How far would you go to prevent harm to your patient and caregivers?

October 3rd, 2018
Aaron Hamilton, MD MBA
Medical Director Patient Safety and Clinical Risk

Cleveland Clinic
Really far...
$3.3$ Trillion or $10,348$ per person

National Health Expenditures as a Share of Gross Domestic Product, 1987-2016

The share of GDP devoted to health was 17.9% in 2016
US Federal Budget

1975

34%
Social Security & Healthcare

2017

51%
Social Security & Healthcare
A Call to Action…
IOM Dimensions

- **Safe** – avoiding injury
- **Timely** – reduce waits and delays
- **Effective** – evidence based
- **Efficient** – avoiding waste
- **Equitable** – consistent care
- **Patient-Centered** – patient values
Three of these crashing, every day
The $17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors

Jill Van Den Bos¹, Karan Rustagi², Travis Gray³, Michael Halford⁴, Eva Ziemkiewicz⁵, and Jonathan Shreve⁶

AFFILIATIONS

PUBLISHED: APRIL 2011  Free Access

https://doi.org/10.1377/hlthaff.2011.0084
Healthcare Value

- Safety
- Outcomes
- Service/Satisfaction
- Cost / Affordability
The Triple Aim

The 4<sup>th</sup> aim?

Joy of Practice for caregivers

Better Population Health

Better Care for Individuals

Lower Cost through Improvement
MISSION
To provide better care of the sick, investigation into their problems, and further education of those who serve.

GOALS
Patients First  Caregivers  Affordability  Growth  Impact

ENTERPRISE PRIORITIES
Access Solutions  Digitalization  Engagement  High Reliability  Population Management  System Development

Cleveland Clinic
“Treat the patient and fellow caregivers as family, and the organization as your home”

Tomislav Mihaljevic, MD
CEO & President
Undisputed Champions of Safety
## Traditional framing

<table>
<thead>
<tr>
<th>Safety:</th>
<th>Complications, Infections, Safety Events, Caregiver Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality:</td>
<td>Sepsis, Readmissions, Clinical Outcomes</td>
</tr>
<tr>
<td>Patient Experience:</td>
<td>Patient satisfaction in all care settings</td>
</tr>
</tbody>
</table>
What patients think…

Safety: Keep me safe.

Quality: Heal me.

Patient Experience: Know and Engage me.
A Safe Organization

- Engages Patient & Family
- Executes as a Team
- Accountable
- High Reliability
- Learning Environment
What IS High Reliability in Healthcare?
“A Collective Mindfulness”

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

High Reliability Model

Leadership
- Commitment to zero patient harm

Safety Culture
- Empowering staff to speak up

Robust Process Improvement
- Systematic, data-driven approach to complex problem solving

“The hallmark of an High Reliability Organization is not that it is error-free, but that errors don’t disable it”
Highly Reliable Teams

START STRONG and FINISH STRONG Together!
Incident Command Center Activation
Metrics that matter: Measuring Culture

- Communication Openness
- Handoffs / Transitions
- Management support
- Nonpunitive
- Learning / CI
- Teamwork
- Overall perceptions

2014: 3.88, 3.90, 4.07, 4.08, 4.29, 4.02, 4.41
2015: 3.88, 3.90, 4.07, 4.08, 4.29, 4.02, 4.41
2017: 4.07, 4.08, 4.29, 4.02, 4.41
National: 4.41
Safety Reporting Theory

• Safest units = highest reporting
• ANY member can “stop the line”

• Non-punitive response
• Loop will be closed – “My voice was heard”
Daily Safety Huddles
Psychological Safety

Opportunities

Curious

Fallible
What “zone” are you in?

- Comfort Zone
- Learning Zone
- Apathy Zone
- Anxiety Zone
“Quality” is integral to our goals. Not something extra.
You get what you measure...
### 2018 Goals Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Device-related infections (CLABSI and CAUTI)</td>
<td>≤ 21/mo</td>
</tr>
<tr>
<td><em>C. difficile</em></td>
<td>≤ 50/mo</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>Patient Safety Indicators (Complications)</td>
<td>≤ 44/mo</td>
</tr>
<tr>
<td>Serious Safety Events</td>
<td>0</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital Wide Readmissions</td>
<td>≤ 12.0%</td>
</tr>
<tr>
<td>Sepsis Mortality</td>
<td>≤ 14.9%</td>
</tr>
<tr>
<td>Hypertension Control</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Diabetes Control HbA1c &gt; 9</td>
<td>≤ 10%</td>
</tr>
<tr>
<td>Diabetes Eye Exam</td>
<td>≥ 80%</td>
</tr>
</tbody>
</table>
## 2018 Goals Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Device-related infections (CLABSI and CAUTI)</td>
<td>≤ 21/mo</td>
</tr>
<tr>
<td><em>C. difficile</em></td>
<td>≤ 50/mo</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>Patient Safety Indicators (Complications)</td>
<td>≤ 44/mo</td>
</tr>
<tr>
<td><strong>Serious Safety Events</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Hand Hygiene</strong></td>
<td>100%</td>
</tr>
<tr>
<td>Hospital Wide Readmissions</td>
<td>≤ 12.0%</td>
</tr>
<tr>
<td>Sepsis Mortality</td>
<td>≤ 14.9%</td>
</tr>
<tr>
<td>Hypertension Control</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Diabetes Control HbA1c &gt; 9</td>
<td>≤ 10%</td>
</tr>
<tr>
<td>Diabetes Eye Exam</td>
<td>≥ 80%</td>
</tr>
</tbody>
</table>
Transparency in healthcare…
Transparency

Welcome to the new Caregiver Celebrations

Safety Champions 2018 Winners

Daily Safety Huddles

Celebrate NICE CATCHES!
“Nothing about us, without us”

- Transformative progress
- Insight on patient perceptions
  - What are our blind spots?
- Focus on patient centered care
- Opportunity for proactive solutions
- Input on goals
- Test concepts prior to roll-out
Patient Involvement

Best Practices

• Patients on standing committees
• Pediatric family on Error Prevention Leadership Team
• Executive Rounding
• Patients involved in goal-setting
• Healthcare Partners
Healthcare Partners

Partnering with patients to promote safety and service

Focusing on patient centered care

Bringing patients and healthcare providers together

Empowering patients to take an active role in improving the patient experience
Healthcare Partners Structure

- Institute / Hospital Based
- 10-12 Patient Members
- Representing diversity of patient community
- One or Two year term (staggered)
- Volunteer Orientation
- Up to 4 employee members
- Meetings Monthly / Quarterly
Successes

• Creation of new caregiver welcome letter
• Standardized volunteer role on inpatient units
• Hospitality Rounds
• Leadership Rounds
# Cleveland Clinic Improvement Model (CCIM)

Your team can start building a Culture of Improvement by answering the question, **What matters most?**

## 1. Organizational alignment
**Identify and communicate what matters most.**

**Senior leaders**
- Set your strategy, aligned with our enterprise goals.
- Share a common, clear and consistent vision of your area’s purpose and future.
- Ensure alignment by talking with managers and frontline caregivers about what matters most.

**Managers**
- Ensure alignment by asking senior leaders and team members what matters most?
- Interpret leadership’s vision by establishing metrics and objectives for success.
- Translate the connection between senior leadership and frontline team members.

**Frontline caregivers**
- Connect your individual work to the goals of your department, institute and hospital and, most importantly, to Cleveland Clinic and to Patients First.

Leverage our strategic direction, strategic agenda, and enterprise mission and goals to guide your work. Apply framework of **Objectives, Goals, Strategies & Measures (OGSM).**

## 2. Visual management
**Manage what matters most.**

**Senior leaders**
- Reinforce what matters most and the desired behaviors that support our culture.
- Recognize what’s going well and remove obstacles.

**Managers**
- Choose meaningful metrics that support what matters most.
- Track and share performance of key metrics visually.
- Enable team participation in the process, and ensure the process drives improvement.

**Frontline caregivers**
- Huddle often.
- Track progress visually, learn from the metrics, and improve your work.
- Communicate as a team.

A step-by-step video tutorial is available by request. Also, use the visual management job aid at [sharepoint.ccf.org/changemanagement](sharepoint.ccf.org/changemanagement), and observe peers performing visual management.

## 3. Problem solving
**Improve what matters most.**

**Senior leaders**
- Help managers and caregivers build capability and find time to solve problems impacting their work.
- Ensure area is focused on the problems that matter most.

**Managers**
- Encourage experimentation and creativity.

**Frontline caregivers**
- Continuously identify wasteful activities that do not add value.
- Follow team problem-solving process to eliminate waste and drive improvement.

Follow the Plan-Do-Check-Adjust (PDCA) process. Perform ‘5-why’ and root cause analyses.

## 4. Standardization
**Sustain what matters most.**

**Senior leaders**
- Ensure standard principles and desired behaviors are embedded in your area.
- Make continuous improvement part of the daily work.

**Managers**
- Maintain processes and standards.
- Deliver outcomes and drive behaviors.
- Deviation from the standard should be clearly visible and immediately corrected.

**Frontline caregivers**
- Identify best practices and develop standards.
- Become disciplined in following those standards.
- Adopt the new standard when a better way is discovered.

Establish standard work. Attend or view online monthly CI Cost Successes Report Out to hear shared best practices. Sustain the Cleveland Clinic Improvement Model.

---

**Right systems. Right behaviors. Right results.**

For questions, improvement tools or assistance, contact Continuous improvement at improve@ccf.org
Culture of Improvement
Professional Practice Model Huddles
Solutions for Value Enhancement (SoIVE)
Falls in healthcare

- Extraordinarily complex
- Lot of risk assessment tools
- How do we engage patients and families?
- Learning from “in-house” expertise?
An unanticipated synergy...
Can iPhones solve all our problems?
Believe it – you are high risk!
Top 10 Safety Issues Campaign

- Clinical alarms
- EMR and results
- High risk medications
- Caregiver safety
- Transitions of care
- Universal protocol
- Diagnostic reasoning
- Decision support
- Scaling safety solutions
- Safety event reporting
Key Takeaways

- We must all get better together
- Committed leadership essential
- Patient and caregiver voice is key
- Transparency drives engagement
- High Reliability mindset is engine
Cleveland Clinic Way
Quality and Patient Safety Intensive

October 24-26, 2018 | Cleveland, Ohio

Contact Global Executive Education to learn more
ExecutiveEducation@ccf.org or www.CCFcme.org/QualityIntensive