

Charles Denham Keynote Presentation

**Chasing Zero:
Welcome to the Arena
It's Personal....!**

Charles Denham MD
January 2013

The Man in the Arena

It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better.

The credit belongs to the man who is actually in the arena, whose face is marked by dust and sweat and blood;

who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming;

but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions;

who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he falls, at least falls while doing greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.

Teddy Roosevelt

CareMoms

HOME ABOUT US PROGRAMS TOOLS & RESOURCES VIDEO

CareMoms™

About Us
As a critical care, and complex care hospital, more important than the risk is a CareMom. Our members are counting on us. Click here to hear our story and the CareMoms mission.

CareMoms

HOME ABOUT US PROGRAMS TOOLS & RESOURCES VIDEO

CareMoms™

Today's life can play a pivotal role in the family's health. CareMoms is a global program to empower you to become an active participant in their families' health care. Click here to learn more.

Chasing Zero

Discovery

Chasing Zero

LEADERS TOOLBOX

"Zero is the number... Now is the time"

Stories of great healthcare leaders and complex risk reduction interventions are shared here to give you the same trust, sense of urgency, and action value to the competitive arena.

MRN CareFusion TMIT

SafetyLeaders.org

www.SafetyLeaders.org

Mayo Clinic Quality Academy Conference: "Chasing and Playing for Zero in Health Care"
May 2-4, 2013, Dr. Denham's Presentations

The Mayo Clinic Quality Academy Conference is the 10th annual event.

The primary audience for this conference includes physicians, administrators, managers, allied health professionals, health care system engineers, operations research, statisticians, and educators.

Improving quality and patient safety is a top priority in health care today. "Chasing and Playing for Zero in Health Care" will provide participants with the latest quality improvement information about how to lead and reduce health care risk.

These best practices can be implemented in any clinical practice setting. All will also learn how to present information and implement care.

The presentations by Dr. Denham and others will provide a wealth of information to the participants and members of the Mayo Clinic to implement the important programs in their practice in our ever-changing world.

The slides presented by Dr. Denham are provided in the player above.

Chasing Zero

Play Video

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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Top 10 Potential Technology Hazards 2013

1. Alarm hazards
2. Medication administration errors using infusion pumps
3. Unnecessary exposures and radiation burns from diagnostic radiology procedures
4. Patient/data mismatches in EHRs and health IT systems
5. Interoperability failures with medical devices & IT systems
6. Air embolism hazards
7. Inattention to the needs of pediatric patients when using "adult" technologies
8. Inadequate reprocessing of endoscopic devices and surgical instruments
9. Caregiver distractions from smartphones & mobile devices
10. Surgical fires

[Source: Top 10 Health Technology Hazards for 2013, ECRI, November 2012]

The New York Times

In Second Look, Few Savings From Digital Health Records

By David G. H. Thompson, January 10, 2013

The government's electronic health records has failed so far to produce the hoped-for savings in health care costs and has had mixed results, at best, in improving efficiency and patient care, according to a new analysis by the influential RAND Corporation.

Optimistic predictions by RAND in 2005 helped drive explosive growth in the electronic records industry and encouraged the federal government to give billions of dollars in financial incentives to hospitals and doctors that put the system in place.

"We've not achieved the production and quality benefits that are responsibility here for the industry," said Dr. Arthur L. Kellermann, one of the authors of a memorandum by RAND that was published in this month's edition of Health Affairs, an academic journal.

Source: Health Affairs, December 2, 2012. Archived link. View savings from digital health records. New York Times, January 10, 2013.

"...conversion to EHR has failed to produce the hoped-for savings and has had mixed results..."

"Optimistic predictions by RAND in 2005 helped drive explosive growth in the EHR industry..."

"\$1 billion saving is overstated"

Forrest Gump Factor



Forrest Gump Factor

SafetyLeaders

Keynote Speaker President Bill Clinton

Issuing a patient safety challenge to the healthcare industry

High Performance 5 Rights Collaborators

Surfing the Healthcare Tsunami: Hospital Leaders' Toolkit

"Cocktails at 5...
...Pistols at Dawn"

Ronald Reagan
Teddy Kennedy
Tip O'Neill

The Man in the Arena

It is not the critic who counts;
But the man...
who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement,
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Teddy Roosevelt

High Performer Webinar

Leadership by Example: Understanding the Principles and Applying Them to Leadership Hazards (Polling Questions)

I would like more inspirational leaders to present their frameworks for Performance	61%
Interoperability failures with medical devices & IT systems	59%
I would like more drill down detail on applying Dr. Chopra's framework	47%
I want a deep dive on medication adverse event prevention ASAR	40%
I want a deep dive on prevention of H.I.T. adoption accident prevention (S.H.R. and C.P.O.E.)	30%
I want a deep dive on failure to rescue prevention ASAR	14%
I want a deep dive on safe blood safety, savings, and adverse event prevention ASAR	8%

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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, have quality care options 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 and other imaging exams are valuable, but MRI often does change the treatments provided for a patient's outcome, in which case the technology is an unnecessary cost.

The High Performance Envelope

At the Leadership-Practices-Technology Intersection

A Venn diagram with three overlapping circles. The top-left circle is blue and labeled 'Technology'. The top-right circle is red and labeled 'Practices'. The bottom circle is black and labeled 'Leadership'. The central area where all three circles overlap is shaded yellow.

Performance Gap Model

The diagram shows a graph with 'Ideal Design' at the top. Below it are two green lines representing 'Best Achievable Performance Scenario 1' and 'Best Achievable Performance Scenario 2'. A red line at the bottom represents 'Most Organizations in State Performance'. The area between the red line and the green lines is shaded pink and labeled 'Danger Zone'.

The 4 T's of Leadership

T RUTH	→		H EAD
T RUST	→		H EART
T EAMWORK	→		H ANDS
T RAINING	→		V OICE

The 5 Rights of Imaging™

A circular diagram with five arrows forming a circle. The arrows are labeled: 'Right Study' (top), 'Right Action' (left), 'Right Report' (bottom-left), 'Right Way' (bottom), and 'Right Order' (right).

The Sociotechnical System: IOM HIT Report

A Venn diagram with four overlapping circles. The top circle is blue and labeled 'People'. The right circle is green and labeled 'Technology (Hardware/Software)'. The bottom circle is red and labeled 'Process'. The left circle is orange and labeled 'Organization'. The diagram is set against a background of 'External Environment'.

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES
Advancing the nation's improving health

FIGURE 3-1
Sociotechnical system underlying health IT-related adverse events.
SOURCE: Adapted from Harrington et al. (2010), Stimp and Singh (2010), and Walker et al. (2008).

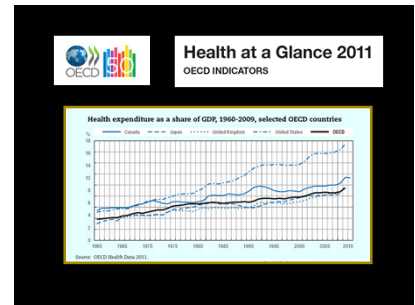
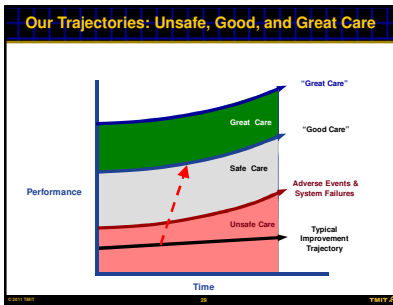
The 4 A's Innovation Adoption Model

- Awareness:** of performance gaps
- Accountability:** of those who must change behavior to close the gaps
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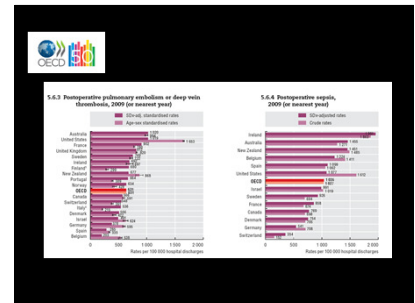
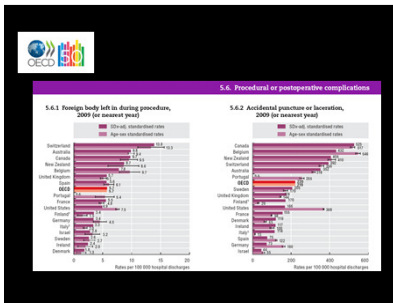
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Our Gap

What is our GAP... where are we?



Country/Region	Population	Hospital Admissions (100k of population per year)	Medical Errors (10% of Hospital Admissions)	Medical Errors (1% deaths & serious injuries)	Reported 5.9% deaths	Reported 5.9% serious injuries
Ireland	3,500,000	350,000	35,500	3,550	1,775	1,775
Denmark	5,300,000	530,000	53,000	5,300	2,650	2,650
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 Dorrell, MPA - OIG Team Leader

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

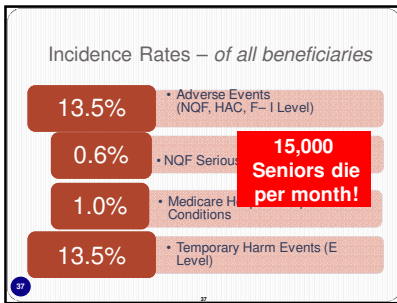
A Briefing on the OIG Report

Ruth Ann Dorrell, 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

Charles Denham Keynote Presentation

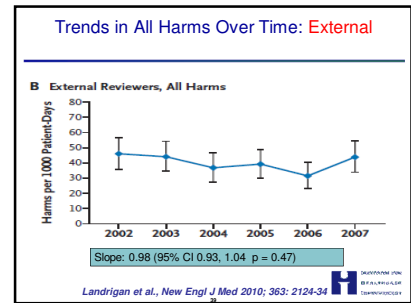


TMIT Medical Research Test Bed High Performer Webinar SafetyLeaders.org

Developing a Method to Track Regional and National Changes in Rates of Harm Due to Medical Care

Christopher P. Landrigan, MD, MPH
Associate Professor of Medicine and Pediatrics, Harvard Medical School
Research Director, Inpatient Pediatrics Service, Children's Hospital Boston
Director, Sleep and Patient Safety Program, Brigham and Women's Hospital

TMIT High Performer Webinar
December 16, 2010



U.S. Department of Health & Human Services
AHRC Agency for Healthcare Research and Quality

You Are Here: AHRC Home > Quality & Patient Safety > Patient Safety & Medical Errors > Surveys on Patient Safety Culture

Surveys on Patient Safety Culture

Start Up for Surveys on Patient Safety Culture (Email Logins)

As part of its goal to support a culture of patient safety, Agency for Healthcare Research and Quality (ahrq.gov) tools for hospitals, nursing homes, and ambulatory care.

AHRQ is in the process of establishing the timeliness of patient safety culture surveys. Please check back for our observations.

If you have additional questions, please contact [Dale](#).

Three surveys on patient safety culture are available:

- Hospital Survey on Patient Safety Culture
- Medical Office Survey on Patient Safety Culture

<http://www.ahrq.gov/qual/patientsafetyculture/>

37% of Staff Are Afraid Of Declaring an Evolving Error

Magnitude of U.S. Error and Harm

- > 30 preventable deaths per hour
- 1 of 4 families have had an adverse event causing suffering, disability or death
- 1 of 3 doctors families - same.
- 2 of 5 imaging and lab studies done due to missing prior studies
- 100 prescriptions written, only 60 are filled and of those who even take the medicine, 25% have an adverse drug event.

Closing the Gaps

QUALITY PROFILE

By Peter J. Pronovost, MD, A. Marikali, and Christine A. Georger

Preventing Bloodstream Infections: A Measurable National Success Story In Quality Improvement

Over the past decade, advances in the quality of care have been made. One area of success, however, has been in combating central line-associated bloodstream infections. Data from the Centers for Disease Control and Prevention suggest that the number of patients in U.S. intensive care units suffering a central-line infection declined by 43 percent between 2001 and 2009. We describe the multidisciplinary process taken by many states—states, federal agencies, hospitals, associations, regulatory and nonprofit organizations, clinicians, and local hospitals—to collaborate on the successful reduction and eradication of these infections. Having begun in Michigan, this program has spread to forty-five states, has shown sustained results in reducing hospital-associated infections and mortality, and constitutes an important, measurable national success story in quality improvement and a model for improving the health and safety of Americans.

Our Performance Gap

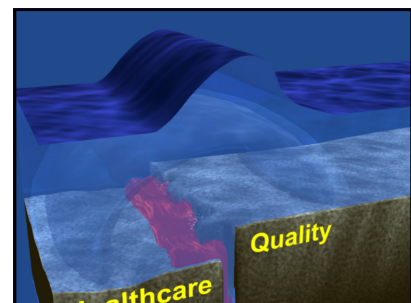
Overuse, Underuse, and Misuse

SOLUTIONS FOR LEADERS

The No Outcome–No Income Tsunami is Here: Are You a Surfer, Swimmer, or Sinker?

Charles R. Denham, MD

Quality Leaders



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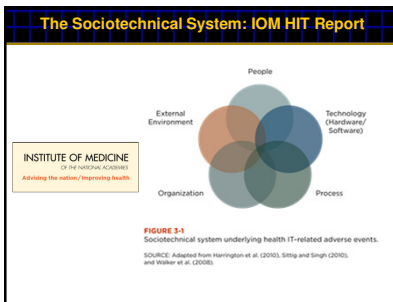
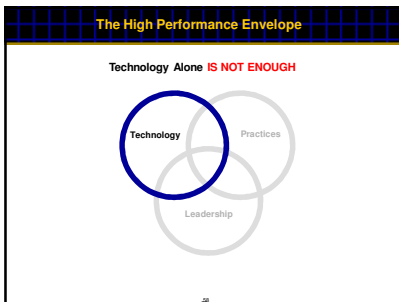
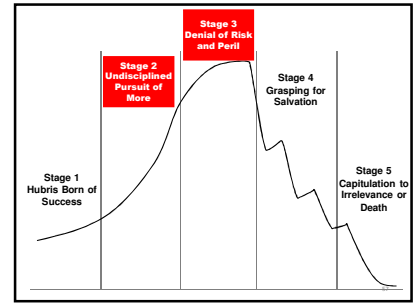
Idea Number 2

Leadership, Practices, and Technologies

BUILT TO LAST
 HOW GREAT COMPANIES ENDURE THROUGH TIME
 JIM COLLINS
 WITH JERRY I. PORAC

GREAT BY DESIGN
 WHY SOME COMPANIES THRIVE WHILE OTHERS FAIL
 JIM COLLINS
 WITH JERRY I. PORAC

HOW THE MIGHTY FALL
 AND WHY SOME COMPANIES NEVER GIVE IN
 JIM COLLINS



Current state of health IT

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

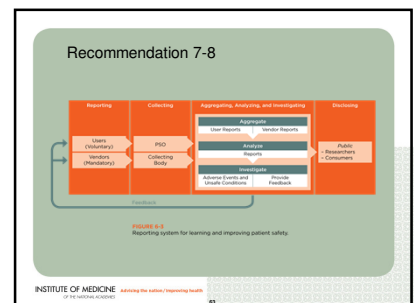
- Heterogeneous nature of health IT products
- Diverse impact on different clinical environments and workflow
- Legal barriers and vendor contracts
- Inadequate and limited evidence in the literature

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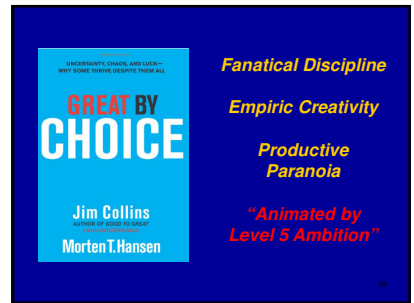
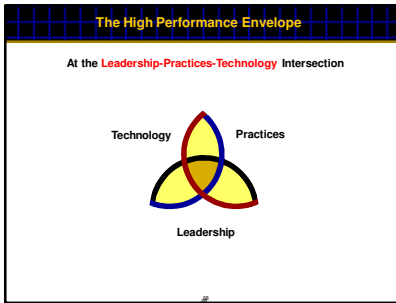
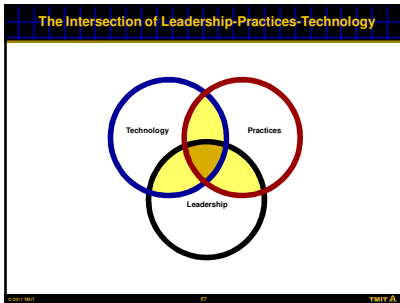
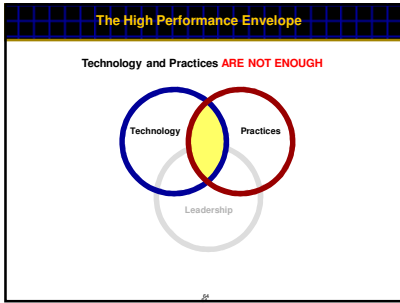
Recommendation 8

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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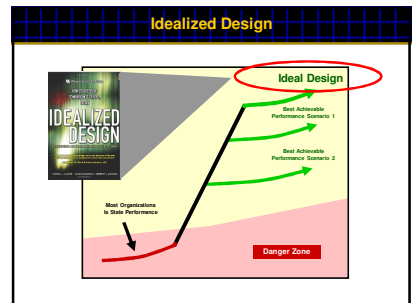
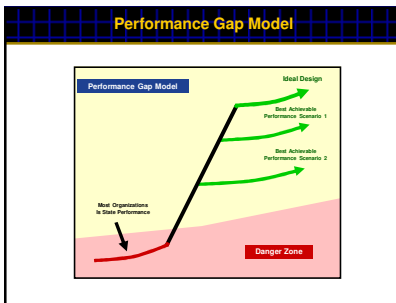


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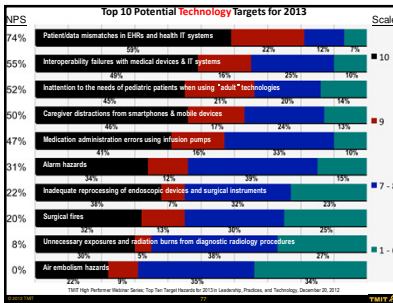
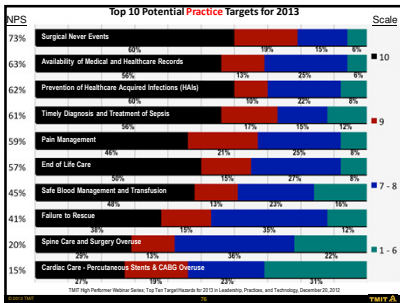
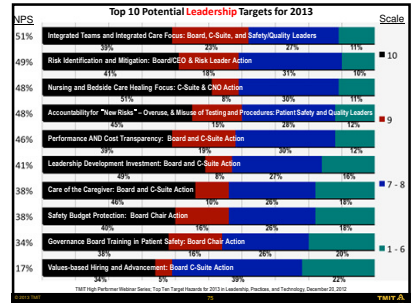
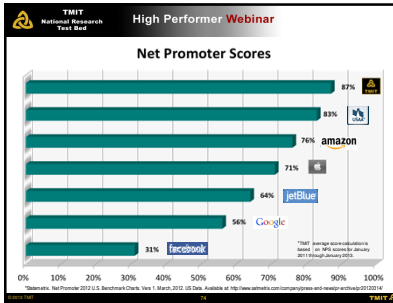
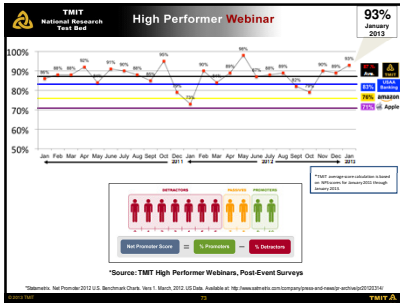


Our Performance Gap

**Idealized Design
And
Best Achievable
Performance**



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The New York Times
In Second Look, Few Savings From Digital Health Records

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...\$81 billion saving is overstated

...conversion to EHR has failed to produce the hoped-for savings and has had mixed results...

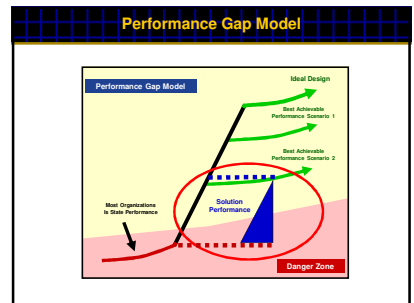
Analysis of HEALTHCARE Interventions that Change Patient Trajectories

- Implement CPOE as a means to reduce ADEs in both patient and ambulatory settings
- In an ambulatory setting, ADE avoidance may eliminate some hospital admissions and some office visits to physicians.
- Monetary Net Benefits of CPOE Intervention (Inpatient and Outpatient) is \$2.3 billion
- Other interventions such as disease management with 100% participation can generate more savings.

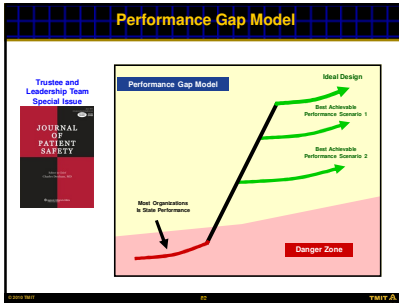
Health Affairs
What It Will Take To Achieve The As-Yet-Unfulfilled Promises Of Health Information Technology

...projected in 2005 that rapid adoption of HIT could save the U.S. more than \$81 billion annually

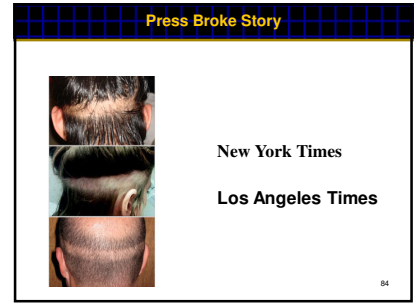
Seven years later...technology's impact on health care efficiency and safety are mixed...original promise of health IT can be met if the systems are redesigned...



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- ### The 4 A's Innovation Adoption Model
- ▶ **Awareness:** of performance gaps
 - ▶ **Accountability:** of those who must change behavior to close the gaps
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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 Assess Existing and New Technologies are Safe	Key Actors AND Leaders ensuring that Technologies are Reliably Safe

CT Accident Sites

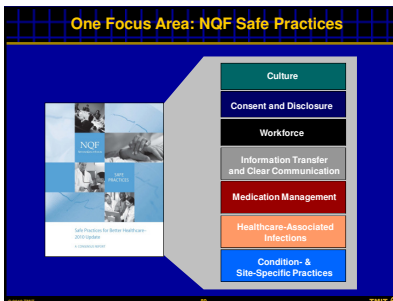
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Surprised Thought Leader Site

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High Performer Site

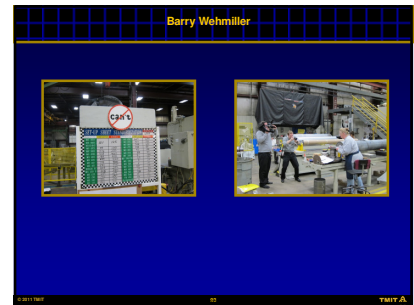
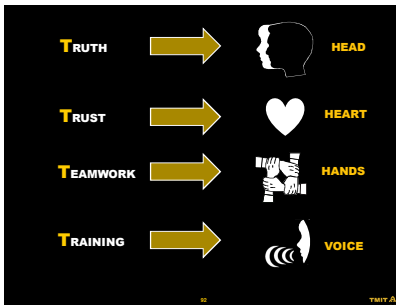
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Our Performance Gap

The 4 T's of Leadership

Charles Denham Keynote Presentation



Loved Ones Caring for Loved Ones

The Power of Leadership to create safe, effective, and compassionate care for ALL!

Bob Chapman
 Chairman and CEO
 Barry-Wehmiller Companies, Inc.

Barry-Wehmiller

Daniel Pink: Motivation Operating Systems

Motivation Operating Systems
 1.0 → 2.0 → 3.0

- Motivation 1.0 – Biology:
 - Food and Sex
- Motivation 2.0 – Carrots and Sticks :
 - Positive and Negative Stimulus
- Motivation 3.0 – Intrinsic:
 - Joy of Work

S.U.C.C.E.S and Switch

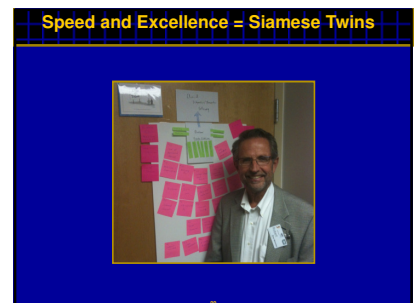
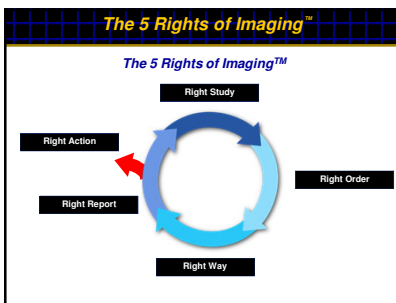
Simple
 Unexpected
 Concrete
 Credible
 Emotional
 Stories

BILL GEORGE
 BESTSELLING AUTHOR OF AUTHENTIC LEADERSHIP
 with Peter Sims

TRUE NORTH

Discover your Authentic Leadership

Bill George



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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

Surfing the Healthcare Tsunami

BRING YOUR BEST BOARD

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