Building Accountability for Transforming Systems of Care: A Case Study

An organizational framework to create leadership accountability in the clinical environment

Barbara Wadsworth, DNP, RN, FAAN
Chief Nursing Officer

Main Line Health
May 6, 2016
Summary of Work

• What prompted us to start high reliability work?

• Reducing preventable harm (2010)
  – personalizing patient safety data into “people harmed” was a call to action! Between 20-30 people/year were experiencing some level of harm prior to 2011.

• Reducing mortality ratios (2013)
  – Mortality observed/expected (O/E) ratios higher than COTH average performance – we were performing below average!
  – Sepsis-related deaths were primary clinical reason for high O/E (1.13)
Preventable Harm Serious Safety Events 2010-2012

MLH Baseline Rate = 0.34

SSE 1: Death

SSE 2: Critical, life-changing harm with no expected change in clinical status including permanent loss of organ, limb, or function

SSE 3: Significant harm with no expected change in condition yet not sufficiently severe to impact activities of daily living (ADL) or business functioning. Includes permanent reduction in physiologic reserve, disfigurement, or impaired or aided sense or function

SSE 4: Critical, life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care or monitoring, transfer to a higher level of care for a life-threatening condition, or additional surgery/procedure/treatment
Overall Hospital Mortality (Actual/Expected 3M),
Main Line Health (Acute)

Source: Premier via MLHS Dashboard database
Sepsis Mortality, Main Line Health (Acute)

Source: Premier via MLHS Dashboard database

Index (Actual / Expected)

Quarters (with count of mortalities at MLHS)

MLHS

QY2013 Target (0.96)
Key Issues and Opportunities: - what we learned was behind preventable harm and high mortality ratios…

- **We did not have a high reliability culture;** didn’t know what a reliable culture of safety looked like or how to begin building.

- **Lack of knowledge** - about accident causation, error prevention and leader methods for reliability

- **Accountability – talked about it, no action plan.** Building and sustaining accountability was critical to improve safety, reliability, clinical outcomes and patient experience.

- **Models of care delivery vary significantly** across MLH. Execution of standardized care processes inconsistent.

- **Roles of clinical leaders lack clarity, substance and empowerment.** Nurse and physician leaders not partnered to own clinical outcomes as a team/a leadership dyad.

- **Competitive culture** among MLH Hospitals make building high reliability culture across hospitals difficult.
Step One: Learning about accident causation

MAIN LINE HEALTH DIAGNOSTIC RESULTS 1/2010

Cause analysis documentation from ~100 patient safety events occurring January 2006 thru December 2009

Interviews with ~565 staff, physicians, and leaders
  • Bryn Mawr ~148
  • Bryn Mawr Rehab ~75
  • Lankenau ~135
  • Paoli ~82
  • Riddle ~115
  • System Execs ~10

Review of documents and outcomes. Tour of facilities.

Review of data from the 2009 AHRQ Safety Culture and Gallup Employee Engagement Surveys
<table>
<thead>
<tr>
<th>Common Cause*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Thinking</td>
</tr>
<tr>
<td>37.5%</td>
</tr>
<tr>
<td>Compliance</td>
</tr>
<tr>
<td>23.4%</td>
</tr>
<tr>
<td>Knowledge &amp; Skill</td>
</tr>
<tr>
<td>14.8%</td>
</tr>
<tr>
<td>Attention to Detail</td>
</tr>
<tr>
<td>10.5%</td>
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<tr>
<td>Normalized Deviance</td>
</tr>
<tr>
<td>7.0%</td>
</tr>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>6.6%</td>
</tr>
</tbody>
</table>
Power Distance is the extent to which the less powerful expect and accept that power is distributed unequally. PD is a measure of interpersonal power or influence superior-to-subordinate as perceived by the subordinate.

Authority gradient is the perception of power and authority as perceived by the subordinate.

Actions:
Use organizational culture to reduce power distance and flatten the authority gradient found in professional cultures.

Source: HPI from * Weick & Sutcliffe attribute of HRO’s:5. Deference to expertise.
Steps To Building A Reliable Safety Culture

1. **Establish Expectations**
   Establish behavior-based expectations consistent with the organization’s mission, goals, and high management standards for event-free performance

2. **Educate - Develop Knowledge & Skills**
   Educate individuals at all levels of the organization on behavior-based expectations and error prevention techniques

3. **Build and Reinforce Accountability**
   Establish an accountability system to convert behaviors to work habits

All three. In that order. Every time.

Source: © 2008 Healthcare Performance Improvement, LLC. Used with Permission.
<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
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<td>Delaware Valley Patient Safety Award Winner: Reducing Mortality!</td>
<td>Lean Six Sigma Green Belt Program launched</td>
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<td>Ebola preparation</td>
<td>MAGNET survey successful: observed COS at every site!</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>WALK THE WALK for Patient Safety!</td>
<td>Ambulatory Care Quality Program!</td>
<td></td>
</tr>
<tr>
<td>I Commit to...</td>
<td>By Practicing...</td>
<td></td>
<td></td>
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<tr>
<td>---------------</td>
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<td></td>
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</tr>
<tr>
<td><strong>Our Safety Behaviors</strong></td>
<td><strong>Error Prevention Tools</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1. Attention to Detail | • *Self Checking Using STAR*
| |   • *Stop*
| |   • *Think*
| |   • *Act*
| |   • *Review*
| 2. Communicate Clearly | • 3-Way Repeat Back & Read Back
| | • Phonetic & Numeric Clarifications
| | • Clarifying Questions
| 3. Handoff Effectively | • Use SBAR to handoff:
| |   • *Situation*
| |   • *Background*
| |   • *Assessment*
| |   • *Recommendation*
| 4. Speak up for Safety | • Crucial Conversations
| | • Question & Confirm
| | • Stop The Line for imminent
| | • Use ARCC to escalate safety concerns
| |   • *Ask a Question*
| |   • Make a *Request*
| |   • Voice a *Concern*
| |   • Use *Chain of Command*
| 5. Got Your Back! | • Peer Checking
| | • Peer Coaching
# Main Line Health Reliability Toolkit for Leaders

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Tools</th>
</tr>
</thead>
</table>
| **Make Safety a Core Value** | 1. Start every meeting with a safety topic or story  
2. Recognize & support people who ask the safety question or “stop the line for safety”  
3. Transparency in sharing safety events  
4. Embed safety in hiring and performance reviews  
5. Encourage and reward reporting of safety events – eliminate fear of reporting |
| We put patient safety first by using our first words for patient safety. We ask the safety question first, and we ensure that good things always happen to those who speak-up for safety. | |

<table>
<thead>
<tr>
<th>Find &amp; Fix System Problems</th>
<th></th>
</tr>
</thead>
</table>
| 1. Daily Check-In  
2. Start the Clock for Safety  
3. Brief / Execute / Debrief | |
| We improve patient care every day by fixing system problems before they find us. We are sensitive to operations, identify problems that make safe patient care difficult to deliver, and solve the causes of those problems. | |

<table>
<thead>
<tr>
<th>Build Accountability</th>
<th></th>
</tr>
</thead>
</table>
| 1. 5:1 feedback  
2. Rounding To Influence  
3. Just Culture  
4. Red Rules | |
| We make reliability a reality by building sound practice habits in our staff. We reinforce sound practice habits, we discipline those who make risky choices, and we never punish those who experience honest mistakes. | |
Celebrating Front Line Safety Heros!

“Great Catch” Winners
The *Safety Heroes* Program
### Measuring Performance – First, Do No Harm

**Quality & Patient Safety Dashboard - Quality Year 2016**

*Year To Date Apr 2015 - Aug 2015 (5 Mos.), unless otherwise noted*  
*Baseline Period Jan 2014 - Dec 2014*

**Safe**

<table>
<thead>
<tr>
<th>Desired Direction</th>
<th>System</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>Hospital D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventable Harm Events SSE1-S</td>
<td>4.00</td>
<td>4.00</td>
<td>3.00</td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Procedure Related Adverse Events</td>
<td>5.00</td>
<td>4.00</td>
<td>3.00</td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Inpatient Falls with Harm Score E or Worse - Acute</td>
<td>6.00</td>
<td>5.00</td>
<td>4.00</td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Pressure Ulcer Incidence - Hospital Acquired, Stage II or Worse, per 1,000 patient days</td>
<td>1.00</td>
<td>0.90</td>
<td>0.80</td>
<td>0.70</td>
<td>0.60</td>
</tr>
</tbody>
</table>

**Timely**

<table>
<thead>
<tr>
<th>Desired Direction</th>
<th>System</th>
<th>Hospital A</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Timely</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time from Arrival (Door) to Qualified Medical Practitioner - Admitted</td>
<td>27</td>
<td>28</td>
<td>17</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Time from Bed Request (Smart Chart) to Time of Departure (from T System) – Admitted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

**Effective**

<table>
<thead>
<tr>
<th>Desired Direction</th>
<th>System</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>Hospital D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Day Readmission within MLHS (Observed / Expected)</td>
<td>0.90</td>
<td>0.88</td>
<td>0.86</td>
<td>0.84</td>
<td>0.80</td>
</tr>
<tr>
<td>Acute Myocardial Infarction 30 Day Readmission</td>
<td>1.00</td>
<td>0.98</td>
<td>0.96</td>
<td>0.94</td>
<td>0.92</td>
</tr>
<tr>
<td>COPD 30 Day Readmission</td>
<td>0.97</td>
<td>0.95</td>
<td>0.93</td>
<td>0.91</td>
<td>0.89</td>
</tr>
<tr>
<td>Congestive Heart Failure 30 Day Readmission</td>
<td>0.51</td>
<td>0.49</td>
<td>0.47</td>
<td>0.45</td>
<td>0.43</td>
</tr>
<tr>
<td>Hip Replacement 30 Day Readmission</td>
<td>0.84</td>
<td>0.82</td>
<td>0.80</td>
<td>0.78</td>
<td>0.76</td>
</tr>
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</table>

**Efficient**

<table>
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<tr>
<td><strong>Efficient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>1.30</td>
<td>1.40</td>
<td>1.50</td>
<td>1.60</td>
<td>1.70</td>
</tr>
</tbody>
</table>

**Equitable**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Equitable</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30 Day Readmission within MLHS (Observed / Expected)</td>
<td>0.92</td>
<td>0.90</td>
<td>0.88</td>
<td>0.86</td>
<td>0.84</td>
</tr>
<tr>
<td>30 Day Readmission Medicaid</td>
<td>0.92</td>
<td>0.90</td>
<td>0.88</td>
<td>0.86</td>
<td>0.84</td>
</tr>
<tr>
<td>30 Day Readmission Commercial Payor</td>
<td>0.69</td>
<td>0.68</td>
<td>0.67</td>
<td>0.66</td>
<td>0.65</td>
</tr>
</tbody>
</table>

**Patient Experience (HCAHPS)**

<table>
<thead>
<tr>
<th>Desired Direction</th>
<th>System</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>Hospital D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCAHPS Response Hospital Staff - 65+ year olds</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
</tr>
<tr>
<td>HCAHPS Response Hospital Staff - 18-64 year olds</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
</tr>
<tr>
<td>HCAHPS Communication re Medicine - 65+ year olds</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
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<td>60.0%</td>
</tr>
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Safe  
Timely  
Effective  
Efficient  
Equitable  
Patient centered
# Main Line Health’s Journey: Building Reliable Culture of Safety

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<th>2010</th>
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![MAGNET Recognized Logo]
Main Line Health – Preventable Harm
Serious Safety Events
January 2010 – September 2015

88% Reduction

SSE 1: Death

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SSE 3: Significant harm with no expected change in condition yet not sufficiently severe to impact activities of daily living (ADL) or business functioning. Includes permanent reduction in physiologic reserve, disfigurement, or impaired or aided sense or function

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SSE 5: Significant harm lasting for a limited time, requires a higher level of care/monitoring or an additional minor procedure or treatment to resolve the condition
Our MAGNET Nurses – LIVING The MLH Reliable Culture of Safety
MLH Journey to High Clinical Reliability

Continuing the Journey: Reducing Mortality Ratios
Our performance was not highly reliable yet…

Sepsis Mortality, Main Line Health (Acute)

Index (Actual / Expected)

MLHS QY2013 Target (0.96)

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<tbody>
<tr>
<td>Jan-Mar</td>
<td>(31)</td>
<td>(24)</td>
</tr>
<tr>
<td>Apr-Jun</td>
<td>(36)</td>
<td>(28)</td>
</tr>
<tr>
<td>Jul-Sep</td>
<td>(36)</td>
<td>(36)</td>
</tr>
<tr>
<td>Oct-Dec</td>
<td>(35)</td>
<td>(32)</td>
</tr>
<tr>
<td>Jan-Mar</td>
<td>(36)</td>
<td>(33)</td>
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Quarters (with count of mortalities at MLHS)

Source: Premier via MLHS Dashboard database
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   Establish an accountability system to convert behaviors to work habits

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Set Expectations, Provide Tools, Build Accountability...

• Get clarity on roles and responsibilities of clinical leadership – Set expectations for accountabilities of dyads

• Focus work at the clinical microsystem level – Accountability for performance of care units/programs/teams

• Create a clinical environment with high reliability characteristics – accountabilities for reliable process design, clinical performance, error prevention and good “citizenship”

• Demonstrate how System - Entity - Microsystem work together cohesively – accountability for coordination of care

See Appendix for “dyadic management model in a clinical environment”
Clinical Microsystems Definition

- Small functional front-line units that provide most health care to most people
- Where patient and providers intersect
- Essential building blocks of larger organizations and health systems
- Quality and value produced by any system can be no better than the services generated its Microsystems.
2 Types of Clinical Microsystem Work

Clinical Environments

• where clinical work is done and used by multiple clinical programs
  – OR/Surgical Services, Inpatient Medicine/Critical Care, ER
• Responsible to optimize efficiency of the environment for those that use it
• “CEWs” – Clinical Environment Workgroups

Clinical Programs/Service Lines

• Clinical teams that care for patients; often across the continuum
• Responsible for clinical outcomes
The Work

• Manage in a matrixed, complex environment
• Create clarity in what is asked of clinical leadership in their management roles
• Try to keep the message simple:
  – How we measure our work
  – How we do our work
  – How we prioritize and project manage our work
Main Line Health Environment

*CIN = MLH Physician Partners
Organizational Structure

Senior Exec Council

System Clinical Operations

- System Clinical Environment Workgroups (CEWs)
- Campus Clinical Operations
- Clinical Programs/Service Lines

Clinical Infrastructure: The Microsystems
Organizing our work

Transforming Systems of Care: MLH Quality and Patient Safety Framework

Senior Executive Council

*PI, Project Management Competencies & Perpetual Readiness

Financial, Clinical & Operational Analytic Competencies

Population Workgroup Focus

Surgical Population
Cardiovascular Conditions
Respiratory Conditions
High Risk Patient Care Management

Cross-functional Workgroups

Safety Initiatives: Reliable Culture of Safety, Eliminating Harm and Reducing Mortality

Quality Initiatives: Improving Transitions of Care, Patient Experience and Delivery of Culturally Competent Care

Clinical Infrastructure work: (e.g. Smart Chart and Next Gen optimization, 3M Clinical Documentation and Ambulatory Quality/ACO)

Optimizing the Clinical Environment: Accountability Infrastructure

System Clinical Operations Council

Campus Clinical Operations Teams

Clinical Environment Workgroups and Microsystems

Inpatient Medicine and Critical Care Microsystems
Emergency Medicine Microsystems
Women and Infants Microsystems
Surgical Microsystems
Rehab Services
Ambulatory Services

Inpatient Medicine and Critical Care CEW
BMH LMC PH RH

Emergency Medicine CEW
BMH LMC PH RH

Women and Infants CEW
BMH LMC PH RH

Surgical Services CEW
BMH LMC PH RH

Revised: 5/14/15
*Process Improvement
### MLH PERFORMANCE IMPROVEMENT PRIORITIES (QY2016-2017)

<table>
<thead>
<tr>
<th>CLINICAL QUALITY</th>
<th>PROCESS/OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eliminate Preventable Harm and Reduce Unexpected Mortality</td>
<td>1. Improve Reliability of Specimen Handling</td>
</tr>
<tr>
<td>2. Optimize Care Management and Care Coordination</td>
<td>2. Improve Patient Flow (decision to admit through arrival in bed)</td>
</tr>
<tr>
<td>3. Improve the Patient Experience (Increase HCAHPS/PG Scores)</td>
<td>3. Reduce Variation in Care (Reduce Cost and LOS)</td>
</tr>
<tr>
<td>4. Decrease Healthcare Associated Infections (HAIs) (Device related, SSI)</td>
<td>4. Optimize/Standardize Perioperative Care</td>
</tr>
<tr>
<td>5. Decrease Falls with Harm</td>
<td>5. Improve OR Flow/Utilization</td>
</tr>
<tr>
<td>6. Decrease Pressure Ulcers</td>
<td>6. Improve Outpatient Throughput Process</td>
</tr>
<tr>
<td>7. Decrease Hospital Acquired VTE</td>
<td>7. Enhancing Healthcare Analytics Competency (New)</td>
</tr>
<tr>
<td>10. Improve Access and Timeliness of Palliative Care &amp; Hospice Services (New)</td>
<td></td>
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</tbody>
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Revised: Sep. 3, 2015
<table>
<thead>
<tr>
<th>STEEEP – How We Measure Our Work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe</strong></td>
</tr>
<tr>
<td>• Avoiding injury to patients from care that is intended to help them, without accidental error or inadvertent exposures</td>
</tr>
<tr>
<td><strong>Timely</strong></td>
</tr>
<tr>
<td>• Reducing waits and harmful delays impacting smooth flow of care</td>
</tr>
<tr>
<td><strong>Effective</strong></td>
</tr>
<tr>
<td>• Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding overuse and underuse)</td>
</tr>
<tr>
<td><strong>Efficient</strong></td>
</tr>
<tr>
<td>• Using resources to achieve the best value by reducing waste and reducing production and administrative costs</td>
</tr>
<tr>
<td><strong>Equitable</strong></td>
</tr>
<tr>
<td>• Providing care that does not vary in quality according to personal characteristics, such as gender, income, ethnicity, location</td>
</tr>
<tr>
<td><strong>Patient-centered</strong></td>
</tr>
<tr>
<td>• Providing care that is respectful of and responsive to individual patient preferences, needs, and values</td>
</tr>
</tbody>
</table>
Clinical Environment and Program Leadership – *How We Do Our Work*

- Standardizing Clinical Work
- Operational Efficiency and Work Flow
- Adverse Event Review and Risk Mitigation
- Clinical Informatics and Data Analytics
- Education and Competency Enhancement
- Communication and Engagement
System Clinical Operations

• System level executive leadership that provides operational oversight of campus clinical operations, clinical program performance and clinical infrastructure

• Membership: CNO, CMO, VP – QPS, Campus Clinical Operations leaders, System CEW leaders, Clinical Infrastructure leaders
  – Includes Nursing VPs, VPMAs, CMIO, Systems Chairs of ER, Medicine, Surgery and OB

• Reviews MLH Quality dashboard, STEEEP reports from CEWs and focuses on variances from target

• Responsibilities: manage escalations, approve clinical variances requested from programs, clinical programs and campuses, facilitate inter-campus collaboration, ensure clinical infrastructure
Campus Clinical Operations

• Campus level executive leadership that provides operational oversight of campus clinical operations, clinical program performance and clinical infrastructure

• Membership:
  – Direct contributors: VPMA, VP – Patient Services, VP Administration, Campus CEW (“microsystem”) leaders
  – Supporting contributors: patient safety specialists, quality director, case management, clinical informatics, infection prevention, etc.

• Reviews campus STEEEP reports to assess microsystem performance with focus on variances from target

• Responsibilities: Campus operational efficiency. Is standard work being done and pathways adhered to? Are the campus clinical interfaces working well? Manage implementation of CEW/microsystem initiatives to improve outcomes.
System Clinical Environment Workgroups (CEWs)

• System leadership of key clinical programs and services within the inpatient environment *across hospitals*
  – Inpatient Medicine/ICU Services
  – Surgical Services
  – OB/Neonatal Services
  – Emergency Services

• Key responsibilities
  – standardize processes
  – assure targeted STEEEP performance in their clinical environment
  – optimize operational efficiency
  – manage key clinical interfaces from a System perspective
Individual Accountability

• Thoughtful selection, on-boarding and mentoring processes for microsystem members

• Clear behavior and operational standards
  – Use of standard order sets, hand hygiene, isolation protocols, scrub the hub

• Regular assessment of team and individual performance

• Aligned performance management system between MLH employee and medical staff (see appendix for performance management algorithm)
Next Step in COS Journey:
Reducing Mortality Ratios
Mortality Content Work

• Targeted efforts in clinical areas associated with mortality
• Content experts develop best practice in specific areas of focus
• Areas of focus
  – Sepsis
  – End of Life/ Palliative Medicine
  – Hospital Acquired Infections
  – Clinical Documentation Improvement
Sepsis Care Efforts

- Created a Sepsis working group for the Main Line Health System
- Determined best practice using national standards
- Sepsis bundle components were defined including Inpatient Sepsis Workflow Alerts
- Campus leaders were charged to oversee implementation and adherence
- Sepsis data reports were developed for tracking
Sepsis Bundle – focused & time sensitive work to develop; reviewed every 2 years and PRN new developments

Sepsis Bundle Components
- Heightened awareness
- Lactate levels
- Blood cultures
- Broad spectrum antibiotics
- Aggressive fluid replacement
- Vasopressors
Accountability Cascade: Sepsis Care

**Inpatient Medicine/Critical Care CEW**
- Creates System multidisciplinary Sepsis team to define best practice
- Defines measurement methods
- Creates educational and implementation process

**Campus Operations**
- Assures operational efficiency of clinical environments
- Assures sepsis protocol adherence by key campus microsystems and functionality of the clinical interfaces
- Manages off variances of STEEEP reports

**Campus Clinical Microsystems**
- Delivers care by protocol
- Measures and manages individual clinician performance
- Manages off variances of STEEEP reports
Managing the Campus Clinical Environment and Interfaces

Critical Care

Emergency Services

Hospital Medicine

Transfer Procedures

Who puts in the central line?

“I think they can go to the floor.”

“Are you kidding me”

Sepsis protocol adherence
End of Life and Palliative Care

• Developed a Palliative Care multidisciplinary care program to serve each acute care hospital and rehabilitation hospital

• Advanced support for futility of care evaluations and appropriate use of hospice services

• Developed a hospice service liaison at each acute care hospital linked back to MLH Hospice and Home Health Care
Hospital Acquired Infections

• Targeted efforts in clinical areas associated with hospital acquired infections that impact observed vs. expected mortality index
• Instituted a restricted blood draw through central line policy with feedback to Inpatient/Critical Care CEW on who/why accessed line
• Reviewed Sepsis Protocols with Infectious Diseases Physicians
• Collaborated with Pharmacy on Antimicrobial Stewardship
• Launched system-wide PI team “Getting to Zero HAIs” (again) 2016
Clinical Documentation Improvement

- Clinical documentation directly influences observed vs. expected mortality index when using administrative data sets.
  - Severity of illness and risk of mortality (used to calculate expected mortality rate) directly related to comprehensive documentation of the patient’s primary clinical condition and major co-morbidities

- A comprehensive program to enhance the quality of clinical documentation and coding was undertaken. Added >20 FTEs.

- Our System case mix index increased, which helped with accuracy of O/E.
Overall Hospital Mortality (Actual/Expected 3M), Main Line Health (Acute)

Index (Actual / Expected)

MLHS

QY2015 Target (0.73)

52% decrease over 12 quarters, p<.001

Quarters (with count of mortalities at MLHS)

Data Source: Premier via MLHS Dashboard database
Sepsis Mortality, Main Line Health (Acute)

Index (Actual/Expected)

- MLHS
- QY2015 Target (0.80)
- Trend

59% decrease over 12 quarters, p<.001

Data Source: Premier via MLHS Dashboard database
MLH Performance, HCAHPS Global Rating % 9 or 10

Calendar Year Trend

MLH is at 78th Percentile Ranking
**Power Distance** is the extent to which the less powerful expect and accept that power is distributed unequally. PD is a measure of interpersonal power or influence superior-to-subordinate as perceived by the subordinate.

**Authority gradient** is the perception of power and authority as perceived by the subordinate.

**Actions:**
Use organizational culture to reduce power distance and flatten the authority gradient found in professional cultures.

Source: HPI *from* *Weick & Sutcliffe attribute of HRO’s:5. Deference to expertise.*
QUESTIONS?

Thank you,

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MurphyD@mlhs.org
The Dyadic Management Model in a Clinical Environment

**Physician Co-Manager**
- Quality of the Clinical Professionals and work
- Provider Behaviors
- Provider Production
- Clinical Innovation
- Compliance
- Patient Care Standards
- Clinical Pathway/Model Management
- Referring Physician Relations
- Provider “Leverage”

**Administrative Co-Manager**
- Mission
- Vision
- Values
- Culture
- Overall Performance
- Internal Org. Relationships
- Strategy
- Operations
- Revenue Management
- Operating Expense Management
- Capital Planning and Application
- Staffing Models
- Performance Reporting
- Supply Chain
- Support Systems and Services
PERFORMANCE MANAGEMENT DECISION GUIDE

Adapted from James Reason’s Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree of the National Patient Safety Agency (United Kingdom National Health Service)

START

- DELIBERATE ACT TEST
  - Did the individual intend the act?
  - YES
    - Intentional Misconduct
    - ACTIONS TO CONSIDER
      - Consult Human Resources
      - Termination
      - Report to Professional Group or Regulatory Body
      - Law Enforcement Referral
  - NO
    - Suspected Medical Condition and/or Ill Health
    - ACTIONS TO CONSIDER
      - Consult Human Resources
      - Occupational Health Referral
      - Leave of Absence
      - Substance Abuse Testing

- INCAPACITY TEST
  - Is there suspicion of ill health, a medical condition or substance abuse?
  - YES
    - Were there any deficiencies in related training, experience, or supervision?
  - NO
    - Possible Careless or Negligent Behavior
    - ACTIONS TO CONSIDER
      - Consult Human Resources
      - Corrective Intervention or Termination
      - Job-fit Consideration
      - Final Expectations Discussion
      - IF SUBSTANCE ABUSE:
        - Substance Abuse Testing
        - Corrective Intervention or Termination
        - Report to Professional Group or Regulatory Body

- COMPLIANCE TEST
  - Did the individual depart from policies, procedures, protocols, or generally accepted performance expectations?
  - YES
    - Were the policies, procedures, protocols, or performance expectations available, understandable, workable, and in routine use?
  - NO
    - Possible Unintended Human Error
    - ACTIONS TO CONSIDER
      - Consult Human Resources
      - Performance Expectations Review
      - Performance Coaching
      - Increase Supervision
      - Adjustment of Duties
      - Review Policies/Expectations
      - Additional Education
      - Console

- SUBSTITUTION TEST
  - Would individuals in the same profession and with comparable knowledge, skills, and experience act the same under similar circumstances?
  - YES
  - NO

The diagram provides a decision-making process to determine culpability and appropriate actions based on the nature of the act and the context of the incident.