

Say "I Promise": Taking Indiana's Quality and Safety Efforts to Scale

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Indiana Hospital Association



Session Objectives

- Describe the current statewide, regional, and national efforts to improve patient safety.
- Discuss opportunities for quality professionals to lead broad-based change efforts
- Outline applicable social movement principles to leverage community health improvements and patient safety efforts.



Indiana Patient Safety Center Mission

*To facilitate the development of safe
and reliable health care systems that
prevent harm to patients.*

Launched July 1, 2006



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IPSC Guiding Principles/Values

- ◆ Leadership
- ◆ Collaboration and inclusiveness
- ◆ Innovation
- ◆ Transparency
- ◆ Integrity, respect, and trust
- ◆ Science-driven
- ◆ Focus on continuous improvement
- ◆ Proactive and positive



Indiana's Bold Aim

- To make Indiana the safest place to receive care in the United States, if not the world



How Might We Do This?

- Focus on initiatives that improve all six IOM aims – safety, effectiveness, efficiency, equity, timeliness, patient-centered care
- Emphasis on measurement and transparency
- Statewide alignment and energy
- Embracing personal and collective nature of change



Achieving Improvement

- Will – role of senior leaders
- Ideas – change package, ideas from other organizations, ideas generated at the front lines of care
- Execution
 - requires senior and mid-level leadership
 - the “work” of improvement and spread

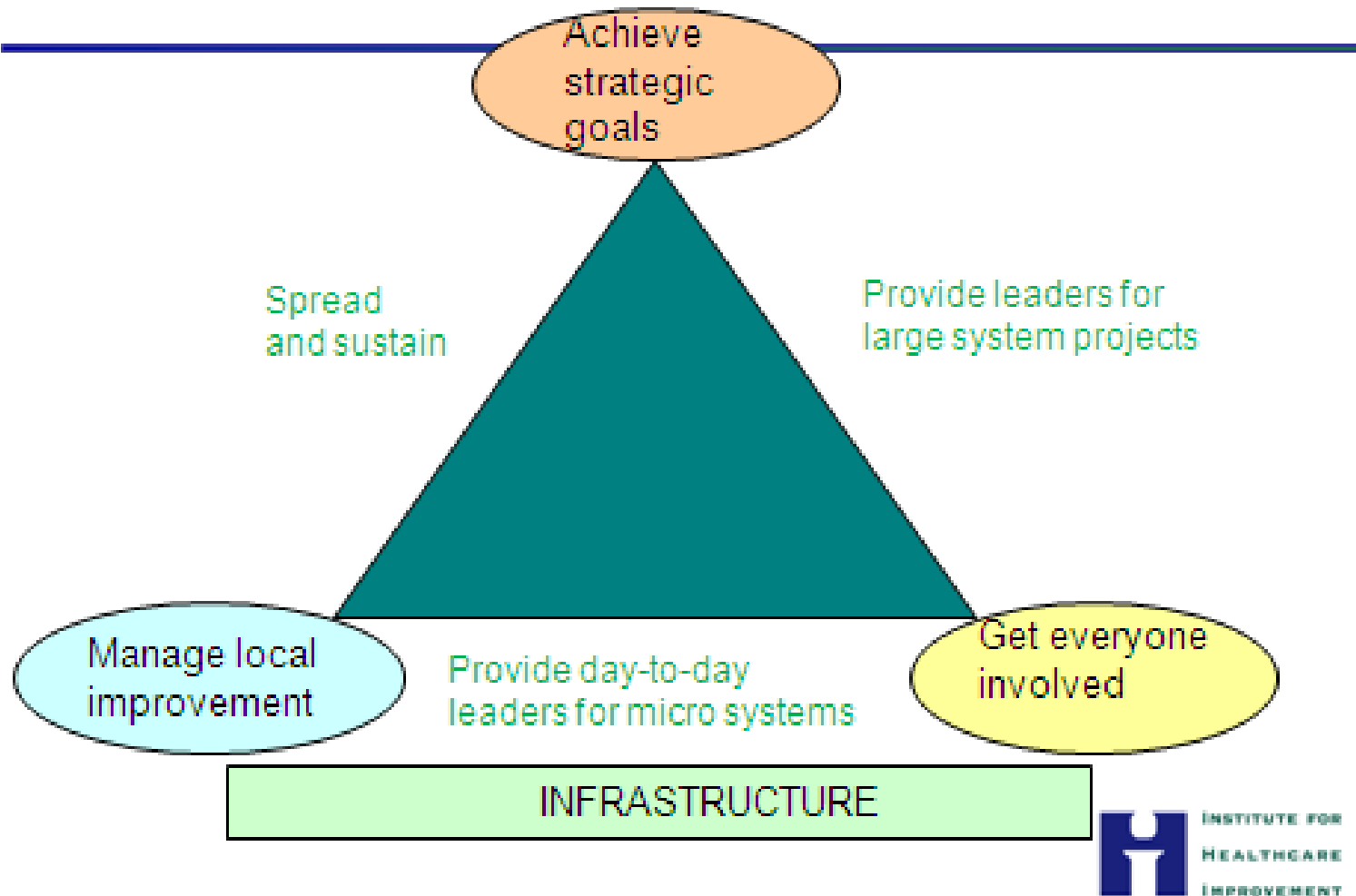
Nolan, T. *Execution of Strategic Improvement Initiatives to Produce System-Level Results*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.ihl.org)



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Execution Framework



Nolan, T. *Execution of Strategic Improvement Initiatives to Produce System-Level Results*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.ihl.org)

Design Challenge

IOM's "New Rules"

1. Care based on continuous healing relationships
2. Customization based on patient needs and values
3. The patient as the source of control
4. Shared knowledge and the free flow of information
5. Evidence-based decision making
6. Safety as a system property
7. The need for transparency
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians



Four Levels of Change Required

- Changes at Level A: experience of the patients and communities
- Changes at Level B: “microsystems” of care
- Changes at Level C: health care organizations
- Changes at Level D: health care environment



Patient Safety is Personal!

- Stories are important means of demonstrating urgency
- Involve patients and families
- Connect health care workers at the level of the heart
- Berwick: Changes at Level A are the “true north” of improvement



Josie King Story

- Book: “Josie’s Story”
- Nursing Journal
- Care Journal

www.josieking.org

- Sorrel King
 - Greenfield, IN on May 19, 2010
 - Community patient safety event sponsored by Hancock Regional Hospital



Indiana's Quality and Safety Initiatives

- Building Cultures of Safety
 - Culture of Safety Survey
 - Just Culture
- Common Tools and Methods
 - RCA, HFMEA
 - Standardization
- Targeted Clinical Topics
 - Eliminating HAIs and Pressure Ulcers
 - Preventing Readmissions



Culture of Safety Survey

- Survey instrument (AHRQ)
- Web-based front-end to measure employee/physician perception of the culture of safety – licensed from GHA
- Comparisons available to AHRQ database, Indiana hospitals, peer groups, districts, and bed size
- Participate in AHRQ national database
- Over 59,000 employee responses in Indiana database from 86 Indiana hospitals between March 2007 and April 2010

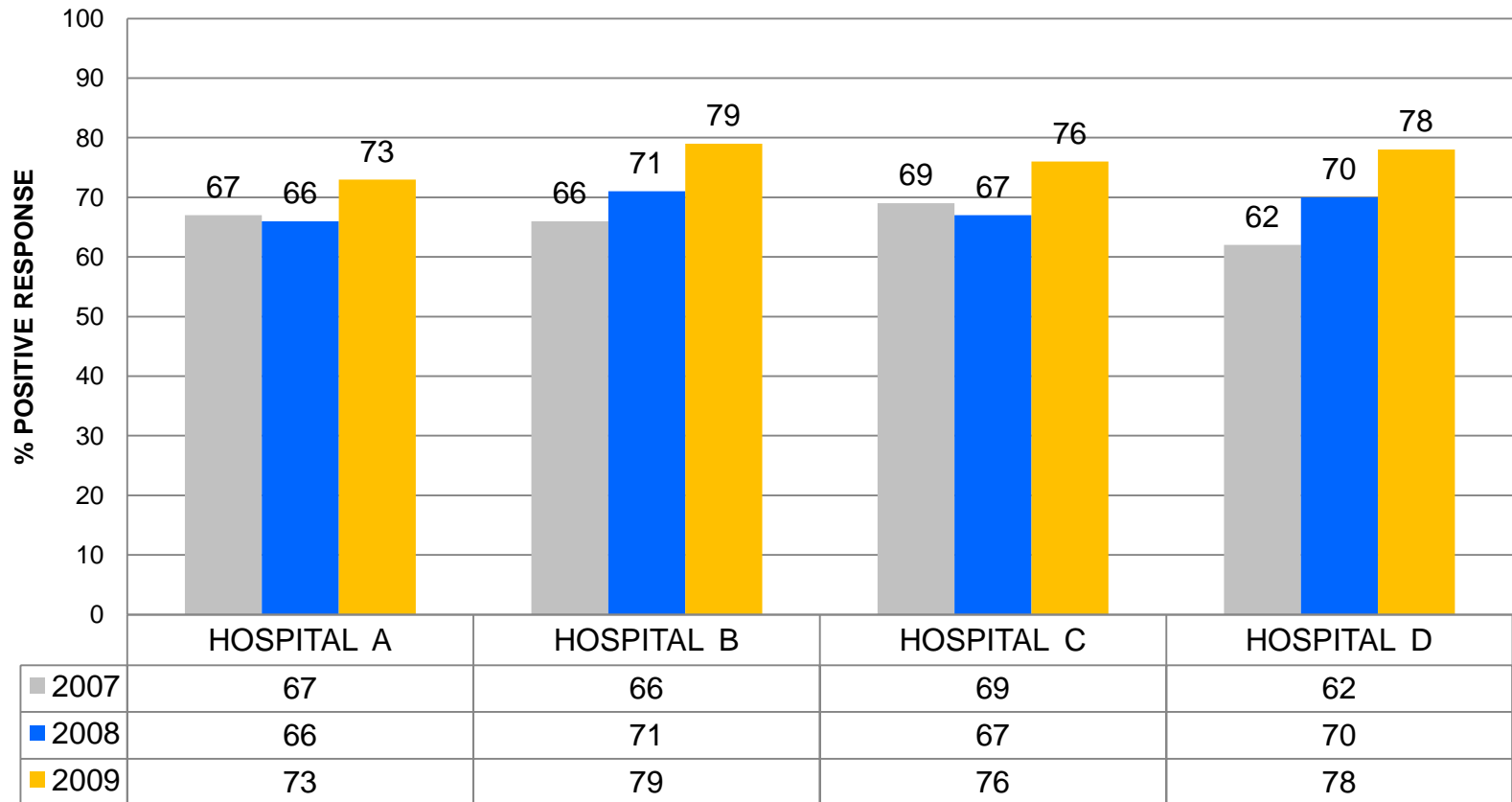


Evaluating Survey Results

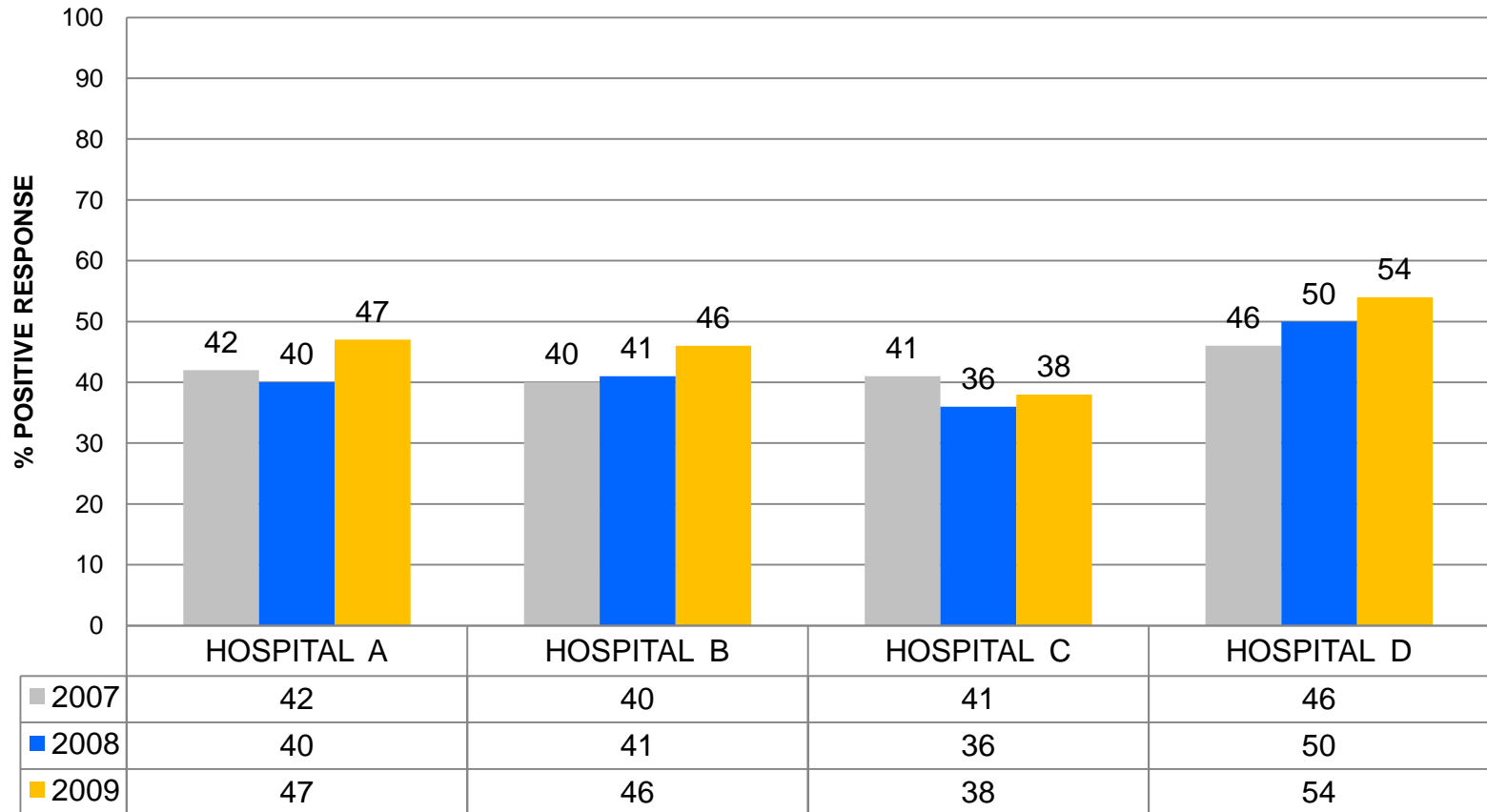
- 2007 – 15,819 surveys
- 2008 – 16,876 surveys
- 2009 – 20,336 surveys
- No significant changes in results in the statewide results
- However, some hospitals that have repeated the survey each year are seeing “significant” changes (of at least 5% per AHRQ)



Management Support for Patient Safety



Non-Punitive Response to Error



Areas for Continued Improvement

- Increasing the frequency of events and near misses reported
- Providing employees feedback about safety changes
- Creating climates with non-punitive response to error and encouraging just cultures
- Improving inter-departmental relations and reducing authority gradients
- Improving hand-offs and communication



Just Culture Algorithm

Differentiate Human Error vs. Unsafe Behavioral Choices

- Human error: “Console”
- “At Risk” Behaviors: “Coach”
- “Reckless” Behaviors: Consider disciplinary action



Common Tools and Methods

- Annual Patient Safety Tools Training
 - Basic (RCA, HFMEA, Error Proofing)
 - Advanced (ex. ST-PRA, advanced RCA)
- Standardization of processes
 - Wristband colors for patient alerts
 - Emergency codes
 - Topics for possible future standardization:
 - Isolation signage
 - Medication lists
 - IV pump medication concentrations



Wristband Standardization

- State and national movement toward standardizing wristband colors for patient conditions.
- Indiana Hospital Association recommendations:
 - White/Clear: Patient ID
 - Red: Allergies
 - Yellow: Fall Risk
 - Purple: Do Not Resuscitate
 - Pink: Restricted extremity
 - Green: Latex allergy (if you feel you need another color)
- Implementation toolkit available on www.indianapatientssafety.org



Emergency Code Standardization

- IHA Council on Quality and Patient Safety recommends moving to “plain language” codes
- If you use colors, move to at least these standard colors:
 - Blue for patient arrest
 - Red for fire
 - Amber for infant or child abduction
- Forming task force to evaluate further standardization



2010 Indiana Clinical Initiatives

- Indiana Pressure Ulcer Initiative (ISDH)
 - Phase II continuing in 2010
- Indiana HAI Initiative (ISDH)
- Preventing Readmissions (IHA educational series)



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ISDH Indiana Pressure Ulcer Quality Improvement Initiative

- **University of Indianapolis coordinating Phase II of the Pressure Ulcer Initiative designed to assist health care facilities, hospitals, home health & hospice, patients, residents and caregivers:**
 - To implement improved pressure ulcer care PRACTICES and
 - To increase CARE COORDINATION across the continuum of health care settings.
- Phase I shows early promising results with pressure ulcer reduction



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**WE
WILL**

**PREVENT PRESSURE ULCERS.
KNOW THE FACTS. TAKE ACTION.**

Indiana HAI Initiative

- Applications due May 14th
- Focus on *c. diff.* and CAUTI
- Continuum of care – nursing homes (30), hospitals (30) and home care (20)
- Two regional learning sessions (10/2010 and 4/2011)
- Congress in Sept. 2011 in Indianapolis
- Data collection using NHSN
- Funded by ARRA funds through CDC



Global and National Quality Initiatives

- IHI Improvement Map
- WHO Surgical Safety Checklist
- WHO Hand Hygiene Day
- On the CUSP Stop BSI



IHI's Improvement Map

- An online tool that distills the best knowledge available on the key process improvements that will lead to better outcomes for patients.
- Maps 70 processes
- Next release in May 2010
- <http://www.ihl.org/imap/tool/>



WHO Surgical Safety Checklist

- Register your participation by completing the following survey:

http://www.surveymonkey.com/s.aspx?sm=v5PfRnrcnAQIX44n9H02EQ_3d_3d



On the CUSP Stop BSI – Preventing Central Line Associated BSI

- Initiative to expand the Michigan Keystone project
- Sponsored by the Agency for Healthcare Research and Quality and the Health Research and Education Trust (AHA)
- Faculty from Johns Hopkins University
- Expanded to include all 50 states
- 20% of hospitals in US are participating
- Standardized data collection tools and evidence
- Applies both technical and adaptive changes
- Resources at www.onthecuspstophai.org



WHO Hand Hygiene Day

May 5, 2010



<http://www.who.int/gpsc/5may/en/>



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Leadership Practices to Lead Social Change (Ganz)

- Enabling people to act together to find solutions to urgent challenges
- Relationships- building mutual commitments to common purpose
- Organizational structure based upon team leadership rather than individual leadership
- Must translate shared values into action – this involves strategy
- Outcomes need to be clear, measurable, and specific









Putting the Pieces Together

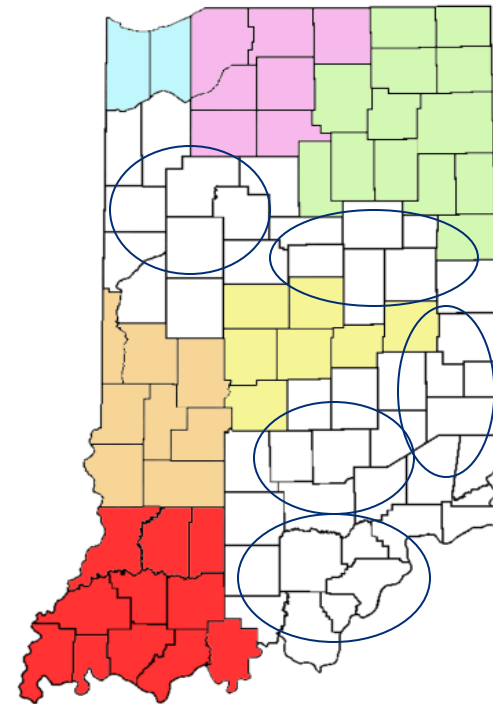
- Aim: To Make Indiana the safest place in the country to receive care
- Measures: Dashboard of aggregate statewide measures
- Innovation and Testing Changes:
 - Expand the regional safety coalitions as the testing grounds for change
 - Align with state and national initiatives
 - Connect to our promises to patients
 - “Raise all boats”



Indiana's Regional Patient Safety Coalitions

	Southwest Patient Safety Coalition
	Central Southwest Patient Safety Coalition
	Indianapolis Patient Safety Coalition
	Northwest Indiana Patient Safety Coalition
	Northeast Indiana Patient Safety Coalition
	Michiana Patient Safety Coalition

- 6 existing coalitions - 90 hospitals
- Focus on local quality and safety issues
- Innovate at the front lines, standardize when beneficial
- Goal – Add 2-5 coalitions in 2010



Regional coalition topics

- Community medication lists
- Standardized IV pump concentrations
- Implementation of wristband colors and emergency codes according to the IHA recommendations
- Preventing readmissions
- Eliminating infections
- Just culture
- Surgical safety/site marking standards



Dashboard Development

Exploring measures that target:

- Mortality (HSMR, AHRQ IQI and PSI)
- Quality and Effectiveness (Readmissions and Appropriate Care Composite scores)
- Patient Safety (HSOPS, Reportable Med Errors, PSIs, HACs not POA)
- Patient Centered Care (HCAHPS)
- Cost Index, if available



National Priorities Partnership

Six overarching aims for national quality agenda:

- Engage patients and families
- Improve health of the population
- Improve safety and reliability of systems
- Ensure well-coordinated care across settings
- Improve end-of-life care
- Eliminate waste and overuse



IHA Health Status Improvement Task Force

- Dual approach through employee programs and community efforts
- Six measures:
 - Smoking rates
 - Obesity rates
 - Adult diabetes
 - Prenatal care in the first trimester
 - Childhood immunizations
 - Self-reported poor mental health
- Tobacco Cessation and Obesity toolkits

on www.ihaconnect.org



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Transforming Care

- Focus on the systems of care and on redesigning work processes
- Must involve “sharp end” caregivers
- Education and training alone will not work – requires increased “mindfulness”
- Cultural change requires strong leadership



Say “I Promise”

- Elevating personal commitment to collective action
- What would happen if every Indiana nurse, doctor, hospital CEO, ancillary team member, manager said, “I promise”?
- What if every Indiana health care provider signed a “Caregivers’ Creed”?



“Quality improvement begins with love and vision. Love of your patients. Love of your work. If you begin with technique, improvement won’t be achieved.”

--A. Donabedian, M.D

The Leadership Challenge

- Model the Way
- Inspire a Shared Vision
- Challenge the Process
- Enable Others to Act
- Encourage the Heart

[The Leadership Challenge](#)

Kouzes and Posner, 2002



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Michelangelo's Thoughts on Transformation



“In every block of marble I see a statue as plain as though it stood before me, shaped and perfect in attitude and action. I have only to hew away the rough walls that imprison the lovely apparition to reveal it to the other eyes as mine see it.” Michelangelo

“I saw the angel in the marble and carved until I set him (her) free.” Michelangelo



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