An Excursion into Deep Engagement

The Orlando Health Journey

December 7, 2015

Carol Haraden, C., Ph.D.

Vice President Institute of Healthcare Improvement
**Agenda**

1. Welcome
2. The Orlando Health Safety Journey
3. IHI Patient Safety Framework
4. Site Visits
5. Lunch
6. Organize Your Experience
7. Debrief
8. Wrap Up

**Objectives**

- Describe the structures that build the deep engagement of clinicians and staff.
- Discuss the leadership behaviors that can be used to deepen the engagement of staff and patients and lead to great results in care.
- Develop two strategies that you will use to improve engagement at your institution.
Why Orlando Health?

- Orlando Health Board of Directors commitment to quality and safety
- Engagement and commitment of physicians, nurses, allied health and administrative leaders on the quality journey
- Statistics:
  - 48 leaders have completed the Patient Safety Executive Development Program
  - Over 300 leaders have attended the IHI National Forum in the past 5 years
  - Board members and executive leadership completed IHI training
  - Resident requirement for Open School education

Framework for Clinical Excellence - Safety

- Culture
- Leadership
- Psychological Safety
- Accountability
- Teamwork & Communication
- Transparency
- Reliability
- Improvement & Measurement
- Continuous Learning
- Engagement of Patients & Family

© IHI and Allan Frankel
Who is Orlando Health?

- Orlando Health is a $2.3 billion not-for-profit health care organization with a community-based network of physician practices, hospitals, and outpatient care centers throughout Central Florida
  - Only Level One Trauma Centers for adults and pediatrics
  - Statutory teaching hospital system with graduate medical education
  - Over 2,000 physicians on the medical staff
  - One of the largest employers with more than 16,000 employees who serve over 2.3 million Central Floridians
  - Orlando as a destination center also serves many national and international tourists
  - Provide nearly $235 million in support of community health needs.
Orlando Health

Improving the health and quality of life of the individuals and communities we serve

Orlando Health Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orlando Regional Medical Center</td>
<td>1</td>
</tr>
<tr>
<td>UF Health Cancer Center at Orlando Health</td>
<td>2</td>
</tr>
<tr>
<td>Arnold Palmer Hospital for Children</td>
<td>3</td>
</tr>
<tr>
<td>Winnie Palmer Hospital for Women &amp; Babies</td>
<td>4</td>
</tr>
<tr>
<td>Dr. P. Philips Hospital</td>
<td>5</td>
</tr>
<tr>
<td>South Seminole Hospital</td>
<td>6</td>
</tr>
<tr>
<td>Orlando Health Central Hospital</td>
<td>7</td>
</tr>
<tr>
<td>South Lake Hospital</td>
<td>8</td>
</tr>
<tr>
<td>St. Cloud Regional Medical Center</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: System Management
## Strategic Agenda

<table>
<thead>
<tr>
<th>Quality &amp; Safety</th>
<th>Physician Loyalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Truven Top 100</td>
<td>- Physician engagement</td>
</tr>
<tr>
<td>- Top 10 percent satisfaction</td>
<td>- Clinical &amp; financial alignment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Place to Work</th>
<th>Growth &amp; Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Engaged team members</td>
<td>- Profitable market share gains</td>
</tr>
<tr>
<td></td>
<td>- Capital investment</td>
</tr>
<tr>
<td></td>
<td>- Process &amp; product innovations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Economics</th>
<th>Ease of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Affordability</td>
<td>- Access &amp; convenience</td>
</tr>
<tr>
<td>- Transparency</td>
<td>- Consumer engagement &amp; satisfaction</td>
</tr>
<tr>
<td>- Financial discipline</td>
<td>- Ambulatory development</td>
</tr>
</tbody>
</table>

### The Orlando Health Safety Journey

**Thomas Kelley, M.D**

**Anne Peach, M.S.N., R.N, N.E.A.-B.C**
Quality Journey: 2010-2015

Watershed Moment

Board Quality Retreat
- The Patient Story
- Holding the mirror up
- Board Quality Goals
- Appointed leaders to lead quality efforts
- Board leadership

2010 – 2015 Quality Journey Milestones

2010
- TRIAD
- IHI PSO
- Board Quality Committee
- 1st Quality Retreat
- Patient Safety Alert

2011
- Quality Structure
- SAFE Teams
- Harm Review Process
- Collaborative Quality Advisory Council
- AHRQ survey

2012
- Scorecards
- Caro Review
- Awards and Recognition
- SAFE Teams
- IHI Open School

2013
- Patient Safety Module
- PDSA and Lean
- GEMBA Boards
- Patient & Family Advisory Council
- Medication Errors

2014
- IHI Framework
- Insights
- Culture Of Safety
- Laser Focus on Surgical Site & C-Difficile Infections
- Barcoding

2015
- Truven Top 100 Hospital
- Standardization
- Team Work Training
- Patient Safety Curriculum
- Diabetes

New System Goals 2016-2020

Journey to Excellence
Board Goals

- Reduce overall mortality (excluding inevitable mortality) by 50% by 2015.
- Reduce all cases of patient harm by 80% by 2015.
- Provide ‘right care’ to 100% of patients by 2015.
- Reduce unplanned readmissions by 80% by 2015.
- Achieve top 10% patient satisfaction scores by 2016.

IHI changed us because we realized …

The building was on fire

…and our results proved it!
Quality Timeline 2010-2011

First Triad

Our Current Team

Thomas Kelley, M.D
Chief Quality Officer

Aurelio Duran, M.D
Chief of Staff

Anne Peach, R.N., M.S.N
V.P. Patient Care
Quality Structure - Triads

System Level
- Chief Quality Officer
- V.P. Patient Care
- Chief of Staff

Hospital Level
- Chief Quality Officer
- Chief Nursing Officer
- Medical Staff Leadership Chair

Department Level
- Nurse or Ancillary Manager
- Unit Director Medical Quality
- Unit Practice Chair

2010 – 2015 Quality Journey Milestones

2010
- Watershed Moment Annual Board Retreat
- TRIAD
- IHI PSO
- Board Quality Committee
- 1st Quality Retreat
- Patient Safety Alert
- Dobhoff Feeding Tube
- Patient Weights

2011
- Quality Structure
- SAFE Teams
- Harm Review Process
- Collaborative Quality Advisory Council
- AHRQ survey
- Scorecards
- Care Review
- Awards and Recognition
- SAFE Teams
- IHI Open School
- Medication Errors
- Barcoding
- Patient Safety Module PDSA and Lean
- Patient Safety & Family Advisory Council
- IHI Framework
- Insights
- Culture Of Safety
- Laser Focus on Surgical Site & C-Diff Infections

2012
- Truven Top 100 Hospital
- Standardization
- Team Work Training
- Patient Safety Curriculum
- Diabetis
Framework for Clinical Excellence - Safety

Culture

Psychological Safety
Leadership
Teamwork & Communication
Negotiation
Accountability
Engagement of Patients & Family
Continuous Learning
Improvement & Measurement
Reliability
Transparency
Learning System

© IHI and Allan Frankel

Orlando Health Quality Formula

Shared Leadership through Collaboration
Journey to Excellence
Transparency of Success and Failures
Structured Approach to Improvement
Data Driven Approach to Decision making
Culture of Shared Leadership

- Quality Structure – System, Hospital and Department and system positions:
  - System-wide Quality Teams (SAFE Teams)
  - Collaborative teams:
    - Collaborative Quality Advisory Council (CQAC)
    - Collaborative Surgery
  - Nursing and Allied Health have practice councils
  - Elected Medical Staff actively engaged
  - Medical Education commitment to quality

Recognition of Excellence

- Certified Zero Awards
- Great Catch Awards
- Physician Exemplar
- Excellence in Nursing Awards
- Allied Health Awards
Recognition of Excellence:
Arnold Palmer Medical Center

Recognition of Excellence
Arnold Palmer Hospital
- Recognized for national excellence in 8 specialties
Recognition of Excellence

ORMC Neuro ICU

5 years NO CLABSI!

DPH and SSEM no CAUTI for one year!

Data Driven Transparency

- Weekly phone call in nursing and each specialty and allied health reviewing all harm events
- Weekly system-wide report of any harm events with follow up
- Report Cards
- Safety Alerts
- Safety Snippets
- Data Warehouse
Learning System

- Culture of Safety Survey - AHRQ
- Care Reviews looking at human factors
- Physician Leadership Academy
- Required resident education – IHI Open School
- Special task force - Wrong Site Surgery
- Quality Rounds
- Unit *Gemba* boards
- Annual Quality Retreat

Failure Points

- Psychological Safety and a Just Culture
- Focus on evidence based practice
- Standardize practice
- Make data accessible and meaningful
- Address issues with electronic medical record
- Effective communication and critical language
System-wide Harm Initiatives Addressed

- Infections:
  - Surgical site infections
  - C. difficile infections
  - Sepsis
  - CAUTIs
- Medication errors
- Falls

What have we learned on the journey? The key is….

- A Culture of Safety
- A Learning System
- Limit the number of initiatives done at once

We are a bit aggressive with our goals!
A CULTURE OF SAFETY

“No one is ever hesitant to speak up regarding the well being of a patient (psychological safety), and everyone has a high degree of confidence that their concern will be heard respectfully and be acted upon.”

- Michael Leonard
Orlando Health Board Quality Goals

- Reduce overall mortality (excluding inevitable mortality) by 50% by 2015.
- Reduce all cases of patient harm by 80% by 2015.
- Provide ‘right care’ to 100% of patients by 2015.
- Reduce unplanned readmissions by 80% by 2015.
- Achieve top 10% patient satisfaction scores by 2016.

Mortality Rate

**Interpretation:** This slide represents our mortality rate for inpatient deaths. The mortality rate shift that began August 2013 was statistically significant.
30-day Readmission Rate

Interpretation: This slide represents our 30-day readmission rate. The decrease in readmissions that began in June 2013 is statistically significant.

Harm Event Rate

Interpretation: This slide represents the rate of harm. The decrease from baseline (FY 11) to FY 14 is statistically significant.
Perfect Care

Interpretation: New 2015 Core Measures in Behavioral Health and Mother/Baby (breastfeeding percentage) impacted overall mean.

Perfect Care* Overlapping Measures

Interpretation: Core measures excluding new core measures added in 2015 in Behavioral Health and Mother/Baby.
Focus Areas for 2014 - 2015

- Surgical Site Infections* (SSI)
- C-difficile**
- Adverse Drug Events* (ADE)
- Patient Experience

Standardized Infection Ratio FY2015

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>All Infections Combined</th>
<th>CLABSI</th>
<th>CAUTI</th>
<th>*MRSA BLD</th>
<th>C Diff</th>
<th>Colon</th>
<th>Hyst</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SIR</td>
<td>SIR</td>
<td>SIR</td>
<td>SIR</td>
<td>SIR</td>
<td>SIR</td>
<td>SIR</td>
</tr>
<tr>
<td>2013</td>
<td>0.80</td>
<td>0.34</td>
<td>1.00</td>
<td>0.33</td>
<td>0.88</td>
<td>0.93</td>
<td>0.73</td>
</tr>
<tr>
<td>2014</td>
<td>0.85</td>
<td>0.29</td>
<td>1.35</td>
<td>0.27</td>
<td>0.92</td>
<td>0.77</td>
<td>1.27</td>
</tr>
<tr>
<td>2015</td>
<td>0.85</td>
<td>0.35</td>
<td>0.74</td>
<td>0.38</td>
<td>1.02</td>
<td><strong>0.72</strong></td>
<td><strong>0.77</strong></td>
</tr>
</tbody>
</table>

An SIR <1 indicates that our number of actual infections is less than the number of expected infections
** - Surgical data not final until 90 days post reporting period
Central Line-Associated Bloodstream Infections

The surgical infection rate has decreased by more than one-third since FY2011.

--- Baseline benchmark by Health Research and Educational Trust (HRET) used by SAFE Teams

Surgical Site Infections

The surgical infection rate has decreased by more than one-third since FY2011.

--- Baseline benchmark by Health Research and Educational Trust (HRET) used by SAFE Teams
Catheter-Associated Urinary Tract Infections

Clostridium Difficile Rate
Ventilator Associated Pneumonias

The VAP rate has decreased; the VAP rate in the current fiscal year to date is 27% lower than it was in FY2011.

---

Baseline benchmark by Health Research and Educational Trust (HRET) used by SAFE Teams

Patient Experience

---

HCAHPS Rating by FY

The VAP rate has decreased; the VAP rate in the current fiscal year to date is 27% lower than it was in FY2011.

---

Baseline benchmark by Health Research and Educational Trust (HRET) used by SAFE Teams
Address Big Obstacles

- Balance quality and efficiency
- Leverage technology
- Broaden communication
- Identify and address system issues
- Convert stories into data

Biggest Issues

- Dealing with exhaustion and fatigue
- Sustainability
- Doing well with spread
- Change management
A Comprehensive Framework for Patient Safety

Orlando Health adopted from IHI
Framework for Clinical Excellence - Safety

© IHI and Allan Frankel
What we have learned....

There are no miracle pills that will suddenly improve quality and safety. It is a journey and takes vigilant effort and hard work.

“The world is not dangerous because of those who do harm but because of those who look at it without doing anything.”

Albert Einstein
Site Visits

Debrief