Taking Quality to the Next Level

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Pre-Flight Check List

- Brief History of the “Quality Movement”
- How We Improve the Fundamentals
- Creating Highly Reliable Organizations
- Taking Quality to the Next Level
A Brief History of the Quality Movement

- 500 year old social contract
- Quality defined primarily by ‘structure’
- “To Err is Human” changed everything
- Purchaser, Payer, Consumer activation
- Global competition based on quality and efficiency
- Healthcare must rapidly and radically change
Defining Quality

- No agreed upon definition of quality
- Value = Quality/Cost
- “Crossing the Quality Chasm”
- Quality care is: Safe, Timely, Effective, Efficient, Equitable, and Patient and Family centered
Progress: Too Little, Too Slow

- International comparisons
- Low active participation in improvement
- Best get it right 50%
How Do We Improve

“The definition of lunacy is keep doing what you’ve always done and expect a different result!”

Albert Einstein
Getting Started on Change

• Focus on ability to change behaviors needing change more than the attitude
• Study the best, seek positive deviance
• Test change with short cycle times
Getting Started on Change

- People are more supportive of change when they have a role in deciding and designing the change. Involve as many as possible as soon as possible
What We Need to Know to Get Started on Improvement

• How are we really doing now?
• How do we compare to others?
• What can we try to improve our results?
• How do we make change happen?
• How do we sustain the change and keep on improving?
Context for Improvement: Structure, Process, and Outcomes

- Variation in outcomes suggests variation in structure and/or process
- Adjusting for patient severity places emphasis on process variation (compare self to self over time)
- Best practice: just do it
- No best practice: possibilities emerge through cycles of improvement. Take advantage of natural experiments
Our Challenge as Providers

“...everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it.”

Paul Batalden, MD
Answering the Challenge

“Be where you are with all your mind”

New York Central Railroad: Machine Shop
Healthcare: A High Risk Environment

• Potential for an ‘excess’ of unexpected events due to the complexity of the patients and the complexity of the technologies and treatments used

• This risk, in part, results from a failure to detect early warning signals and respond aggressively to them
Highly Reliable Organizations

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Deference to expertise
- Resilience

- When all characteristics are present and fully functioning, an organization is said to have “collective mindfulness”
Preoccupation with Failure

• Any lapse is a symptom of system vulnerability. Treat all failures and near misses as windows on the health of the system

• All errors and near misses are reported and used as learning opportunities. Reward the reporting of failures

• Examine all real failures, near misses, and failures of success (expect the same action to yield same result)
Sensitivity to Operations: Situational Awareness

- “Latent failures” are loopholes in any system’s defenses. Will always occur because we are human. We are often the weakest link.
- Discover latent failures in the course of normal operations before a failure occurs. (near miss)
- Attentive to the front line where the real work gets done
- Culture: open, speak-up
Sensitivity to Operations

- The hospital is a complex integration of interrelated, interdependent processes. What is happening upstream and downstream?
- Must maintain explicit and communicated situational awareness, such as pre and post shift briefing sessions (huddles). “What/who are we worried about; what went well; what could have gone better”?
- Real time information permits early identification and action. Real time fixes.
- Perception-Integration-Extrapolation
Deference to Expertise

• Hierarchy can slow response and amplify errors, especially if error occurs near the top
• Open access to information
• Decision making migrates with the issue—who is the best person to address the challenge?
Building a Highly Reliable Organization

• Create a climate where it is safe to report and question assumptions
• Conduct incident reviews (debriefs) frequently and soon after the event
• View close calls as sign of potential danger not success, look deep within the system
• Maintain situational awareness of current practices and changes in those practices-real time auditing
• Make knowledge about the system transparent and widely known (process measures)
Maintaining and Supporting Behavioral Change

- Huddles
- Leadership rounding
- Support real-time auditing and review
- Support on-going education and training
- Support a ‘culture of safety’ that is “Just” and encourages reporting and questioning
“When an ever increasing amount of information has to be squeezed into the relatively constant amount of time each of us has at our disposal, the span of attention necessarily decreases”

social anthropologist Thomas Eriksen
How We Too Often Work

• When we don’t see what is really happening, we act out of habit, our propensity to do certain things in certain ways...this may not be the right response for the actual event
How Humans Usually Think

We are faced with an overwhelming amount of information.
How we pay attention, filters and limits the information we have.
We then use that limited information as the basis of our decision making and actions.
We tend to hold onto and seek support for our ‘good’ ideas and theories (confirmation bias) and exclude/discount contradictory information.
Mindfulness: Individual, Team, and Organization

Individual mindfulness: Paying attention to present experience, non-judgmentally

Collective Mindfulness includes: a Culture of respectful interaction (team and organization); the Desire to continually update situational awareness (team and organization); Regular and standardized communication and Competence via education and training (team and organization)
Mindlessness

• Mindlessness is more likely when people are distracted, hurried, or overloaded. To deal with production pressures people ignore discrepant clues and cut corners (work-around)

• Mindlessness also occurs when people feel they are not heard and can not act upon their concerns
Mindlessness vs. Mindfulness

Comfort with policies and procedures (designed for the perfect environment)

versus

Continuing efforts to update procedures, perceptions, expectations, and actions by always checking if information fits expectations and plans
Sustaining New Behaviors

• What actions by leaders and staff are needed to support the new behavior patterns? More than new policies and procedures.
• What new structures and information flows are needed to support and sustain the new behaviors?
• What new training, education, meetings, communications are needed for staff to perform and interact appropriately
Sustaining the Gains

• The #1 enemy of sustaining the gains is the next new initiative
• Must embed the work into routine, everyday practice (the way we do things around here)
• Evolve from ‘a project’ to on-going discovery and improvement
Role of Leaders

• Stay engaged
• Seek and welcome in-put. Active listening vs. advocacy
• Support training and education
• Support real-time auditing
• Be patient. Focus on behavior more than attitude
• Focus on majority not the outliers
• Celebrate and promote results
• Maintain focus on big picture
Role of Staff

- Actively participate
- Openly share what is working/what’s not
- Ask the tough questions: why 5 times
- Be patient
- Expect transient losses of competency
- Be mindful, pay attention
- Keep learning
Taking Quality to the Next Level

A Journey of “Self” Discovery
Self =

• Each Individual

• The Team

• The Organization
Mindfulness

• Individual/Personal: pay attention

• Team: respectful communication

• Organization: what information is gathered and shared and acted upon
Reliability

- Personal/Individual: Technical skills
- Team: Non-technical skills (communication and culture)
- Organization: Process Design (culture, communication, flow)
Achieving High Reliability

Each “self” must be mindful, must be paying attention, in ways unique to that ‘self’.

Yet, together, they work in total harmony as a whole, highly reliable organization.
The Bottom Line

The way Each individual pays attention to and performs their job

plus

The way All individuals inter-relate, interact, and communicate while working ultimately determines the quality and safety of health care.
Delivering Highly Reliable Care

A Call to Action

If not us, who...if not now, when?