Never Again Never Events

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HealthWorks

Who We Are

HealthWorks provides high-value management consulting services to bring about important results for hospitals, healthcare systems, and other healthcare organizations. We are distinguished by excellent staff, each having extensive experience in leadership positions in healthcare organizations. more

Services We Offer

Clinical Services Development and Improvement
- Trauma Centers
- Emergency Services
- ICU, NICU and NICU
- Neurosurgical Services
- Laboratory Services
- Obstetric Care

Process Improvement & Redesign: Evaluation, Problem Solving, and Redesign
- Planning: Strategic, Service Line, Facility, Medical Staff
- Physician Economics: Fair Market Value, Valuation, Community Need Analysis, Management Consulting Advice on Contracting

Rating Improvement
- HealthCare Alert / Consultation, Expert Witness Services
**What are we trying to accomplish?**

- Never again injure (or kill) a patient
- Never again be docked by a payer for a Never Event
- Never again “lose” a lawsuit, or “fail” an investigation for a pattern of Never Events
- Never again fail to fix a serious patient care problem -- or take too long
- Never again fail to sustain an improvement

**Outline for today**

- How to know when “Quality” faddism will get in the way
- How to avoid some common pitfalls
- How to get a complex process fixed - FAST
- How to sustain your success
Performance Improvement methods have been popular in health care for the last 25 years

What have we learned?

A lot, actually...

- Analysis of statistical variation, tools and charts (Deming)
- Models and Methods (Juran, Nolan)
- Reengineering (Hammer)
- Peer Review methods improvement (Craddick)
- Systems Thinking (Senge, Gardner)
- Lean, Six Sigma (Toyota, GE)
- Aviation Safety
- Checklists (Pronovost, Gawande)
Faddism

*How to know it when you see it...*

“The Journey”
“Purity and Perfection”

“You must measure precisely and accurately.”

“The Language”

“Actually, the proper term is value stream mapping...”
Some Pitfalls

(My personal nominations)

Root cause analysis

Searching for the root cause of a problem...
- Gets into blame (or psychoanalysis) really quickly
- Is not productive - there is never only one root cause
- Wastes time - it may not really matter

Is there a better way?
- Redesign looking forward not backward
- Trust the team process
  - they always eliminate negative causal factors anyway
  - supportive environment
Peer Review

The M&M approach—often does considerable emotional damage
- “Sort by Provider” = the blame game
- “Education” is rarely what’s needed
- Adults do not learn well in an atmosphere of fear

Is there a better way?
- Multidisciplinary teams do not stifle openness; they are usually very supportive
- Some thoughts on addressing legal confidentiality issues
- It’s the system

“Most organizational errors are made by good but fallible people working in dysfunctional systems.”
Pilot projects

Piloting an improvement project will ...
- Find the “bugs” and label it a failure
- Lose momentum and increase resistance
- Derive no gain from process and people interdependencies

Is there a better way?
- Intervention “bundles”
- Big!Improvement™
- Holding implementers’ feet to the fire

Setting targets

Numerical success targets are...
- Shots in the dark
- Punitive if not achieved
- Motivation-dampening
- Career-ending

Is there a better way?
- Display comparative benchmarks
- Simulate future scenarios
What does work well?

(A few more recommendations)

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Pick up the pace

- A “surgical” approach
- Concentrated and contiguous team time
- Research and measurement in advance
- Focused, time-limited implementation
Use the power of a team

- A skilled, objective (and frank) facilitator
- The “Process Owner” (often not easy to identify)
- A best practices pioneer
- Middle managers, supervisors, staff on the team (not Administration)
- But Administration must pay attention
- Think outside...(patients, retired physicians, a lawyer, someone from a government agency or a different industry)

Use measurement to celebrate

- A short list
- Identify in advance: how will we know a change is an improvement?
- Why you should always monitor the money
- Simple graphical displays
- What about dashboards?
- How much statistical skill is needed?
Complexity itself is the issue

“Here is the puzzle of ICU care: you have a desperately sick patient, and in order to have a chance of saving him you have to make sure that 178 daily tasks are done right—despite some monitor’s alarm going off...despite the patient in the next bed crashing...despite a nurse poking his head around the curtain to ask whether someone could ‘help get this lady’s chest open.’ So how do you actually manage all this complexity?”

--Atul Gawande
“THE CHECKLIST”
The New Yorker,
December 10, 2007

Rewiring the house with the lights on

• Selecting the problem to work on
• Sizing the problem: collect benchmark data in advance
• Painting a picture: the power of the flow chart
• Finding best leverage points among many opportunities for improvement
• How to simplify and use the FMEA (Failure, Mode and Effect Analysis) tool to focus your efforts
**Auditing for sustainability**

A formal 6-months-post-project report

- A dashboard of only 3-5 measures
- Search for organizational “artifacts”
- Enumerate the lessons learned, but refuse to label the project a failure
- Brag! Celebrate and publicize the stories
A How-to-Fix-It Summary

1. Launch a multidisciplinary team
2. Gear up with data
3. Rapidly redesign the process in which the “never event” resides
4. Implement immediately
5. Audit for sustainability
6. Reinforce and spread success

Where are we now?

On the horns of a few dilemmas...
Dilemmas you will probably face

- Compliance vs. Science
- Specialization vs. Standardization
- Never Event solutions vs. their Unintended Consequences

Unintended Consequences of Improvement Efforts

- Nurse staffing ratio requirements (for patient safety improvement) have led to hospital bed shortages and patient flow logjams.
- A “sea change” has occurred as a result of improved hospital access: “Emergency” Rooms are not.
- Improved medical specialization has created more expense, fragmentation and handoffs in the system.
“We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right—one after another, no slipups, no goofs, everyone pitching in.

“. . .making medicine go right is less often like making a difficult diagnosis than like making sure everyone washes their hands.”

--Atul Gawande