Moving a Healthcare System Towards Higher Reliability

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President and CEO
GBMC HealthCare System
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- Greater Baltimore Health Alliance (GBHA)
  - Private Practicing Physicians (800+)
  - Greater Baltimore Medical Associates (GBMA) (200+)
- Greater Baltimore Medical Center (300 beds)
- Gilchrist Hospice Care (Daily census of 600)
- GBMC Foundation
Our History

• We became one hospital in 1965 when 2 hospitals merged:
  – The Hospital for the Women of Maryland, of Baltimore City: opening in 1882 as only the second women's hospital in the country.
  – The Presbyterian Eye, Ear and Throat Charity Hospital: originating as a clinic in a Civil War surgeon's East Baltimore carriage house in 1887.

• We are known in our market as a community hospital who has always had excellent physicians who determined the hospital’s direction: a bastion of the independent practice of medicine
Our Mission Then and Now

The Mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.
Our Vision Statement 2011-2014

In order for GBMC to maintain its status as a provider of the highest quality medical care to our community, in the context of an evolving national healthcare system, we must transform our philosophy and organizational structure, and develop a model system for delivering patient-centered care.

We define patient-centered care as care that manages the patient’s health effectively and efficiently while respecting the perspective and experience of the patient and the patient’s family. Continuity of care with a focus on prevention and ease of navigation through a full array of services will be the rule. Our professional staff will be able to say with confidence that the guidance and medical care they are providing mirrors what they would want for their own family.

We will create the organizational and economic infrastructure required to deliver evidence-based, patient-centered care and for holding ourselves accountable for that care. This new organization will be defined by collaboration and continuous improvement. Physicians will lead teams that will manage patient care.

We are moving into the future with renewed energy and increasing insight. We look forward to building relationships with both community-based and employed physicians that will form the foundation of the Greater Baltimore Health Alliance. We welcome all those who share our vision of health care as it is transformed to meet the needs of our community and nation in the 21st century.

Vision Phrase: To every patient, every time, we will provide the care that we would want for our own loved ones.
The essence of the strategy

1. Better care coordination through the eyes of the patient (patient-centered) leading to better health, better care, and lower cost.

2. A new compact with our practicing physicians that allows for the private practice of medicine as we seek to achieve better health, better care, and lower cost.
Vision Phrase:

To every patient, every time, we will provide the care that we would want for our own loved ones.

This is a vision of **perfection**. We must move to ever higher reliability.
How would you want the care to be

.... if it were your daughter?
What would be important to you in the care of your daughter?

• The best possible *health outcome*
• The best possible *satisfaction* with the way the care is delivered
• The least *waste* (time, effort, money)
• The most *joy* for those providing the care
How do we get to our vision?

Our business model:
Performance Improvement

1. Focus on the patient and his or her family
2. Deep Process knowledge (*Design*)
3. Decisions driven by data
4. Teamwork
5. Empowerment
### Stages Of Maturity in Health Care Organizations’ Path To High Reliability

<table>
<thead>
<tr>
<th>Organizational characteristic</th>
<th>Stage of maturity</th>
<th>Developing</th>
<th>Approaching</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td>Minimal</td>
<td>Chief executive officer leads proactive quality agenda</td>
<td>Organization commits to goal of high reliability for all clinical services</td>
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<tr>
<td></td>
<td>Quality activities focused on regulatory requirements</td>
<td>Board reviews adverse events</td>
<td>Organization aims for near-zero failure rates in vital clinical processes</td>
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<tr>
<td></td>
<td>Strategic importance of quality improvement not recognized</td>
<td>Organization sets a few measurable quality aims</td>
<td>Some services demonstrate near-zero failure rates in some vital clinical processes</td>
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<td></td>
<td>Metrics for quality goals not part of strategic plan or incentive compensation</td>
<td>Information technology supports some quality and safety initiatives</td>
<td>Reward systems for staff prominently reflect accomplishment of quality goals</td>
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<tr>
<td></td>
<td>Information technology provides little support for quality improvement</td>
<td>Physician leaders champion quality goals in some areas</td>
<td>Information technology integral to sustaining quality improvement</td>
</tr>
<tr>
<td></td>
<td>Physicians not actively engaged in quality improvement</td>
<td></td>
<td>Physicians routinely lead quality efforts</td>
</tr>
<tr>
<td><strong>Safety culture</strong></td>
<td>No program to assess safety culture</td>
<td>Establishing safety culture accorded high priority by leaders at all levels</td>
<td>Safety culture is well established</td>
</tr>
<tr>
<td></td>
<td>No assessment of trust or intimidating behavior</td>
<td>First measures of safety culture deployed</td>
<td>Measurement of safety culture is routine and drives improvement</td>
</tr>
<tr>
<td></td>
<td>Root-cause analyses limited to most serious adverse events; close calls not recognized or evaluated</td>
<td>Beginning initiatives to encourage reporting and analysis of close calls</td>
<td>Regular reporting of close calls and unsafe conditions leads to early problem resolution</td>
</tr>
<tr>
<td><strong>Robust process improvement</strong></td>
<td>No formal quality management system</td>
<td>Organizational commitment to adopt strong quality improvement tools</td>
<td>Robust process improvement tools used throughout organization</td>
</tr>
<tr>
<td></td>
<td>External requirements are focus of improvement efforts</td>
<td>Training of selected staff beginning Improvement tools used to achieve gains in quality and safety in addition to routine business processes</td>
<td>Patients engaged in redesigning care processes</td>
</tr>
<tr>
<td></td>
<td>No commitment to sustainable improvement</td>
<td></td>
<td>Mandatory training of all staff in robust process improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Proficiency in robust process improvement required for career advancement</td>
</tr>
</tbody>
</table>
So where are we?

- Leadership
- Safety Culture
- Robust Process Improvement
Leadership

• Developing  →  Approaching
  – CEO leading the agenda
  – Board is engaged

• Board Quality Committee Taking Ownership
  – Aggressive educational agenda
    » Why hospitals should fly
    » Reinertsen-Orlikoff series
    » Day long retreat
  – Set system goals
  – Review all major events and performance reports
<table>
<thead>
<tr>
<th>Measurement</th>
<th>FY 11 Actual</th>
<th>FY 12 Goal</th>
<th>FY12 YTD*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL: BEST HEALTH OUTCOMES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Reduce Serious Safety Events</td>
<td>20</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>2. Increase Number Of Other Reported Events and “Good Catches”</td>
<td>2,265</td>
<td>3,398</td>
<td>5,311</td>
</tr>
<tr>
<td>3. Reduce Hospital Acquired Infections</td>
<td>216</td>
<td>162</td>
<td>55</td>
</tr>
<tr>
<td><strong>GOAL: BEST SATISFACTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Improve HCAHPS Overall Rating</td>
<td>63%</td>
<td>66%</td>
<td>70%</td>
</tr>
<tr>
<td>2. Improve Nurse Communication with Patients</td>
<td>71%</td>
<td>74%</td>
<td>76%</td>
</tr>
<tr>
<td>3. Improve Patient Room Cleanliness</td>
<td>58%</td>
<td>64%</td>
<td>63%</td>
</tr>
<tr>
<td>4. Gilchrist – Reduce Number of Patient Centered Care Concerns</td>
<td>580</td>
<td>545</td>
<td>633</td>
</tr>
<tr>
<td>5. GBMA – Improve Overall Patient Rating</td>
<td>90</td>
<td>90.5</td>
<td>89.1</td>
</tr>
<tr>
<td><strong>GOAL: LEAST WASTE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Improve System Operating Margin</td>
<td>1.8%</td>
<td>2.1%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>2. Reduce Costs Through Work Redesign And Elimination of Waste</td>
<td>n/a</td>
<td>$400,000</td>
<td>$471,058</td>
</tr>
<tr>
<td><strong>GOAL: MOST JOY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Increase Overall Employee Satisfaction</td>
<td>70.0</td>
<td>71.0</td>
<td></td>
</tr>
<tr>
<td>2. Increase Physician Satisfaction</td>
<td>79.0</td>
<td>79.5</td>
<td></td>
</tr>
</tbody>
</table>
Leadership

• Developing Approaching
  – Information Technology
    • Closed loop medication delivery system for inpatients
    • All employed and some “compact” physicians on same EHR
    • Quantros error reporting system
Leadership

• Developing → Approaching
  – Some services demonstrate near-zero failure rates in vital clinical processes
  • 170 days without a CLABSI
GBMC has been 161 days CLABSI free; last infection November 23, 2011
Leadership

- Developing Approaching
  - Physician Leaders
    - Elected Chief of Staff champions change
    - CMO respected improvement leader
    - Some others engaged
Safety Culture

- Developing Approaching
  - Establishing safety culture accorded high priority by leaders at all levels
    - Leadership education
      - Off-site quarterly institute
        › Just Culture: *Whack a Mole*
        › Reasons Human Factors Model of Error (Level II reliability)
        › The five characteristics of mindfulness (HRO)
      - Mandatory education for all staff
        › *Getting in Action for Patient Safety*
Safety Culture

• Developing → Approaching
  – Measurement of safety culture is routine and drives improvement
    • 2011 first culture of safety survey using Pascal Metrics tool
      – Team leaders working on local results
    • 2012 second measurement scheduled
Safety Culture

- Developing → Approaching
  - “Regular” reporting of close calls and unsafe conditions leads to early problem resolution
  - 5000+ events and near misses reported in last 9 months
Robust Process Improvement

• Developing
  – Organizational commitment to adopt strong quality improvement tools
    • Training of selected staff: 15 Lean Masters
    • Many staff familiar
    • Kaizen events happening
    • Now teaching the model for improvement to supplement Lean tools
Robust Process Improvement

- Developing
  - Improvement tools used to achieve gains in quality and safety in addition to routine business processes
    - Reducing hospital acquired infections
    - Creation of evidence-based orders
    - Reducing artificial variability in demand: surgical smoothing
    - Standardized orientation and training of new hires
Major Challenges

• Moving experienced staff from “I do whatever it takes to get my patient what he needs” to “I am part of a complex system and I follow the design unless it is an emergency and the design won’t work”.

• Engaging our physicians.
  – 3 Groups:
    1. Engaged and collaborating
    2. Not-engaged
    3. Critical and often cynical
Summary

• We have made much progress in two years.
• We have much work to do to get to HRO status
Thank You