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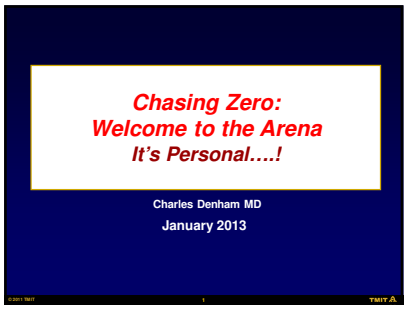

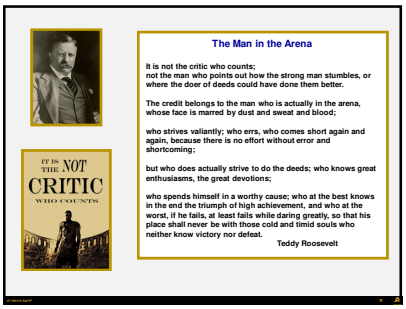

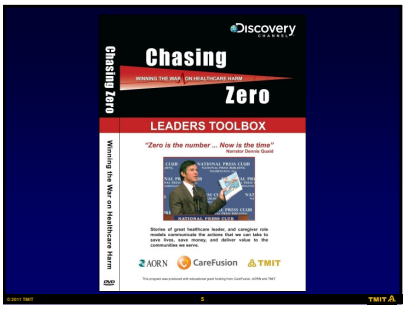

Top 10 Potential Leadership Targets for 2013

1. Governance Board Training in Patient Safety: *Board Chair Action*
2. Safety Budget Protection: *Board Chair Action*
3. Risk Identification and Mitigation: *Board/CEO & Risk Leader Action*
4. Performance AND Cost Transparency: *Board and C-Suite Action*
5. Leadership Development Investment: *Board and C-Suite Action*
6. Care of the Caregiver: *Board and C-Suite Action*
7. Accountability for "New Risks" – Overuse & Misuse of Testing and Procedures: *Patient Safety and Quality leaders Action*
8. Integrated Teams and Integrated Care Focus: *Board, C-Suite, and Safety/Quality Leaders*
9. Nursing and Bedside Care Healing Focus: *C-Suite & CNO Action*
10. Values-based Hiring and Advancement: *Board C-Suite Action*

Top 10 Potential Practice Targets for 2013

1. Failure to Rescue
2. Timely Diagnosis and Treatment of Sepsis
3. Safe Blood Management and Transfusion
4. Cardiac Care - Percutaneous Stents & CABG Overuse
5. Spine Care and Surgery Overuse
6. Pain Management
7. End of Life Care
8. Prevention of Healthcare-Acquired Infections (HAIs)
9. Availability of Medical and Healthcare Records
10. Surgical Never Events

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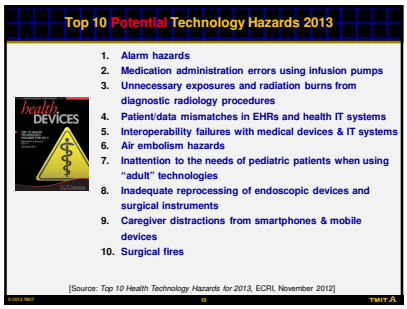

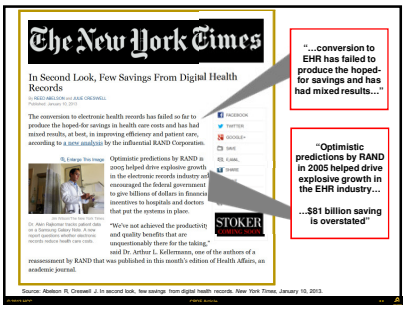

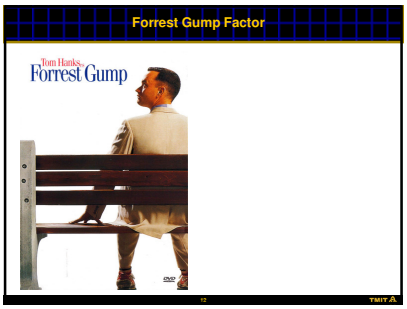

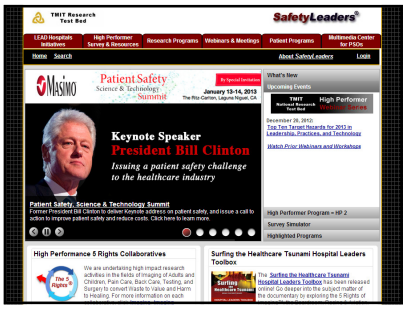

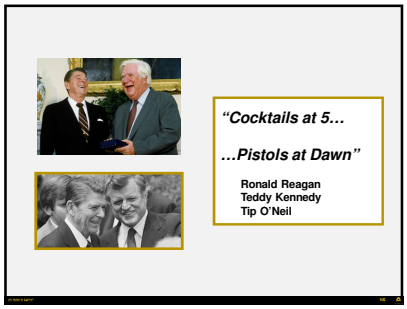

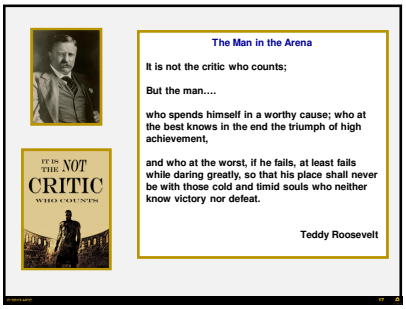

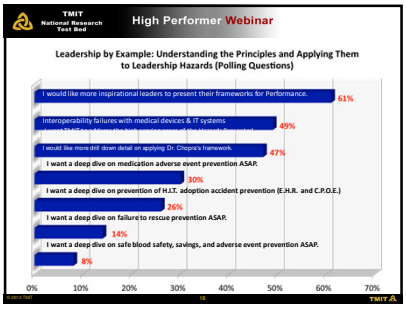

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Models for Consideration

- **Overuse, Underuse, and Misuse:** Popularized by IOM.
  - The Second Curve – Accountable Care
- **Leadership-Practices-Technology:** The high performance sweet spot
  - The Sociotechnical System
- **Idealized Design and Best Achievable Performance:** Working back from ideal with reason and wisdom.
  - Closing the Performance Gap
- **The 4 T's of Leadership:** Truth, Trust, Teamwork, and Training.
  - Engaging the Head, Heart, Hands and Voice

THE EXAMPLE: *The 5 Rights of Imaging®*

national partnership for women & families
Because actions speak louder than words.

Overuse, Underuse and Misuse of Medical Care

FACT SHEET

Across America, there are dangerous gaps between the health care that people should receive and the care they actually receive. These variations in care result in major costs in both lives and dollars.

Delivering the best care to every person every time will only happen when we understand the scope and depth of the problem. Poor-quality care comes in three forms: overuse, underuse and misuse. We give people care they do not need, we fail to give people care that we know works, and we make mistakes that hurt or kill people. We must address all three problems to create a more efficient, equitable and high-value health care system in America.

What is overuse?

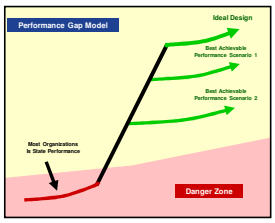
Overuse occurs when a drug or treatment is given without medical justification. It includes treating people with antibiotics for simple infections – or failing to follow effective options that cost less or cause fewer side effects. For example, antibiotics are prescribed inappropriately for children's ear infections 80 percent of the time despite the finding that these infections get better within three days without antibiotics.

In health care, more is not always better. More spending and treatment does not translate into better patient outcomes and health. For example, when used appropriately, MRI's and other imaging exams are valuable. But MRI's often don't change the treatments prescribed or a patient's outcome, in which case the technology is an unnecessary cost.

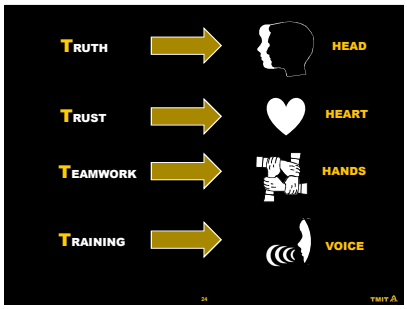
The High Performance Envelope

At the Leadership-Practices-Technology Intersection

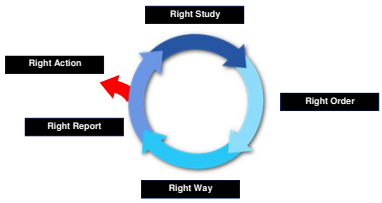
Performance Gap Model



The 4 T's of Leadership



The 5 Rights of Imaging™



The Sociotechnical System: IOM HIT Report

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FIGURE 3-1
Sociotechnical system underlying health IT-related adverse events.

SOURCE: Adapted from Harrington et al. (2010), Sittig and Singh (2010), and Walker et al. (2008).

The 4 A's Innovation Adoption Model

- **Awareness:** of performance gaps
- **Accountability:** of those who must change behavior to close the gaps
- **Ability:** of those who must act to close the gaps
- **Actions:** that must be taken to close the gaps

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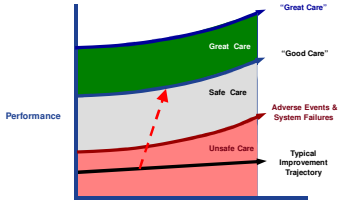
Our Gap

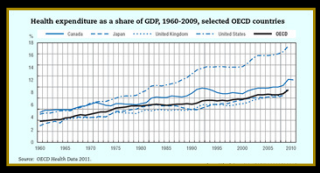
What is our GAP…
where are we?

Our Trajectories: Unsafe, Good, and Great Care

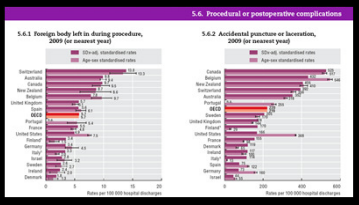


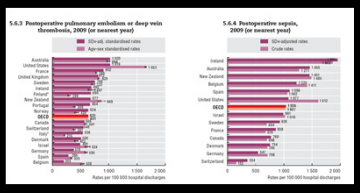
Health at a Glance 2011

OECD INDICATORS



Country/ Region	Population	Hospital Admissions 10% of popultaion per year	Medical Error Rate 10% of Hospital Admissions	Medical Errors 1% deaths & ser. injuries Victims	Approx 0.5% deaths Victims	Approx 0.5% ser. injuries Victims
Ireland	3,500,000	355,000	35,500	3,550	1,775	1,775
Denmark	5,300,000	530,000	53,000	5,300	2,650	2,6500
Austria	8,200,000	820,000	82,000	8,200	4,100	4,100
Belgium	10,000,000	1,000,000	100,000	10,000	5,000	5,000
Netherlands	16,000,000	1,600,000	160,000	16,000	8,000	8,000
Australia ***	20,000,000	--------	--------	--------	18,000	50,000
Italy	57,000,000	5,700,000	570,000	57,000	28,500	28,500
France	58,000,000	5,800,000	580,000	58,000	29,000	29,000
UK	60,000,000	6,000,000	600,000	60,000	30,000	20,000
Germany	83,000,000	8,300,000	830,000	83,000	41,500	41,500
USA **	300,000,000	30,000,000	3,000,000	300,000	150,000	150,000
EU 25 states	450,000,000	45,000,000	4,500,000	450,000	225,000	225,000
Council of Europe ****	800,000,000	80,000,000	8,000,000	800,000	400,000	400,000





The New Game: Harm Documentation

Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

The NEW ENGLAND JOURNAL of MEDICINE

HEALTH AFFAIRS
The Policy Journal of the Health Sphere

Adverse Events in Hospitals:
Measurement and Results

OIG Report to Congress

Lee Adler, DO - *Lead Physician Reviewer*
Stephen Knych, MD - *Physician Reviewer*
Amy Ashcraft, MPA – *OIG Team Leader*
Ruth Ann Dorrill, MPA – *OIG Team Leader*

TMIT National Research Test Bed — High Performer Webinar — SafetyLeaders.org

A Briefing on the OIG Report

Ruth Ann Dorrill, MPA

Team Leader
U.S. Department of Health and Human Services
Office of Inspector General

Amy Ashcraft, MPA

Senior Analyst and Team Leader
U.S. Department of Health and Human Services
Office of Inspector General

TMIT High Performer Webinar
December 16, 2010

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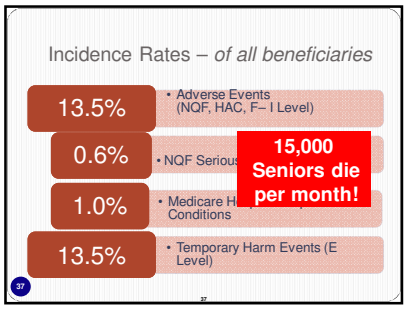

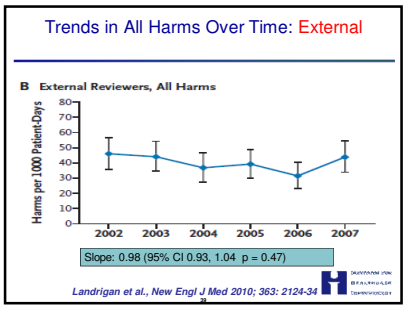

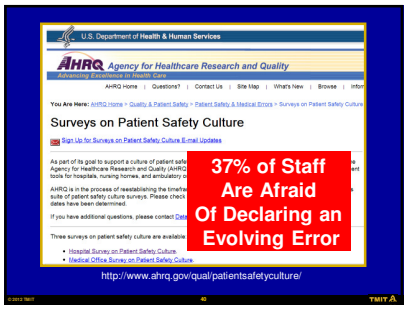

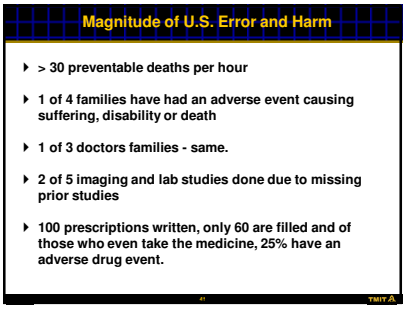

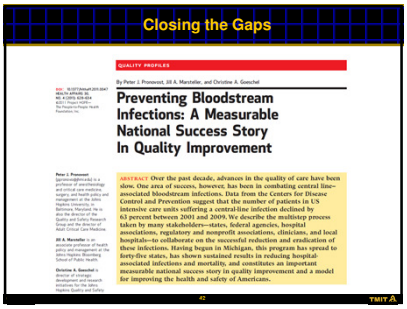

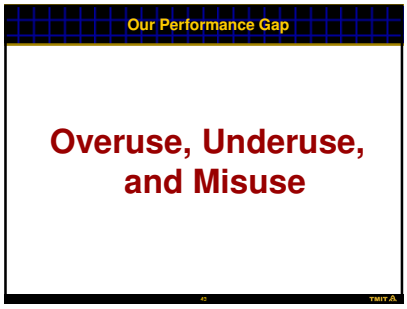

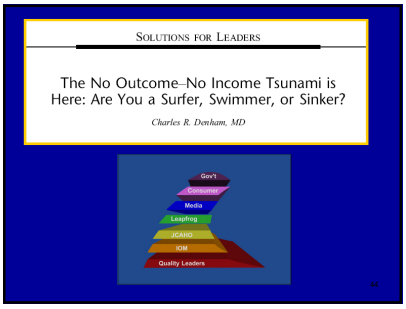

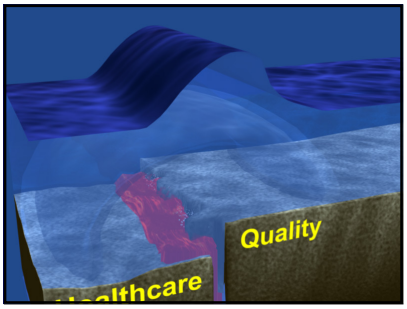

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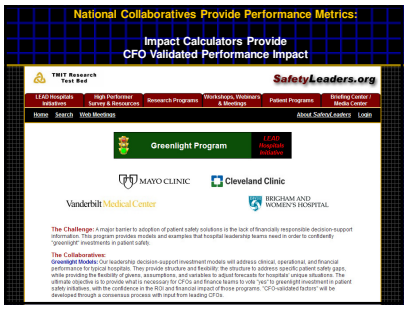

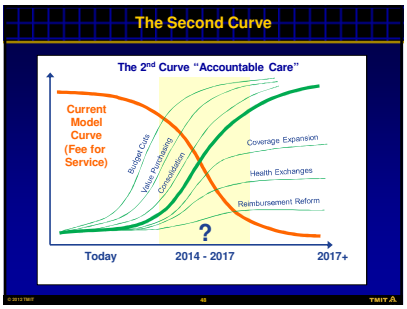

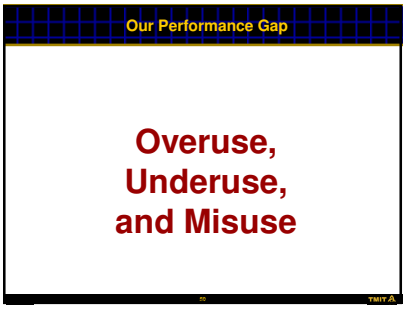

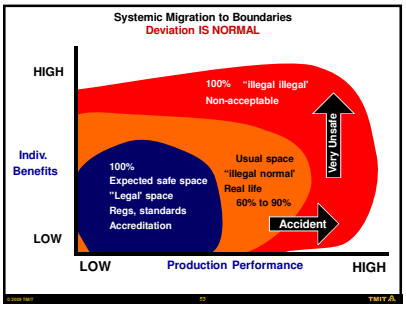

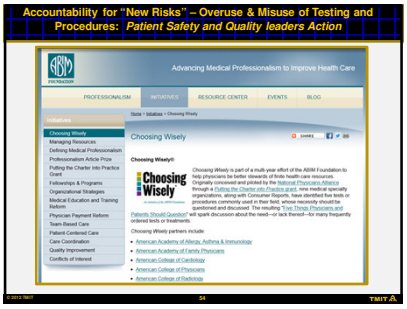

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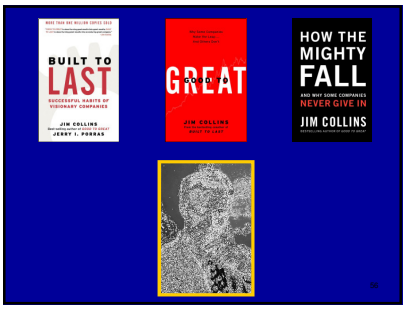
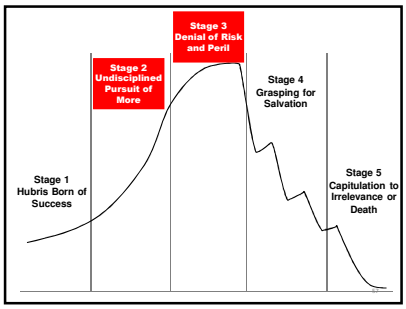
Idea Number 2

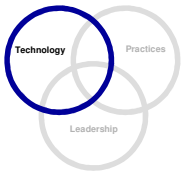
Leadership, Practices, and Technologies





The High Performance Envelope

Technology Alone IS NOT ENOUGH



The Sociotechnical System: IOM HIT Report

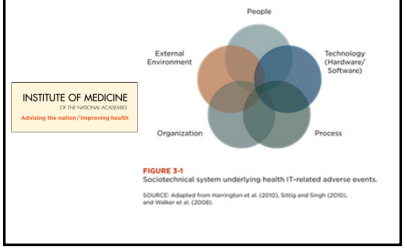


FIGURE 3-1
Sociotechnical system underlying health IT-related adverse events.

SOURCE: Adapted from Harrington et al. (2010), Sittig and Singh (2010), and Walker et al. (2008).

Features of safer health IT

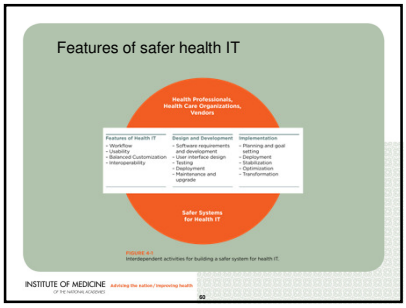


FIGURE 4-1
Interdependent activities for building a safer system for health IT.

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Current state of health IT

Magnitude of harm and impact of health IT on patient safety is not well known because:

- Heterogeneous nature of health IT products
- Diverse impact on different clinical environments and workflow
- Legal barriers and vendor contracts
- Inadequate and limited evidence in the literature

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Recommendation 8

The Secretary of HHS should recommend that Congress establish an independent federal entity for investigating patient safety deaths, serious injuries, or potentially unsafe conditions associated with health IT. This entity should also monitor and analyze data and publicly report results of these activities.

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Recommendation 7-8

FIGURE 6-1
Reporting system for learning and improving patient safety.

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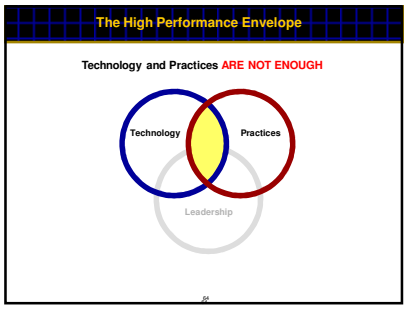

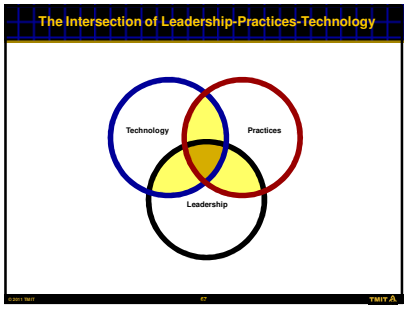

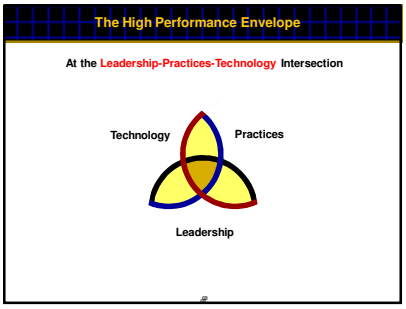

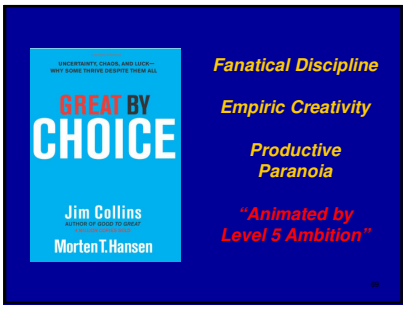

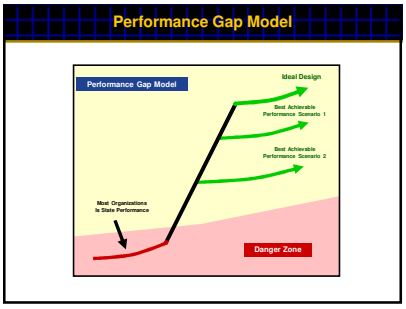

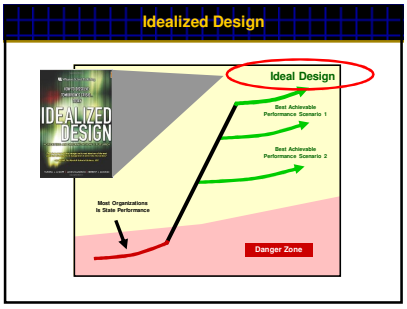

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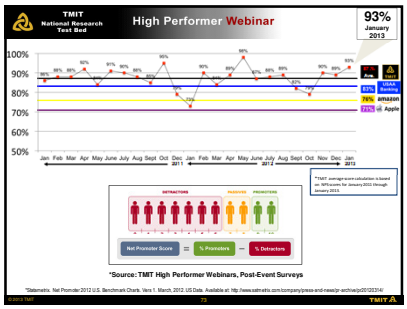

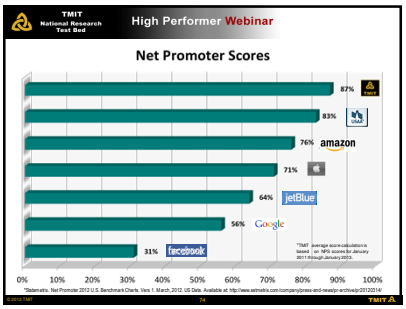

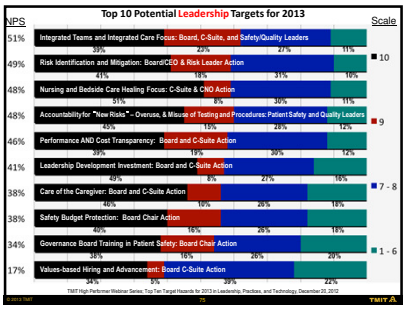

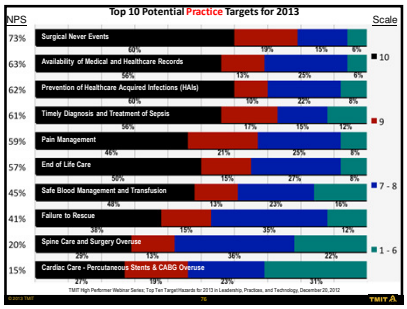

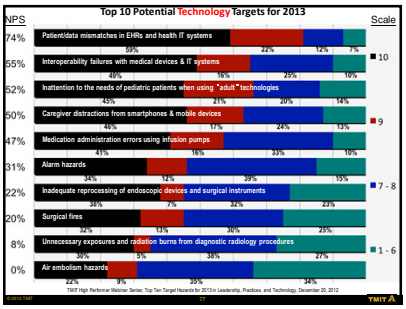

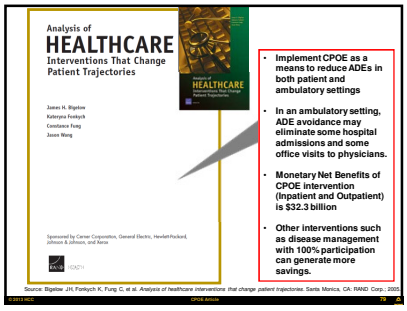

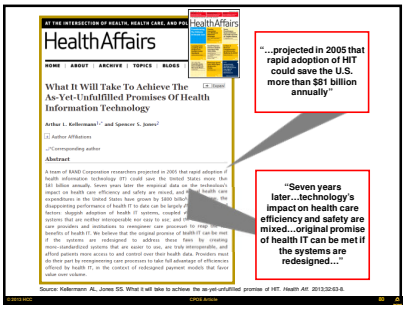

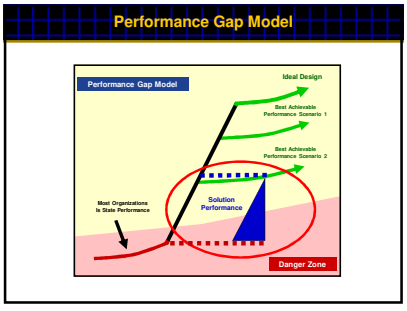

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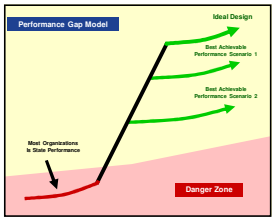
Performance Gap Model

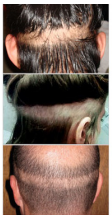
Trustee and Leadership Team Special Issue



The 4 A's Innovation Adoption Model

- **Awareness:** of performance gaps
- **Accountability:** of those who must change behavior to close the gaps
- **Ability:** of those who must act to close the gaps
- **Actions:** that must be taken to close the gaps

Press Broke Story



New York Times

Los Angeles Times

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Leaders-Practices-Tech and 4 A's

	AWARENESS	ACCOUNTABILITY	ABILITY	ACTION
LEADERSHIP	Leaders Aware of Performance Gaps	Leaders Personally Accountable to Close Gaps	Leaders Investing in Ability of Organization to Close the Gaps	Leaders Assuring that Action are Being Taken to Close Gaps
PRACTICES	Organization Aware of Best Practice	Key Actors Personally Accountable to Adopt Best Practice	Key Actors Able to Adopt Best Practice (Know How and Resources)	Key Actors Reliably Acting on Practices Consistently
TECHNOLOGIES	Organization Aware of Benefits AND Risks of Current and New Technologies being Adopted	Staff AND Leaders Accountable for Safety Envelope of Technologies	Staff AND Leaders Able to Assure Existing and New Technologies are Safe	Key Actors AND Leaders ensuring that Technologies are Reliably Safe

CT Accident Sites

	AWARENESS	ACCOUNTABILITY	ABILITY	ACTION
LEADERSHIP	Leaders Aware of Performance Gaps	Leaders Personally Accountable to Close Gaps	Leaders Investing in Ability of Organization to Close the Gaps	Leaders Assuring that Action are Being Taken to Close Gaps
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Surprised Thought Leader Site

	AWARENESS	ACCOUNTABILITY	ABILITY	ACTION
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High Performer Site

	AWARENESS	ACCOUNTABILITY	ABILITY	ACTION
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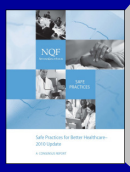
One Focus Area: NQF Safe Practices



- Culture
- Consent and Disclosure
- Workforce
- Information Transfer and Clear Communication
- Medication Management
- Healthcare-Associated Infections
- Condition- & Site-Specific Practices

Our Performance Gap

The 4 T's of Leadership

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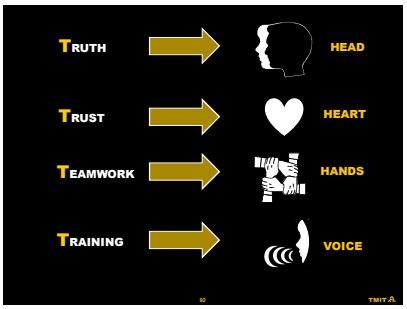

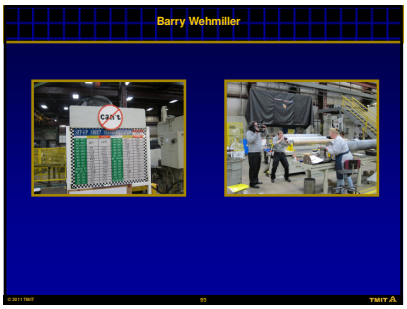

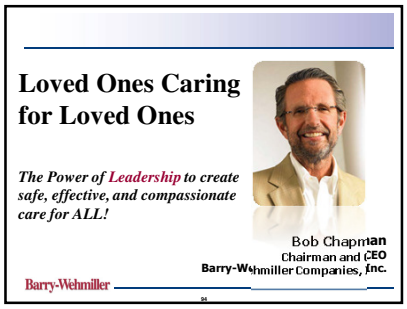

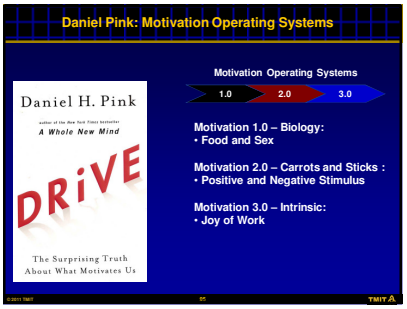

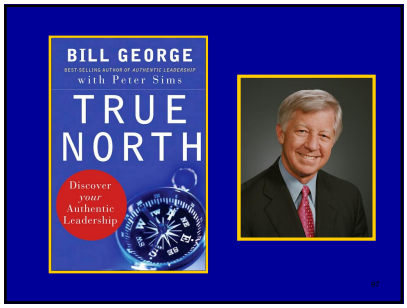

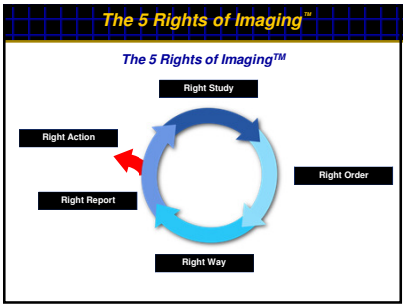

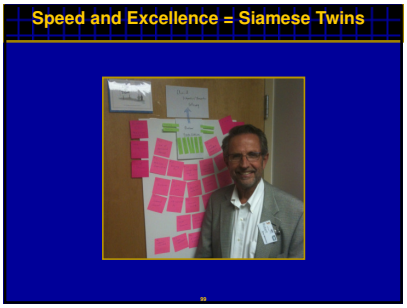

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Speed and Excellence = Siamese Twins

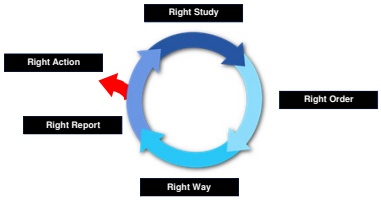
Hill Country Memorial *Image Gently*™

Hill Country Memorial *Image Gently*™

Measure of Success: Touching People's Lives

What is next?

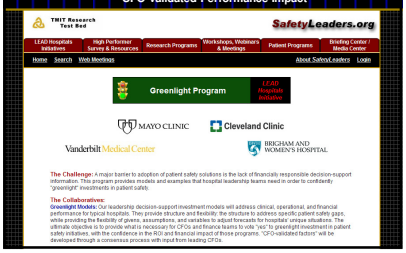
The 5 Rights of Imaging Children™



Forbes Clay Christensen: The Survivor

Global Collaboratives Provide Performance Metrics:

Impact Calculators Provide CFO Validated Performance Impact



Performance AND Cost Transparency: *Board and C-Suite Action*

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