Culture, Systems and Systems Change

What Is Involved in Making Major Change

- Tackling the core issues
- The basis for success
- The underlying essentials
- The process
- Tools to changing your system

LeapFrog Releases Bi-annual Hospital Safety Grades (Nov 2019)

- One third of 2,600 general, acute care hospitals **across the nation** rated in The Leapfrog Group's fall 2019 **Hospital Safety Grades** got an 'A,' grade, while 1% flunked. https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings
- Did you check your rating?
- 2,600 hospitals graded with breakdown as follows: 33% earned an "A," 25% earned a "B," 34% earned a "C," 8% a "D" and just under 1% an "F."
- Johns Hopkins analysis found "D" and "F" hospitals have nearly twice the risk of mortality of "A" hospitals
- 20 Years After "To Err is Human", Leapfrog Hospital Safety Grades Prove Transparency Can Save Lives

Preparing for Change

Hospitals vary in organizational culture, and the type of culture relates to the safety climate within the hospital. These results suggest a healthcare organization's culture is a critical factor in development of its patient safety climate and in the successful implementation of quality improvement initiatives. *British Med Journal*

Organisational Culture: Variation Across Hospitals and Connection to Patient Safety **Guide**

NEJM Insights Report · April 2019

Organizational Culture Is the Key to Better Health Care

Stephen J. Swensen**,** MD, MMM**,** FACR Mayo Clinic College of Medicine Namita Seth Mohta**, MD** NEJM Catalyst

Organizational culture is the essential element in meeting health care goals, according to Stephen Swensen, MD, Professor Emeritus at the Mayo Clinic College of Medicine and Senior Fellow at the Institute for Healthcare Improvement. “Culture, more than anything else, drives performance,” he says

What is the current state of culture change at your organization?

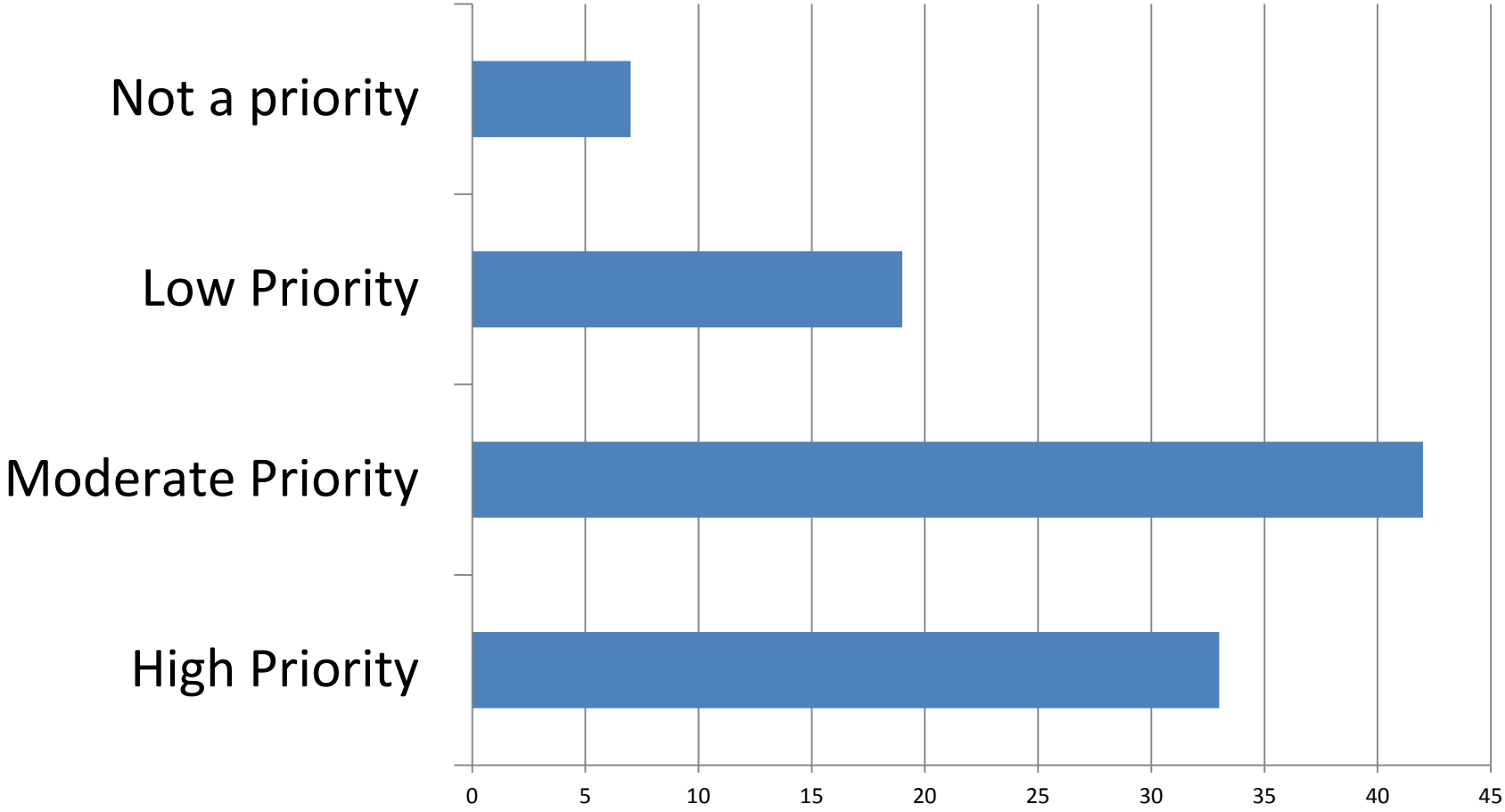
- A commitment to quality,
- An emphasis on patient care, and
- A focus on each individual's impact

Have resulted in positive culture change at their organizations, whereas concentrating too heavily on the bottom line and **productivity** has had negative repercussions.

What is The Effect of Culture?

- ***Culture is the way in which organizations make decisions about what they are and aren't going to do, and***
- ***The cumulative way in which employees experience their jobs and lives at the organization.***
- ***Both of these directly influence the types of care that patients experience.***
- ***Simply put: Change your organizational culture and you change the patient experience.***

How Much of a Priority is Culture Change at Your Organization



The Primary Observation About Making Change

All discussions need to be done with the people doing the real work. If culture change is done properly, physicians and nurses shouldn't feel that decisions are being made from the top.

What makes a caring culture hard?

- Caring is largely empathy and understanding
  - Empathy means accepting the emotion the other person feels
- Health care providers often feel a need to be aloof
- Maybe we don’t want to change that?
- Can we treat co-workers one way and consumers another?
- So what’s the answer?

Patient Safety Culture Composite	Definition: The extent to which…
Communication Openness	Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority.
Feedback and Communication About Errors	Staff are informed about errors that happen, are given feedback about changes implemented, and discuss ways to prevent errors.
Frequency of Events Reported	Mistakes of the following types are reported: (1) mistakes caught and corrected before affecting the patient, (2) mistakes with no potential to harm the patient, and (3) mistakes that could harm the patient but do not.
Handoffs and Transitions	Important patient care information is transferred across hospital units and during shift changes.
Management Support for Patient Safety	Hospital management provides a work climate that promotes patient safety and shows that patient safety top priority.
Non-punitive Response to Error	Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.

Patient Safety Culture Composite	Definition: The extent to which…
Staffing	There are enough staff to handle the workload and work hours are appropriate to provide the best care for patients.
Organizational Learning—Continuous Improvement	Mistakes have led to positive changes and changes evaluated for effectiveness.
Supervisor/Manager Expectations and Actions Promoting Patient Safety	Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.
Teamwork Across Units	Hospital units cooperate and coordinate with one another to provide the best care for patients.
Teamwork Within Units	Staff support each other, treat each other with respect, and work together as a team.
Overall Perceptions of Patient Safety	Procedures and systems are good at preventing errors and there is a lack of patient safety problems.

A bad system will beat a good person every time.

The climate of an organization influences an individual's contribution far more than the individual himself.

W. Edwards Deming
1900-1993

Is Your Culture Working Against You?

- Have you had co-workers suffer burn out? Happens when people aren't given enough time to disconnect, rest, focus on other aspects of life and recharge. Harvard Business Review July 31, 2018
- Physicians aren't burning out; they're suffering from 'moral injury Simon Talbot MD Becker's Hospital Review July 30, 2018
- The moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of health care. Failing to consistently meet patients' needs has a profound impact on physician wellbeing — this is the crux of consequent moral injury

Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy Rand Corporation Winter 2014
https://www.rand.org/pubs/periodicals/health-quarterly/issues/v3/n4/01.html

Areas of Concern

- Dealing with each other
- Dealing with leadership
- Dealing with the client/consumer/patient
- Dealing with concerned supporters
- Dealing with advocates
- Dealing with the public non-utilizers

How Do We Identify the Culture?

Use a standard instrument for evaluation

Links to AHRQ information on measuring Culture (Below)

http://www.ahrq.gov/qual/patientsafetyculture/usergd.htm

http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html

http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html?utm_campaign=20161028&utm_medium=Email&utm_source=SOPSanc

Sample Questions from Hospital Survey on Patient Safety

Measured on a scale of agree-disagree

1. People support one another in this unit
2. We have enough staff to handle the workload
3. When a lot of work needs to be done quickly, we work together as a team to get the work done
4. In this unit, people treat each other with respect
5. It is just by chance that more serious mistakes don't happen around here
6. We work in "crisis mode" trying to do too much, too quickly
7. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts

"The slightest voice inflection, the most innocent remark, can land hard on those you have authority over, causing them to make up stories that support increased caution and distort further interaction."

Goleman et al **Primal Leadership** 2013

Guidelines for Cultural Change

- Formulate a clear strategic vision
- Display top-management commitment
- Model culture change at the highest level
- Modify the organization to support organizational change: identify current systems, policies, procedures and rules to be changed to align with the new values & desired culture.
- Select and socialize newcomers and terminate deviants.
- Develop ethical and legal sensitivity
- Include a periodic evaluation process to monitor the change progress and identify areas that need further development.

7 Actions All Leaders Must Take When Guiding Change: Art Petty's Leadership Caffeine™

1. **Show respect for your employees by providing advanced and in-depth context for internal or strategy changes.**
2. **Give people a voice in how changes will be implemented.**
3. **Solicit ideas that may minimize or eliminate the need for adverse changes**.
4. **Teach people about the business drivers behind change.**
5. **It's a process, not an event!** Set up feedback loops and allow people to adjust and improve on the fly.
6. **Answer the burning question.** ***"What does this mean for me?"***
7. **Don't shoot yourself in the credibility foot.** (By doing dumb counter productive things)

Changing Systems

- Striving to improve is the way we anticipate the future – otherwise we are passive objects on the sea of life
- To create the future, instead of letting it happen to us, we imagine a different future and begin to build it
- The start is recognizing **what bothers us**
- By testing small changes we find out what works - better
- Data collection lets us know the results

A Process for Improving Results

- Get Senior Leaders whole-hearted support
- Get the key others on the team
- Establish a basic objective or objectives
- Understand the current culture
- Modify the current culture
- Initiate the improvement process
- Identify a way to know an improvement works
- Create a supply of possible improvements

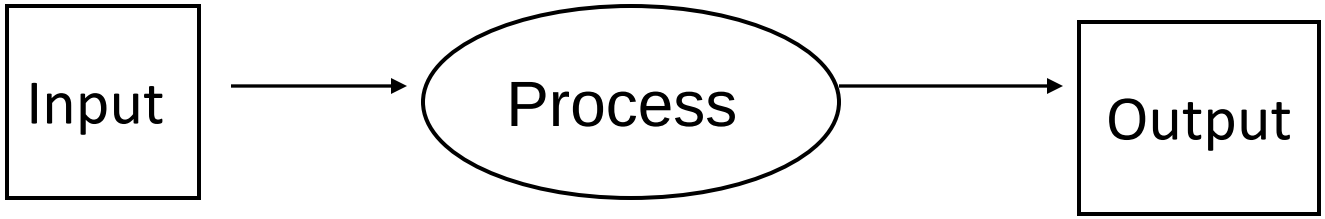
Creating a Team

- Senior Executive Champion (CEO,COO,CFO, Someone similar)
- Team Leader with authority: ED Director?
- Key technical leaders: Physician champion

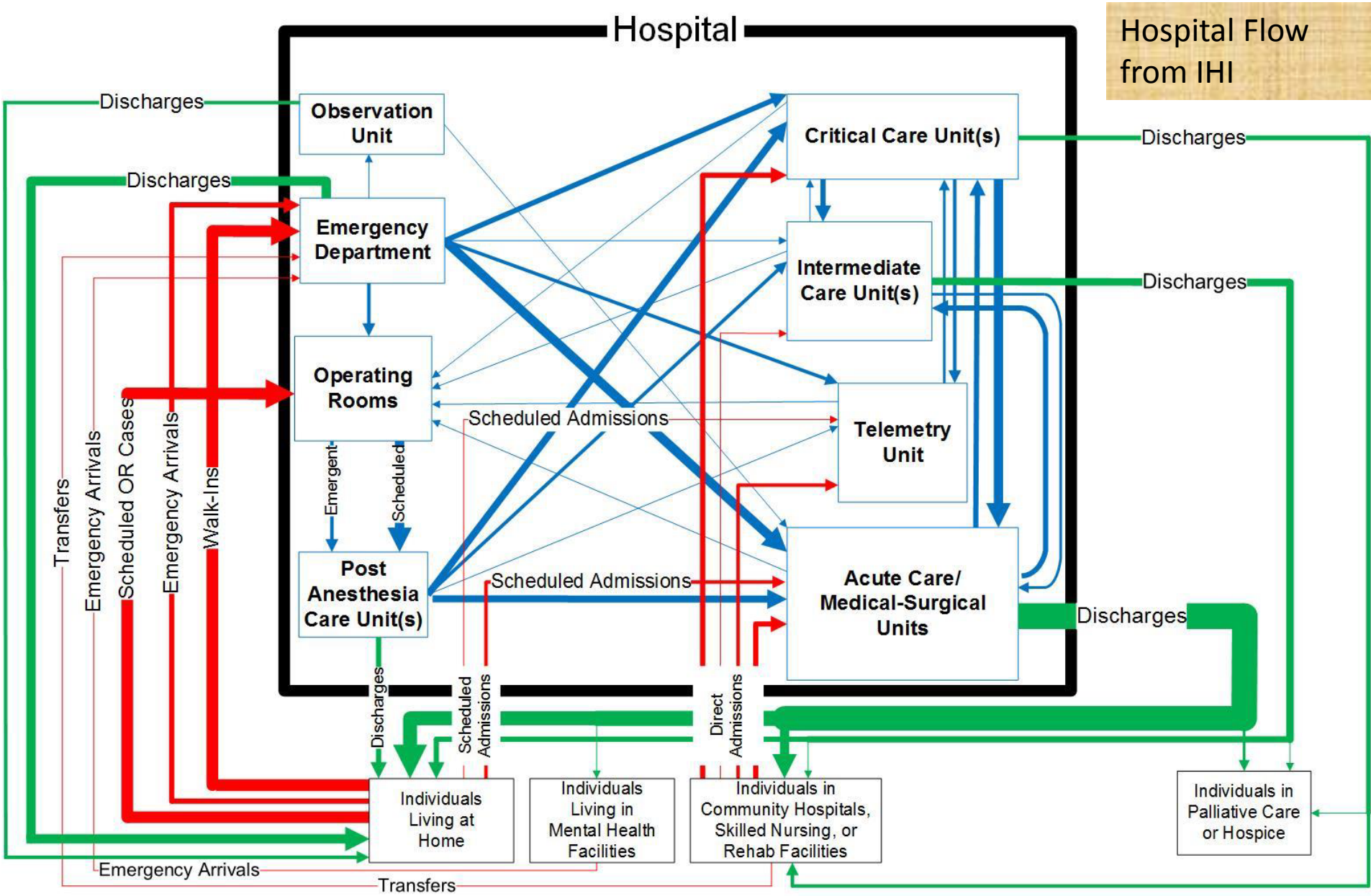
  behavioral health leader, general medical leader
- Others with imagination

What is a system, why should we care ?

System components



Hospital Flow from IHI



Key: **Blue arrows:** Flow within hospital | **Red arrows:** Flow into hospital | **Green arrows:** Flow out of hospital | **Width of arrows:** Typical flow volumes

- “Every System is perfectly designed to achieve the result it gets.”

- “If you want a different result, you have to change the system.”

  Donald Berwick, MD and others

It is not the strongest of species that survives, nor the most intelligent, but the one most responsive to change.

--Charles Darwin

Quality Improvement vs. Quality Assurance

- Quality Assurance
  - Matching standards
  - Controlling
  - Punitive
  - Closed
- Quality Improvement
  - Creating new standards
  - Empowering
  - Rewarding
  - Open

Getting a Better Result

- Establish a goal
- Understand and manage the culture
- Identify a process
- Involve others
- Try changes
- Measure results
- Repeat

Starting Improvement

- **Involve senior leaders**

  Leadership must align the aim with strategic goals of the organization.

- **Base your aim on data**

  Examine satisfaction and performance data within your organization. Set **goals** in the Improvement Charter and focus on issues that matter.

- **State your aim clearly and use numerical goals**
  Unambiguous, specific aims make for better progress. Setting numerical targets clarifies the aim, helps to create tension for change and directs measurement

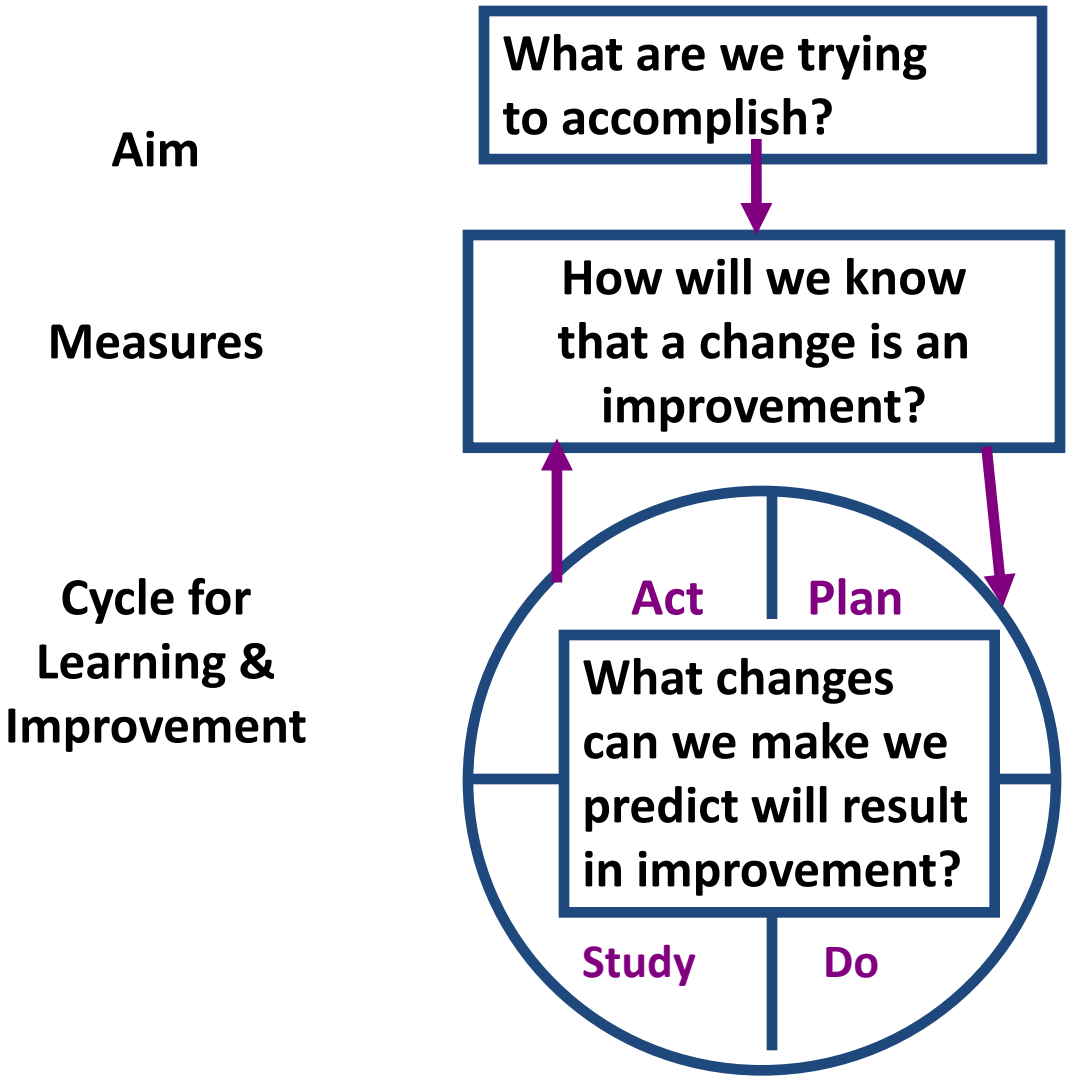
Key Questions

- What are we trying to accomplish?
- How will we know we have made an improvement?
- What changes can we make that we predict will result in improvement?

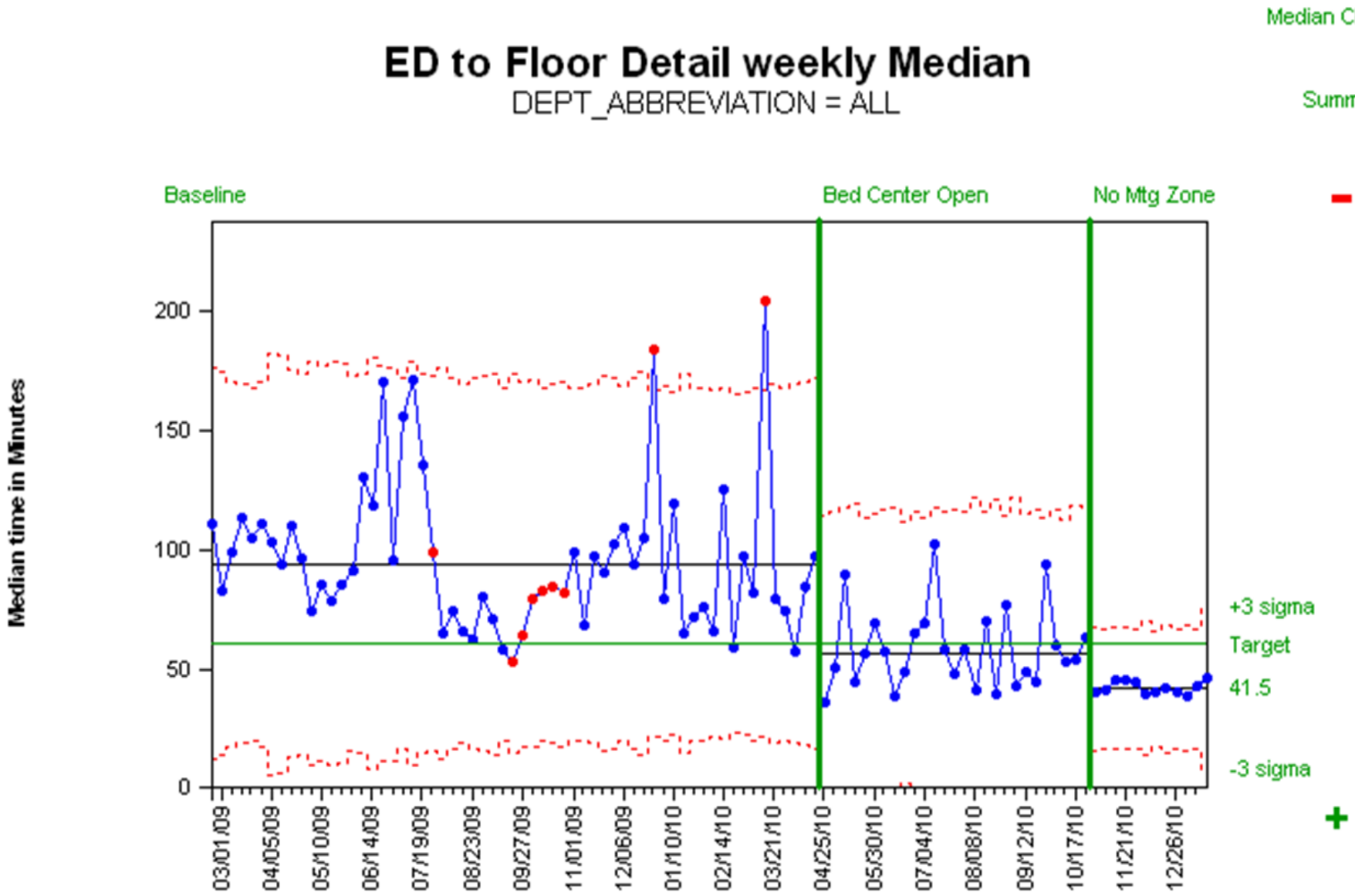
Identifying Your Issues

- Gather data on length of stay, restraints, satisfaction and other key issues you identify
- Interview five (5) people who recently went through the ED
  - Why did they come
  - What was the result
  - What did they like and not like
- Have a staff person go through becoming a client

Model for Improvement



From South Sacramento Hospital

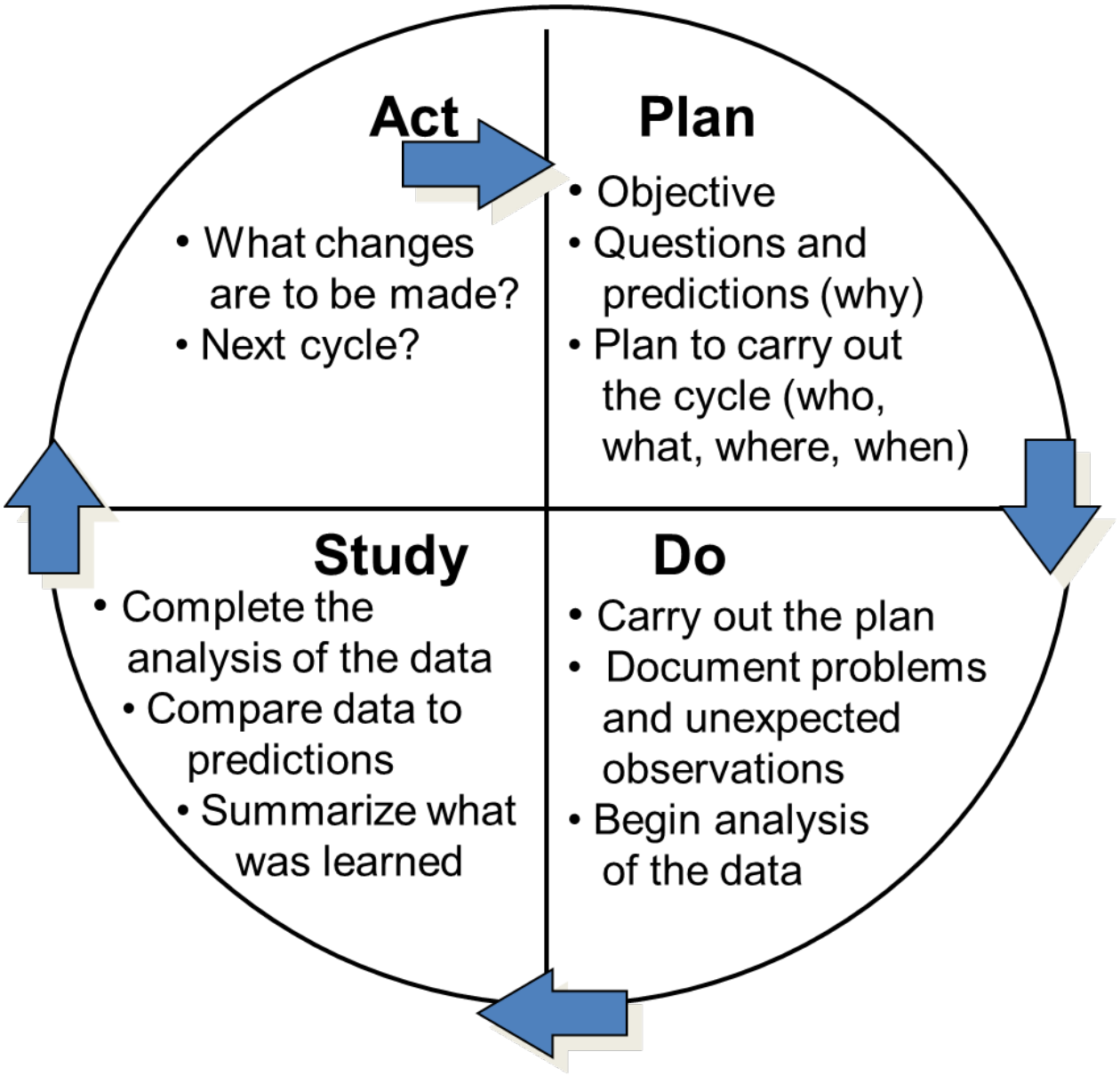


Example of Aim Statement

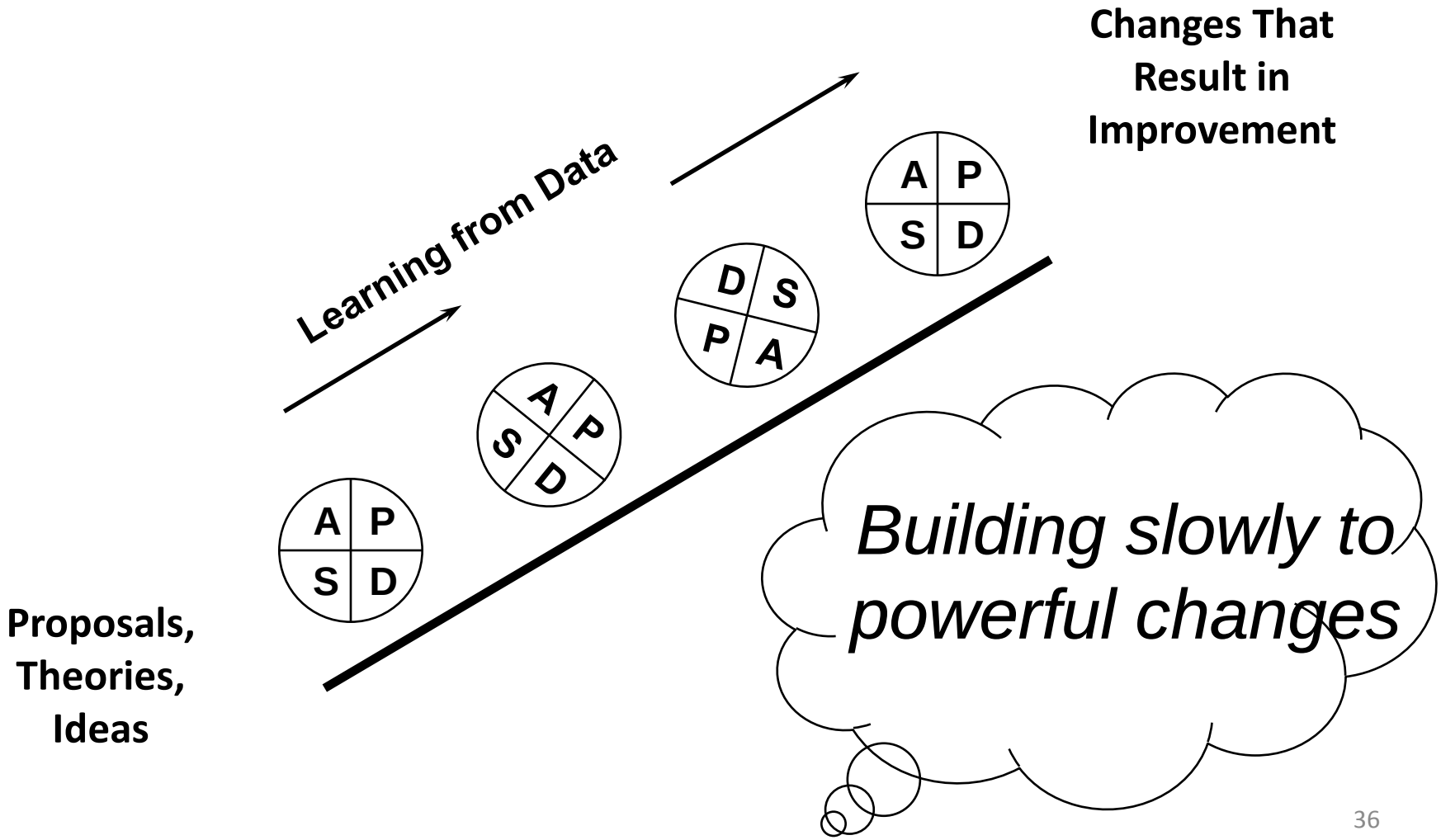
(Some is not a number, Soon is not a time)

- Reduce the average length of stay to three hours
- Reduce the rate of use of restraint to no more than 1% of intake
- Improve the discharge to home rate to 65%
- Reduce returns within 30 days to 15%

The PDSA Cycle



Repeated Use of the PDSA Cycle



Why Test?

- Increase the likelihood the change will result in improvement
- Predict how much improvement can be expected from the change
- Minimize resistance upon implementation
- Learn how to adapt the change to conditions in the local environment
- Evaluate costs and side-effects of the change

Types of Measures

- Outcome Measures
  - **Results - system level performance**
- Process Measures
  - **Inform changes to the system**
- Balancing Measures
  - **Signal "robbing Peter to pay Paul"**

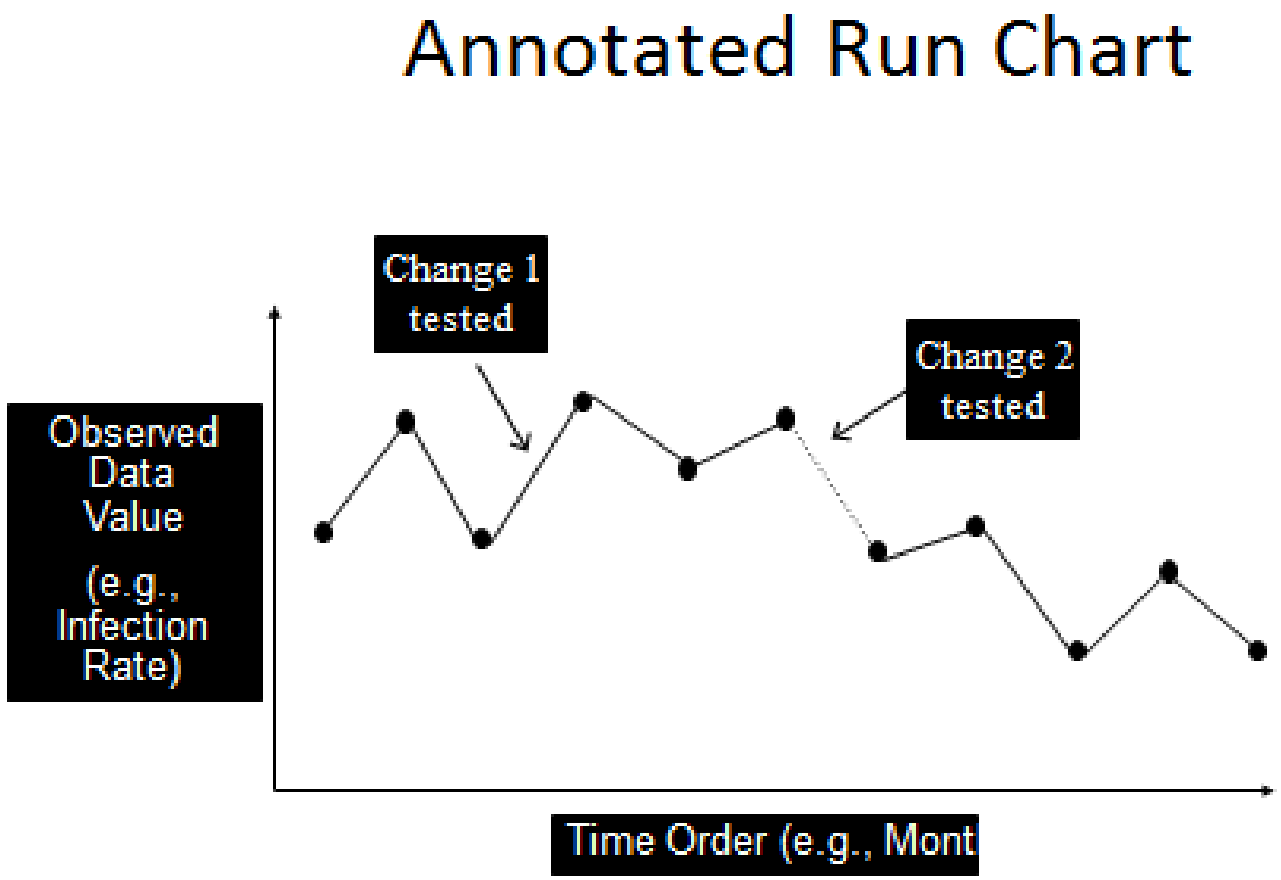
Measurement: Guidelines

- Need a balanced set of 4 to 8 measures reported each month to assure the system is improved.
- These measures should reflect your aim statement & make it specific
- Measures are used to guide improvement and test changes. They must be identifiable.
- Integrate measurement into daily routine
- Plot data for the measures over time and annotate graph with changes

Some Measurement Assumptions

- The purpose of measurement is for ***learning*** not judgment
- All measures have limitations, but the limitations do not negate their value
- Measures are one voice of the system. Hearing the voice of the system gives us information on how to act within the system
- Measures tell a story; goals give a reference point

Using Run Charts



- Plot small samples frequently over time

Some Typical Issues Complicating Change

- Staffing very limited
- No effective, or rigid, hierarchy of management
- Lack of staff concern for behavioral health issues
- Physical space constricted and in demand
- No flexibility in space utilization
- Waiting area disconnected from treatment area
- General health staff not trained to see/treat BH symptoms
- No expedited care for general health emergencies
- Hospital protocols not related to needs
- Fear of adverse outcomes drives unnecessary admissions
- Staff hardened to the ED environment
- Security staff eager to assure they have a role
- Some staff may see development of welcoming environment as encouraging undesired behavior such as overuse

Addressing the Broader Issues

- Often Emergency Care is affected by outside influences
  - In-hospital issues such as slow discharges
  - Outside issues such as police tendency to bring everyone to the ED
- Get everyone involved:
  - Hospital, outpatient providers, police, courts, EMS as in examples
  - Stay focused on the larger issue – stay away from issues which are not part of the primary objective

Program Improvements, Innovations, and Changes

Use of Tests of Change

- Train all staff on reducing agitation esp. security staff in training programs (one facility uses the Broset Scale)
- Establishing crisis beds outside ED
- Expedited movement into in-patient care
- Earlier discharges from inpt. psych facilities and working with pharmacy for availability of discharge meds
- Beginning development of rapid community placement

More Changes in Operations to Improve Flow

- Developed single point of entry program to lower Avg. time from arrival to triage, and time to MH Prof to incr. number of patients evaluated and reduce LWOBS
- Embed behavioral health specialists in ED
- Create behavioral crisis or swat teams to deal with behavioral emergencies in ED and Hospital
- Establish protocols and workflow for medicating agitated patients and reducing restraints
- Developed Peer program utilizing consumers in improvement.
- Educating staff to using consumers

Key Training Changes

- Police and security integration and education
- Training all staff on use of verbal techniques in reducing agitation
- Including security staff in training programs
- Bringing in outside experts to discuss use of psychotropic meds with ED MDs
- Use brief suicide screening tool (PHQ & Columbia)

Changes in physical space and organization

- Establishing Psych Obs. beds in space outside ED
- Developed a short stay inpatient unit 1-5 days
- Reached agreement on standardized lab tests and toxicology screens with local psych programs
- Transportation improvements in moving and receiving BH patients - psych transport vs. police transporting patients was important
- Created a room just for psych pts and families
- Customizing existing patient satisfaction tools to BH patients' needs
- Measure rate of diversion and LWOBS

Safer Environment

- Improved Observation:
  - Use of Video
  - Protocols for security
  - One-on-one
- Dedicated space
  - Quiet area
  - Dedicated room
  - Unit – Locked/unlocked

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Changes in Operations to Improve Flow

- Use of a nurse practitioner
- Behavioral health professional as greeter, e.g. having a social worker in the waiting area
- Bi-Weekly dashboard reports
- New triage system to distinguish medical or more severe psych pts. from those who can be referred to outpatient settings
- Use paper pajamas and scrubs, change policies on disrobing
- Phone screening/Advice line
- Established new protocols for movement into in-patient care

Program Improvements, Innovations, and Changes

- Develop and apply specialized training for behavioral health crisis team to respond to BH emergencies. (“Code Purple”) Noted reduction of assaults on staff.
- Establish protocols and workflow for medicating agitated patients, and bring in outside expert to discuss with MDs
  - Est. medication guidelines for use of atypical anti-psychotics in addition to typicals
  - Adding Zydis ODT to Pyxsis machine
- Develop a psych transport vs. police transport for patients
- Monitor restraint process, especially common definition, correct orders and documentation.
- Met with community physicians, community mental health programs, community agencies, and outpatient programs.
- Gero. Community Diversion Program
- Psych Emerg. Sys. recidivist system case conferences

Mental Health Admissions Rapid Cycle: November 19, 2014

What went well:

- Patient was seen fast by clinician, doctor, and nurse. Able to get place quickly.
- Techs were more observant of their surroundings and everything had a decent flow. Officers were able to do a fair amount of patrols for 5 officers, but mainly respond to the high volume of calls received by employees and visitors. SPOE saw patients as they checked in, which has been most effective element of change to this test because we are able to discourage many of the patients within 30 minutes that normally would sit on for hours. If this is the only thing we take from this pilot, I would consider it a win.
- Tech and/or security were present each time. Seemed to go fast.
- Things went smoothly; communication was good, not busy.
- Patient/Tech interaction, Tech/Security interaction, all communication was good.
- Although I needed assistance from security and they responded promptly and everything worked out.
- Process really came together tonight. Went really well.

What I need help with or did not know to do or did not understand:

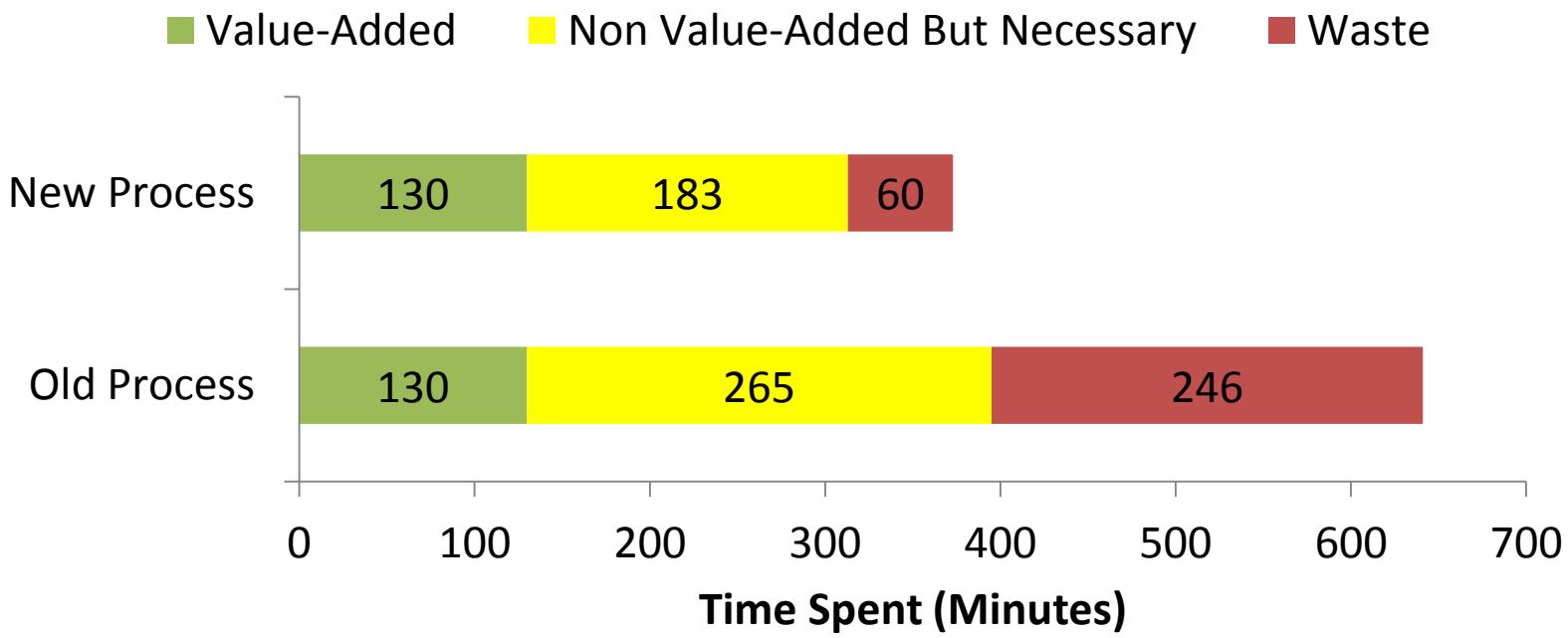
- Patients are asking why they are required to stay to see the doctor if they are just here for behavioral assessment. One patient questioned if we are violating her rights because she was told to see medical, but she was cleared by counselor.
- No problems apparent
- If we clear them, does the tech wait until they are medically cleared too?
- I needed assistance from security and they responded promptly. I was not sure what the appropriate protocol was for the situation
- Time. How long is the patient supposed to wait?

What did I not have that I needed:

- N/A

Value Analysis

Which tasks provide value to the customer?

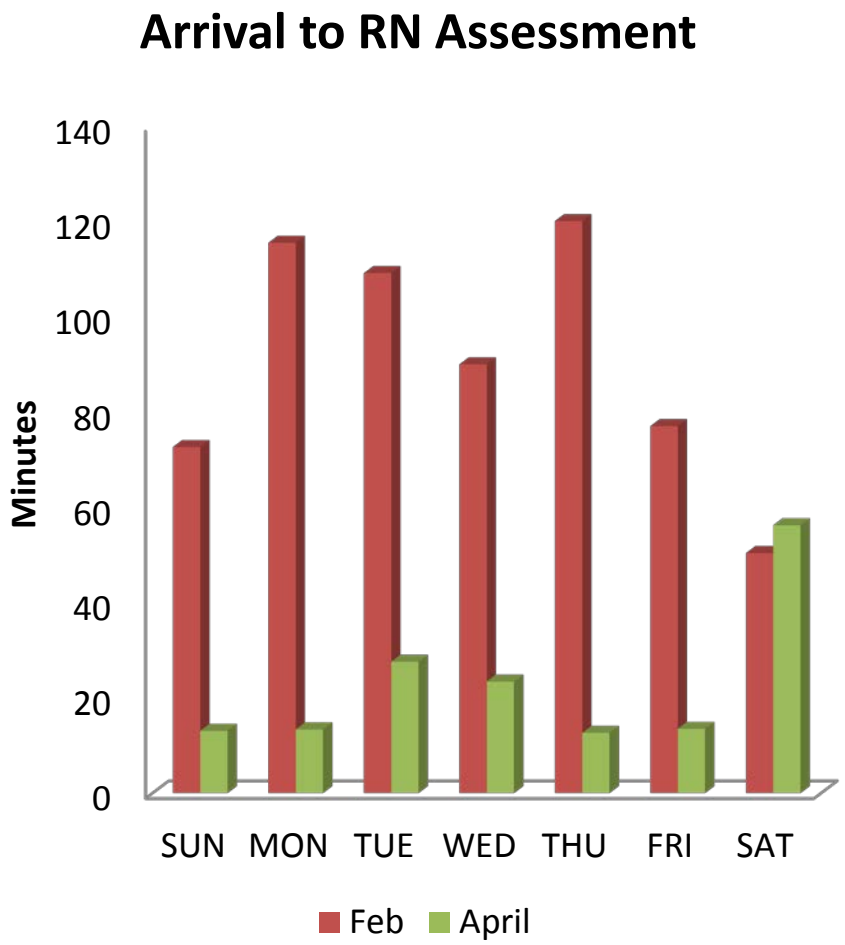


Examples:

- Value-added: Doctor meeting with the patient to do a psych eval
- NVAN: Unit clerk entering demographics information in the chart for billing
- Waste: Patient sitting in the waiting room twiddling her/her thumbs

Impact of sharing data with staff

- **Problem:** Nurses were assessing patients on arrival, but delayed entering their assessment into the EHR where others could read it.
- **Intervention**: Gave this graph to the Charge Nurses.
- **Result**: Dramatic reduction in the time from Arrival to RN Assessment
- **Cost**: Printing 4 copies of this graph.



connections HEALTH SOLUTIONS

Emergency De-escalation Team (EDT)

- De-escalation = therapeutic communication
  - when necessary apply least restrictive measure to ensure safety
- Process
  - Any staff member may call for an EDT response.
  - HUC is notified of the need for an EDT **or** ECC operator if EMS arrival
  - "Send word now" page goes out to the team from HUC or ECC operator indicating the location: "EDTResponsGMMC"
  - Trauma RNs, Charge RN for both Adult and Peds, PFC (does not need to respond), Security and Law Enforcement Officers
  - Leadership Team Members (Director, Managers, Supervisors, Educators)
  - Physician pagers in C pod and A pod (C pod is primary responder)
    - 7a-3p 2p-10p 9p-7a physician holds the pager

King County Alternatives to Boarding Task Force

Five Priority Areas of Focus

- Diversion and front-end/upstream re-engineering
- Alternative processes and resources for patients with dementia, developmental disabilities (DD), and traumatic brain injury (TBI)
- Workforce support and development
- Behavioral health integration
- Legislation and policy changes

Crisis Solution Center

- **Crisis Diversion Facility**
  - 16 beds
  - Up to 72 hours
- **Crisis Diversion Interim Service**s
  - 30 step-down beds
  - Up to 14 days
- **Mobile Crisis Team**
  - 24/7 assistance to police & medics
  - Transportation from E.D. to CSC

Admission Criteria

- Hospital subcommittee established medical acuity criteria
- Continued oversight by subcommittee chaired by hospital representative
- Referrals only from E.D.'s, Medics or Police
  - Stable behavioral and medical control
  - Non-violent charge and no known history of violence
  - Good faith agreement to participate in services of the program instead of going to jail or hospital

UW Medicine

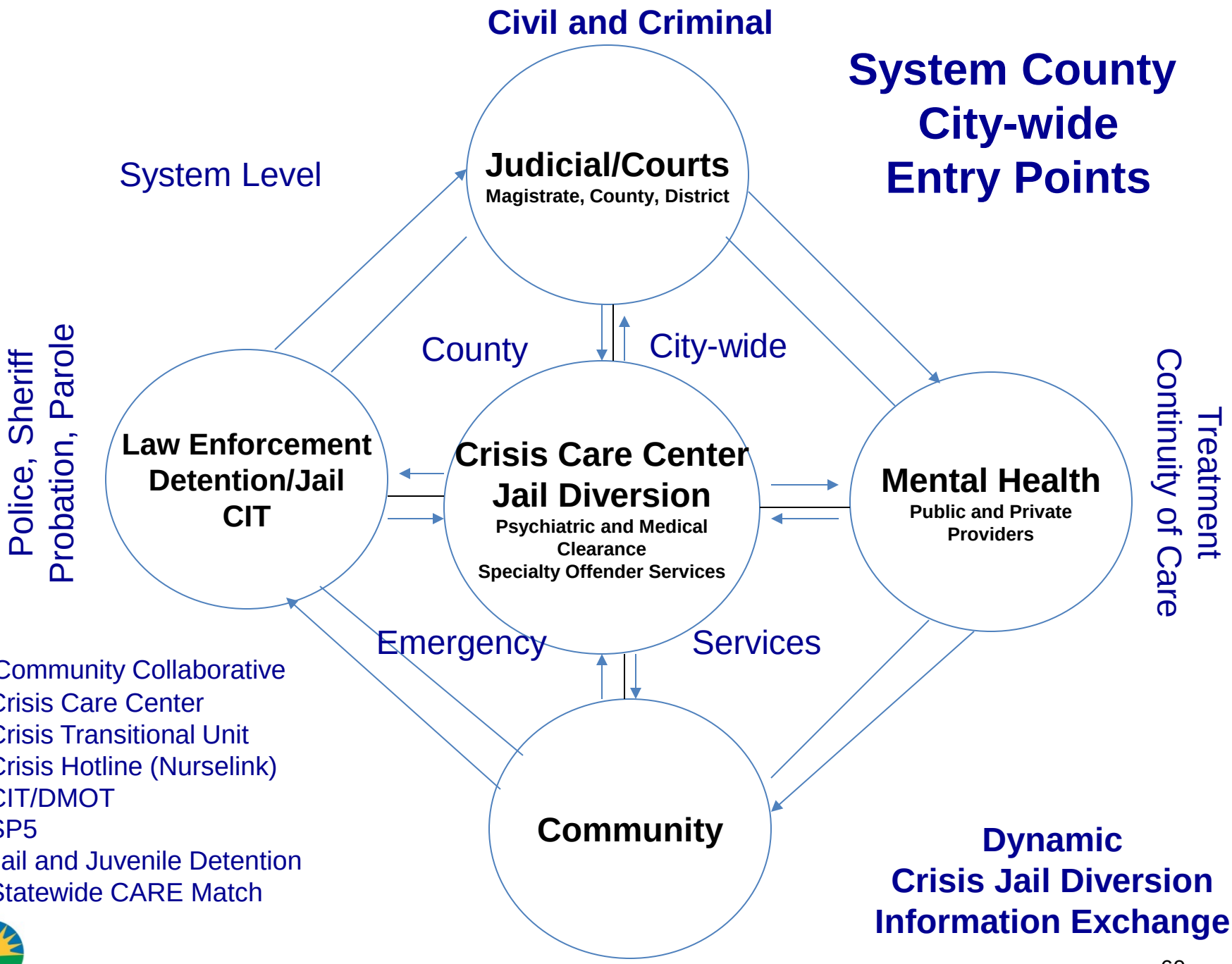
- Daily e-huddle with the four medical centers regarding status of boarder patients
    - Prioritize UWM boarders over elective referrals
    - HMC prioritizes ITA less than 60 y.o.
    - NWH prioritizes ITA over 60 y.o.
    - UWMC prioritizes voluntary
- "Open Bed: Boarder" mismatch data collection

Network Case Review Process

- Community Collaboration to engage and plan for patient services
- County Organized Coalition includes all stakeholders
- Data sharing via shared release of information
- Community Ownership of the Care plan with assigned roles and responsibilities

Outcomes suggest that after collaboration, E.D. use decreases for 60% of individuals

System County City-wide Entry Points



- Community Collaborative
- Crisis Care Center
- Crisis Transitional Unit
- Crisis Hotline (Nurselink)
- CIT/DMOT
- SP5
- Jail and Juvenile Detention
- Statewide CARE Match

Dynamic Crisis Jail Diversion Information Exchange

Sobering Unit

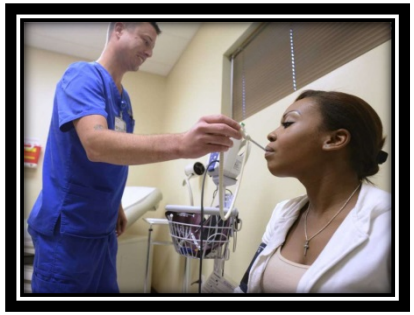
- Designed to offer treatment alternative in lieu of arrest
- Provides a medically safe environment
- Patients are monitored by EMT/Recovery Support Specialists
- Not treating medical, just sobering, and engaging in relationship
- Multiple admissions are never viewed as a failure

Detox Unit

- Licensed, accredited 28 bed facility
- Medical oversight and recovery programs are provided
- Typical stay is 3-7days
- Program helps patients complete a safe withdrawal
- Staff motivates and empowers patients to develop a healthy lifestyle

Injured Detainee Clinic

- Added service to reduce ER waits and get
  law enforcement back on street
- Blended funding through City and County
- Open when University Hospital Clinic is closed
- PA/NP on duty fills dual roles of medical care and physicals for detox after hours



Integrated Care Clinic

- Provides ongoing, primary care and preventive medications
- Keep individuals from becoming high utilizers of emergency rooms
- Added ancillary medical services for Haven for Hope residents
- Care and Benefits Coordinators are on-site

Major Local Collaborators