Maryland Association of Healthcare Executives presents:

Leading a Culture of Safety
January 17, 2019
Sheraton Columbia Town Center Hotel
Panel

Moderator:
Daniela Macander, MPH, LSSBB, Senior Manager, Atlas Research

Speakers:
Kathryn (Kate) Kellogg, MD, MPH, CPPS Assistant Vice President, Ambulatory Quality and Safety, MedStar Health and Associate Medical Director, National Center for Human Factors in Healthcare in Washington, DC.

Lisa Grubb, D.N.P, M.S.N., R.N., Deputy Director, Armstrong Institute at Howard County General Hospital Senior Director of Quality

James Gardner, MBA, RT(R), CSSBB, Senior Operational Excellence Consultant at Adventist Healthcare
MedStar Health Overview

- 10 hospitals
- 176K stays/year
- 280+ ambulatory sites
  - Clinics
  - Ambulatory surgery centers
  - Urgent cares
- 4.6M visits/year
- Net operating revenue = $5.53B
Underlying safety principles

- System safety science & human factors engineering integration
- Primary/Secondary/Tertiary model
- High Reliability Organization
2000 deaths annually
Causes of Death in the US, 1997

- Accidents: 96k
- Medical errors: 98k
- Lung disease: 109k
- Stroke: 160k
- Cancer: 540k
- Heart disease: 727k

Adapted from: Bleich S. Medical errors: five years after the IOM report. Issue Brief (Commonw Fund). 2005;(830):1-15
Causes of Death in the US, 2013

Motor vehicles 34k
Firearms 34k
Suicide 41k
COPD 149k
Medical error 251k
Cancer 585k
Heart disease 611k

0.7% of admissions with preventable lethal adverse event

Adapted from: BMJ 2016;353:i2139, http://www.bmj.com/content/353/bmj.i2139
0.0002% of jumps with lethal adverse event

www.besthealthdegrees.com/health-risks
Lack of accountability

Carelessness

Incompetence
80% of flights involve one or more errors
Human Factors

The scientific discipline focused on

(1) understanding human capabilities and

(2) designing tools and machines, systems, and processes for safe, efficient, and effective use.

Human Factors

- Psychology
- Physiology
- Cognitive Science
- Industrial Engineering
- Anthropometry
- Interaction Design
At the core of NTSB investigations is the "Go Team." The purpose of the Safety Board Go Team is simple and effective: Begin the investigation of a major accident at the accident scene, as quickly as possible, assembling the broad spectrum of technical expertise that is needed to solve complex transportation safety problems.
MedStar Health Go Team

• Patient Communication Consult Service
• Care for the Caregiver
• Event Review
• Early Resolution
Event Review 2.0

Immediate Response
- Inform system leadership
- Care for patient and family/Early disclosure
- Care for caregiver
- Gather time sensitive info

In Depth Event Review
- Interviews
- Understanding the context
- Identify causal factors
- Identify core team

Confirmation & Consensus Meeting

Solutions Meeting
- Templates, project management techniques and documentation

Follow Up
Fallibility is part of the human condition.

We cannot change the human condition, but we can change the conditions under which people work.

- James Reason, PhD
Get in the tube
Organizational Influences
- Resources
- Culture
- Policies and procedures

Supervisory Hazards
- Inadequate oversight
- Emergency procedures
- Supervisory breach

Conditions for Hazards
- Physical environment
- Tools/technology
- Associate condition
- Patient condition
- Coordination of care

Hazards
- Errors – decision vs. skills based
- Violations

Modified from: Shappell SA, Wiegmann DA. The Human Factors Analysis and Classification System – HFACS.; 2000
Prevention of Heart Disease

Primary Prevention
- Healthy Lifestyle
- Don’t Start Smoking

Secondary Prevention
- Screening for Risk Factors
- Control of Risk Factors (HTW, DM)

Tertiary Prevention
- CAD: Management After Heart Attack
- Optimizing Management of Heart Failure
MedStar Health’s Integrated Patient Safety Transformational Model (PST)™

Proactive

Primary Prevention
Design System for High Quality and Safety, Low Risk

Realities of Actual Context

Proactive

Secondary Prevention
Identify and mitigate existing hazards

Reactive

Tertiary Prevention
Recover and learn from events
What is a High Reliability Organization?

High Reliability Organizations (HROs) “operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents.”

Managing the Unexpected
By Karl E. Weick & Kathleen M. Sutcliffe
Five Common Principles of High Reliability Organizations (HROs)

1. PREOCCUPATION WITH FAILURE
   No matter how well these organizations are doing, they never rest on their success. They constantly look for any threat to successful execution, no matter how irrelevant it may seem.

2. RELUCTANCE TO SIMPLIFY
   HROs embrace a critical eye and healthy skepticism of the easy answer. The more variables they can picture, understand and plan for, the better.

3. SENSITIVITY TO OPERATIONS
   HROs recognize that manuals and policies constantly change, and are mindful of complexity of the systems in which they work. HROs work quickly to identify anomalies and problems in their system to eliminate potential errors.

4. COMMITMENT TO RESILIENCE
   By preparing to prevent failure on a continual basis, HROs are ideally able to keep failures manageable or prevent them altogether. When errors occur, HROs have embedded within their culture the ability to solve problems and move forward without delay.

5. DEFERENCE TO EXPERTISE
   HROs cultivate a culture in which team members and organizational leaders defer to the person with the most knowledge relevant to the issue they are confronting. A high reliability culture requires staff at every level to be comfortable sharing information and concerns with others.
Setting and maintaining HRO culture

- Initial training
- Training during onboarding
- Safety moments
- Good catch emails
- SSE reports
Leading a culture of safety

• Based in the science of safety
• Common language (HRO)
• Non-punitive response to error/event review
Armstrong Institute at Howard County General Hospital – constructing a fractal model

A member of Johns Hopkins Medicine
Objectives

- Verbalize the history behind the Armstrong Institute
- Understand the mission, vision, and values that drive Howard County General Hospital and the AI at HCGH
- Describe the structure of AI at HCGH
- State how to operationalize the patient safety and quality structure
- Replicate the metrics that we use to measure patient safety and quality
- Construct a fractal model for quality and patient safety
Armstrong Institute

The Armstrong Institute works at Johns Hopkins and around the world to realize Mr. Armstrong's vision of zero preventable patient harm.
HCGH Mission, Vision, and Values

To provide the highest quality of care to improve the health of our entire community through innovation, collaboration, service excellence, diversity and a commitment to patient safety.

To be the premier community hospital in Maryland.

- Excellence and discovery
- Leadership and integrity
- Diversity and inclusion
- Respect and collegiality
Armstrong Institute Mission, Vision, and Values

We partner with patients, their loved ones and all interested parties to end preventable harm, to continuously improve patient outcomes and experience, and to eliminate waste in health care.

Saving lives by leading the world in patient safety and quality care.

Excellence and discovery

• Leadership and integrity
• Diversity and inclusion
• Respect and collegiality
The Armstrong Institute’s work focuses on:

- Eliminating medical errors and complications of care
- Enhancing clinical and patient-reported outcomes for all patients
- Delivering patient- and family-centered care
- Ensuring clinical excellence
- Improving health care efficiency and value
- Eliminating health care disparities
- Creating a culture that values collaboration, accountability and organizational learning

1 – Establish leadership structure
2 – Formalize a system to declare and establish goals

Pillars

- Principles of a Highly Reliable Organization
- Environment of continually learning and improving

Self learning

Peer to peer

Clinical communities

- Accountability

Self improvement

Peer to peer

Bedside to Boardroom

Pronovost, Armstrong, Demski, Peterson, & Rothman, 2017
Highly Reliable Organizations

High reliability organizations are organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures.

3 Core Components of an HRO

- Safety (Just) Culture
- Robust Process Improvement
- Leadership Commitment to Zero Harm
Six Principles to build a fractal model

- Ensure oversight for quality
- Create a framework to organize and report the work
- Identify care area where quality is ambiguous or underdeveloped
- Create a consolidated quality statement
- Ensure data integrity
- Share and report data and information with transparency and with accountability

Pronovost, Armstrong, Demski, Peterson, & Rothman, 2017
Six Principles in action

- Ensure oversight – horizontal and vertical accountability
- Framework to organize and report the work – boardroom to bedside and bedside to boardroom
- Identify islands that are not reported anywhere – pediatric surgery
- Accountability and reporting – define who is responsible for quality in every area
- Quality “financial” statement – Management Discussion and Analysis
- Share – bedside to boardroom and boardroom to bedside

Pronovost, Armstrong, Demski, Peterson, & Rothman, 2017
Quality Framework

• Patient Safety
  Internal risk, voluntary reporting, patient events
  External reporting

• Patient Experience

Hospital Consumer Assessment of Healthcare Providers (HCAPS)

• Value - quality of care divided by cost

Pronovost, Armstrong, Demski, Peterson, & Rothman, 2017
Management Discussion and Analysis

- Patient Safety
- Patient Experience
- Value

Austin et al., (2017)
Recap

• Completed MD & A

• Accountability

• Communication - bedside to boardroom and boardroom to bedside

• Performance improvement activities

• Learning environment

• Value

• Patient Centered Care
References


AHC Standard Management Approach

Adventist Healthcare
Standard Management Approach Lifecycle

- Core Process Mapping
- Process Measure Selection
- DMAIC
- Our Main Thing
Our Main Thing

**Step 1:** Define your Core Purpose

**Step 2:** Define your Core Processes

**Step 3:** Define your Core Roles & Responsibilities

**Step 4:** Identify Measures of Success

**Step 5:** Define the Vision/Strategy

### Table: Our “Main Thing” – Core Purpose, Processes, & Responsibilities

<table>
<thead>
<tr>
<th>Department Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE IDEOLOGY</strong></td>
</tr>
<tr>
<td>Core Purpose</td>
</tr>
<tr>
<td>(Why do we exist?)</td>
</tr>
<tr>
<td>Core Processes</td>
</tr>
<tr>
<td>(What are the core processes to fulfill the purpose that you exist for?)</td>
</tr>
<tr>
<td>Core Roles &amp; Responsibilities</td>
</tr>
<tr>
<td>(What roles are critical to carry out your core processes? What are their responsibilities?)</td>
</tr>
<tr>
<td><strong>ENVISIONED FUTURE</strong></td>
</tr>
<tr>
<td>Dashboard Measures of Success</td>
</tr>
<tr>
<td>(Current or Future Dashboard Goals)</td>
</tr>
<tr>
<td>5 Year Strategic/Visionary Goal</td>
</tr>
<tr>
<td>(What do you hope to accomplish and be known for?)</td>
</tr>
</tbody>
</table>
Define your Core Purpose

✓ Simplify – Should be easy to speak to
✓ Key Words
✓ Measurable

Example:

**OUR “MAIN THING” – CORE PURPOSE, PROCESSES, & RESPONSIBILITIES**

<table>
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</table>

<table>
<thead>
<tr>
<th>Core Purpose</th>
<th>(Why do we exist?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>To efficiently, safely and accurately provide medication therapy to all our patients in order to promote healing and improve quality of life.</td>
</tr>
</tbody>
</table>
Define your Core Processes

✓ Must assist the department in fulfilling the purpose
✓ Aligns to the APQC framework (American Productivity & Quality Center)

Example:
• Nursing
  • 4.8.1 Perform the initial intake
  • 4.8.4 Determine care plan
  • 4.8.5 Execute care plan
  • 4.8.6 Discharge patient from care
Define your Core Roles & Responsibilities

✓ Identify the roles that are essential to carry out your core processes

✓ Keep it simple – this should be a “cover page” to your organizational chart and job descriptions

✓ Example:
  • Rehabilitation
    • Rehab staff - deliver interventions and discharge planning recommendations
    • Therapy scheduler - matches patients to clinicians in real time on a daily basis
    • Rehab manager - promotes achievement of departmental goals in each of five pillars.
    • Physiatrists - provide strategic clinical direction and serve as a liaison to physician stakeholders.
Identify Measures of Success

✓ Reflects the Core Purpose

✓ 6 Key Measures of Success – How will you know when you’re successful at what you set out to do?

✓ Must represent at least 3 of the 6 Pillars of Excellence
  • People, Quality & Safety, Patient Experience, Finance, Growth, & Population Health Management

✓ Example: Employee Engagement
  • Aligns to the People Pillar of Excellence
YOU are the CEO of your department

What does your team hope to accomplish in the next 5 years?

- Reflects your Core Purpose
- Sets direction for your department
- Measurable
- Inspirational

Examples:

- World class performance in each measure of success
- Highly reliable equipment and systems
- To produce positive operating margins
Complete SIPOC for each Core Process
Map & Validate Each Process

✓ Turn your SIPOC into a process map using the standard process map template
Identify Process Measure

- Identify a process measure for the core process & create a graph

What can we measure to know if our process is working?
What is a Process Measure?

- A measure that **leads** to something that you’re trying to accomplish
- Represents your day-to-day improvement efforts

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Process Measure</th>
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<tbody>
<tr>
<td>Falls</td>
<td>Fall Risk Assessment Completion</td>
</tr>
<tr>
<td></td>
<td>Fall Protocol Compliance</td>
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<tr>
<td></td>
<td>Hourly Rounding Compliance</td>
</tr>
<tr>
<td>Nurse Communication - Domain</td>
<td>Bedside Shift Report Compliance</td>
</tr>
<tr>
<td></td>
<td>Leader Rounding Compliance</td>
</tr>
<tr>
<td></td>
<td>AIDET Compliance</td>
</tr>
<tr>
<td>Responsiveness of Staff - Domain</td>
<td>Hourly Rounding Compliance</td>
</tr>
<tr>
<td></td>
<td>Call Bell Timeliness</td>
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<tr>
<td>Certified RNs</td>
<td>Eligible RNs Enrolled in Class</td>
</tr>
<tr>
<td>Turnover</td>
<td>Staffing Ratio Compliance</td>
</tr>
<tr>
<td>Employee Engagement</td>
<td>% of Staff in PCAP</td>
</tr>
</tbody>
</table>
DMAIC Performance Improvement

✓ Complete at least one DMAIC performance improvement project that aligns to your six measures of success.
Rinse & Repeat

- Core Process Mapping
- Our Main Thing
- DMAIC
- Process Measure Selection

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Next Meeting

March 21, 2019