Kotter at the Organizational level

Daniel Hyman, MD, MMM
Chief Medical and Patient Safety Officer
Children’s Hospital Colorado
Associate Professor, Pediatrics
University of Colorado School of Medicine
No model is perfect.... But some are more useful than others
YOU'VE GOT TO IMPLEMENT A SIX SIGMA PROGRAM OR ELSE YOU'RE DOOMED.

AREN'T YOU THE SAME CONSULTANT WHO SOLD US THE WORTHLESS TQM PROGRAM A FEW YEARS AGO?

I ASSURE YOU THAT THIS PROGRAM HAS A TOTALLY, TOTALLY DIFFERENT NAME.

WHEN CAN WE START?
What’s in your toolbox?

- Kotter, Leading Change
- Complexity Theory
- Deming - Profound knowledge
- IHI Model for Improvement
- Robust Process Improvement - TJC
- Baldridge
- High Reliability - W and S
- Lean, Six-Sigma, Lean-Six sigma

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Leading Change

John P. Kotter

- Increase urgency
- Build guiding coalition
- Set the right vision
- Communicate for Buy-in
- Empower action
- Create short term wins
- Implement and sustain
- Don’t Let Up
- Make it Stick

Creating a climate for change

Engaging and enabling the teams
Create a sense of urgency
Two narratives about our hospital
The usual story - we are seen as great, we are growing, and we are improving
Reduce Codes Outside the ICU
Target: 0.22 codes per 1000 Non-ICU Patient Days

The Number of Patient ID Errors
2010, 2011, 2012 (Jan-Oct 22nd)

- 2010: 51
- 2011: 37
- 2012 (Jan-Oct 22nd): 25

2012 YTD = 1.98
Target < 2.85
There is a darker side to the story.....
In our hospital...

Alyssa

Grant
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Ohio Children’s Hospitals’ Solutions for Patient Safety (OCHSPS) National Network
Pressure Ulcers Rate
Children’s Hospital Colorado

<table>
<thead>
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<td>6</td>
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<td>6</td>
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<td>0.85</td>
<td>2.13</td>
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These are individual patients (and families) who experienced Preventable Harm....

ADE
- Aneshka M. (NICU)

CAUTI
- Ariana O. (6th Floor)
- Manish R.P. (PICU)

CLABSI
- Genisys S. (CCBD)

Patient ID
- Graycin C. (NICU)
- Joseph Q. (UC-Uptown)
- Meklit D. (Child Health Clinic)

Pressure Injuries
- Hayden O. (PICU)
- Rowan V. (PICU)

Falls
- Andrew C. (Rehab Research)

VTE
- Breanna R. (8th Floor)
- Talon H. (PICU)
- Anastasia B. (6th Floor)
- Snow T. (6th Floor)
## 2012 Pillar Goal HACs Outcome Data

<table>
<thead>
<tr>
<th>2012 Pillar Goal HACs</th>
<th>Jan-12</th>
<th>Feb-12</th>
<th>Mar-12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>TOTAL</th>
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<td>CLABSI (all areas)</td>
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<td>4</td>
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<td>7</td>
<td>8</td>
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<td>Falls (Inpt severe-moderate &amp; outpt intrinsic)</td>
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<td>0</td>
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<td>5</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>33</td>
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<tr>
<td>Pressure Ulcers (3,4,DTI, Unstageable)</td>
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<td>3</td>
<td>7</td>
<td>4</td>
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<td>MONTHLY TOTAL</td>
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<td>13</td>
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<td>18</td>
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<td>VTE</td>
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If….“every system is perfectly designed to achieve the results it achieves…..”

(Paul Batalden, Dartmouth)

Are we improving our system fast enough?

URGENCY
A deviation from generally accepted performance standards (GAPS) that...

**Serious Safety Event**
- Reaches the patient
- Results in moderate to severe harm or death

**Precursor Safety Event**
- Reaches the patient
- Results in minimal harm or no detectable harm

**Near Miss Safety Event**
- Does not reach the patient
- Error is caught by a detection barrier or by chance
Why go “all in” on patient safety?

- Because we are sometimes not as good as the story we usually tell about/hear about ourselves
- Because kids are experiencing preventable harm, and we are not improving as fast as it is possible to improve
- Because our system is perfectly designed to have a child experience potentially preventable harm every other day
- There really isn’t a question on what our aspirational goal should be- it MUST be zero.
CHSPS’s “Theory of Knowledge”

Organizational Safety Culture

- SAFETY GOVERNANCE (SG)
- LEADERSHIP METHODS (LM)
- ERROR PREVENTION (EP)
- CAUSE ANALYSIS (CA)
- HIGH-RELIABILITY UNITS (HRUs)
- PATIENT & FAMILY ENGAGEMENT (PFE)

Conditions:
- READMISSIONS
- CLA BLOOD STREAM INFECTIONS (BSI)
- URINARY TRACT INFECTION (UTI)
- VENTILATOR-ASSOCIATED PNEUMONIA (VAP)
- SURGICAL SITE INFECTIONS (SSI)
- ADVERSE DRUG EVENTS (ADE)
- PRESSURE ULCERS (PU)
- SERIOUS FALLS (SF)
- OBSTETRICAL ADVERSE EVENTS (OBAE)
- VENOUS THROMBOEMBOLISM (VTE)
Target Zero is a multi-year effort to progressively eliminate preventable harm at Children’s Hospital Colorado.
Build a guiding coalition
Target Zero Governance

Target Zero Steering (Oversight of all harm reduction work)

HAC Steering
(Strategize and coordinate the HAC work and OCHSPS)

HAC Leadership
(Coordination of all HAC leads with HAC Steering Group)

HAC Work Groups
(Drive improvement for a specific HAC)
Get the right vision
How the Pieces Fit Together

Best-practice clinical care
  supported by
Behaviors designed to prevent error
  reinforced by
Leaders who model, support, recognize and redirect
  informed by
Ongoing measurement/analysis to show what’s happening, and ongoing learning about what needs to happen next on the journey
  will achieve

70+% decrease in preventable harm in 4 years
# Initial Training and Coaching

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<tr>
<th>Safety Culture Domain</th>
<th>Time</th>
<th>Trainees</th>
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<tr>
<td><strong>Error Prevention</strong></td>
<td></td>
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<tr>
<td>Train the Trainer</td>
<td>1 day</td>
<td>TBD</td>
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<tr>
<td>Internal Training</td>
<td>3 hours</td>
<td>all staff</td>
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<tr>
<td><strong>Leadership Methods</strong></td>
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<tr>
<td>Train the Trainer</td>
<td>1 day</td>
<td>Training Teams</td>
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<td>Internal Training</td>
<td>1.5 - 2 hours</td>
<td>LDI</td>
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<td><strong>Cause Analysis</strong></td>
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<td>SSE Classification</td>
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<td>risk/safety core group</td>
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<tr>
<td>RCA</td>
<td>2 days</td>
<td></td>
</tr>
<tr>
<td>ACA/CCA</td>
<td>2 hours</td>
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Target Zero Training Sequence

Phase 1
- Highest Risk of harm
- Has greatest frequency of opportunity to achieve 2013 goal

Phase 2
- High risk of harm
- Less frequent opportunity to affect forms of harm measured in 2013 goal

Phase 3
- Does not interact directly with patients/families
- Only influences goal indirectly

- PICU
- NICU
- Heart Institute
- CCBD
- Respiratory Therapy
- Pharmacy
- Float Team

All patient care areas not included in phase one, including ED, Inpatient, Surgery, Ambulatory, Network of Care

Non-patient contact departments, such as HR, Finance, IT, Strategy/Marketing

June - Sept ‘13
Sept ’13 - March’14
TBD: 2014+

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Target Zero: Personal Commitments

Everyone in the organization is asked to make three personal commitments:

• Commitment to safety
• Commitment to always communicating clearly, completely, and respectfully
• Commitment to promoting a questioning attitude among all staff
Target Zero: Safety Practices and Tools

Personal Commitment
• Introductions
• Pause to Care
• ARCC: Ask, Request, CUS, Chain of Command

Clear, Complete Respectful Communication
• SBAR, Read-backs (Repeat backs)

Questioning Attitude
• ART, Stop and Resolve

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Target Zero Leadership Practices

Practices which leaders use to ensure a reliably safe environment:

1. **JUST CULTURE**: Respond to errors and deviations in practice in ways that promote learning and are perceived to be fair and just

2. **ROUNDING TO INFLUENCE**: Actively observe and speak with staff about safety practices

3. **EFFECTIVE FEEDBACK**: Give positive feedback when safety practices are demonstrated, corrective feedback when not
Cause Analysis

• Ongoing measurement and analysis to identify root cause and apparent cause of errors and deviations in practice
• Explores both individual and systemic causes
• Identifies specific opportunities for ongoing learning about becoming safer
2013 Top Level Operational Pillar Goals

**People**
- 15%
- Be the best work environment by:
  - Achieving employee engagement of 4.08 (weight 7.5%)
  - Achieving faculty satisfaction of 3.59 (weight 7.5%)

**Quality/Safety**
- 40%
- Improve the safety, effectiveness and efficiency of care by:
  - Reducing preventable harm by 10% (weight 40%)

**Service**
- 15%
- Provide the best service to our customers by:
  - Achieving referring physician satisfaction of 4.10 (weight 7.5%)
  - Achieving patient satisfaction to a weighted average score of 75.3% excellent (weight 7.5%)

**Growth**
- 15%
- Expand services to children by achieving strategic and budgeted growth projections by:
  - Achieving referring physician satisfaction of 4.10 (weight 7.5%)
  - Achieving market share of X* (weight 7.5%)
  - *target to be set in Feb/March

**Finance**
- 15%
- Fund the fulfillment of our mission by:
  - Achieving an annual operating margin of 6% (weight 15%)
  - Achieving outpatient visits of 591,371 (weight 7.5%)

GATE for Incentive Payout

Indicates Take it to Heart Staff Incentive Goals
CHCO Central Line Maintenance Bundle Compliance
CLABSI Prevention

- Overall Bundle Compliance
- Daily Assessment/Goals (SR)
- Dressing Change (O)
- CAP Change (D)
- Tubing Change (D)
- Accessing the Line at the Patient (SR)

Bundle Element Audit Legend
(D) - Documentation
(O) - Observation
(SR) - Self Reported

Gray bar indicates all or none bundle compliance
Communicate for Buy-in
Communication strategies

- Daily (now 3x/week) safety story email
- Meetings “start with safety”
- Daily brief
- Leader rounding supported by TZ buzz
- Landing page of intranet - days since, links to dashboards
- Monthly TZ Open Forum
- Data sharing everywhere
- Target Zero safety buggy
- Great catch awards
- Still could do a better job with learning from serious events
Safety Coaches
Empower Action
Target Zero
Hospital Acquired Conditions

Target Zero Executive Steering
(Oversight of all preventable harm reduction work)

Target Zero Bundle Sponsorship
(Provide high level direction and barrier removal)

Target Zero Bundle Steering
(Strategize and coordinate the bundle work and OCHSPS)

Target Zero Bundle Leadership
(Coordination of Bundle Leads)

Target Zero Bundle Work Groups
(Drive improvements for a specific Bundle)

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What drove the specific improvements?

• Mostly “Model for Improvement” based efforts
• Very team based, collaborative, interdisciplinary
  – Led by patient safety improvement specialists
  – Significant nursing involvement in leadership and on teams
  – Patient family engagement (at various points)
• Lots of IT based changes within Epic and data warehouse
Technology, Innovation and Creativity

• Engaged, empowered teams, including patients/families
• Partnerships across divisions, particularly IT, analytics, decision support, improvement, and clinical leadership
• Using the EMR as a tool to advance risk recognition and prevention process reliability, and to automate/simplify auditing

• **Note!**

  *Opportunities for maintenance of certification credit for medical staff*
Create short term wins
Reduction in Harm- 2012 to 2013

Children's Hospital Colorado
Total Pillar Goal HACs by Month
2012 and 2013

2013 Target Goal (10% reduction from 2012 baseline) = <177

- 2012 Cumulative
- 2013 Cumulative
Reduction in Harm (rate)- 2012 to 2015
ADVERTISEMENT

THIS WAS OUR
COMPROMISE
WITH LEGAL
Don’t Let Up
PATIENT ID MARCH MADNESS

WEEK ONE: bar coding compliance
6TH FLOOR 94.1%
6TH FLOOR 92.4%

WEEK TWO: barcode compliance
CCRD 94.2%
CCRD 92.1%

WEEK THREE: photo compliance
CMO/CNO 100%
TIE BREAKER - 94.6%

WEEK FOUR: photo compliance

PATIENT ID CHAMPION!

Number of Patients: 100
Days Towards 100

Quality & Patient Safety

Target Zero Germ Crusher

HOME: CHCO

DAYS WITHOUT PATIENT ID EVENT
29

Germ crusher

Challenge Details - CLICK HERE
Coming July 13, 2015
2015 Leader Rounding Dashboard

What is Leader Rounding?

Leader Rounding is an essential, routine activity for all levels of leadership at CHCO. It is focused on discussions, observations and coaching of front line staff where their work is done. The purpose of leader rounding is to ensure team members are effective and engaged in their work, that their barriers are identified, shared, and addressed, and that as a result, outcomes improve. It also enhances visibility and support of leaders for their team members.

Select Executive for a roll up

Select your name to view your individual report

*Hover over the green target lines to see Target details

7/13/2015 8:31:35 AM
Conclusions

• Kotter’s and other system/change theories can be enabling
• Board and senior team support is critical for a comprehensive improvement program to succeed
• Collaboration is a huge plus- externally and internally between all members of the health care team
• More to come in the patient safety module....
Open Dialog and Questions