Spreading Bundle Tools and Resources on High Reliability Culture Event

December 7, 2023

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Welcome!

Jane Brock, MD
Medical Director, Telligen
Data Validation & Administrative Contractor (DVA)
Moderator

Brianna Gass, MPH
Senior Manager, Health Management, Telligen
Data Validation & Administrative Contractor (DVA)
Moderator

Reminders

- Welcome back to the afternoon session of today's High Reliability Culture Event. We hope you are able to listen to all of the presentations this afternoon and will come away with renewed enthusiasm and some additional high reliability tools and resources to help reach the goal of providing safer, superior quality care.
- Please be sure to participate as we go along and submit your questions and comments via the Q&A feature.
- The slides, recording and resources from today's event will be posted on QIOProgram.org within a week.

Agenda – Morning Session

Time (EST)	Topic	Presenter
10:00 – 10:15	CMS Leadership Welcome	Anita Monteiro, iQIIG Director Ally McCoy, DQIIMT Director
10:15 – 10:45	Resiliency Engineering and Human Factors as a Path to High Reliability Organizing	Oren Guttman, MD, MBA Healthcare Association of New York State (HANYS)
10:45 – 11:15	Experiences Implementing High Reliability Organizing in Hospitals	Russell Kohl, MD, FAAFP TMF Health Quality Institute
11:15 – 11:45	Implementing an Incident Decision Tree	Jen Murphy, MHA, CCPS Health Quality Innovators
11:45 – 12:30	Lunch Break	

Agenda – Afternoon Session

Time (EST)	Topic	Presenter
12:30 – 1:00	Iowa Healthcare Collaborative (IHC) - High Reliability Organization Wins and Applying High Reliability Organization Concepts in Critical Access Hospitals	Tom Evans, MD, FAAFP Julia Pyle, MSN, RN / Julie Noah, MBA, MSN, RN / Jennifer Newton, MSN, RN Iowa Healthcare Collaborative (IHC)
1:00 – 1:30	A Critical Access Hospital's Journey to High Reliability	Carrie Coen Jeannie Eylar Alliant Health Solutions
1:30 – 2:00	Addressing Characteristics of a High Reliability Organization	Rebecca Boll, MSPH, CPHQ / Julia Harbuck-Valley, RN, BSN / Jennifer Anderson, CPHQ / Jim McCarville Island Peer Review organization (IPRO)
2:00 – 2:15	Break	

Agenda – Afternoon Session Continued

Time (EST)	Topic	Presenter
2:15 – 2:45	Learning from Community Organizing Approaches to Build High Reliability Organizations	Risa Hayes, CPC Telligen
2:45 – 3:15	Leveraging the Zero Harm Program to Promote High Reliability	Beth Morgan, MHA, BSN, RN, CNOR, CPHQ Nan Carter, MPH Health Services Advisory Group (HSAG)
3:15 – 3:30	Break	
3:30 – 4:00	HRO is a Journey, NOT a Destination: Lessons From an International Roundtable on Healthcare Resilience During the Pandemic	Bruce Spurlock, MD Convergence Health Consulting
4:00 – 4:30	Q&A/Open Discussion and Event Wrap Up	CMS

Spreading Bundle Tools and Resources on High Reliability Culture

Iowa Healthcare Collaborative (IHC)

Compass Hospital Quality Improvement Contractor

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Featured Speakers

Tom Evans, MD, FAAFP
President and CEO
Iowa Healthcare Collaborative

Julie Noah, MBA, MSN, RN
Director of Inpatient Services
Clay County Medical Center

Julia M. Pyle, MSN, RN
Quality Improvement Advisor
Kansas Healthcare Collaborative

Jennifer Newton, MSN, RN
Chief Nursing Officer
Neosho Memorial Regional Medical Center

Iowa Healthcare Collaborative Compass
Hospital Quality Improvement Contractor (HQIC)
High Reliability Organization (HRO) Wins

Applying High Reliability Organization Concepts in Critical Access Hospitals

Iowa Healthcare Collaborative

Compass HQIC

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Thank You!

Tom Evans, MD, FAAFP
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Iowa Healthcare Collaborative

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A Critical Access Hospital's Journey to High Reliability

Alliant Health Solutions

December 7, 2023

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Meet Your Speakers

Carrie Coen, DPT
Chief Reliability Officer
HIPAA and Corporate Compliance Officer,
Pullman Regional Hospital

Jeannie Eylar, RN, MSN
Chief Clinical Officer
Patient Safety Officer
Pullman Regional Hospital

Our Journey

Pullman Regional Hospital and Clinics

Patient Safety, Continuous Improvement and Just Culture

2006 - Patient Safety Team

2011 - Commitment to Patient Safety Pullman Regional Hospital is committed to creating and sustaining a work environment where patient safety is consistently a top priority. This environment demonstrates a commitment to designing policies and processes to prevent errors, providing appropriate numbers of qualified staff, encourage event reporting, learning from errors, and commitment to continuous improvement.

2012- Just Culture Screening Tool developed

2013 – 2020 Adverse Events and Just Culture case reviews

CENTERED ON EXCELLENCE

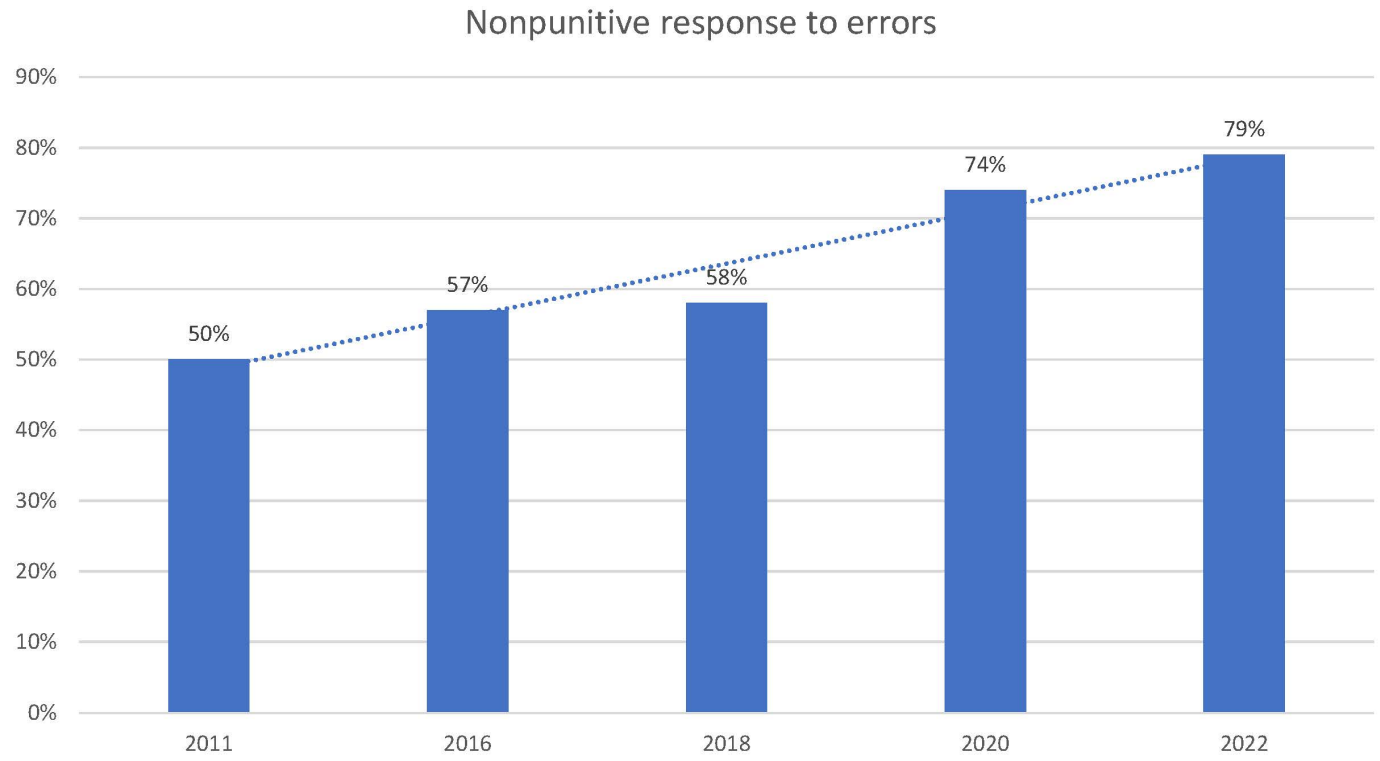
Just Culture Screening Tool

To error is human To drift is human Risk is everywhere

	Criteria	Human Error	At-Risk Choice Behavioral choice that increases risk where risk is not recognized or is believed to be justified			Reckless Choice Behavioral choice to consciously disregard a substantial and unjustifiable risk		Score
		0	1	2	3	4	5	
G	**General Practice**	No prior written counseling	Prior written counseling for single, non-related issue within last 12 months	Prior written counseling for single related issue within past 12 months	Prior written counseling for various issues within the last 12 months	Prior written counseling for same issue within last 12 months	Prior written counseling for same or related issue within last 6 months with minimal to no evidence of improvement	
U	**Understanding level of experience**	Has knowledge, skills, and ability. Incident was accidental, inadvertent or oversight	Limited understanding of correct procedure. May be novice <6 months experience or with current event/activity	Limited understanding of options/resources. Aware of correct procedure but in this instance cut corners. May be advanced beginner – 6 months to 2 years' experience or with current event/activity.	Aware of correct action / rationale but failed to apply in this incident. Did not obtain sufficient information or utilize resources before acting. May be competent > 2 years' experience or with current event / activity.	Conscious disregard to act / not act according to standards. Risk to client outweighed benefits. May be in a position to influence others.	Conscious disregard of substantial and unjustifiable risk	
I	**Internal policies or standards**	Unintentional breach or no policy / standard exists.	Policy/ standard has not been enforced as evidenced by cultural norm (common deviation of staff) or policy /standard / order was misinterpreted.	Policy / standard is clear but employee deviated in this instance as a time saver. Failed to identify potential risk for client. **No evidence of pattern.**	Aware of policy / standard / order but ignored or disregarded to achieve perceived expectations of Management, client, or others. Failed to utilize resources appropriately, **May indicate a pattern**	Intentionally disregarded policy / standard	Conscious disregard of substantial and unjustifiable risk	
D	**Decision / choice**	inadvertent error.	Emergent situation - quick response required	Non-emergent situation. Chose to act / not act because perceived advantage to client outweighed the risk	Emergent or non-emergent situation, Chose to act / not to act without weighing options or utilizing resources, Used poor judgment	Clearly a prudent person would not have taken same action. Unacceptable risk to client / agency / public. Intentional disregard for client safety.	Willful/ egregious/ flagrant choice. Put own interest above that of client /agency / public. Intentional disregard of substantial and unjustifiable risk.	
E	**Ethics / credibility / accountability**	Identified own error and self-reported. Honest and remorseful	Readily admitted to error and accepted responsibility when questioned. Identified opportunities and plan for improvement in own practice.	Reluctantly admitted to error but attributed to circumstances to justify action / inaction, Cooperative during investigation and demonstrated acceptance of performance Improvement plan.	Denied responsibility until confronted with evidence, Blamed others or made excuses for action / inaction. Failed to see significance of error, Reluctantly accepted responsibility and denied need for corrective action.	Denied responsibility despite evidence. Indifferent to situation. Uncooperative, insubordinate and/or dishonest during investigation.	Took active steps to conceal error or failed to disclose known error. Provided misleading information during investigation or destroyed evidence.	Total

Patient Safety, Continuous Improvement and Just Culture

When staff make errors, this unit focuses on learning rather than blaming individuals.



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Patient Safety, Continuous Improvement and High Reliability

- **2015 to 2019**: Exploring new ways to look at our Quality Management System
- **2019**: Introduced to High Reliability and Risks
- **2020**: Adopted the Collaborative Just Culture™ Framework
- **2020**: Developed the High Reliability Team
- Initial High Reliability Training
- Executive Triad Team learning
- **2021** Quality Improvement Committee & Patient Safety developed a Commitment to Reliability
- **2022** Hired a Chief Reliability Officer

Commitment to Reliability

In order to strengthen our capacity to fulfill our Mission, realize our Vision, embrace our Values, and sustain our Culture, we are committed to achieve and maintain DNV (Det Norske Veritas) certification as a high reliability organization, *which aligns and integrates our systems of Safety, Clinical Practice, Quality and Risk Management, Human Resources, Finance, and Operational Performance Improvement.* Ensuring our success in meeting this commitment will require us to apply the following principles:

- Seeing and understanding risk
- Managing systems reliability to become effective and resilient.
- Strengthening staff reliability, both human performance and behavior.
- Instituting organizational reliability to achieve sustainment and become predictive.

Today - Collaborative Just Culture™

System Reliability

- See and Understand the risks
- Assess the system
  - Effective?
  - Resilient?

Human Performance

- Knowledge (Facts, theory)
- Skills (Task Proficiency)
- Ability (Application in the work setting)

Human Behavior

- Human Error
- At-Risk Choice
- Reckless Choice

Building The Program

- Creating the Team and Key Learnings

Reliability Activities

2022 Activities

- Reliability Management Team Evolved
- In person training for RMT team, Leadership, board, & medical staff
- RMT training and practice twice/month
- Received outside role qualification for the RMT
- Executive Team focused weekly on Collaborative Just Culture™ (Triad Review)
- Aligned the QMS with the Reliability

Building our Program

- We melded our vision of Collaborative High Reliability Program and integrated it with DNV's ISO standards and certification
- Received Board of Commissioner approval in 2021 through the Quality Management System Committee for establishment of a Collaborative High Reliability Program
- DNV Beta Survey in February 2022 for Collaborative High Reliability/RMT

Key Learnings

Struggles along the way ……. what we didn't know!

- Alignment of policies to integrate across the organization
  - HR policies and Employee Handbook
  - Code of Conduct
  - Compliance
  - Quality Management
  - Risk / Safety plans
  - Performance Improvement
  - Labor Union contracts – invited to participate
- Wording/definitions/concepts have to be the same throughout
- Realized how much we didn't have in place

Created guide/gap analysis assessments of DNV Collaborative Just Culture™ Program and Reliability Management Team Standards

Hierarchy of Taxonomy Terms	• **Activity** – actions that are usually not documented (e.g., practices); • **Process** – a documented set of activities (e.g., procedures, checklists, methods, etc.); • **Program** – a documented alignment of related processes and/or other components; • **System** – a documented alignment of programs, processes, and/or other components; • **Integrated System** – a documented coordination of aligned systems, programs, policies, pr components.

Term	Feature			
	Undocumented	Documented	Aligned	Integrated
Activity	✓			
Process		✓		
Program		✓	✓	
System		✓	✓	
Integrated System		✓	✓	✓

Table 1

Consistent with the CHR hierarchy of terms above, at a minimum, a CHR organization documents, aligns and integrates the following departments and/or functions:

- Operations
- Quality
- Safety
- Risk
- Human Resources
- Finance
- Performance Improvement
- Accreditation
- Compliance

Standards	Actions - Plans
CJC.1 QR.1 Executive Leadership and Governing Body responsibilities	Responsible for **documenting their commitment** to Collaborative Just Culture Program • Thru written policy, statement of commitment, strategic plan that allocates support to CJCP QR.1b – establish a CJCP policy QR.1c – aligns with other organizational polices, processes, programs and systems QR.1d – training to proficiency those necessary for program Administration QR.1e – Monitoring and measuring reliability
CJC.2 – Labor Association Involvement	QR.1 – labor associations and their leaders shall be invited to participate in program development and operation. • If labor association declines participation, we shall encourage labor input and involvement on regular recurring basis (e.g., labor leadership changes, contract and MOUs renegotiated) • *CJCP description in employment contracts and/or MOU would satisfy the requirement. Or involved in Triad reviews and documented.*

Key Learnings - We Changed How We Look at RISK

System Reliability

- Does the organization see and understand the risks?
- Assess the system
  - Effective?
  - Resilient?

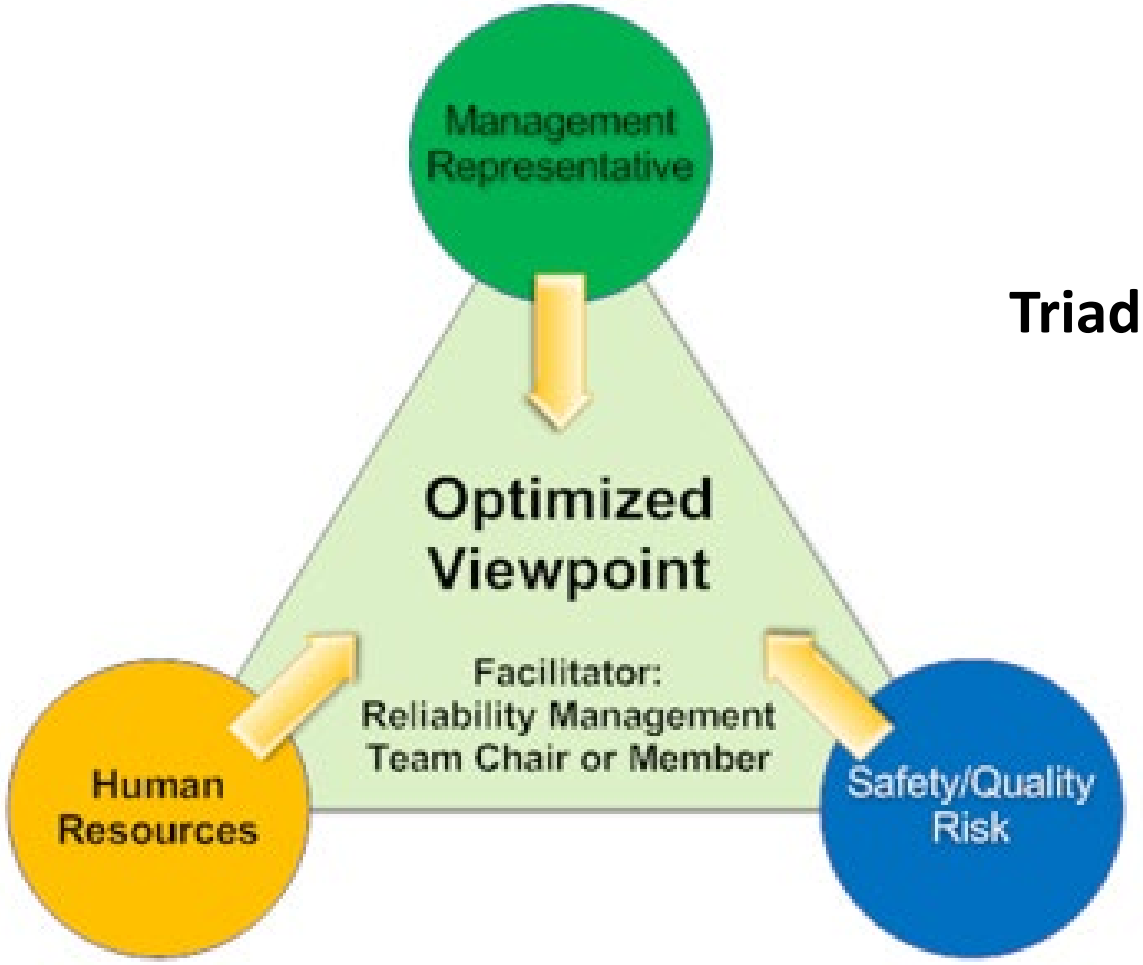
Human Performance

- Knowledge
- Skills
- Ability
- Performance IP, Coaching
- Remedial, not disciplinary

Human Behavior

- Human Error
  - Support/Educate
- At-Risk Choice
  - Support/Educate
  - If repeat offense, begin discipline
- Reckless Choice
  - May lead to termination

Key Learnings



Triad Review Process

Key Learnings

Confidential Risk Reporting: available to all employees

- Provides a continued means of risk identification
- Ensures risks are triaged, stratified, processed and responded to
- Helps determine the use of a Collaborative Risk Review to drill down on our systems and processes.
- Supports our daily huddles and use of Datix for event reporting
- Systematic approach to look at the risks first then the system

Our Final Journey

- After our Beta Survey – the real work began and continues
- December 13-15, 2022 – Remote DNV survey for CJCP and RMT Qualifications
- Corrective action plans were completed and sent off to DNV
- We received our qualifications certificate for Collaborative Just Culture Program and Reliability Management Team January 17, 2023
- Pullman Regional Hospital is the first Critical Access Hospital to receive this qualification by DNV!

Practical Applications

- Collaborative Risk Reviews
- High Reliability Improvement Projects

Collaborative and Preventive Risk Reviews

- Meetings with all stakeholders that take place within a very short time after an unexpected outcome
- Getting perspectives from ALL stakeholders is crucial

- We use a systematic approach
  - Looking at Risk and System Design
  - Human Performance
  - Human Behavior

Collaborative Risk Review Example

Pediatric Weight Near Miss

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Pediatric Weight Near Miss

- 5 yo patient came to the ED
- They were weighed on the ED stretcher
- They weighed 19 kilos
- NS was dosed based on this weight

Facts About The Case

- They were admitted to MSU
- They were weighed in MSU on a standing scale
- They weighed 27 kilos (A difference of nearly 20 lbs)
- The weight was rechecked on 3 different scales to verify that they actually weighed 27 kilos and not 19 kilos
- The NS being administered was adjusted for the heavier weight, no harm done

You would think this would be simple

Collaborative Fact Finding

The fact finding team composition

- ED nurse
- MSU Director
- Biomedical Equipment staff member
- Quality Director
- Chief Reliability Officer
- 1 additional member of the RMT

Collaborative Fact Finding

“You don’t want to hear about the work arounds”

That led us to discover:

- Policy confusion and discrepancy
- Stretchers weren’t in PM system
- Nursing didn’t know how to zero the stretchers
- New EMR was sending alerts, 2nd day of Go Live
- Some scales weren’t calibrated
- Options of KG and LBS on some scales

THIS WAS OUR SYSTEM!

System Fixes

- Clarify policies and align them across departments
- Staff education on zeroing beds, policies, double checks
- Calibrate scales and include stretchers in PM system
- Conversion charts available to help with double check for parent input from kilos to lbs
- Skills fair education focus
- Signs on all beds
- Finally - removing the scales that weigh in lbs

High Reliability Improvement Project Example – New Employee Onboarding

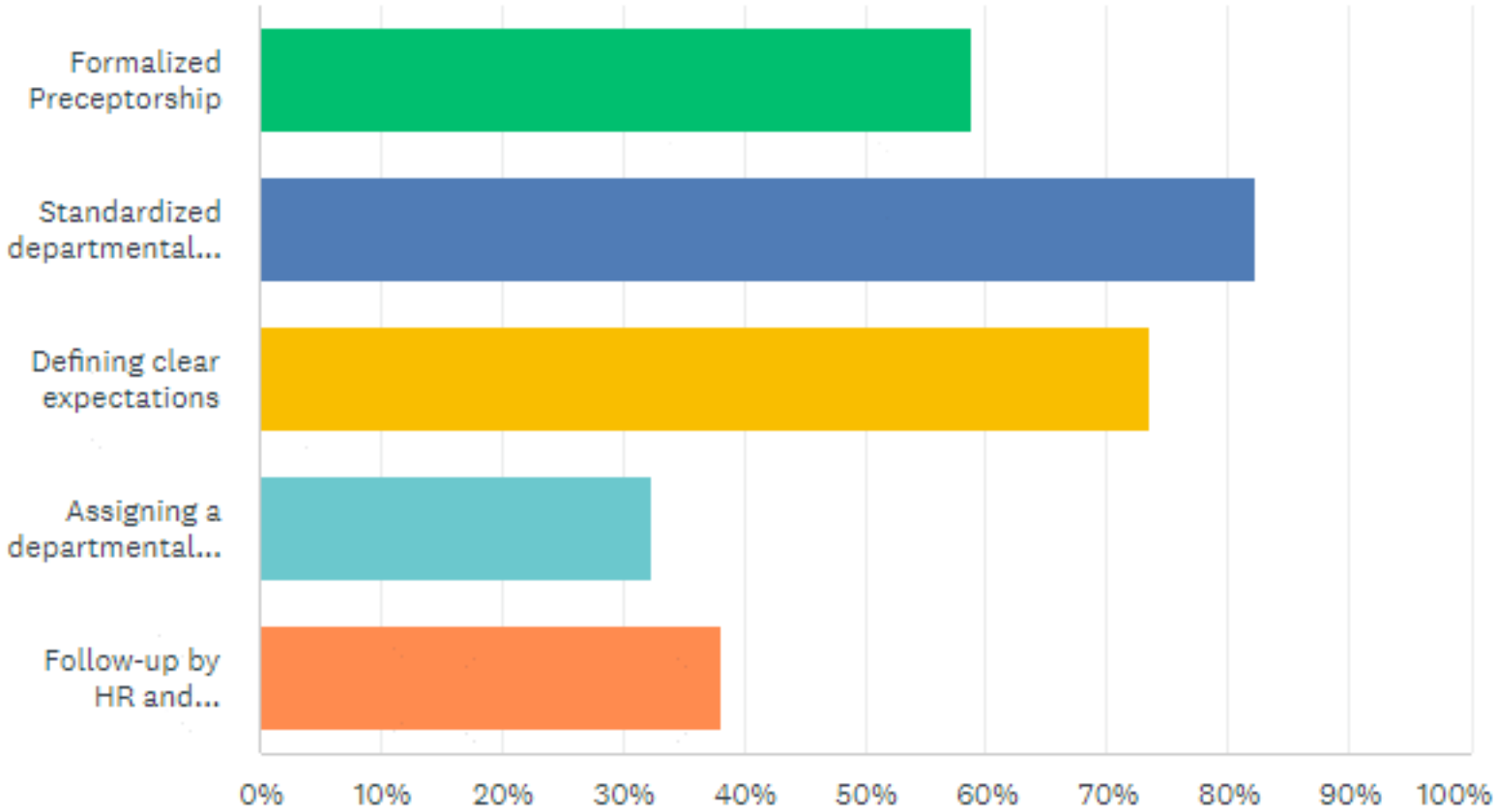
High Reliability Improvement Project Example

- All nursing units participated in identifying the highest risks to patients through a survey process
- Collaborative process
- 4 areas of choice based on patient safety events
- Medication, Infection Prevention, Care Transitions and Onboarding
- They chose new nurse onboarding and orientation

Q10

In the area of New Employee Onboarding, please select the top three categories that you feel have the most risk to patient safety.

Answered: 34 Skipped: 1



RN ORIENTATION CHECKLISTS

A. ORGANIZATIONAL ORIENTATION								
Method of Instruction Key: **M** = Manager Discussion **PP =** Protocol/Procedure/ Memorandum Review **E =** Education Session **S =** Self Learning (Online, Books etc.) **C =** Clinical Practice **D =** Demonstration/simulation **V T=** Validation Tool required	**Method of Evaluation Key: D = demonstration O = observed V = verbalized P = Post test**	**Self-Assessment by Employee**				**Validation of Competency**		
		Never Done	**Needs Review/**	**Competent**	**Method of Instruction**	**Date**	**Initials**	**Evaluation Method** (Use
New Employee Orientation					E			
Reliability / QI Introduction					E C			
Phones & Vocera					E D			
Hospital facility and access					E			
Parking					E			
Badges					E			
Code response					E C			
How to call for assistance (Security, Clinical Coordinator, Rapid Response, Codes)								
Employee Handbook					E			
Epic Access					E C			
Computers - Logging in, safe use					E			
Downtime procedures					E C			
Policy Stat					E D			
Datix reporting					E			
Care Learning Access								
Origami Entry								
WorkDay - Timecards					E D			

Benefit of Collaborative High Reliability Approach

- Gives a collaborative 360º risk perspective
- Gives staff a voice
- Engages staff in the process
- Connects staff to the work of the organizational metrics

Collaborative High Reliability™

By implementing reliable systems and adopting Collaborative Just Culture™, we create an environment that fosters patient safety

Thank You!

Carrie Coen, DPT
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Addressing Characteristics of a High Reliability Organization

Island Peer Review Organization (IPRO)

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Featured Speakers

Rebecca Boll, MSPH, CPHQ
Senior Director
Healthcare Quality Improvement Program
IPRO HQIC

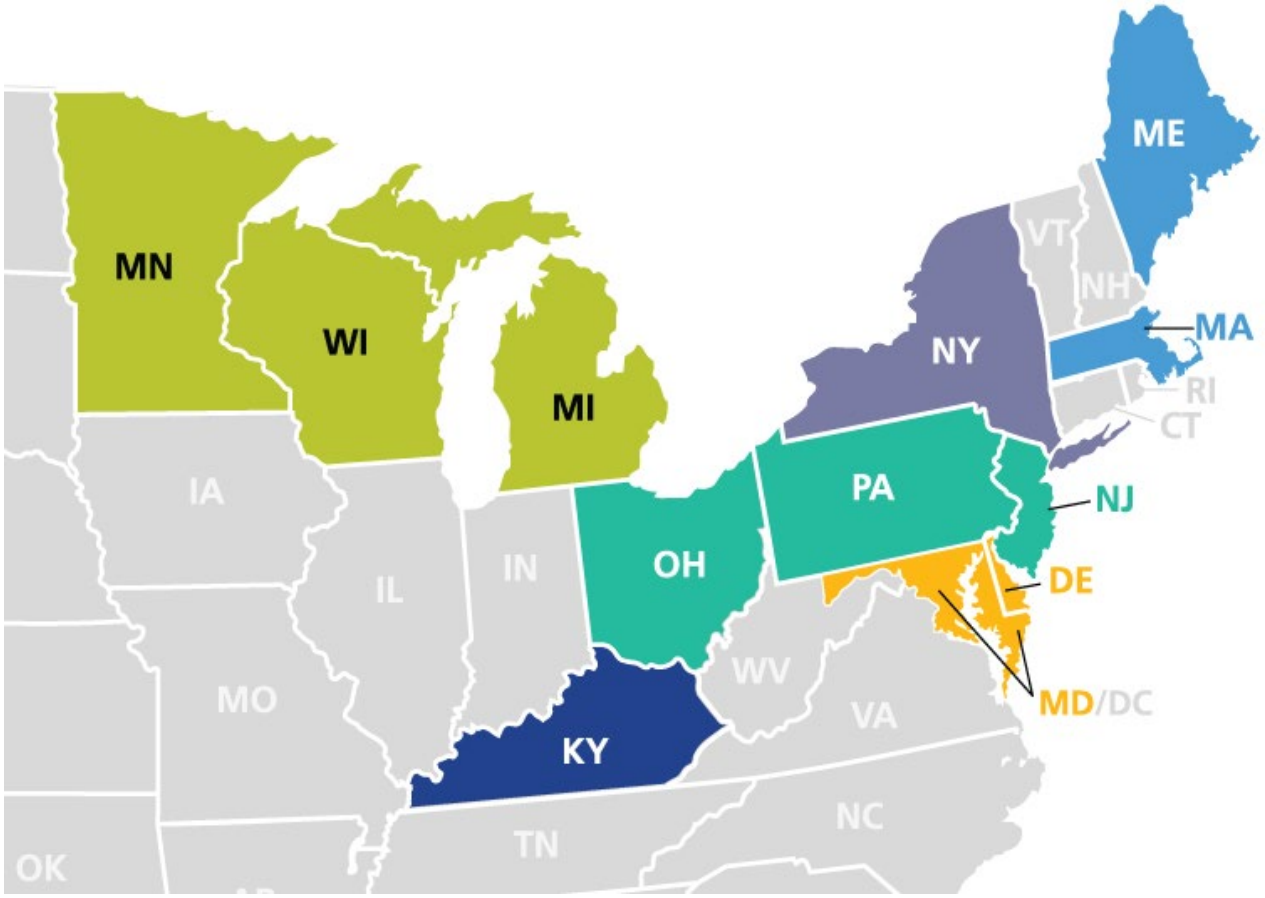
Julia Harbuck-Valley, RN, BSN
Quality Manager
Scheurer Health
Michigan

Jennifer Anderson, CPHQ
Lead Quality-Performance Improvement Specialist
University of Michigan Health - Sparrow
Michigan

Jim McCarville, BSIE, MBA, FHIMSS, LSSBB
Vice President Quality Operations
St. Elizabeth Healthcare
Kentucky

IPRO Hospital Quality Improvement Contractor (HQIC)

ENROLLMENT		
	Enrolled at 6 months post contract award	Enrolled at 36 months post contract award
Total # of hospitals the HQIC has enrolled	270	272
Total # of rural hospitals	97	94
Total # of Critical Access Hospitals (CAHs)	137	142
Total # of tribal hospitals	0	0
Total # of Targeted IPPS (not included in the categories above)	36	35
Total # of REH	N/A	1



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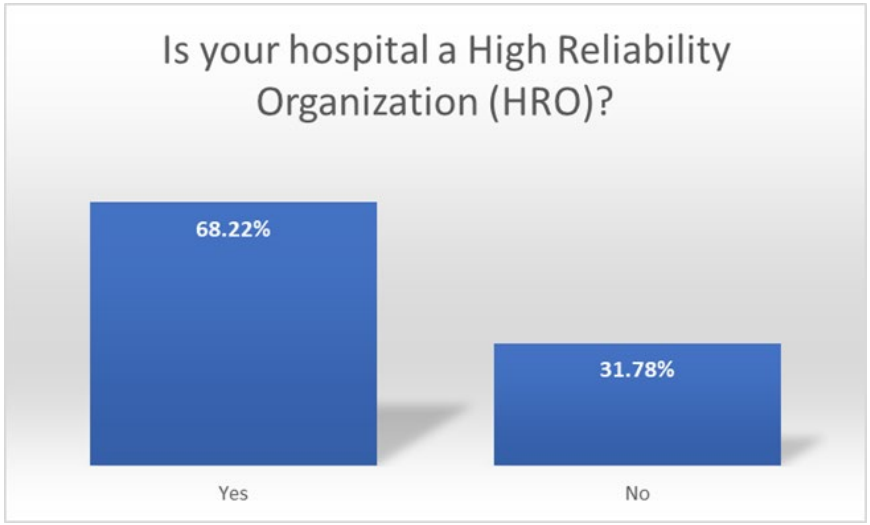
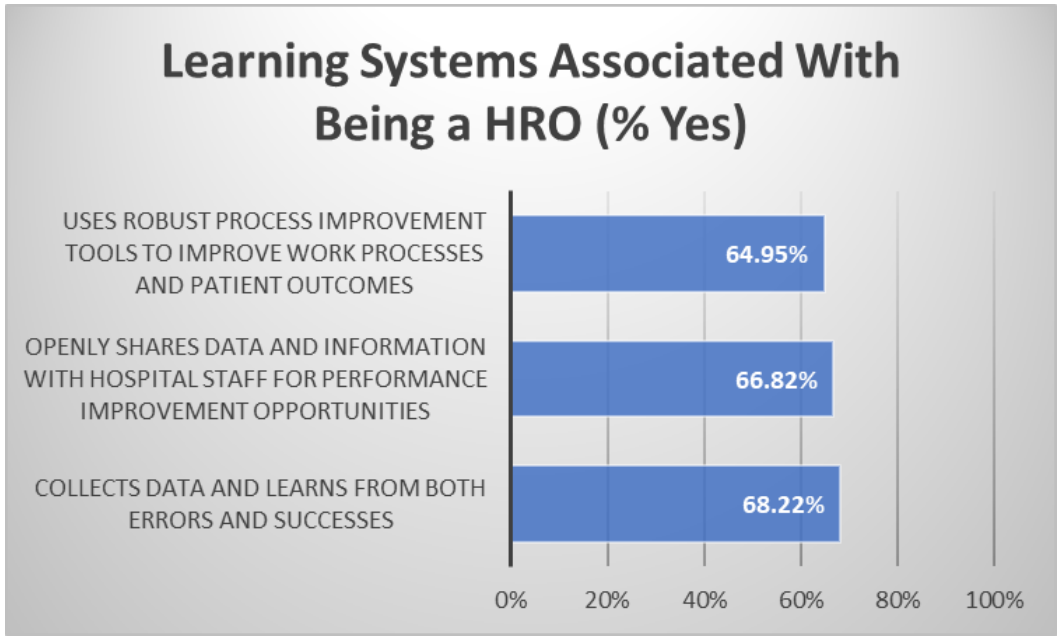
IPRO Environmental Scan on HROs - Results

- Multi-topic scan – workplace violence, PFE, infection prevention training, HRO
- Received 214 completed assessments (78.7%)
- 8 questions focused solely on HROs



58% of HROs wanted additional resources (85/146)

IPRO Environmental Scan on HROs - Results



Interactive Discussion: Panelists and Attendees

Please enter your questions or comments into Q&A

Panelist Question 1

One of the foundational characteristics of a high reliability organization is maintaining a culture where staff and patients feel equally safe.

Can you talk about how your organization has established and fostered a culture of safety?

Scheurer Health
Better Health. Better Life.

Culture of Safety

Julia Harbuck-Valley RN, BSN
Manager of Quality

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Scheurer Health
Better Health. Better Life

Reaching to be an HRO

Purpose

Leadership & Education

Data & Transparency

Improvement Activities

Reassessment

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Culture of Safety

- Education
  - Leadership
  - All Employees
  - Orientation
- Data & Transparency
  - Great Catch vs Occurrence
  - Dashboard
- Assessment of Culture
  - Employee Engagement Survey
  - Senior Leadership Survey (ORO)
  - SCORE Survey

Scheurer Health
Better Health. Better Life

Successful Tools

- The Joint Commission – Root Cause Analysis Questions Guidelines
- Failure Mode & Effects Analysis (ASQ)
- Event Timeline
- Process Improvement
- RCA Action Hierarchy

Scheurer Health
Better Health. Better Life

Process Improvement Plan						
Incident that occurred:						
Goal:						
Root Cause: --SELECT--		holders:	Date Implemented:	Comments:	F/U Date:	Outcome:

Root Cause:	Action:
--SELECT--	

--SELECT--
Communication
Environmental
Equipment/Supply/IT
Task/Process
Staff Performance
Team
Management/ Supervisory
Organizational/ Culture

RCA Action Hierachy

Action Strength	Action Category	Action
Stronger Actions (These tasks require less reliance on humans to remember to perform the task correctly)		
Intermediate Actions		
Weaker Actions (These tasks rely more on humans to remember to perform the task correctly)		

- Architectural/physical changes
- Engineering control/IT problem
- New devices with usability testing
- Simplify process
- Standardize on equipment or process
- Tangible involvement by leadership
- Other

Panelist Question 2

Another foundational characteristic of a high reliability organization is using robust process improvement tools and sharing data for performance improvement.

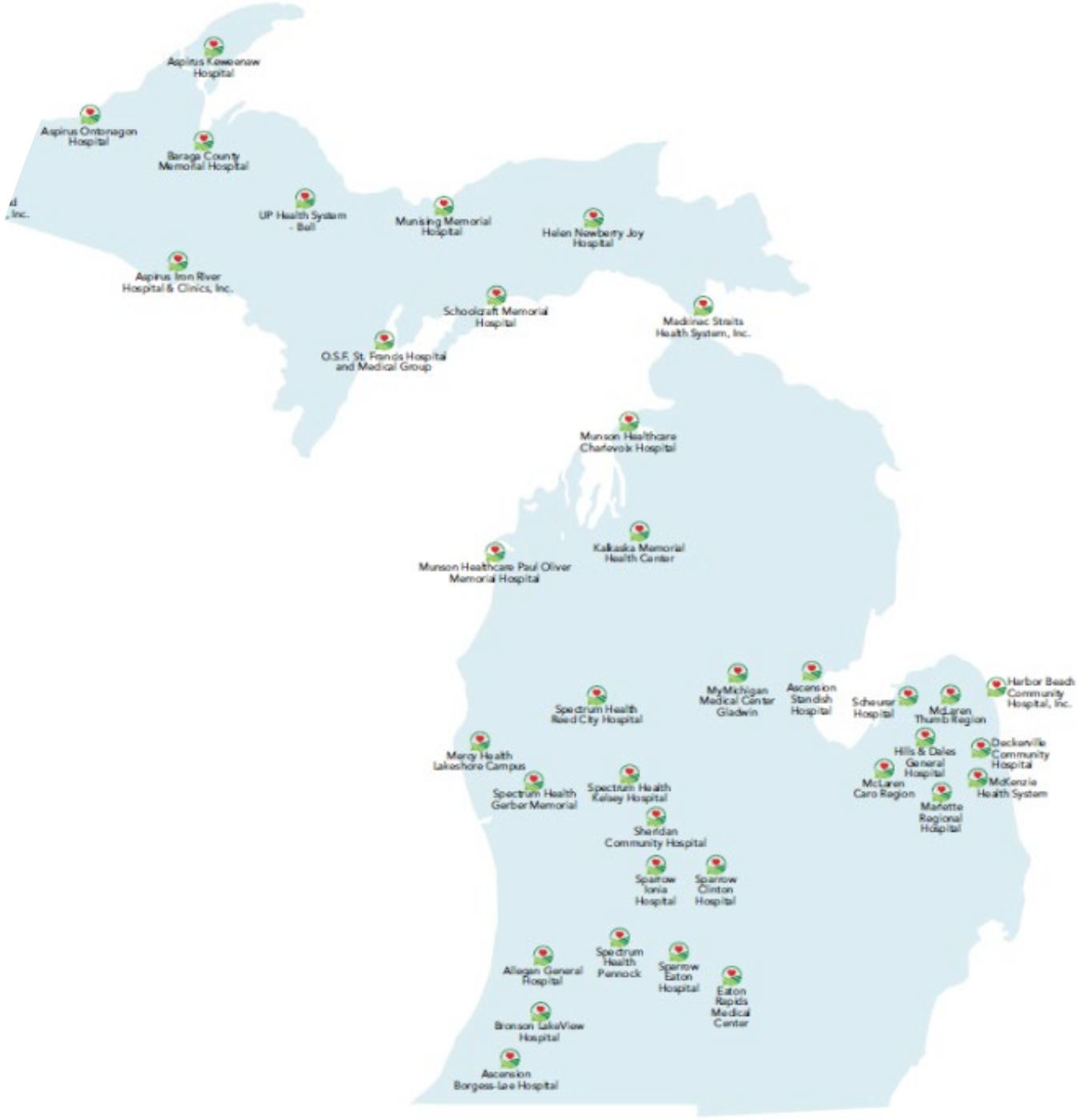
Can you talk about how your organization has used learning systems to support quality improvement and improve patient outcomes?

High Reliability Journey

Jennifer Anderson, CPHQ

Sparrow Health System

Community Hospital Lead Qualit
Performance Improvement Speci



Sparrow Ionia Hospital

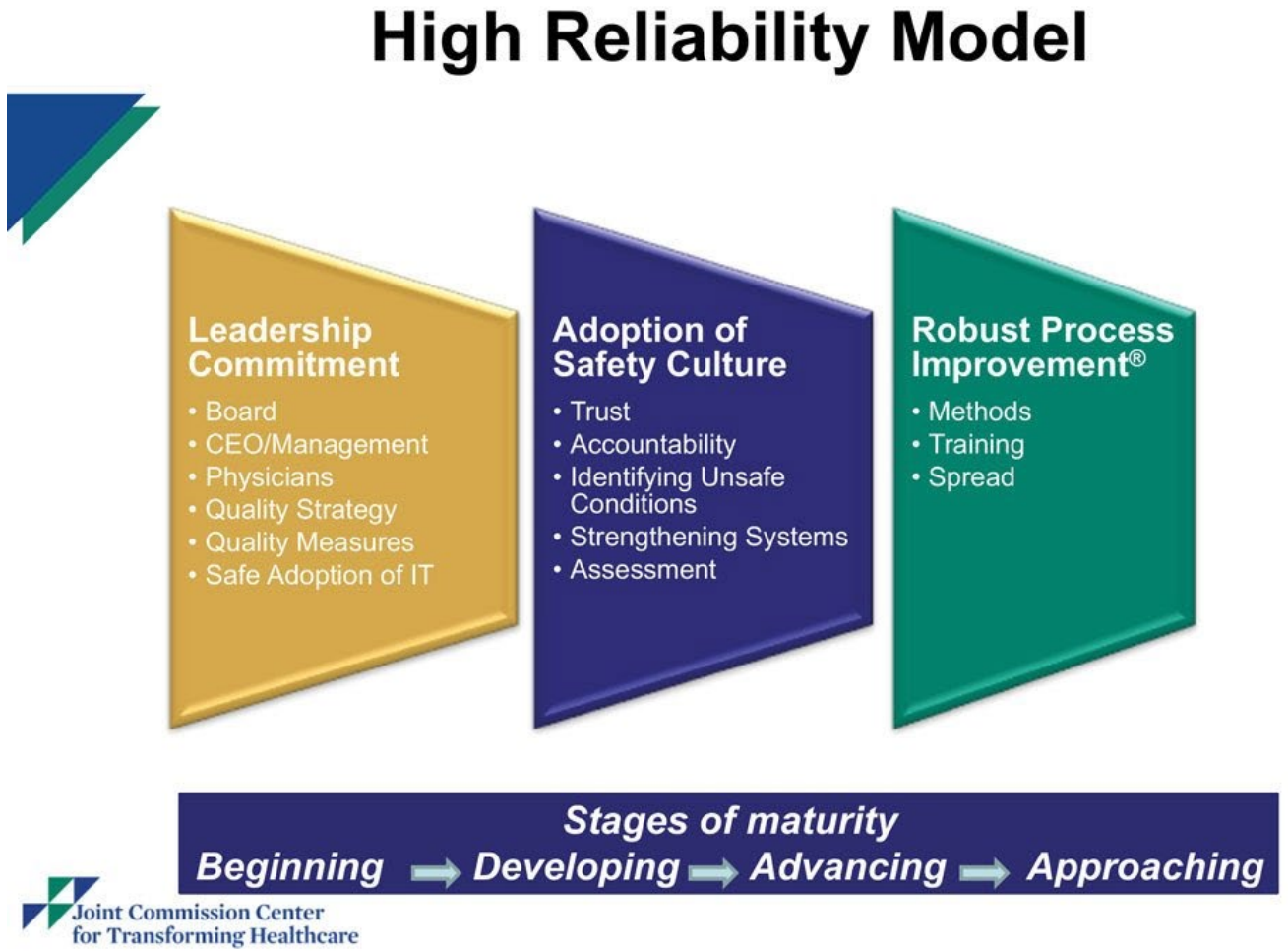
- 22 Licensed Inpatient Beds
- 24/7 Emergency Department
- Surgical Services – Orthopedics, General Surgery, Urology, Gynecology,
- Radiology, Lab, Infusion, Chemotherapy, Cardiology
- 3 Rural Health Clinics
- Rehabilitation / Physical Therapy
- Occupational Health services
- Oncology
- Sleep Studies

HRO Journey

- 2016 – Completed first ORO Assessment
- Board of Directors, Physician Leaders and Hospital Executives complete the assessment.
- Consensus meetings were held
- Action Plans developed to align with the Board of Directors strategies

Insights:

- Turnover in positions have resulted in variation on responses over time.
- Board of Directors / Executive Leadership has continued strong support for the journey.



Adoption of a Safety Culture

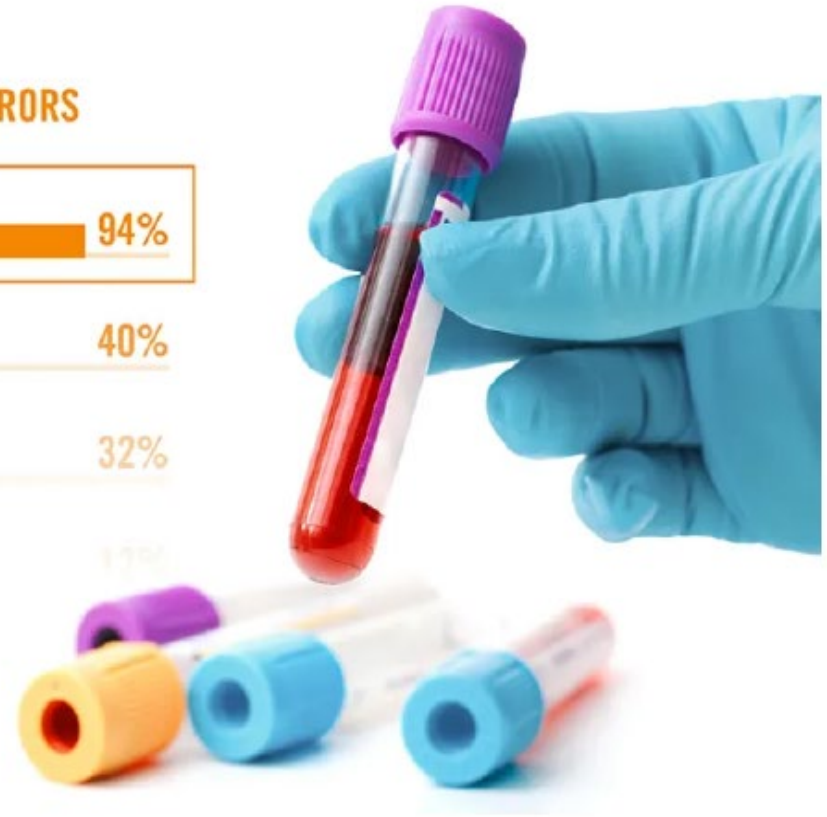
COVID pandemic impacting patient care:

- Isolation precautions
- Increase in the number of patients
- Decrease in staff
- Supply chain issues with products

Incident Reporting

- In 2021, a noticeable increase in identification/specimen labeling errors occurred.

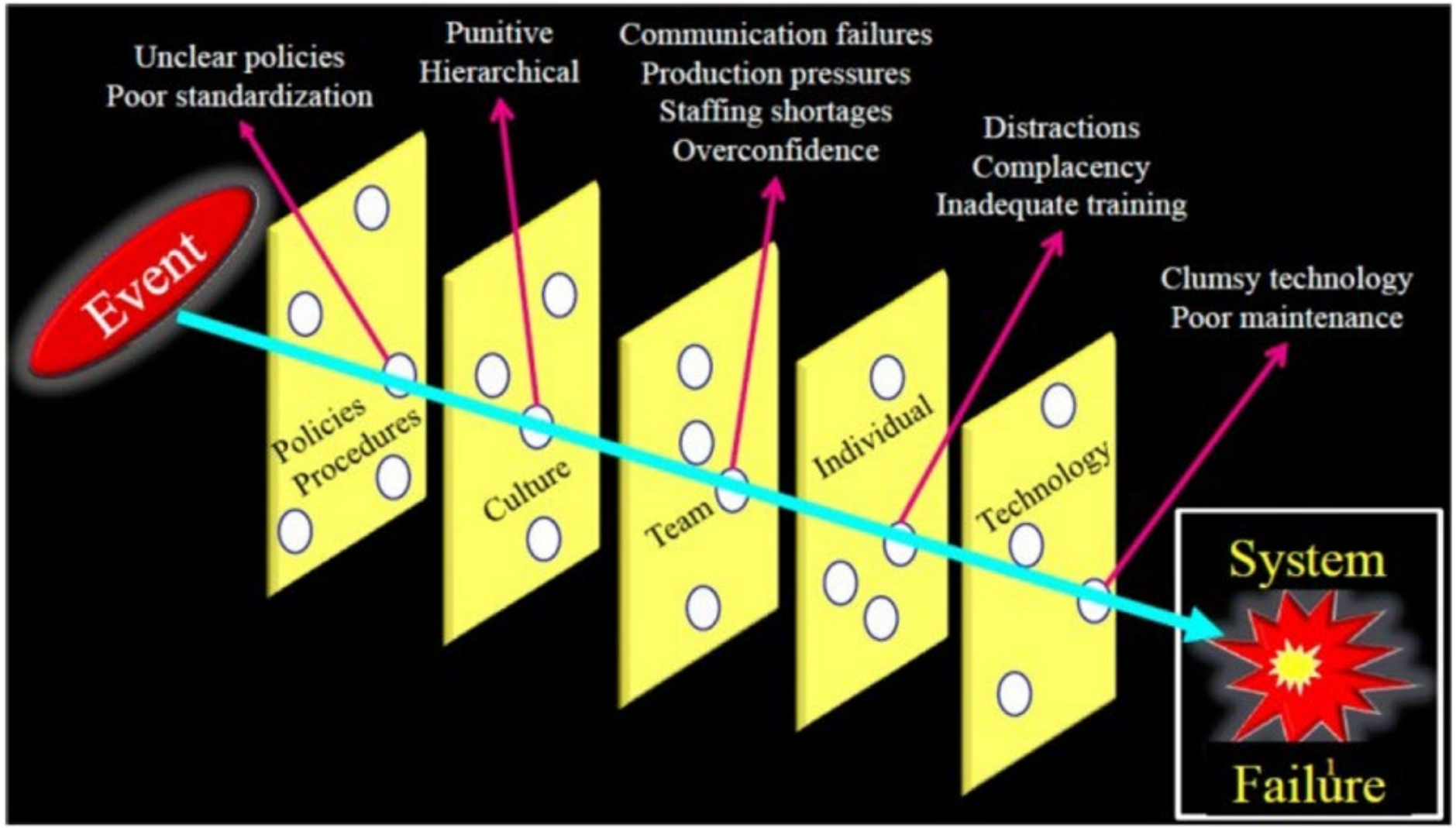
- What really is the root cause of the errors?

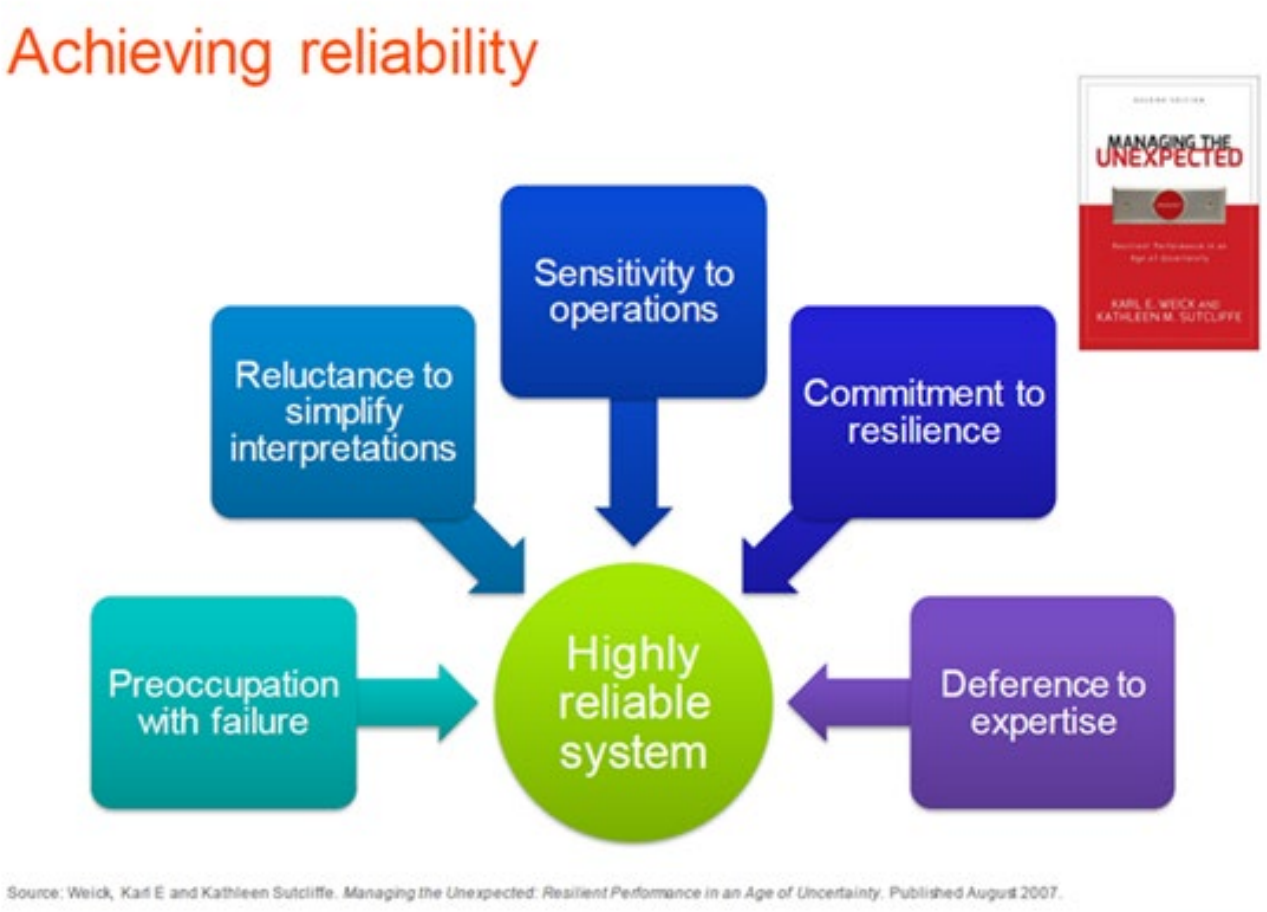


Dr. W. Edwards Deming

94 percent of variations observed in workers' performance levels have nothing to do with the workers. Instead, most of the performance variations are caused by the system, of which those people are but a part.

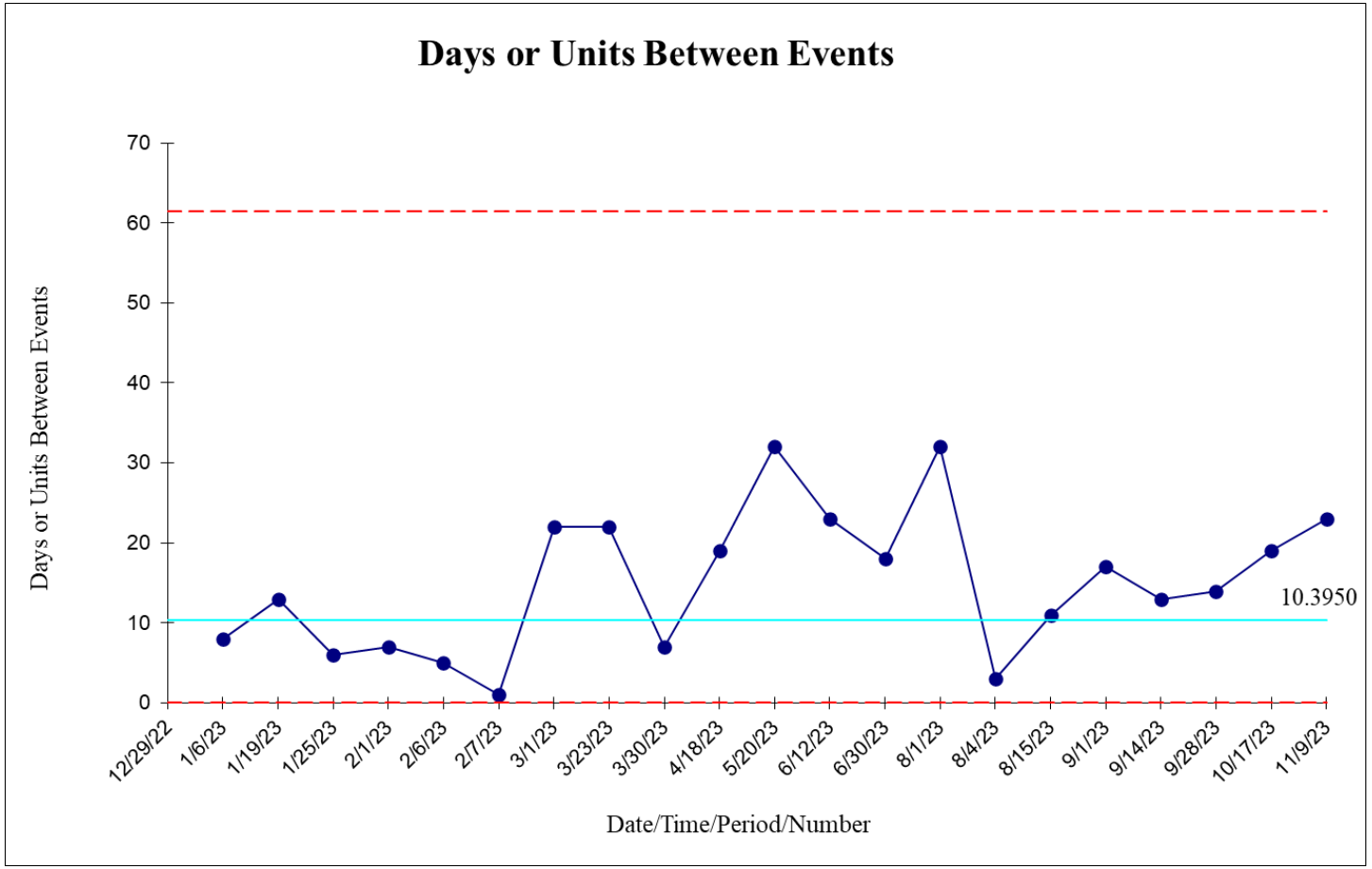
Specimen Labeling





- **Preoccupation with Failure**: any near miss / failure was to be reported in our incident reporting system
- **Deference to expertise**: reviewed current process with frontline caregivers. Identified process issues to supply gathering and patient labels.
- **Sensitive to Operations**: staffing challenges have nurses, phlebotomists, medical assistants, and sometimes med techs collecting specimens. Improved hand-off communication of specimens.
- **Commitment to resilience**: lab was empowered to stop the line when there were questions about specimens received for processing. Leadership was notified in real-time to determine next steps. Just Culture was reinforced.
- **Reluctance to simplify** double checks were put in place to ensure accuracy of specimen labeling
- **Daily Safety Call**: any near misses / failures are reported daily, monitoring last error.

Results


Days or Units Between Events
Days or Units Between Events
70
60
50
40
30
20
10
0
10.3950
12/29/22
1/6/23
1/19/23
1/25/23
2/1/23
2/6/23
2/7/23
3/1/23
3/23/23
3/30/23
4/18/23
5/20/23
6/12/23
6/30/23
8/1/23
8/4/23
8/15/23
9/1/23
9/14/23
9/28/23
10/17/23
11/9/23
Date/Time/Period/Number

Panelist Question 3

We understand that it is a journey to become a high reliability organization and navigating the process and obtaining buy-in from all levels can be difficult.

What key milestones did you use to build support and what are lessons learned for other organizations who may be either beginning the journey or are doubtful of achieving this goal?

Lessons Learned

Jim McCarville, BSIE, MBA, FHIMSS, LSSBB

VP Quality Operations

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Hospital Quality Improvement Contractors
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Overview

More than 10,000 associates and a Medical Staff of nearly 1,600 physicians and advanced practice providers in Northern KY and SE Indiana.

5 Hospitals

- Edgewood
- Florence
- Ft Thomas
- Dearborn (IN)
- Grant (CAH)

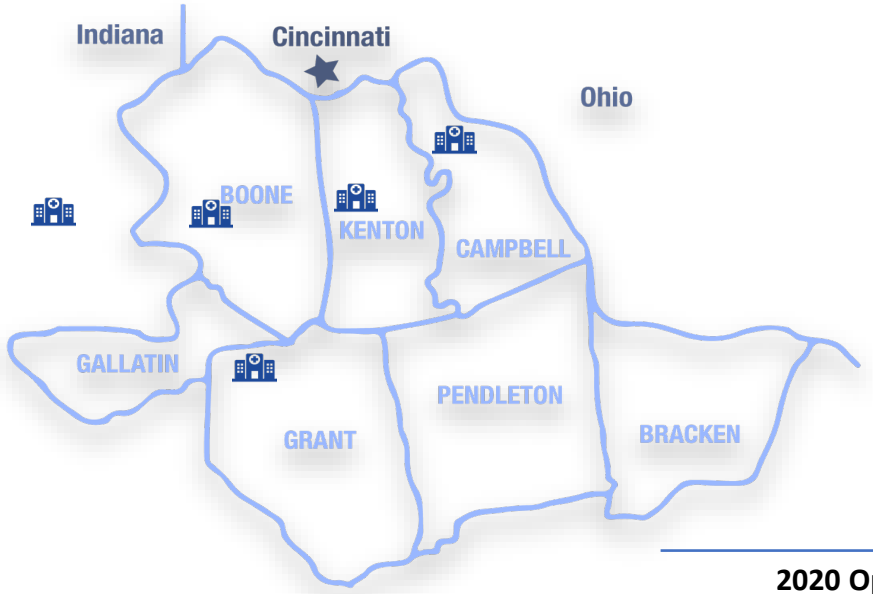
Ambulatory Care Center

Hospice Center

3 Imaging Centers

St. Elizabeth Physicians

- 460 Physicians
- 245 Advanced Practitioners
- 1500 non-provider associates
- 172 offices in Kentucky, Ohio, and Indiana



2020 Operating Statistics	
Licensed Beds	1,191
Inpatient Discharges	42,459
Births	4,157
Outpatient Registrations	917,953
ED Registrations	220,000

Creating our Journey to High Reliability

- May 2017 – Held Senior Leader Retreat
- Dec 2017 – Completed 1 day training for all leaders on Lean concepts,
- Feb 2018 – Kickoff “Journey to Excellence” HRO pathway, established JTE leadership practices, reintroduced senior leader rounding
- May 2018 -contracted with coaches to support leader’s transition
- Jan 2019 – Formal Director 1:1 mtgs, internal customer rounding, JTE leader expectations adopted in job descriptions
- Feb 2020 – COVID
- Jul 2020 – re-establish JTE practices, incorporate JTE into strategic plan

Creating our Journey to High Reliability

- May 2021 – added leader training on A3 standard problem solving
- Mar 2022 – initiated Tiered Huddles
- Oct 2022 – Standard work documents added to automated policystat system, Begin leader education on Just Culture
- Nov 2022 – Just Culture education, JTE leader practices RECAP, Accountability tips
- Feb 2023 – Inclusion of Physician Practices into JTE
- July 2023 – Achieved CMS 5 star rating, Over 350 leaders certified as “Quality Leader”

Creating our Journey to High Reliability

Key lessons learned

- Have a leader knowledgeable in HRO or get outside help
- Start education with leaders, avoid training everyone
- Establish leadership practices as mandatory and monitor (e.g. std work)
- Name your journey and adapt HRO principles to highest level possible
- Get model of 1 area working if needed to convince others to follow

Thank You!

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Jim McCarville, BSIE, MBA, FHIMSS, LSSBB
Vice President Quality Operations
St. Elizabeth Healthcare
Kentucky
Jim.McCarville@stelizabeth.com

Island Peer Review Organization (IPRO)

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15-Minute Break

Learning from Community Organizing Approaches to Build High Reliability Organizations

Telligen

December 7, 2023

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Meet Your Speaker

Risa Hayes, CPC

Program Specialist
Patient Family Engagement & Community Organizing Lead
Telligen QIN-QIO

Objectives

- Reflect on how the leadership practices used in community organizing foster strong commitment, build effective teams, and mobilize people to action.
- Compare the similarities between community organizing and high reliability organizations.
- Explore and identify practices and tools you can use to create a culture of safety and transformational leadership in order build and/or strengthen a high reliability organization.

What can we possibly learn from community organizing?

What is Community Organizing?

- A leadership practice and framework for building capacity to achieve goals.
- These practices enable a group of people to be transformed into a constituency that is mobilized towards a common goal and equipped to take action.

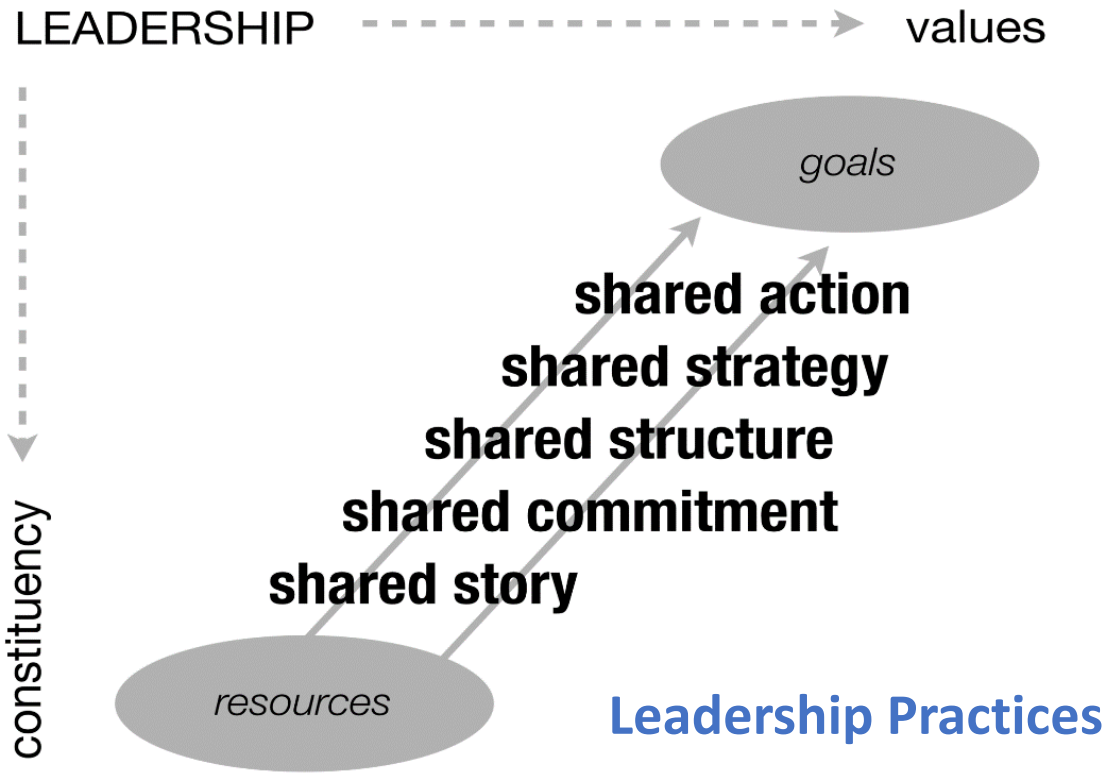
HROs are organizations that achieve safety, quality, and efficiency goals

Pillars of High Reliability Organizations

- Leadership commitment
- Culture of safety
- Process improvement

Community Organizing: Leadership Commitment & Practices

Leadership is accepting responsibility for enabling others to achieve shared purpose in the face of uncertainty.



The Impetus of Organizing

People

Power

Change

- Reed (2008) suggests that society fosters the privatization of pain.
- **Isolation prevents people from understanding shared self-interest with others** – it keeps our problems private and personal.
- The problems that people regularly face (physical/mental health, crime, unemployment, job dissatisfaction, death, community deterioration) are part of the human experience, yet typically experienced as private pain.
- As long as pain is privatized and kept personal, people are isolated in our experiences of hardship.
- **We are also isolated in our attempts to make change**, ***and that isolation prevents us from operating with power.***

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POWER

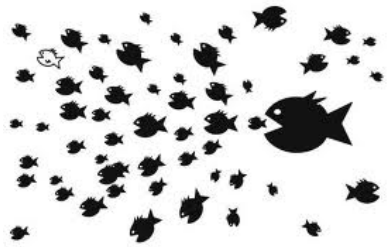
The ability to **achieve purpose**
The ability to **grow in capacity**

PEOPLE
Recruiting & developing leadership at all levels

POWER
Building a community through leadership to create *power*

CHANGE
Using this power to address challenges

… people acting together to change the status quo



POWER WITH

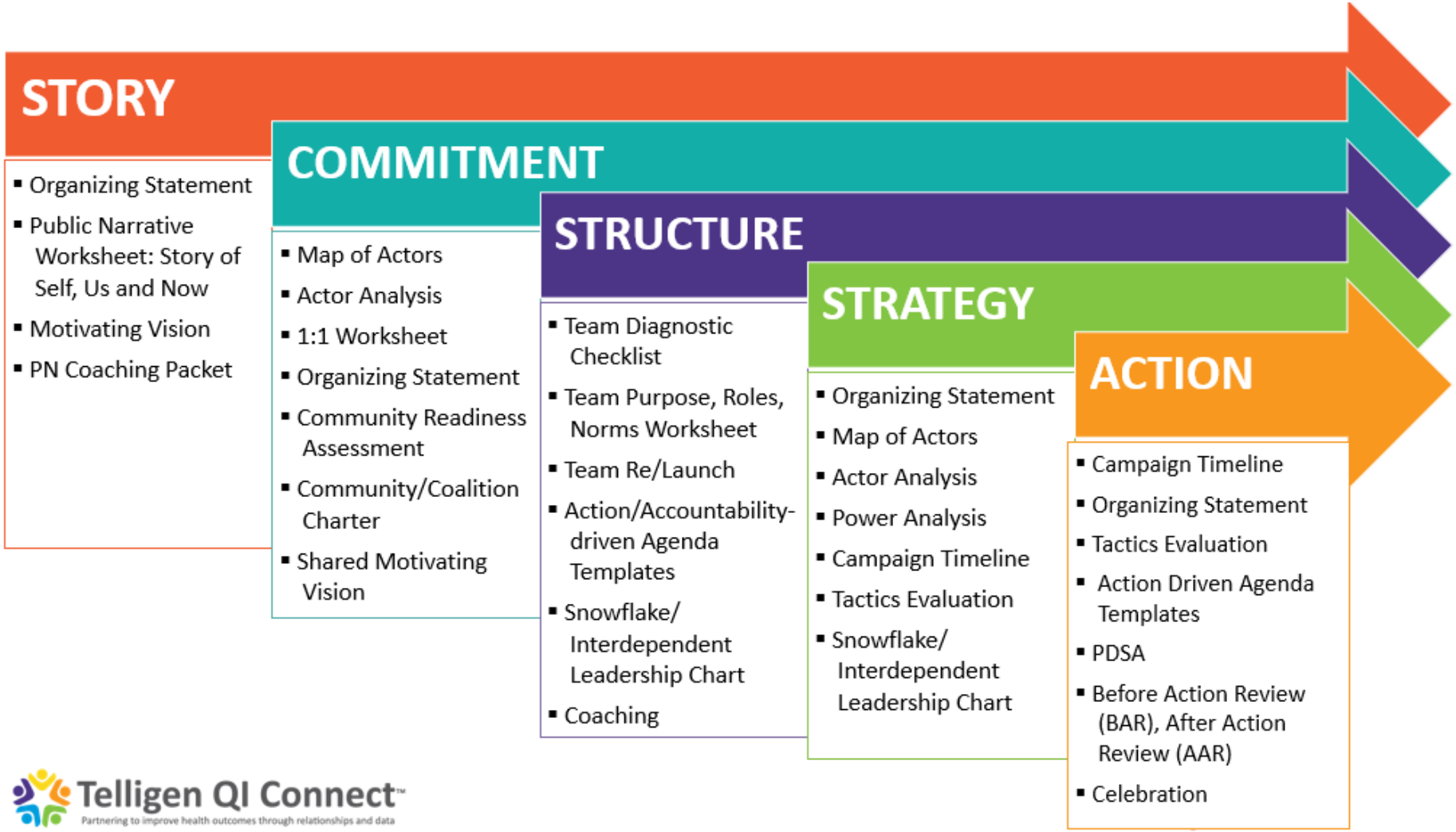
Safety Culture
DEI
Innovation
Commitment
Resilience

POWER OVER

Low trust
Culture of Fear
Stagnation
Inequity
Disengagement

LEAD! Leadership & Organizing in Action (LEAD! LOA) Toolbox

LEAD!LOA
LEADERSHIP & ORGANIZING IN ACTION



Telligen QI Connect™
Partnering to improve health outcomes through relationships and data

Shared Story: The 3 Stories Every Leader Must Tell

- **Story of Self**: Understand and articulate why the work matters to you – why you *care*
- **Story of Us**: The collective experience of our community – shared hardship, shared values, shared interests
- **Story of Now**: The nightmare/s that require us to act, the vision of the future we can create together, and the specific call to action.

If **you** don't tell your story, **someone else will** . . .

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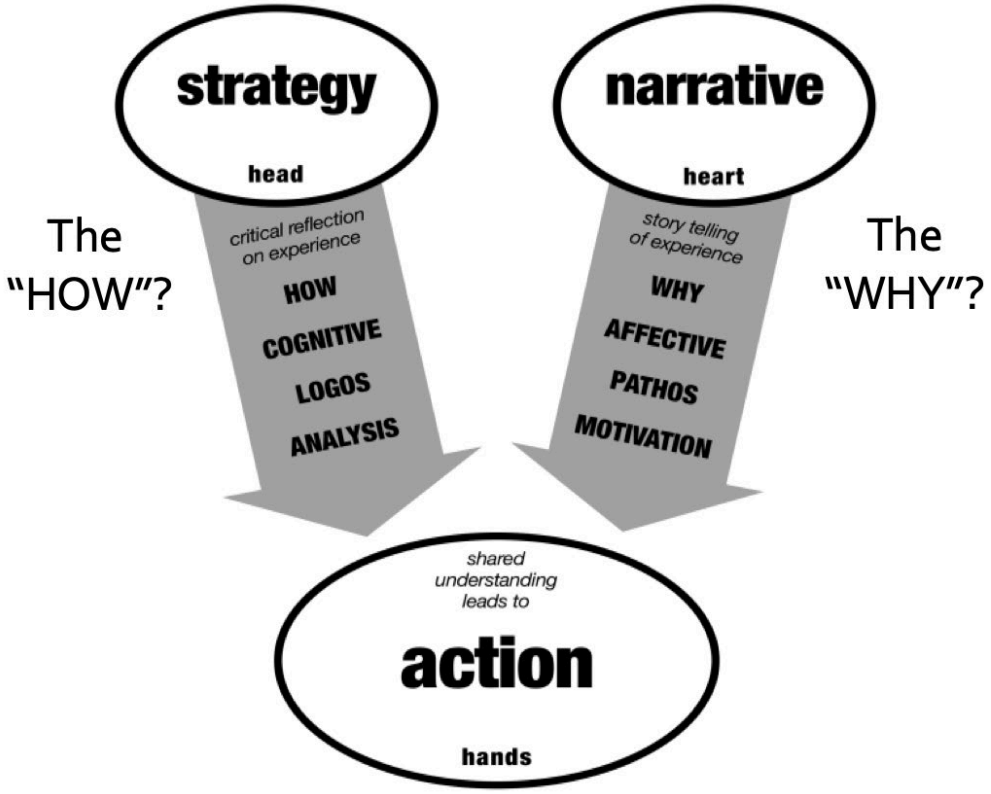
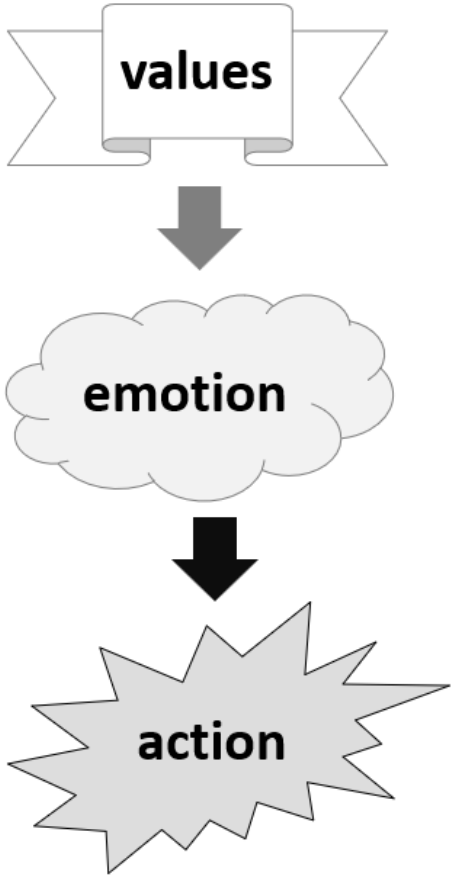
Shared Story: The Art & Skill of Public Narrative

Why is Story Important?



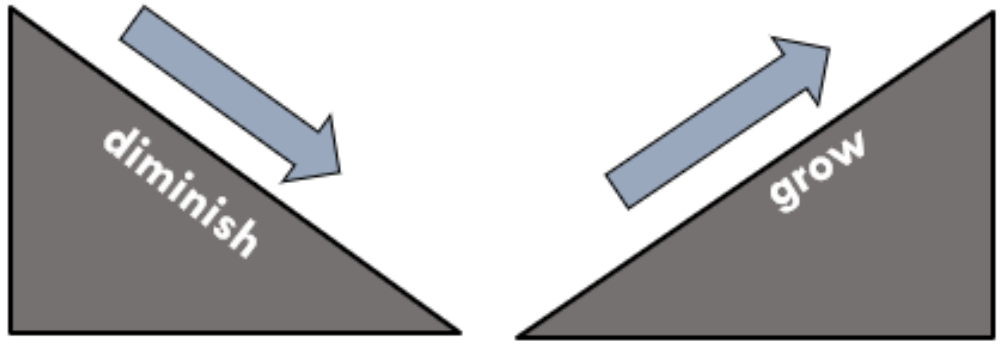
...you need both to inspire effective action.



Shared Commitment: Mapping Actors, Resources & Assets

- **Community**:
  - who is impacted? who is harmed? who benefits?
  - who wants the change?
  - who has resources? who can take/is taking action?
- **Leadership:** who do you want to help you lead?
- **Support:** may have resources or influence, outside of your direct community.
- **Competition:** wants what you want, but is competing for resources
- **Opposition:** opposes your goal and competes for resources

A Closer Look at How We Think About Resources & Assets

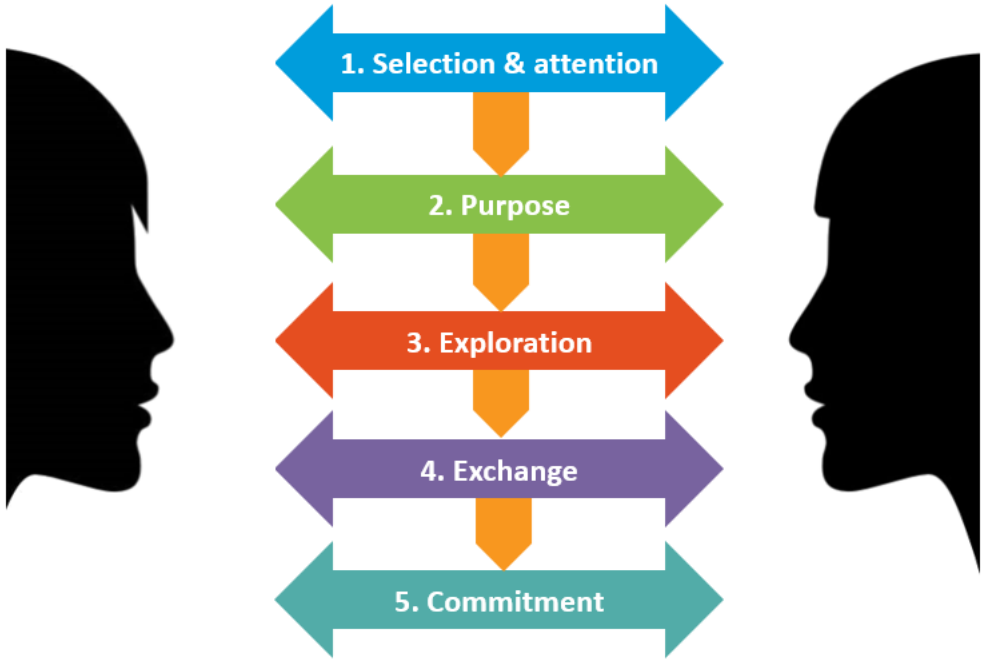


Economic resources
diminish with use
- money
- materials
- technology

Natural resources
grow with use
- relationships
- commitment
- discretionary effort

Based on principles from Albert Hirschman, *Against Parsimony*

Shared Commitment: Efficient, Comprehensive & Relational Meetings



The One-to-One Meeting

1:1 "Step/Component"	Agenda Topic	Clarification/Planning Tip

1. Selection & attention	**Why are we here?**
	
	I/we wanted to meet with you to explore ….
		▪ Be explicit about why these attendees were invited
		▪ What is it about them, in particular?
		  ○ Why it's important for them/to them
		  ○ Not what you want/need from them
		▪ What you think you might connect with them about

2. Purpose	**Purpose for this Meeting:** What we'd like to explore	▪ Make sure the "purpose" is not the same as 'the ASK" – you need to explore first before you know what and IF you'll ask
3. Explore	**Topics to Explore/Questions to Ask**	▪ Share your Story (of self of Full Public Narrative) ▪ Let them see you care, what motivates you – they can identify with you ▪ Invite them to share why they care, what motivates them ▪ Ask them what their vision/dream is (Appreciative Inquiry is great here) ▪ Begin exploring ideas they have for how to improve/change, and what actions we can each take
4. Exchange	**Ideas for Action We Can Take**	▪ Begin to talk about what resources you each bring to the effort ▪ What roles are needed and who can fill them ▪ Who else needs to be involved
5. Commitment	**Action Items and Next Steps**	▪ Make a strong ask ▪ Leave with a clear plan – dates, times, accountability ▪ When will you meet again

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Shared Structure: Conditions Necessary for Effective Teams

The Essentials

- Bounded, stable & interdependent
- Essential resources, skills, and capabilities to lead inter-dependently
- Clear, compelling purpose
- The work is understood, challenging, it matters. And everyone knows why it matters!

Enabling Structures

- Sound structures for how the team functions and interacts with one another
- Supportive organization systems
- Coaching

Team Processes

- Interdependent roles
- Real teamwork
- Accountability
- Effort builds shared commitment

From the work of Dr. Ruth Wageman, Harvard, Columbia, Dartmouth

Shared Strategy: The Organizing Statement

We are organizing _____(WHO - community)_____

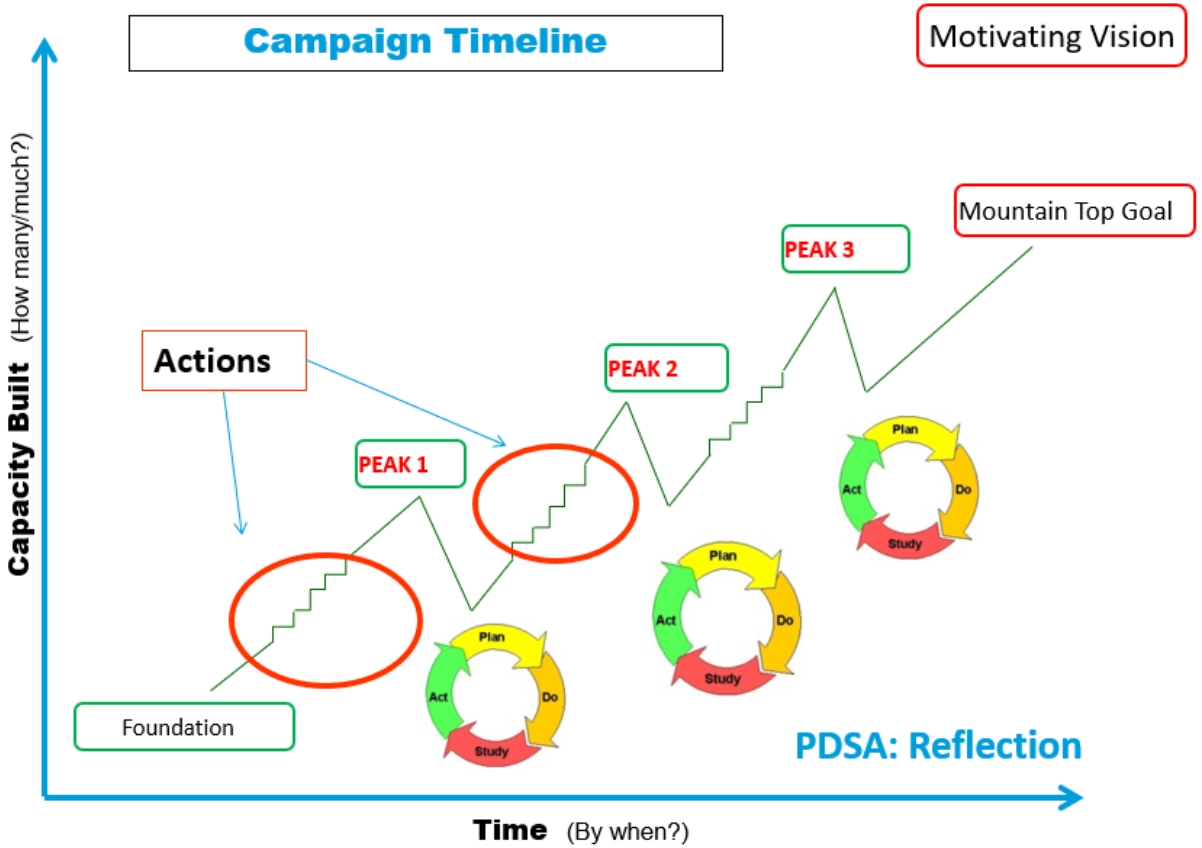
to do _____(WHAT - measurable aim)_____

by _____(HOW - tactics)_____

in order to _____(WHY - motivating vision)_____

by _____(WHEN - timeline)_____.

Shared Action: Campaign Timeline



- Easy to see the rhythm and progress of a campaign/project
- Scalable
- QI/PDSA is built in
- Fosters a culture of
  - Learning
  - Safety
  - Continuous quality/process improvement

So, what can we learn from community organizing?

About …

- Leadership?
- Engaging and motivating internal staff and external partners?
- Commitment?
- The importance of story?

CHAT IN: One new learning or insight you gained. How will you use it?

IT IS POSSIBLE.

It is possible for us to emerge from our time together refreshed, surprised and less burdened than when we came.

Our work together can provide renewal, refreshment and possibilities for what we can do together to create the future that is waiting to be born

Seeds planted here will keep growing and flourish in the days ahead in the service of our work.

Adapted from Touchstones used in The Center for Courage and Renewal's Circles of Trust Retreats - Covenants of Presence

Thank You!

Risa Hayes, CPC

Program Specialist

Patient Family Engagement & Community Organizing Lead

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Telligen

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Leveraging the Zero Harm Program to Promote High Reliability

Health Services Advisory Group (HSAG)

December 7, 2023

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Meet Your Speakers

Josh Hazelton, MPH, CPH
Senior Quality Improvement Specialist
Health Services Advisory Group

Beth Morgan, MHA, BSN, RN, CNOR, CPHQ
Director of Clinical Affairs and Workforce
South Carolina Hospital Association

Nan Carter, MPH
Manager of High Reliability and Innovation
South Carolina Hospital Association

Goals

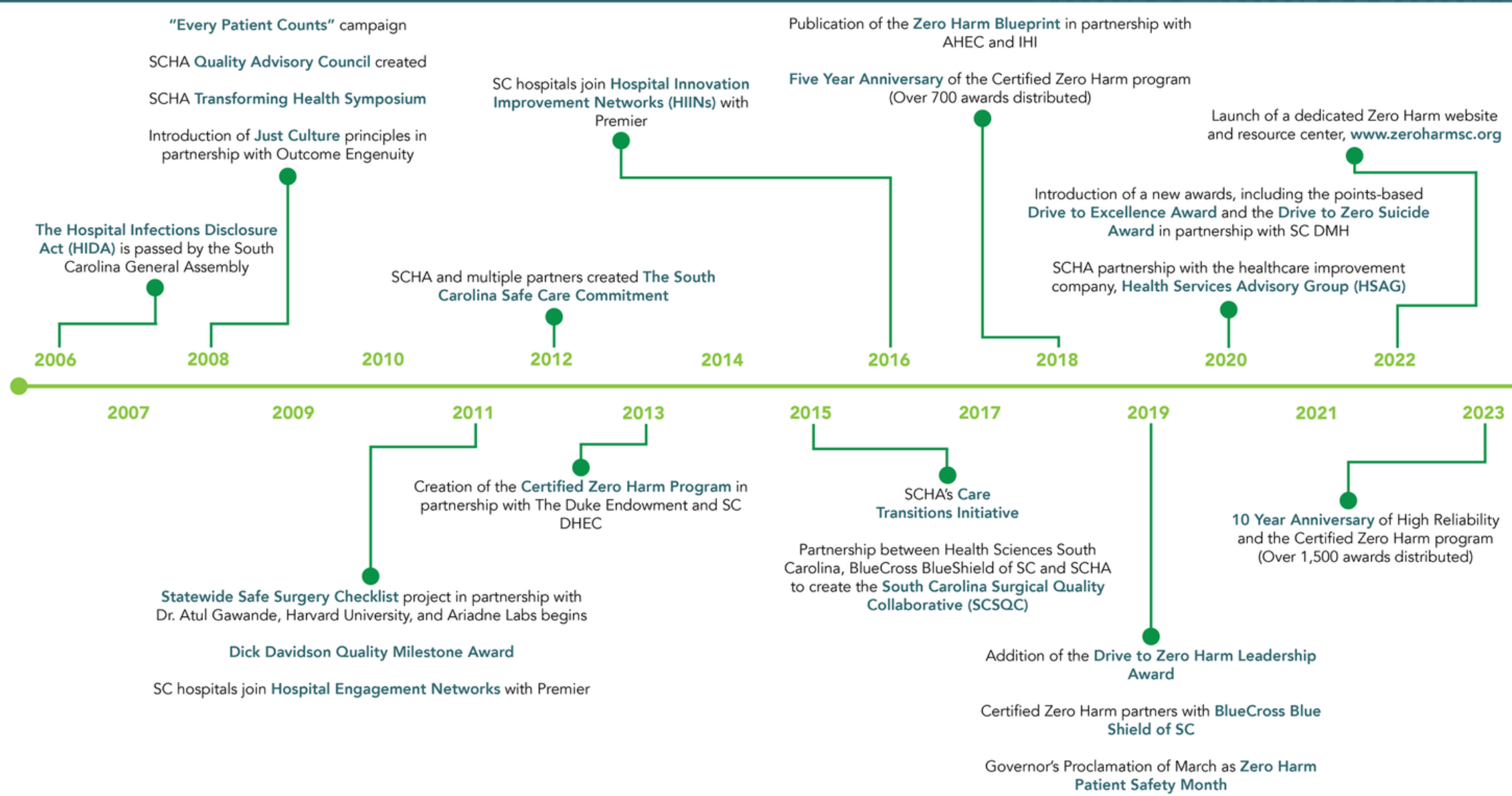
1. Review the South Carolina Hospital Association (SCHA) – HSAG Hospital Quality Improvement Contractor (HQIC) partnership.
2. Identify how the Zero Harm Program promotes high reliability.
3. Discuss the Zero Harm Blueprint.
4. Highlight the success of the High Reliability/Zero Harm Program as a foundation for the HSAG HQIC hospitals in SC.
5. Review how the Zero Harm Program has integrated critical topics of workplace violence and health equity.

SCHA – HSAG HQIC Partnership

- SCHA historical collaboration on previous CMS hospital quality initiatives
- SCHA and HSAG formed a collaborative partnership for the HQIC
- Successfully engaged 21 eligible hospitals
  - 14 Small Rural
  - 1 Critical Access Hospital
  - 5 Urban
  - 1 Academic Medical Center

Milestones in the Zero Harm Journey

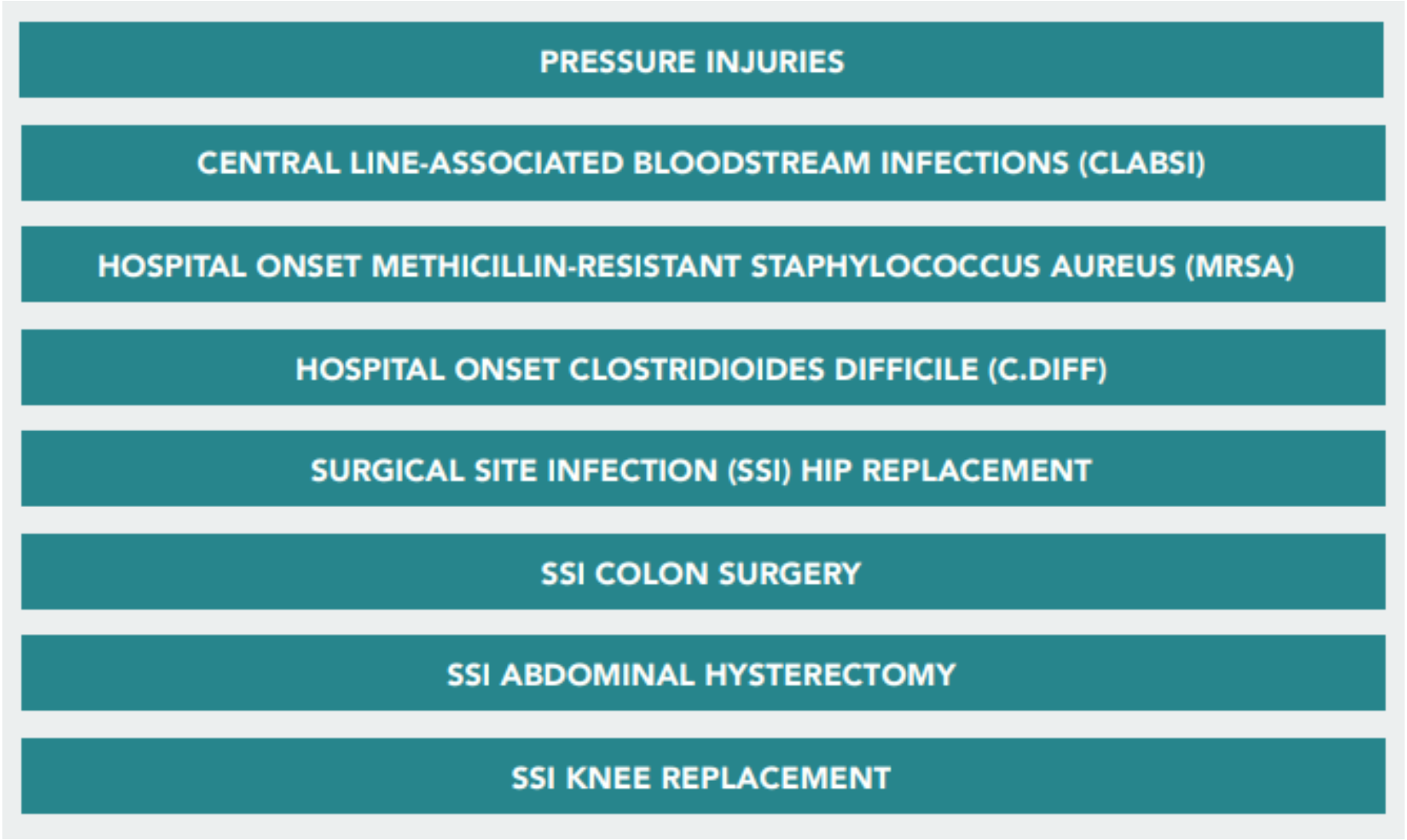
ZERO HARM



Zero Harm Overview

- Certified Zero Harm Clinical Awards
- Zero Harm Priority Awards
  - Drive to Zero Suicide
  - Drive to Zero Disparities
  - Drive to Zero Workplace Violence
- Drive to Leadership Award

Certified Zero Harm Clinical Awards



- Drive to Zero Suicide
- Drive to Zero Disparities
- Drive to Zero Workplace Violence

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Drive to ZERO HARM Leadership Award

- Leaders are nominated by their organization
- Models a highly reliable culture
- Demonstrates a vision for safety
- Ensures board engagement
- Promotes Just Culture
- Establishes systemwide trust and inclusion
- Represents the mission, vision, and values of the organization

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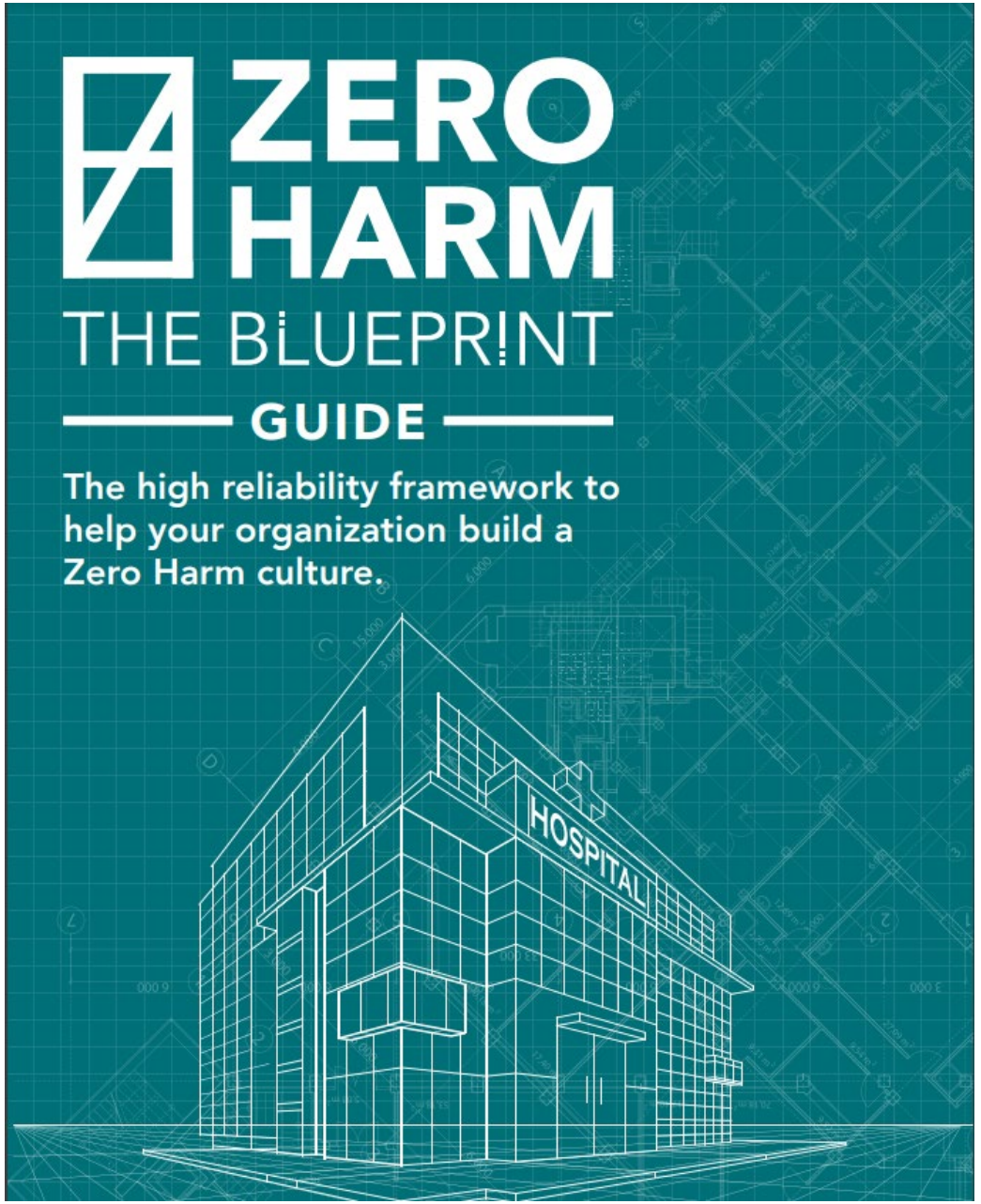
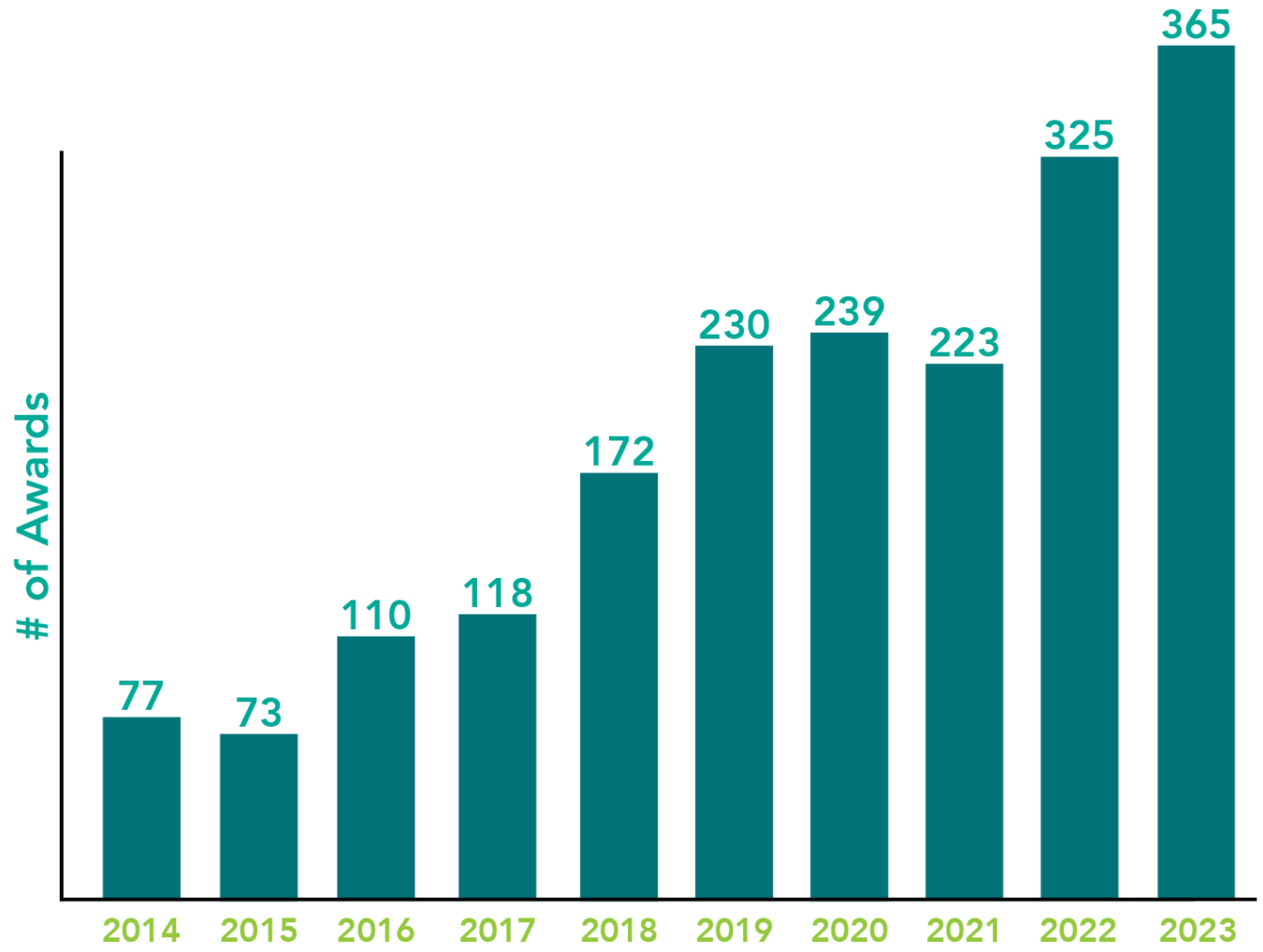


- Launched in 2018
- Adapted from “Leading a Culture of Safety: A Blueprint for Success”
- Comprehensive framework for creating and sustaining a culture of safety

ZERO HARM

SCHA
SC HOSPITAL ASSOCIATION



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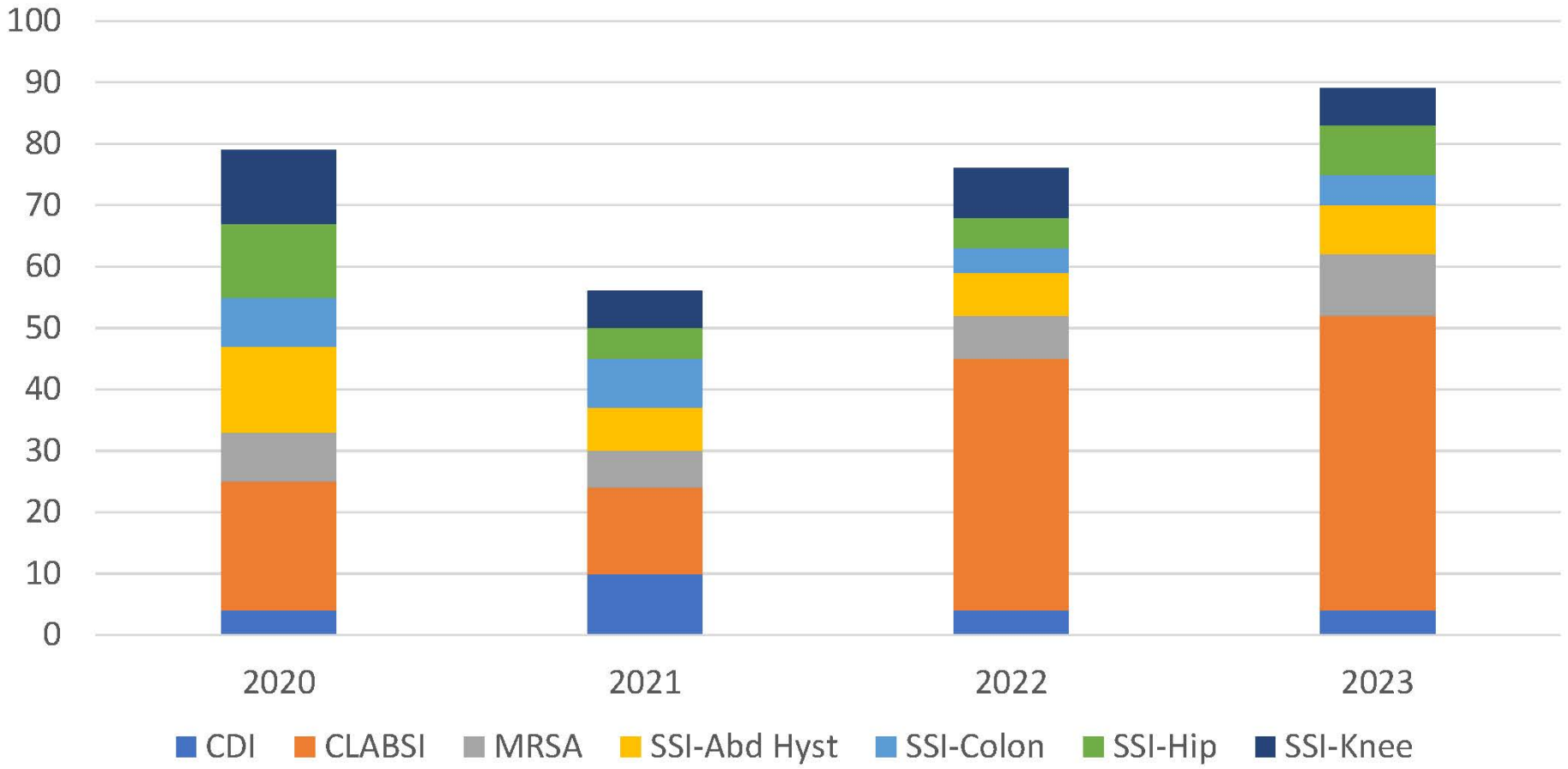
SCHA – HSAG HQIC Hospitals Zero Harm Awards



Thank You

ZERO HARM

www.zeroharmsc.org

Thank You!

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Health Services Advisory Group (HSAG)

15-Minute Break

HRO is a Journey, NOT a Destination: Lessons From an International Roundtable on Healthcare Resilience During the Pandemic

Convergence Health Consulting

December 7, 2023

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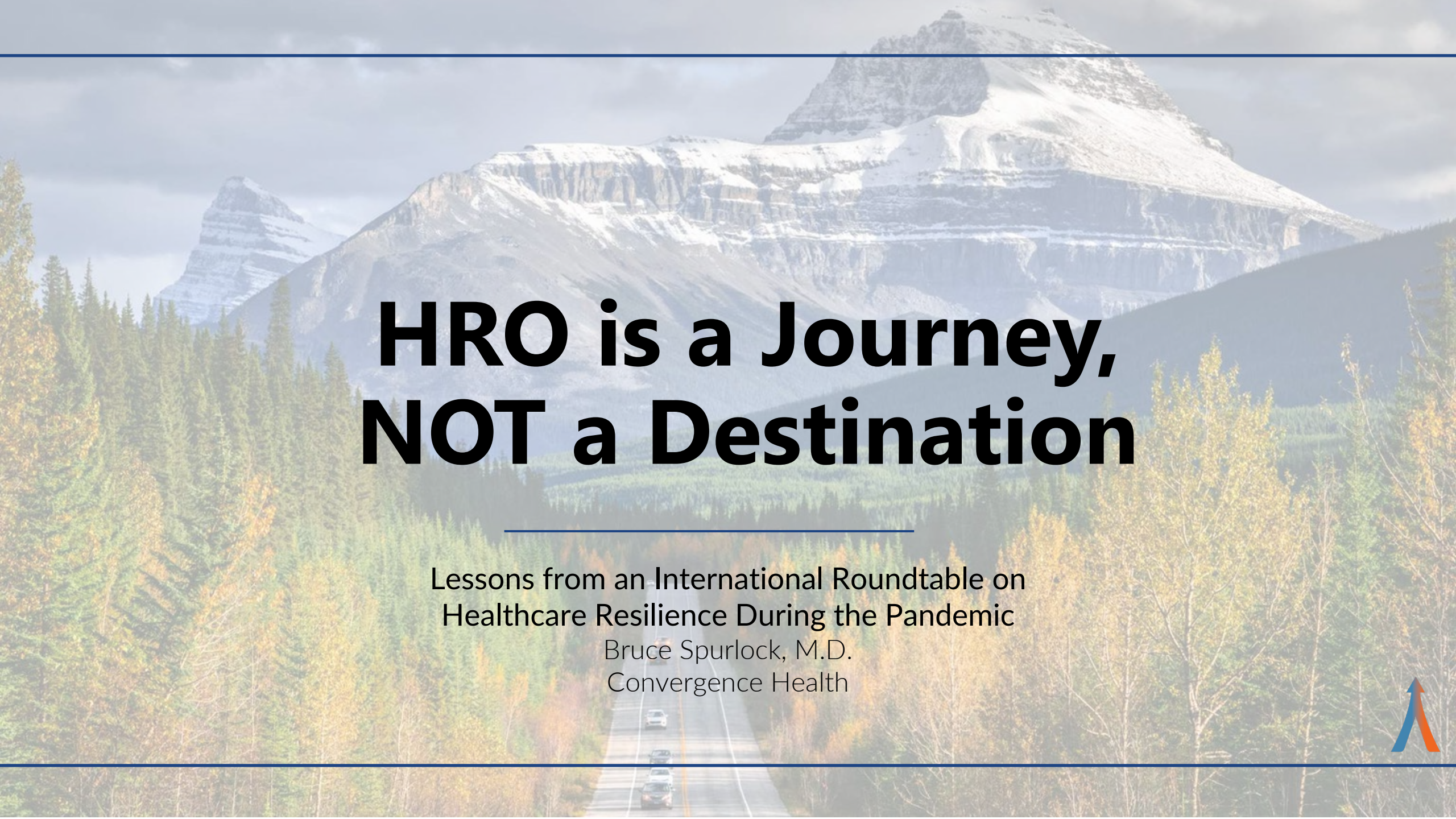
Meet Your Speaker

Bruce Spurlock, MD
President and CEO
Cynosure Health



HRO is a Journey, NOT a Destination

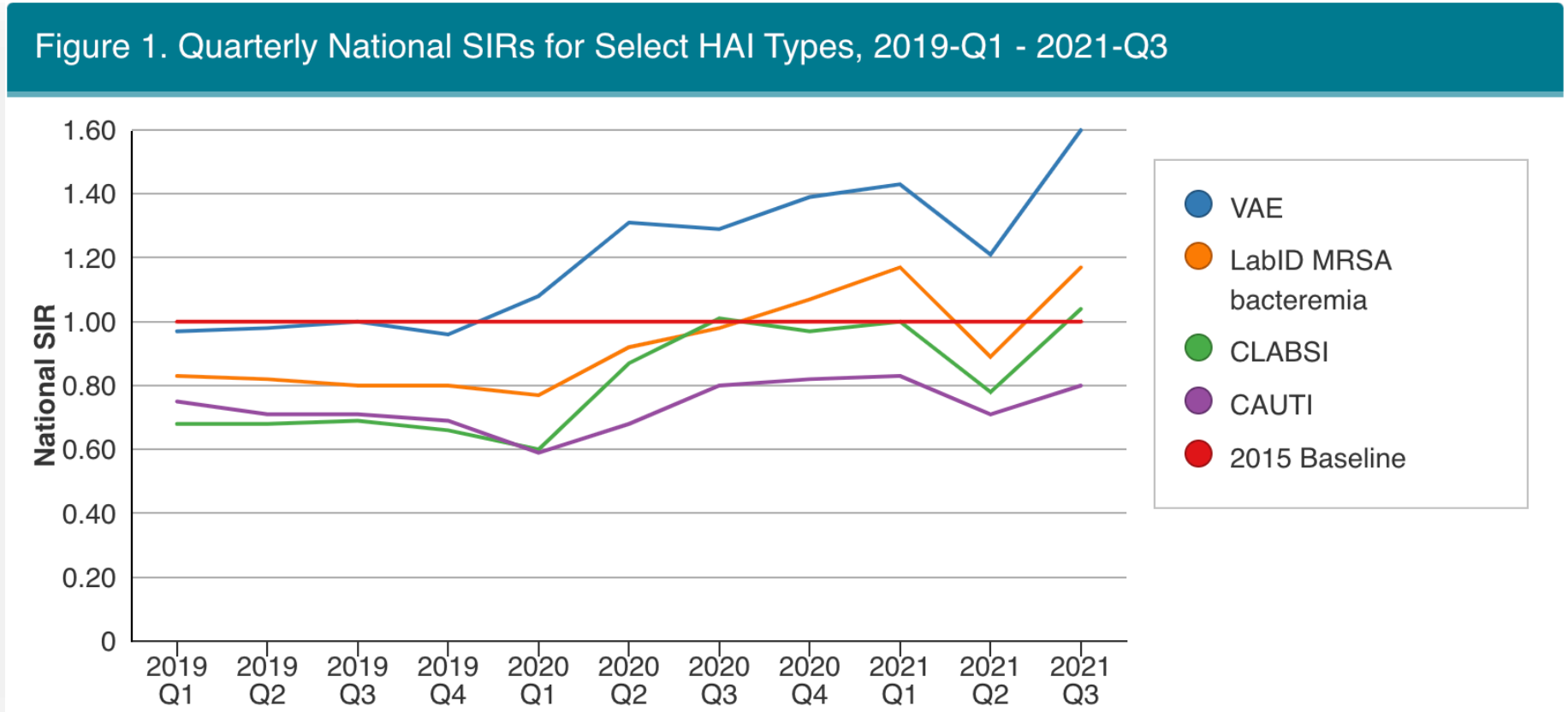
Lessons from an International Roundtable on Healthcare Resilience During the Pandemic

Bruce Spurlock, M.D.
Convergence Health

Agenda

- Setting the Context – Infections go backwards
- Mind shift – It's a verb not a noun
- Convening International Experts – The Resilience Roundtable
- Resilience - The space between hope and grit

During pandemic surges, HAIs increased



Source: CDC 2023

Listening Sessions – What Did We Learn?

FEAR AND UNCERTAINTY WERE HIGH, ESPECIALLY DURING SURGES

- Fear of getting close to the face during central line insertion – prefer the groin
- Fear of spreading COVID meant nurses reduced time in patient rooms
  - Less skin support, fewer central line hub checks
  - IV lines running (on the floor) to pumps outside of an ICU room

STAFFING AND CAPACITY OVERWHELMED ROUTINE PRACTICES

- Safety huddles and leadership walk rounds were deferred
- Quality and safety measures had a mix of actions – some stopped when CMS stopped requiring submission, others continued but currency was often collateral damage

NEW CLINICAL PRACTICES EMERGED

- Prone positioning increased complications, especially pressure injuries
- Supratherapeutic anti-coagulation tolerated because of a lethal hypercoagulable state

WHAT IS RELIABILITY?

WHAT IS RELIABILITY?

Reliability [ri-lahy-*uh*-**bil**-i-tee]

noun

1. the ability to be relied on or depended on, as for accuracy, honesty, or achievement.

From Dictionary.com

WHAT IS RESILIENCE?

Reslience [ri-**zil**-y*uh*ns, -**zil**-ee-*uh*ns]

noun

1. the power or ability of a material to return to its original form, position, etc., after being bent, compressed, or stretched; elasticity.
2. the ability of a person to adjust to or recover readily from illness, adversity, major life changes, etc.; buoyancy.

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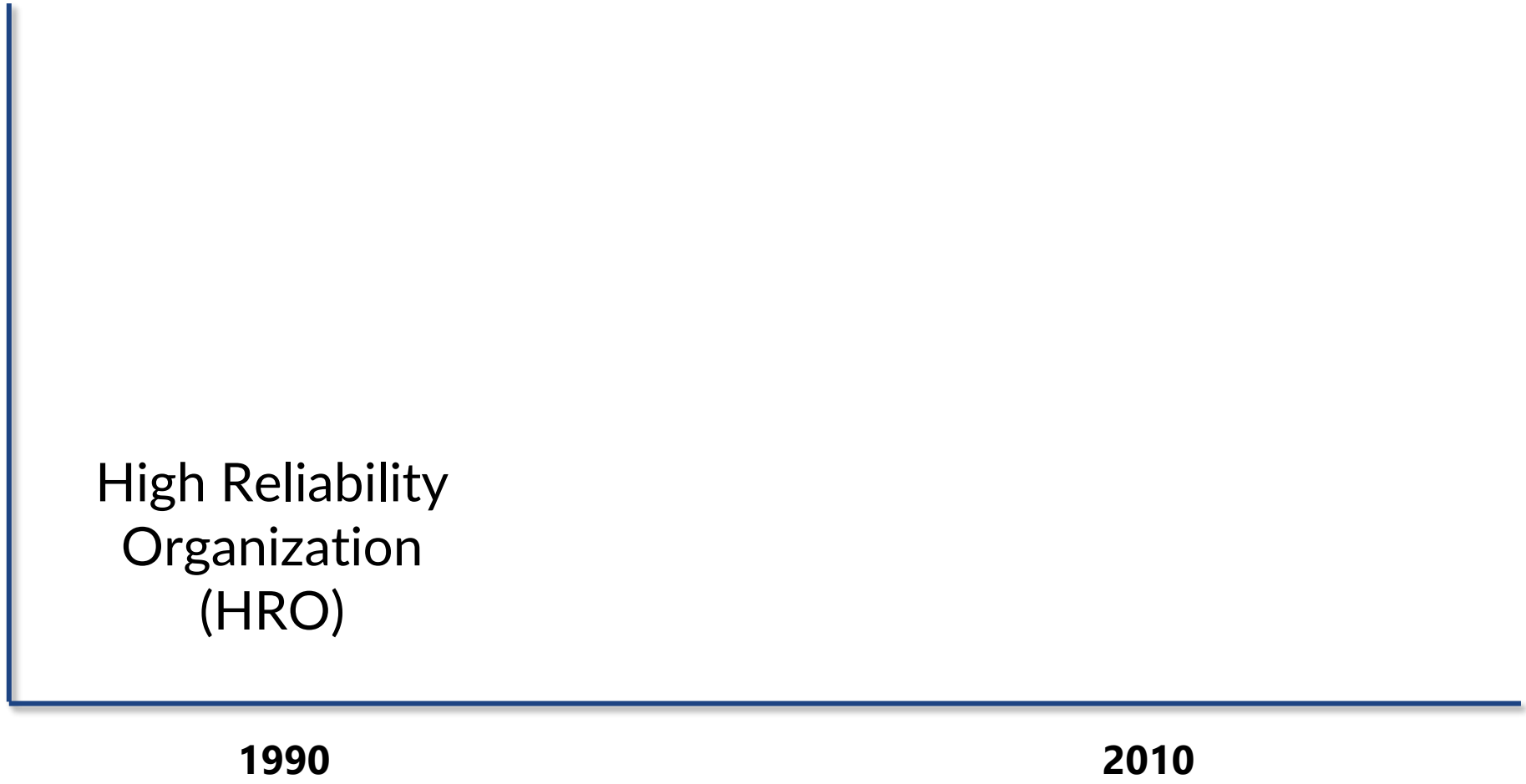
From Dictionary.com

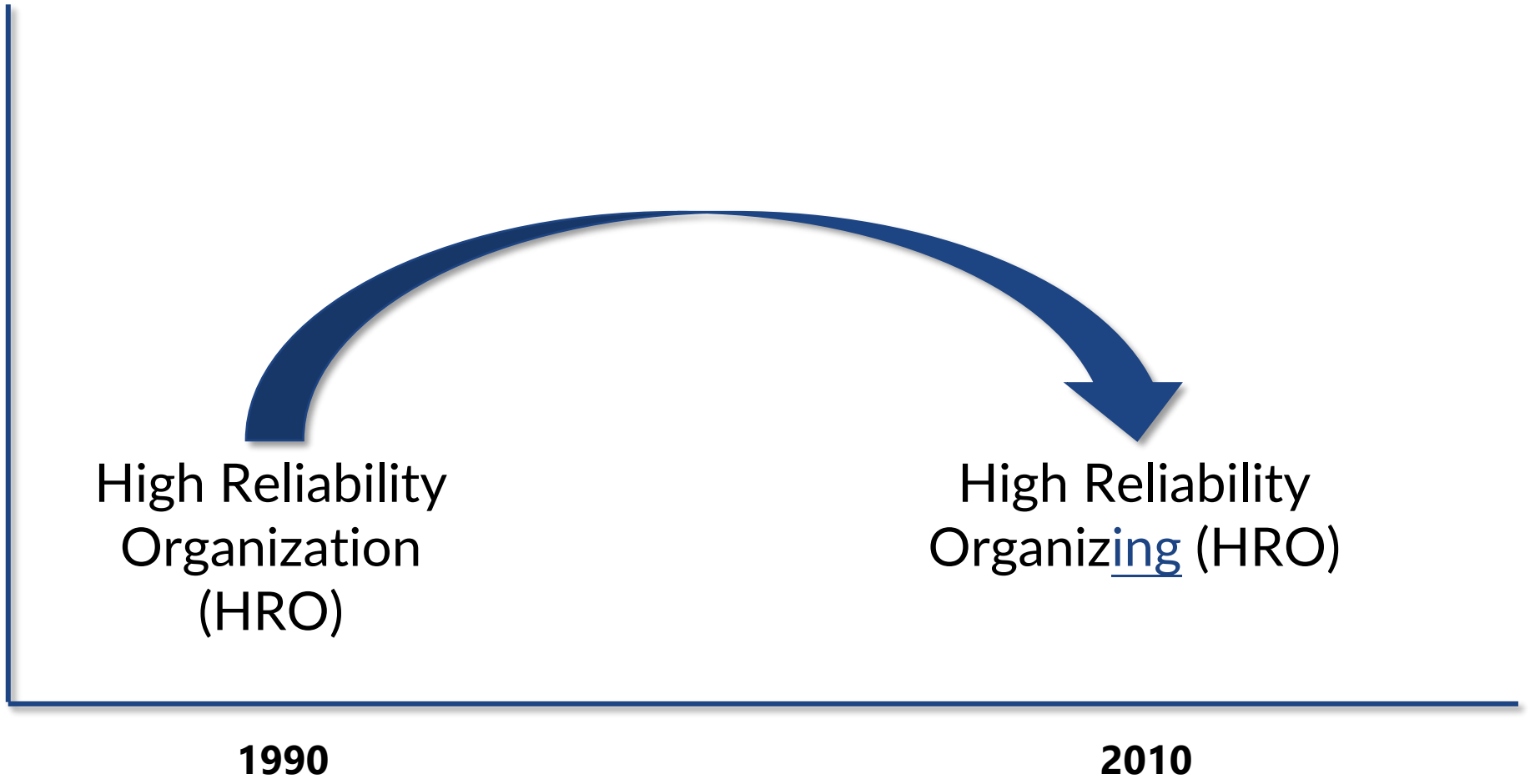
HIGH RELIABILITY ORGANIZATION

KARLENE ROBERTS

It's a VERB not a NOUN



It's a VERB not a NOUN



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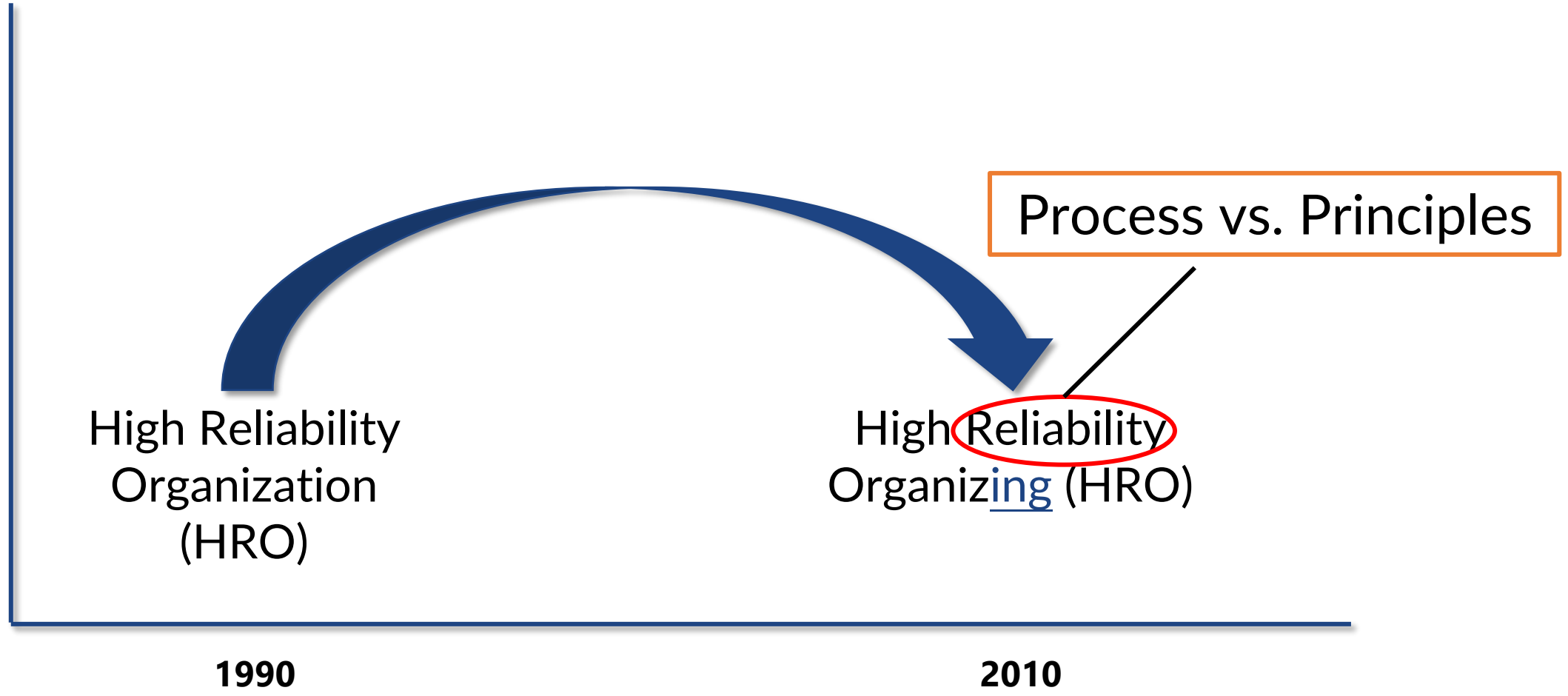

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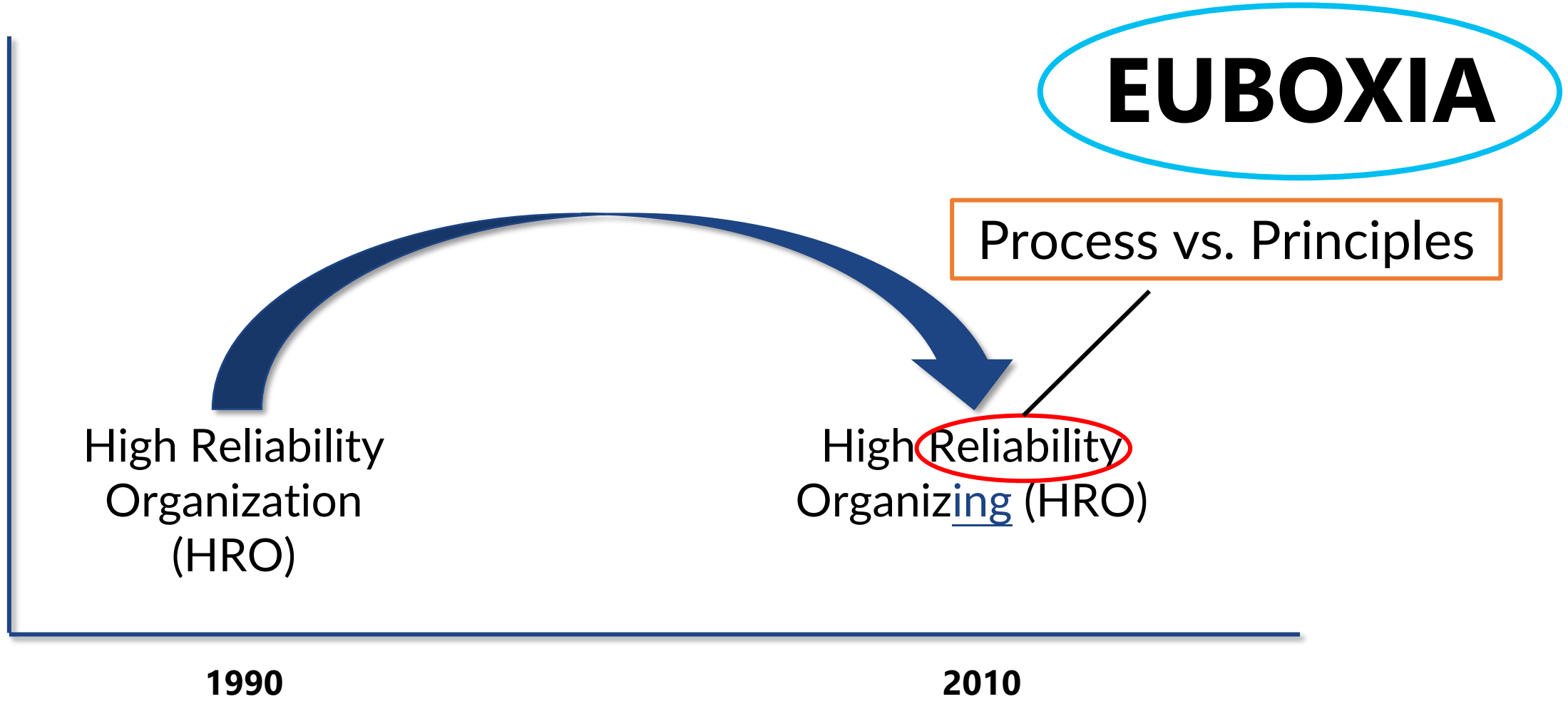

“You are asking the wrong question.”

Karl Weick

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RESILIENCE IS…

- Stretching without breaking
- Rapidly snapping back to usual or better performance.
- Anticipated and built into the system to mitigate the amount or impact of a stressor

Adapted from Kathleen Sutcliffe

LEADING IN TOUGH TIMES:
Applying Cross Sector Lessons on Resilience to Health Care

- Resilience Roundtable

Cynosure HEALTH

THE AGENDA

m - 11am ET

SETTING A **STRATEGY** THAT PROMOTES RESILIENCE

CHARLES VINCENT, PHD
Professor, Oxford University

JAN HAGEN, PHD
Professor, ESMT Berlin

PETER ANGOOD, MD
President/CEO, American Association for Physician Leadership

m - 12pm ET

CREATING A **CULTURE** THAT ENABLES RESILIENCE

AMY EDMONDSON , PHD
Professor, Harvard Business School

SARA SINGER, MBA, PHD
Professor, Stanford University School of Medicine

TIM VOGUS, PHD
Professor, Vanderbilt University

m - 1pm ET

OPERATIONALIZING SYSTEMS TO RESPOND TO UNEXPECTED CIRCUMSTANCES

DAVID GABA, MD
Associate Dean, Stanford University School of Medicine

LIBBY HOY
Founder/CEO, PFCCpartners

JOHN CHESSARE, MD, MPH
President/CEO, GBMC Healthcare System

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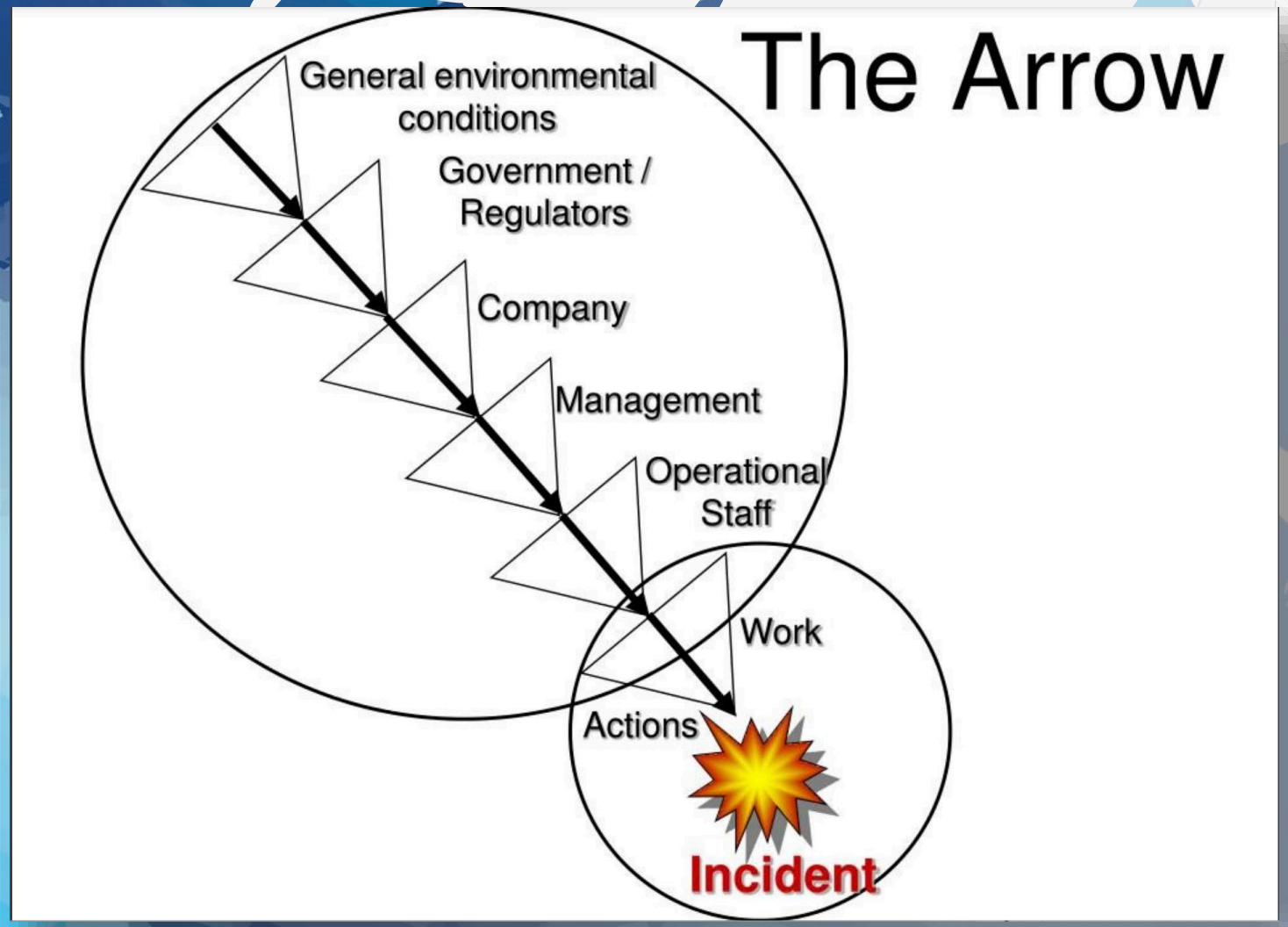
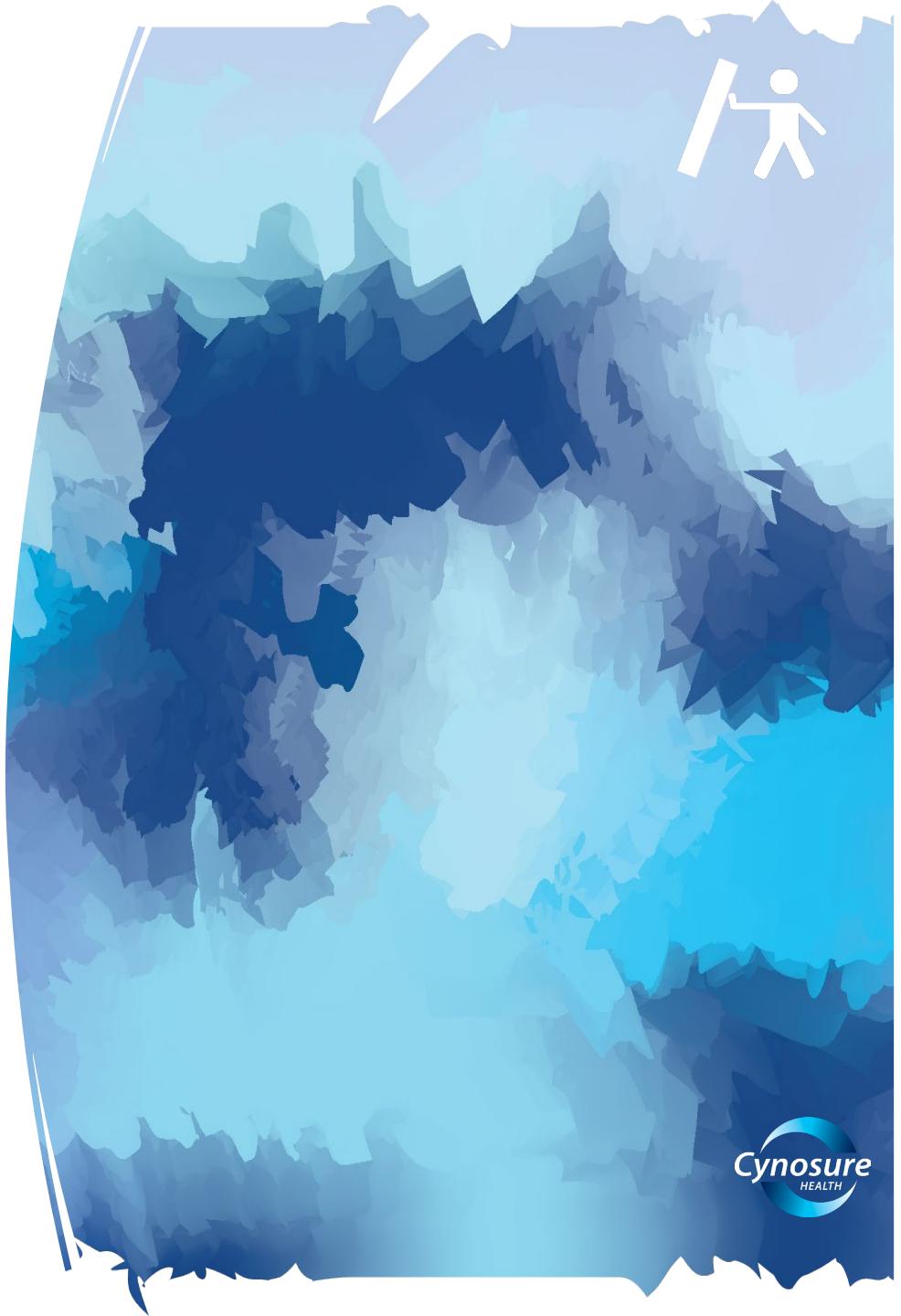
The “blunt ends” and “sharp ends” influence results at all levels



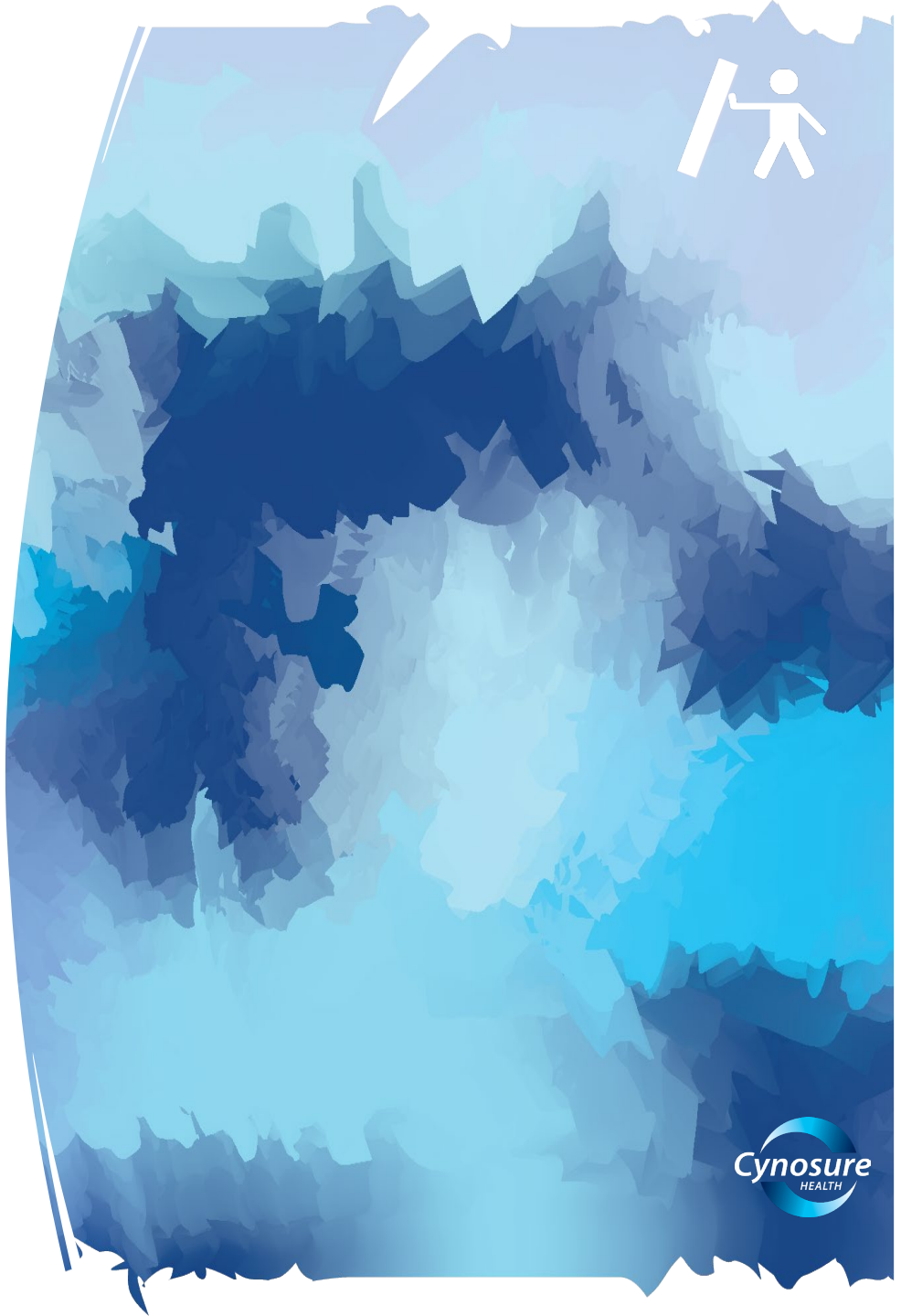
“Setting a Strategy that Promotes Resilience,” Charles Vincent, Jan Hagen, and Peter Angood

- Necessary versus unnecessary resilience in health care –team members often exhibiting resilience. We must ask – how can we recognize when resilience is not the solution?
- Need for better data – drawing from experiences in the airline industry, we heard a call for better data on both negative and positive patient safety events, as well as the multiple internal and external factors that influence health care.
- Transparency and collective improvisation – Leaders should engage their teams in planning how they will collectively improvise in the face of both acute and chronic stressors.



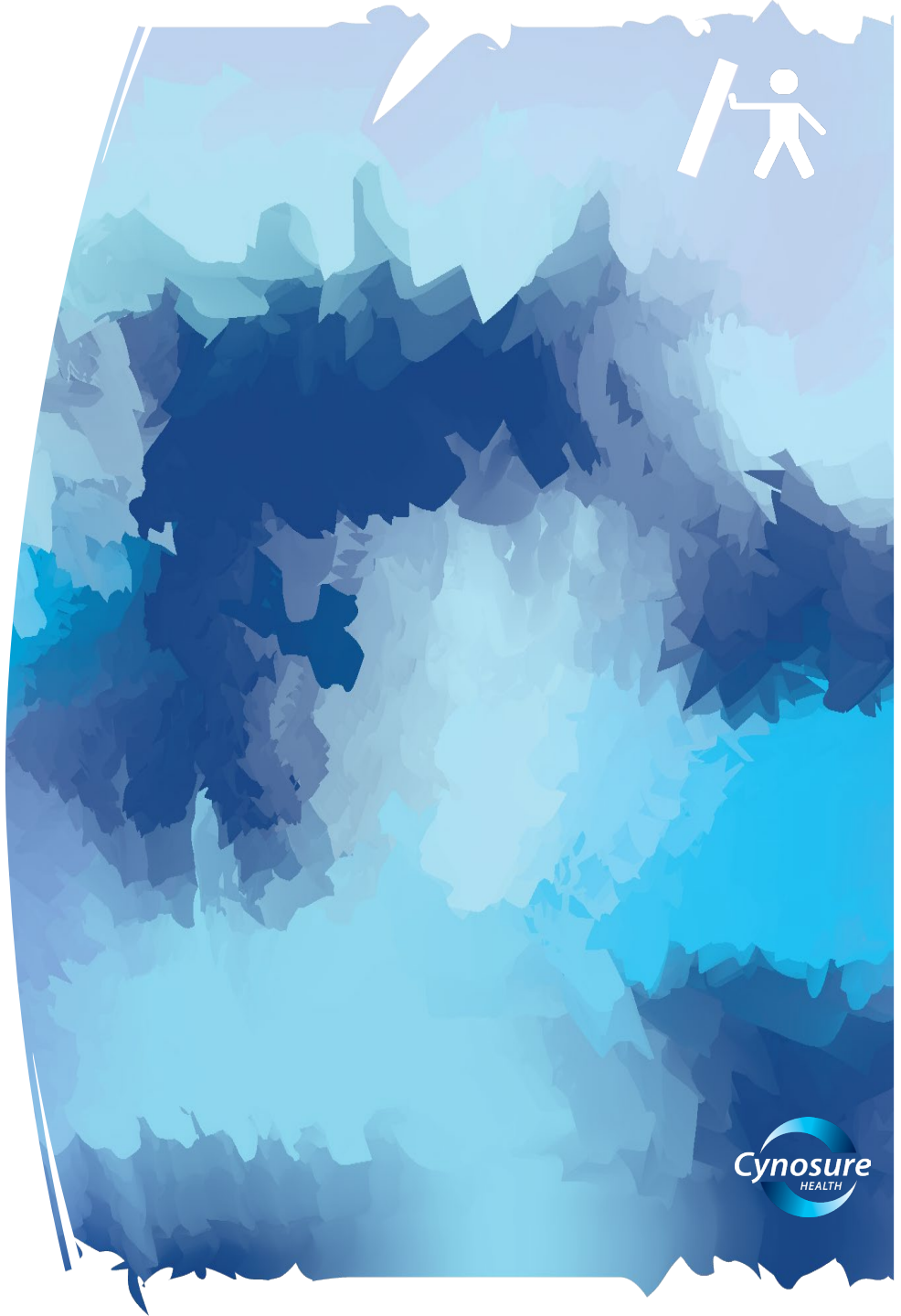
“Creating a Culture that Enables Resilience,” Amy Edmondson, Tim Vogus, and Sara Singer

- Psychological safety – the imperative to create an environment in which team members support each other in anticipating and addressing failures.
- Creating the right culture…and fixing broken systems and processes – Simplify and standardize where possible to free up time to focus on improvement efforts.
- Who is on “the team”? – Family members are a crucial source of health care resilience and early detection for patient safety. Consider ways to think more broadly about who is “essential” in supporting patient safety.

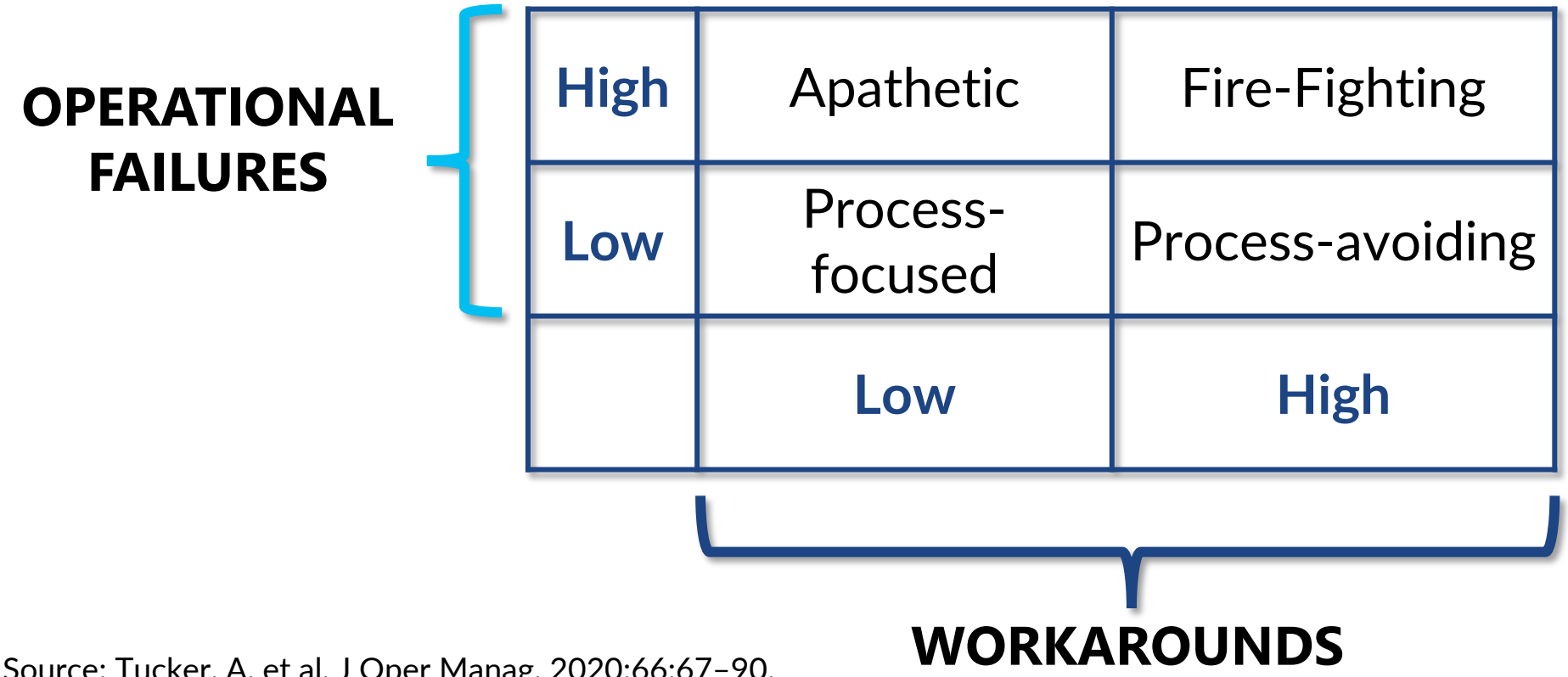


“Operationalizing Systems to Respond to Unexpected Circumstances,” David Gaba, Libby Hoy, and John Chessare

- How to narrow the gap from the front office to the frontline – transparency and improved communication can help all stakeholders understand the true nature of the challenges we face.
- Fantasy documents – although we spend time and resources developing emergency plans and procedures, we often know they won’t actually work. How can we improve our efforts to prepare for stressors?



Workarounds as a Symptom – Abusive Resilience



Source: Tucker, A, et al. J Oper Manag. 2020;66:67–90.

Created by Julie Morath 2023

If you are interested in receiving a copy of the Resilience Roundtable Playbook, send your request to bspurlock@cynosurehealth.org

Photo by Benjamin Suter: https://www.pexels.com/photo/black-asphalt-road-near-mountains-under-cloudy-sky-3733269/

Thank You!

Bruce Spurlock, MD
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Convergence Health Consulting

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Q&A / Open Discussion

Latrail Gatlin

Health Insurance Specialist

Division of Quality Improvement

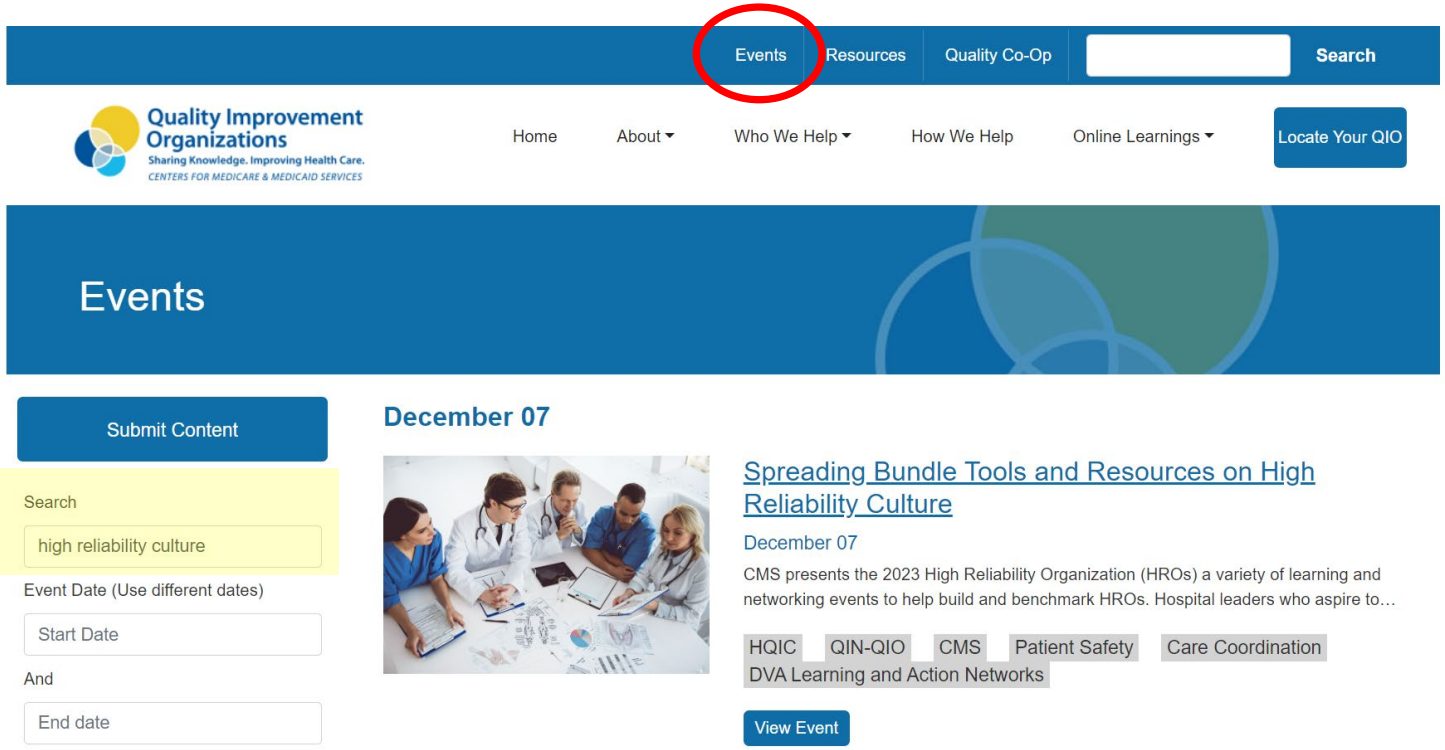
Innovation Models Testing

iQuality Improvement and Innovations Group

Center for Clinical Standards and Quality

CMS

Accessing Post-event Slides and Resources



- Post-event materials will be available on **QIOProgram.org** starting December 11
- Materials can be accessed via Events by typing “high reliability culture” into the search field or by clicking on the following URL directly: **Spreading Bundle Tools and Resources on High Reliability Culture | qioprogram.org**

Polling Questions

Questions to be Answered

1. Has the material shared today been helpful to you or your organization?

2. Based on what you have learned today, can you take any immediate action over the next 30, 60 or 90 days?

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post assessment.

We will use the information you provide to improve future events.

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