Iowa Health System Journey
Toward Ideal Care and Safety for Patients
2000 to 2012

Gail Nielsen, Director of Learning and Innovation, Iowa Health System
Objectives

• Describe the leadership role in reducing harm in health care.

• Identify three keys to engaging hearts and minds in performance improvement.
Systems of Care

“The quality of patients’ experience is the ‘north star’ for systems of care.”

– Don Berwick
Quantum Leaps in Medication Safety

Iowa Health System

Adverse Drug Events: % of Sampled Charts with Harm Levels ADEs E-I

Targets: 2002 = 10%, 2003 = 4%

% of Charts

'03 Target 4%

Reduced Sample Size

'03 Target 4%
Faster Lab Results for Patients

- Reduced gram stain results time 66 percent.
  - Target turn-around time = 1 hour
  - Actual = 40 minutes

- Increased employee process satisfaction 30 percent.

- Reduced the specimen time from receipt in the laboratory to culture incubating from two hours to one.

* Based on average of 300 specimens processed daily.
Efficient Blood Gas Analysis Process

- Percentage of blood gas analysis process over 30 minutes reduced from 8.4 percent to goal of 0 percent.

- Blood gas collection turn-around-time reduced from 18.6 minutes to 13.15 minutes Clinical and Laboratory Standards Institute = 30 minutes.

* Based on over 6000 specimens.
“There is absolutely no inevitability as long as there is a willingness to contemplate what is happening.”

- Marshall McLuhan
Reliable Hand Washing

*Based on 20 “secret shopper” observations per month per hospital
Effective Purchase Requisition Process

Methodist West Purchase Requests returned because of errors or incomplete information

- 1st manual purchase order for Methodist West
- Start Electronic Requisitions for Methodist West
- Orders increase closer to construction completion
- Orders increase closer to construction completion
- Methodist West Purchase Requests returned because of errors or incomplete information

*Based on 392 purchase orders over a 7-month period

- Time per purchase order decrease: 143 to 45 minutes.
- Purchase order cost decrease: $52.30 to $16.65.
Fewer Pressure Ulcers

IHS System-wide HAPU Incidence: 13 Hospitals
Quarterly Q1 2009 - Q2 2011

Hospital 1 began AD Q2 2009
25 units were active and spreading by end of 2010

Quarterly 2009 - Q2 2011
Fewer Admissions to Acute Care for Patients with Home Care

Integrated chronic care disease management training to 600 clinicians is one strategy of many.
Decrease in the number of patients readmitted within the first 2 weeks after discharge
IHS System-wide Improvement in Perinatal Care

Percent Performance by Elective Induction Indicator by Quarter for All IHS Affiliates (Baseline to Date)

- % of Pts w/ Gest age >= 39 wks
- % of Pts w/ Reassuring Fetal Status
- % of Pts w/ All Pelvic Exam Elements
- N of Pts w/ Tachysystole & Approp Tx or No Tachysystole

Baseline: Q405, Q107, Q207, Q307, Q407, Q108, Q208, Q308, Q408, Q109, Q209, Q309, Q409, Q110, Q210, Q310, Q410, Q111, Q211, Q311, Q411
IHS Roles of Leadership in Reducing Harm in Health Care

- System Board Quality Committee
- System Clinical Council
  - Executive sponsors for system-wide work
- System PI Leaders
- Center for Clinical Transformation
  - Providing clinical scorecards
  - Building infrastructure for improvement
  - Leading system-wide collaboratives
  - Convening system shared learning
Building Infrastructure for Improvement

- 2000 – Established the Patient Safety Implementation Team in response to the IOM’s 1999 report To Err is Human
- 2001 – IOM’s report Crossing the Quality Chasm; IHS joined Quantum Leaps in Medication Safety, reduced ADEs 75% by 2004
- 2004-’05 – Nielsen’s IHI Fellowship
Building Infrastructure for Improvement


• 2006 – system-wide collaboratives integrated the learning methods and reinforced skill building.

• 2008 – department directors and unit managers joined the program and incorporated the skills into regular work.
Building Infrastructure for Improvement

- 2009 – 1,000 managers trained in Lean Redesign to remove waste and make more time for improvement efforts.
- 2009 – adaptive problem solving began spreading across the system from Blueprint Units in each hospital.
- 2010 – by July A3s were in use system-wide on Falls and related injuries, HAPU, HAIs.
Three Keys to Engaging Hearts and Minds in Performance Improvement

Key 1

- Health care workers find joy in changing their work when it achieves better patient outcomes.
  - Honor the work that exists.
  - Equip and support workers to achieve change.
  - Celebrate successes large and small.

Excitement and willingness to change develop with the right approach and feedback.
Three Keys to Engaging Hearts and Minds in Performance Improvement

Key 2

• Strong day-to-day unit leaders create enthusiasm for change and lead the way.
  − Improvement is a primary accountability.
  − Managers enable problem solving in the course of daily work.
  − Assumptions are checked through observations.
  − Frontline ideas drive tests of change.
Three Keys to Engaging Hearts and Minds in Performance Improvement

Key 3

• Senior leaders are visible, provide support opens doors and improves team results.
  • Be there to see the work without placing blame while encouraging deep learning and tests of change.
  • Consistently listen to the barriers, tests and successes.
  • Remove barriers.
  • Free up time to test and learn.
Lessons Learned

• Build the infrastructure of learning for performance and process improvement for your organization to thrive.

• Connect important work to strategic aims.

• Engage senior executives in the work.

• Get to the roots of problems at all levels with adaptive learning and problem solving.

• Spread learning faster through collaboratives.
Lessons Learned

• Best Outcome for Every Patient Every Time vision gives teams energy.
• Focus on Ideal Care engages hearts and minds.
• Focus of the IHS Board builds spirit.
• Focus of the IHS Clinical Council keeps “eyes on the prize”.

IOWA HEALTH SYSTEM
Best Outcome for Every Patient Every Time
“We are what we repeatedly do. Excellence, then, is not an act, but a habit.”

- Aristotle
10 Years: Reducing Falls and Injuries

System-wide for 12 hospitals:

• 5466 fewer falls.
• 40 percent fewer serious injuries.
• Major injuries annually reduced from 26 to 4.
• No major injuries, seven consecutive months.
• No fall-related deaths in the past 30 months.
System-wide Reductions in Falls and Related Injuries Since 2002

- 2002 collaboration and sharing across IHS and IHI.
- 2003 core fall risk assessment standards across IHS.
- 2004 standard IHS data definitions and collection.
- 2005 standard IHS risk assessment for falling – Morse.
- 2006 collaboration with IHI and RWJF on injury risk assessment.
- 2009 began using A3s on falls on pilot (Blueprint) units.
- 2010 use of A3 for all falls in regular use was system-wide by July.
- 2012 IHS Board recommended thanks and celebration.
Falls Team Progress

Congratulations
IOWA HEALTH SYSTEM

5,466 FALLS PREVENTED
STATEWIDE
SINCE 2001
Falls Team Celebration
Rate of Serious Fall-related Injuries per 1,000 Patient Days, by Year
Number of Major Fall-related Injuries by Year

Number of Fall Related Major Injuries (e.g. hip fractures) for 2004 - 2011

- 2004: 26
- 2005: 25
- 2006: 22
- 2007: 15
- 2008: 12
- 2009: 10
- 2010: 10
- 2011: 4

IH/IRWJF Grant: Added injury risk assessment to fall risk assessment

Began A3s on Falls

A3 use system-wide
Rate of Major Fall-related Injuries per 1,000 Patient Days, by Month

Major Injury Fall Rate per 1000 Patient Days
Jan 08 - Dec 11

July 2010 A3s use System-wide
Achieving Desired Results

- Ideas
  - New possibilities
  - Sequencing and tempo

- Will
  - Builds confidence

- Execution

RESULTS
Will: Strategic Vision

Best Outcome Every Patient Every Time

Ideal Care for Our Patients

Reducing Fall-related Injuries Strategic Aim

Senior Leaders Engaged
IDEAS: Evidence-based Changes

- Learning from A3s on Every Fall: learning together & customizing to patients
- Assessing & Addressing Patients’ Risk of Falling
- Assessing & Addressing Patients’ Risk of Serious Injury
- Reliable Focused Rounding and more!

IOWA HEALTH SYSTEM
Best Outcome for Every Patient Every Time
Execution

- Clearly articulated change leadership framework
- Effective project setup, and management
- Communications process to spread learning
- Move from pilot units to every patient every time
Our Motivation

“The Iowa Health System Board’s interest in our work is the wind beneath our wings.”

- Falls teams members, July 2012
“It is only with the heart that one can see clearly, for what is essential is hidden from the eyes.”

- Antoine de Saint Exupery
The Safety Gap

“YOU are stewards of something precious.”

- Author unknown