Reliability in the Column:
Operations Management, Executive, Governance

Making It the Way Leaders Do the Work

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Touch Points in a Journey
Leadership for Reliability & Safety

• A Leader’s Early Learning
• A Framework For Leadership
  – Focus on Governance
• Respectfully Confronting The Realities Of Practice
• Making It The Way Leaders Do The Work
...ALL Work is a Process!

LEADER – “How I think things work or should work”

FRONT-LINE – How things really work: unintended variation

Confusion...Conflict...Complexity...Chaos
DANA-FARBER ADMITS DRUG OVERDOSE CAUSED DEATH OF GLOBE COLUMNIST, DAMAGE TO SECOND WOMAN

When 39-year-old Betsy A. Lehman died suddenly last Dec. 3 at Boston's Dana-Farber Cancer Institute, near the end of a grueling three-month treatment for breast cancer, it seemed a tragic reminder of the risks and limits of high-stakes cancer care. In fact, it was something very different. The death of Lehman, a Boston Globe health columnist, was due to a horrendous mistake: a massive overdose of a powerful anticancer drug that ravaged her heart, causing it to fail suddenly....
Key Learning in Journey

- The responsibility and power of all leadership [trustee, clinical and administrative] over safety throughout the ten years
- The need for relentless vigilance to safety, risk, error, near-miss, harm
- Addressing the multiple victims of error
- The crucial role the design of systems and application of technology play in support of safe practice by excellent staff
- The synergy of interdisciplinary practice and team work
- Patient and Family Centered Care
DFCI: A Culture of Safety

Some Reflections

- Based in trust, respect, human rights, repentance, and forgiveness
- Patient and family centered
- Supports staff, enabling and motivating the highest levels of performance
- Acknowledges high risk, error-prone nature of healthcare
- Ensures individual and shared acceptance of responsibility and accountability for safe delivery of quality care, risk reduction, care outcomes in a systems based approach
- Encourages and facilitates reporting and open communication about safety concerns in a fair and just environment
- Ensures organizational structures, processes, goals and rewards are aligned with improving patient safety [HRO]
- Learns from errors
- Shares stories of safety
Our systems are too complex to expect merely extraordinary people to perform perfectly 100% of the time. We as leaders must put in systems that support safe practice.
Framework: Leadership for Improvement

Setting Direction: Mission, Vision and Strategy

Changing the old

Making the future attractive

Establish the Foundation

Will

Ideas

Execution
Framework: Board Leadership of Quality

1. Set Direction: 100% or Zero
   - Make the status quo uncomfortable
   - Make the future attractive

3. Build Will
   - Involve patients and families
   - Understand the gap between your current performance, the best in class and the theoretical ideal
   - Use stories and data
   - Go transparent
   - Show courage

4. Generate Ideas

5. Execute Change
   - Establish accountability for results
   - Establish good oversight process on “are we achieving our aims?”
     - Watch your own dots
     - Weekly or monthly data
     - 25% Board time on quality

2. Establish the Foundation
   - Establish Quality Committee
   - Bring knowledgeable quality leaders onto the board
   - Quality education standards for board

   - Build a board culture of healthy conversations with MEC and administration
Getting the Boards on Board
A Community Comes Together

- ~ 2,200 organizations enroll
- > 3,000 Trustees and executive leaders Interest sustained over 5 years
- Governance of quality and safety EVERYWHERE by EVERYONE
  – Push / Pull
- Safety improving: many organizations more of the time
Serious Safety Events
Total Number of SSEs in Comparison to Baseline Rate

Since 7/1/06, we've had 33.6 fewer SSEs than would have resulted from the baseline rate.

At any point on the blue line... if the dashed red line is below it, then the average event rate over the entire time period following that point is less than the baseline rate by a statistically significant margin (p < 0.05). Note: The dashed red line is recalculated each month and moves up or down with the latest point. So the lower the latest point, the lower the dashed red line.

# SSEs Relative to Baseline Rate
 Jul 2004 - Jun 2006 Baseline
FY07/FY08/FY09 Goals
Statistical Significance (p < 0.05)
(See Explanatory Note on Chart)

Chart Updated Through 31Aug09 by Art Wheeler, Legal Dept.
Source: Legal Dept.
Infections per month

HAI Reduction July 08-April 09

VAPs, CLBSIs, PH CaUTIs

HAI FY 08 Target FY 09 target
Winchester Hospital
Preventable Harm Events

Patient Safety
Ventilator Associated Pneumonia
Serious Med Errors
Surgical Site Infections
Central Line Associated Blood Stream Infection
Falls with Injury

October 2008 through September 2009
Fiscal Year 2009 Goal: Reduce preventable harm by 50%

2008 total
2009 Goal
2009 Total
2010 Goal
2011 Goal

Falls with Injury
28

Central Line Associated Blood Stream Infection
38

Surgical Site Infections
2

Ventilator Associated Pneumonia
2

Serious Med Errors
6

Chairman, age 65
Judy, age 86
Ed, age 82
Kelly, age 1

Jane, age 56
Jim, age 48
Kevin, age 50
Sam, age 90

Susan, age 88
Rob, age 76

Rose, age 80
Rick, age 80
Bill, age 77

Paul, age 67
Leo, age 80

Bob, age 76
Karl, age 33
Doug, age 72

Linda, age 84
Joan, age 76
Susan, age 28
Karen, 45

Joe, age 62
Frank, age 88
Chris, age 87

Lisa, age 60
Tim, age 76
Mary, age 81

Michael, age 90
Timothy, age 84

Fiscal Year 2009 Goal: Reduce preventable harm by 50%
Selected Preventable Harm Events

**Baseline 2008**: 108

**Goal for FY2009**: 54

Exceeded our 2009 Goal:

**Current Score**: 38

**Goal for FY2010**: 27

**Goal for Q1 FY2012**: 0

**FY2010 October 2009 through September 2010**

Updated through July 31, 2010

- Inpatient Falls with Serious Injury: 1
- Ventilator Associated Pneumonia (ICU): 0
- Central Line Associated Bloodstream Infections (ICU): 0
- Serious Medication Errors: 0
- Surgical Site Infections: 3

**Our Aim**: Eliminate Preventable Harm by Dec. 31, 2011
Preoccupation with Failure?
## ACHE Annual Top 3 Survey
### Top Issues Confronting Hospital CEOs

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<th>Issue</th>
<th>2004</th>
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<th>2008</th>
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<td>76%</td>
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<td>HC Reform</td>
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<td>Care—uninsured</td>
<td>36%</td>
<td>35%</td>
<td>37%</td>
<td>38%</td>
<td>41%</td>
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<td>Pt Safety &amp; Quality</td>
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<td>--</td>
<td>43%</td>
<td>32%</td>
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<td>Gov. mandates</td>
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<td>16%</td>
<td>23%</td>
<td>22%</td>
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<td>MD/hosp. relations</td>
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<td>33%</td>
<td>40%</td>
<td>35%</td>
<td>32%</td>
<td>25%</td>
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<td>Patient satisfaction</td>
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<td>Quality</td>
<td>18%</td>
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<td>33%</td>
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ADVERSE EVENTS IN HOSPITALS

NATIONAL INCIDENCE: MEDICARE

An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays—projects to an estimated 134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the 1-month study period.

An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a month.

An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm.

Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable.

Hospital care associated with adverse and temporary harm events cost Medicare an estimated $324 million in October 2008.

The call to IHI...and many others.

“We’ve just had a terrible error in the ICU. A patient died who shouldn’t have. What should we do?”
The Second Victim

Children's Hospital nurse under investigation ends own life

By Tracy Vedder

SEATTLE -- A nurse involved in a case under investigation at Seattle Children's Hospital has committed suicide.

KOMO News has learned Kimberly Hiatt

Summary

KOMO News has learned Kimberly Hiatt took her own life earlier this month. At the time, she was still under investigation by the state in connection with the death of a critically-ill baby at the hospital.
Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management

http://tinyurl.com/IHIEffectiveCrisisMgmt

“In the aftermath of a serious adverse event, the patient/family, staff, and community would all say, “We were treated with respect.”

Checklist: Respectful Management of a Serious Clinical Event

PROBING ALL STEPS

COMPLETING ALL STEPS

• Prepared Plans & Systems
• Internal Notification
• Crisis Team Activation
• Priority 1: Patient / Family
• Priority 2: Staff
• Priority 3: Organization
  • AE Management
  • Communications
• External Notification / Visits
Leadership System
IHI Improvement Map

Making it the way we do the work
Leaders are positioned to achieve well-defined and thoughtful annual aims (clinical, financial, satisfaction) within one year.

Set Direction
Build the Foundation
Will
Ideas
Execution

Aim
Alignment
Capability
Governance & Leadership
Values
Connections
Measure, Oversee
Patients and Families
Innovation / KM
Scan
Projects Portfolio
Processes Reliability

AIM FRAMEWORK IM LEADERSHIP PROCESSES
High Reliability Organization

Sophisticated design of human interactions and working relationships

Weick’s Attributes
1. Preoccupation with failure
2. Reluctance to simplify interpretations
3. Sensitivity to operations
4. Commitment to resilience
5. Deference to expertise
"Do not go where the path may lead; go instead where there is no path and leave a trail”

Ralph Waldo Emerson
References

• IHI Boards on Board
  – http://www.ihi.org/IHI/Programs/Campaign/BoardsonBoard.htm

• IHI Framework Leadership Improvement
  – http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFrameworkforLeadershipofImprovement.htm

• DFCI Key Learning

• Effective Crisis Management Resource Center