Why Safety is So Important to Me
What’s Changed Since Robbie Died

- We define harm in new ways
- We can measure safety
- We can predict problems and prevent them
- Transparency is driving improvement
- Teamwork is producing better, safer care
- We now have the safety “change packages” (the what) and the improvement tools (the how)
- Patient and families are becoming more engaged in their care
The Leader’s Role:  
A Trilogy of Assurance, Improvement, and Innovation

- You are juggling a lot
  - Leaders are responsible for running their organizations and producing reliable outcomes
  - New program ideas surface and need activation
  - Expectations from patients, families, and staff rise and we need to do better to meet them
  - There are increasing needs to access the care system
The Quality Trilogy

- Assuring quality
- Improving quality
- Innovating quality

The Trilogy: Assurance

- Assurance is inspecting to ensure that safe and effective standards of care are in place every day
  - Accreditation
  - Leadership rounds and triggers
  - Listening to staff and patients
**Assurance**

- What happens when assurance is not in place and the patient/staff voice is not heard?
Don Berwick’s Four Principles for the NHS as a Learning Organisation

- Place the quality of patient care, especially patient safety, above all other aims.
- Engage, empower and hear patients and carers at all times.
- Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in the area in which they work.
- Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

The Trilogy: Improvement

- Four Leadership Questions:
  - Do you know how good you are?
  - Do you know where you stand relative to the best?
  - Do you know where the variation exists?
  - Do you know the rate of improvement over time?

- Building improvement capability

- Chartering and supporting teams to close gaps
What Improvement Skills are Needed for Each Role?

- **Everyone** (Staff, Supervisors, UBT lead triad)
  - Setting goals and measures
  - Identifying problems
  - Mapping process
  - Testing change
  - Simple waste reduction
  - Simple standardization
  - Team behaviors

- **Change Agents** (Middle Managers, Stewards, project leads)
  - Setting goals and measures
  - Identifying problems
  - Mapping process
  - Sequencing tests of change
  - Simple understanding variation
  - Implementation and spread
  - Simple waste reduction
  - Simple standardization

- **Operational Leaders** (Executives)
  - Setting direction and big goals
  - Results leadership
  - Portfolio selection and management
  - Managing oversight of improvement
  - Being a champion and sponsor
  - Understanding variation to lead
  - Managing implementation and spread

- **Experts**
  - Analysis, prioritization of portfolios
  - Deep statistical process control
  - Deep improvement methods
  - Leadership team advisory re portfolio selection, process
  - Effective plans for implementation and spread
Building PI Capability and Skills

Develop and Test the System at a Facility level

- Improvement Advisor
- Leadership
- First project
- Oversight responsibility
- Several teams
- 90 days

Expand Improvement system to more departments

- Several Improvement Advisors
- Prioritization and portfolios
- Oversight groups
- Sponsor and champion accountability by service
- Team development and alignment of goals

Deepen improvement knowledge within services and units

- Service line IA’s
- All leaders know role and skills
- Prioritization and oversight in operations
- Alignment of portfolios
- Standard work
- Teams know goals and test change

Learning and sharing systems regionally and program-wide Improvement Institute

Mentors care management institute

© Kaiser Permanente 2011 reproduce by permission only
Progress on Key Indicators: 2008 - 2012

<table>
<thead>
<tr>
<th>Hospital Standardized Mortality Ratio</th>
<th>BSI Rolling 12 Mo. Rate</th>
<th>Cdiff</th>
<th>SRAES</th>
<th>HAPUS</th>
<th>Readmissions</th>
<th>Inpatient Utilization</th>
<th>RFO</th>
<th>Worker Injury Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>52%</td>
<td>35%</td>
<td>19%</td>
<td>82%</td>
<td>7%</td>
<td>21%</td>
<td>20%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

© Kaiser Permanente 2010-2011. All Rights Reserved.
Dramatic Reduction in Risk Adjusted Hospital Mortality

Hospital Standardized Mortality Ratios

NOTE: Data above reflects rolling twelve month observed/expected ratio
Significant Reduction in Use of Inpatient Beds
National Patient Day Rate

Inpatient Days per 1000, 2009Jan-2013Mar
All Lines of Business, All Regions, Unadjusted
All Regions

Source: Inpatient Days per 1000 report, National Inpatient Analytic
All Kaiser Permanente Medicare Plans Receive 5 out of 5 Stars

October 15, 2013

TOPICS: EXPERT MEDICINE, PRODUCTS AND BENEFITS | REGIONS: NATIONAL | KEYWORDS: MEDICARE STARS

OAKLAND, Calif. — Kaiser Permanente has announced that all of its Medicare health plans have earned 5 stars — the highest overall rating for quality and service from the Centers for Medicare & Medicaid Services. The 5-star rating applies to Kaiser Permanente’s 2014 Medicare health plans that operate in California, Oregon, Washington, Hawaii, Colorado, the Mid-
Results from New Zealand

- Celebrating 930 days without a central line-associated bloodstream infection (CLABSI)!
The Trilogy: Innovation

- Harvesting new ideas and translating contextually
  
  - IHI’s R&D processes (e.g., 90-day cycles)
  
  - Innovation labs (e.g., Mayo Clinic’s Center for Innovation, Harvard’s i-Lab)
2013 R&D 90-day Projects

- Creating a Regional Resource Network for Quality Improvement, Part III
- Primary Care and the Complex Patient, Part II
- Programming for National Impact: The Quality Innovation Centers and the Joint Learning Network
- Quality Functions and Structure at Half the Expense
- 10 Percent Project
- Cost and Quality Meeting Preparation
- Health Disparities
- Improving Neonatal Care within the First Hour of Life
- Leadership in the Emerging Health Care Environment
- Organizations and Population Management
- Patient Needs Pathway Assessment
- Rethinking IHI's Innovation Networking
- Working with Employers
- Working with Nations Change Package
- Accelerating Improvement
- Cost & Quality: IHI's position on a state strategy to achieve value
- Essential Behaviors for Leaders in the New Health Care Environment
- Health Technologies that may drive the Triple Aim
- Improving Neonatal Care within the First Hour of Life
- Informing Virtual Education at IHI
- Nation-level Action
- Population Segmentation and Service Design based on Patient Motivation
- State-level Action
- Time-Driven Activity-Based Costing for Chronic Conditions
- Working with Employers: Prototyping Launch
- Cost and Quality Diagnostic Tool
- IHI's Approach to Mental Health Integration in Primary Care
- IHI's Approach to State-level Initiatives, Part II
- Population Management, Part II
- Using Big Data in IHI's Work
Innovations in Safety

- Cincinnati's Children's huddles
- Moving from “What’s the matter?” to “What matters to you?”
- Self-Dialysis Unit
- Intermountain Healthcare’s work on sedation and mobility
- Scotland’s national collaborative – *Scottish Patient Safety Programme*
- IHI’s 100K Lives Campaign
Huddles
at Cincinnati Children’s Hospital Medical Center
Situational Awareness
Cincinnati Children’s Medical Center

Huddle three times in 24 hour period and discuss

- **Flow**
  - Capacity and demand
  - Predicted admissions and discharges

- **Situational Awareness – Identify specific patient concerns**
  - Early warning scores
  - ‘Watchers’/clinician gut feeling
  - High Risk
  - Family Concern
  - Communication Concern
  - Medical Response Team prediction

Moving from “What’s the matter?” to “What matters to you?”
What Matters To Me

My Name is Kendra

My Mom's Name is Deborah

I am 7

I don't like medication by my

I can dress myself

With some help

I can do his 5

I love noise

Toys

24.10.2013
Organizations Learning from Patients

The Old Way

- Ryhov Hospital in Jönköping had traditional hemodialysis and peritoneal dialysis center.
- But in 2005, a patient, Christian, asked about doing it himself.
The New Way

- Now they aim to have 75% of patients to be on self-dialysis
- They currently have 60% of patients
Lessons to Date

From Christian (patient):
- “I have a new definition of health.”
- “I want to live a full life. I have more energy and am complete.”
- “I learned and I taught the person next to me, and next to her. The oldest patient on self-dialysis is 83 years old.”
- “Of course the care is safer in my hands.”
Update

- Now calculated costs at 50% of costs in other hemo-dialysis units

- Complications dramatically reduced and subsequent expensive care avoided

- Measuring success by “number of patients working”
Reducing Patient Harm from Sedation, Immobility, and Delirium
Live Case Visit
Salt Lake City, March 29-30, 2011
Intermountain Healthcare
Intensive Medicine Clinical Program
Program Objectives

- Present methods to monitor for delirium, agitation, confusion, and sleep using the CAM-ICU technique
- Discuss how to reduce patient time in a delirious state and identify patients at high risk for acute brain injury
- Outline new techniques to increase patient mobility earlier in the care process
- Outline proven practices for reducing sedative overuse
- Present ways to reduce patient time on ventilators in the ICU
- Review policies that increase patient safety and engage the entire critical care team
Testimonials

“It was life changing to see a patient walk!”
“This was a career-changing experience.”
“Come on – let’s go get on a plane and start doing this! I’m ready….I’m ready!”
“I was very inspired, I wish I could have brought my whole unit.”
“I feel badly how I have misjudged my patients’ abilities.”
Inventory national programmes and measurements

Meet with programme leader to understand programme intent, audience, history

Harmonize our metrics

Improve Safety of Hospital Healthcare Services in Scotland

Boards Accept Safety as Key Strategic Priority for Effective Governance

Scottish Executive Sets PSA as Strategic Priority

Robust, evidence based proven clinical changes

IHI/QIS Team Expert at Content, Coaching and Programme Management

Align national SPSP with national improvement programmes and measures

Secondary Drivers

Ownership of agreed upon set of outcomes
Review of outcomes at each meeting
Quality and safety comprises 25% of agenda
Recovery plans for unmet outcomes
Infrastructure supports improvement and measurement
Involve patients in safety

Demonstrable results to community
Clear, shared measurement set
Visible on all senior leader agenda
PSA represents & demonstrates cohesive, united programme

Acceptance of pragmatic science Royal College Supports PSA Programme

International expert clinical faculty
Faculty expert at improvement methods and coaching
Programme design and structure

Inventory national programmes and measurements
Meet with programme leader to understand programme intent, audience, history
Harmonize our metrics
Improve healthcare safety by reducing:

1. Mortality by 15%
2. Adverse events by 30%

**National Priorities, Programs, Strategies**

**Technical Driver Diagram**

**Primary Drivers**

- Leadership
- System for Safety
- Care of General Ward Patients
- Perioperative Care Management
- **Infection Prevention**
- Medicines Management
- Care for Acute MI Patients

**Secondary Drivers**

- Safety as a Strategic Priority
- Sustainable Infrastructure
- Engaged and Committed Leadership
- Pressure Ulcers
- CHF key processes
- Handoffs **Hospital at Night**
- Communication Failure to Rescue *SEWS*
- Clean Surgical Site Infection**
- Medicines Reconciliation**
- High Alert Medicines (**anticoagulation, narcotics, insulin**)
- Handoffs and Transitions
- MRSA + MSSA infections
- C-difficile infections
- Hand hygiene and general infection prevention
- AMI mortality
- Seven key AMI processes
NHSScotland Surgical Safety Briefings

% Compliance

83.70%

94.50%

97.20%
NHSScotland Surgical Mortality

P' Chart for surgical mortality

Surgical in hospital mortality rate (%)


23%
Hospital Standardised Mortality Ratio
Scotland: 2006 to Apr-Jun 2013

12.4% reduction

10671 less than predicted deaths
So how far have we come?

- Hundreds of thousands of lives saved
- Clinicians are feeling more rewarded in their work
- Patients and families are engaged in co-producing their care and health
But not every time, and not everywhere...
A Tale of Two Patients
Jess

- Team rounds
- Patient drives goal-setting
- No “visitors” – all are welcome
- Daily planning with Jess, her family, and team, with tollgates
- Discharge planning and support
Jess
• 4 hour journey in surgery with “wait two hours”
• “Who let them in?”
• No whiteboard; no daily plans; no team communication
• Sudden discharge
A Tale of Two Patients
So let’s create a learning system to help you achieve your ambition of being a model health system for all of the Triple Aim

**IHI Triple Aim**

- Health of a Population
- Experience of Care
- Per Capita Cost
“When you come upon a wall, throw your hat over it. Then go get your hat.”
Thank You!

Maureen Bisognano
President and CEO
Institute for Healthcare Improvement
20 University Road, 7th Floor
Cambridge, MA
mbisognano@ihi.org