Session 25AB
Transform the Patient Experience: Consistently Delivering Safe, High-Quality, Patient-Centered Care

Presented by:
Gary Yates, MD
Craig Clapper
Denise Murphy
Transform the Patient Experience: 
*Consistently Delivering Safe, High-Quality, Patient-Centered Care*

Denise Murphy, RN, BSN, MPH, CIC, CPPS, FAAN
Craig Clapper, PE, CMQ/OE
Gary Yates, MD

Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:
- Denise Murphy

The following faculty of this continuing education activity has financial relationships with commercial interests to disclose:
- Craig Clapper
  - Press Ganey – Salary – Employee
- Gary Yates, MD
  - Press Ganey – Salary – Employee
Presenters

• Denise Murphy, RN, BSN, MPH, CIC, CPPS, FAAN
  Vice-President for Patient Care Systems and Senior Nurse Executive, BJC HealthCare

• Craig Clapper, PE, CMQ/OE
  Partner, Strategic Consulting, Press Ganey Associates

• Gary Yates, MD
  Partner, Strategic Consulting, Press Ganey Associates

Learning Objectives

• Discuss the critical interdependency of safety, quality, and service as three elements of the patient experience and recognize the value of high reliability.

• Identify proven examples of organizational structures and practices that can be harnessed to improve all three elements of the patient experience.
Agenda

• The interdependency of safety, quality, and patient-centeredness
• High reliability as a chassis for improving the patient experience
• Health system case study
• Evolving thinking and current approaches

The Patient Experience: More Than Just Satisfaction

• Our starting point:
  – Meeting the needs of patients cost-effectively

• Our goal:
  – Deliver safe, high quality care with empathy and understanding for every patient every day

• More than just patient satisfaction or service experience or safety or quality alone

• Physician and employee engagement as the foundation
Engagement Impacts HCAHPS

Employee Engagement Improves Patient Experience

- 62 percentile

Physician Alignment Improves Patient Experience

- +103%
- +40%

Patient Experience of Care and Quality

Association Between Medicare Summary Star Ratings for Patient Experience and Clinical Outcomes in US Hospitals

Stephen Trzeciak, MD, MPH, John P. Gaughan, MS, PhD, MBA, Joshua Besiro, MS, and Anthony J. Mazzarelli, MD, JD, MBA

Abstract

Objective: In 2015, the Centers for Medicare and Medicaid Services (CMS) released new summary star ratings for US hospitals based on patient experience. We aimed to test the association between CMS patient experience star ratings and clinical outcomes. Methods: We analyzed readmission data for more than 3,600 US hospitals from CMS Hospital Compare using linear regression. Results: We found that better patient experience was associated with favorable clinical outcomes. Specifically, a higher number of stars for patient experience had a statistically significant association with lower rates of readmission for 30-day mortality and unplanned readmissions. A higher patient experience star rating was associated with lower rates of unplanned readmissions to the hospital within 30 days. Conclusion: Better patient experience according to the CMS star ratings is associated with favorable clinical outcomes. These results support the inclusion of patient experience data in the framework of how hospitals are paid for services.

Keywords:
patient experience, patient satisfaction, hospitals, quality, outcomes
Patient Safety Impacts HCAHPS

Effective Communication

- **Improves patient satisfaction**
  
  Like et al., 1987; Kaplan et al., 1989; Ong et al., 1995; Wainman et al., 1998

- **Decreased patient emotional stress**
  
  Roter, 1995

- **Improves adherence/compliance**
  
  DiMatteo et al., 1993; Squier et al., 1995; Brasher et al., 2000; Ciechanowski et al., 2001

- **Improves health outcomes**
  
  Woolley et al., 1978; Patrick et al., 1983; Stewart et al., 1995

- **Reduces medical errors and malpractice**
  
  Levinson et al., 1997; Lester et al., 1999; Beckman et al., 1994; Sudcliffe et al., 2004

- **Improves physician satisfaction**
  
  Suchman et al., 1993; Educ for Health, 2004
Safety as an Operating System

“I feel safe
“I would feel safe as a patient on my unit”

Learning & improving
Personal commitment to outcomes

The Virtuous Cycle

Quality
Engagement
Safety
Experience
Efficiency
Reliability From Our Patient’s Perspective

Don’t harm me

Heal me

Be nice to me

… in that order

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 (Weick & Sutcliffe)

Risk is a function of probability and consequence.
By decreasing the probability of an accident,
HRO’s recast a high-risk enterprise as merely a high-consequence enterprise.

HROs operate as to make systems ultra-safe.
Aviation & Nuclear Power Experience

**Commercial Aviation**
- U.S. and Canadian Operations Accident Rates by Year

**Nuclear Submarines**
- 5,500 cumulative years of nuclear reactor operations
- 127 million miles submerged (265 trips to the moon and back)
- Zero Reactor Accidents

- Lost USS Thresher (SSN-593) – seawater fire (1963)
- Lost USS Scorpion (SSN-589) – torpedos (function or collision or enemy action 1968)

Optimizing Reliability

**Design to Optimize Human Performance at the point of people interface:**
- Easy to do the right thing – impossible to do the wrong thing
- Intuitive design
- Mistake proofing by design (i.e. poka yoke)

**Behavior Accountability**
- Safety as the core value
- Behavior expectations for error prevention
- Collaborative Interactive Teams
- Leadership behaviors for reliability

**Process, Protocol & Technology**
- Resource allocation
- Evidence-based practice (e.g. bundles)
- Technology enablers

**Reliability Culture**
- Evidence-based practice (e.g. bundles)
- Technology enablers

© 2010 Healthcare Performance Improvement, LLC. ALL RIGHTS RESERVED.
Influencing Behaviors at the Sharp End

Adapted from R. Cook and D. Woods, Operating at the Sharp End: The Complexity of Human Error (1994)

Behaviors of Individuals & Groups

Outcomes

Design of
Policy & Protocol
Design of
Culture
Design of
Work Processes
Design of
Technology & Environment

High Reliability – the genius of the AND

Safety Focus + performed as intended consistently over time = No Harm

Evidence-Based Process Bundles + performed as intended consistently over time = Clinical Excellence

Patient Centered + performed as intended consistently over time = "Satisfaction"

Financial Focus + performed as intended consistently over time = Margin

RELIABILITY CULTURE
"Failure Prevention"
Journey to High Reliability: A Story from The Front Line

Denise Murphy, BSN, MPH, CIC, CPPS, FAAN
Vice President, Patient Care Systems, BJC HealthCare, St. Louis
Formerly: Vice President, Quality and Patient Safety, Main Line Health, Bryn Mawr, PA

**Reliable Culture of Safety Journey**

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>• COS Diagnostic results presented</td>
<td>• Leaders and staff selected “Leader Methods for Reliability” and “Error Prevention Tools”</td>
<td>• COS completed for over 10,000 staff and physicians</td>
<td>• Transforming Systems of Care – QPS Framework</td>
<td>• Patient who experienced harm joined QPS Council</td>
<td>• Patient who experienced harm joined QPS Council</td>
</tr>
<tr>
<td>• Quantified Preventable Harm Events</td>
<td>• COS Curriculum completed and training underway for leaders</td>
<td>• SSER “People Graph” created</td>
<td>• Joint Commission survey: OBSERVED COS at every site!</td>
<td>• Surgical CEW</td>
<td>• Surgical CEW</td>
</tr>
<tr>
<td>• Commitment to Reliable Culture of Safety</td>
<td>• COS Curriculum 101 development</td>
<td>• HAP Award Winner for Reduction of CLABSI, Falls and Mandatory Flu Vaccine Program</td>
<td>• HAP Award Winner for Culture of Safety and Reducing Preventable Harm</td>
<td>• WALK THE TALK</td>
<td>• WALK THE TALK</td>
</tr>
<tr>
<td>• COS Curriculum 101 development</td>
<td>• New MLH Quality and Patient Safety Dashboard created</td>
<td>• Safety Heros Program</td>
<td>• June: 80% reduction in Preventable Harm!</td>
<td>• Lean Six Sigma Green Belt Certification Program launched</td>
<td>• Lean Six Sigma Green Belt Certification Program launched</td>
</tr>
<tr>
<td>• New MLH Quality and Patient Safety Dashboard created</td>
<td>• Leaders completed for over 10,000 staff and physicians</td>
<td>• Red Rule: Two Patient Identifiers</td>
<td>• HAP Award Winner for Culture of Safety and Reducing Preventable Harm</td>
<td>• MAGNET survey successful: observed COS at every site!</td>
<td>• MAGNET survey successful: observed COS at every site!</td>
</tr>
<tr>
<td>• SSER “People Graph” created</td>
<td>• Great Catch Program and PSSST</td>
<td>• STEEP Dashboard</td>
<td>• WALK THE WALK for Patient Safety!</td>
<td>• June: 88% reduction in Preventable Harm!</td>
<td>• June: 88% reduction in Preventable Harm!</td>
</tr>
<tr>
<td>• Transforming Systems of Care – QPS Framework</td>
<td>• Joint Commission survey: OBSERVED COS at every site!</td>
<td>• STEEP Dashboard</td>
<td>• Ambulatory Care Safety and Quality Program!</td>
<td>• Delaware Valley Patient Safety Award Winner: Reducing Mortality!</td>
<td>• Delaware Valley Patient Safety Award Winner: Reducing Mortality!</td>
</tr>
</tbody>
</table>
The beginning of the story

**MAIN LINE HEALTH DIAGNOSTIC RESULTS 1/2010**

- Cause analysis documentation from ~100 patient safety events occurring January 2006 thru December 2009
- Interviews with ~ 565 staff, physicians, and leaders:
  - Bryn Mawr ~ 148
  - Bryn Mawr Rehab ~ 75
  - Lankenau ~ 135
  - Paoli ~ 82
  - Riddle ~ 115
  - System Execs ~ 10
- Review of documents and outcomes. Tour of facilities.
- Review of data from the 2009 AHRQ Safety Culture and Gallup Employee Engagement Surveys

---

**Individual & System Causes of Events 2007-2009**

<table>
<thead>
<tr>
<th>Common Cause*</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Thinking</td>
<td>37.5%</td>
</tr>
<tr>
<td>Compliance</td>
<td>23.4%</td>
</tr>
<tr>
<td>Knowledge &amp; Skill</td>
<td>14.8%</td>
</tr>
<tr>
<td>Attention to Detail</td>
<td>10.5%</td>
</tr>
<tr>
<td>Normalized Deviance</td>
<td>7.0%</td>
</tr>
<tr>
<td>Communication</td>
<td>6.6%</td>
</tr>
</tbody>
</table>
Our Patients’ Story

2011
• Anna 01/02/11, harmed
• James 01/03/11, harmed
• Dana 01/05/11, harmed
• Deborah 01/24/11, harmed
• Wilhelmina 02/21/11, died
• Pearl 02/21/11, died
• Charles 03/22/11, harmed
• Kathleen 04/06/11, harmed
• Laura 04/06/11, harmed
• Norma 04/14/11, harmed
• Wayne 04/18/11, harmed
• Mary 04/19/11, died
• Joseph 04/28/11, harmed
• Annig 07/01/11, harmed
• Ronna 08/02/11, harmed
• Sandra 08/11/11, died

2012
• Jacqueline 01/07/12, harmed
• William 03/22/12, harmed
• Richard 03/26/13, harmed
• Cirian 04/07/12, died
• Luisiana 04/14/12, harmed
• Eric 06/26/12, died
• Florence 06/12, harmed
• Lawrence 07/24/14, harmed
• Reza 03/08/14, died
• Patrick 03/24/14, harmed
• Cheryl 06/01/14, harmed
• Frances 07/09/14, harmed
• Angela 07/14/14, harmed
• Robert 07/20/14, harmed
• Joan 09/22/14, harmed
• Jeremy 12/15/14, harmed

2013
• Paraic 01/18/13, harmed
• Mary 03/14/13, died
• Beverly 04/18/13, harmed
• Susan 08/29/13, harmed
• Barbara 09/10/13, harmed
• Patricia 12/13/13, harmed

2014
• Lawrence 02/24/14, harmed
• Reza 03/08/14, died
• Patrick 03/24/14, harmed
• Cheryl 06/01/14, harmed
• Frances 07/09/14, harmed
• Angela 07/14/14, harmed
• Robert 07/20/14, harmed
• Joan 09/22/14, harmed
• Jeremy 12/15/14, harmed

2015
• Paraic 01/18/15, harmed
• Mary 03/14/15, died
• Beverly 04/18/15, harmed
• Sue 04/28/15, harmed
• Michelle 05/26/15, harmed
• Allison 08/26/15, harmed

Main Line Health – Preventable Harm Serious Safety Events
January 2010 – September 2012

SSE 1: Death
SSE 2: Critical, life-changing harm with no expected change in clinical condition
SSE 3: Significant harm with no expected change in condition yet not sufficiently severe to impact functioning. Includes permanent reduction in physiologic reserve, disfigurement, or impaired or aided sense or function
SSE 4: Critical, life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care or monitoring, transfer to a higher level of care for a life-threatening condition, or additional surgery/procedure/treatment
The Commitment to Becoming a HRO

"You know leaders are committed when you are on their calendar and in their checkbook!"
Source: Clay Dunagan, MD, Chief Clinical Officer, BJC HealthCare. Circa 1999

Michael Buongiorno,
EVP and CFO Main Line Health

Strategy for Transforming Culture

Step 1: Set 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
## MLH Error Prevention Toolkit

<table>
<thead>
<tr>
<th>I Commit to...</th>
<th>By Practicing...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Safety Behaviors</td>
<td>Error Prevention Tools</td>
</tr>
</tbody>
</table>
| 1. Attention to Detail | - Self Checking Using STAR  
Stop  
Think  
Act  
Review |
| 2. Communicate Clearly | - 3-Way Repeat Back & Read Back  
Phonetic & Numeric Clarifications  
Clarifying Questions |
| 3. Handoff Effectively | - Use SBAR to handoff:  
Situation  
Background  
Assessment  
Recommendation |
| 4. Speak up for Safety | - Crucial Conversations  
Question & Confirm  
Stop The Line for imminent  
Use ARCC to escalate safety concerns  
Ask a Question  
Make a Request  
Voice a Concern  
Use Chain of Command |
| 5. Got Your Back! | - Peer Checking  
Peer Coaching |

---

## Main Line Health Reliability Toolkit for Leaders

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Tools</th>
</tr>
</thead>
</table>
| **Make Safety a Core Value** | 1. Start every meeting with a safety topic or story  
2. Recognize & support people who ask the safety question or “stop the line for safety”  
3. Transparency in sharing safety events  
4. Embed safety in hiring and performance reviews  
5. Encourage and reward reporting of safety events – eliminate fear of reporting |
| **Find & Fix System Problems** | 1. Daily Check-In  
2. Start the Clock for Safety  
3. Brief / Execute / Debrief |
| **Build Accountability** | 1. 5:1 feedback  
2. Rounding To Influence  
3. Just Culture  
4. Red Rules |

---

27

28
Safety Culture 101 – A Day in the OR

Monthly – Great Catches

Annual Safety Hero Award
We're using our Safety Behavior Tools to Prevent Harm to patients!

<table>
<thead>
<tr>
<th>Safety Behavior</th>
<th>PSSST (stories) Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention to Detail</td>
<td>1458</td>
</tr>
<tr>
<td>Speak Up for Safety</td>
<td>1456</td>
</tr>
<tr>
<td>Got Your Back</td>
<td>580</td>
</tr>
<tr>
<td>Communicate Clearly</td>
<td>479</td>
</tr>
<tr>
<td>Handoff Effectively</td>
<td>131</td>
</tr>
</tbody>
</table>

WALK THE TALK
2015
Safe
Timely
Effective
Efficient
Equitable
Patient centered
CEW - Program Leadership Work

- Standardizing Clinical Work
- Operational Efficiency and Work Flow
- Adverse Event Review and Risk Mitigation
- Clinical Informatics and Data Analytics
- Education and Competency Enhancement
- Communication and Engagement

Preventable Harm Serious Safety Events - Results of Safety Culture Implementation

Sample Data to Demonstrate Trend
OVERALL IN-HOSPITAL MORTALITY (Observed / Expected)

58% decrease over 5 Quality Years

QY2012 ①  QY2013 ②  QY2014 ②  QY2015 ③  QY2016 ③

Data Source: Premier via MLH Dashboard

Hospice patients excluded
Premier APRDRG Comparative versions updated
Pediatric and newborn patients excluded

MLH Performance, HCAHPS Global Rating % 9 or 10
Calendar Year Trend

MLH is at 78th Percentile Ranking

Source: MLH scores data from Press Ganey. National Rankings data from Hospital Compare Database October 2013 and September 2014
## MLH Performance Improvement Priorities (2016-2017)

<table>
<thead>
<tr>
<th>Clinical Quality</th>
<th>Process/Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eliminate Preventable Harm and Reduce Unexpected Mortality</td>
<td>1. Improve Reliability of Specimen Handling</td>
</tr>
<tr>
<td>2. Optimize Care Management and Care Coordination</td>
<td>2. Improve Patient Flow (decision to admit -&gt; arrival in bed)</td>
</tr>
<tr>
<td>3. Improve the Patient Experience (Increase HCAHPS/PG Scores)</td>
<td>3. Reduce Variation in Care (Reduce Cost and LOS)</td>
</tr>
<tr>
<td>4. Decrease Healthcare Associated Infections (HAIs) (Device related, SSI)</td>
<td>4. Optimize/Standardize Perioperative Care</td>
</tr>
<tr>
<td>5. Decrease Falls with Harm</td>
<td>5. Improve OR Flow/Utilization</td>
</tr>
<tr>
<td>6. Decrease Pressure Ulcers</td>
<td>6. Improve Outpatient Throughput Process</td>
</tr>
<tr>
<td>7. Decrease Hospital Acquired VTE</td>
<td>7. Enhancing Healthcare Analytics Competency</td>
</tr>
<tr>
<td>8. Reduce Disparities in Care</td>
<td>8. Implementation of new EHR</td>
</tr>
<tr>
<td>9. Improve Ambulatory Quality Measures Related to Reducing Avoidable Admissions</td>
<td></td>
</tr>
<tr>
<td>10. Improve Access/Timeliness of Palliative Care &amp; Hospice Services</td>
<td></td>
</tr>
</tbody>
</table>

### Top Ten Warning Signs of Complacency

- Group Think
- Failure to systematically identify, prioritize and correct safety/quality/service concerns at every level of the organization
- Satisfaction with benchmarking data (comparing to the floor vs. the ceiling)
- Cost-containment impacts safety focus
- Increasing or stable SSER
- Reduction of Precursor/Near-Miss Safety Event reporting
- Low investment/effort in lessons-learned sharing
- Lack of common cause analysis and event trending
- Morale decreasing and/or work stress rising
- Leadership (operational and medical staff) not leading for reliability
A Case Study of Organizational Improvement Curves

Preventable Harm Serious Safety Events
Example – Stable Trend

Top Ten Warning Signs of Complacency
✓ Increasing or stable SSER
Leader Action Plan: Back to Basics!

Step 1: Set 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

Leader Action Plan

1. Define and demonstrate SAFETY AS OUR CORE VALUE!

2. Find problems and fix causes in systems and processes

3. Reinforce and build accountability for behavior expectations

High Reliability Leaders Act Differently...
Focus - Learning/Embedding Principles of HIGH RELIABILITY

Back to the basics...

Leaders of HRO get out and look to **find and fix** problems before harm can occur

**Sensitivity to Operations**
It’s not about being seen. It’s what you’re seen asking and doing.

Rounding to Influence

ASK THE RIGHT QUESTIONS.....
Questions to get better information, reinforce safety behavior expectations, and encourage front-line critical thinking

Remain focused on reducing POWER GRADIENT!

Power Distance & Authority Gradient ("power gradient") remains an issue as evidenced by staff still scoring key engagement survey questions below 90% ...

- “Staff will question those with more authority….” (78%)
- “Abusive behavior is not tolerated in my organization” (81.6%)
- Departmental scores below national benchmark = opportunities for improvement

Defer to expertise  Reinforce behavioral expectations  Build accountability
Leadership Long Term Goal

Measureable Reduction of Power Gradient:

Clinical staff
- AHRQ Patient Safety Culture Survey question: Staff feel free to question the decisions or actions of those with more authority
- Goals: Target - 90th % based on projected 2019 national performance metrics (AHRQ participating organizations similar to MLH hospitals; N=300).

Non clinical staff
- AHRQ Patient Safety Culture Survey question: Staff feel free to question decisions or actions of those with more authority.
- Goals: Targets will be developed based on % improvement over baseline (set with results of 2016 upcoming survey).
- Will establish 90th%ile goal if (national) benchmark data allows.

Leader Action Plan

Each Clinical Environment Workgroup will be asked to present defined work plans related to “Creating High Reliability” to QPSC.

CEW leaders will be trained in cause analysis using principles of high reliability.

Hospital Presidents and Campus Clinical Operation teams to Round for Influence within and across their internal microsystems (e.g. ED dyad will round in the OR).
1. **Audience for ARCC Training**
   - Senior Executives – SEC meeting dedicated
   - CEW Leadership – CEW meeting dedicated
   - Directors and Managers – Leadership Assemblies
   - Managers – Lunch & Learn – 1 hr.
   - Safety Coaches – Lunch & Learn 1 hr.
   - Staff – Lunch and Learn – 30 – 45 minutes
   - Medical Staff – through MEC and local MOC

2. **Select ARCC Coaches to Train Groups**
   - Ask ARCC Walk the Talk Facilitators to consider becoming Coaches
   - Ask for recommendations from those who worked on the ARCC booth
   - PSS for volunteers
   - Conduct ARCC Coach Training

3. **Use data from AHRQ, Employee Engagement, and Physician Engagement Survey to make the case for Speaking Up for Safety**

   ARCC – Ask a question, make a Request, voice a Concern, use the Chain of Command

---

**TARGETED ARCC TRAINING for 2017**

**1. Audience for ARCC Training**

- Senior Executives – SEC meeting dedicated
- CEW Leadership – CEW meeting dedicated
- Directors and Managers – Leadership Assemblies
- Managers – Lunch & Learn – 1 hr.
- Safety Coaches – Lunch & Learn 1 hr.
- Staff – Lunch and Learn – 30 – 45 minutes
- Medical Staff – through MEC and local MOC

**2. Select ARCC Coaches to Train Groups**

- Ask ARCC Walk the Talk Facilitators to consider becoming Coaches
- Ask for recommendations from those who worked on the ARCC booth
- PSS for volunteers
- Conduct ARCC Coach Training

**3. Use data from AHRQ, Employee Engagement, and Physician Engagement Survey to make the case for Speaking Up for Safety**

ARCC – Ask a question, make a Request, voice a Concern, use the Chain of Command

---

**MLH System Competency Development**

Vision for embedded reliability in safety, quality, efficiency

---

*2017 CONGRESS ON HEALTHCARE LEADERSHIP*
“The world is not a dangerous place because of those who do harm, but because of those who look on and do nothing.”

> Albert Einstein

Thank you. Denise.Murphy@BJC.org
Reliability Culture - Genius of the AND

- Safety Focus + performed as intended consistently over time = No Harm
- Evidence-Based Process Bundles + performed as intended consistently over time = Clinical Excellence
- Patient Centered + performed as intended consistently over time = “Satisfaction”
- Financial Focus + performed as intended consistently over time = Margin

HIGH RELIABILITY

© 2010 Healthcare Performance Improvement, LLC. ALL RIGHTS RESERVED.

HPI Compare

Common Cause Analysis Data 2012-2013

<table>
<thead>
<tr>
<th>“How” Data</th>
<th>“Why” Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People Causes</strong></td>
<td><strong>Systems Causes</strong></td>
</tr>
<tr>
<td>Knowledge &amp; Skill</td>
<td>12.8</td>
</tr>
<tr>
<td>Attention on task</td>
<td>14.5</td>
</tr>
<tr>
<td>Information processing</td>
<td>6.1</td>
</tr>
<tr>
<td>Critical Thinking</td>
<td>34.3</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>26.5</td>
</tr>
<tr>
<td>Normalized Deviance</td>
<td>5.7</td>
</tr>
<tr>
<td>Acts coded for human error</td>
<td>2,329 of 4,203 (55.4%)</td>
</tr>
</tbody>
</table>

Comparison based on 4,204 inappropriate acts from 84 sites in HPI CCA Database
Complementary Strategies

- Central Line Infections
- Hand Hygiene
- Surgical Site Infections
- Codes Outside the ICU

Culture

Process Bundle + People Bundle

4 for VAP Prevention
1. Elevation of the head of the bed to between 30 and 45 degrees
2. Daily "sedation vacation" and daily assessment of readiness to extubate
3. Peptic ulcer disease (PUD) prophylaxis
4. Deep venous thrombosis (DVT) prophylaxis (unless contraindicated)

Read More:
Community Health Network Reduces Deadly Infections Through Culture of Reliability, American Society for Quality (June 2008)
Serious Preventable Harm

Personal Safety at Group Health
Patient Experience at Group Health

Getting Started

- COOKIE CUTTERS ARE GOOD FOR COOKIES – BUT NOT CULTURE

1. Authentic “safety first” leadership
2. Safety Culture or Safety Climate assessment (to confirm a firm foundation)
3. Common Cause Analysis:
   a. Rule-out broken process(es) and knowledge & skill deficiencies as majority causes
   b. Select behaviors/skills indicated by study
4. Culture design leaders, staff, and medical staff
5. Educate leaders, staff, and medical staff
Non-Technical Skills

Non-technical skills describe how people interact with technology, environment, and other people. These skills are similar across a wide range of job functions. These skills include attention, information processing, and cognition.

Generic non-technical skills:
- Situational awareness
- Attention
- Communication
  - repeat backs
  - call outs
  - phonetic & numeric clarification
  - clarifying questions
  - inquiry, advocacy, assertion
- Critical thinking
- Protocol use
- Decision-making

Authority Gradient

Balance of decision-making power or the steepness of command hierarchy. Members of a team with a domineering, overbearing, or dictatorial team leader experience a steep authority gradient. Expressing concerns, questioning, or even simply clarifying instructions would require considerable determination...

Most teams require some degree of authority gradient; otherwise roles are blurred and decisions cannot be made in a timely fashion.

The perceived steepness – not necessarily the real – as seen by the subordinate
Power Distance

The *perceived* difference – not necessarily the real difference – as seen by the *subordinate*

**Small Distance**
- Relations are consultative and democratic
- Relate as equals regardless of formal positions

**Large Distance**
- Relations are autocratic and paternalistic
- Power acknowledged based on formal, hierarchical positions


---

**Collegial Interactive Teams (CIT) = Tone + Tools**

Setting the tone…
- “You had me from Hello”
  - Greetings – include first names
  - Cordiality, openness
  - Eye contact and body language
- Team goals
  - Use “we” and “us” vs. “I” and “you”
  - What’s best for the patient…
- Invite a Questioning Attitude
  - Leaders set the tone for the flow of information
  - “If any member of the team sees anything that is unsafe, I expect you to speak up…”
Patients’ rating of quality is better predicted by their rating of the quality of communication between the healthcare team and the patient.


Physician communication is significantly positively correlated with patient adherence to treatment regimens. Studies found a 19% higher risk of non-adherence among patients whose physician communications poorly than among patients whose physician communicates well.

Source: 2009 meta analysis (Zelneirek & Dimatteo) of physician-patient communication studies.

An increase of one standard deviation in the quality of a physician-patient interaction summary score was associated with approximately 35% lower risk of a patient complaint for primary care physicians and 50% lower risk for high-risk specialists.

Source: 2009 study (Rodriques et al.)

Empathy Matters

Physicians with high empathy scores had better clinical outcomes than other physicians with lower scores.
Thomas Jefferson University. “Physician’s empathy directly associated with positive clinical outcomes.” ScienceDaily, 8 March 2011.

Clinical empathy to patients can improve their satisfaction of care, motivate them to stick to their treatment plans and lower malpractice complaints.

Physicians do not express empathic responses frequently. A recent study found oncologists responded to 22% of moments thought to be an empathic opportunity.
Tones
1. Smile and greet
2. Ask for and use preferred names
3. Listen with empathy...
4. Explain positive intent
5. Provide opportunities for questions

Tools
1. Pay attention to detail
2. Communicate clearly
3. Apply a questioning attitude
4. Know and comply with protocol
5. Support each other

Power Tools
1. AIDET
2. SBAR
3. Red Rules
4. 4 Habits Model
5. Service Recovery

Not a sprint – a marathon

"Four Stages of Learning," a theory posited by 1940s psychologist Abraham Maslow

© 2006 Healthcare Performance Improvement, LLC. ALL RIGHTS RESERVED.
Evidence-based Leadership

**Message the Mission**
Safe + Effective + Patient Centered + Efficient
High Reliability Organization
Design Reliable Systems

**Lead Learning**
Internal / external, success / failure
Prospective / retrospective

**Maintenance of Competency**
Hiring for fit / building skills
Managing drift / managing change
Accountability (engagement) of staff

**Group Health**
Lean as Performance Improvement
Visual display + FLI into Learning Boards
Daily management into HRO leadership

**Operational Leadership**
Work load / resource mismatch
Infrequent / complex work
Anticipate to avoid events

1. **Message on reliable safety, quality...**
   - Start meetings with patient story
   - Put safety first in every decision
   - Support those who ask the safety question

2. **Support operations**
   - Hold daily safety huddles
   - Round for reliability
   - Engage rapid chain of command
   - Lead service recovery

3. **Build engagement and accountability**
   - Provide 5:1 feedback
   - Know and implement Red Rules
   - Use incident decision tree
   - Apply just culture principles

4. **Create and maintain reliable systems**
   - Share and teach from harm reports
   - Develop action plans

5. **Learn as a team**
   - Display unit results
   - Use learning boards
Bibliography/References


Craig Clapper is a founding partner and the chief knowledge officer of Healthcare Performance Improvement (HPI), a Press Ganey solution. Craig has more than 25 years of experience improving reliability in nuclear power, transportation, manufacturing and health care. He specializes in cause analysis, reliability improvement and safety culture improvements. Craig has led safety culture transformation engagements for Duke Energy, the US Department of Energy, ABB, Westinghouse, Framatome ANP, and Sentara Healthcare. He is now the lead consultant on several safety culture transformation engagements for health care systems. Previously, Craig was the chief operating officer for HPI, the chief operating officer for Performance Improvement International, the systems engineering manager for Hope Creek Nuclear Generating Station, and the systems engineering manager for Palo Verde Nuclear Generation Station.

Craig Clapper, PE, CMQ/OE
Partner, Press Ganey Strategic Consulting
Email: Craig.Clapper@pressganey.com
Phone: 757.226.7479
Denise Murphy is currently Vice-President for Patient Care Systems and Senior Nurse Executive for BJC HealthCare, a 15 hospital System in St. Louis, MO. She had previously served as Vice President, Quality and Patient Safety for Main Line Health System in Suburban Philadelphia. From 2003-2008, she was Chief Safety and Quality Officer at Barnes-Jewish Hospital at Washington University Medical Center in St. Louis. Prior to taking that position, Denise spent 7 years as Director of Healthcare Epidemiology and Patient Safety for BJC HealthCare. Ms. Murphy is considered an international expert on the business of infection prevention and establishment of effective patient safety and quality programs, optimizing process improvement in healthcare, and creating and sustaining a highly reliable safety culture.

Denise was the 2010 winner of APIC’s Carole DeMille Lifetime Achievement Award for Infection Prevention and, in 2013, Denise was inducted into the American Academy of Nursing for her leadership in the fields of infection prevention, patient safety and quality.

Denise Murphy, RN, BSN, MPH, CIC, CPPS, FAAN
Email: Denise.Murphy@bjc.org

Gary Yates is a Partner with Press Ganey Strategic Consulting. He is the former President of Healthcare Performance Improvement, LLC (HPI) and Senior Vice President and Chief Medical Officer for Sentara Healthcare where his responsibilities included the clinical effectiveness programs, patient safety programs, physician integration efforts and medical management initiatives for Sentara’s hospital system and health plan. He is a board-certified family physician and fellow of the American Academy of Family Physicians.

Dr. Yates served as co-chair of IHI’s ninth annual National Forum on Quality Improvement in Healthcare and is a member of the AHA/McKesson Quest for Quality Prize Selection Committee. Dr. Yates serves as a member of the CHI Board of Stewardship Trustees and is a member of the editorial board for the American Journal of Medical Quality.

Gary Yates, MD
Email: Gary.Yates@pressganey.com