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 Health System

- 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

Secret to Creating a High Reliability Organization

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.

What is Required for a Cultural Transformation

- Governance Commitment
- Senior Leadership Mandate
- Employee/Physician Engagement

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
Essential Success Factors

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

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

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?
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

“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

Accountability - Fair and just culture

Leaders treat an employee fairly when performance does not meet expectations

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.

Management "moment of truth”

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.
“When Progress is measured, Progress improves …

When Progress is measured and REPORTED, Progress accelerates …”

When Measuring Progress, Remember

“Some is not a number and Soon is not a time.”

Donald Berwick

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
Differentiators of High Performing Organizations

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

Critical Success Factors (CSF)

- Growth
- Financial
- Quality
- Service
- Physicians
- People

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.

MHHS Safety Culture Training

Hospital Training Complete

->20,000 Employees Trained

->3,000 Physicians Trained

->540 Safety Coaches Trained

->$18M Expense

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
Red Rules
Absolute Compliance

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

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

“Sort of makes you stop & think, doesn’t it?”

Support Each Other:
CUSS Words

• I am Concerned
• I am Uncomfortable
• This is for Safety
• Stand up and Stand Together
Hemolytic Transfusion Reactions

Transfusion Events Jan 2007 – Dec 2012

1,425,000 Adjusted Admissions
7,762,000 Adjusted Pt Days
763,000 Transfusions

Zero

Leadership – An Evolution in Perspective

“If you do the things you’ve always done, you’ll get the results you’ve always gotten.”

From…

Externally driven safety focus (e.g. Joint Commission, CMS)
Safety is a priority
We are creating a safety culture
The board and senior leader support culture change
Medical staff support culture change

To…

Internally driven safety focus (First, Do No Harm – it’s the right thing to do)
Safety is a core value that cannot be compromised
We are shaping a reliability culture that creates safety
The board and senior leaders own and manage the culture
Medical staff own and promote safety culture
**Joint Commission Center for Transforming Healthcare**

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

- University of Health Sciences
- Johns Hopkins Hospital
- Trinity Health
- Duke University Medical Center
- Memorial Hermann Healthcare System
- New York Presbyterian Hospital
- Johns Hopkins Hospital
- Barnes-Jewish Hospital
- Rhode Island Hospital
- Newport Hospital

**TJC Hand Hygiene Compliance**

Center for Transforming Healthcare

Baseline Compliance 44%

Adult ICU Central Line Associated Blood Stream Infections (CLABSI)

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<th>Year</th>
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Mean = Mean + 3 * Standard Deviation

**UCL** = 9.64
**LCL** = 1.64

February CLABSI rates not available due to ISD technical difficulties.

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Produced by System Quality and Patient Safety
NICU Central Line Associated Blood Stream Infections (CLABSI)

Adult & Pedi ICU Ventilator Associated Pneumonias (VAP)

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
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Patient Safety Indicator

iatrogenic Pneumothorax
Patient Safety Indicator
iatrogenic Pneumothorax

Central Line Associated
iatrogenic Pneumothorax

Bedside Real Time
Ultrasound Guidance

MH Southeast Hospital
iatrogenic Pneumothorax

MH Southeast Hospital
iatrogenic Pneumothorax
MH Southeast Hospital
Iatrogenic Pneumothorax

MH Southeast Hospital
Real Time Ultrasound Guidance
High Reliability Certified Zero Award

1. Zero Events

2. 12 Consecutive Months

3. Certified Zero Category

Katy: Zero Pressure Ulcers Stages 3 & 4

Northwest: Zero Retained Foreign Bodies
MH Katy: Zero Central Line Blood Stream Infections Hospital-Wide

Woodlands: Zero Hospital Acquired Injuries

TeamHealth 8 EDs: Zero iatrogenic Pneumothorax
TIRR: Zero Serious Safety Events

High Reliability 2011-12
Certified Zero Awards

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)

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
System Zero Adult Retained Foreign Bodies

System Zero Adult Iatrogenic Pneumothorax

System Zero Ventilator Associated Pneumonia

Each Month:
21,000+ Admissions
100,000+ Days of Care

Mean = 0.34

UCL = 0.92

100,000+ Days of Care

21,000+ Admissions

Each Month:
21,000+ Admissions
100,000+ Days of Care

Each Month:
21,000+ Admissions
100,000+ Days of Care

Do No Harm

produced by System Quality and Patient Safety
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

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 zero 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

Does All This Make A Difference at Memorial Hermann?

Safety/Quality Leader
Next Generation Healthcare Quality Assurance

Healthcare as a High Reliability Organization

MHHS as a High Reliability Organization

Modern Healthcare
EXTENDING THE COST CURVE

A new standard

From the C-Suite

Converting the healthcare system to a high reliability organization (HRO) requires a fundamental change in thinking and approach. The concept of HRO has been applied successfully in industries such as commercial aviation, nuclear power, and nuclear aircraft carriers. The lessons learned from these industries can be applied to healthcare to improve patient safety and outcomes.

Memorial Hermann Healthcare System

Nuclear Aircraft Carriers

Commercial Aviation

Air Traffic Control
Thank you!

“You must be the change you want to see in the world”

Mahatma Gandhi (1869-1948)