Building Will

Leadership for Innovation and Improvement

Juanita Romans

This presenter has nothing to disclose.

In Collaboration with
Hamad Medical Corporation
Institute for Healthcare Improvement

Session Objectives

- Understand the IHI Leadership Framework for Innovation and Improvement
- Begin to develop new ideas of what leaders can do to accelerate the rate of improvement

The Question

How good is your hospital?

Another Way to Think About How Good…

- If you are the patient?
  - What is the right number of medication errors, infections or falls?
  - How long is an acceptable time to spend in the Emergency Department waiting to be seen or admitted?
  - What is the correct % of the time that you should get the right care?

What Patients Really Want

Don’t hurt me

Help me

Be Nice to Me

Don Berwick, MD

Quality: Two Sides of the Coin

Patient Harm Occurs Because…

"Every system is perfectly designed to produce the results it gets."

Dr. Paul Batalden

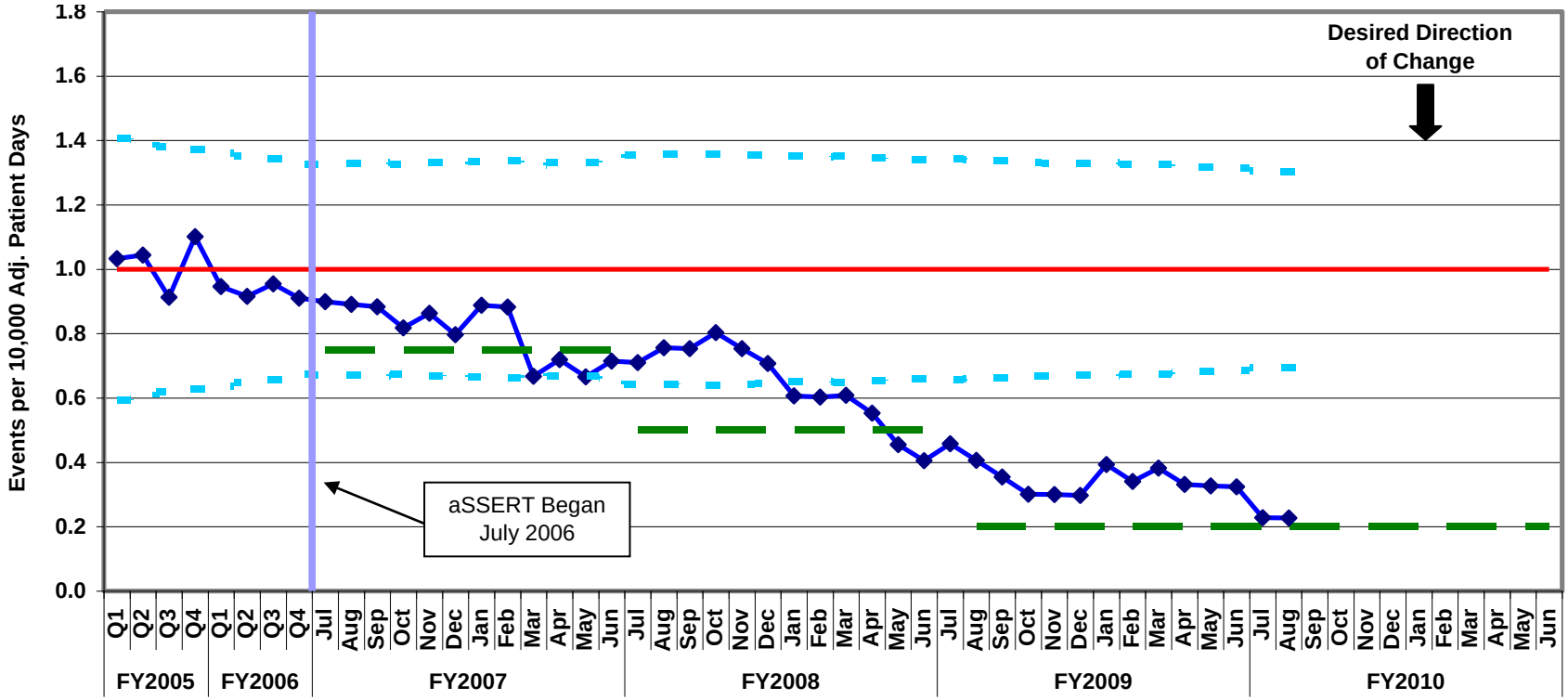
What is this Award Winning Hospital Perfectly Designed to Produce?

- Outcomes/System-level Measures
  - Excellent patient experience
    - 98% willingness to recommend
  - Risk-adjusted inpatient mortality rates that track with US “average”
    - 30-day AMI mortality is 12.9% (better than the US average16.6%)
  - Low overall costs of care for Medicare population
    - 30-day readmission rates for AMI (16.9%) and CHF (20.5%) better than US norms

But It is Also Designed to Produce…

- Safety events each year
  - 9 sentinel events
  - 19 deaths associated with “occurrences”
  - 9 permanent injuries associated with “occurrences”
  - 695 temporary injuries associated with “occurrences”
  - 27 CLAB infections (9 in Q4 2009)
  - 25-30 VAP (7 in Q4 2009)
  - 40-50 MRSA infections (12 in Q4 2009)
  - ~800 CA-UTI (207 in Q4 2009)
  - ~100 C. difficile infections (27 in Q4 2009)
  - 32 surgical “occurrences” (2 deaths, 2 sentinel events, 24 temporary harms

Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average



** Each point reflects the previous 12 months. Threshold line denotes significant difference from baseline for those 12 months (p=0.05).

** The narrowing thresholds in FY2005-FY2007 reflect increasing census. Adjusted patient days for FY07 were 27% higher than for FY05.

SSEs per 10,000 Adj. Patient Days

Baseline [1.0 (FY05-06)]

Fiscal Year Goals (FY07=0.75 / FY08=0.50 / FY09=0.20)

Threshold for Significant Change

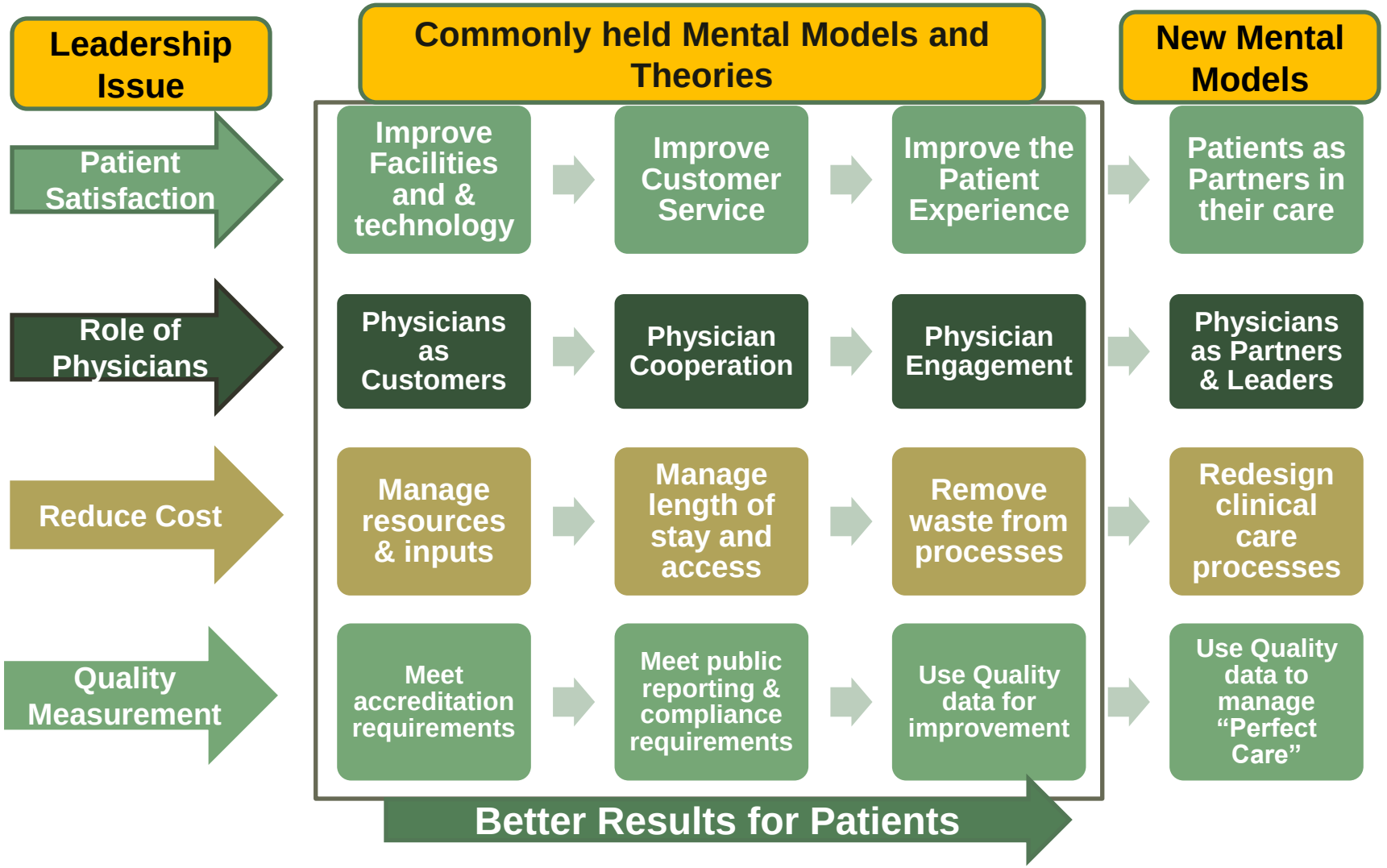
Chart Updated Through 31Aug09 by Art Wheeler, Legal Dept.

Source: Legal Dept.

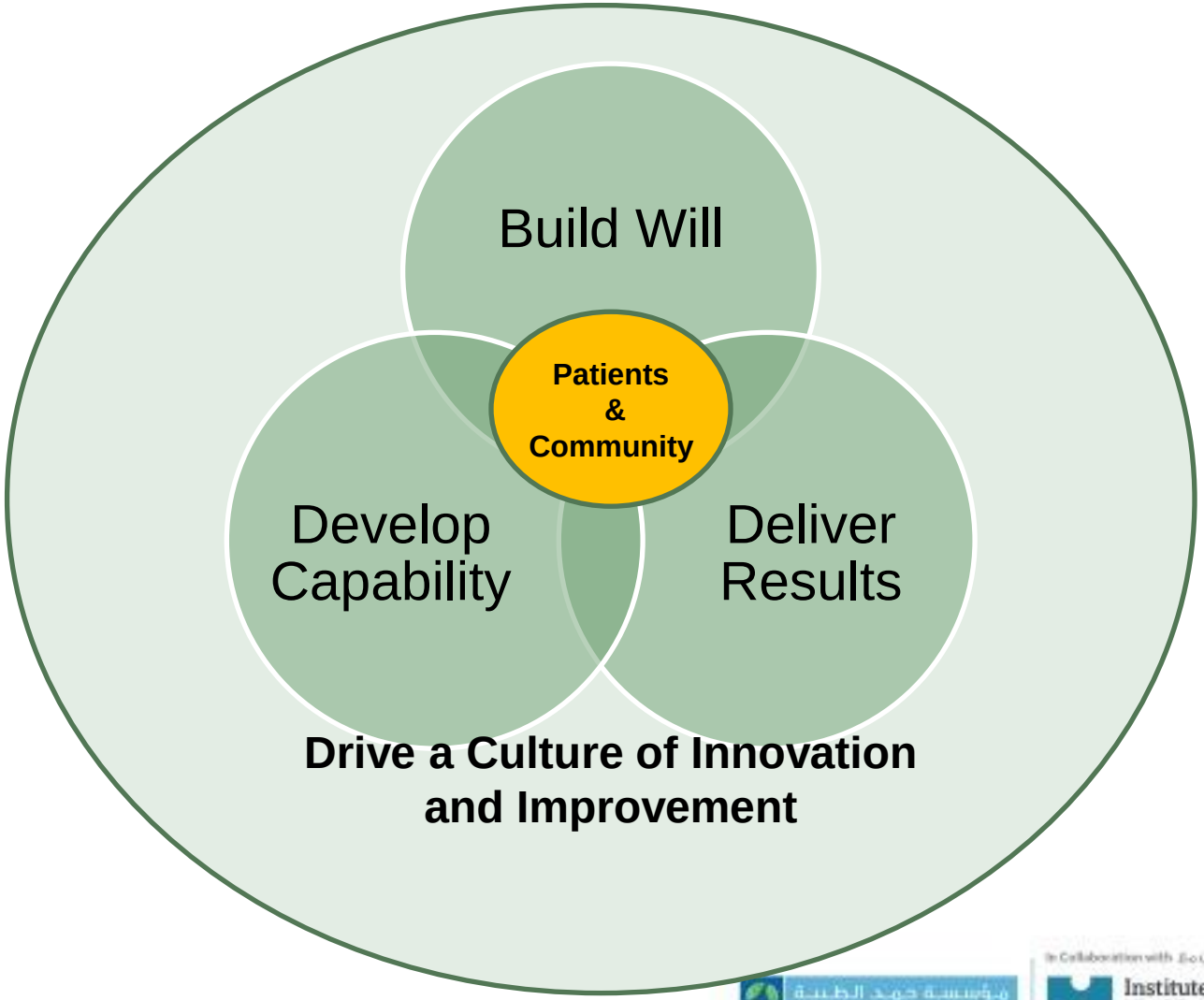
So what's it going to take?

1. Leadership
   - Engaged Boards and Executive Teams
   - Clear Strategies and Focus
   - Better Execution
2. New Mental Models and Strategies
   - We have to think differently about both the challenges and the solutions

Mental Models & Theories Drive Leadership Actions and Behaviors



IHI's Framework for Leading Improvement and Innovation



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Build Will

Leadership Actions and Behaviors

- Leadership “ownership” of safety and quality results
- Promote transparency of performance and results
- Focus on processes not people
- Articulate a clear and compelling vision
- Engage the board, physicians and the leadership team
- Devote leadership time and attention to efforts
- Sense-making for the organization—setting priorities
- Systematic leadership review of results and improvement processes
- Leadership visibility and engagement in improvement work

Building Will

Senior Leadership and Board Actions

- Leaders and Board members must have a clear, consistent focus on quality
  - Adopt bold, specific, system-level Safety, Quality, and Experience strategic aims
  - Oversee system-level measures of progress toward those aims, using a strategic dashboard
  - Engaged Quality Committee
    - Asking a lot of hard but useful questions

Seven Leverage Points:

If you want to achieve system-level results in safety…

1. Set specific system-level aims and oversee their achievement at the highest levels of governance.
2. Build an executable strategy to achieve the aims, and oversee the execution at the highest levels of administration.
3. Channel attention to system-level aims and measures
4. Get patients and families on your team!
5. Engage the Finance Director in achieving the aims
6. Engage doctors in achieving the aims
7. Build the improvement capability necessary to achieve the aims

1. Examples of Bold, Specific, System-Level Aims

- "We will achieve a 50% reduction in hospital-acquired infections within 12 months, as measured by the sum of Central Line Bloodstream Infections, Ventilator-Acquired Pneumonias, and Catheter-Associated Urinary Tract Infections." - *WellStar Health System*
- "We will cut hospital-acquired infections in half every year, on our way towards zero, as measured by the sum of C Diff, SSI, VAP and MRSA." - *Delnor Community Hospital*
- "We will reduce Harm by 80%, as measured by Serious Safety Events, within 3 years." – *Cincinnati Children's*

Not-So-Specific Aims

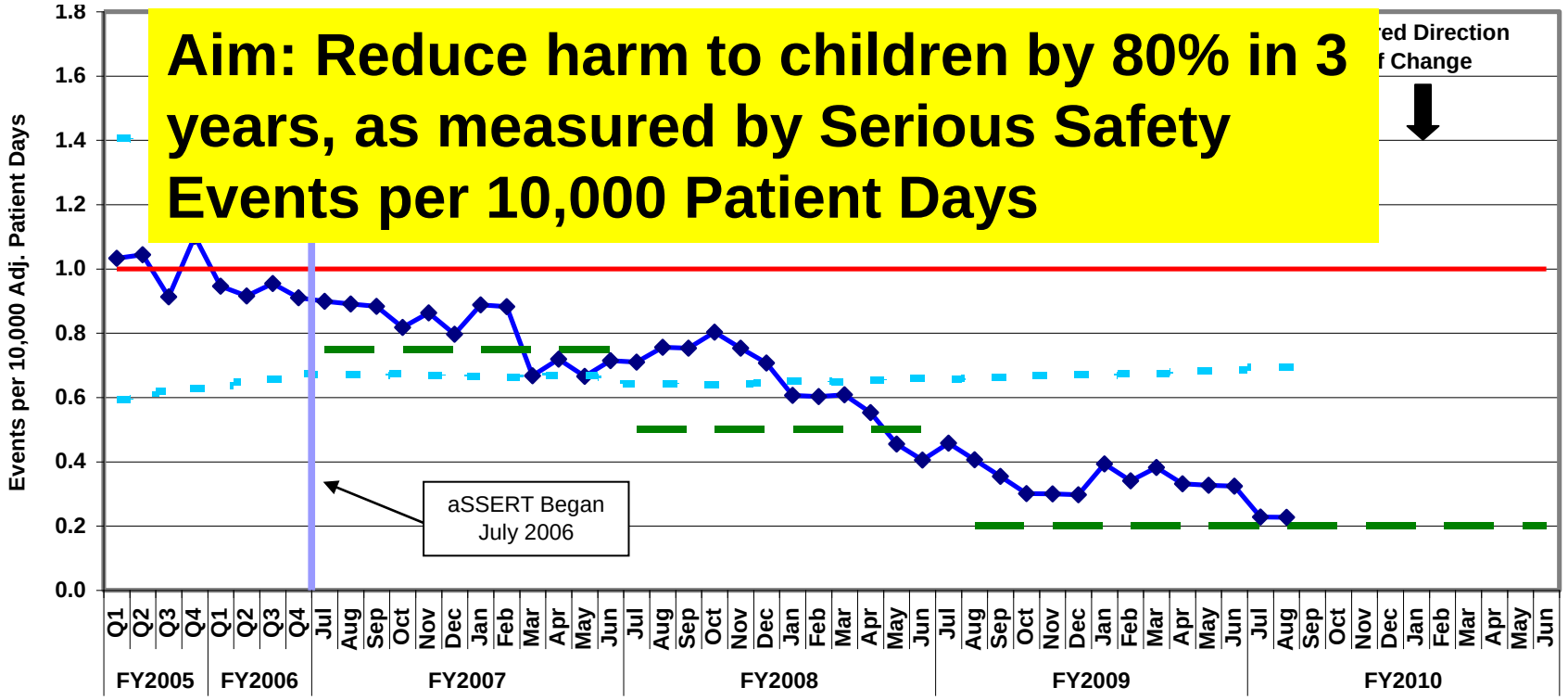
- “Our hospital strives to achieve the highest levels of quality”
- “Memorial General aims to be in the top tier of hospitals for quality and safety”

As measured by….?

By when…?

Cincinnati Children's Hospital Medical Center

Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average



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Building Will

Leadership Actions and Behaviors

- Building Will
  - Start every meeting with a story
  - Engage in the difficult conversations
  - Eliminate the denominator
  - Convert data to names, dates, and events
  - Go transparent

Sometimes we cannot see what is in front of us…

- When we measure harm, eliminate the denominator…
  - You don't need denominators to compare yourself to yourself, over time
  - Denominators are often part of the problem (ADEs per 1000 doses, SSEs per 1000 patient days)
- Denominators make the problem abstract, rather than personal

What makes more sense… if the right answer is 0?

Traditional Display (Rates)

- .005 ADEs /1000 doses
- 2.67 infections/1000 patient days
- .003 Falls with harm per/1000 patient days
- .00234 Mortality Rate

Actual Count

- 35 Adverse Drug Events last month
- 220 hospital acquired infections last quarter
- 65 Patient falls—16 with harm last month
- 15 unnecessary deaths

Modified from M. Pugh

Counting Noses:

How do you think the Leadership & Board reacted to this report?

	Q2 2010 System-wide
Falls	488
Medication Error	725
Readmission for proc/surgery site infection	11
Birth Injury	9
Difficult Delivery	42
Fetal Resuscitation	47
Maternal transfer to critical care	3
Delay in diagnosis	456
Delay in treatment	291
Mislabeled labs	327
Attempted suicide	3
Trauma to healthy tissue	117
Pressure sore	79
Complications during surgery	56
Return to OR	79
Unexpected change in condition	101
	2834

3rd Quarter, 2010 Risk Events

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…and whenever possible

Put a face on the data

Jim Reinertsen, MD

Baseline SSER, Calendar Year 2008, 46 Events

John B.
9/06/2008
Delay in Dx

Shirley H.
12/23/08
Post Proced Death

Florita H.
7/03/2008
Delay in Tx

Wade W.
7/16/2008
Delay in Tx

Baby Boy S.
8/1/2008
Wrong Pt. Procedure

Joseph R.
9/08/2008
Delay in Dx.

Tamika M
4/21/2008
Med Error

Andrea M.
6/24/2008
Wrong Procedure

Nancy H.
6/18/2008
Med Error

Jimmy P.
7/07/2008
Fall

Joann E.
9/23/2008
Wrong Site Surgery

Cynthia M.
10/27/2008
Med Error

Regina D.
12/9/2008
Wrong Site Surgery

Baby Girl V.
5/12/2008
Mother's Delay in Tx

Kyle W.
9/13/2008
Delay in Tx

Teodur C.
1/29/08, 2/12/2008
Delay in Tx

Alvin G.
8/17/2008
Fall

Nicole S.
1/4/2008
Delay in Dx

Margaret H.
2/6/2008
Med Error

Ursula H.
2/12/2008
Fall

Ms. L.
2/14/2008
Delay in Tx

Sandra M.
12/10/2008
Post Procedure Death

Karen G.
8/5/2008
Proced Cx/Delay in Tx

Cynthia K.
11/10/2008
Delay in Tx

Lance D.
10/30/2008
Delay in Tx

Nicole H.
8/12/2008
Post-proced Cx

Robert S.
10/13/2008
Fall

Mary D.
3/9/2008
Med Error

Baby Boy G.
3/25/2008
Med Error

Lorena W.
11/10/2008
Post Procedure Death

Priscilla W.
8/30/2008
Delay in Tx

Dale W.
10/12/2008
Med Error

Eugene B.
10/27/2008, 10/28/2008
Med Error, Fall

Kathy W.
12/16/2008
Post Proced Loss of Function

Robert B.
12/2/2008
Post Procedure Death

Virginia L.
8/12/2008
Delay in Tx

Helene C.
9/5/2008
Fall

Lester J.
9/5/2008
Fall

Calvin P.
4/4/2008
Med Error

Gwendolyn P.
10/28/2008
Wrong Implant

Chantal E.
6/26/2008
Inapprop Touching

Gary B.
6/13/2008
Fall

Mary C.
12/19/2008
Fall

Douglas T.
10/18/2008
Med Error

24 Patients & Events – Jan-Dec,2009 vs. 46 Total for 2008

Loueene D.
9/23/09
Fall

Beverly S.
2/4/09
Med Error

Robert D.
5/12/09
Post Procedure Death

Karen C.
9/28/09
Delay In Treatment

Peggy P.
7/1/09
Burn

Sharenda W.
2/15/09
Med Error

Edward R.
4/23/09
Wrong Side Procedure

Brenda R.
10/14/09
Delay In Treatment

James H.
10/25/09
Post Procedure Death

Lilliam C.
4/3/09
Retained foreign object

47% Reduction SSER from Dec. 08 Baseline
48% Reduction in # of events year to year

Dorothy R.
1/28/09
Delay In Treatment

Donna S.
6/4/09
Retained foreign object

Monroe K.
5/18/09
Post Procedure Death

Jerry Y.
11/7/09
Fall

Yoland C.
7/7/09
Delay in Treatment

Juanita A.
5/14/09
Delay In Treatment

Johnny B.
11/9/09
Fall

Alma M.
11/6/09
Fall

Scott G.
9/5/09
Delay in Treatment

Michael F.
8/20/09
Retained foreign object

Willie B.
11/5/09
Med Error

Helen C.
11/4/09
Delay In Treatment

Pauline M.
11/2/09
Fall

Ronnie D.
11/3/09
Delay in Treatment

A 78% reduction through Nov. 2010

Lois R.
4/16/10
Surgical Fire

Mary B.
5/22/10
Post Procedure Cx

Lamar A.
6/3/10
Med Error

Bruce C.
5/25/10
Delay In Dx

Marilyn C.
1/21/10
Med Error

Ruby B.
5/30/10
Fall

Sylvia L.
3/31/10
Delay In Dx

Doyle L.
7/22/10
Med Error

Frank S.
2/22/10
Surgery Cx

"The currency of leadership is attention."

Heifetz

Ways to Channel Attention

- Personal
  - Choices in calendar
  - Body language
  - Doing project reviews
  - Behavior-based observation rounds
  - Stories
  - What is top of mind?
- Organizational
  - Transparency of data
  - Meeting agendas
  - Compensation
  - Promotion
  - Appointments
  - Follow-up and consistency

Using Leadership Leverage:

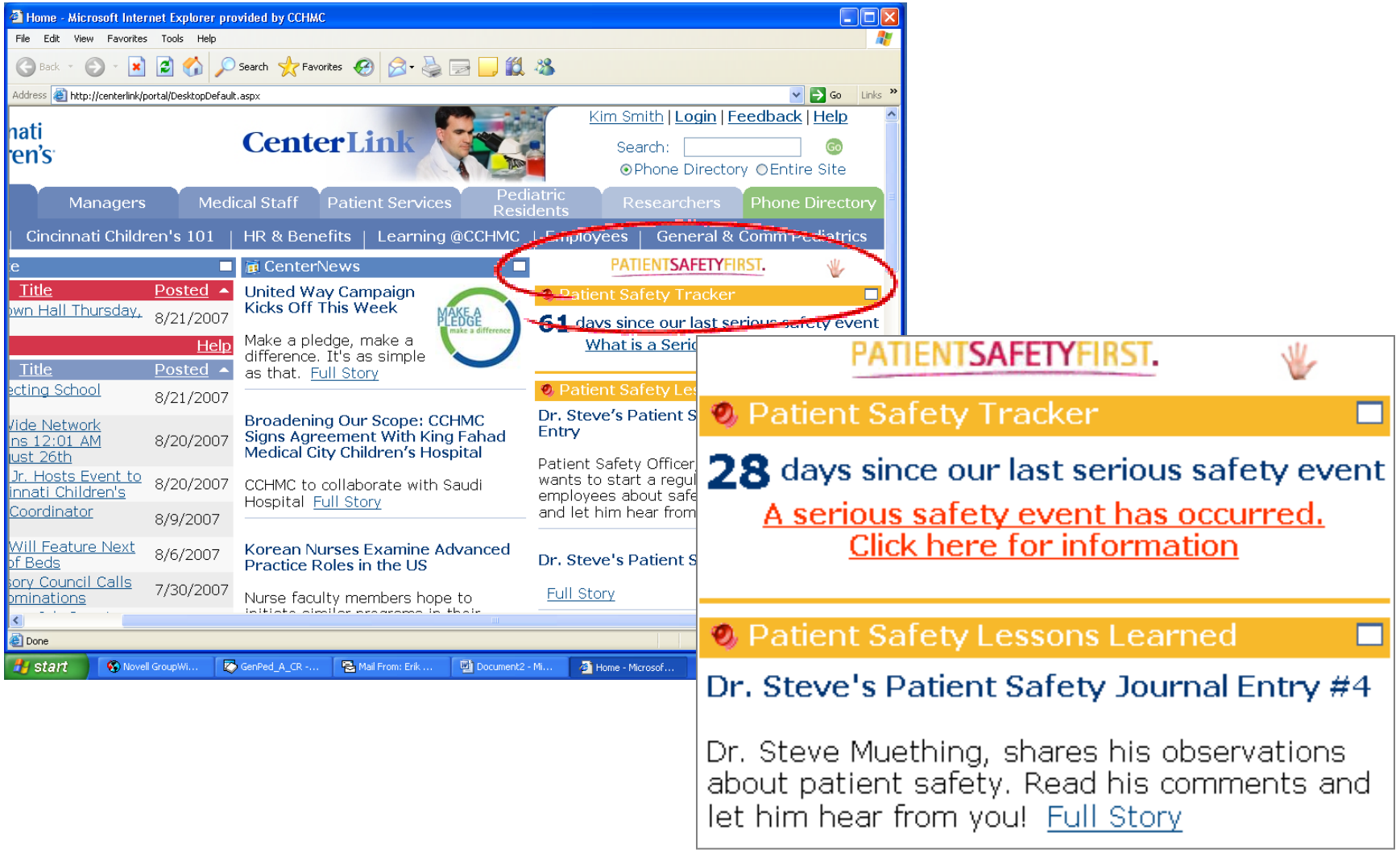
Four Questions to Channel Attention

1. Are your exec and physician leaders personally doing improvement project reviews?
2. Are exec leaders doing “Reality Rounds?”
3. Do you start every executive leadership, or medical staff, or board meeting with a “needless death” or “patient harm” report?
4. Are your aims and your data on performance widely available to staff and to the public, whether good, bad, or ugly?

Transparency...

- Pushes internal performance
- Sustains will through distractions of
  - Financial challenges
  - Leadership changes
  - New mandates

Courageous Transparency Driven by Cincinnati Children's Board



Patient and Community

- Focus on “What matters to me” rather than “What is the matter”
  - Promote listening and feedback from patients
- Promote redesign of care processes with patient participation
- Give the data a human face when presenting information
- Bring patients and families into all improvement meetings, with meticulous listening
- Role model patient and family engagement in rounding

Build Capability

- Promote knowledge development, first with self and then with team
- Foster collaboration and teamwork
- Recognize and reward innovation and promote idea generation, especially at the front lines
- Set demanding goals and targets
- Role model idea generation at the front line
- Adapt and learn from others
  - don't recreate the wheel

Deliver Results

- Establish a set of projects and activities that will assure reaching the organizational goals
  - Integrate quality goals with strategic and financial goals
- Install leaders in key projects and hold them accountable for results
  - Part of daily leadership work, not “extra”
- Remain focused on desired results
  - No tolerance for failure
  - Transparency of progress and results
- Review progress frequently and systematically and provide in-person feedback to teams and leaders
- Build the required capability to improve
  - Require the use of proven project and process improvement methods

Driving Culture

- Develop and articulate a vision of the organizational culture you desire
  - Articulate an aim: This is a place where…….
- Identify the behaviors that all staff need to follow that will promote the aim
  - Role model the behaviors personally
  - Track the way leaders promote these behaviors.
  - Reward and celebrate positive behaviors
  - Take visible and swift action against transgressions
- Promote teams and teamwork as the foundation of care delivery
- Understand the linkage between leadership actions and organizational culture

Leading Improvement and Innovation

10 Questions for Senior Leadership

1. How much time are we (the senior leadership team) really spending on our quality and safety aims?
2. How might we more effectively engage the medical staff in our improvement and safety efforts?
3. What answers would we get if we were to randomly ask 100 employees: "What should be our top 3 initiatives to make care safer for patients?"
4. Are we taking full advantage of the power of the Board to leverage and accelerate our rate of improvement?
5. Are our leadership actions and behaviors aligned to drive our desired organizational culture?
6. Do we know what we need to know and what capability do we need to have to accelerate improvement
7. How are we bringing patient experiences into the daily work to motivate and enlighten our staff?
8. What barriers exist to adopting policies and procedures from elsewhere that are proven to decrease harm to patients?
9. What should _____ cost and how fast can we redesign care to achieve that target?
10. Can everyone on the senior leadership team articulate our safety aims and cite our current results?