NPSF
National Patient Safety Foundation®

Keeping Quality and Safety Front and Center: Managing Your Influence in the Right Direction

Executive Summary of the
Leadership Day Pre-Congress Session
16th Annual NPSF Patient Safety Congress
May 14, 2014 • Orlando, Florida

The Leadership Day Pre-Congress Session, entitled "Keeping Quality and Safety Front and Center: Managing Your Influence in the Right Direction," was a one-day program organized for the National Patient Safety Foundation's 16th Annual Patient Safety Congress in Orlando, Florida, and was held on May 14, 2014.

Co-Chairs

Susan A. Abookire, MD, MPH, FACP, Senior Vice President, System Chief Quality and Patient Safety Officer, Houston Methodist Health Care; President, Society for Physician Quality Officers

Jennifer Daley, MD, FACP, Physician Executive

Pamela A. Thompson, MS, RN, FAAN, Chief Executive Officer, American Organization of Nurse Executives

Faculty

Richard J. Brilli, MD, FAAP, FCCM, Chief Medical Officer, Nationwide Children's Hospital

Janet M. Corrigan, PhD, MBA, Distinguished Fellow, Dartmouth Institute for Health Policy and Clinical Practice

Gerald B. Hickson, MD, Senior Vice President for Quality, Safety and Risk Prevention, Joseph C. Ross Chair in Medical Education and Administration, Assistant Vice Chancellor for Health Affairs, Vanderbilt University Medical Center

John Jones, RPh, Vice President, Enterprise Pharmacy, Geisinger Health System

Andrew Knight, PhD, Assistant Professor of Organizational Behavior, Olin Business School, Washington University, St. Louis

Linda Knodel, MHA, MSN, NE-BC CPHQ, FACHE, Senior Vice President and Chief Nursing Officer, Mercy Health

Gregg S. Meyer, MD, MSc, Chief Clinical Officer, Partners HealthCare

Elliot Wakeam, MD, Brigham and Women's Hospital

NPSF thanks:

Lillee Gelinas, MSN, BSN, RN, FAAN, Vice President and Chief Nursing Officer, Christus Health System, for her help in facilitating the program and for her contributions to this Executive Summary.

Yvonne Y. Cheung, MD, MPH, Interim Medical Director, Department of Quality and Safety, Mount Auburn Hospital, for her contributions to this Executive Summary.

Educational Grant Support

NPSF thanks **McKesson** for an educational grant in support of the 2014 NPSF Congress Leadership Day program. McKesson had no involvement in content development for the program or this Executive Summary.

About This Program

The program evolved from discussions at the National Patient Safety Foundation and the NPSF Lucian Leape Institute about the challenge of advancing patient safety activities in a health care environment where so much emphasis is being directed at reducing the costs of care. Over the past 20 years, the patient safety movement has done a good job of communicating the human toll of medical error and arguing for the application of safety science in caring for patients. Yet there is also a cost benefit to providing safe care. With the advance of value-based purchasing and the need for drastic cost reductions, increased expectations for quality outcomes, and renewed emphasis on patient satisfaction, it is time to begin serious conversations about the connection between safety and cost.

The essential question this program set out to answer was: How should health care leaders and patient safety professionals conduct those conversations? The content of the program was designed to help participants become confident in explaining the value of patient safety strategies and in making the case to support safety programs in their institutions.

The program was organized into several areas of discussion:

I. Using Influence to Make a Difference

II. The Relationship between Safety and Cost

III. Decreasing Costs while Improving Safety: Stories of Successful Implementation

IV. Summary and Closing Challenge

Attendees included patient safety directors and managers, risk managers, health care quality executives, chief nursing officers, chief medical officers, and ambulatory care pharmacists.

I. Using Influence to Make a Difference

> Implementing innovations—even seemingly trivial ones—almost always requires obtaining cooperation, support, and resources from others outside of your formal control.
>
> *— Andrew Knight, PhD*

While there is wide acceptance that some degree of organizational politics is a given, as individuals, people vary in their willingness and ability to participate. Yet, as Dr. Knight explained, quite often, being right is not enough; convincing others to change their practice often requires evidence, diplomacy, patience, and a strategy.

Dr. Knight identified implementation of safety improvements as very challenging—it is time consuming, and the true cost of implementation may not be foreseen (for example, introducing a new workflow may actually slow down output, at least temporarily). This is partly because the decision to adopt an innovation is usually made at the top of an organization, whereas implementation is often done from the bottom up, creating gaps in understanding, motivation, and incentives. Moreover, human beings strive to create stability, and change may involve altered roles, routines, and norms, leading to instability.

Dr. Knight presented his Framework for Using Influence to Implement Change Initiatives (see figure) with four components:

Situational awareness

- Specify objectives and determine how they fit with the organization's goals.
- Assess who the key stakeholders are and how much power they hold.
- Assess your own influence and vulnerability.

Influence planning

- Analyze stakeholders. Who will be an ally or an opponent, and what perspectives, objectives, or constraints is each likely to present?
- Explore tactics, resources, and timing. Tactics may include appeals to logic, using facts and figures; emotional appeals, using storytelling or tradition; building a rapport with your audience; benchmarking with relevant comparison groups; using incentives; or by fostering the commitment of others through your own involvement. Consider favorable moments and deadlines to achieve maximum impact.

Execution

- Be flexible. Your interactions with stakeholders may not proceed as you plan or expect, so have Plan B ready and be able to adapt or change course.
- Be ethical. Frame the issue in a way that will help the audience understand it, not by manipulating their emotions or beliefs.

Reflection

- What did your team do well in the process?
- What did the team do poorly?
- What would you do differently?

Rather than thinking strictly in terms of "playing politics," Dr. Knight recommended taking a more idealistic view. Being a leader in a group requires building meaningful relationships, doing exceptional work for its own sake, complimenting others sincerely, and considering how your plans or actions may impact others.

A Framework for Using Influence to Implement Change Initiatives

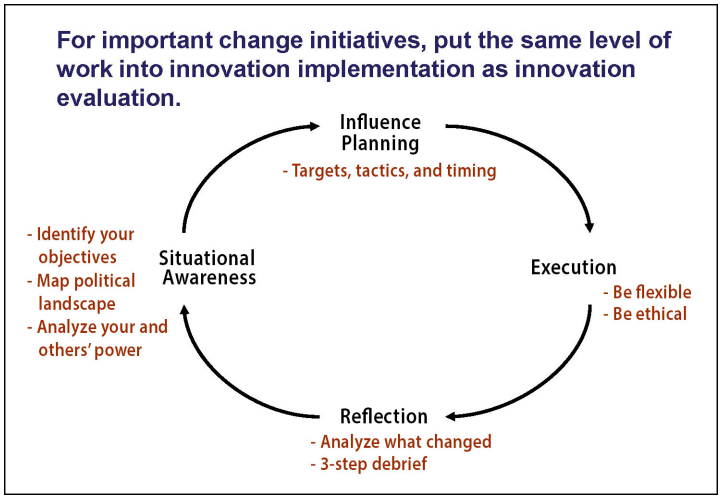

Illustration by Andrew Knight. Reproduced with permission.

II. The Relationship between Safety and Cost

Janet Corrigan, PhD, MBA, cited efforts under way to reduce the costs of care, which include reducing or eliminating unnecessary or duplicative services and improving coordination of care across settings and disciplines. Health systems are consolidating, with many transitioning to value-based payment programs. The costs of unsafe care can have a substantial impact on the bottom line of a health system, including direct costs of care, malpractice and legal costs, and human capital costs (i.e., reduced morale and difficulty retaining good clinicians).

The health care sector is also seeing continued movement toward transparency of information related to safety, quality, and cost. Consumers have an increased interest in knowing the total costs of care, as many of them are paying increased out-of-pocket costs.

Elliot Wakeam, MD, helped frame the issue by presenting preliminary findings of a literature review that focused on studies conducted in the US and published in the last 5 years dealing with the care of adult patients and looking at costs. A total of 38 studies were selected, addressing national data, state or local data, costs in specific populations, or other factors.

Most of the studies looked at hospital-acquired infections, while some addressed drug reactions, redundant testing, or patient safety indicators defined by the Agency for Healthcare Research and Quality (AHRQ PSI Overview). Dr. Wakeam noted that one challenge of interpreting study results is that "definitions of safety, harm, injury, and error vary from study to study."

Overall, the literature suggests preventable adverse events among hospitalized patients are estimated to cost between $17.1 billion and $24.6 billion per year, with societal costs (such as work-years lost) placing the toll in the realm of hundreds of billions of dollars (Goodman et al. 2011).

With that summary to set the stage, participants were asked to discuss, in groups, several broad questions.

- *Why is investing in safety critical to the financial survival of your institution?* What messages and methods can best convey the impact of safety on cost to CEOs and board members?
- *How can market forces be strengthened to reward investments in safety?* Should there be greater transparency? Should there be a sharper connection between payment programs and adverse events?

There was general agreement that more transparency is needed, but also that there is a need to improve metrics so that organizations are interpreting and reporting the same events in the same way. Other notable recommendations:

- Approach investment in patient safety the way people invest in their personal finances: with short-term, mid-term, and long-term goals. Consider risk versus benefit of your efforts.
- Include the value equation (safety X outcomes ÷ cost) in all conversations.

- Highlight the indirect costs of unsafe care (liability, loss of market share).
- Balance messaging between data and storytelling.
- Appeal to internal audiences: "We can do better." Present data that is meaningful to them (i.e., instead of publicly reported falls data, have a dashboard for "days since last fall," to better engage staff in improving that metric).
- Look at the cost of total avoidable harm (including misuse, overuse).
- Where there are established metrics, focus on areas where the organization really can improve, not on areas where things are already going well.
- Be transparent about the total costs of care (a motivator for patients, who are becoming more engaged in the cost discussion).

Participants cited the following barriers to the cost/safety discussions within organizations:

- Lack of resources/investment in safety science.
- Short-term thinking and misaligned incentives at the federal level.
- Focusing on projects, rather than on system transformation to high reliability.
- Changing the culture; leadership's fear of failure if they take this on as "the" project.
- Board makeup and focus (still largely centered on finances).
- Perception of competition between quality and finance, between "soft" and "hard" dollars.

III. Decreasing Costs while Improving Safety: Stories of Successful Implementation

The program included speakers from three organizations who reported on specific approaches they have used to improve safety that have also resulted in reduced costs.

Nationwide Children's Hospital: Looking at the Numerator

Zero Hero is an initiative aimed at eliminating preventable harm at Nationwide Children's Hospital. Richard Brilli, MD, said a key to the program's success was translating the hospital's strategic goals into language that was understandable to all, motivational, action-oriented, and seen by everyone in the organization (Brilli et al. 2013). Goals were written from the patient and family's point of view, and the program introduced new ways of talking about safety and quality:

- Within the organization, adverse events or safety lapses are discussed in terms of total number of harm events ("the numerator only").
- Looking at the total number of events personalizes the data by focusing the discussion not on rates of harm events, but rather on how many patients were harmed. For example 0.02 medication errors per 1,000 doses administered is not compelling, but if this rate translates into 50 patients – that gets the attention of staff and leadership alike. This also allows the organization to review its performance and progress over time.
- The use of storytelling gives leaders a picture of the true impact of harm.
- Metrics are framed in ways that resonate more effectively with all (such as "days since last serious safety event").

Dr. Brilli emphasized the importance of working on both safety and teamwork culture (through training, transparency, and real-time reporting) and quality improvement tactics/projects (through consistent use of one methodology, such as the IHI model for Improvement, Lean, or Six Sigma). Measuring compliance with policies is also essential.

Since the Zero Hero program began, Nationwide Children's has decreased all preventable harm by 53%, Serious Safety Events (a subset of all preventable harm) by 83.3%, and severity adjusted mortality by 25%. Dr. Brilli provided data suggesting that the cost of care related to medical harm decreased by 36% between 2010 and 2013, saving the organization more than $3 million.

Nationwide Children's Hospital is a member of Children's Hospitals' Solutions for Patient Safety (CHSPS), a network of children's hospitals that are aligning their organizational goals to transform the safety and quality of care. Dr. Brilli shared data estimating that, in 2013, network hospitals saved more than $16 million by preventing harm.

Geisinger Health System: Medication Therapy Disease Management

Geisinger Health System (GHS) has demonstrated improved outcomes and reduced costs by embedding pharmacists into the direct care teams of patients with certain chronic conditions to provide comprehensive, ongoing pharmacy oversight. The GHS Medication Therapy Disease Management program goes beyond the counseling scope of the Medicare MTM program by establishing a collaborative practice agreement with the physicians group. This agreement gives designated pharmacists broad privileges to provide comprehensive services, including:

- Providing patient education and consultation
- Providing medication education to physicians and mid-level clinicians
- Managing of the medication reconciliation process during transitions in care
- Consulting on complex medication regimens and at-risk patients
- Facilitating authorizations for restricted medications
- Managing medication adherence challenges

John Jones, RPh, said the program has saved GHS more than $400,000 per year by preventing hospitalizations and visits to the emergency department; and $1,320,000 in medication costs (by eliminating unnecessary, duplicative, or contraindicated prescriptions).

There are 46 clinical pharmacists embedded in 44 clinics throughout GHS. Mr. Jones reported 81% adherence to medications overall.

This success, in turn, can be extrapolated to additional savings. For example, Mr. Jones estimated that 1 stroke per year is prevented for every 33 patients with atrial fibrillation who are given anticoagulation therapy. With more than 7,000 patients with atrial fibrillation on anticoagulation therapy, GHS clinical teams potentially prevented 216 strokes in 2013, with avoided costs estimated at $2,588,000.

Physicians and patients alike have expressed high satisfaction with the program. Although not all states permit collaborative practice agreements like that in place at Geisinger, Mr. Jones concluded with tips for integrating pharmacists more directly into care teams and communicating with leaders and clinicians:

- Lead with principles in all discussions (putting the patient first, use of best practices, eliminating unjustified variation, waste, redundancy).
- Make the decision-making process collaborative and inclusive at all levels.
- Meet with clinical departments, physicians, and hospital management to explain your plans, seek input, clarify scope and goals.
- Deploy pharmacy services that make sense to your system.

Mercy Health: Nursing and Interprofessional Practice

Linda Knodel, MHA, MSN, NE-BC, CPHQ, FACHE, summarized patient safety and quality improvement work at Mercy Health, which has included the use of innovation, interprofessional teams, and nurse specialists.

The Mercy SafeWatch program (a telehealth program) provides nursing and physician oversight and consultation to intensive care units throughout the system. Over the last 5 years, the Mercy SafeWatch program has consulted on more than 262,800 patients in 4 states. System-wide outcomes have improved since the program began:

- Ventilator-associated pneumonia has decreased from 40% to 2% (at a savings of $20,000 per case).
- Hospital length of stay has decreased by 20% (an estimated annual savings of $25 million).
- Mortality rates are now 25% below what would be expected in predictive modeling.

Through the efforts of collaborative, interprofessional teams, Mercy Health has been able to record significant improvement in quality at its hospitals:

- Central line bloodstream infections: An interprofessional workgroup researched best practices and developed a standardized central line insertion kit. As a result of the consistent and effective use of the bundle, an estimated 71 infections were prevented in 2013 (at an estimated cost savings of more than $3 million).
- Pressure ulcers: A comprehensive program was put in place that included using nurses certified in wound care to assess patients at the bedside, treat, and teach; and standardized order sets that were developed collaboratively. The number of pressure ulcers decreased greatly as a result, with better early identification and treatment of stage I and II ulcers.
- Falls prevention: Reporting was improved by merging NDNQI (National Database of Nursing Quality Indicators) data and the Mercy Event Reporting System. The program also educated staff about how to analyze trends and refined the fall risk assessment. The falls rate decreased from 4.06 to 0.11 falls per 1,000 patient days. Moreover, there is now greater appreciation for the importance of interprofessionalism in the effort, and falls are no longer seen as strictly a nursing responsibility.

Overall, Ms. Knodel said, interprofessional work has led to greater patient satisfaction scores and much less turnover among staff nurses because "they feel valued as a member of the team."

IV. Summation and Closing Challenge

Gerald Hickson, MD, chair of the National Patient Safety Foundation Board of Directors, provided insight from his work at the Center for Patient and Professional Advocacy (CPPA) at Vanderbilt University. According to Dr. Hickson, one of the reasons patient safety and quality improvement initiatives fail is because there is no plan to deal with noncompliance, and true leadership commitment is lacking. To be successful, patient safety initiatives require not just a good idea and sound science, but people, processes, and technology.

The CPPA team has developed a tiered intervention strategy for managing what they refer to as "unreasonable variation in human performance." This standardized method is used to address noncompliance, with agreement from leadership at the start that people will be treated the same across all departments and disciplines—even if that means firing a high-volume clinician.

According to Dr. Hickson, analysis of reports of noncompliance – and comparison with other organizations – shows that 40% of reports concern only 2% of clinicians.

Dr. Hickson proposed a number of elements required for success of safety initiatives:

1. Leadership commitment not just to the project, but to the methods of enforcing codes of conduct
2. Understanding by all of the need and the impact
3. Measurement tools and plans
4. Multilevel training
5. Alignment of the project with the organizational goals, vision, or core values
6. Resources for the project
7. A dedicated project team
8. A project champion
9. The will to address unnecessary variation in human performance

Gregg Meyer, MD, MSc, vice chair of the NPSF Board of Directors, closed the program by asking attendees to think about "What are you going to do differently based on what you heard today?" He summarized the major points of the day:

1. Data plus anecdote equals action. Make the best use of storytelling and metrics.
2. Talk about the outcomes that matter. Instead of talking about hand hygiene, show MRSA and VRE rates. Show: "This is the impact it had on us financially."
3. Search for positive deviance. We spend too much time on the lower end of performance. Understanding what is going on at the positive end is a powerful opportunity.
4. Expose biases and seek to understand naysayers.
5. Never waste a crisis: use a serious safety event to effect change.
6. Patient safety professionals have the opportunity to be seen as part of the solution. By investing in safety, organizations will see a return on that investment.
7. Be flexible with execution. Keep a single promise: It's going to get better (not perfect).

References

Agency for Healthcare Research and Quality (AHRQ). Patient Safety Indicators Overview (web page). U.S. Department of Health & Human Services. http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx

Brilli RJ, McClead RE, Crandall WV, Stoverock L. 2013. A comprehensive patient safety program can significantly reduce preventable harm, associated costs, and hospital mortality. *J Pediatr.* 163(6);1638–1645.

Goodman JC, Villarreal P, Jones B. 2011. The social cost of adverse medical events, and what we can do about it. *Health Aff (Millwood).* 30(4);590–595. doi: 10.1377/hlthaff.2010.1256