A26/B26: Goal Zero: South Carolina’s Commitment to Safety

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A26/B26
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9:30 AM-10:45 AM and 11:15 AM-12:30 PM

Objectives

1. Explain the methodology applied by the SCSCC to achieve dramatic reductions in preventable harm.

2. Describe how the SCSCC helped shift hospital cultures of safety and the methods it used to embed these changes within and across hospital systems.

3. Identify ways in which an organization can apply the learnings, methods, and tools to replicate the results and improvements achieved by the SCSCC.
Disclosures

- Coleen Smith has nothing to disclose.
- Thornton Kirby has nothing to disclose.
- Thomas Diller has nothing to disclose.

http://www.youtube.com/watch?v=tXtWY73Yeqo
Joint Commission Center for Transforming Healthcare

**Our Mission:** Transform health care into a high-reliability industry by developing highly effective, durable solutions to health care’s most critical safety and quality problems in collaboration with health care organizations, by disseminating the solutions widely, and by facilitating their adoption.

High Reliability Defined

“High reliability organizations”: Have nearly error-free operations in extremely trying environments
- Aircraft carrier flight decks (Weick & Roberts, 1993)
- Nuclear power plants (Schulman, 1993)
- Air traffic control (Rochlin, 1997)
High Reliability Science

- Research has defined how HROs produce sustained excellence over time
- We cannot simply and directly import the practices of HROs to healthcare
- No guidance on how to transform organizations from low to high reliability
- How do we create blueprints for healthcare to build high reliability?

Current State of Quality

- Routine safety processes fail routinely
  - Hand hygiene
  - Medication administration
  - Patient identification
  - Communication in transitions of care
- Uncommon, preventable adverse events
  - Surgery on wrong patient or body part
  - Fires in ORs, retained foreign objects
  - Infant abductions, inpatient suicides
Current State of Improvement

- We have made some progress
  - Project by project
  - Satisfied with incremental improvement
- But it is not nearly enough
  - Improvement difficult to sustain/spread
  - Excellence is isolated
- High reliability offers a different approach
  - The goal is much more ambitious
  - High reliability is not a project
Stages of Maturity in Moving Toward High Reliability

- Four stages for each of 14 components:
  - Beginning
  - Developing
  - Advancing
  - Approaching

- Health care organizations are following different paths toward high reliability
High Reliability Self-Assessment Tool™ (HRST)

Leadership:
- Board, CEO, physicians
- Quality strategy, quality measures
- Safe adoption of IT solutions

Safety culture
- Trust and accountability
- Identifying unsafe conditions or practices
- Strengthening systems, assessment

Robust process improvement
- Methods, training, spread

Leadership

All components of leadership must be committed to the goal of high reliability: Board, management, MD and RN leaders

Quality program must go beyond what is required by regulators or other outside entities

Improvement efforts directed at most important causes of harm in your patient population

Commitment means setting an ultimate goal of zero major quality failures, zero harm
Safety Culture
- Aim is not a “blame-free” culture
- A true safety culture balances learning with accountability
- Must separate blameless errors (for learning) from blameworthy ones (for discipline, equitably applied)
- Assess errors and patterns uniformly
- Eliminate intimidating behaviors

Quality Strategy
- To illustrate the progression to high reliability:
  - Leadership must set priorities
  - One of the HRST variables
- What priority is quality in your hospital?
  - Important, but not a top strategic priority
  - One of many competing priorities
  - One of our top 3 or 4 priorities
  - Our highest strategic priority
Safety Culture and HRST

Does your hospital measure safety culture?

What do you do with your measures?
- Track and trend
- Feed data back to managers; no specific expectations for action plans
- Feedback with expectation for individual department actions
- Organization-wide effort to improve, using standardized improvement methods

Evolution of Safety Culture

Today, we mostly react to adverse events

Close calls are “free lessons” that can lead to risk reduction --- if they are recognized, reported, and acted on

Unsafe conditions are further upstream from harm than close calls
Robust Process Improvement

Systematic approach to problem solving:
(RPI = lean, six sigma, change management)

- Most effective in clinical quality
- Establishes a common approach/language

- Cannot be limited to quality department
- Most effective programs embed skill in QI into staff development and reward systems
- Engage patients in care process redesign

Partnering with the South Carolina Hospital Association
One of these things...

One of these things...
Is our system broken? Absolutely not.

**WARNING:**

Every system is perfectly designed to get the results it gets.

- Paul Batalden,
  Dartmouth Institute for Health Policy and Clinical Practice

The US health care system was designed to **fix acute illness at any cost**.

It does **exactly** what it was built to do.

What was the US health care system built to do?

- Recruit workers in the era of wage controls during WWII (employer-sponsored health insurance)
- Provide health insurance to retirees from age 65 until end of life (Medicare)
- Cover the uninsured in America (Medicaid)
- Treat everyone in emergency conditions even if they are unable to pay (EMTALA)
What was the US healthcare system NOT built to do?

- Promote good health
- Manage chronic disease
- Contain costs
- Encourage collaboration among competing hospitals and physicians

Key strategic objectives

- Coverage
- Insurance Reforms
- Delivery System Reforms
- Payment Reforms
- Transparency
- Health IT
Implications for hospitals

- Achieve solid clinical alignment between hospital and physicians
- Deliver superior outcomes
- Reduce costs
- Develop integrated information systems
- Form strategic alliances
- Prepare for new payment models

Change your business model.
The political fights in DC will continue. What can we actually control?

Among the best heart care in country

Cut response time for heart attack in half

Average door to balloon time in SC is 45 minutes

Consistently rated one of best states
Hospital infection rate below national average

“We won’t stop until we eliminate the threat of health acquired conditions in all hospitals across our state.”

Dr. Rick Foster

Lead state for safe surgery initiative

“SC has a tremendous history of successfully introducing other quality initiatives such as improving the care of heart attack patients and reducing infection. We would like to collaborate with SC hospitals in developing a model to improve surgical safety at a state level that other states can follow.”

Dr. Atul Gawande
### SC hospitals aren’t working alone

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<th>Rank</th>
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<th>Percent of Hospitals Getting a Bonus</th>
<th>Percent of Hospitals Getting a Penalty</th>
<th>Total Number of Hospitals Per State</th>
<th>Average Change In Payment From Value-Based Purchasing Program</th>
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### SC is #5 in the nation for getting the highest bonuses on average in the VBP program
Lessons learned

- Collaboration accelerates performance improvement
- Public scrutiny and positive peer pressure ensure leadership engagement
- We can’t make a population healthy by giving them high quality health care
- The Triple Aim is an essential strategy
- Fatigue among QI professionals is a problem, but we will never get off the project treadmill until we build a culture of safety
SC Safe Care High Reliability Commitment

- Partnership between SCHA and The Joint Commission Center for Transforming Healthcare
- First ever statewide effort to promote the adoption of high reliability practices in hospitals.
- Ultimate goal is significant improvement in patient safety and quality, resulting in a dramatic reduction in events causing preventable harm.

HRST Results: Leadership

- **Board**, **CEO**, **Physicians**, **Quality Strategy**, **Quality Measures**, **Information Technology**
- Colors indicate progression:
  - **Beginning**
  - **Developing**
  - **Advancing**
  - **Approaching**
HRST Results: Safety Culture

Safety Culture Domain

- Trust
- Accountability
- Identification of Unsafe Conditions
- Strengthening Systems
- Assessment

Bar chart showing the levels of:
- Trust (Beginning, Developing, Advancing, Approaching)
- Accountability (Beginning, Developing, Advancing, Approaching)
- Identification of Unsafe Conditions (Beginning, Developing, Advancing, Approaching)
- Strengthening Systems (Beginning, Developing, Advancing, Approaching)
- Assessment (Beginning, Developing, Advancing, Approaching)

HRST Results: Robust Process Improvement®

Bar chart showing the levels of:
- Methods (Beginning, Developing, Advancing, Approaching)
- Training (Beginning, Developing, Advancing, Approaching)
- Spread (Beginning, Developing, Advancing, Approaching)
Challenges and Opportunities

Thomas Diller, MD, MMM
Formerly VP Quality and Patient Safety – Greenville Health System and Chair SCHA Quality Advisory Committee

Currently VP and System Chief Medical Officer – Christus Health
High Reliability Framework

- Leadership
- Safety Culture
- Robust Performance Improvement

Leadership

Concepts
- Full Engagement by Leadership
- Safety Becomes THE Number One Priority

Corporate Leadership
- Supportive, but not directly involved in the initiative
- Tended to delegate participation to operations leadership
- Make safety a top priority in the organization

Operational Leadership
- Very engaged with a good understanding of the need to change
- Lacked knowledge of high reliability principles
- Initially looked at the initiative as another project with a set of tasks
- Very responsive to examples from other organizations
Culture

Concepts
- What is culture and how do we change it
- How do we measure safety - absence of adverse events

Problems with Safety Metrics
- Many are a rehash of quality metrics
- The better metrics (HAI) are narrow in scope
- Administratively derived (PSIs, HACs) are unreliable and dependent on documentation and coding

Our Metrics
- HRST – Leadership perception survey
- Safety Culture Survey – Staff perception survey
- Serious Safety Event Rate

Robust Performance Improvement

Essential Tools
- Lean and Six Sigma
- Change Management

Focus is on the essential tools and addressing opportunities identified in the safety culture perception surveys

Training and Reinforcement of Culture
- Dynamic curriculum for all staff
- Substantial resources to allow all staff to continually train
- Collective Mindfulness and Collective Enactment
  - Example … How do we address “work-arounds”
QUESTIONS OR COMMENTS?