Establishing a Culture of Quality and Safety and the Journey to High Reliability

Becker's Hospital Review
May 9, 2013

Charles D. Stokes
System Chief Operating Officer

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

MEMORIAL HERMANN

Memorial Hermann Health System






Woodlands | Sugar Land | TMC | Katy | Memorial City | Southeast

Fiscal Year Ended June 30, 2012

- 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

Secret to Creating a High Reliability Organization

MEMORIAL HERMANN

Create a Quality and Safety culture that is aligned with your employees' personal mission statements.

How Do I Do That?

Create a leadership environment based on a balanced approach that is tied to your Mission, Vision, and Values.

4

What is Required for a Cultural Transformation

Governance Commitment

↓

Senior Leadership Mandate

↓

Employee/Physician Engagement

5

Culture of Quality and Safety

- **Servant Leadership Philosophy/ Leadership Development**
- **Employee/Physician Engagement**
- **Patient-centered focus**
- **Open door, open communication, no secrets, organizational transparency**
- **Results oriented/"No excuses" accountability**
- **Listening and learning**

6

Essential Success Factors

- Precise Execution
- Organizational Hardwiring
- Sustainability of Results
- No Excuses Accountability

7

What is the Burning Platform for Becoming a High Reliability Healthcare System?

- **It is the right thing to do … "First Do No Harm"**
- **Higher public accountability**
- **Transparency of quality data**
- **Our current healthcare system is harming and killing patients at an unacceptable rate**
- **Reimbursement is now tied to quality**

8

Move the organization from Safety as a priority to

Safety is a Core Value

….

What is the leadership behavioral expectation when safety is a core value?

9

Transitioning Toward High Reliability Requires…

1. Highly visible CEO and executive staff continuously emphasizing patient safety as a core value
2. A manager/safety coach team continuously mentoring error prevention techniques through discussions (rounding for influence) and 5:1 feedback
3. Physician champions demonstrating and teaching error prevention techniques and modeling teamwork
4. The frontline associates integrated into the team through reward and information

10

"No Excuses Accountability" from Leadership

How Do We Improve Quality and Patient Safety?

- Senior leadership rounding
- Hourly nurse rounding
- "Just culture"
- Patient safety is everyone's responsibility

11

Accountability - Fair and just culture

Leaders treat an employee fairly when performance does not meet expectations

Management "moment of truth"

If employees perceive that individuals are unfairly punished:

- Reduced likelihood to report events, errors, and mistakes
- Missed opportunities to find and fix problems impacting performance and outcomes.

If employees see management tolerance when there is intentional, disregard for work rules:

- Performance of other individuals and of the team as a whole will decline over time.

12

"When Progress is measured, Progress improves …

When Progress is measured and REPORTED, Progress accelerates …"

13

When Measuring Progress, Remember

"Some is not a number and Soon is not a time."

Donald Berwick

14

10 Leadership Principles

- Relate everything back to reason for being
- Operationalize M V V
- Measure and communicate what's important
- Quality and Safety as a core value
- Create a culture around patients/customers
- Develop leaders (current and future)
- Relentless focus on employee engagement
- Communicate with everyone
- Celebrate (reward and recognize)
- Insist on results

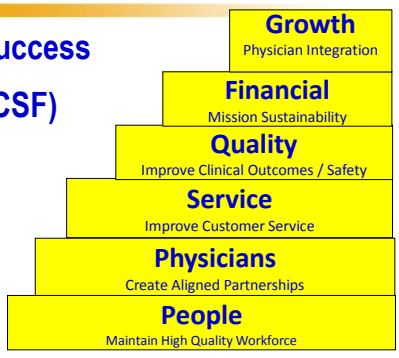
15

Differentiators of High Performing Organizations

- Systematic
- Aligned
- Deployed
- Ongoing Cycles of Improvement
- Ability of an Organization to Execute its Strategy

16

Critical Success Factors (CSF)



17

Memorial Hermann's Journey to High Reliability

Becker's Hospital Review

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

May 9, 2013

Role of the Board

Moving the Memorial Hermann Healthcare System
from
Safety as a priority to

Safety is our Core Value

….

Leadership behavioral expectations change when safety is the core value

19

OPERATION BREAKTHROUGH PATIENT SAFETY BEST OF THE BEST

MHHS Safety Culture Training

Hospital Training Complete

>20,000 Employees Trained

>3,000 Physicians Trained

>540 Safety Coaches Trained

>$18M Expense

20

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 2: **Educate**
  Educate our staff and medical staff about the Safety Behaviors and Error Prevention Tools
- Step 3: **Reinforce & Build Accountability**
  Practice the Safety Behaviors and make them our personal work habits

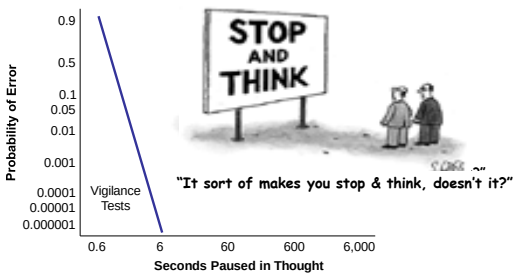
21

Red Rules
Absolute Compliance

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

22

Self-Checking With STAR*
(Stop, Think, Act, & Review)



* Jefferson Center for Character Education

23

Support Each Other:
CUSS Words

- I am *Concerned*
- I am *Uncomfortable*
- This is for *Safety*
- *Stand* up and *Stand* Together

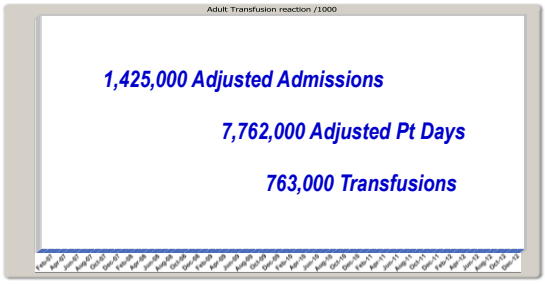
24

Hospital Acquired Conditions
"Never Events"

MEMORIAL HERMANN

Hemolytic Transfusion Reactions

Transfusion Events Jan 2007 – Dec 2012



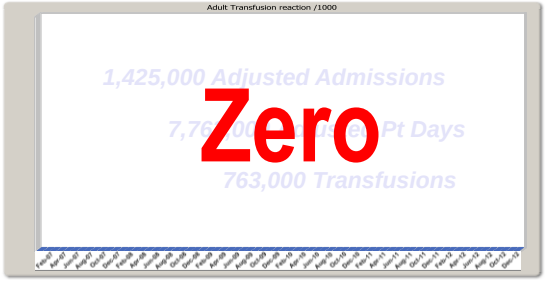
25

Hospital Acquired Conditions
"Never Events"

MEMORIAL HERMANN

Hemolytic Transfusion Reactions

Transfusion Events Jan 2007 – Dec 2012



26

Leadership – An Evolution in Perspective

MEMORIAL HERMANN

"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

27

Joint Commission Center for Transforming Healthcare

The Joint Commission's Center for Transforming Healthcare aims to solve health care's most critical safety and quality problems. The Center's participants -- the nation's leading hospitals and health systems -- use a proven, systematic approach to analyze specific breakdowns in patient care and discover their underlying causes to develop targeted solutions that solve these complex problems. In keeping with its objective to transform health care into a high reliability industry, The Joint Commission will share these proven effective solutions with the more than 16,000 health care organizations it accredits.

Joint Commission Center for Transforming Healthcare

Bringing the Leading Health Care Organizations Together to Solve Challenging Health Care Problems

- Cedars-Sinai Health System
- Exempla Healthcare
- Froedtert Hospital
- Memorial Hermann Healthcare System
- The Johns Hopkins Hospital and Health System
- Trinity Health
- Virtua
- Wake Forest University Baptist Medical Center
- Fairview Health Services
- Intermountain Healthcare
- Kaiser Permanente
- Mayo Clinic
- New York-Presbyterian Hospital
- North Shore-Long Island Jewish Health System
- Partners HealthCare System
- Stanford Hospital & Clinics
- Rhode Island Hospital
- Newport Hospital

How Will We Get There?

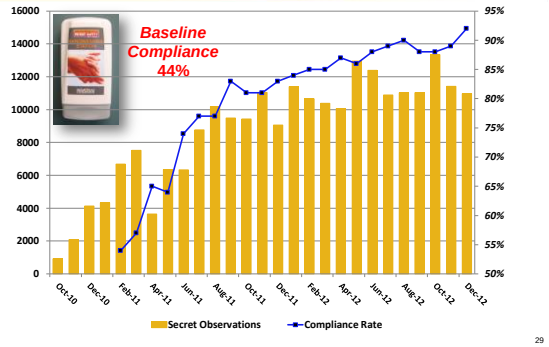
Change Management • Lean Six Sigma • High Reliability

The Roadmap to Developing Solutions

- Measureable Success
- Targeted Solutions
- Industry Engagement
- Sustainability

TJC Hand Hygiene Compliance
Center for Transforming Healthcare

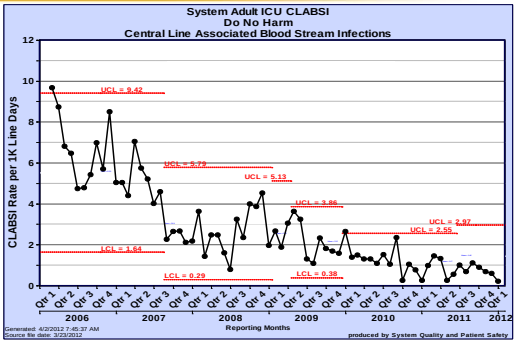
MEMORIAL HERMANN



29

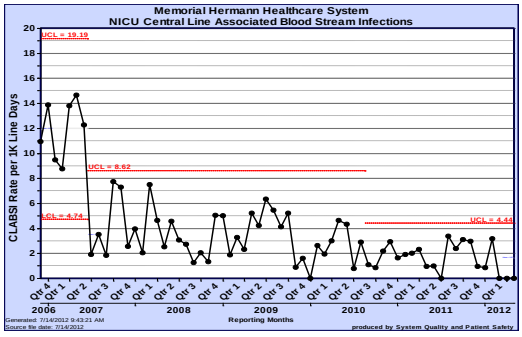
Adult ICU Central Line Associated Blood Stream Infections (CLABSI)

MEMORIAL HERMANN



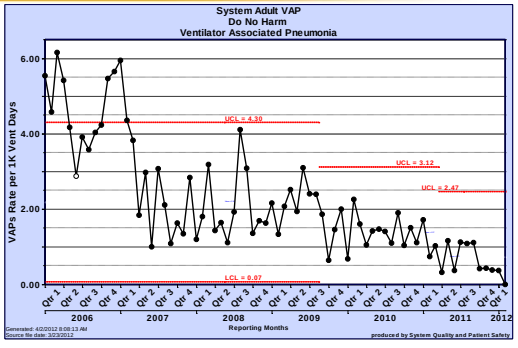
30

NICU Central Line Associated Blood Stream Infections (CLABSI)



31

Adult & Pedi ICU Ventilator Associated Pneumonias (VAP)



32

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

33

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

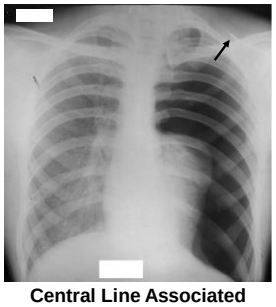
34

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

35

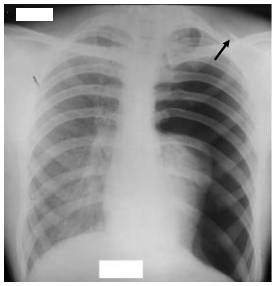
Patient Safety Indicator *Iatrogenic Pneumothorax*



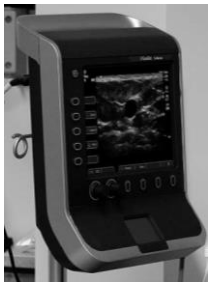
Central Line Associated Iatrogenic Pneumothorax

36

Patient Safety Indicator
Iatrogenic Pneumothorax



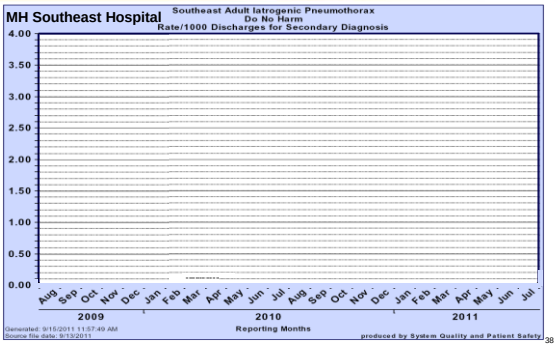
Central Line Associated Iatrogenic Pneumothorax



Bedside Real Time Ultrasound Guidance

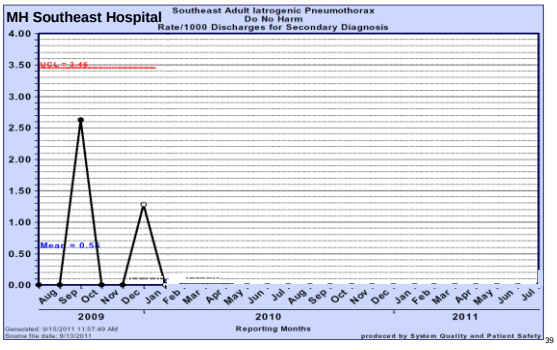
37

MH Southeast Hospital
Iatrogenic Pneumothorax



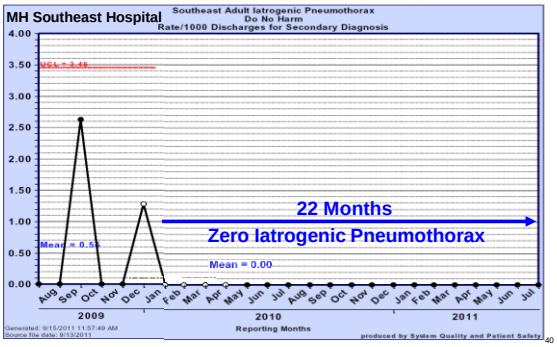
38

MH Southeast Hospital
Iatrogenic Pneumothorax



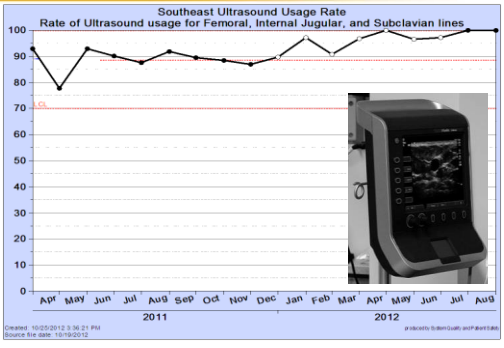
39

MH Southeast Hospital
Iatrogenic Pneumothorax



40

MH Southeast Hospital
Real Time Ultrasound Guidance



41

42

High Reliability
Certified Zero Award

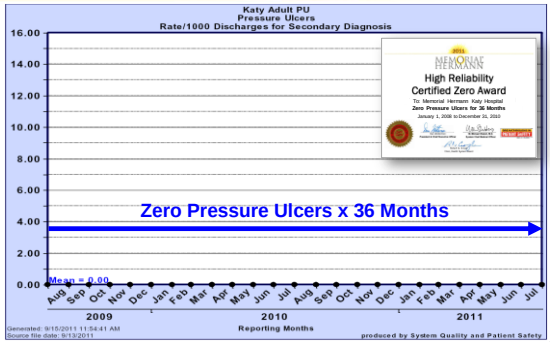
1. Zero Events

2. 12 Consecutive Months

3. Certified Zero Category

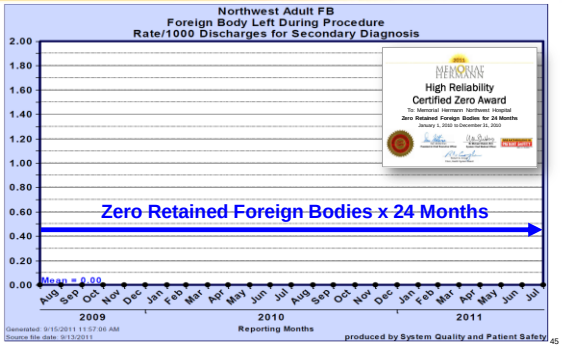
43

Katy: Zero Pressure Ulcers Stages 3 & 4



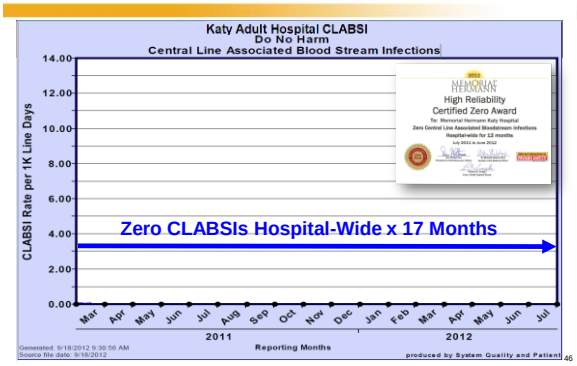
44

Northwest: Zero Retained Foreign Bodies



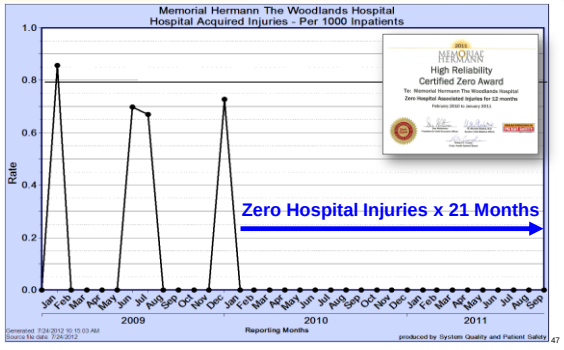
45

MH Katy: Zero Central Line Blood Stream Infections Hospital-Wide



46

Woodlands: Zero Hospital Acquired Injuries

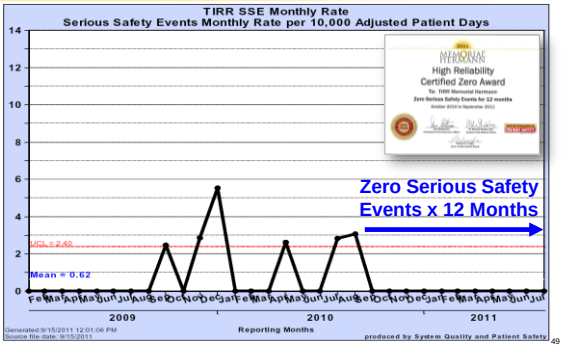


47

TeamHealth 8 EDs: Zero Iatrogenic Pneumothorax

48

TIRR: Zero Serious Safety Events



49

High Reliability 2011-12
Certified Zero Awards

91

ICU Central Line Associated Bloodstream Infections (8)
Hospital-Wide Central Line Associated Bloodstream Infections (1)
Ventilator Associated Pneumonias (20)
Surgical Site Infections
Retained Foreign Bodies (19)
Iatrogenic Pneumothorax (12)
Accidental Punctures and Lacerations (3)
Pressure Ulcers Stages III & IV (16)
Hospital Associated Injuries (3)
Deep Vein Thrombosis and/or Pulmonary Embolism
Deaths Among Surgical Inpatients with
Serious Treatable Complications
Birth Traumas (8)
Serious Safety Events (1)

50

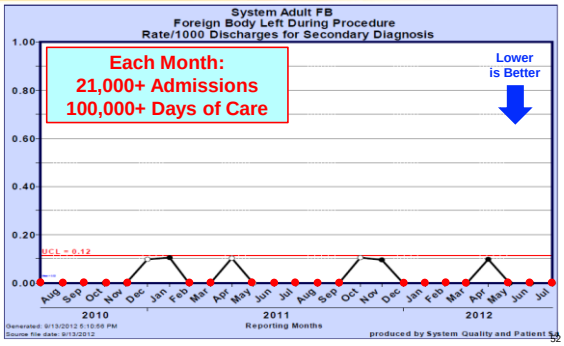
System Zero Achievements
July - September 2012

Zero Adverse Events for a Month for all Memorial Hermann Hospitals:

Hospital Acquired Infections
Patient Safety Indicators
Hospital Acquired Conditions

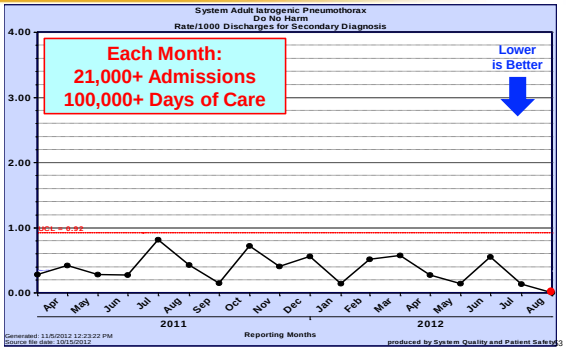
51

System Zero Adult Retained Foreign Bodies



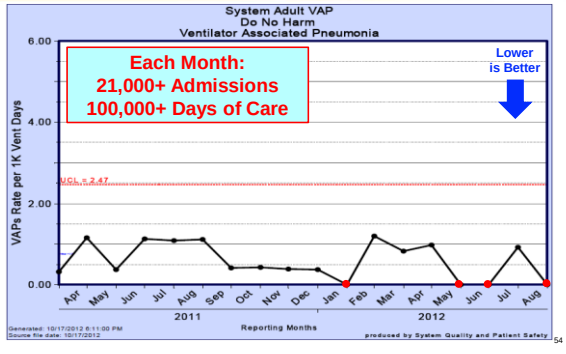
52

System Zero Adult Iatrogenic Pneumothorax



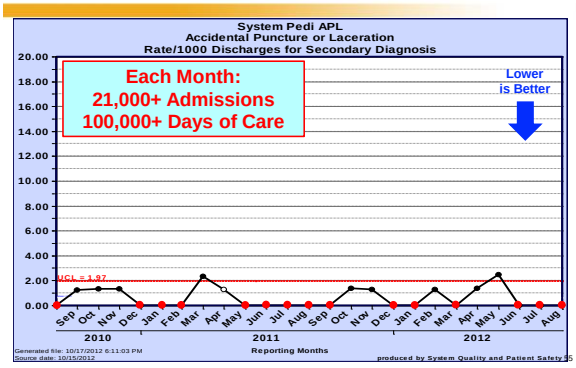
53

System Zero Ventilator Associated Pneumonia

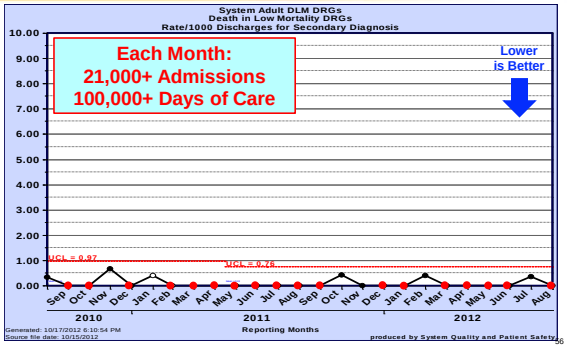


54

System Zero Pediatric Accidental Puncture & Laceration



System Zero Adult Death in Low Mortality DRGs



High Reliability Jul-Sep 2012
System Zero Achievements

System Zero Months July - September 2012

25

- ICU Central Line Associated Bloodstream Infections (1)
- Ventilator Associated Pneumonias (2)
- Adult Retained Foreign Bodies (3)
- Pediatric Retained Foreign Bodies (3)
- Iatrogenic Pneumothorax (1)
- Pediatric Iatrogenic Pneumothorax (3)
- Adult Pressure Ulcers Stages III & IV (1)
- Pediatric Pressure Ulcers Stages III & IV (3)
- Pediatric Accidental Punctures or Lacerations (3)
- Death in Low Mortality DRGs (2)
- Adult Would Dehiscence (3)

Journey to High Reliability

- Getting to <u>zero</u> serious safety events
- Commitment from governance
- Senior leadership mandate
- No excuses accountability
- Connecting the heart of your employees with quality and patient safety
- Transparency with your board, physicians and employees

58

Does All This Make A Difference at Memorial Hermann?

59

Safety/Quality Leader

15 Top Health Systems; Top 5 Large Health Systems (2012)

National Patient Safety Leadership Award, Sponsored by VHA Foundation & National Business Group on Health (2009)

National Quality Forum National Quality Healthcare Award (2009)

Joint Commission-NQF John M. Eisenberg National Patient Safety & Quality Award (2012)

Texas Hospital Association Bill Aston Quality Award (2011)

Healthcare's "100 Most Wired" 7th consecutive year

America's #1 Quality Hospital for Overall Care (2011 & 2012)

HealthGrades®
- America's 50 Best Hospitals (2010, 2011 & 2012)
- Distinguished Hospital for Clinical Excellence (2011, 2012)

2011 Texas Healthcare Foundation Quality Improvement Awards (9 Memorial Hermann Campuses)

60

Next Generation Healthcare Quality Assurance

MEMORIAL HERMANN

61

Healthcare as a High Reliability Organization

MEMORIAL HERMANN


From the C-Suite

Dan Wolterman and Dr. M. Michael Shabot

A new standard

Aim for safety of planes, nuclear plants

Everyone counts on high-reliability organizations to ensure their safety when flying on commercial airlines or traveling near nuclear power plants. Air traffic control, nuclear submarines, nuclear aircraft carriers and naval aviation all have well-deserved reputations for high-reliability operation.

But can hospitals be evaluated by HRO standards? In general, the answer seems to be no, beginning with the Institute of Medicine's 2000 publication of *To Err is Human* and continuing to the 2010 report by HHS' inspector general's office that 13.5% of Medicare beneficiaries suffer a preventable serious adverse event during hospital stays.

In 2006, the Memorial Hermann Healthcare System in Houston embarked on a quest to become an HRO. The high-reliability program is a key element of

Wolterman

Shabot

lists were implemented in all intensive-care units and operating rooms. Memorial Hermann worked with the Joint Commission's Center for Transforming Healthcare to radically improve hand hygiene.

In 2010-11, the results of these initiatives became apparent. Zero cases of blood incompatibility (transfusion reaction) occurred from January 2007 to present among a population of 867,000 adjusted admissions, 6.3 million days of care and nearly 900,000 transfusions.

Several hospitals had gone for years without a ventilator-associated pneumonia or a central-line-associated blood-stream infection. Serious medication errors decreased to zero most months while nearly a million medications per month were being administered. Many of our hospitals had gone a full year without the occurrence of a particular HAI, PSI or HAC

62

MHHS as a High Reliability Organization

MEMORIAL HERMANN

Memorial Hermann Healthcare System

Nuclear Aircraft Carriers

Commercial Aviation

Air Traffic Control

OPERATION BREAKTHROUGH PATIENT SAFETY BEST OF THE BEST

63

Thank you!

"You must be the change you want to see in the world"

Mahatma Gandhi (1869-1948)

64