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

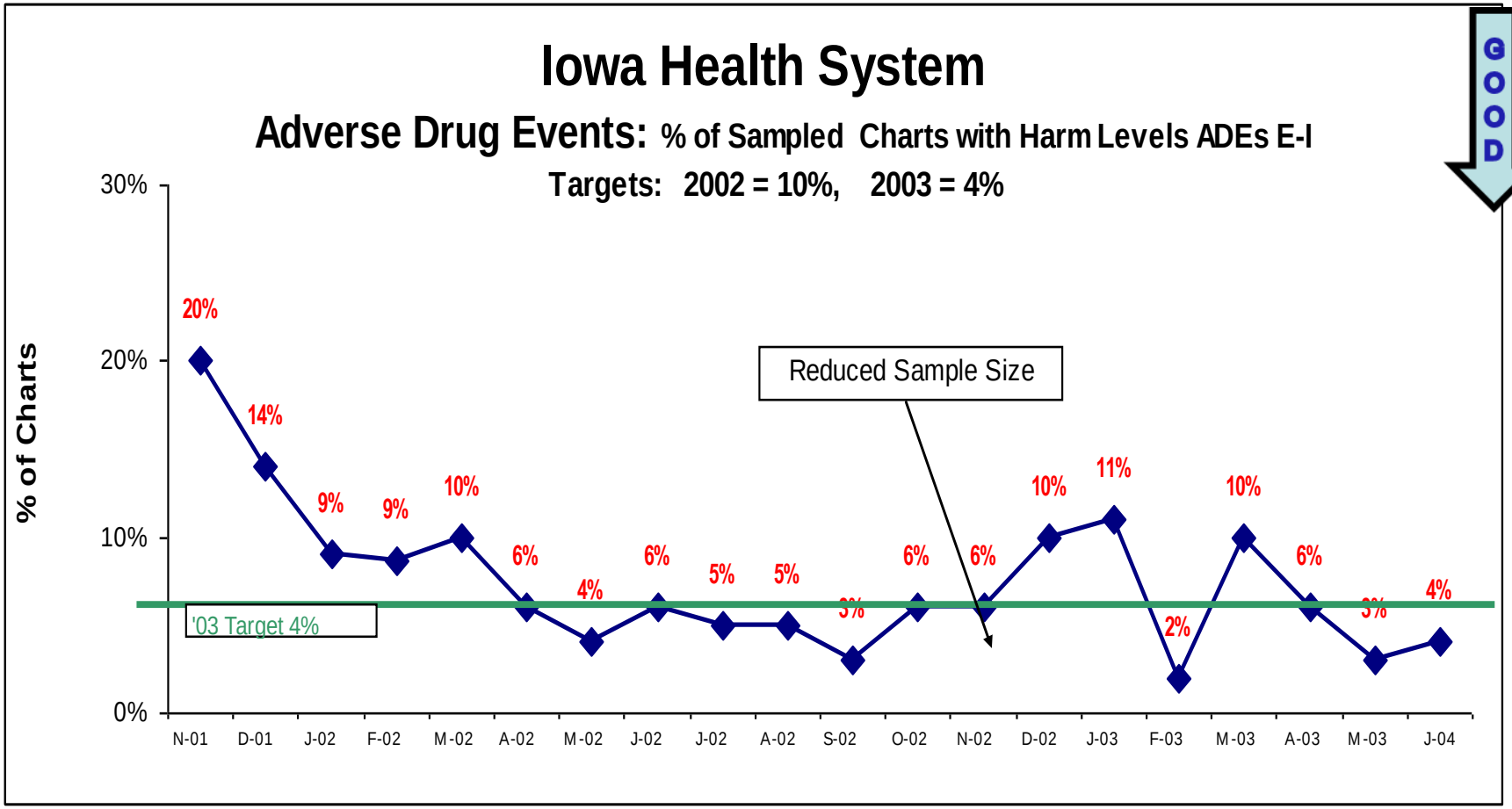
- Describe the leadership role in reducing harm in health care.
- Identify three keys to engaging hearts and minds in performance improvement.

Systems of Care

"The quality of patients' experience is the 'north star' for systems of care."

– Don Berwick

Quantum Leaps in Medication Safety



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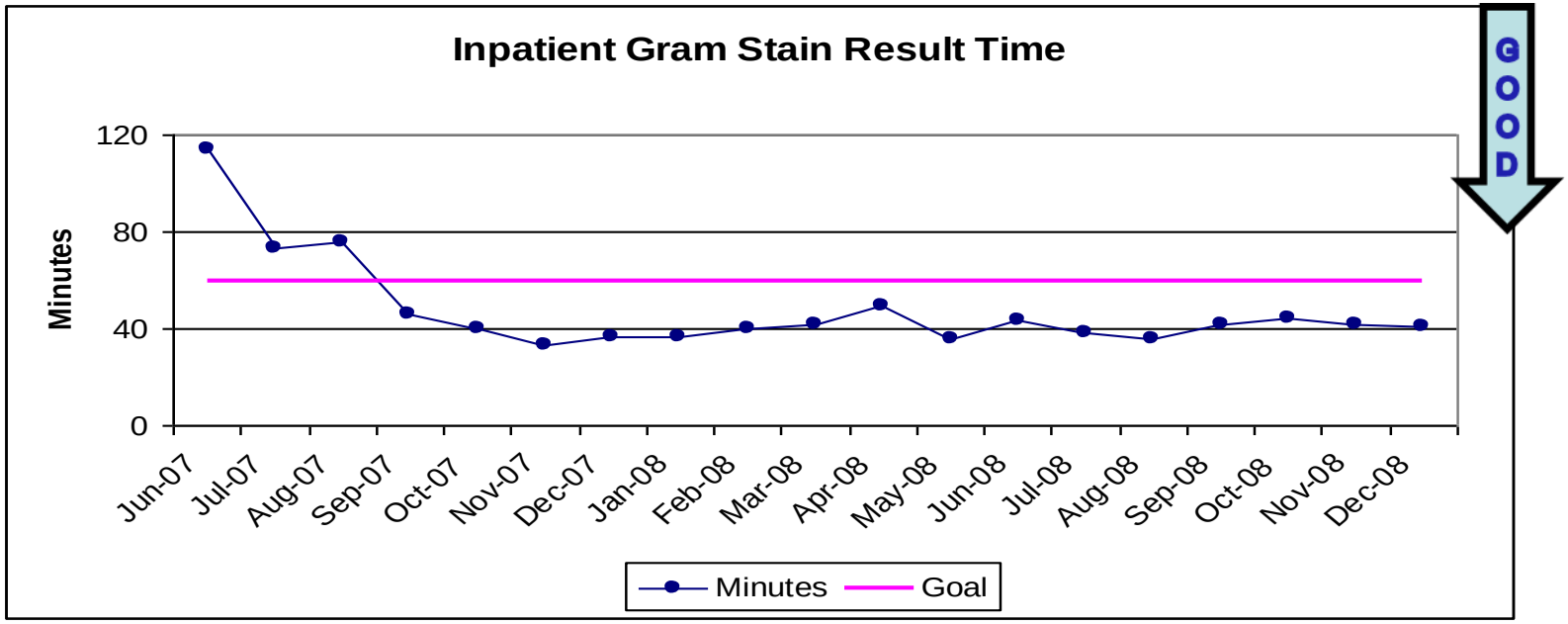
Best Outcome for Every Patient Every Time

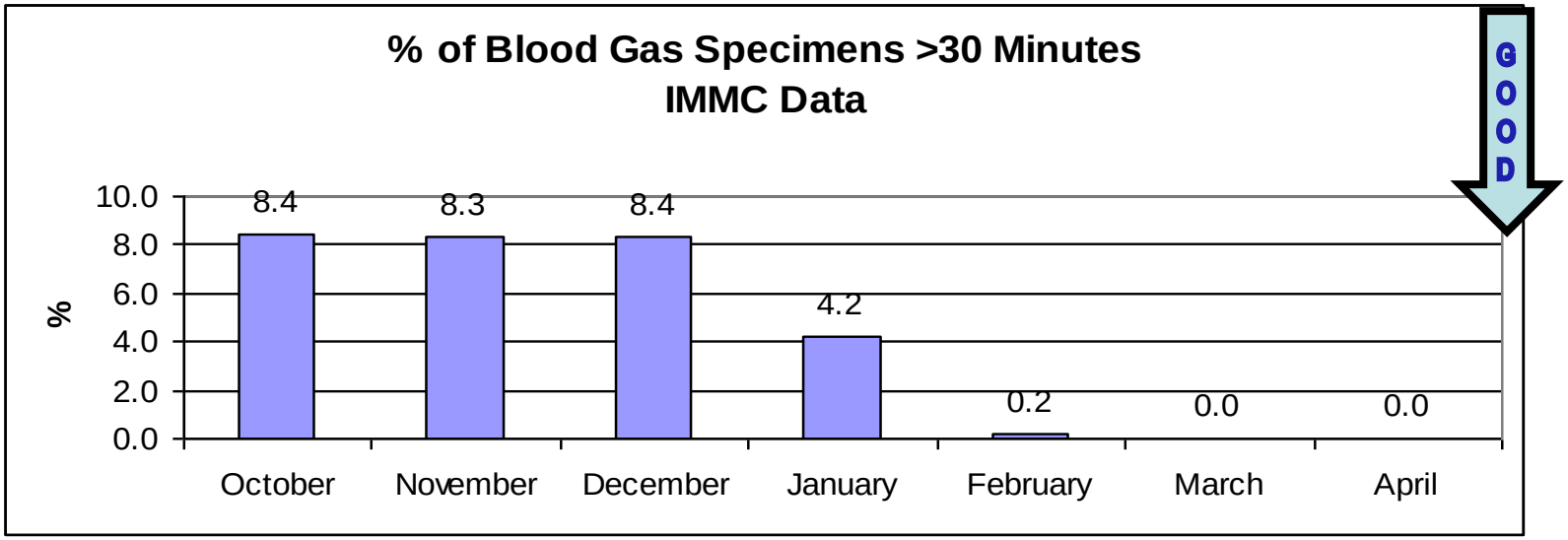
Faster Lab Results for Patients



- 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

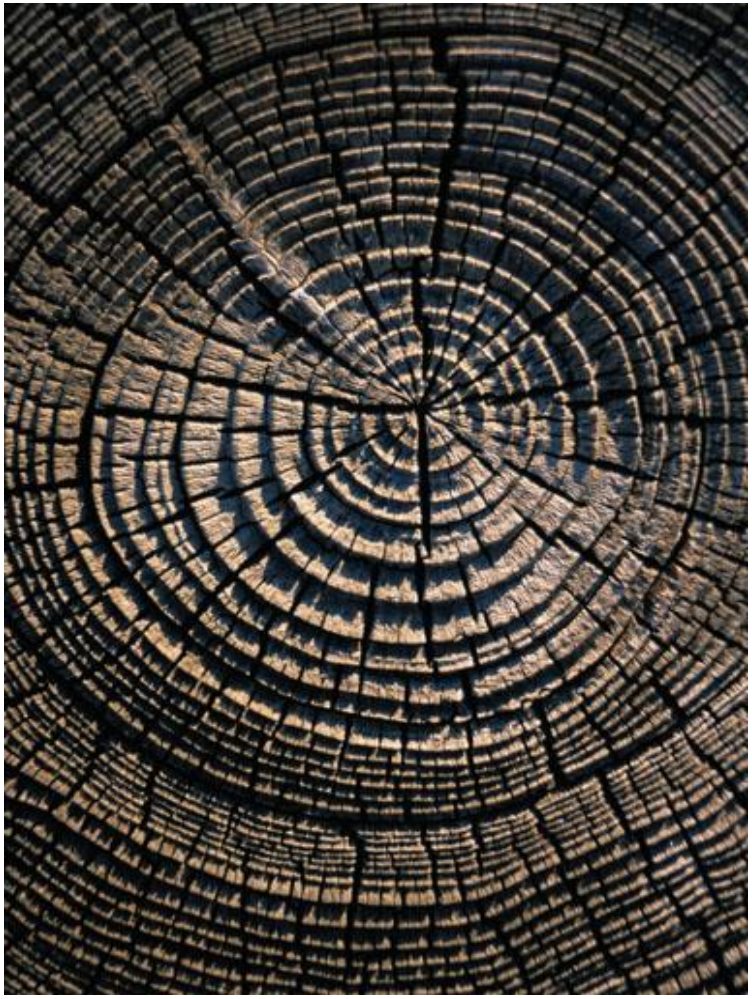


- Percentage of blood gas analysis process over 30 minutes reduced from 8.4 percent to goal of 0 percent.
- Blood gas collection turn-around-time reduced from 18.6 minutes to 13.15 minutes Clinical and Laboratory Standards Institute = 30 minutes.

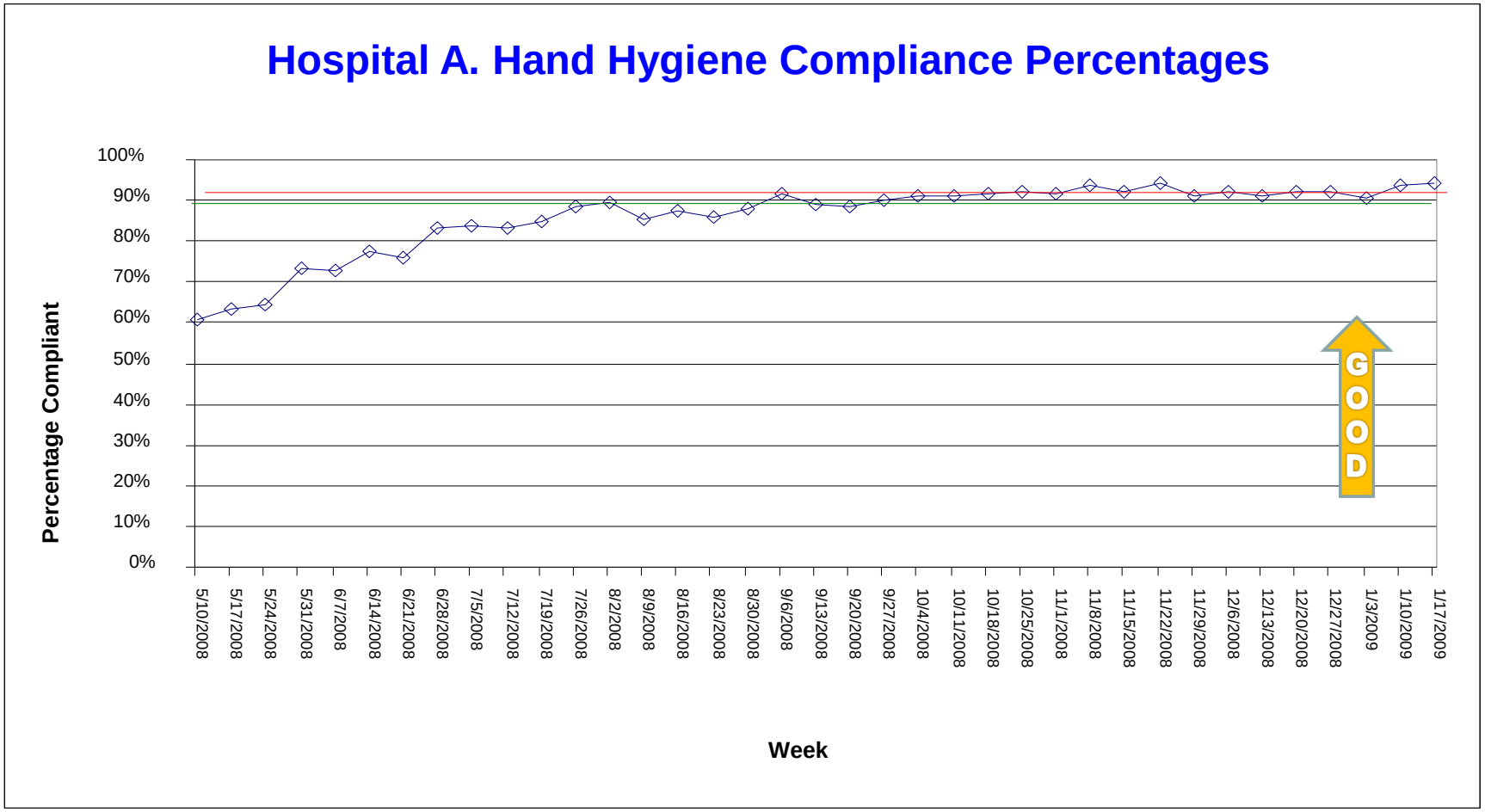
* Based on over 6000 specimens.

“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

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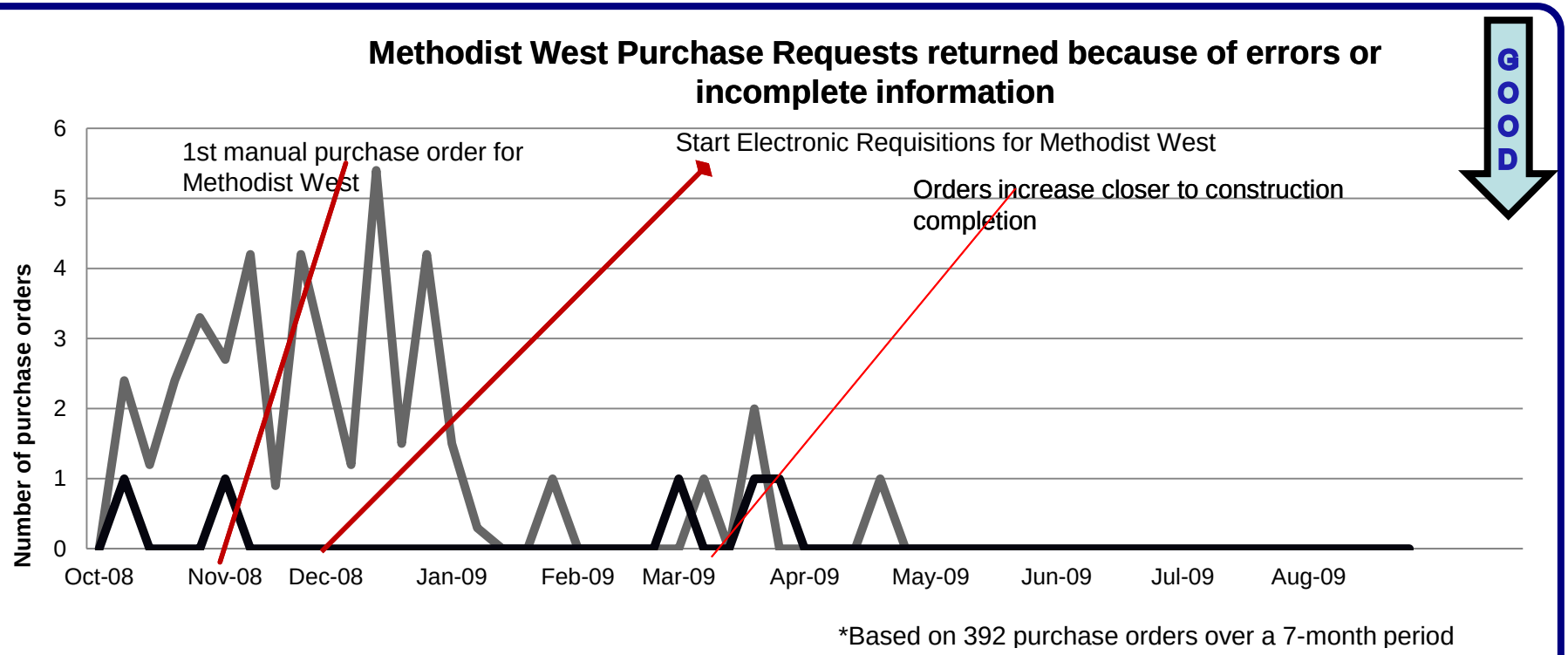
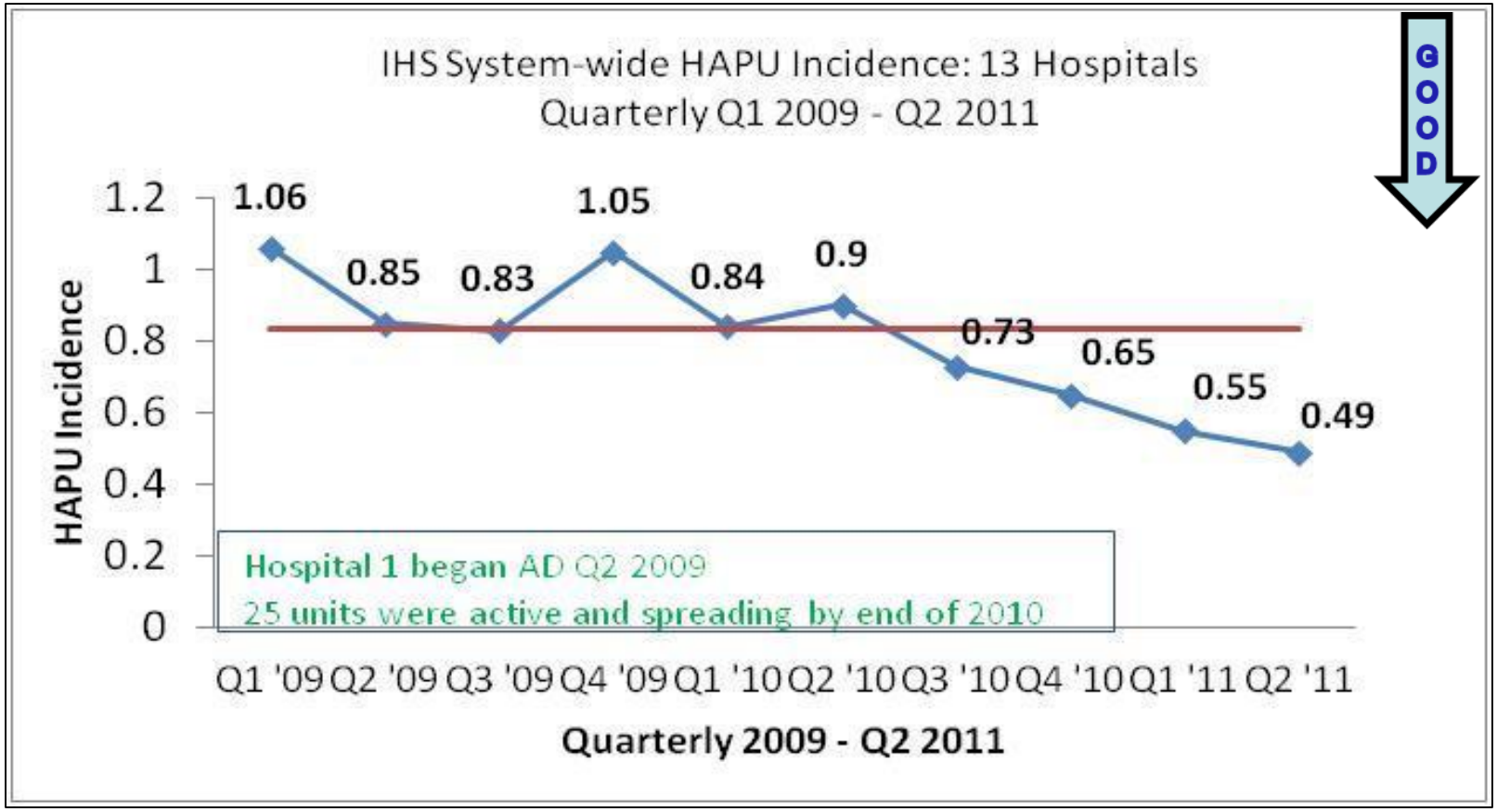
Effective Purchase Requisition Process

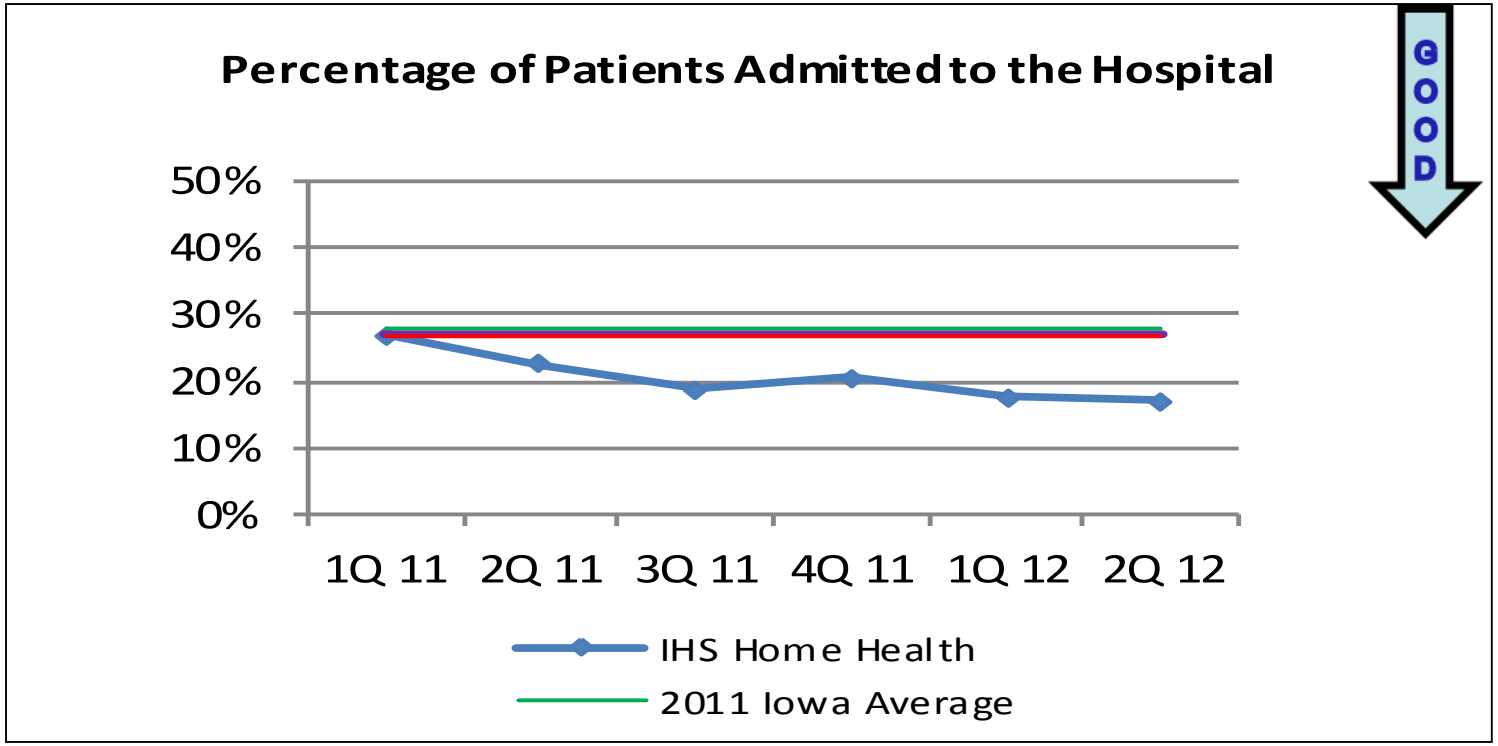


- Time per purchase order decrease: 143 to 45 minutes.
- Purchase order cost decrease: $52.30 to $16.65.

Fewer Pressure Ulcers



Fewer Admissions to Acute Care for Patients with Home Care



Integrated chronic care disease management training to 600 clinicians is one strategy of many

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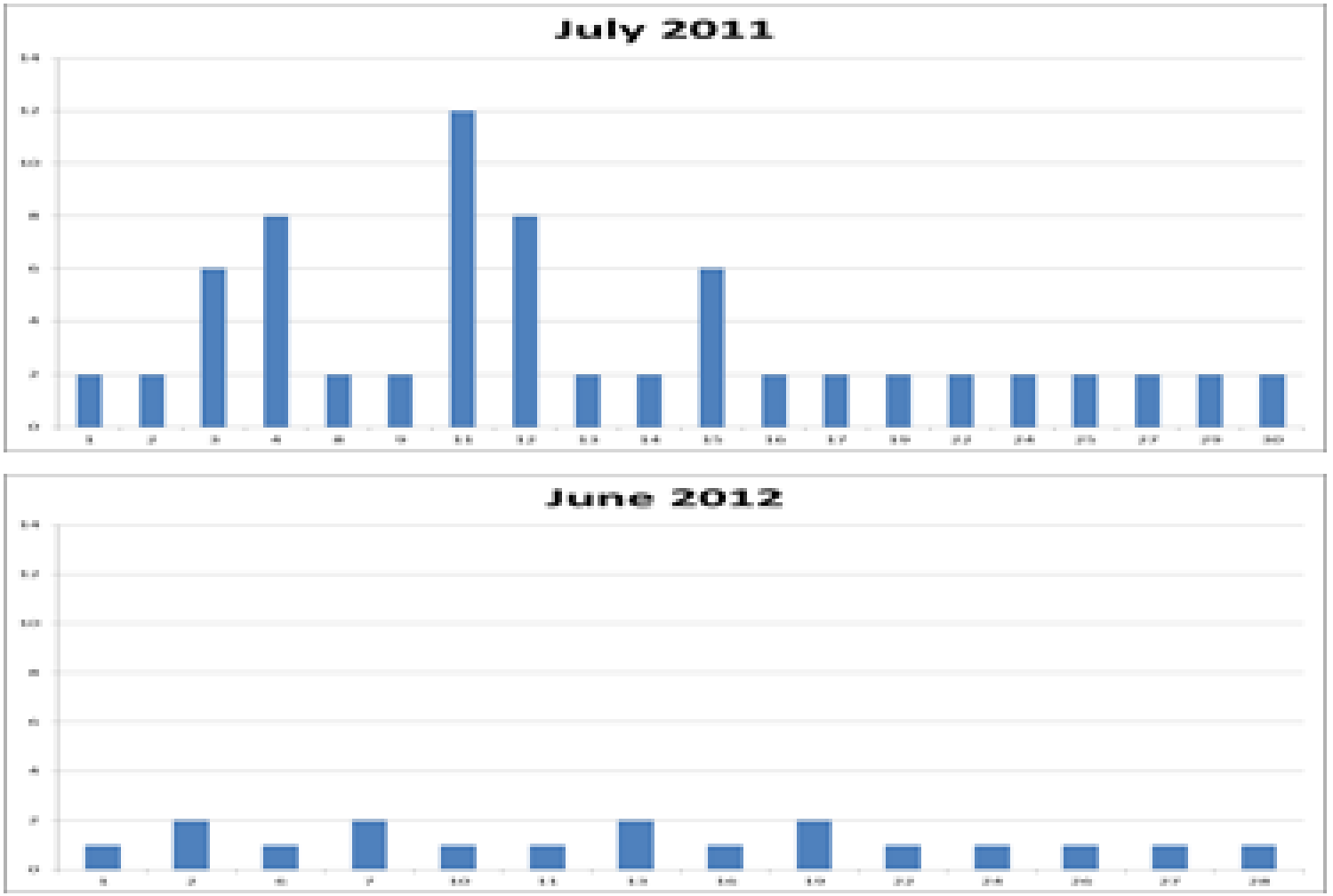
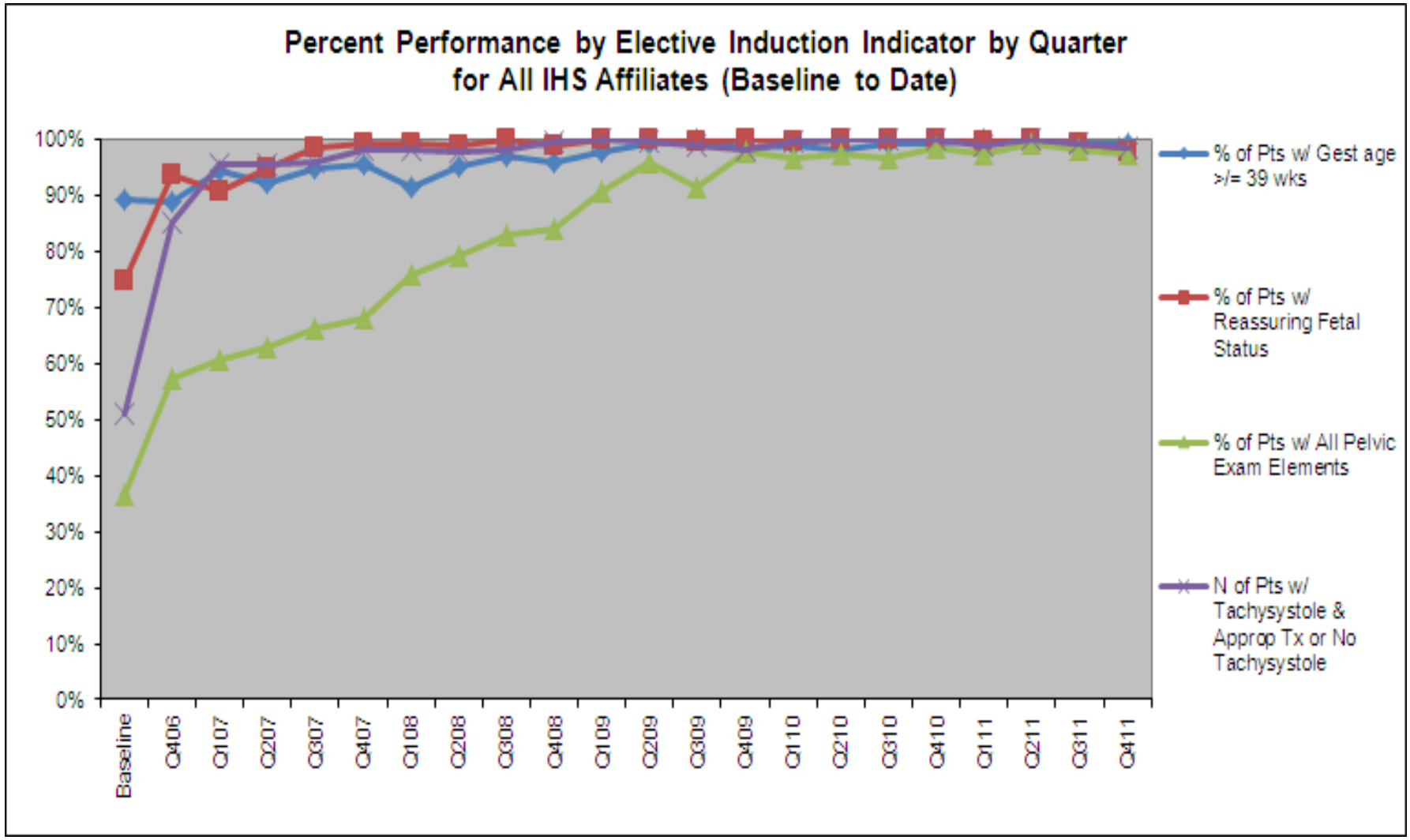
Decrease in the number of patients readmitted within the first 2 weeks after discharge



IHS System-wide Improvement in Perinatal Care



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Working together. Making a difference.

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

- 2005 – began teaching the Science of Improvement curriculum of the Institute for Healthcare 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

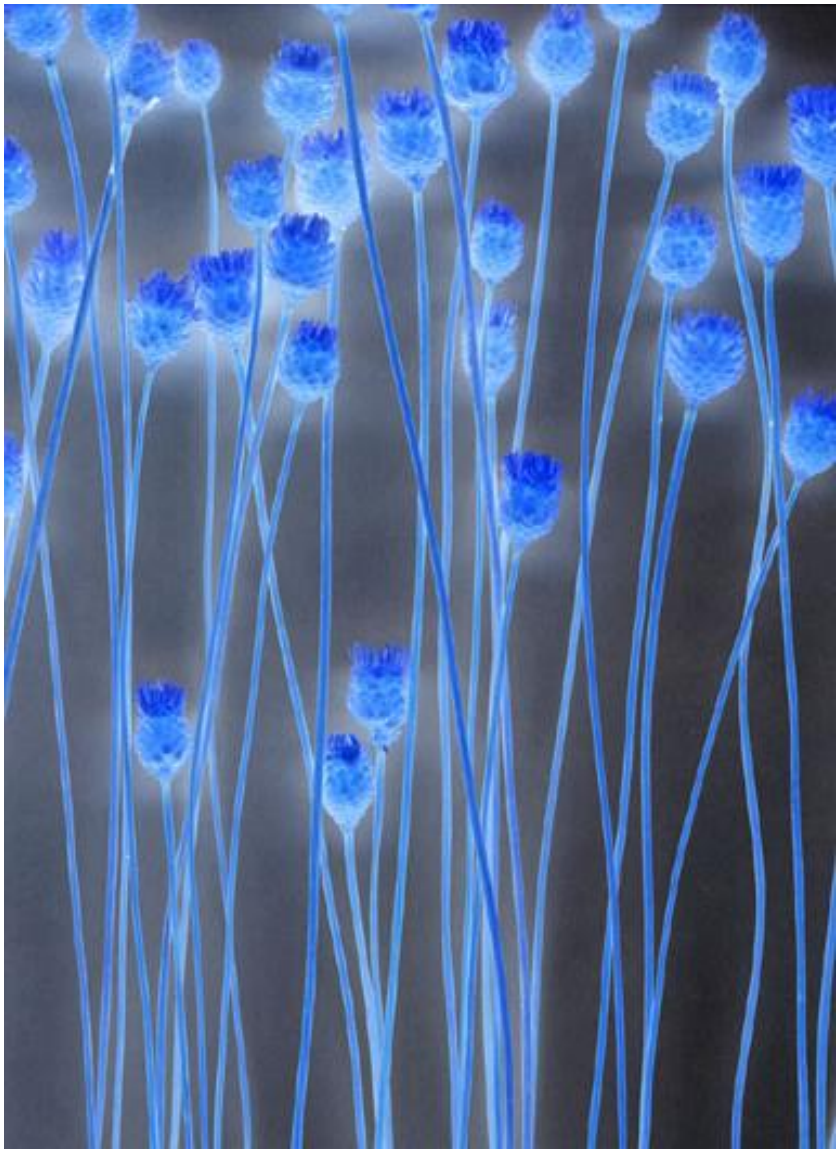
- Build the infrastructure of learning for performance and process improvement for your organization to thrive.
- Connect important work to strategic aims.
- Engage senior executives in the work.
- Get to the roots of problems at all levels with adaptive learning and problem solving.
- Spread learning 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”.

“We are what we repeatedly do. Excellence, then, is not an act, but a habit.”

- Aristotle



10 Years: Reducing Falls and Injuries

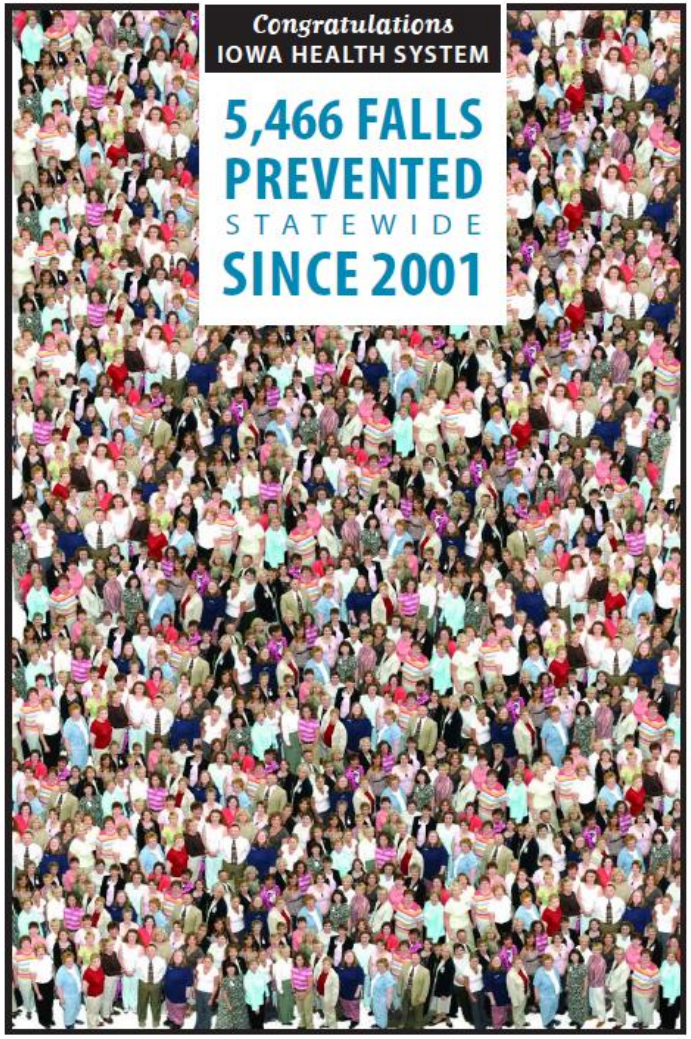
System-wide for 12 hospitals:

- 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



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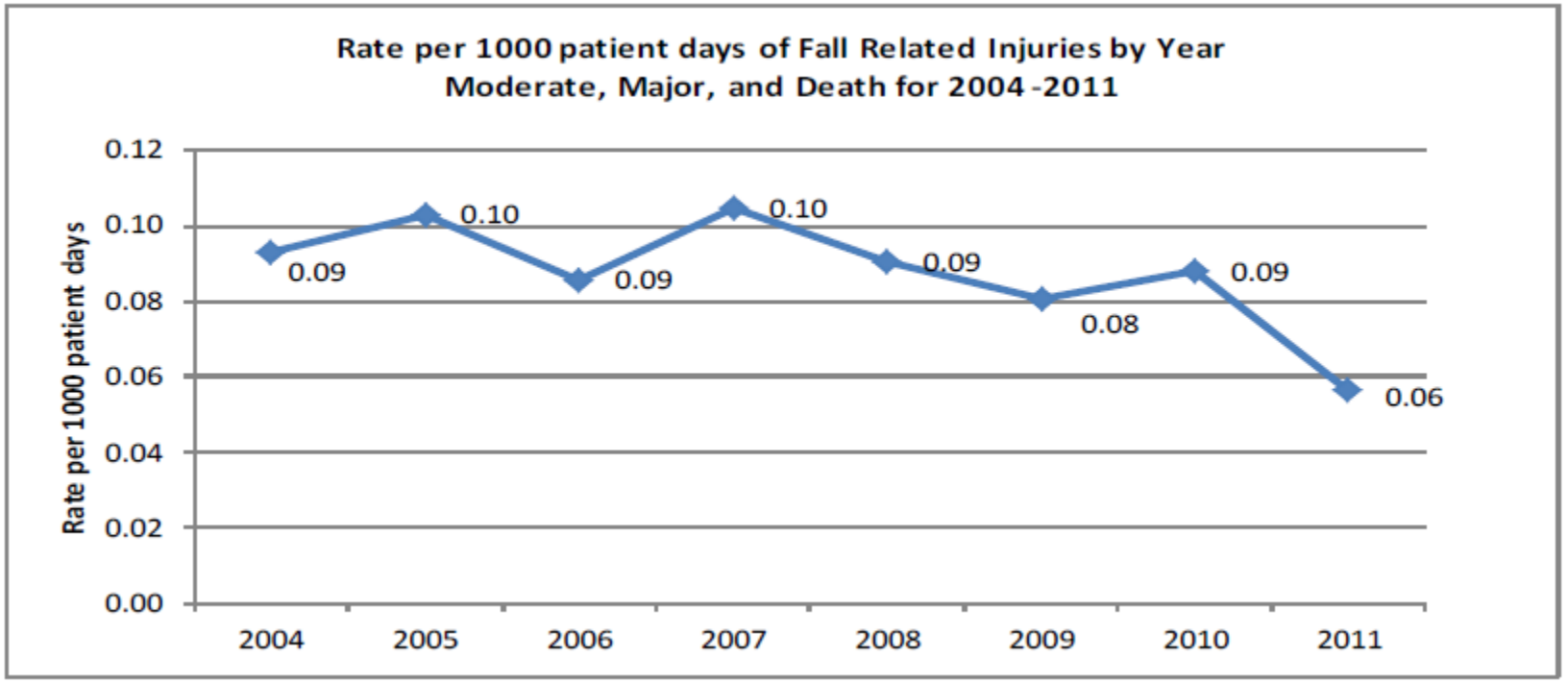
Falls Team Celebration

Rate of Serious Fall-related Injuries per 1,000 Patient Days, by Year



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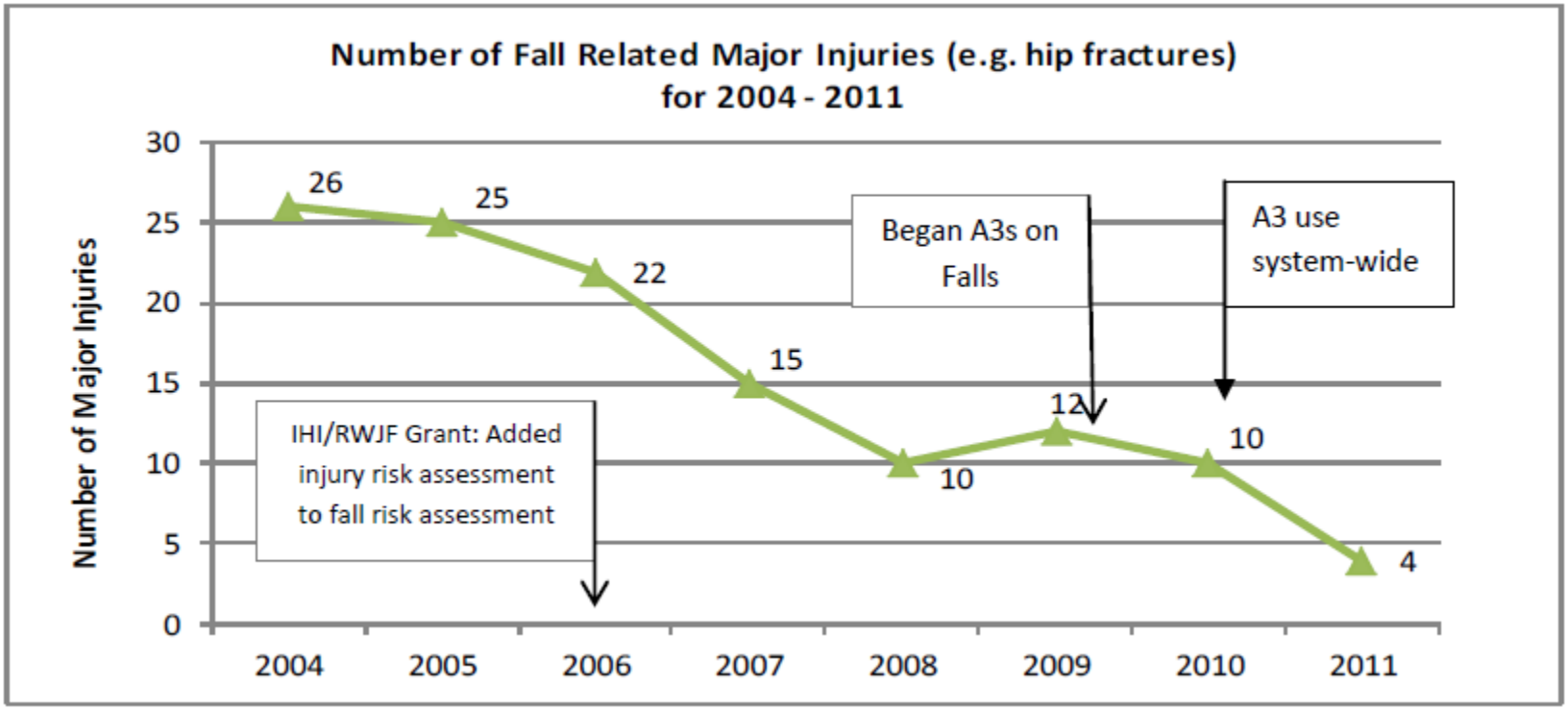
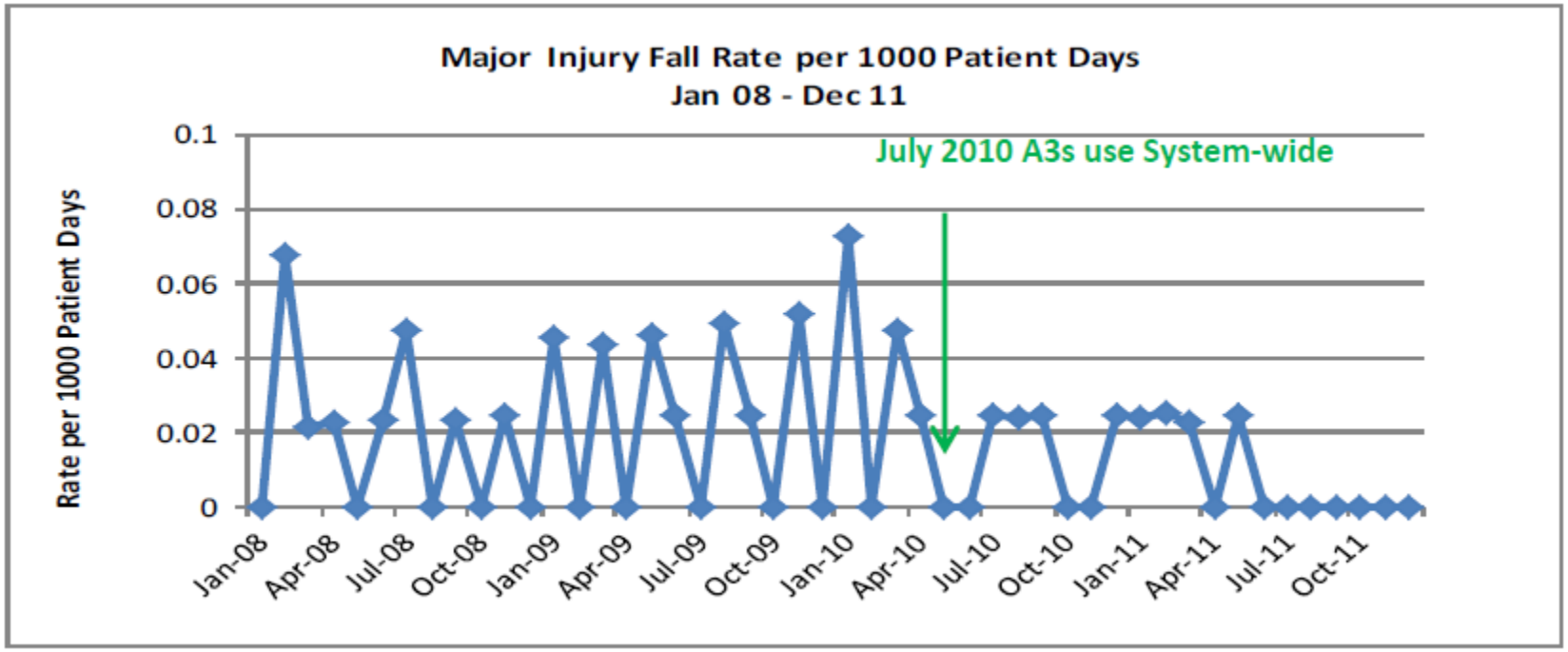
Number of Major Fall-related Injuries by Year



Rate of Major Fall-related Injuries per 1,000 Patient Days, by Month



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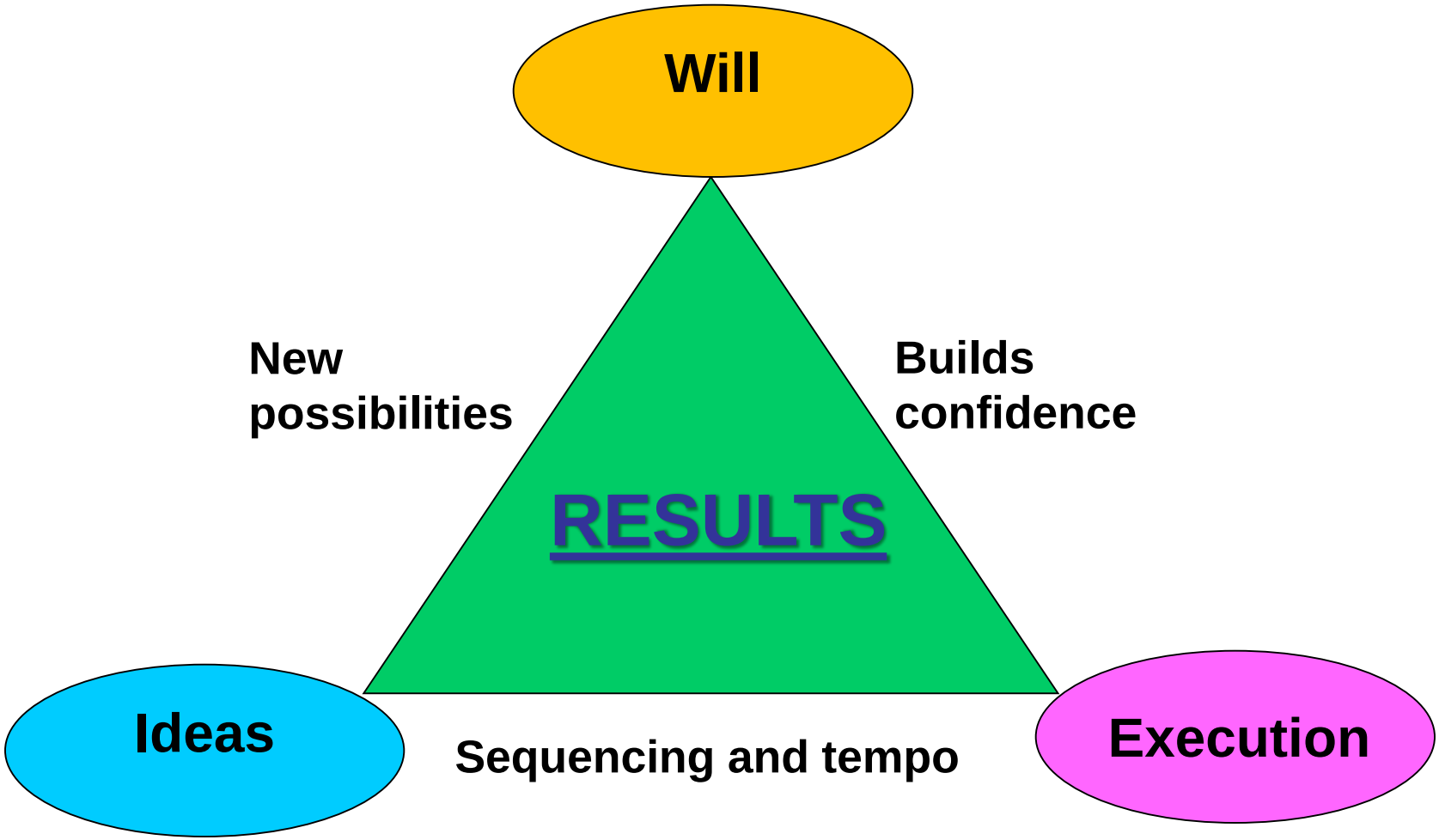
Achieving Desired Results



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!

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