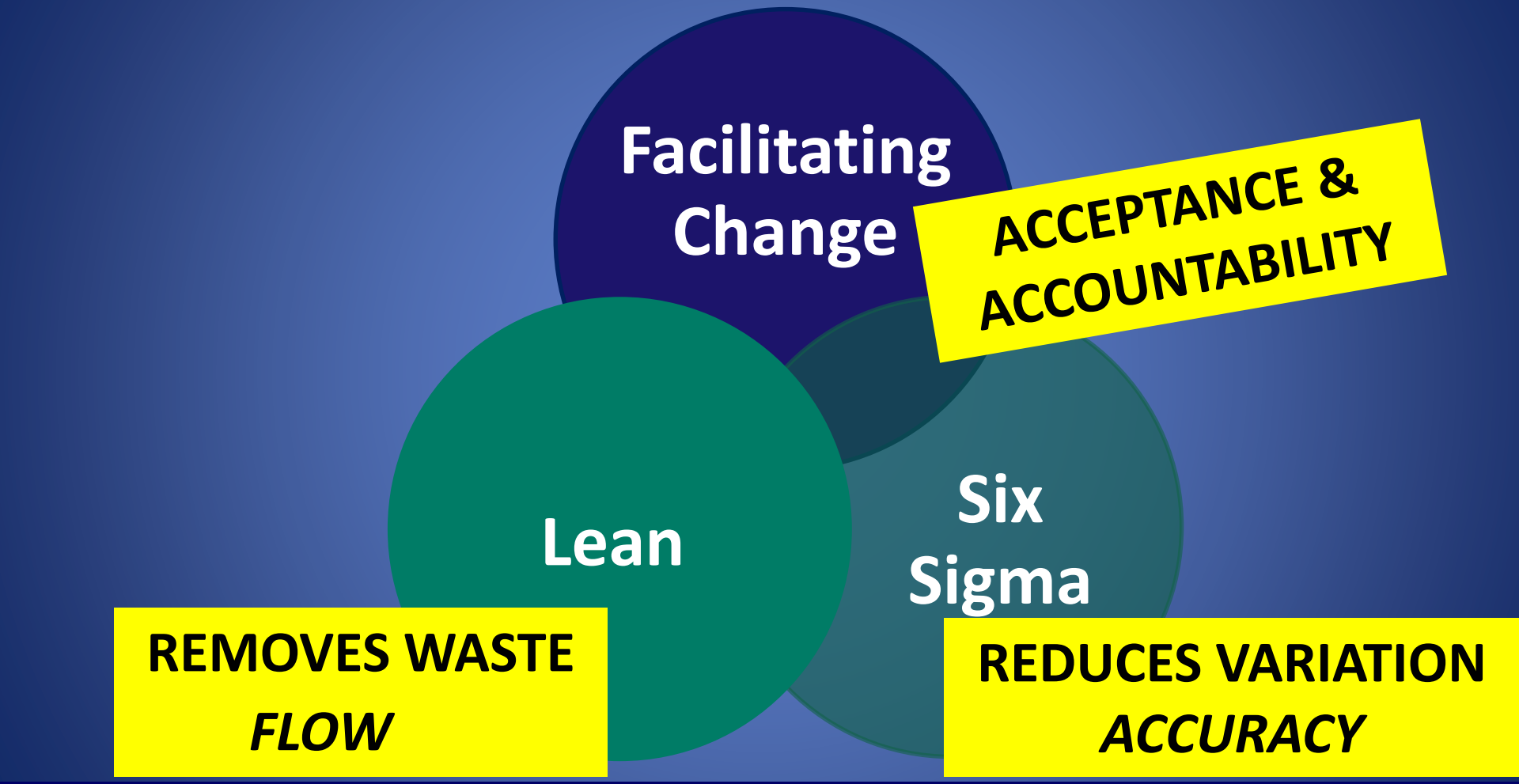
Sentinel Event Alert

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

ROBUST PROCESS IMPROVEMENT®



FOCUS IS ON THE PATIENT

FACILITATING CHANGE

Plan

Inspire People

Launch

Support the Change

Facilitating Change

A Systematic Approach for Complex Problem Solving

Define & measure the impact of the problem

Discover specific causes

Solutions are targeted to each specific cause

DEFINE & MEASURE **ANALYZE** **IMPROVE & CONTROL**

CAUSES DIFFER BY HOSPITAL

Each letter = one hospital

Main Causes of Failure to Clean Hands (across all participating hospitals)	A	B	C	D	E	F	G	H
Ineffective placement of dispensers or sinks		x		x	x		x	x
Hand hygiene compliance data are not collected or reported accurately or frequently	x	x		x	x			x
Lack of accountability and just-in-time coaching		x	x	x	x		x	x
Safety culture does not stress hand hygiene at all levels			x	x	x	x		x
Ineffective or insufficient education		x	x	x	x		x	
Hands full	x	x	x	x	x		x	
Wearing gloves interferes with process	x	x	x	x			x	
Perception that hand hygiene is not needed if wearing gloves	x		x	x	x		x	x
Health care workers forget	x	x		x			x	
Distractions	x	x				x	x	

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.

RELIABILITY

The Joint Commission
Journal on Quality and Patient Safety®
Improvement from Front Office to Front Line
January 2015
Volume 41 Number 1

"If other quality and safety problems exhibit the same characteristics as hand hygiene noncompliance, attempting to address them everywhere with exactly the

Sustaining and Spreading Improvement in Hand Hygiene Compliance

Features

Infection Prevention and Control

- Editorial: Toward More Reliable Processes in Health Care
- Improving Hand Hygiene at Eight Hospitals in the United States by Targeting Specific Causes of Noncompliance
- Beyond the Collaborative: Spreading Effective Improvement in Hand Hygiene Compliance

CHANGE AGENTS

Memorial Hermann Health System

Woodlands

Sugar Land

TMC

Katy

Memorial City

Southeast

- Total Hospitals: 12 (9 Acute, 2 Rehab, 1 Children's)
- Ambulatory Surgery Centers: 18
- Heart & Vascular Institutes: 3
- Imaging Centers: 21
- Breast Care Centers: 9
- Sports Medicine & Rehab Centers: 32
- Diagnostic Laboratories: 21
- Retirement/Nursing Center: 1
- Home Health Branches: 3
- Cancer Centers: 7

- Adjusted Admissions: 256,175
- Annual Emergency Visits: 450,010
- Annual Deliveries: 23,111
- Employees: 20,241
- Beds (acute licensed): 3,147
- Medical Staff Members: 5,790
- Physicians in Training: 1,694
- Annual Labor Cost: $1.191 billion

Northwest

Northeast

TIRR

PaRC

Children's

Southwest

Journey to Cultural Transformation

August 14, 2006

A Call to Action on Patient Safety

Transfusion Errors
Serious Safety Events

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Red Arm Band Task Force

Red Arm Band task force with representation from all hospitals and divisions

Developed

- Policies and Procedures
  - System
  - Local
- Implementation Plan
  - Communication Plans
  - Education Plans
  - Monitoring Plans
  - Roll out schedules

Go Live - September 5th, 2006

Board Commitment

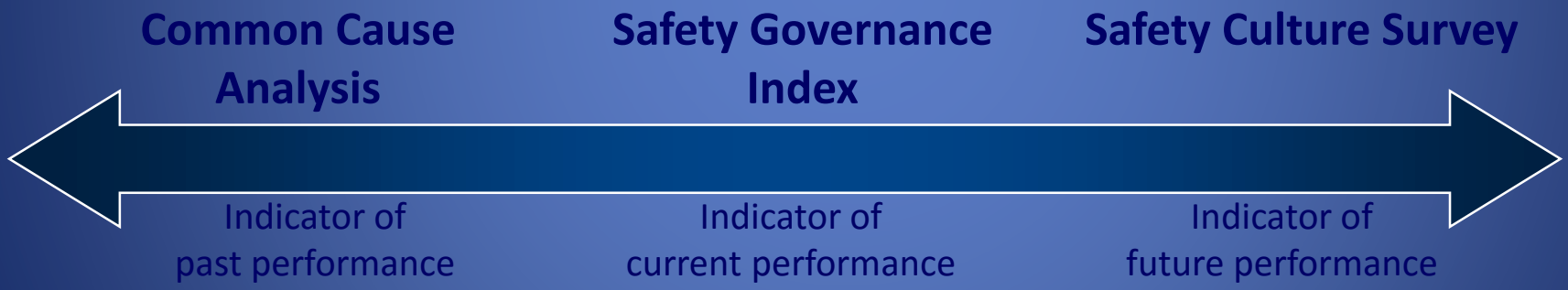
- Provide leadership for high reliability, safety & quality initiatives
- Ensure the Board receives quality & safety results information it needs
- Provide guidance for the System Quality Committee
- Provide support for safety & quality initiatives, including financial support

Journey to Cultural Transformation

Leadership Commitment to “safety first”

Partner with Healthcare Performance Improvement

Diagnostic assessment to determine readiness



Gaps in communication, critical thinking, knowledge, attention to task, and compliance

OPERATION BREAKTHROUGH
PATIENT SAFETY
BEST OF THE BEST

Safety Culture Training

Step 1: **Set Behavior Expectations**

Define Safety Behaviors & Error Prevention Tools proven to help reduce human error

Step

Step 3: **Reinforce & Build Accountability**

Practice the Safety Behaviors and make them our personal work habits

Take Action.
Make Patient Safety Your Priority.

OPERATION BREAKTHROUGH
PATIENT SAFETY
BEST OF THE BEST

MHHS Safety Culture Training

2007-2008

Hospital Training Complete

>15,000 Employees Trained

>1,000 Physicians Trained

>540 Safety Coaches Trained

>$18M Expense

200% Accountability

I am 100% accountable for the behavior and results of my Unit(s).

My Unit is also 100% accountable for their behavior and results.

"The measure of success is not whether you have a tough problem to deal with, but whether it is the same problem you had last year."

-John Foster Dulles
US statesman

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Leaders:
Rounding with a Purpose

Connect with front-line staff, patients & physicians

- Understand the front line perspective
- Engage with our people
- Identify problems impacting operations

Reinforce safety & service performance expectations

- Understand employee's knowledge
- Reward and recognize
- Provide feedback and coaching
- Support blame-free variance & possible event reporting

OPERATION BREAKTHROUGH

PATIENT SAFETY

BEST OF THE BEST

Red Rules
Absolute Compliance

1. Patient Identification
2. Time Out
3. Two Provider Check

Performance Management Decision Guide

Adapted from James Reason's *Decision Tree for Determining the Culpability of Unsafe Acts* and the *Incident Decision Tree* of the National Patient Safety Agency (United Kingdom National Health Service)

Start

Deliberate Act Test

D1 Did the individual intend the act?

- **No** → Impairment Test
- **Yes** → **D2**

D2 Did the individual act with malicious intent (i.e. to cause physical/mental harm or other damage)?

- **No** → Impairment Test
- **Yes** → Malevolent or Willful Misconduct

Impairment Test

I1 Is there suspicion of ill health (either mental or physical) or substance abuse?

- **No** → Compliance Test
- **Yes** → **I2**

I2 *If ill health or a medical condition:* Was the individual aware of the illness or medical condition?

- **Yes** → Compliance Test
- **No** → Suspected Medical Condition and/or Substance Abuse

Compliance Test

C1 Did the individual depart from policies, procedures, protocols, or generally accepted performance expectations?

- **No** → Substitution Test
- **Yes** → **C2**

C2 Were the policies, procedures, protocols, and performance expectations available, understandable, workable, and in routine use?

- **No** → Substitution Test
- **Yes** → **C3**

C3 Is there evidence that the individual chose to take an unacceptable risk **OR** has a history of poor performance or decision making?

- **No** → Substitution Test
- **Yes** → **C4**

C4 Were there significant mitigating circumstances that support the act in this case?

- **Yes** → Substitution Test
- **No** → Possible Reckless or Negligent Behavior

Substitution Test

S1 Would individuals in the same profession and with comparable knowledge, skills, and experience act the same under similar circumstances?

- **Yes** → Possible System Induced Error
- **No** → **S2**

S2 Were there any deficiencies in related training, experience, or supervision?

- **Yes** → Possible System Induced Error
- **No** → Possible Unintended Human Error

Malevolent or Willful Misconduct

Actions to Consider

(Consult Human Resources)

- Disciplinary action
- Report to professional group or regulatory body
- Law enforcement referral

Identify Contributing System Factors

Suspected Medical Condition and/or Substance Abuse

Actions to Consider

(Consult Human Resources)

- Occupational health referral
- Adjustment of duties
- Leave of absence

If substance abuse:

- Substance abuse testing
- Disciplinary action

Identify Contributing System Factors

Possible Reckless or Negligent Behavior

Actions to Consider

Consult Human Resources)

- Disciplinary action
- Job-fit consideration

Identify Contributing System Factors

Possible Unintended Human Error

Actions to Consider

(Consult Human Resources)

- Console
- Coaching
- Mentor assignment
- Increased supervision
- Performance improvement plan
- Adjustment of duties

Identify Contributing System Factors

Possible System Induced Error

Console and/or Coach the individual **AND** Find & Fix Process Problems

HPI®

Revision 4, July 2009

2010 Change in Focus: Journey to High Reliability

- *We've come a long way since 2006*
- *We've got a long way to go*
- *We have to do something different to get a different result*
- ***Enlightened leadership is the key***
- ***The staff is primed to follow your lead***

MEMORIAL HERMANN

OPERATION BREAKTHROUGH
PATIENT SAFETY
BEST OF THE BEST

Take Action.

Make Patient Safety Your Priority.

1. Attention to Detail

Self-Check with S

Stop	Pause for one
Think	Focus on the a
Act	Perform the ac
Review	Check for desi

2. Communic

Three-way Repeat
the "Three-peat":

- Sender initiates comm
- Receiver repeats back
- Sender acknowledges by saying, *"That's cor*
  "That's not correct"

Ask Questions:

Ask one or two clarifying questions when in high-risk situations or when information is incomplete and/or ambiguous

Phonetic & Numeric Clarifications

Say the letters and say the numbers

SBAR (Quick, To the Point)

Situation	What is problem, patient, or project?
Background	What is important to know?
Assessment	What is your thought?
Request	What action do you need?

3. Questioning Attitude

5. Support Each Other

Be a Safety Partner

- Look out for each other
- Positively reinforce safe and productive behaviors (X5)
- Correct unsafe behaviors in a helpful manner

Speak Up ARCC and CUSS Words

Ask a question	**CUSS words**
Request a change	I am ***concerned***
Concern, state your concern using the safe word	I am ***uncomfortable***
Chain of command	This is for ***safety***
	Stand Up and ***Stand*** Togeth

MEMORIAL HERMANN

BREAKTHROUGHS IN
PATIENT SAFETY
BEST OF THE BEST

Make Every Day a Safe Day.

Patient Safety Is Our Core Value.

1. Attention to Detail

3. Questioning Attitude

- Receiver repeats/reads back
- Sender acknowledges accuracy by saying, "That's correct' or NOT correct...(state error correction)"

Ask Questions

Ask one or two clarifying questions when in high-risk situations or when information is incomplete and/or ambiguous.

Phonetic & Numeric Clarifications

Say the letters and say the numbers.

SBAR (Quick, To the Point)

Situation	What is problem, patient, or project?
Background	What is important to know?
Assessment	What is your thought?
Request/**R**ecommend	What action do you need?

Protect Patients from Harm

- Absolute compliance with Red Rules
- Perform hand hygiene
- Prevent falls
- Activate Rapid Response

RED RULES

5. Support Each Other

Be a Safety Partner

- Look out for each other
- Positively reinforce safe and productive behaviors (X5)
- Correct unsafe behaviors in a helpful manner

Speak Up: Use ARCC and CUSS Words

Ask a question	**CUSS Words**
Request a change	I am ***concerned***
Concern, state your concern using the safe word	I am ***uncomfortable***
Chain of command	This is for ***safety***
	Stand up and ***stand*** together

Make Every Day a Safe Day.

Patient Safety Is Our Core Value.

System-Wide Strategies

Quality & Safety	***Lead healthcare to superior patient outcomes through creation of a high reliability culture with evidence-based quality and patient safety as our core value***
Patients	*Create strong customer loyalty by providing exceptional experiences for all patients.*
Physicians	*Build sustainable, trusting & collaborative relationships to advance our respective quality and economic objectives.*
People	*Recruit, develop, & retain top performing employees.*
Operational Excellence	*Achieve financial operating performance to fund capital needs and strengthen the balance sheet.*
Growth	*Strategically grow services to meet the expanding needs of the Greater Houston community.*

Understanding Failure

The question is not:

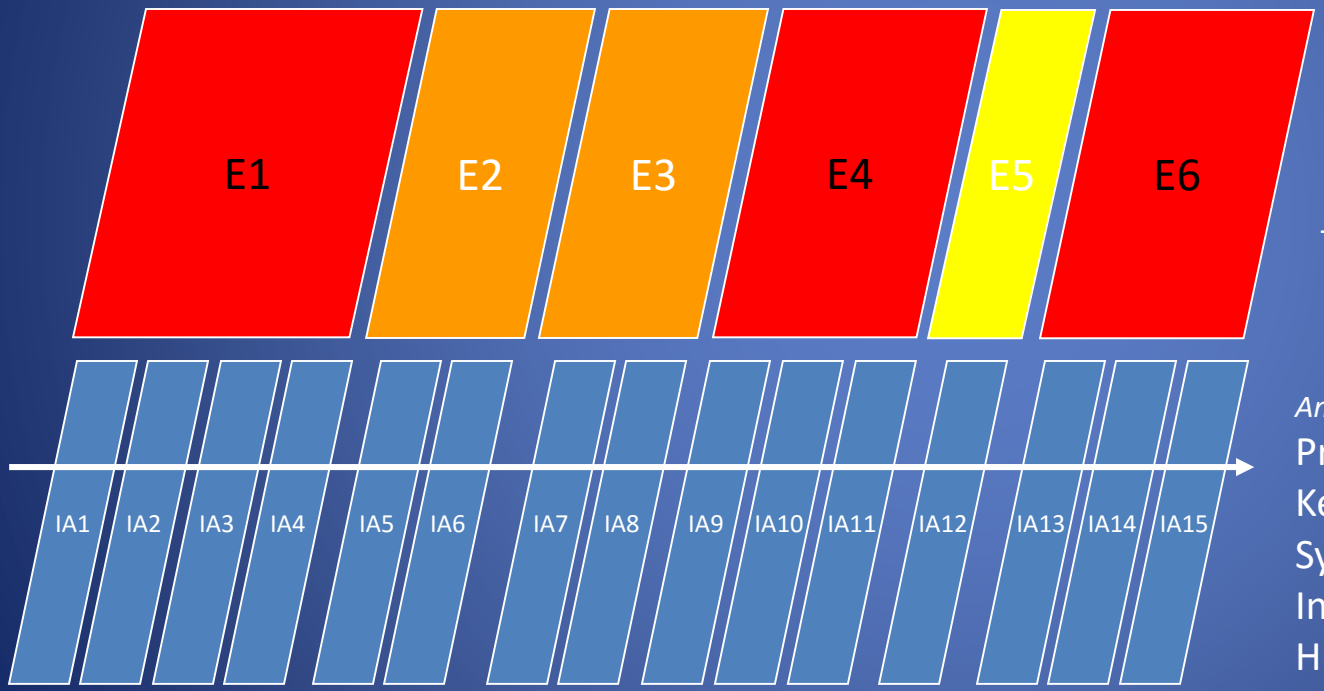
- What mistake was made?
- Why didn't they notice what we find important now?

The question should be:

Why did it make sense to do what they did?

Common Cause Analysis

A collective examination of past events for “common causes” (not common outcomes)



Event (E): a condition that results from a deviation from practice expectations or standard of care

Analyze by:
Profession, Organization, Key Process, Key Activity, System Failure Mode, Individual Failure Mode, Human Error Type

Inappropriate Act (IA): a human error that violates performance expectations or takes a task outside acceptable limits

Common Causes

Investigating Individual Failures (IFM)

Individual failures are beyond the person that got caught. It's all of the people with the same practice shaping the culture that caused the error.

The question is: "Why did it make sense to do what they did?"

It requires a hard look at the expectations we have placed on the staff and their understanding of those expectations.

Investigating System Failures (SFM)

System failures are weaknesses in the current culture, processes and safeguards.

Reconstruct the world in which individuals found themselves at the time.

The question is: Why don't we have thoughtful and reliable use of safety behaviors? Or if we do, why did they fail?

What can we do to increase the reliability in the process?

Hospital Acquired Infections, Conditions and Patient Safety Indicators

Central Line Associated Bloodstream Infections

Ventilator Associated Pneumonias

Surgical Site Infections

Retained Foreign Bodies

Iatrogenic Pneumothorax

Accidental Punctures and Lacerations

Pressure Ulcers Stages III & IV

Hospital Associated Injuries

Deep Vein Thrombosis and/or Pulmonary Embolism

Deaths Among Surgical Inpatients with Serious Treatable Complications

Birth Traumas

Serious Safety Events

Hospital Acquired Infections, Conditions and Patient Safety Indicators

Central Line Associated Bloodstream Infections

Ventilator Associated Pneumonias

Surgical Site Infections

Retained Foreign Bodies

Iatrogenic Pneumothorax

Urinary Tract Infections

Pressure Ulcers Stage III & IV

Vascular Associated Injuries

Thrombosis and/or Pulmonary Embolism

Deaths Among Surgical Inpatients with Serious Treatable Complications

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Serious Safety Events

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Deaths Among Surgical Inpatients with Serious Treatable Complications

Birth Traumas

Serious Safety Events

High Reliability
Certified Zero Award

1. Zero Events


2011

MEMORIAL HERMANN

High Reliability
Certified Zero Award

To: Memorial Hermann Southeast Hospital

Zero Iatrogenic Pneumothorax for 12 Months

February 1, 2010 to January 31, 2011

Dan Wolterman
President & Chief Executive Officer

M. Michael Shabot, M.D.
System Chief Medical Officer

Robert G. Croyle
Chair, Health System Board

BREAKTHROUGHS IN PATIENT SAFETY

2. 12 Consecutive Months

3. Certified Zero Category

High Reliability 2011-15
Certified Zero Awards

160

ICU Central Line Associated Bloodstream Infections (13)

ICU Catheter Associated Urinary Tract Infections

Hospital-Wide Central Line Associated Bloodstream Infections (3)

Ventilator Associated Pneumonias (23)

Surgical Site Infections

Retained Foreign Bodies (33)

Iatrogenic Pneumothorax (17)

Accidental Punctures and Lacerations (3)

Pressure Ulcers Stages III & IV (25)

Hospital Associated Injuries (5)

Deep Vein Thrombosis and/or Pulmonary Embolism (1)

Deaths Among Surgical Inpatients with Serious Treatable Complications

Birth Traumas (12)

Serious Safety Events 1 & 2 (9)

All Serious Safety Events (1)

Early Elective Deliveries (1)

Manifestations of Poor Glycemic Control (14)

Leadership – An Evolution in Perspective

"If you do the things you've always done, you'll get the results you've always gotten."

From…	*To…*
Externally driven safety focus (e.g. Joint Commission, CMS)	***Internally driven*** safety focus (First, Do No Harm – it's the right thing to do)
Safety is a priority	Safety is a ***core value*** that cannot be compromised
We are creating a safety culture	We are shaping a ***reliability culture*** that creates safety
The board and senior leader support culture change	The board and senior leaders ***own and manage*** the culture
Medical staff support culture change	Medical staff ***own and promote*** safety culture

Attention is the currency of leadership.

Ronald Heifetz