Hospital Quality Institute
Leadership in quality and patient safety

Mining California's Gold- Helping CA Hospitals Achieve Excellence

HASC Annual Meeting
April 3, 2014

Julianne Morath, RN, MS
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Engage MD and Executive Champions

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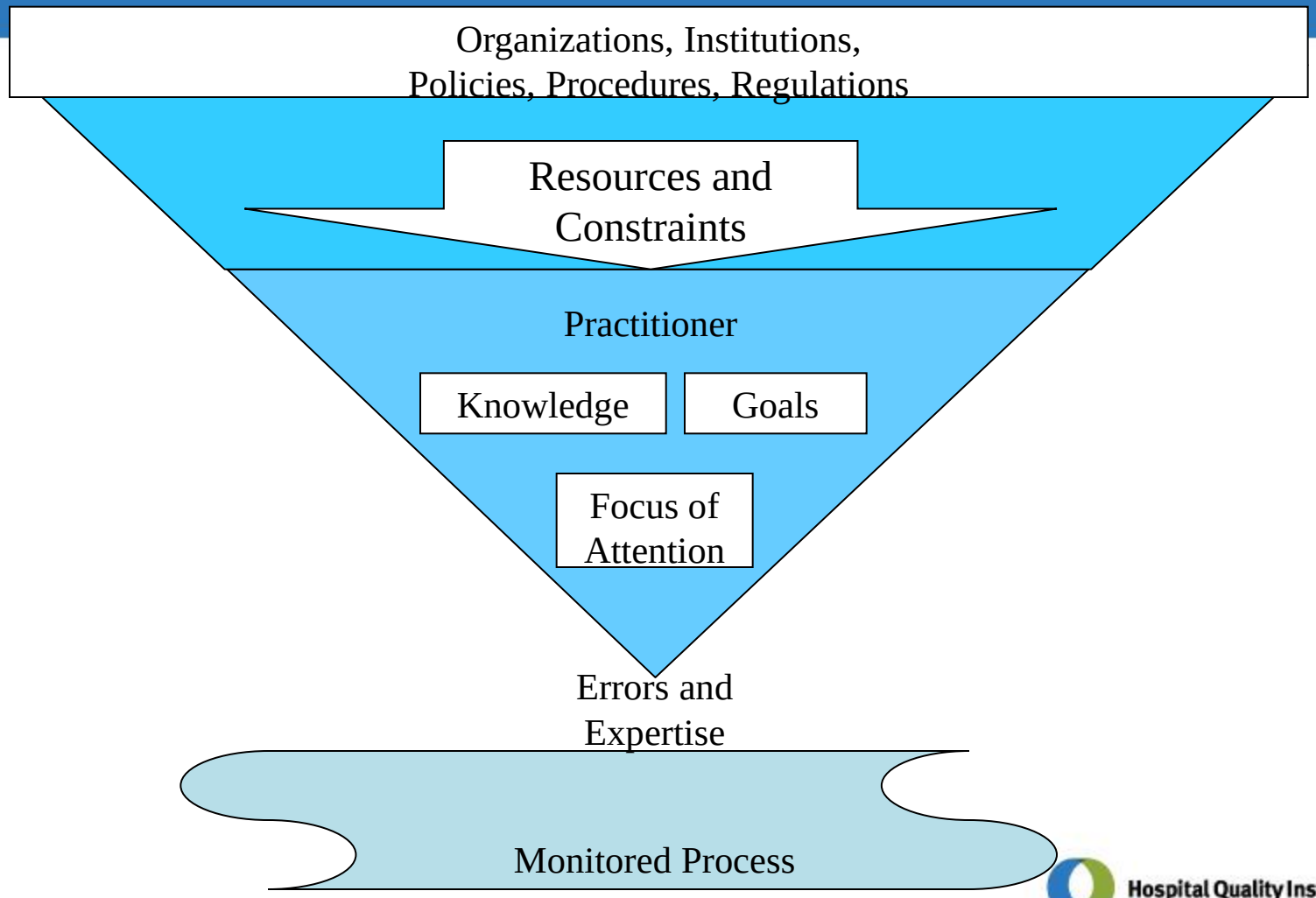
Create Alignment From Board Rooms to Frontlines



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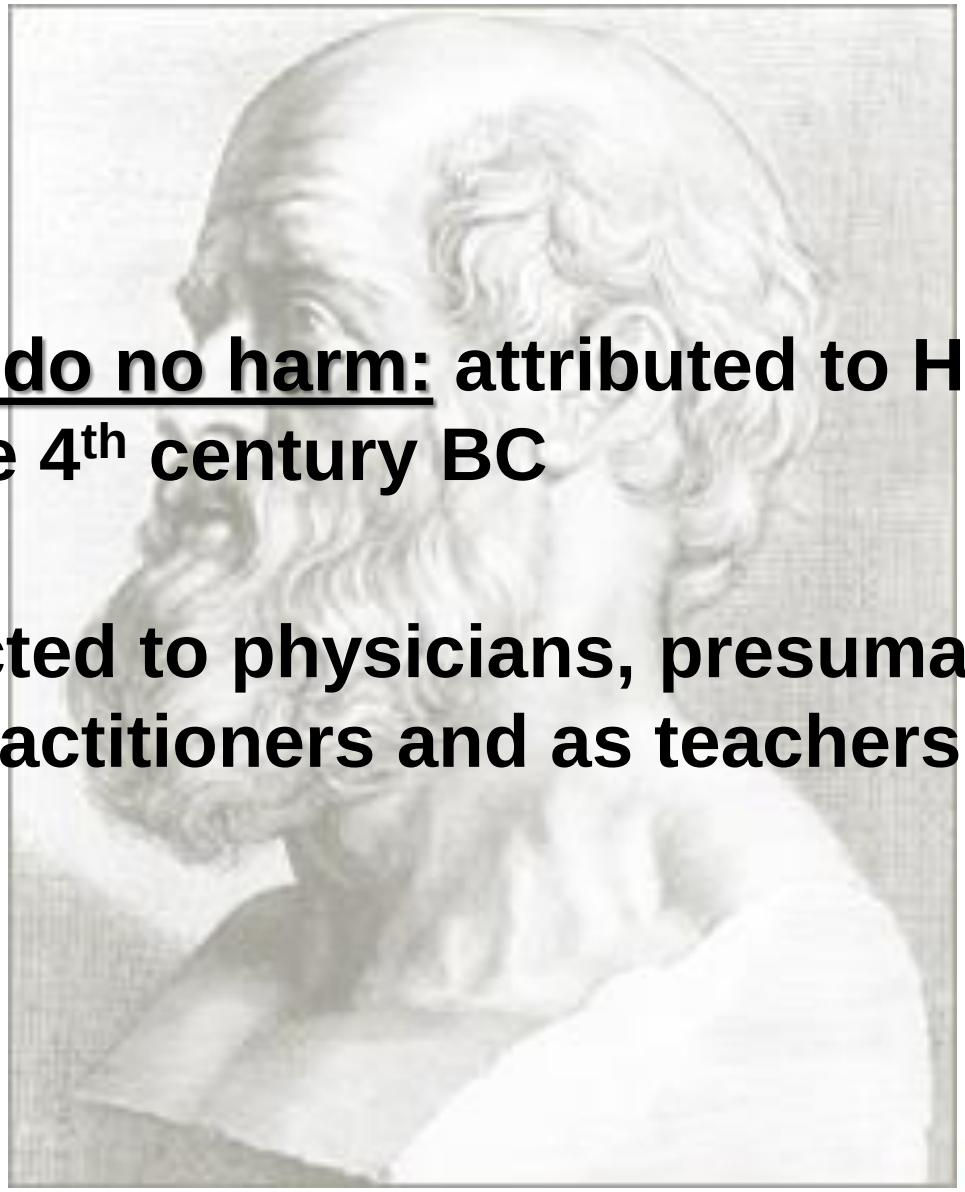
Modified from Woods, et al., 1994

Quality and Safety in Health Care is Not New



- **<u>First do no harm:</u> attributed to Hippocrates in the 4th century BC**
- **Directed to physicians, presumably both as practitioners and as teachers.**

Hippocrates (ca. 460 BC – *ca.* 370 BC)

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Pioneers Who Faced Resistance

- In 1847, Ignaz Semmelweis, an obstetrician, urged his colleagues to **wash their hands** in order to prevent puerperal sepsis

- His germ theory of infection and insistence on sanitary birth conditions advanced the concepts of sterility, antisepsis, and antibiotics

Ignaz Semmelweis (1818 – 1865)

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- 1863 – Florence Nightingale coined the term **Hospitalism**
  - Identified that hospitals could be a secondary source of harm
- Led study on infection and conditions on the Crimean War Front
- Credited as the first health services researcher and hospital epidemiologist

Florence Nightingale (1820-1910)

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- **In 1910, Ernest Amory Codman set forth his End Results Thesis**
- He insisted on the obligation of physicians to:
  - study the outcomes of the care they provide
  - take action to remedy their errors
  - make public their results

Ernest Amory Codman (1869-1940)

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Contemporary Pioneers

- Donald Berwick, MD, former President of the Institute for Health Improvement calls for:

  No needless death
  No needless pain
  No unwanted waits
  No helplessness
  No waste

Dr. Donald Berwick

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- Lucian Leape, MD, credited as the father of the Patient Safety Movement:

"The single greatest impediment to prevent harm is that we judge and punish people for making mistakes."

Dr. Lucian Leape

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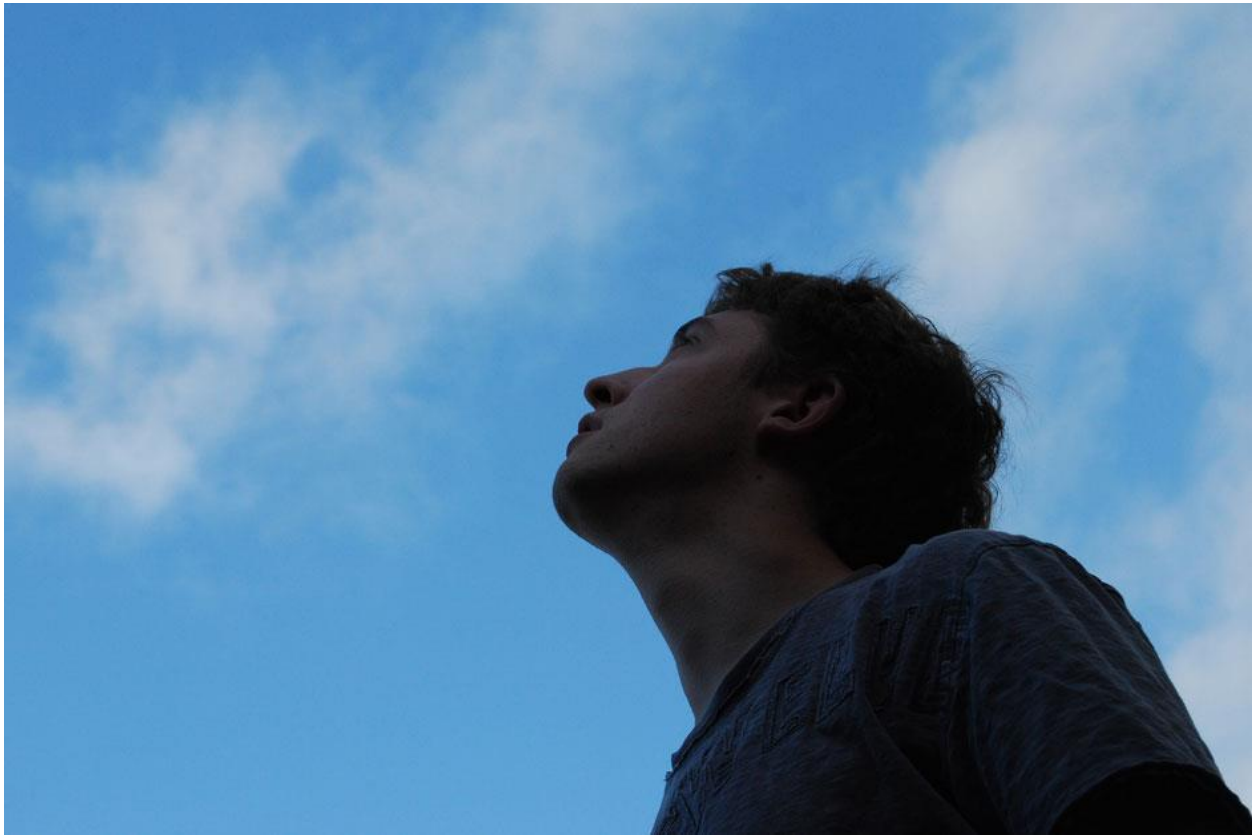
Vision



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Vision

California hospitals will lead the nation in patient safety and quality performance with high reliability and zero defects in care on behalf of the people and communities they serve.

They will lead through respect for people and a culture of habitual excellence.

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Lens:
Leadership with “Radical Clarity”

What you give your time, resource, and commitment to and what you do not.

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Board Role

Board Leadership: A Driver of Health Care Quality

The Developing Requirements and How to Meet Them

The purpose of this brief is to provide an overview of the evolving role and expectations for hospital Boards in achieving higher levels of clinical quality and patient safety.

Situation

It is well established that hospital governing Boards have responsibility for the quality of care provided in their institutions.[1] Historically, how Boards fulfilled this responsibility has been open to interpretation and varying practices. In recent years, the changing social, political and economic environment has led to a new era of publicly reported comparative quality measures, transparency, and new reimbursement models that reward performance. The role of hospital Boards in assuring quality of care in this context is more focused that ever before.[2] A challenge in meeting these evolving expectations was framed in a recent study that raised questions about whether hospital Boards are sufficiently educated about and engaged in oversight of quality.[3] Hospital Boards that have met this challenge, however, demonstrate great positive impact on institutional and patient outcomes.

Background

Momentous events occurred during the course of the last decade that are an impetus for today's heightened expectation that hospital Boards exercise active oversight of the quality of care delivered by their organizations. First, the Institute of Medicine (IOM) published two seminal reports, *To Error is Human*[4] and *Crossing the Quality Chasm*[5], in 2001 and 2002, respectively. These reports documented the serious and pervasive nature of the nation's overall quality problem, finding nearly 100,000 deaths per year from medical errors, as well as systemic failure to provide evidence-based care nearly half of the time. Second, concurrent with the release of the IOM reports, the for-profit business sector experienced a series of ruinous accounting fraud scandals leading to the bankruptcies of Enron and WorldCom, and the related demise of Arthur Anderson. Additionally, the notorious $1.3 billion bankruptcy of the Allegheny Health, Education and Research Foundation reverberated with many of the issues

Key Points

- Engaged Boards improve quality outcomes
- The nation has a serious quality and patient safety problem
- There are new expectations for governance oversight of quality
- Quality is at the center of healthcare reform
- Best practices for Boards are available

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We Have Collective Work to Do

- **Accountability**
- **Responsibility**
- **Visibility**
- **Recognition**

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Measurement

What is our statewide opportunity?

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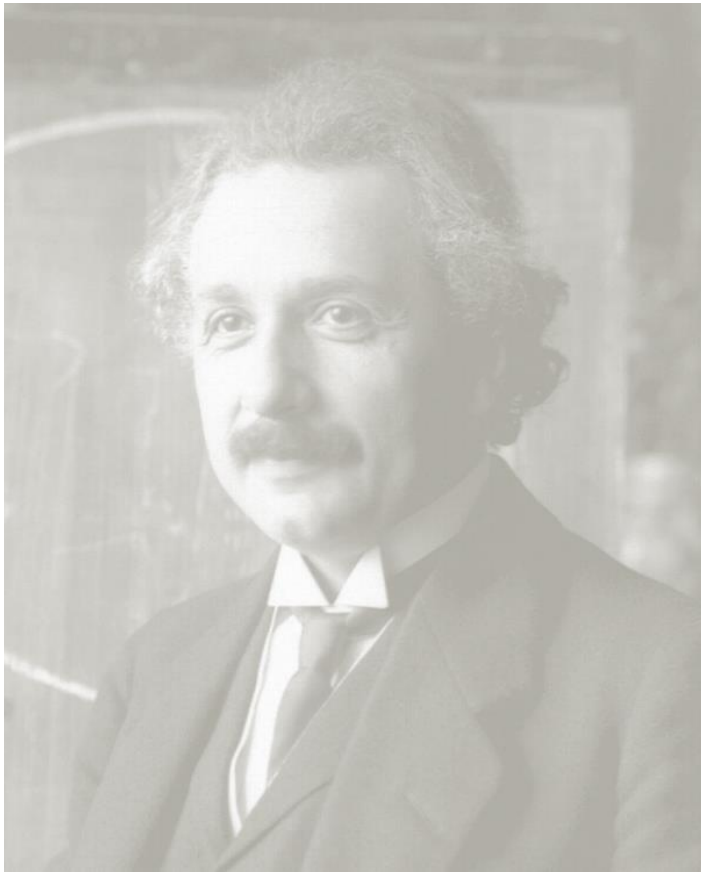
Measurement

"Not all that can be measured matters, not all that matters can be measured."



Albert Einstein (1879 – 1955)

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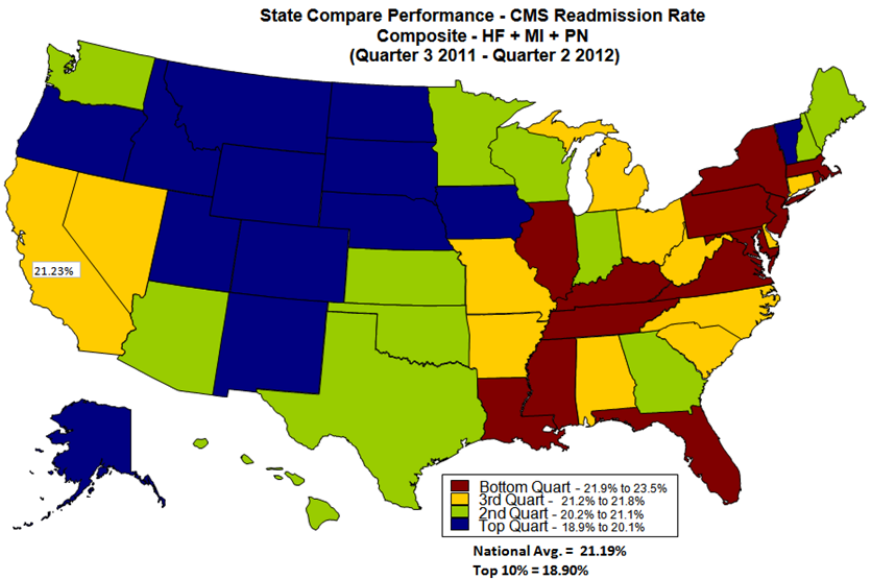
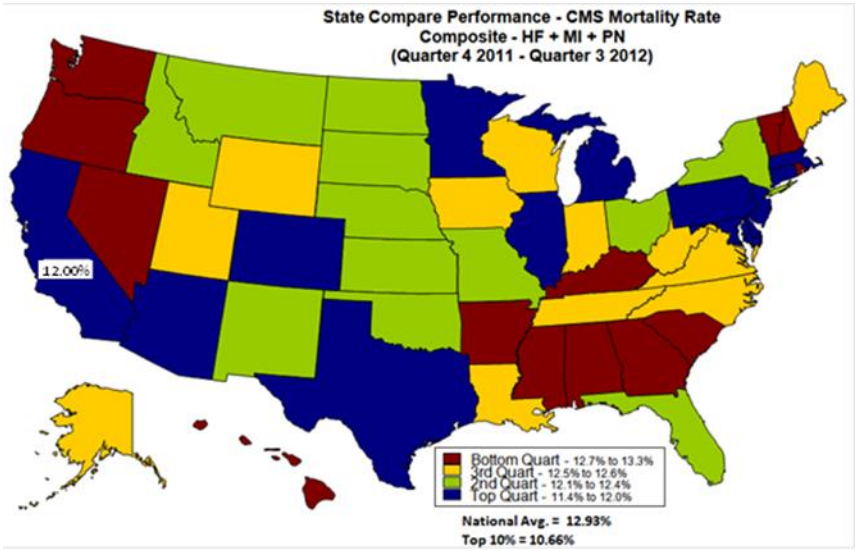
National Comparative Data

CMS Readmission Rate



CMS Mortality Rate



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Readmission

286,755/year **786/day** **33/hour**

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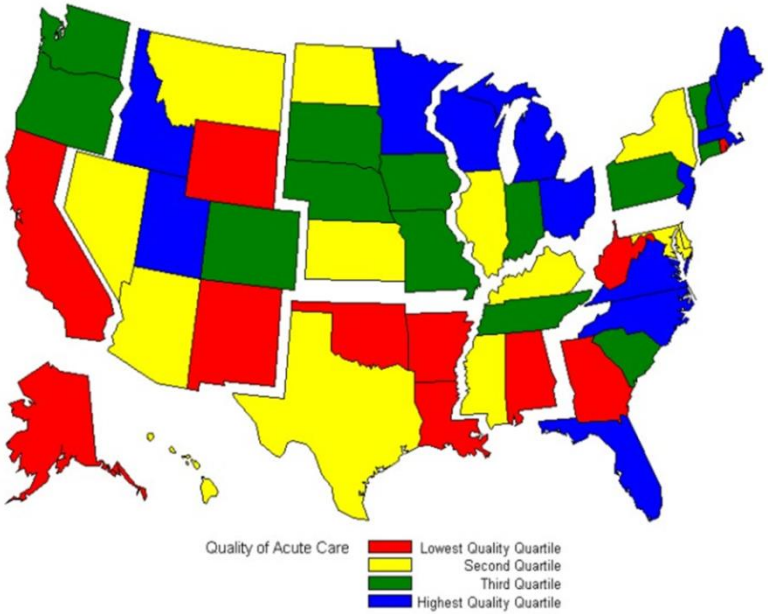
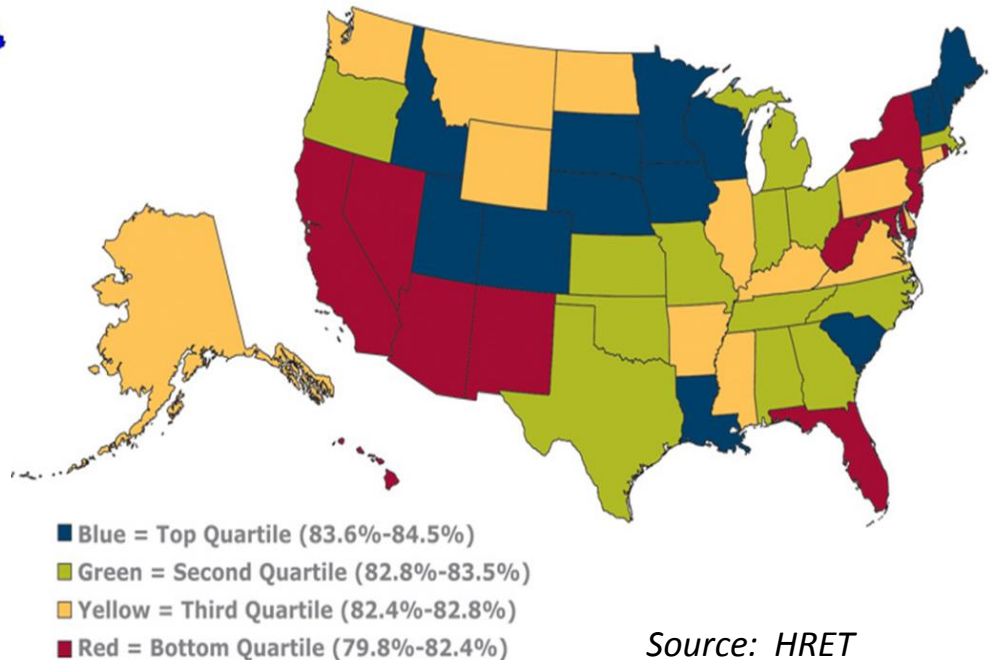
Our Challenge

State Comparison of Quality of Acute Care



Source: AHRQ

State Performance of Quality in Overall Score



Source: HRET

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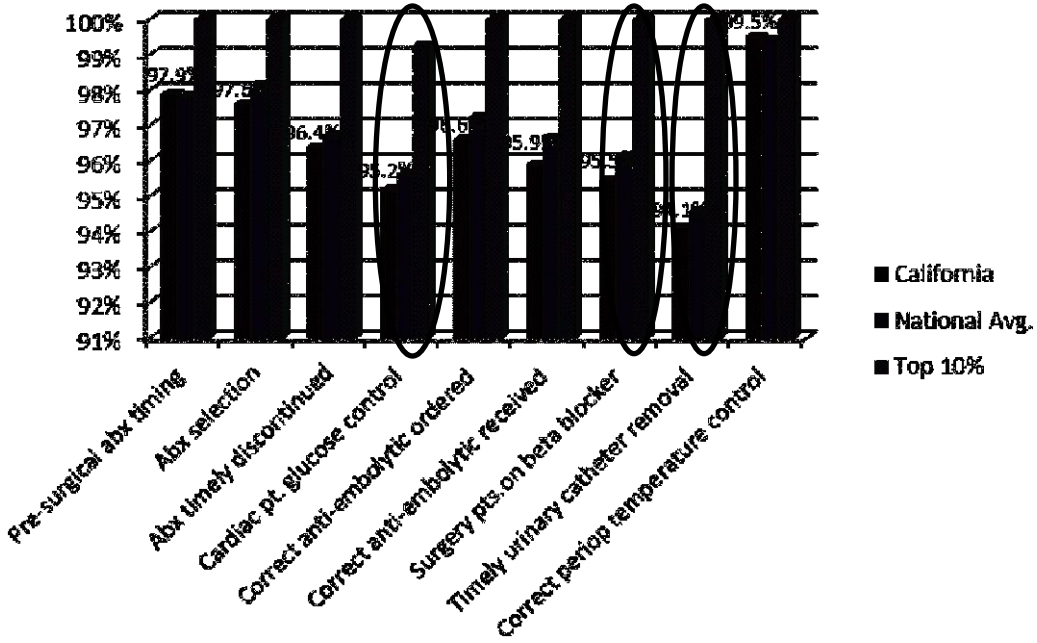
Surgical Care

Surgical Care Measures – slightly below the national average in 7 of 9 indicators

Higher is better



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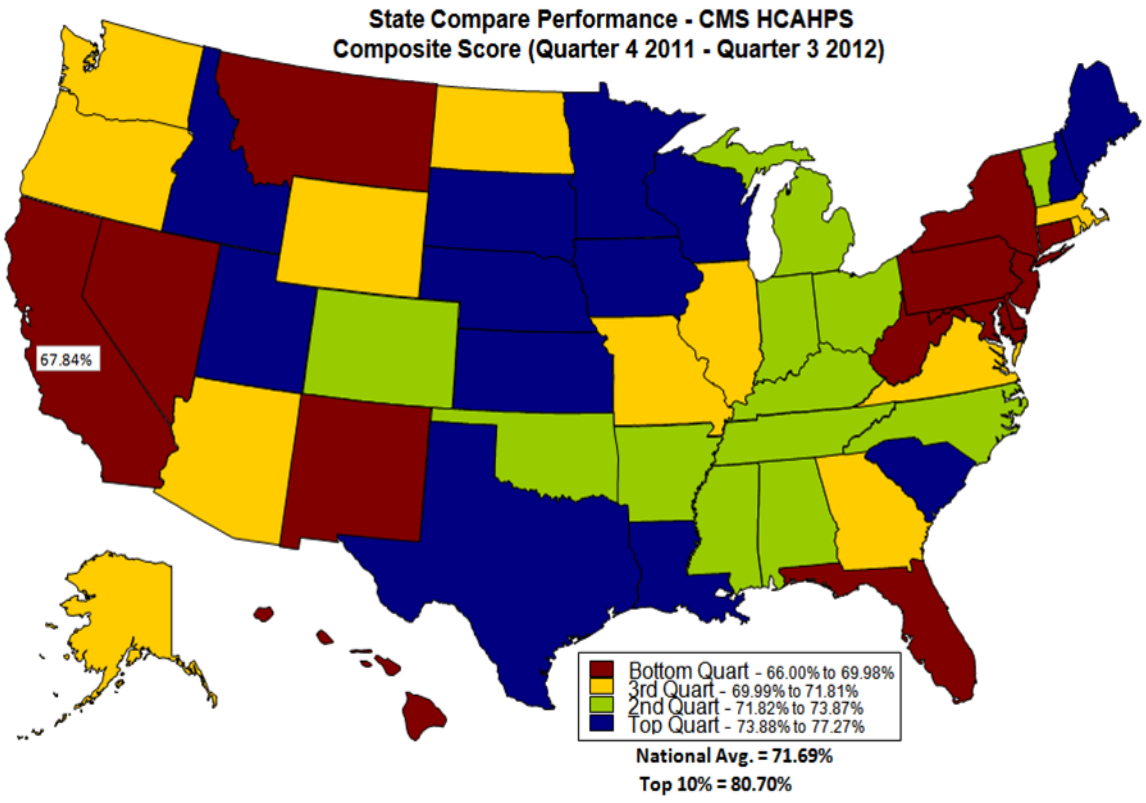
HCAHPS Results



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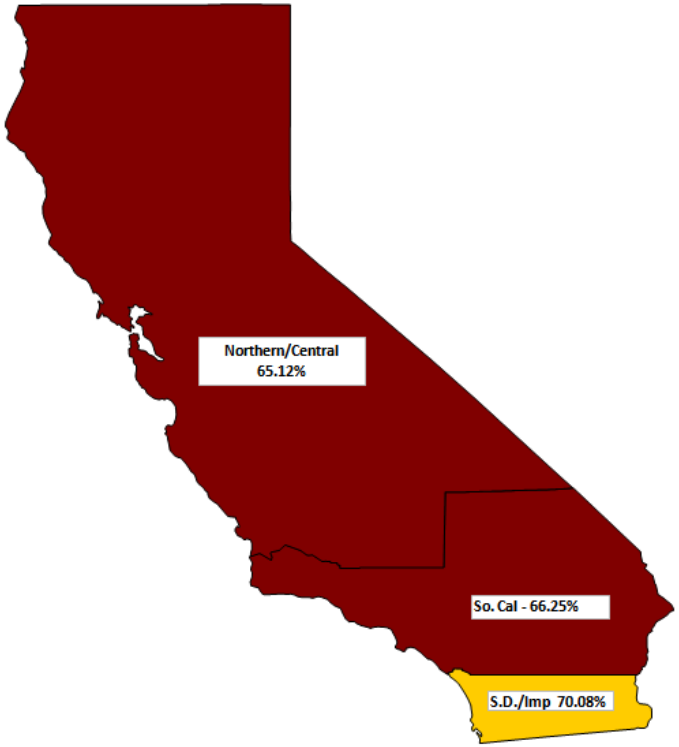
California Regional Performance
CMS HCAHPS Composite Score

Quarter 4 2011 – Quarter 3 2012



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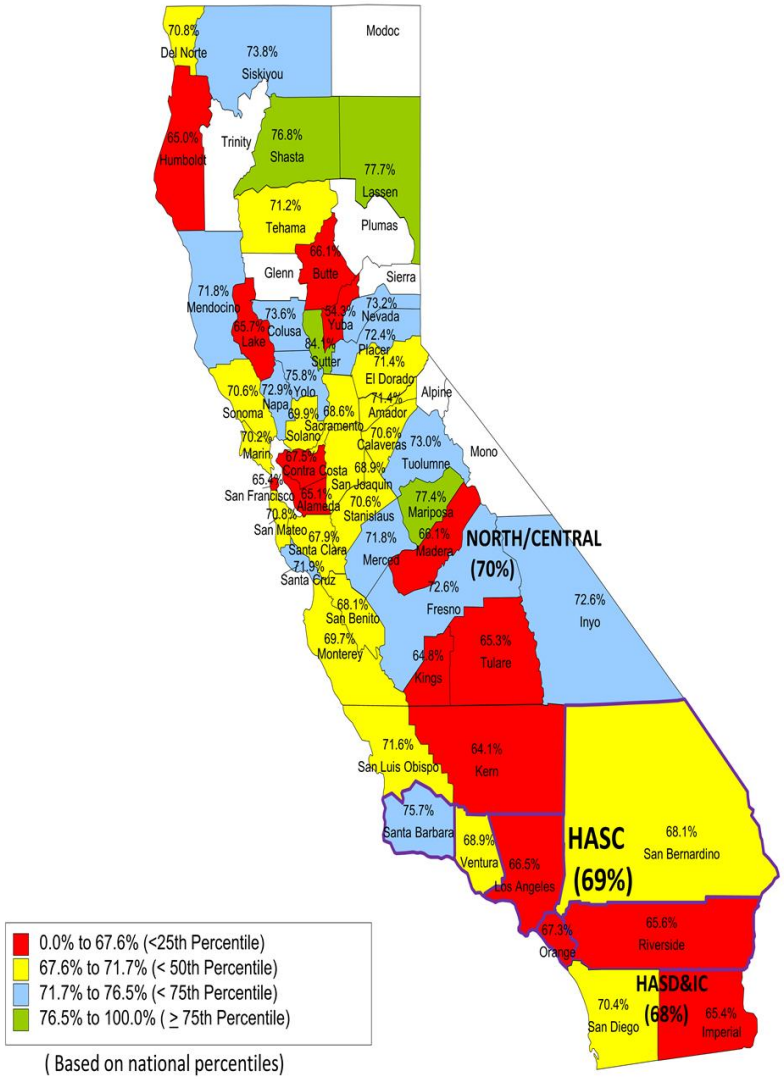

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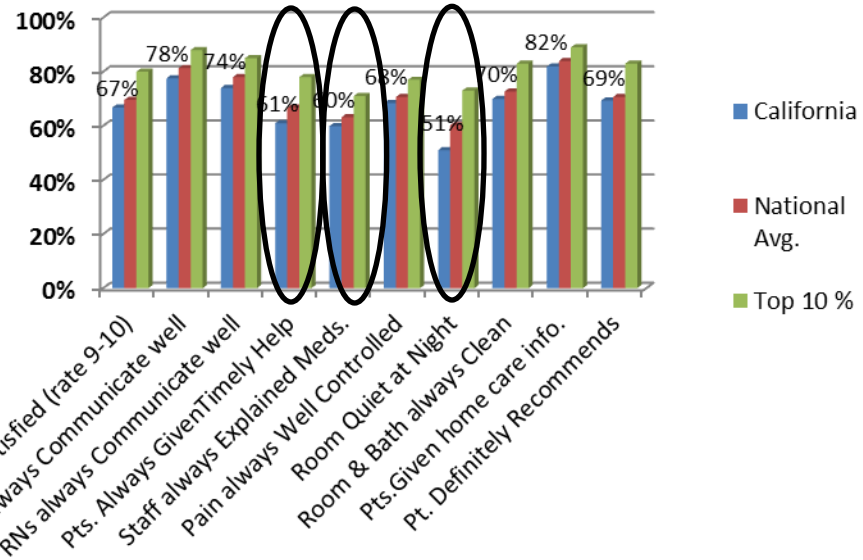
10 Publicly Reported HCAHPS Measures

California is below the national average

Higher is better



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What are the Patients and Families Telling Us?

- Be respectful of my need to rest and heal (quiet)
- Give me help when I need it
- Use language I can understand
- Provide care worthy of trust

Experiences convince more than words.

Experience is perception based on individual value system and personal context.

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Key Performance Indicators
Pennsylvania Hospital - 1754

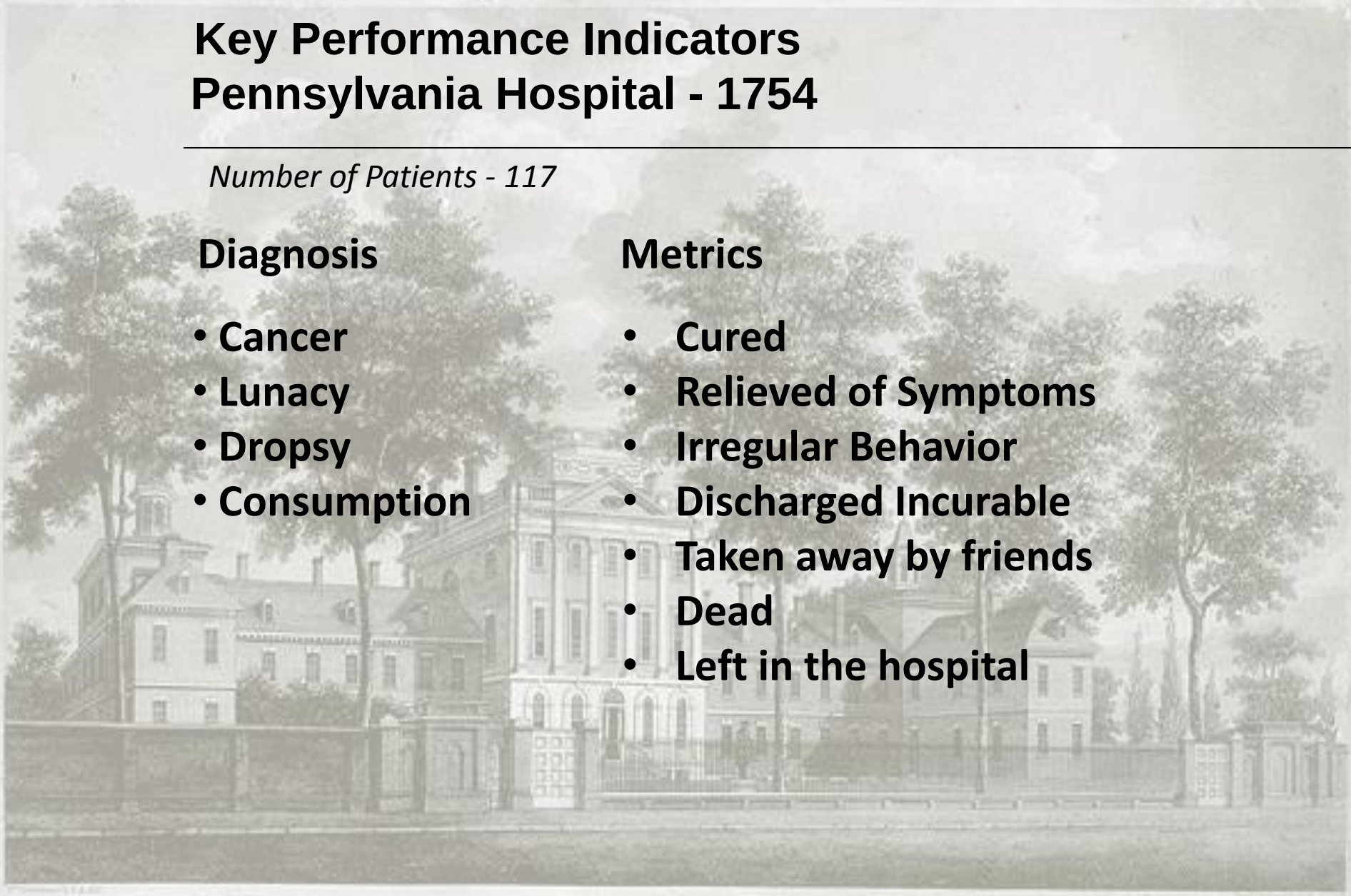
Number of Patients - 117

Diagnosis

- Cancer
- Lunacy
- Dropsy
- Consumption

Metrics

- Cured
- Relieved of Symptoms
- Irregular Behavior
- Discharged Incurable
- Taken away by friends
- Dead
- Left in the hospital



Healthcare is, at its heart, people caring for people. And people are unpredictable, complex, and full of paradox. Particularly when we interact with each other and when we
are anxious, sick, and confused.

Richard Smith, MD
British medical doctor, and director of the Ovations Initiative to combat chronic disease in the developing world.

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Our Challenge

"Medicine used to be simple, ineffective and relatively safe.

Now it is complex, effective and potentially dangerous."

Sir Cyril Chantler
Chairman of the King's Fund,
Chairman of the Board of the Great Ormond Street Hospital for Children NHS Trust.
Liverpool, England

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Think about all that is going on today.

People - relationships - complexity

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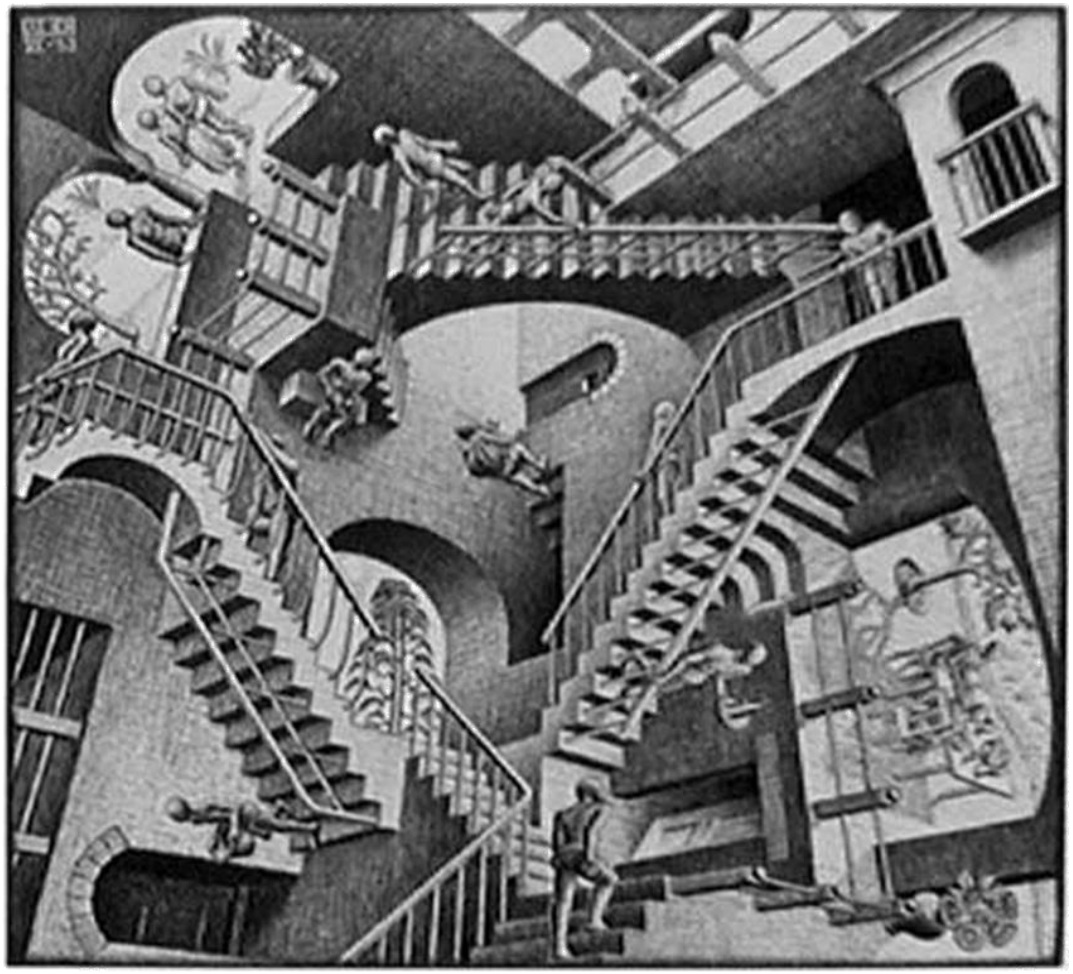
Care Delivery Complexity



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Escalating Risk – Probability of Failure

Here is what the research says:

- Production demands
- Management efficiencies
- Tightly coupled processes
- Technology
- Loss of buffers
- Escalating risk (volume, severity, complexity)
- Lack of established teamwork
- Perverse reward systems

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Leadership Lessons from the Field

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1. Leaders build culture: engagement inquiry, stories, belief that harm free care is possible
2. Transparency and story of failure and error: defines boundaries, allows learning
3. “Just Culture” removes blame: create trust-eliminate fear
4. Safety is dynamic, emerging, adaptive
5. Harm is the focus: a diagnostic category
6. Anticipation creates reliability and resilience to predict, rehearse, close gaps.
7. Teaming is required: individual skills are essential but insufficient
8. Stories create safety
9. Measurement and feedback drive getting better

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Leaders Shape Culture

Results

Artifacts – Stories - Heroes

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Bring the Patient to the Table

- Patient Stories
- Testimonials
- Listening and Learning

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Personalize Harm

"It is by going down into the abyss that we recover the treasure.

Where you stumble, there lies your treasure."

Joseph Campbell
Anthropologist, Journalist
1904-1987

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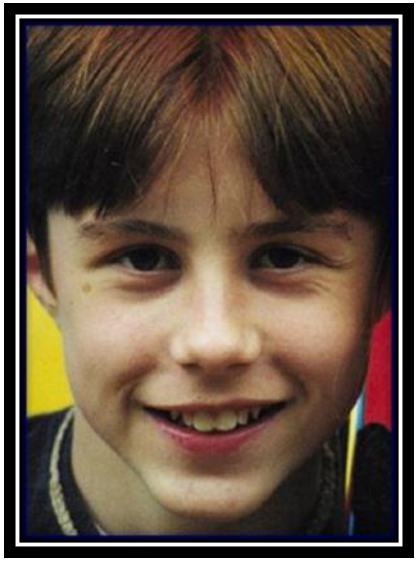

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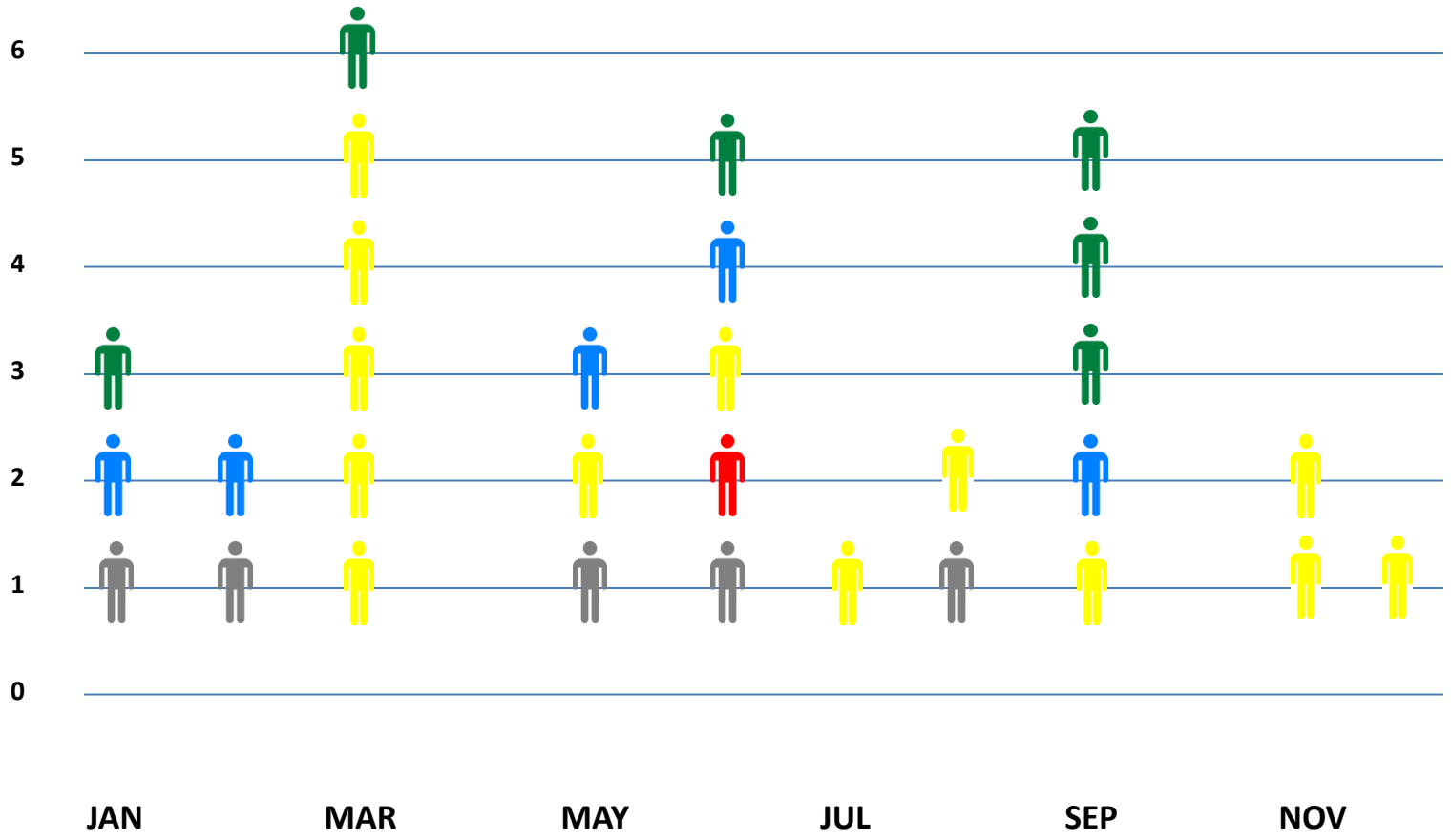
Sample Chart of Serious Safety Events



Warren Browner, CEO

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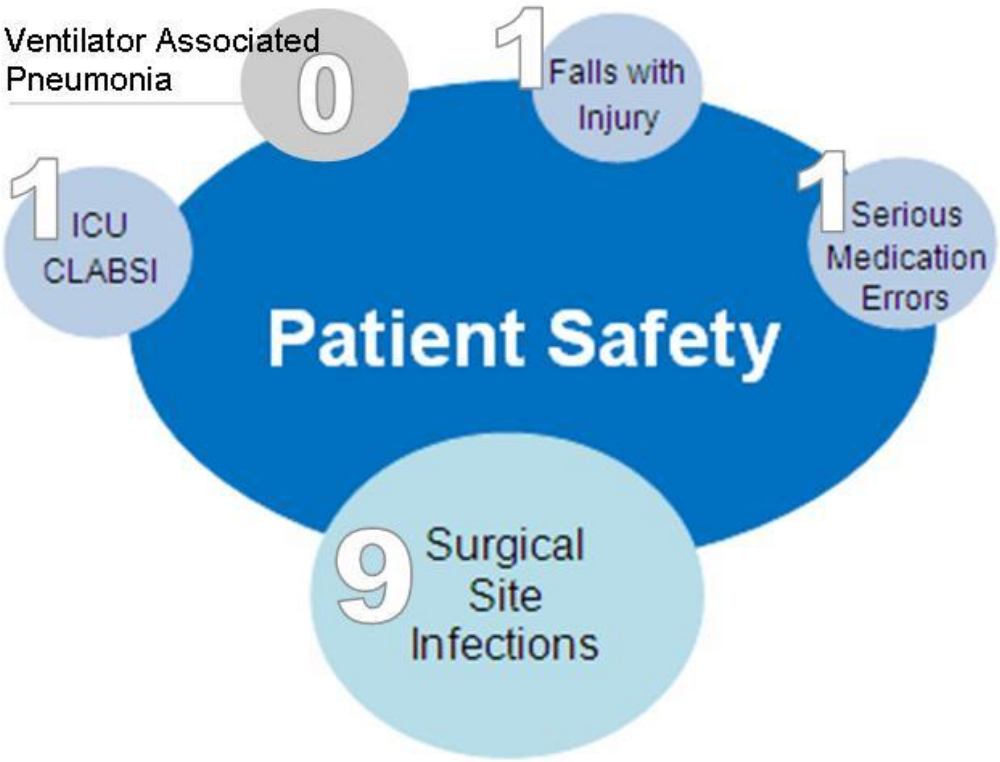
Preventable Harm Events – 2013



Preventable Harm Events	
FY2012	FY2013
27	12

Engage, Align, Model the Way

A string is needed to pull together scattered beads…

Somali proverb

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