HQIC Reliability and Resilience Learning Action Series

Session 1
April 16, 2024

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Learning Objectives:

1. Discuss the foundations, theories, and applications of resilience and high reliability organizing in healthcare

2. Describe practical implementation strategies for activities that promote reliability and resilience, plus tools and resources available to healthcare organizations

3. Identify one idea to test at the local level to address reliability and resilience

Component 1 - Foundational Knowledge

Self Study: Links below

HANYS / EQIC HQIC Expert – Dr. Oren Guttman, Jefferson Health

Resiliency Engineering and Human Factors as a Path to High Reliability Organizing
Learning Session **Slides** / Learning Session **Recording**

Convergence HQIC Expert – Dr. Bruce Spurlock, Convergence Health

HRO is a Journey, Not a Destination: Lessons from an International Roundtable on Healthcare Resilience
Leading in Tough Times: A Resilience Playbook Summary of the Proceedings

Component 2 - Practical Application of Resilience and Reliability at Scale

Today's session featuring:

Risa Hayes / Telligen HQIC Expert

Jen Murphy / HQI HQIC Expert

Component 3 - Stories from the Field

June 21 session featuring:

Hospital cases studies of reliability and resilience in action at the local level

Today's Speakers

Risa Hayes, CPC
Program Specialist, Telligen Health

Risa provides training, coaching, and strategy facilitation to change leaders, advocates, community coalitions, non-profit and community-based organizations in numerous sectors from healthcare to food access, quality improvement, and local and national government. She has been leading coalition building programs, leadership development and team dynamics work at Telligen for over ten years. She has provided leadership coaching, team effectiveness and community organizing training here in the U.S. and internationally. Risa is trained in Human Centered Design, Motivational Interviewing, the Care Transitions Intervention (CTI™), holds two certifications in professional coaching, a certification in Appreciative Inquiry, and has a Six Sigma Black Belt, and Silver Level Lean certification. Risa has employed a tailored mix of these strategies to empower healthcare providers, patients, leaders, and communities to build capacity for change and transformation for more than twenty-five years.

Jen Murphy, MHA, CPPS
Senior Consultant, Health Quality Innovators

Jen Murphy, MHA, CPPS, is a senior consultant with Health Quality Innovators, based in Richmond, Virginia. In her role supporting hospitals through the CMS-funded Health Quality Improvement Contractor (HQIC) program, she provides subject matter expertise on quality improvement, leadership, high reliability and patient safety culture.

Jen previously served as Director of Quality, Patient Safety and Infection Prevention at Mary Washington Healthcare and as Patient Safety Manager at Virginia Commonwealth University Health System. At these organizations, she supported quality and patient safety improvement efforts and provided guidance in developing high reliability cultures.

Jen holds a Master's in Health Administration from Virginia Commonwealth University and is a Certified Professional in Patient Safety.

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Learning from Community Organizing Approaches to Build High Reliability Organizations

Telligen

April 16, 2024

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Meet Your Speaker

Risa Hayes, CPC
Program Specialist
Patient Family Engagement & Community Organizing Lead
Telligen QIN-QIO
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Objectives

- Reflect on how the leadership practices used in community organizing foster strong commitment, build effective teams, and mobilize people to action.
- Compare the similarities between community organizing and high reliability organizations.
- Explore and identify practices and tools you can use to create a culture of safety and transformational leadership in order build and/or strengthen a high reliability organization.

What can we possibly learn from community organizing?

What is Community Organizing?

- A leadership practice and framework for building capacity to achieve goals.
- These practices enable a group of people to be transformed into a constituency that is mobilized towards a common goal and equipped to take action.

HROs are organizations that achieve safety, quality, and efficiency goals

Pillars of High Reliability Organizations

- Leadership commitment
- Culture of safety/patient safety
- Process improvement
- Radical Commitment to Teamwork

Community Organizing: Leadership Commitment & Practices

Leadership is accepting responsibility for enabling others to achieve shared purpose in the face of uncertainty.

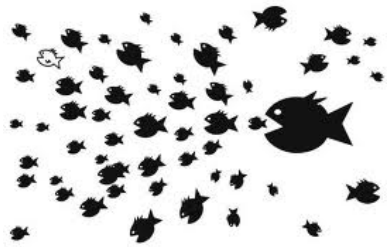
POWER The ability to **achieve purpose**
The ability to **grow in capacity**

PEOPLE
Recruiting & developing leadership at all levels

POWER
Building a community through leadership to create *power*

CHANGE
Using this power to address challenges

… people acting together to change the status quo



POWER WITH

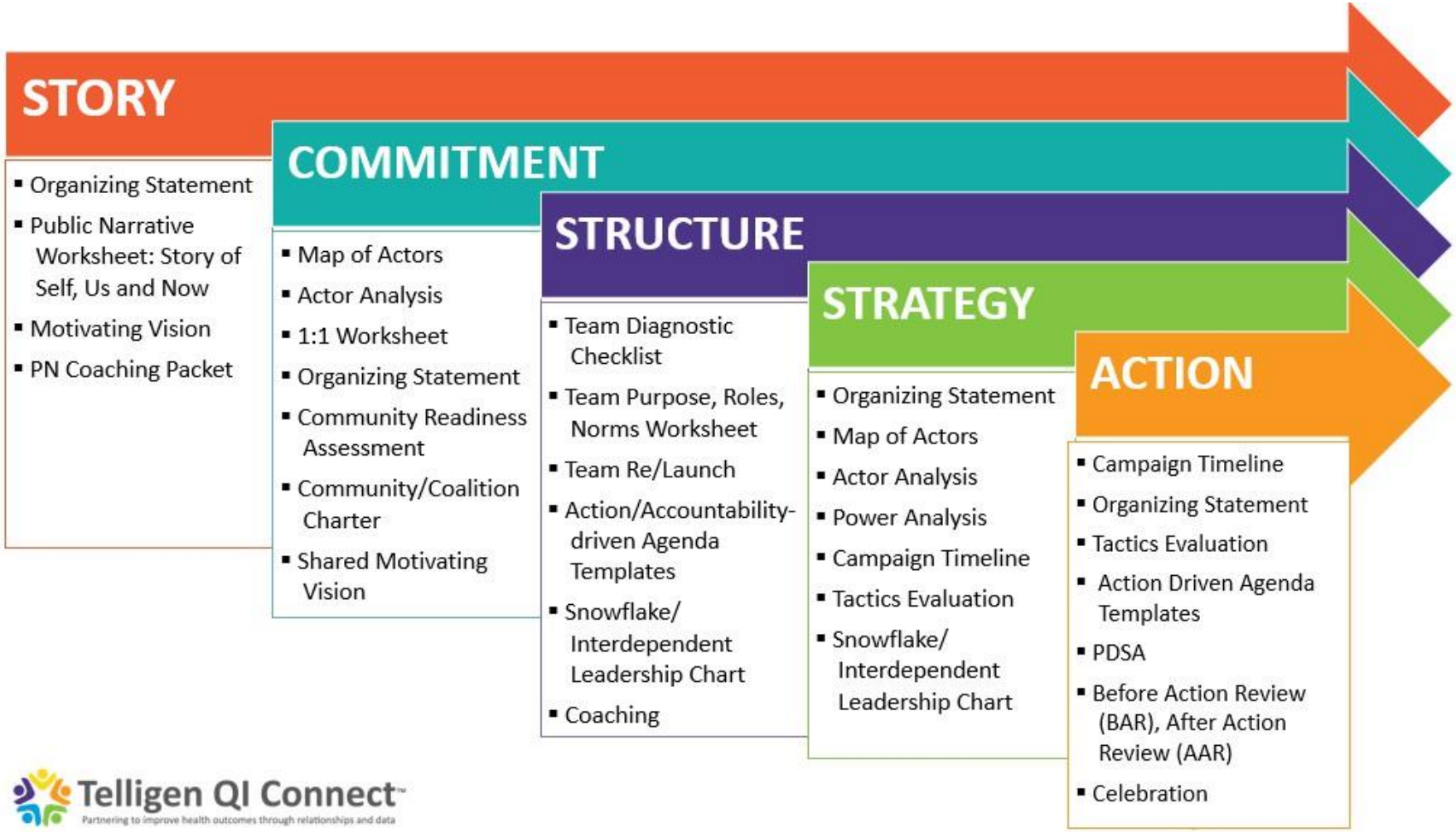
Safety Culture
DEI
Innovation
Commitment
Resilience

POWER OVER

Low trust
Culture of Fear
Stagnation
Inequity
Disengagement

LEAD! Leadership & Organizing in Action (LEAD! LOA) Toolbox

LEAD!LOA
LEADERSHIP & ORGANIZING IN ACTION



Telligen QI Connect™
Partnering to improve health outcomes through relationships and data

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Shared Story: The 3 Stories Every Leader Must Tell

- **Story of Self**: Understand and articulate why the work matters to you – why you *care*
- **Story of Us**: The collective experience of our community – shared hardship, shared values, shared interests
- **Story of Now**: The nightmare/s that require us to act, the vision of the future we can create together, and the specific call to action.

If **you** don't tell your story, **someone else will** . . .

Shared Commitment: Mapping Actors, Resources & Assets

- **Community/Neighborhood**:
  - who is impacted? who is harmed? who benefits?
  - who wants the change?
  - who has resources? who can take/is taking action?
- **Leadership:** who do you want to help you lead?
- **Support:** may have resources or influence, outside of your direct community.
- **Competition:** wants what you want, but is competing for resources
- **Opposition:** opposes your goal and competes for resources

Shared Structure: Conditions Necessary for Effective Teams

The Essentials

- Bounded, stable & interdependent
- Essential resources, skills, and capabilities to lead inter-dependently
- Clear, compelling purpose
- The work is understood, challenging, it matters. And everyone knows why it matters!

Enabling Structures

- Sound structures for how the team functions and interacts with one another
- Supportive organization systems
- Coaching

Team Processes

- Interdependent roles
- Real teamwork
- Accountability
- Effort builds shared commitment

From the work of Dr. Ruth Wageman, Harvard, Columbia, Dartmouth

Shared Strategy: The Organizing Statement

We are organizing (WHO - community)

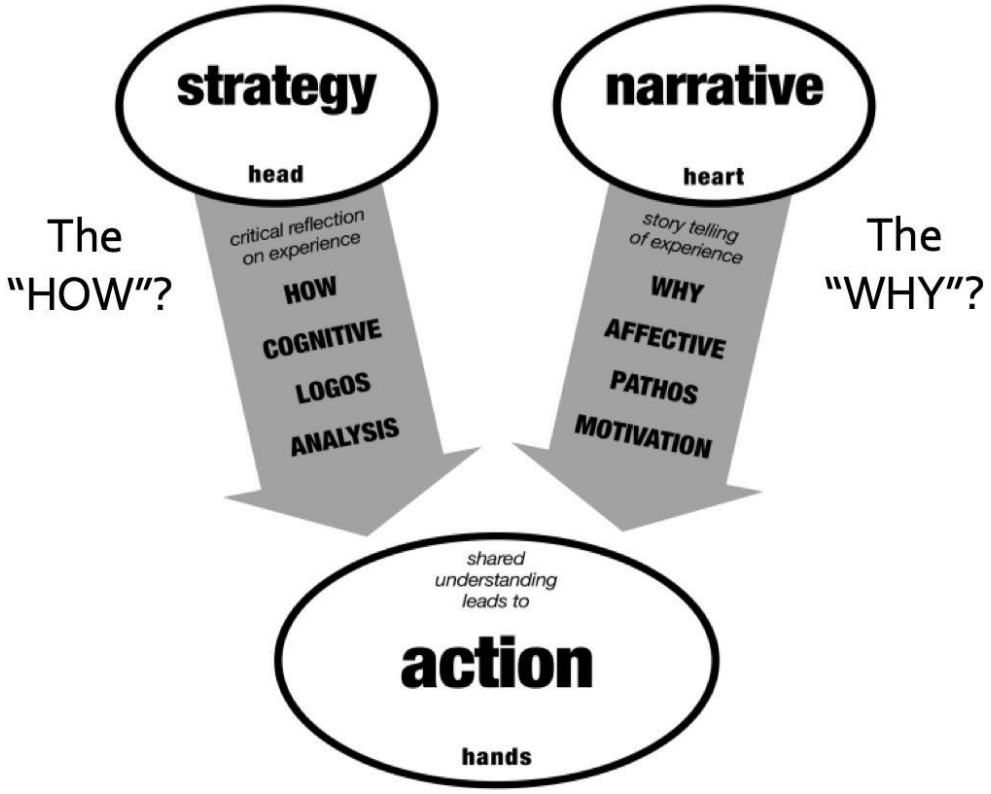
to do (WHAT - measurable aim)

by (HOW - tactics)

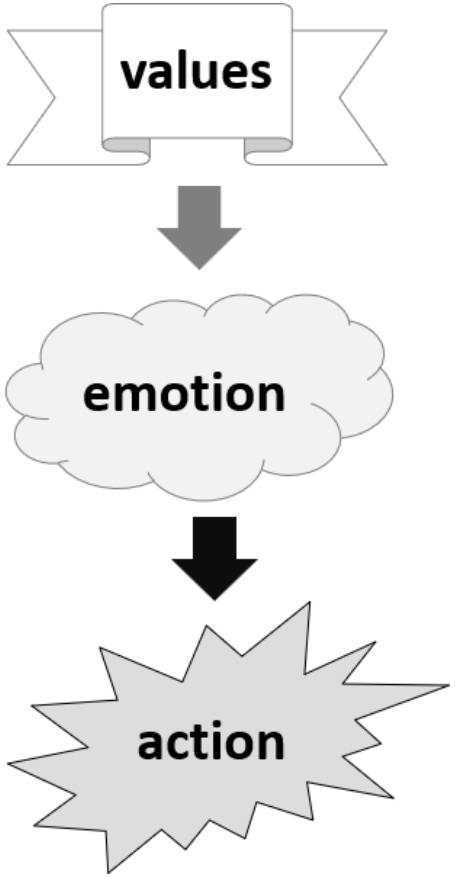
in order to (WHY - motivating vision)

by (WHEN - timeline).

Shared Action: Head, Heart & Hands

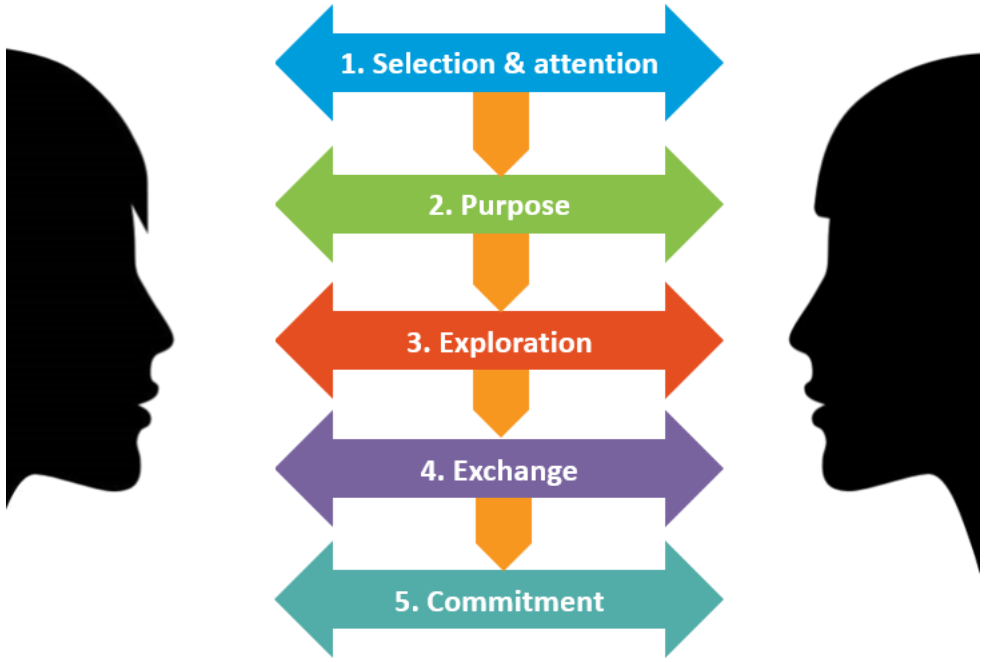


...you need both to inspire effective action.



Leadership & Teamwork: Transformational, Relational & Action Driven

One-to-One Meetings



Group Meetings

1:1 "Step/Component"	Agenda Topic	Clarification/Planning Tip

1. Selection & attention	**Why are we here?**
	
	I/we wanted to meet with you to explore ….
		▪ Be explicit about why these attendees were invited
		▪ What is it about them, in particular?
		  ○ Why it's important for them/to them
		  ○ Not what you want/need from them
		▪ What you think you might connect with them about

2. Purpose	**Purpose for this Meeting:** What we'd like to explore	▪ Make sure the "purpose" is not the same as 'the ASK" – you need to explore first before you know what and IF you'll ask
3. Explore	**Topics to Explore/Questions to Ask**	▪ Share your Story (of self of Full Public Narrative) ▪ Let them see you care, what motivates you – they can identify with you ▪ Invite them to share why they care, what motivates them ▪ Ask them what their vision/dream is (Appreciative Inquiry is great here) ▪ Begin exploring ideas they have for how to improve/change, and what actions we can each take
4. Exchange	**Ideas for Action We Can Take**	▪ Begin to talk about what resources you each bring to the effort ▪ What roles are needed and who can fill them ▪ Who else needs to be involved
5. Commitment	**Action Items and Next Steps**	▪ Make a strong ask ▪ Leave with a clear plan – dates, times, accountability ▪ When will you meet again

So, what is one insight or inspiration you gained?

About …

- Leadership?
- Engaging and motivating internal staff and external partners?
- Commitment?
- The importance of story?

What is one thing you can start today?

Thank You!

Risa Hayes, CPC

Telligen, Inc.

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IT IS POSSIBLE.

It is possible for us to emerge from our time together refreshed, surprised and less burdened than when we came.

Our work together can provide renewal, refreshment and possibilities for what we can do together to create the future that is waiting to be born

Seeds planted here will keep growing and flourish in the days ahead in the service of our work.

Adapted from Touchstones used in The Center for Courage and Renewal's Circles of Trust Retreats - Covenants of Presence

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Implementing an Incident Decision Tree

Health Quality Innovators

April 16, 2024

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Meet Your Speaker

Jen Murphy, MHA, CPPS
Senior Consultant
Health Quality Innovators

Objectives

- Define just culture and fair accountability.
- Describe the components of an incident decision tree.
- Review best practices for implementing an incident decision tree in your hospital.

Principles of HROs

Principles of Anticipation

- Preoccupation with failure
- Reluctance to simplify
- Sensitivity to operations

Principles of Containment

- Commitment to resilience
- Deference to expertise

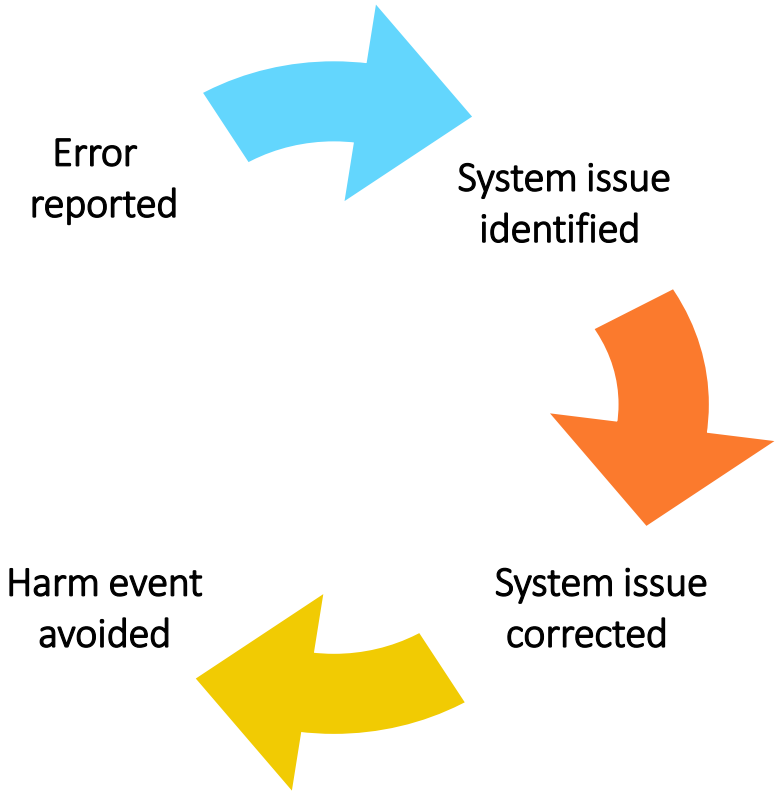
Quote

"The single greatest impediment to error prevention in the medical field is that we punish people for making mistakes."

- Lucian Leape

Just Culture

- System problems are the main causes
- Encourages reporting of and learning from errors
- Issues are fixed to prevent future harm
- Focus on behaviors and not outcomes



Surveying Level of Just Culture

- “In this unit, staff feel like their mistakes are held against them.”
- “When an event is reported, it feels like the person is being written up, not the problem.”
- “When staff make errors, the focus is on learning rather than blaming individuals.”
- “There is a lack of support for staff involved in patient safety errors.”

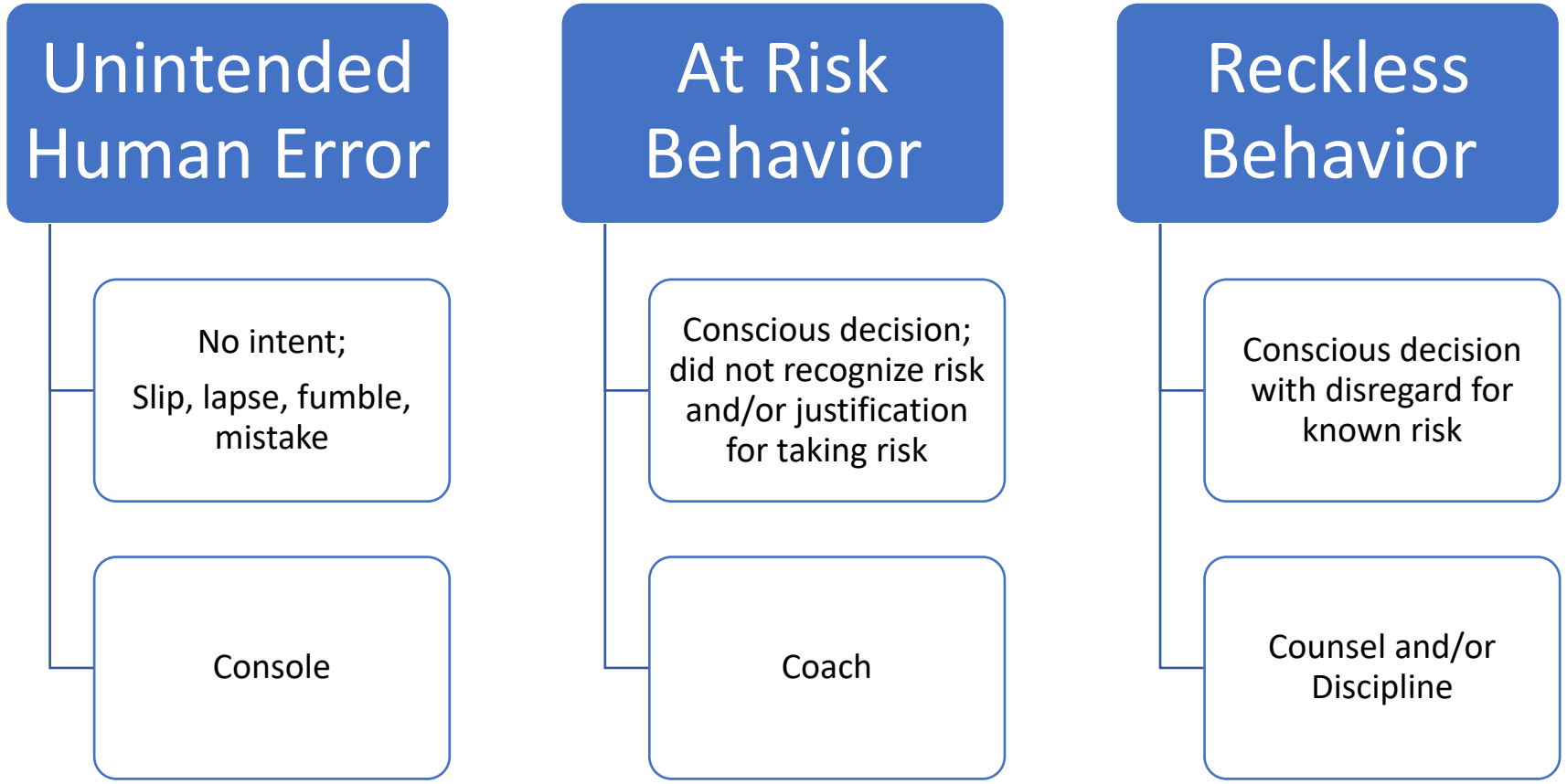
From AHRQ SOPS Hospital Survey

Accountability Spectrum

Fair Accountability

- Taking the appropriate action in response to an error based on the behaviors exhibited and not solely based on the outcome
- May or may not include formal disciplinary action
- May or may not include notification to professional organization or licensing bodies

Behavior versus Outcome

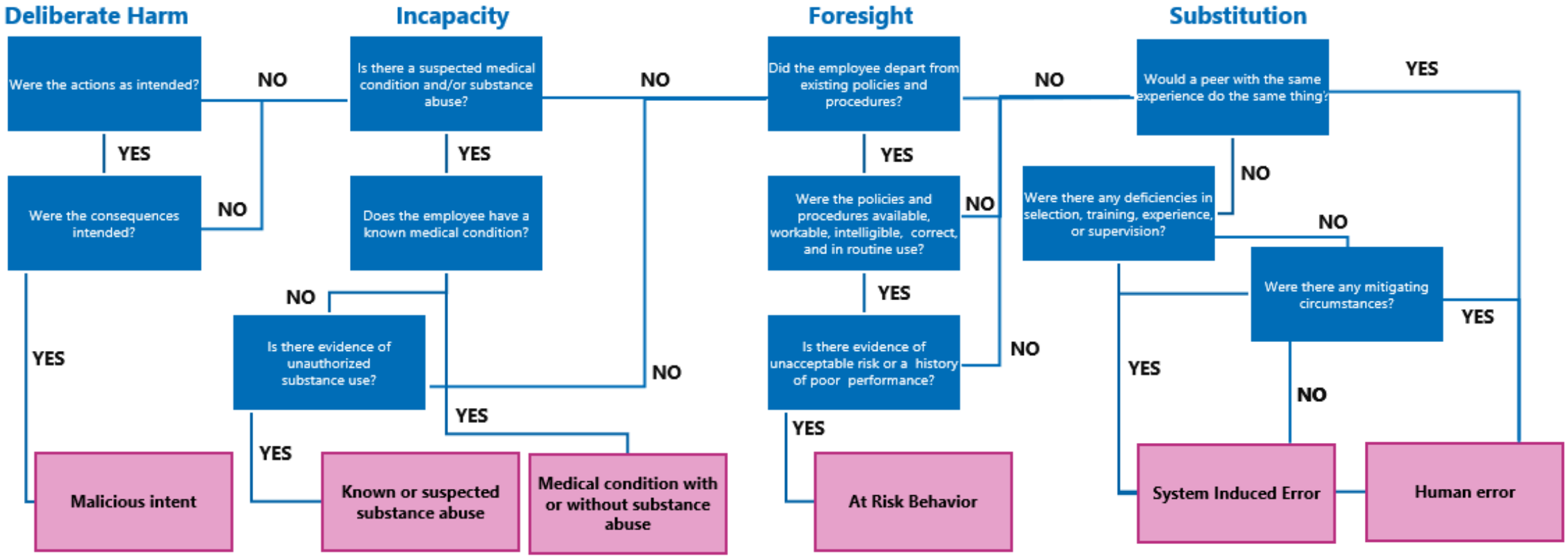


Marx, 2001, Patient Safety and "Just Culture:" A Primer for Healthcare Executives

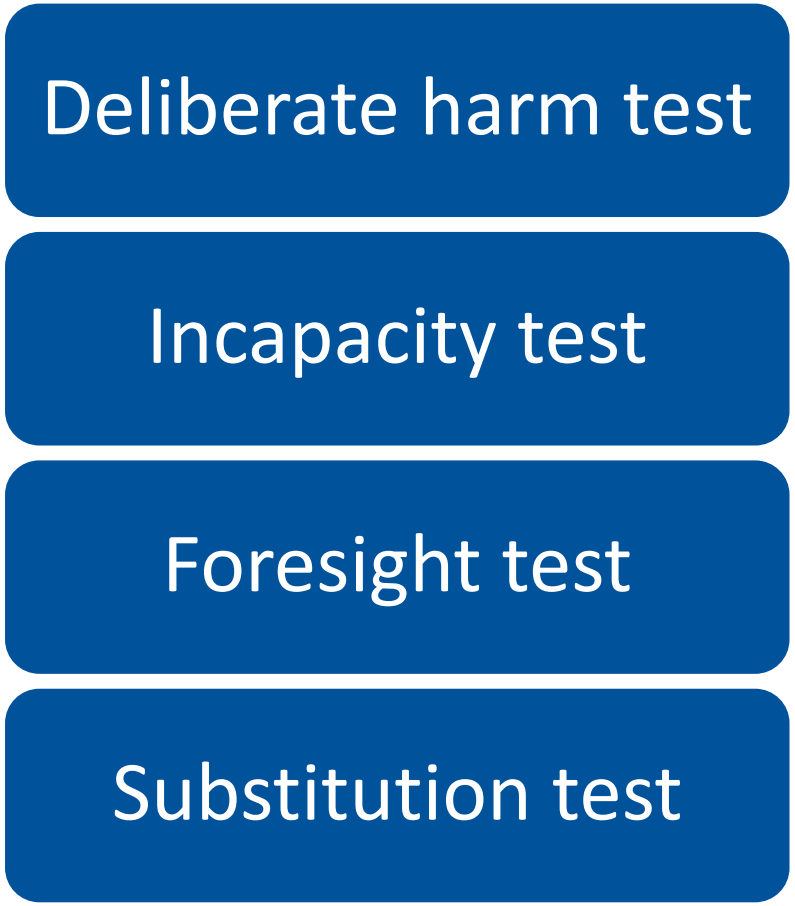
Incident Decision Tree Background

- Based on the work of James Reason
- Accepts that humans are fallible and will experience errors
- Determines intentionality and riskiness of behaviors
- Determines when disciplinary action is appropriate versus counseling, coaching, or consoling

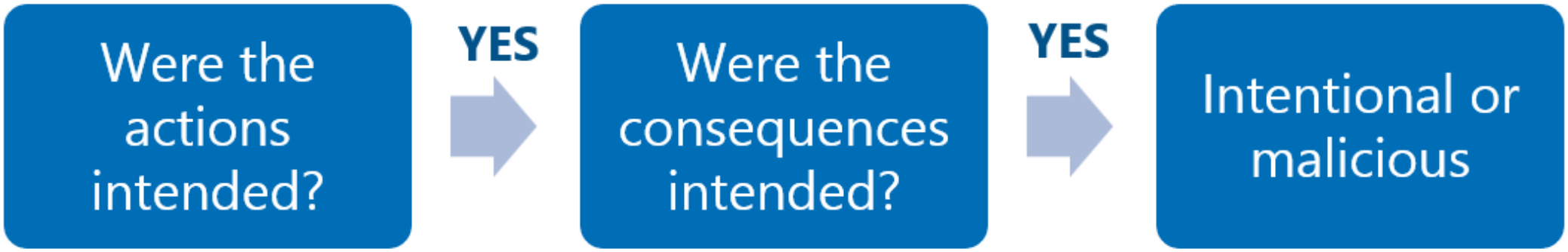
Incident Decision Tree



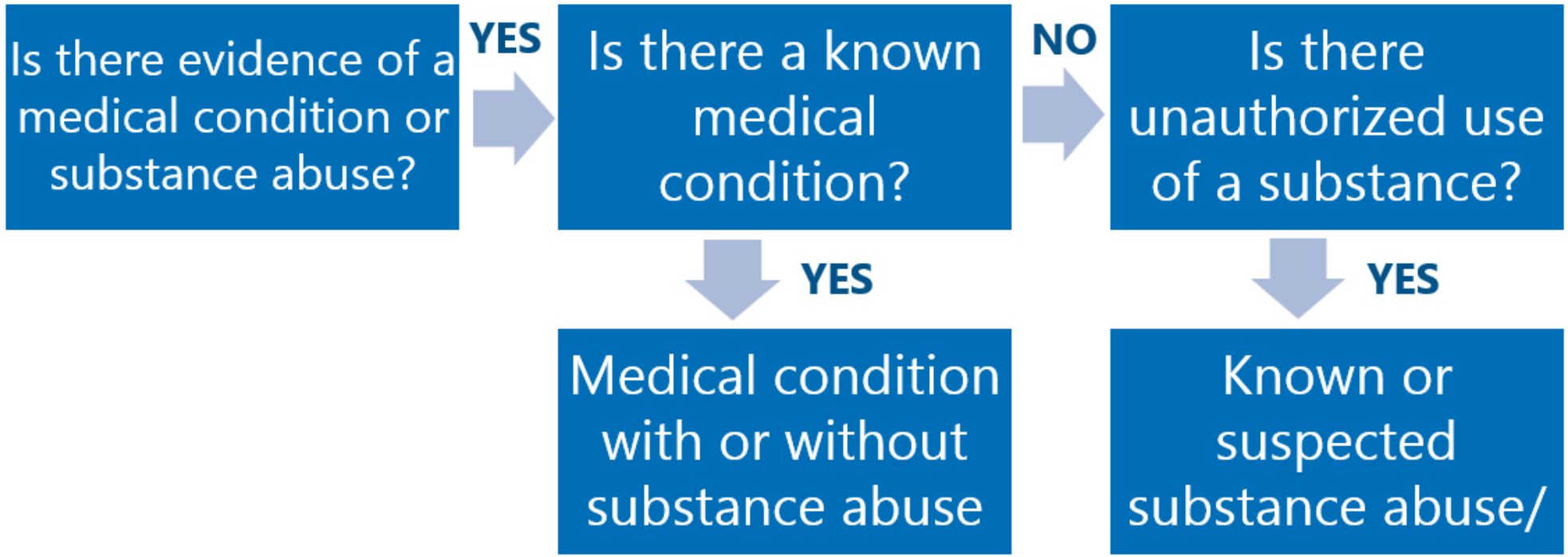
Incident Decision Tree Components



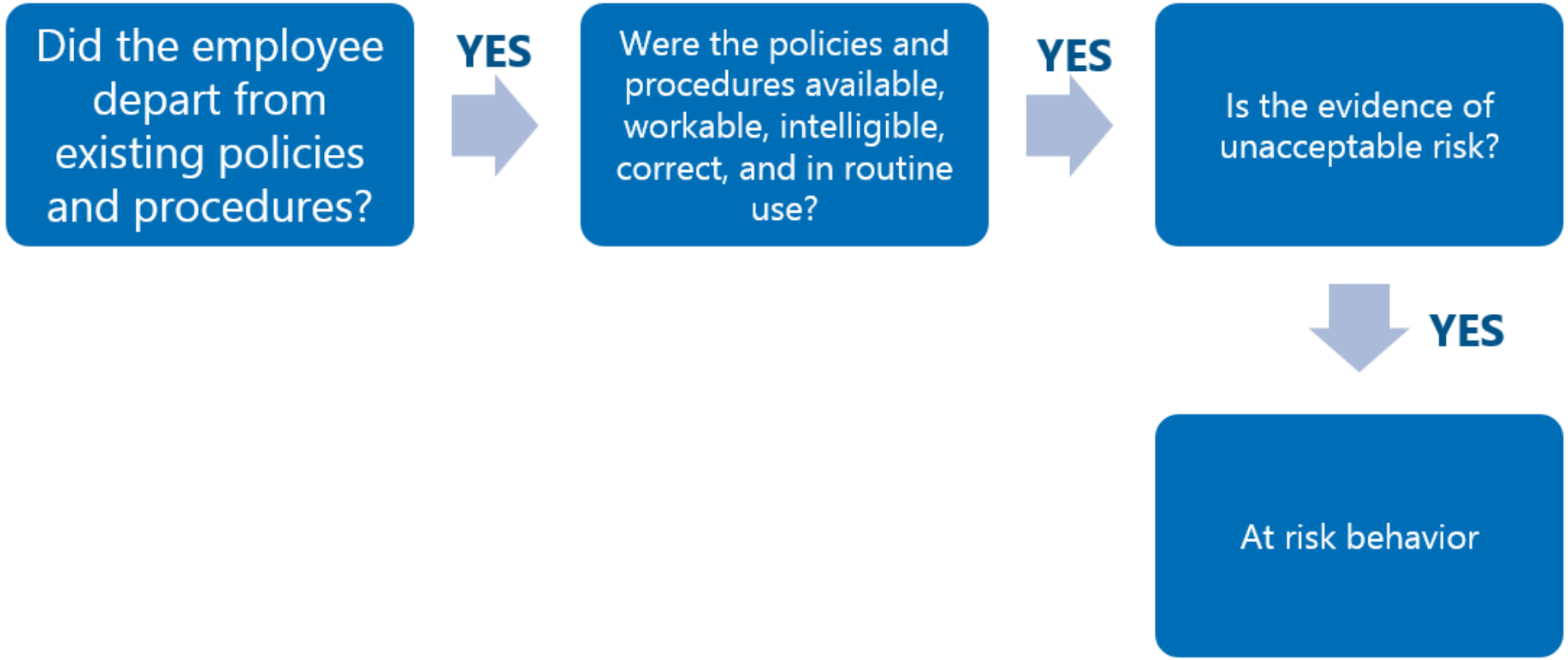
Deliberate Harm Test



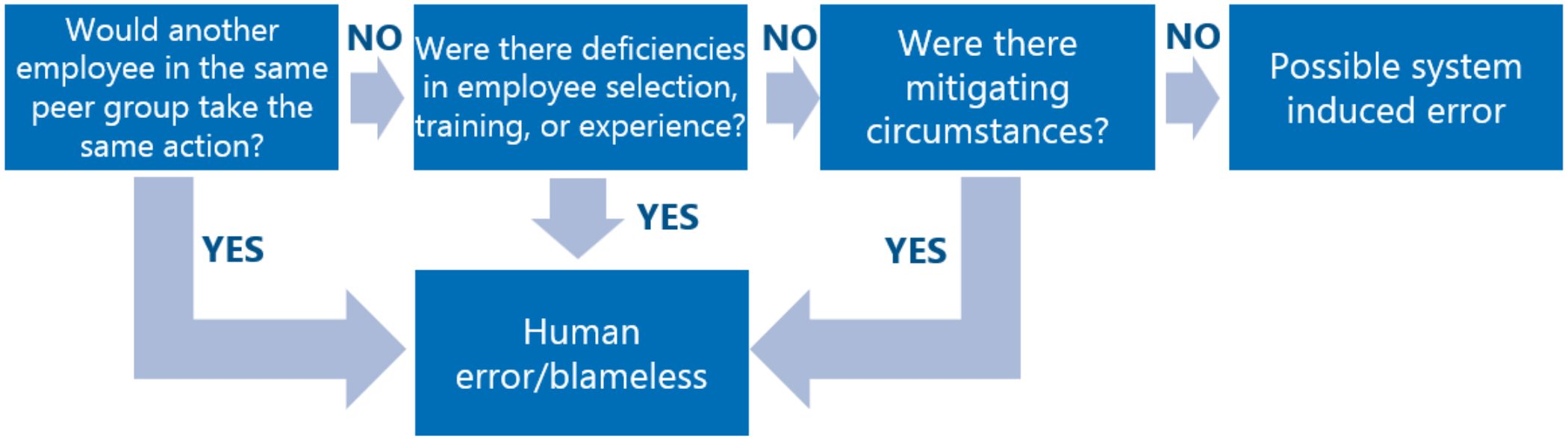
Incapacity Test



Foresight Test



Substitution Test

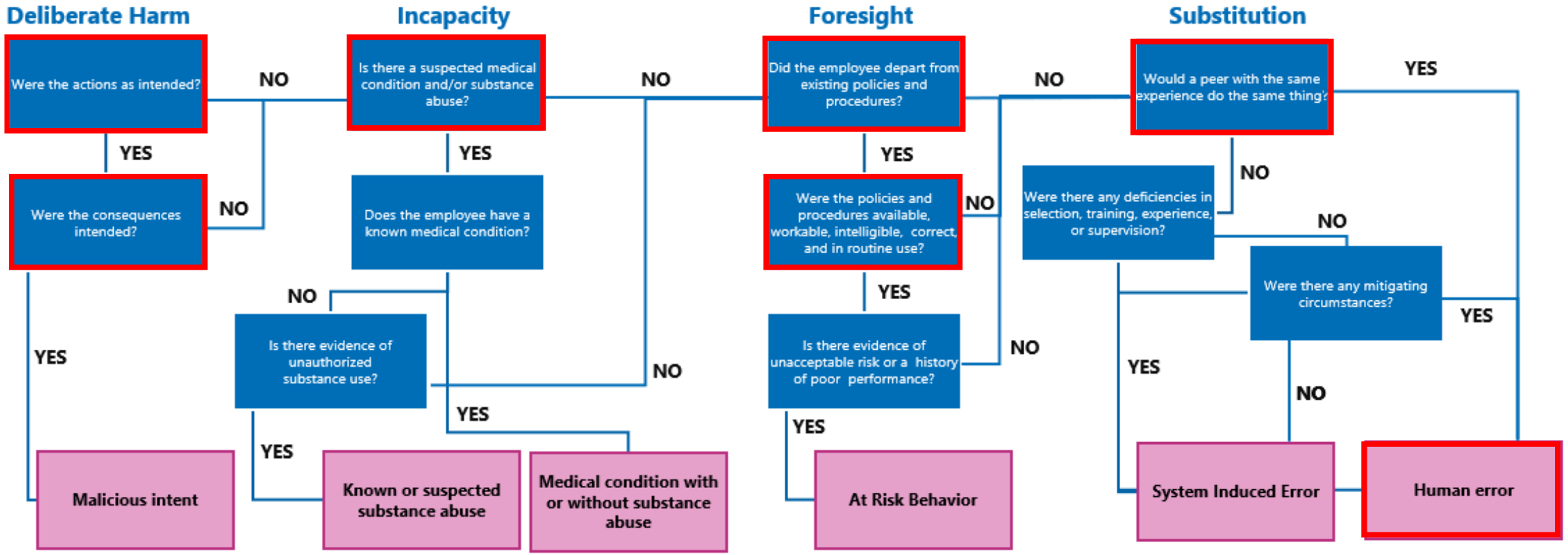


Case Example

A nurse is administering a high-risk medication to a patient and does not adhere to the two-nurse check. The patient experiences an adverse event, and it is discovered that an incorrect dose was given.

After investigating, the nurse manager discovers two-nurse checks are routinely not being conducted by other nurses on the same unit due to low-staffing. It has been hard to find another nurse who was not busy and administer medications on time.

Example



Implementing an Incident Decision Tree - Planning

Interprofessional team

C-suite, HR, Quality/Safety, medical staff leadership, professional group representatives

Policy review and revision

Incorporate medical staff

Review of bylaws

Peer review process

Implementing an Incident Decision Tree - Testing

Development of organization specific incident decision tree	Incorporate state reporting guidance and medical staff bylaws
Test case review	Use real events Maintain confidentiality
Identify champions	Utilize safety survey results to identify leaders

Implementing an Incident Decision Tree – Go Live

Piloting

Leadership training and staff education

Launch and monitor

HR reporting

Event reporting system/manager reviews

High Reliability Leadership Series

Visit the HQIN Resource Center for our full High Reliability Organization (HRO) leadership series.

Contact Information

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Questions?

See you for Session 2 on June 21!