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NYSPFP: Accelerating Improvement, Getting Results

Good morning. We're going to get started. If everybody could find a seat, we also have several – I would say maybe about 100 -- people on the webinar; so hopefully they are all joining in as well right now. As you find a seat, I'm just going to introduce myself and welcome you.

I'm Lorraine Ryan from Greater New York Hospital Association, but here in the context of the New York State Partnership for Patients; and in that capacity, I serve as the co-Director with my colleague Kathy Ciccone. We both welcome you to the session [audio break] for the next six months and potentially another year after that if the third year of this contract is granted to the New York State Partnership for Patients. We'd like to just review the year very briefly, Kathy and I, and then get right into our program.

As you know, part of the accommodation is Dr. Robert Wachter, our keynote speaker, will be joining us via the web. He does have a slide presentation and presents very well coming through the microphone on the phone. And our other speakers will be joining us in person. So we very much look forward to your participation.

I very, very quickly just want to introduce the team that is behind the Partnership in addition to Kathy and I. Zaynep Sumer and Nancy Landor serve as the Senior Project Directors, along with Hillary Jalon. And there are a number of Project Managers; -- please stand – from both Greater New York and HANYS that have been working with you both in the room and on the phone over the last year. They've been just an enormous, hopefully, source of support and inspiration to you and helped you as you tried to drive this message home.

One last thing I want to say – it's never been more important for us to improve outcomes. And only yesterday, Kathy and I were in Albany advocating against a bill of prescribed, fixed nurse-to-patient ratios – RN to patient ratios; and the biggest argument that we have are our outcomes and our improvements. And we have been able to demonstrate improvements through the Partnership for Patients and through the work that you all do every day. So this is very meaningful and very timely, but we need to do better. I think all of you contribute to that and will help us get there.

So at this point, I'd like to introduce Kathy Ciccone, the co-Director of the Partnership and Executive Director of the Quality Institute at HANYS, who's going to take us through where we've come from; and I will take us to where we're going to, hopefully.

I want to add my welcome to Lorraine's. I really do appreciate all of your flexibility and also the flexibility of our faculty. You know, as you move from an in-person conference to a hybrid conference, it is great for those of you who were not able to join us at the Greater New York location to do it by WebEx; but it does, I think, increase some of the challenges, the complexities that our faculty are dealing with. So thank you so much for all of that.

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As Lorraine said, today really is about a celebration. As we think about where we were last year – I don't know how many of you were in the room when we had Joe McKenna – and we were talking about really launching the Partnership for Patients. And we have so much to be proud of, so much that we have accomplished, so much that you have accomplished over the past year. But our work isn't done; we still have some challenges. We can sharpen our focus on some areas, and we can repurpose some of our efforts to lead to greater improvements.
So today is about celebration. It's about learning. We hope to learn from you; we hope to learn what's working, what we can do better. We hope that you'll learn from each other. The answers very often are in this room, and we know that. I hear that time and time again. And we also hope that you'll learn from our renowned faculty. We are just so excited to bring the faculty that we have to you today; and really, really, I want to thank the Greater New York staff and the (inaudible) staff for being able to make the change in location because I know it was a lot of last-minute maneuvering and you guys did a great job; so thank you so much.

Our agenda today, as Lorraine said, we're going to talk a little bit about where we've been. We're going to talk a little bit about where we're going. More importantly, we're going to talk about action because we want all of you to be able to leave here energized and perhaps a little bit challenged about ways that we can continue to innovate, we can continue to improve, to make health care better. And we also hope that you'll give us additional feedback as we go forward and, working with the project managers, help to develop some further action plans.

Many of you have seen this slide before; it's one that we've used a number of times. We all know that environmental forces really are driving transformation in the health care system, and they absolutely are demanding a change in the way that we do our work. CMS is very serious about engaging every hospital in the country in an effort to reduce hospital-acquired conditions and readmissions by 2040. And the reason for that is because we have two burning platforms. Those platforms are we can do better in terms of patient outcomes, and we have to do better in terms of costs because the current trend is simply not sustainable.

Last year, a couple of the CMS administrators told many of us who were in Baltimore that every agency in HHS was positioned to leverage its policies and its activities to support Partnership for Patients. So while this is not a regulatory mandate, it really is something where there is a lot of pressure on us to really be able to perform because it's all about, of course, the outcomes that we achieve. I wasn't in the room of course at the time, but in my mind CMS took a real gamble. And they must have had a conversation that went something like, "We can achieve greater improvements in health care if we really reach out and engage the industry versus if we only use our regulatory approach."

The bottom line is that CMS has to achieve certain savings in order for the health care system to be sustainable. And so they made the decision we would be better off investing in education about best practices and training, about ways to execute on best practices, and making a health care system that is sustainable in the future than we will just by cutting. But one way or the other, CMS has got to get the budget in line. And for us really, quality improvement is a strategy to get there. So CMS really sees the Partnership for Patients as an initial step in helping hospitals to be successful in terms of health reform.

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This slide, I think, is interesting. And one of the quotes that I read in one of the HFMA – you know, the Financial Management Association newsletter – and this was written by their CEO, is that the future of hospital finance is quality. This particular slide lists the various clinical focus areas that are in PFP and estimated cost savings that are associated with preventing each of these events. Of course you could calculate this out for your own organization, and each of you may actually want to do that; or you could calculate it out for the country. But you can see why CMS is so interested in working with us in these areas.

Those of you who follow some of the policy briefs know that CMS just released its proposed Inpatient Rule; that's a rule that governs payment. And there's a lot of information in there about quality reporting, value-based purchasing, and readmissions – things like that. But one new area that was included in this year is the provision for implementing the new hospital-acquired condition payment policy. And that policy is unlike value-based purchasing, which is budget neutral. The hospital-acquired condition policy actually is a penalty. And so hospitals who are in the bottom 25 percentile in the country in terms of hospital-acquired conditions are at risk of losing a full 1% of their payment.

CMS has proposed a couple of different models in terms of domains and categories, but there's tremendous overlap with the conditions that you've been working on over the past year and even before that and those conditions that are in this policy. And although the policy affects payment beginning in October of 2014, so it's FY 2015, that seems like a long time away. In fact the performance period that we'll be judged on is in our rearview mirror. The performance period actually ends June 30th of this year. So fully half of a hospital's score on hospital-acquired conditions is related to CAUTI and CLABSI – tremendous focus on infections in areas where you've all been doing a lot of work. So the work you've done actually will affect your hospital's payment actually a couple of years from now.

So the strategy that we've been using with respect to PFP is we really are trying very much to focus on meaningful results. We've tried to work with you in terms of building some of the strategies that lay the groundwork for a sustainable infrastructure that will serve you well beyond the PFP focus areas. A large part of our work has been to provide you with access to education programs, in person or by the web – or like today, sort of a hybrid. We've been trying to bring experts to the hospitals. We've been engaging the physicians and the frontline staff, as well as the executive staff. We've done a lot of conferences. As of April, we had 28 in-person conferences over the past little more than a year, with more than 1,600 attendees; and it doesn't include of course today. We had 69 web conferences with 5,400 people who logged in for those. That's a tremendous outreach, and we really appreciate all your participation.

We've tried to balance the in-person with the WebEx. We know you get WebEx fatigue, but it's just so difficult and challenging when we've got a statewide initiative to bring everybody together in a single place; and so we really are trying to reach out. We work a lot on measurement. I hope all of you are taking advantage of the terrific graphs now and trend lines that are on the New York State Partnership for Patients website. We can really look at your own hospital's performance and compare it to some different benchmarks.

I'm going to make a plug for the Culture of Safety Survey that we're again repeating in September. I hope everybody is preparing and gearing up to do that. And we've worked a lot on enhancing culture in communications. The communications we send out, I think we've tried to streamline them. Our project

managers, our "secret sauce" if you will – we really hope that you are enjoying working with them as I know they are with you.

We're also working a lot on communications within the team and the team hospitals, and that is through Team Steps. I was at a CEO meeting last week, and there were about 20 CEOs; and I've got tell you, almost half of them raised Team Steps as one of the strategies they're using to help themselves move forward in terms of preparing for the delivery system. And I think that's a real legacy with respect to the Partnership for Patients and the work you're all doing.

So we hope that enjoy today's conference very much. I wanted to mention also we did a lot of work in terms of sharing both clinical knowledge as well as knowledge on execution and improvement, and we hope we've balanced that pretty well for you.

But I want to turn it now over to Lorraine, who's going to talk a little bit about where we're going.

First, a little bit of where we've been – measurement is always a blessing and a curse. It's a blessing if it makes you look good, and it's a curse if it doesn't make you look good. And we have struggled mightily and put a lot of effort into a measurement strategy that was fair to all hospitals across the state in all their various sizes, shapes and missions. CMS required of us, as a CMS contractor or a hospital engagement network, to come up with a measurement strategy; and we are one of 26 HENS. And what they encouraged was 26 different measurement strategies. However, when it all comes down to really evaluating the improvement across the board, they have another independent measurement strategy. So suffice it to say that measurement has been a thorn in our side, to say the least; and we're still at it, and we're still wanting to improve upon that.

Some of the documented improvement efforts or results, if you will, that we feel very comfortable talking about and standing behind are the following. We've seen a tremendous decrease in early elective deliveries, in part because we very early on in the partnership realized that we should engage with an already ongoing effort by the New York State Department of Health to reduce early elective deliveries. And in that partnership, I think we have brought support and energy that has even furthered their already positive results.

But we have even better results than you see on the screen today that were just condensed for our monthly report to CMS, and we've seen a 64.1% in the RPC rate among our regional perinatal centers. And many of you are in the room today. And that rate is 2.6%, and that's fabulous. Although CMS wants to see it at zero, getting close to 2% in this amount of time – since June of last year – is absolutely wonderful and should be applauded.

You have also – you RPCs – have taken your affiliate hospitals along with you. And those affiliate hospitals – and there are about 75 participating with us – are down to a rate of 11.1%. And many of those affiliate hospitals were experiencing rates in the 30% range for early elective deliveries where they could not document a medical indication for that delivery. So that is wonderful improvement. It's something that we are being recognized for by CMS, and we want to really applaud you all for the energy and efforts you put into getting yourselves and your patients those results.

What we do have to work on is really bringing up our rate of education in terms of the prenatal stage with mothers with regard to the risks of early elective deliveries; and even that, which is our process measure, is improving.

We've seen a decrease in the CLABSI standardized infection ratio to the tune of 28%, which is fabulous. We know we started at a good place with CLABSI. Many of you and both associations had concerted efforts in this area before the Partnership for Patients, but we're still delighted to see a sustained level of improvement. We've seen a decrease in the VAP rate by 35%. But as you all know, we're moving to ventilator-associated events in the future, which is broader in its scope of the types of events that we'll capture; and we are with you in helping you both understand those measures and to get the same kind of improvement once the category is expanded.

The SSI rate is decreased by 25%. Again, we had some good traction in certain clinical procedures; and we are focused on those where we need to improve even more.

And a tremendous decrease in our pressure ulcer rate of two or greater, I guess, staging pressure ulcers. And we are a leader across the country and, again, are being recognized for this rate. And I will tell you in yesterday's discussion in comparing New York to California in terms of the impact of nursing ratios, it was very good to be able to say that without prescribed ratios and mandated numbers we are able to document this kind of outcome with regard to pressure ulcers relative to California, which is actually on this one, woefully behind. But we have a ways to go; and those areas of opportunity you all know very well, and you might have other areas within your own organizations. And we hope that the data reports and the soon-to-come dashboards will help you even focus those attentions even more.

With regard to CAUTI, the rate has actually increased as we've spread beyond the ICU; but as this demonstrates, we have more units reporting. We have seen, however, a substantial reduction in catheter utilization and more appropriate utilization, better monitoring of catheters and getting rid of catheters when they're not needed more expeditiously and really focusing efforts on catheter utilization, appropriateness of putting it in in the first place, and maintenance. So we do hope to see the CAUTI rate over time – it's slightly trending in the right direction, but we hope to be able to document a real hard reduction.

With regard to falls, we've seen a slight increase in falls in different parts of the state of moderate or greater harm since our baseline data of 2010; and again, this is an area where we have tremendous concerted efforts. A regionally-based fall session is going on across the state next week, and we have identified a tremendously inspirational and impactful national expert who we are bringing to the hospitals once again to really go through, in a very detailed and granular way, what it is you can do for patients with regard to falls in context of the holistic approach that you all are already taking. And I've actually participated in these webinars, and I thought I knew what it took to reduce the fall risk for a particular type of patient. And the kinds of things that she elucidated for me, and I'm not taking care of patients these days, I found just so obvious, practical and something that you can really use day in and day out.

With regard to adverse drug events, we again have seen a slight increase. We know that there has been some feedback from some, but not all. For some, the measurement strategy has worked; they've seen a reduction in adverse events with regard to medication use – ADEs and ADRs. But for others, this has not

been as meaningful as it could be. So we think we have a little work to do on this and going back to the drawing board to make this a more meaningful measure.

I talked about EEDs. And with regard to readmissions, we are slowly starting to see some improvement – both on our CMS measures as well as the PPR measures that we are using. We've seen a reduction in the all-payer rate by 7% to about 13%, and a reduction in our PPR rate of 1% to about 13%. So again, areas for improvement – but we knew that readmissions was something that we would be tackling and challenged with for a very long time. And as we transform the care delivery system and we engage our partners across the delivery system – long-term care, VNS, home care – I think that we will make even greater strides going forward.

How do we aim to get there over the next half a year or year and a half? It's something that we still don't know yet. But we have been engaging your CEOs. We now talk about quality at Greater New York Board meetings, and that's a really good thing. In the past, there was an assumption that I must be flying with all the high performers, and my rate's clearly at the top. But when we start to demonstrate, well, not necessarily – and looking at the aggregate across the board, your institution may have a ways to go.

We know it's very, very important for you to be the messengers to your CEOs. So we will not be going out to them directly with results until you are perfectly comfortable with what those results yield. What we talk about in the broader contents of the Board level is in the aggregate – where are we as a state and where are you as a hospital, in an anonymous fashion? And what I love is that they're interested.

Supporting clinical leadership – we're going to hear from a number of speakers today, including Dr. Jeremy Boal, of how we can do that better and how institutions have demonstrated real engagement from their clinical staff, both at the bedside level and from the administrative level. And how can we absorb some of those practices or approaches into what you're currently doing.

Empowering patients and families is something else that you're going to hear a lot of coming out of the federal government. All of the agencies have been charged with this. It's no longer just about the patient experience of care, but it's engaging patients and families. And part of this is a strategy to really help bring down costs overall. Are patients responsible for all the safety parameters within the episode of care? Not at all. And in some cases, it can have unintended consequences when you give patients too much responsibility. But they do have a responsibility as best they can understand where they sit in their own world of health literacy to understand their illness, to understand the plan of care when they leave the hospital, and for us to engage those family caregivers who may need to understand for them in a better way. And we're hoping to bring more and more of this to you in terms, again, what's worked for others? What are those best practices in the coming year?

Focusing on accelerating improvement is another area that we're going to intently focus on this morning – in again, a very practical, tangible way of identifying a handful of best practices that we think if you implement and you execute appropriately can have broad-based, cost-cutting impact.

And ultimately, whether or not we get a third year of the contract, Greater New York and HANYS will be with you on this quality improvement journey going forward. It's been an unprecedented partnership and opportunity to learn from one another, again to harvest the best and harness the best of our collective

resources. So whether we do that through the Partnership or we do that independently, we are here for you; but we want to be led by you. And part of today's meeting is for us to hear from you in terms of what's working and what's not working. And there will be plenty of time in the later sessions for some of that interactivity.

At this point, we're a little bit behind. But we want to introduce our keynote speaker, Dr. Robert Wachter, who is patiently waiting on the line; and I'm going to let Kathy do that.

Thanks, Lorraine.

Actually I'm so excited to introduce Dr. Wachter. I think so many of you know his work. He certainly has been honored multiple times, including being a recipient of the John Eisenberg award, which is America's top honor in patient safety. All of you have in your packet a copy of his bio; but I'd like to just take a minute and walk through some of his accomplishments because he really and truly is a leader in quality and patient safety in this country. In fact, Dr. Wachter has been named one of the most influential physician executives in the United States by *Modern Healthcare* for ten years running.

He was a Fulbright scholar, studying patient safety in hospital medicine in London just two years ago. He coined the term "hospitalist." So all of you who have hospitalists in your organization, you have Dr. Wachter to thank for that. He is a prolific writer in terms of journal articles and books.

And I think one of the most interesting things -- many of you probably are familiar with his blog. His blog is www.wachtersworld.org. If you're not familiar with it, I encourage you to take a look at it; but on there what he says is, "I enjoy analyzing complex situations and articulating my understanding to others. Few things make me happier than dissecting and explaining health care issues, particularly when they are clinically meaningful, politically and ethically charged with a passionate advocates and foes. My real interest lies in how changes in policies, practices, science, economics and culture affect the way we care for patients, teach our trainees and organize our work."

I've enjoyed Dr. Wachter's presentations many times; and I know he will do his best to be fun, to be interesting; and I fully expect he'll be a bit confrontational or at least provocative.

So with this, if I can turn over to Dr. Wachter.

Good morning. Thank you so much for that kind introduction. I'm going to assume that people can hear me okay; and if you can't, someone will jump in and tell me that.

Thank you for indulging me with the change in logistics. I was unable to be there personally. I'm not all that much to look at, so you're doing okay this way as long as the slides show up okay and you can hear me fine.

I'm very impressed with the things that you're doing in New York in the Partnership for Patients. I have a lot of connections to New York, having been born here and grown up here. And my wife Katie writes for the *New York Times*, and my son Douglas just started a job working for the New York Yankees. So that's

a little difficult for me to take having grown up as a Mets fan, but I'm learning to deal with it. Since I was a Seinfeld fan, it's actually okay -- and a lot of George Costanza references in my family running around.

I will talk for probably about 40 minutes or so about what I see as the key issues in the field of patient safety in 2013, and I called it the Maturation of Patient Safety: Reflections on a Decade of Successes, Failures, Surprises and Epiphanies. Because what I've come to recognize is part of what's been so interesting and so challenging about this is the field is still relatively new, and we're all learning as we go along. I think we didn't know very much about not only patient safety, but about safety and improvement more generally. I think we've learned from each other; we've learned from the things that have gone well; we've learned probably just as much from the things that have not gone well. And one of the real joys of the kinds of partnerships that you have struck through the Partnership for Patients is the opportunity to accelerate that learning and learn from each other and not completely reinvent the wheel.

So with that, I'm going to start; and you'll see it's a little bit of a potpourri. I'm going to be flipping around through a variety of topics, and I will leave plenty of time for discussion. I hope I'm not confrontational, but I hope I am controversial or at least stir you up a little bit and get you to think about some things in slightly different ways.

So let me start by reflecting on one of the great challenges here. I'm on the board of a mid-sized community hospital in Oregon. And I know we think a lot about integration and communication. And one of the things I think we've come to recognize is a lot of us spoke different languages. Boards and physicians spoke different languages. Physicians and nurses spoke different languages. People who do management and leadership and improvement for a living and clinicians, to some extent, spoke different languages. And yet I think we all have recognized that the only way we're going to achieve the results that we need in terms of safety and quality and cost reduction is to begin communicating with each other more effectively. I think health care people and patients spoke different languages. That's already been commented on.

So as was mentioned, I spent a couple of years ago in the United Kingdom. This is a sign from the country of Wales. And one of the things that's interesting about Wales, it's a little bit like Quebec; pretty much everybody speaks English, but they're trying desperately to hold on to their ancient language of Welsh. Very few people now speak it; but there is a rule in the country that when a street sign goes up, it has to be in both English and Welsh. It's really their effort to try to hold on to the language and not have it die.

Quite helpfully, when you put up a street sign – because not that many people know Welsh anymore – you can send in the English to an e-mail address or website, and they send you back the Welsh translation. That's a very nice feature. And so this is a sign that went up a couple years ago: "No entry for heavy goods vehicles, residential site only." They sent this in to that e-mail address. They quickly got back the translation. The translation is shown here. I don't happen to speak Welsh, but there it is for those of you who do. And it was only a little bit later that someone who did speak Welsh pointed out that what that actually says is, "I'm not in the office at the moment. Please send any work to be translated."

So this is our challenge. I think we have all grown up in our own silos, and I think we got away with it because we were not accountable for the value of the care we were providing. We could get away with

providing care that wasn't terribly safe and wasn't of demonstrably high quality and certainly wasn't cost-effective. And I think you can see the pressures that you're feeling and I'm feeling as an attempt by the system to shake us up and say "You can't get away with that anymore, folks. We want high quality, safe, satisfying care. And by the way, we don't want you to bankrupt our country." And so given those pressures, we can't get away anymore with living in our silos and speaking our own languages. That really is what all this is about.

I'm going to cover six topics. The first will be the pace of change, and I'll spend the most time on that. I want to take you through my own version of a timeline of the last 10 or 12 years to give you a sense of the breathtaking changes that we're all feeling. The reason I think it's worth some time going through this is I think it's pretty difficult to predict where we're going to be in three to five, seven years, unless you understand this arc of history and where we are in this really remarkable portion of the world of health care.

If you do understand the arc of history and where we are in that arc, I think it's relatively easy to predict where we're going to be; and it's not going to be very comforting as you think about it because I think we're only at the kind of beginning/middle of the changes that will ultimately completely transform our work.

I'm going to talk about top-down versus bottom-up, a little bit about information technology, a little bit about culture. Because the role of patients is growing to be so large, and as already mentioned is a big part of the CMS agenda, I want to give you my take on it which is just a little bit contrary, and then just a last moment on dealing with change.

So I personally date this patient safety movement back 13 years to the publication of *To Err Is Human* by the Institute of Medicine in December 1999. Now, that's not to say that any of us who were practicing or involved in management prior to December '99 wanted to hurt patients or didn't care about safety. But I think it's fair to say we weren't thinking about it very much, and there was certainly no concerted movement and really no policy pressure to focus on safety.

Now, how did a single report create a movement? Well, you probably know this – that the Institute of Medicine took some data from a study that had been done by Harvard a decade earlier, did a little bit of fancy statistics, and came out with the estimate that between 44,000 and 98,000 patients a year in the United States die from medical errors – a big, nasty number that would have gotten attention for a couple of days and then gone away were it not for the most impressive bit of spin I've seen in my life in health care – the translation of those relatively bloodless numbers into what I sometimes call "jumbo jet units." They did a little bit of simple math and said, "This is the equivalent of a large plane crashing every day." And that was of course the metaphor that launched the patient safety field – that was the "oh, my god" moment – people saying, "How can this possibly be?" And in fact, if you do the math, that's right.

And if you think we're under a lot of pressure, think for a moment what would be happening in the aviation industry if a large plane crashed every day – let's just say for two days in a row or three days in a row. They would shut down the entire industry until they figured out how to fix that. And so we're under a lot of pressure, but probably less than one would expect from a parallel industry with a similar toll.

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Well, as I think about life in December '99 or 2000 when this report came out, here's my take on where we were and why there was so much room for growth. I think most people thought that quality and safety were pretty goods. Patients thought that. I would think most hospital boards thought that because that's what they were being told by their CEO and by the medical leadership. I think most patients sort of thought that. They went into a hospital; it looked like a nice place; the people were obviously well-trained and committed and careful – and so why shouldn't quality and safety be good? I think it was in many ways our dirty secret. I think many of us in the health care world knew that quality and safety were not what they should be, but it was not something that was widely appreciated.

This may be the biggest one of all. I don't think there was any business case to focus on quality and safety as concerted enterprises. Again, this is not to say that nurses or doctors or hospital leaders wanted to harm patients. Obviously they didn't. But the business case to improve patient safety – if you were a CEO, if you were a hospital board and you said, "I have $3 million left over at the end of the year. Should I spend it on team training, on simulation, on the fall reduction program?" you name your favorite safety target, "or should I spend it on building another operating room or hiring another CT surgeon or putting up billboards or buying a surgical robot?" You were not making a bad business decision not spending it on safety and quality. That's a double negative, but I think you get what I mean. The right business call was to spend it on things other than safety and quality because of course the best hospital and the worst hospital in the country got paid exactly the same.

Now, that's different than did you have an ethical obligation to focus on safety and quality? Of course you did, but I think we live in the real world; and absent a business case, people and institutions did not put the energy into it that they should have. I think in part because of that – the assumption it was pretty good, the absence of a business case, and I think importantly the fact that our mental model for improvement was wrong. We thought about defects in quality and safety as being manifestations of human failures rather than problems with systems. Nobody really knew how to do this. And in part because of all of this, there was relatively little concerted effort to improve; and we got what we didn't pay for. The state of improvement was not very good, and I don't think we knew how to do improvement very well.

Just think about the kinds of lessons that you were all sharing at today's conference and through your work at HANYS and through the Partnership. Very few of us knew anything about these domains 10, 12, 13 years ago.

Okay, with that I want to take you on a timeline; so fasten your seatbelts. There's a lot that happened in the last 12 or 13 years, and I want to take you through this again to give you a sense of the arc of history and the number of angles that the pressure is being generated from. It's not just CMS, it's not just the Joint Commission, it's not just the state regulators – all that. It's coming at us from every angle you can imagine because every stakeholder now is feeling the pressure to either improve quality and safety or use the levers that they control to promote improvement in quality and safety.

So let's begin in the beginning. I already mentioned that I think the safety field began with *To Err I*s *Human* published in December 1999. About a year and a half later, the Institute of Medicine put out another report crossing the quality chasm; and it really did for quality what the *To Err Is Human* did for safety. This is the report that first developed and promoted this idea of the six domains of quality.

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Here in 2002, the slide here shows a surgical retractor left inconveniently inside some poor patient's thorax. I put this up here because an organization called the National Quality Forum, which in 2002 was three years old – only formed in 1999 -- came out with a list. The list had eight things on it. The list was put out by the founding chair whose name was Ken Kizer. And Ken said, here's a list of things that should "never happen in health care." This of course the shorthand became the "never events list," and it ultimately grew to close to 30 events now. And it became the scaffolding for the health care associated conditions policies, for not paying for those, for the majority of U.S. states now requiring that many of these be reported to the state. In California, when we have one of these things and we report it, they come and visit us. It's relatively unpleasant; they often fine us. So the "never events list" in and of itself in 2002 didn't have a whole lot behind it, but it was important as really the substrate, the scaffolding for a lot of additional policy maneuvers that followed over the next five to seven years. It's only 11 years old.

This is Beth McGlynn. Beth is a colleague of mine. She works at Kaiser Permanente in California. In 2003, she published a study in the *New England Journal*. And the study said, "When we know the right thing to do – the evidence is clear – whether it's preventative care or acute care, hospital or clinic – when we know the right thing to do, we do that thing in American medicine 54% of the time. If you're a Six Sigma fan, that's about one or half a sigma. It's a level of reliability that would of course lead every other business to shut down. Imagine of Fed Ex got their package to you correctly half the time. But that was the state of American medical practice as it pertained to adherence to evidence-based practices – a fairly damning indictment ten years ago.

I show the Joint Commission here in 2004, and the reason I do – obviously, the Joint Commission has been around forever -- but in part because of the pressure that they were feeling by virtue of the two IOM reports on safety and quality. If you're the Joint Commission and you are certifying the majority of American hospitals and now the media now knows that we are killing the equivalent of a large plane every day – in fact, mostly in hospitals that you have accredited and blessed and said these passed our Good Housekeeping seal – then what happens, you start getting a lot of very unpleasant questions. And these questions involve someone sticking a mic in front of you and saying something like, "What exactly are you people doing?"

I can tell you as the Chair of the American Board of Internal Medicine this year, which is the organization that certifies internal medicine doctors, those questions are very unpleasant; and they stimulate a level of action that you would not take otherwise. If you're the Joint Commission in 2004 after the IOM Report, you're beginning to get those questions, you transform the way you accredit hospitals. And they did it in two ways right around that time.

The first was they began releasing their National Patient Safety Goals. Sign Your Site, for example, came out that year getting rid of certain high-risk abbreviations. The second thing they did I think was even more transformative. Up until 2004, if your hospital is Joint Commission certified, your hospital and mine received between one and two years notice of the day we were going to be inspected. And I can tell you on those days the floors were waxed beautifully, and the medications were all locked up. To me it was an extraordinarily dangerous day at my hospital because the floors were slippery as could be, and nobody could find any of the medications; but that's how you prepare when you know you're going to be inspected and you have a year's notice.

In 2004, they changed their process. And if you're a Joint Commission hospital, your hospital and mine now have 30 minutes' notice – not a year – 30 minutes' notice that you're going to be inspected. In fact, my hospital – UCSF – was just inspected about a month ago; and it is someone's job at my hospital to go on the Joint Commission website at seven o'clock in the morning every Monday to see whether they are going to be in our lobby at 7:30 a.m.; and in fact, ten of them were. This is what you do if you are an accreditor in an environment where the public and the media and legislators now believe that care is not as safe as it should be. Again, that was only nine years ago.

Also about nine years ago, Medicare launched Hospital Compare. So for the first time, public reporting of hospital safety and quality processes and outcomes – and as you well know, every hospital in the country is on it. It began pretty simply with a set of processes. Did you give beta blockers and aspirin to patients with heart attacks? Over the last eight years, it has matured so that it now has HCAP survey results; so patient experience results. It now has outcomes, including readmission rates and risk-adjusted mortality rates. It's now beginning to load in some efficiency measures. So this is all a growing movement toward the use of transparency as a motivator only began eight years ago.

Here's Don Berwick, arguably the person who has made the most difference in quality and patient safety probably in the world. Don launched his organization, the Institute for Healthcare Improvement, in the late '80s. It was pretty sleepy for a decade and a half; nobody paid much attention. But by 2001/2002, it had become an essential organization for hospitals and clinics and others learning to do improvement to the point that when in 2005, Don launched the 100,000 Lives Campaign – five or six practices that he wanted hospitals to commit to following – more than half the hospitals in the United States signed on to it. Don doesn't have regulatory or accreditation pressure. He just said, "We should do this." And more than 2,500 hospitals signed on – just showing you benefit of kind of communities and collaboratives and social pressure motivating change.

Here's Peter Pronovost. Peter is an intensivist at Johns Hopkins, also one of the, I think, world leaders in patient safety. And I think you know Peter's story; I'll tell you a little bit more about it in a few minutes. Peter in the early part of the decade got very interested in CLABSI. He looked at the evidence, and it said that there are five or six different things that all seem to decrease rates of central line infections. He had the idea of bundling them together. And then he had the epiphany that if I'm trying to remember to do five or six things when I go to the supermarket, I use this thing called a checklist. I tell friends who are not in health care that our main discovery in the last decade was the checklist worked. They look at me like I'm crazy, but in fact that's true. Rolled it out first at Johns Hopkins, then at more than 100 ICUs in the state of Michigan; and it worked nearly magically, markedly reducing mortality rates, CLABSI rates and health care costs -- published that in the *New England Journal* in 2006 or so. So that only was four, five, six years ago.

Starting a year or two ago, Medicare began giving all of us money if we implement effective computer systems that meet certain criteria known as "meaningful use." The office that is organizing that program, the Office of the National Coordinator for Healthcare IT, launched in 2004 with a budget of about $5 million – that was with an "M." The budget of that office today, which is what is being given out to hospitals and doctors' offices for the meaningful use payments, is about $20-$25 billion – with a "B" – again, driven by the safety movement. This was an area that both parties really agreed we needed to wire

American health care if we truly were going to make transformational steps in improvement. Again, that's really a movement that's only five or six years old; and the meaningful use payments are really only for the past year. And they have worked. You can argue some of the details; but the rate of uptick in computerization of American hospitals has tripled over the last couple of years, from about 10% now up to about 30% based on these payments.

And of course you know Medicare in October of last year rolled out value-based purchasing, really for the first time using the payment system to promote improvement both to pay for it and to penalize it when it's not there -- what's going to be a major game changer, really the imposition of the payment system on top of all of these other pressures.

Okay, I don't know about you but I am exhausted. That is 13 years of activity. And if you'd asked me in December '99 when *To Err Is Human* came out, how much activity our policymakers – and I'm using that quite broadly, whether it's Medicare or the Joint Commission or IHI – really influencers, stakeholders – how much pressure are they capable of developing and transmitting to hospitals, doctors, nurses, clinics, I would not have guessed this much. And on the other hand, how much change are we all capable of absorbing and dealing with? And I would not have guessed this much either, and yet this has what has happened – an amazing snowball effect because really everyone has gotten into the act of improvement. And again, I think the reason I want you to see this and appreciate it is if you're coming to this field now, it may seem like this is kind of old hat – sure we're under a lot of pressure to improve. But this is really quite a new phenomenon in the life of our health care system. And if you connect the dots, there's nothing on here that makes me believe that we're not going to see continued acceleration of these pressures over the next few years.

So to simply all that, what I see is a growing business case for safety and quality and now value – now safety, quality, patient experience divided by cost. What I also see here is a steady progression from what began with relatively weak pressure. You know, the 100,000 Lives Campaign was social pressure; nobody had to sign on, but we all did. Sure the Joint Commission is getting tougher, but you have to kind of work to fail a Joint Commission survey – it's not that easy. Sure Medicare is publishing your results on the web, but there aren't many real people going and looking and driving past your hospital's ER to go to the place across town because of poor results.

What you see now is all of the above – every institution, every stakeholder that has a lever to pull or push to try to promote value improvement is doing it. So you're seeing all of the above. From where we sit if you're in the hospital business, it of course is incredibly challenging because you're getting hit from a hundred different directions; but that is our world. And now, just in the last couple of years, you see the imposition of payment changes – still relatively small at this point, but clearly growing and clearly the trend for the future.

Important to say that while the Affordable Care Act promotes these changes, most of these changes predated ObamaCare. Relatively few of these changes are written into the law of the ACA; most of them were built into laws or regulations or had nothing to do with Washington. Joint Commission does its own thing. These things were really running in an independent track of the ACA. I think that's important to say because whatever your politics are, if you think the ACA will go away – I don't – but even if it went away, I don't think these pressures would go away. If the Supreme Court had thrown it out, if the next

administration decides it doesn't like it, if Congress somehow succeeds in getting rid of it – none of that matters very much. I think it matters a lot in other ways, but none of that matters very much in terms of the pressures that hospitals and clinicians are feeling and will continue to feel to improve performance.

And the thing about this that's so exciting and the reason I think we're all here is in the beginning of this – for example when Hospital Compare launched and said you have to give discharge counseling to patients with heart failure or document that you did smoking cessation counseling to patients who were admitted with pneumonia. When it was one thing or two things or three things, we could treat this as one-offs. We could treat this as individual items and say, "I'm not going to try to change the way we do our business – the way the docs and nurses collaborate, what our incentive systems are, how information flows. I'm going to hire a nurse or a case manager, and they'll just sort of do this thing."

I think you could get away with that when you had three things or five things to do. When it's 20 or 30 or 50, you just can't. And that's why I think we're in such a challenging but exciting era. We have all come to recognize that transformation is no longer just a buzz word. You will not succeed in the environment where the pressure to perform is this intense and only growing unless you transform everything – unless you change the nature of the way you do your work, the culture, the relationships, the flow of information, the incentives. It's too big; it's too diverse now to deal with as one-off projects.

Now, this has already been mentioned – and just to put a finer point on it – up until quite recently, most of these pressures have not involved the payment system. Up until a couple years ago, the amount of money – let's say a hospital's Medicare payments or a doctor's Medicare payments – the amount of money that hinged on your performance was zero percent. When you add up the impact of value-based purchasing, the HACs, readmission penalties, meaningful use right now, bonuses – that's kind of nice. In about three years, it flips over into penalties if you don't have IT systems that meet the criteria. In addition, the impact of all the new payment models – which is still a little bit unknown – when you add all that up in the next couple of years, and I think as already was mentioned, some of this is actually reflecting your performance today. A hospital's payments – about 7% will hinge on your performance in terms of your Medicare care payments; and obviously, all the privates are joining on to this bandwagon. And I don't think anybody believes that it's going to stop at 7%.

The evidence for example that pay for performance hasn't worked that much better than transparency -- there are some people that believe that pay for performance doesn't work very well in health care; but I'd say the predominant feeling among health policy folks is that the dollars at stake are simply not enough, and it's got to be 10% or 15% before it really gets people's attention. So we are no longer in an era that performance doesn't matter and you can do perfectly well as a hospital or a delivery system or a clinician by delivering care of demonstrably poor quality, safety, patient experience or value. That's the new world that we find ourselves in.

Okay, so that's the most time I'm going to spend on anything. I'm going to quickly go through some of these other issues. These are just some of the things that I've seen in the last ten years that I found either particularly interesting or particularly surprising. The next one is the limitation of top-down approaches. I've already told you about the Pronovost CLABSI story. You all are aware that he tried it at home, rolled it out in the Keystone project in Michigan; it worked remarkably well. Then something very interesting happened, which is Peter became a celebrity. And he became a celebrity in part because Atul Gawande,

a spectacular writer and a Harvard surgeon, wrote an article about Peter's work in the *New Yorker* – ultimately then wrote a book called *The Checklist Manifest,* a great book – got a lot of attention. And then Atul and his co-workers rolled out a similar program using checklists to surgery, and it worked equally well.

And then this program diffused through the United States, including through New York. And some of the work that you've done in CLABSI and now CAUTI and in the OR is based on – really the foundation of that work was what Peter did with Checklist. Now, what's important about that for this part of what I wanted to tell you is that to me this is the quintessential bottom-up innovation. It really began with a single clinician working with a team of people who just had an idea and saw in his own work in the ICU that patients were dying and being harmed from central line infections and had this belief that these were not inevitable – that we might actually be able to do something about it. And so this really was what I think of as a bottom-up innovation – had the idea, tried it locally at Hopkins, then tried it in a state, and then scaled it up through the entire country; and it really became a national movement. But it began really in the mind of a single individual and embedded in a team – I think really a wonderful story.

As was mentioned earlier, a couple of years ago I spent in the United Kingdom looking at patient safety. And the United Kingdom has a single payer system, has virtues and has challenges. But one of the elements of having a single-payer system is there's one health care system and it's run by the government. And so its instinct is to be top-down. Its instinct is that when something that seems like a good thing for every hospital, every doctor, every nurse to do, its instinct is to develop a rule or a policy and send it out to everybody. If you work at the VA, you kind of know what that instinct looks like; it has a similar feel except it is the only health care system there really.

So when the WHO Surgical Safety Checklist was published in the *New England Journal* seemed to work, the Patient Safety Program of the UK put out a rule. It's a Central Alert System reference, and you see the letters and numbers there. It's an alert. And here it is – their organizations are required to engage in this, have a checklist, monitor that they're using it. In other words, it felt like to doctors and nurses and others in the UK as a top-down, rule-based imposition by the central authority. And when I was there, basically every surgeon, anesthesiologist and surgical nurse that I met said, "This is yet another top-down mandate."

And I found that both amusing and troubling – amusing because I knew its history. Its history was it began life as a bottom-up innovation. But because when it got there it really came on down from high and was promoted as a rule or a policy, the pushback from frontline clinicians that yet it's another rule – and of course you know what clinicians do with rules. They tend to duck them or work around them. It was really, really striking to me. And so this notion of top-down versus bottom-up is one of the real tensions in improvement generally and patient safety specifically. There's no right answer, but we have to think hard about it because the pressure is on all of us to get it right; and pressures are growing because of payment changes and transparency changes.

The instinct to become more top-down is difficult to withstand. It's just natural for the organization to just say, "We don't have time for this buy-in stuff and local ownership and tweaking. We know the right thing to do. Here it is; just do it." It's a perfectly logical, understandable instinct. It's probably right some of the time – for example, things like hand hygiene, where it should just be that we all just do it. But other times,

it's actually going to be wrong. It's going to get in the way of improvement; and the reason is that health care is a complex, adaptive system. We've come to understand this only over the last five to seven years. Health care theorist Brenda Zimmerman writes here are some of the elements of complex depth systems – that the system and the environment are constantly changing and uncertainty and paradox are just baked into the process. You can't wish them away.

Because of that, problems cannot be solved in a machine-like fashion. Sometimes they can be moved forward that way, but it just doesn't work that cleanly. Individuals – they're not just cogs in a machine, but their independent and highly interdependent creative decision makers. And if you take that away from them so that they just say, "All right, there's going to be another rule coming if we just wait long enough," this sense of learned helplessness hits them, and it really gets in the way of improvement.

Finally, solutions often emerge from minimal specifications and simple rules. Overspecification gets in the way. Gawande makes that point in the *Checklist Manifesto* that when they were developing the surgical checklist, initially they thought of putting like 50 things on it; and it just got in the way because you don't want to overspecify. So there are a relatively small number of things, including things that are really more cultural than anything – like having everybody introduce themselves, lowers the authority gradient, makes it more likely that people will speak up, will see themselves as an important player in this ballet of trying to do safe surgery.

So to me this has been a very big surprise – something I didn't understand very well when the safety field launched, but I think absolutely crucially important for those of us involved in improvement. And I think we forget that at our risk, and there is tendency to forget it when we're feeling stressed to kind of move it along a little bit more quickly – to just say, "Let's just create a rule. Forget about all this process change; it's slowing us down too much." We've got to be very careful about following that instinct.

IT – IT has become an incredibly interesting element. You of course all know this. Now that we're all implementing IT very quickly, we're all beginning to feel not only its wonders buts its challenges. And I think I'd summarize it that it's harder than it looks. I think 10 or 12 years ago, we all had kind of magical thinking about this; but I think we've come to recognize that it's not quite so easy.

Here are some of my observations about IT. Health care IT is clearly getting better; but it feels in a way like it's getting worse because when I compare the state of health care IT to my iPad or my ability to order a medicine correctly or check lab results with my ability to get a seat at a restaurant – an open table, or check in on www.united.com, it actually feels like it's getting worse because IT is getting so much better so much faster in the rest of our lives.

I think it's also clear that the early glowing studies about how great IT in health care was and how easy it was to implement all came from two or three institutions that are very, very atypical – the Brigham in Boston, Regenstrief in Indianapolis, LDS in Salt Lake City – all of whom have been working on IT for two or three decades, all had home-built systems. And the generalized ability of those early results to what we all are doing, which is buying vendor-built systems and airlifting them in, I think was quite limiting. And we're all seeing how limited this is.

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We're all seeing unforeseen consequences from IT, including a growing literature on IT-related errors. Now, in the same way that I think the early literature was biased toward the optimistic and the positive because it was from very atypical institutions, I actually think the literature now is biased in the other direction. It's no longer interesting to publish a study that says we implemented Epic and our medication error rate when down; that's boring. So the studies that are getting published now are ones that are showing, you know, we implemented this system and it caused this kind of problem. So I think there's a bias in the other direction. I still think that we have to computerize – that even though the systems are pretty clunky, the only way they're going to get better and we're going to reach the goals that we all need to reach are that we have computer systems, we have data, we have computerized decision support. I think we've got to go through this stage, but it is clear that it's harder than we thought it was.

Here are a couple of areas where I want to highlight, and this again gets at the patient role here. This is my friend Abraham Verghese. Abraham is a physician at Stanford but also a fantastic writer. Abraham wrote a very important article in the *New England Journal* five years ago where he talked about something he called the iPatient. And he wrote, "The patient is still at the center, but more as an icon for another entity clothed in binary garments: the 'iPatient.' Often emergency room personnel have already scanned, tested and diagnosed, so that interns meet a fully formed iPatient long before they meet the real patient. The iPatient's blood count and emanations are tracked and trended like a Dow Jones Index and pop-up flags remind caregivers to feed or bleed. We discuss the iPatients in a team's conference room -- which he calls the 'bunker' – while the real patients keep the beds warm and ensure that the folders bearing their names stay alive on the computer."

I like that. First of all, I think it's a beautiful piece of writing. But second of all, I think it says something really quite important and quite troubling as we all lurch headlong into this new world of computerization. I do not think we have figured out how do we create an experience where the patients really are engaged in this world, particularly with the present day computers as clunky as they are and as demanding as they are.

This was shown I think most poignantly in this article in JAMA last year. A seven-year-old girl went to see her doctor and sent in a picture. Kids come and see their pediatricians and sometimes send back pictures, and pediatricians display them proudly on their wall. I don't think this pediatrician displayed this one all that proudly. You see the patient sitting on the table and mom and sister are right next door in one corner of the room; and there in the other corner of the room is the doctor typing into the computer, back to the patient. This has to trouble us, and there is no way that this little girl or her mother can possibly believe that this doctor cares as much about me as he cares about the computer. So, yes, we have to computerize. We've got to figure out how to get this right. We've got to come up with better systems, but we can't forget that we're not taking care of bits and bytes; we're taking care of real people. And I do not think we've even begun to figure out how to train people to do this well and how to build in technologies that really allow us to do this well. It has become our master, and we have to figure out a way to return to the patient even as we're using these computers.

Let's spend a word on the importance of culture. This has been one of my huge learnings over the last 12 or 13 years. I don't think I ever thought about culture in health care until the patient safety movement really put it on the radar screen and I began learning about culture in aviation or culture on aircraft carriers and began to learn about its importance. And I think that's one measure of how important the

safety movement has been in not only teaching us lessons for safety, but teaching us lessons about improvement and change more generally.

Here's Atul Gawande again, an article in *The New Yorker* a couple of years ago, pointing out particularly around physician culture why change has been so challenging and is so important. Atul wrote, "The core structure of medicine, how health care is organized and practiced, emerged in an era when doctors could hold all the key information patients needed in their heads and manage everything required themselves. We were craftsmen; we could set the fracture, spin the blood, plate the cultures, administer the antiserum. The nature of the knowledge leant itself to prizing autonomy, independence and self-sufficiency and to designing medicine accordingly." This sounds very much like what I thought I was getting into when I went into medical school in the 1980s.

And Atul went on and wrote, "But you can't hold all the key information in your head, and you can't master all the skills. No one person can work up a patient's back pain, run the immunoassay, do the physical therapy, protocol the MRI and direct the treatment of the unexpected cancer found in the spine." I don't even know what it means to protocol the MRI. I think it's a beautiful statement of when we talk about the need for teams. It can become a cliché or a little bit of a buzz word. And I think Atul's point here is it has to be because the nature of the work has changed so dramatically. And those of us, I think particularly physicians, who were not really taught about teams and taught about that the team is the way we're going to deliver care most effectively --it's in part because in our life during our training and socialization, it probably was less important – still very important and we still missed it if we practiced as pure individuals. But these days it's just impossible; it doesn't matter how good you are as a doctor, you can't deliver high-quality safe care if you're not practicing as a member of a highly-effective team.

Now, one other point I want to make about culture which I found fascinating and I didn't understand -- I don't think anyone did when we started. If you'd asked me in 2000, where does culture live? I would have said, "In an institution." You know, my hospital has a safety culture. And in fact, there's a little bit of truth to that. This is a study that Peter Pronovost and Brian Sexton – Brian's now at Duke -- did in 2005. And what they did was they looked at safety culture through this Safety Attitudes Questionnaire, one of the validated surveys, across 100 different hospitals. And you see here that it varies quite a bit, that their hospitals were only 40% of the workers reported a good safety culture, others that 75% or 80% reported a good safety culture. So it's not completely wrong to say, "My hospital does have a culture, and it's a good one or it's a crummy one."

But what was so provocative and interesting about this study was look at just that one bar for Hospital X. You see its mean safety culture – about 50%-55% of folks there said it had a good safety culture. It's a little bit below the mean. What they then did was look at the safety culture in 49 different units in Hospital X. And you see there its norm, again, is at about 55%; but you see units, and a unit might be the ICU on the seventh floor or labor and delivery or the ER or the clinics. You see there the splay is far larger within Hospital X than it was across different hospitals, with some units within Hospital X having dismal safety culture – 10%, 15%, 20%, 25% saying, "We've got a good culture," others at 100% saying, "Yes, we have a spectacular culture here," pointing out I think a really, really central issue in the area of safety culture, which is that safety culture is much more local than the hospital. In fact, your hospital does not have a safety culture. Your ICU has one, and the step down unit that might be 50 feet away has another.

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The reason I think this is so central is if you say, "I want to improve safety culture. We're going to try to do Team Steps," or other things that you might do to try to improve safety culture, "because we want to figure out how can we have a safety culture that's as good as Mayo Clinic or Geisinger" -- or you name your favorite – Virginia Mason. I find those arguments don't get very far because people immediately say, "Well, the Mayo Clinic. That's in Rochester, Minnesota. They've been doing this for a hundred years, and they've got a lot more money than we have and…."

But when you say, "We want to improve our safety culture and we know we can do it in our building because look at how good it is on the step down unit on the third floor. I think that's much more compelling because you've taken all of those other arguments off the table – those arguments that they're not like us – because they are like you. They're exactly like you; they have just figured out something that you have not figured out and if you can figure out, you'll do better. So I think this is really a compelling piece of information that I think has real practical importance.

The role patients – this is a very hot issue. You know, people have started hyping this and calling patient engagement the new wonder drug or the new miracle drug. I think patient engagement is very important, but I'm a little bit worried about it. And so what I will say about it will be somewhat contrarian. In some ways, it feels like a "like, duh" proposition. Of course we want patients engaged, and that in fact is true. Patient engagement respects the ethical imperative to value the autonomy of people; it's the right thing to do. Patient advocacy has clearly been an important catalyst to garner resources and attention for patient safety, and there are a number of patients or family members of patients who have been harmed or killed by errors who are really incredibly important and brave advocates for the field. And I think they lead to very, very important changes; and I really respect what they're doing.

The patient perspective can be vital in designing not just safety programs, but improvement programs more generally. They are the customers, and we need to understand what they want and how they feel about things. But here's the area where I'm a little contrary and going against the grain. I'm a little bit less "duh" on the idea that patients can be a second set of eyes and ears to catch errors. And we hear that as a theme in the patient safety field – that patients should be part of our safety system, and an engaged patients can prevent errors by themselves. That's a logical way of thinking. My mother had lung surgery at a hospital in Miami a couple of years ago; and I said, "Do you have a bed that I could stay by her bedside?" And they pulled out a cot that would have been rejected by every youth hostel I've ever stayed in. It was absolute despicable, but that's what I slept on for a couple of days. So I completely get why a patient or family member would want to do this; I'm just a little skeptical that it works. So here's why.

And this, again, is not politically correct; the politically correct view here of course is, yes, patients should be engaged in this and that it will work. So here are my concerns. My concerns are that it might not work; that it will always be an inconsistent and therefore perhaps unreliable safety strategy; it will be hard for patients to calibrate their response in order to be productive and not self-defeating; and finally, that it risks increasing the sense of guilt that patients and families often feel after errors. Let me briefly take you through each of those items.

It might not work. In the early days of Sign Your Site, which of course the Joint Commission made a national standard about ten years ago, but prior to that you had both patients and doctors doing it in ways that were pretty chaotic. I know of certain orthopedic surgeons that were marking an "X" some of them on

the leg to be operated on – that was "X" marks the spot; and others marking on the leg not to operate on – like, okay, there's a big "X" there. Of course I won't cut there. Sometimes patients were coming in and marking their own limb – sometimes on the limb to operate on, sometimes on the limb not to operate on. Because it was not a standardized process – and it's awfully difficult to get patients to do something in a standardized way, it's hard enough to get clinicians to do it -- it might not work. It might actually turn out to be another source of unreliability.

Now, added to that, here's a safety engineer, Melinda Lyons from the UK, who wrote a few years ago: "In safety engineering terms, patients are unlikely to provide a consistent and reliable contribution to the safety of the process of their own care. In a domain with a safety problem that's advocating 'systems approach,' it seems nonsensical to advocate a solution with apparently decreased reliability." I worry about that a lot. Safe systems don't embed in elements of safety that you can't count on. So of course some patients and families will be very engaged, but others will not want to be or won't be capable of being or will be confused or anxious and do things wrong not through any fault of their own. And so if this is a central component of our safety algorithm, I think it will always be a relatively unreliable component.

Third, it's hard for patients to calibrate a response that's acceptable and effective. The data on whether patients are comfortable challenging their clinicians – for example, there's a theory out there now that we should be telling patients to ask their doctors or nurses did they clean their hands? There have been studies of this; and the majority of them say the patients really don't want to do this and have a very hard time confronting their clinicians – worrying that they're going to piss their doctor or nurse off. And I can tell you even as a physician, I sometimes worry about that when I'm in the position of a family member.

And I think there's also a thin line separating the empowered and appropriately skeptical patient versus the bellicose and confrontational patient. Those of us who still practice know this. There are certain rooms that I will go in where the family is very engaged, wants to know what's going on, has tough but good questions. I love that; I think it's terrific. There are other rooms that as I'm about to go into the room, I say to myself, "You know, I'm not ready for this yet. I need another cup of coffee." And if I'm saying that, I'm guessing a lot of nurses and other doctors are saying that. I actually don't think in those rooms those patients are getting better and safer care; my guess is they're getting care that's less safe. And so how do you get that right? How do you balance that? I think it's a very, very tricky thing to do.

Finally, my last concern – and this is a big one. Here's a study that was in the *New England Journal* about six years ago from Tom Delbanco. And what they demonstrated was that families and patients often felt terribly guilty after a medical error. And one family member said the feeling was impotence because you can't stay with a patient 24 hours a day; that's why you rely on hospitals. You rely on nurses. You feel like you've failed your family in terms of, "I should have been there." That's a guilt that everyone shares. And to me, putting more of this on the backs of patients just increases that feeling if something does go wrong that somehow they screwed up.

I read a book called, *Understanding Patient Safety*. The last edition came out last year. And I wrote in that edition this; this is my reflection. "As I've reflected over the years on my own ambivalence regarding the role of patients and protecting themselves from mistakes, I've discovered that it flows partly from my lingering doubts about whether it works. But I've also come to realize that it stems from a more

fundamental rejection of the premise itself. Why should it fall to patients and family members to ensure their own safety?

"When I board an airplane, I know there's nothing I can do to keep myself safe. This allows me to relax mostly because my feelings of impotence are outweighed by my trust that the airlines and their regulators have done all they can to ensure my own safety. Patients lack this trust, which makes relaxation and passivity seem maladapted, even near suicidal. That patients and families would want to do whatever they can to improve their odds is completely understandable. I'm just not sure how well it works or how to apply it most effectively.

"In the meantime, while we should support efforts by patients and families to participate in their safety when feasible, our primary focus should be on making such hypervigilance unnecessary. In my judgment, this problem is ours to fix – not theirs."

Let me end with one comment on dealing with change. This is a story I heard from Don Berwick and show it to you with his permission – a wonderful story. Don tells the story of a bridge that was built over a river in Honduras. It was called the Choluteca Bridge. It's an area of Honduras that gets a lot of floods and a lot of hurricanes. And when they were building this bridge about 20 years ago, they turned to the leading bridge design firm in the world. It happens to be in Japan. And they said, "Here's the story. It's a pretty tough area. Build it – build it really strong." And so this design firm did that. They used the best material, the best techniques, their best people, computer modeling; and they built this bridge -- the Choluteca Bridge.

And of course along comes a hurricane only a few years later – Hurricane Mitch – and blows through the area. And a lot of houses went down, a lot of infrastructure went down, and the bridge was barely touched. It stayed up firm and strong; and I'm sure in Tokyo they were giving each other high fives about what a wonderful job they did on the bridge. There was only one little problem, and that was that the river moved. And I think this is where we are today in health care. We have built this really, really strong bridge; but it was for an era when the river flowed under that bridge. And in this world in which we are going to be held accountable for the quality, the safety, the patients' experience and the cost of care, we have to build a bridge that's just this strong but it has to go over the river as it presently exists and will exist over the next decade or two. And that's the work that you're all doing, and that's why I'm so pleased to be a small part of your conference today.

Thank you for indulging me doing this by webinar, and thank you so much for your attention.

Dr. Wachter, thank you so much for such an insightful presentation. Every time I hear you talk, I just marvel at your talent for taking complex information and translating it so simply. You know, I've been paranoid for about ten years now thinking somebody's been sneaking in my office when I'm not looking and just ramping up the metrics on the treadmill because I seem to be running faster and faster. And you've actually given me some words and some pictures to explain that I'm really not paranoid, that the treadmill is moving faster -- not just for me but for all of us.

Now, Dr. Wachter, I think you have a few minutes for questions?

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Yes, sure.

Couple things – we'll take questions in the audience if anybody has any; and for our colleagues who are online and participating through WebEx, if you would just type in your questions we have some staff here who are monitoring that, and they can ask them. But please wait for the mic as you ask questions so that we make sure everybody can hear them. Any questions in the audience?

Oh come on, New York's never been shy.

Yeah, unless the state has changed a lot since I lived here, that would be shocking.

Hi, I'm Lori Baker from New York. I would just be interested in some of your comments about overcoming the barriers to achieving a bottom-up approach in the culture of the New York or any of the medical establishments that we have. Even though there is buy-in on the top level that this is something that's supported, it still doesn't get into the minds and the system of care on the bottom level. The teams are a good idea; but if you're not on them constantly, they go back to the old ways of doing things. And the priorities of all of the team members are to accomplish their other objectives that they have to do – like the medical residents have to meet their residency requirements, educational requirements; and the physicians have to see the patients and get on to the next – well, you know what happens.

Yeah, of course.

So even the bundle that went into effect years ago for the CLABSI and it worked, those of us that implemented it, it needs constant, constant attention and resource to keep going; and the resources are being drained tremendously.

So, Bob, you must have some comments on that – maybe talk a little bit about culture. And I know you lead what – a 60 physician department?

Yeah, I run a hospitalist program at UCSF; so I have 60 doctors who work for me. They're terrific, and I think they all buy into this; and we actually have been leaders in our institution, being the ones sort of helping this along. But I think it's a fairly atypical group.

Look, Lori, I think we're all learning how to do this together. It's sort of easy to say and very [audio break] and I don't believe it will change until the incentives change so that in fact the doctors [audio break] know that unless they figure out ways of delivering care more effectively, it actually will harm their objectives. I think that's part of the difference. It's very difficult to get people to do whatever training it takes, to take the time to go to a team meeting – all those sort of things when, for example, as a doctor you're being paid on piecework. Sure the hospital may get hurt if there are too many readmissions, but you don't. That's all going to change. Once we're all together in an ACO if we are, not only is hospital payment hinging on performance, but doctor payment hinges on performance. Then you begin to have the burning platform where people say, "The old ways no longer work," or the people who say, "I only do the old ways; I'm not going to change," they begin to get marginalized because enough people get on board.

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I think it's important – it's very hard when resources get constrained, but you have to figure out ways of building in the systems and the structures. I work with a number of health care systems that are doing pretty impressive physician leadership training. It's not inexpensive for them to do it, but they believe it's a really important investment. They have come to believe that, "How are we going to get the docs on board unless the doctors really understand performance improvement and lean thinking and they understand the policy environment?" And when they do, not everybody is going to salute and change the way they do all their work; but enough do that you begin to see the needle change and the culture begin to move.

So it can be done. Good organizations are doing it. I think the ones that don't and don't figure out their way around it will ultimately take it on the chin. There will be winners and losers here. And part of the goal here is that you convince all your frontline people that we don't want to be the losers, and that means that we've got to figure out a new way of doing our work. But I don't want to trivialize it; it's really, really hard stuff.

Well, hopefully the physician value-based purchasing program if that goes into place, will begin to help I think reinforce some of that alignment.

Are there other questions?

Yes, hi – Kate Moranda calling up from Lenoxville Hospital. I do have a question, doctor; and thank you for a wonderful presentation. I was very impressed with the timeline that you shared. Thinking about that – especially how you showed in 2000 or 2002 it was publications that had been talked about for five years beforehand -- so we must know something else is coming. And what is that something that's coming?

I think we know what's coming. What's coming is the immense pressure on cost. It may get muted a tiny bit because today's report that the deficit is a little bit less than we thought in health care. Spending has gone down more than anybody thought. But I think the real shift here is that I think for the first seven or eight years of this decade, believe it or not, we had it easy. I don't know how you felt; but in my hospital I felt growing pressure to improve quality and to improve safety, and maybe over the last few years to improve the patients' experience. But I felt relatively little pressure to cut costs and cut waste.

And as hard as improving quality and safety are, I think they're pretty easy compared to cutting cost and waste because they're politically easier. If I'm going to cut costs and waste and we put together a committee saying, "Let's look at why we're doing so many CAT scans." It took about three seconds before I got a call from my chairman of radiology saying, "What are you folks doing up there?" because that's his income. So I think that's the new thing. I think part of the challenge over the next five years is to maintain a broad focus on value – on quality, safety, patient experience, access and cost reduction – and not to have this flip too strongly in the direction of it's all about cost and it's all about reducing waste.

If you think about what happened in the mid '90s, that's what happened with managed care; it flipped so strongly. Even though people were talking about quality, they really didn't mean it; it was all about cost reduction. And I think we need to hold on to our balanced approach. But that's the new thing. Anybody who says, "It's just like the mid '90s; it'll go away," I think they're wrong because in the mid '90s you didn't see school districts that couldn't afford to have enough teachers or places laying off policemen because

of the cost of health care, and now you do. So I think the cost pressures are going to begin to dominate the equation over the next five years.

I think we have time for just one more question if there are any.

Okay, with that then, Dr. Wachter, I really want to thank you again for such a wonderful presentation and also for your flexibility in joining us today by WebEx. We really appreciate it. Thank you so much. Have a wonderful day.

Thanks so much.

Thank you, Kathy.

We're now going to move in to the next segment of our program, which is going to be live and in person. How about that? But we do appreciate your patience and your staying power with regard to Dr. Wachter's presentation. It's a little bit harder; but I think he's such a compelling speaker that you always learn something. So thank you, that was terrific.

And relative to that last comment, and I can't agree with Dr. Wachter more, that the imperative is all about reducing costs. And I think the New York State Partnership for Patients is engaged in a national effort that is what we call the "carrot" phase. CMS has invested a significant amount of money to help hospitals get to a higher level of performance because performance will be the basis for reimbursement going forward. So whether it's another happy year or year and a half, I hope that you all take advantage of this opportunity to position yourselves and your organizations to be in a much better place when the other shoe drops.

The next segment of our program is called, Accelerating Improvement to Patient Safety Commitments. And it's all about reducing harm across the board. And we're delighted to be joined today by Dr. Maulik Joshi from the American Hospital Association, where he serves not only as a hospital engagement director for 1,500 hospitals across the country; but also as President of Health Research and Educational Trust, which is a part of the American Hospital Association.

He has an amazing bio that you have at your places. And I look at him and I think, "How can you possibly be old enough to have held all these very prestigious positions?" But I am going to read a couple of them. Prior to being at the AHA or to assuming his current position, Dr. Joshi served as President and CEO of the Del Mar Foundation, which is a QIO in Maryland, I believe. He was also prior to that Senior Director of Quality for the University of Pennsylvania Health System; prior to that, Executive VP for an HMO group; and at some point in your career, you were Vice President of the IHI – so working with Don Berwick.

So Dr. Joshi comes to us with not only a wealth of experience, but he brings great intelligence and practicality to this whole challenge of improving outcomes. He's going to be joined in his presentation by Nancy Landor, to my left, whom many of you know already from the Healthcare Association in New York State, from HANYS. Nancy is Senior Director of Strategic Quality Initiatives at HANYS. And by Zeynep Sumer, who is Vice President for Regulatory and Professional Affairs in Greater New York. Both Nancy and Zeynep, as I'm sure you know by now, are really boots on the ground, brains behind the Partnership

for Patients. They make it happen every day. They churn the engine – make the project managers run faster and faster, as Kathy said, on that treadmill. So can't thank them enough for their contributions to this.

Dr. Joshi, please come to the podium.

Good morning, everyone. Thank you very much, Lorraine, Kathy, Nancy, Zenep – just a great honor to be here. It's always hard to follow Bob, who I've known for a while. He's just a fantastic, fantastic person in terms of not just knowledge but execution. And so it's a little bit of a challenge, but I know that three of us will do it quite well in terms of keeping the energy going.

It's a privilege for me to be here. I really do thank you. As Lorraine said, the HEN – the Hospital Engagement Network – along with you, we work with 31 states and 1,500 hospitals. And so achieving our bold goals is a challenge, but one that I know we're all achieving in terms of progress. And I'm here to hopefully give you a little bit in terms of some of the lessons we've learned, some of the things to think about for accelerating improvement. I know you're building terrific capacity at the state level, as you have been doing; and you're showing really solid improvement. How do we continue to drive that?

And then as Bob talked a little bit -- culture. What are some of these commitments potentially that we could all make, that you take care of patients on a daily basis? And if we're going to give it a shot, do some action planning. It's always a little bit of a risky endeavor to try this virtually; but I think we've got some momentum here, and we'll try it out here.

So let me start with reducing harm across the board. I start with the *Full Monty*. Some of you may remember this movie from the late '90s. A number of individuals who were unemployed – steelworkers – and were trying to make some money; and their objective was, "Well, let's do a strip tease; and maybe that will raise enough money." And the Full Monty was total nudity in the strip tease, and so that was the big kind of risk and the opportunity for them – going to the full Monty.

Well, we're at our health care full Monty. As Bob said, what's next and what's coming up – but we today are making incredible improvement. When I look at the results in New York in terms of early elective deliveries, in terms of VAPS – terrific. I know there's opportunity ahead. But when you think about this work across all the topics, it raises the stakes; and it gets us to that full nudity. When you think about all the HACs and where we are today, where we're trying to get to, and the improvement rate, it's a real challenge for sure. But we're doing it.

So we use this as an example at the hospital level to think about not just how we are doing in one project, but how are we doing across all projects. Where are we today, what's our target and how quickly are we getting there? So something for you to think about – I know you've got a great report card and dashboard system on the website, and I would just continue to encourage you to think about looking at it across all the HACs.

I know sometimes we do great in infections, and we are just doing terrific on that; and others are a challenge. Sometimes we're doing great in falls and pressure ulcers, and some of the others are a

challenge. When you put the whole portfolio down, it forces you to think through not just the topics but what are the underlying safety systems that get us there.

What have we learned so far? Also has Bob has done, I give credit to Dr. Don Berwick who talked about "some" is not a number and "soon" is not a time. When we put these down by topic and look at overall harms, it really drives the improvement. When we talk about trying to do it by the ambitious goals we have together in the Partnership for Patients, it drives the acceleration. The timeline really encourages us to get to where we want to for our patients.

The other thing that we've learned is multiple topics mean multiple people are engaged. As we all know in our own organizations, sometimes it's easier to start in one microsystem, one unit, one service line, one department; and that's great. But when you start really building that through multiple individuals, multiple, departments, go housewide, it really forces the opportunity to engage everybody in this effort. And so that's both a challenge and an incredible opportunity.

And then setting visible commitments really increases what we found in peer support. So we have hospitals who have said, "Here's the number of harms or risks that we're trying to avoid. Here are the number of deficiencies we're trying to correct in this timeframe," which we've all done in Partnership for Patients. When you put that down and you involve multiple people and multiple topics, again we see the incredible peer support and peer pressure almost in terms of working and supporting each other so that we all make it together. The best part about this is it's not a contest in terms of who wins. Patients win; but if we can all do it as a state, as a country, it's an incredible, powerful story that helps when some of us go to Washington D.C. and try to help address some of the other changes that are happening that we don't like – whether it's from HHS or others. So this is our offensive strategy.

Accelerating change, again, varies so much in reducing harm; and nothing on this slide other than just to again reiterate the knowledge is within us. This is about execution and accelerating the execution. The great part about this work, I've seen you're resources; they're phenomenal. And the things – I mean, the checklists, the way we go about it -- we have the knowledge; we have the tools. It's how do we implement it reliably; so that's the real trigger to accelerating change.

I'm going to turn it over to Nancy, I think, who's going to then talk a little bit about the building capacity; and we'll come back to the patient safety commitments and the action planning.

We apologize a little bit for the jumping around, but we have to stay in one place so that all the folks on the line – over 100 lines – can also see us too. So the original panel approach isn't as conducive.

What you're looking at now is something that I want to try to help connect the dots to. From the very time we started the Partnership in New York, from the very first presentation that we had, we offered this visual as the way to talk about building capacity because we were very clear that doing this portfolio of work that you continue to hear about today in a very rapid period of time really, really forced us – and it's going to force us as organizations – to look at how we can handle this from a systematic point of view. And so we wanted to start addressing this.

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The basic essence of this is that there are quality improvement activities that are happening in the vertical part of the matrix – you know, going down the side. But what's important to address, if you're talking about building capacity and really taking a look at spreading it and getting other systems going, is you need to look at those kinds of operational drivers that cross over all of the activity because strengthening and building those systems will reduce the amount of work that will happen in the actual teams and progress and poor performance improvement.

Basically just think about it from if you have 12 teams working on it and no system lever drivers in operation, you have 12 teams repeating and going over the same kinds of work if you don't have that hospital level system in place. So it's really very important, and we really went out of the gate talking about building capacity first; and it relates to what we're reinforcing here today, 18 months later.

Just to give you some practical examples to connect some dots, our nursing conference that we did for all of you in last October and November, talked about almost exclusively the integration of patient safety systems within the patient care delivery system -- again, our point being that there are many patient safety systems that we went over with you that will transcend and help improve a variety of different kinds of quality improvement activities -- and so if you're really looking for efficiency in operations and really building capacity, certainly taking a look at that.

And then we had a six-month follow up. On April 3rd, we had a webinar that actually had hospitals demonstrate some of the work that they've done in terms of building these practices into a delivery system.

Another example that you'll hear all morning today – bottom-up -- Dr. Wachter talked about this is not about one-off projects. Lori asked, "How do you get the bottom involved?" And you really need to look at your systems in your organization for how you share the vision and how you involve the staff and what part of quality improvement is part of their job description, is part of their annual competency evaluation, and how much do we really empower and let frontline staff do the work?

We've done a number of things. We've given you, again, some transforming care-at-the-bedside tools. More importantly, we've given you a lot of tools around Team Steps and having critical conversations and building that teamwork. And we want to encourage us to, again, really bring this down to the front lines as much as possible.

We've also tried to address other kinds of operational drivers throughout the campaign. Obviously data – we've talked about it a lot this morning with the focus on outcomes. But even the CMS Z-scores, which I'm sure you all just love, but the reality is there are Z-scores for the purposes of monitoring progress and your engagement in the project; but they're really actually a measure of pace too. Because as you go through the Z-scores from a 2 to a 3 to a 4, you're really looking at how fast you can build and move and make change happen in your organization. And that might in and of itself be an aha moment for you as you take this kind of information to your leaders and to your boards.

I can't assay enough about the culture. I think we have completely addressed it this morning in terms of how effective having a positive learning culture, adjust culture as an organization. We've provided Team Steps as one of the tools. Kathy brought up that we were going to re-survey again, using the Our Culture

Safety Survey in September. Your work in this area will not go without tremendous value. That's one of those sweeping operational drivers that will have just unprecedented positive impact in everything that you're going.

And there are a lot of other operational drivers that we've been addressing throughout the campaign – patient centered care and patient involvement in QI, I think we need to heed what Dr. Wachter said about patient engagement. But there's still educating the patient and doing teach-backs and understanding what the system looks like from the patient's perspective; and those things are still important without actually putting the responsibility of patient safety on the patient. There's still a whole scope of satisfaction, input, perspective that we really need to understand from the patient.

The last thing that we've really tried to do – so I hope that you all go, "Uh-huh, we know" – is that we've also tried to look at ways to integrate the initiatives that we're working on so that, again, we're looking at efficiency and some lean ways of approaching things. So for example, the pressure ulcers and falls – a lot of the systems that will improve the care or reduce pressure ulcers and falls are similar systems. So we've encouraged you to really take a look at that and maybe make those teams come together and really look at how they blend.

If you're working on anticoagulants and you've got a team working on adverse drug events and anticoagulants, and you've got a team working on VTE, you need to put those teams together. So we've done a lot of FYI – just in time information about really how to make it more efficient and perhaps how to really build capacity by looking at the operational drivers and ways to combine activities. So I just wanted to connect to that, and we'll continue with this approach.

The next thing I want to talk about is Dr. Benjamin Taylor was hoping to be with us today; and because of all the changes, he was not able to be here. However, he had a couple of pearls that I do want to humbly at least let you know some of the points that he was going to make today.

First of all, the important thing to know about Dr. Taylor is let's think about an organization that can make rapid change. Dr. Taylor comes from a 1,100 bed hospital – huge – academic teaching, so he's got a bunch of people doing research probably conflicting with quality in some ways. It's a public health hospital in a very poor socioeconomic area. So if you're talking about an organization that sort of has all of those barriers, yet he has really been able to move his organization forward, particularly at a very fast pace. And so because he has been able to do that, he actually is now co-chairing the No Harm Across the Board affinity group for the Partnership for Patients. But I want to give you some of his top messages because I think that they're important.

And one of them is get rid of the denominators. And I listened to a No Harm Across the Board program yesterday from PFP for the HENS as well. And the feeling is that there is a place for rate (inaudible). There is a place for rates and tracking rates and ratios and all those things over time that's absolutely important. But for the frontline staff, it really shouldn't be; and even for the Board, it really shouldn't be about the rate – it should be about the patient. And so it is much more important that if I'm a nurse on a unit that I know that I harmed three people this month or I was part of harming somebody who got a urinary tract infection or who fell.

And so one of the things that he really is pushing is to really get rid of the denominators and make the stories very personable about Mrs. Jones or Mrs. Lee or whoever it may be. And one of the key tools that is recommended – and a lot of you, I think, are doing this already – but there is the idea of having nurses on the units not only get the run charts from quality and post them, but also to keep track themselves on their units the number of days since the last time they had an event. So maybe it's been ten days since the last time I had a urinary tract infection, or it's been 55 days since I had a VAC.

So we really are getting the message of how effective that is; and for that purpose, we've actually developed a tool. So for the people who are off-site and can't see this, I'm going to try to do the Vanna White thing; but it probably won't work. They are around the room. We have developed ten posters, one for each initiative. The poster basically says, "No Harm Across the Board." There's a space for where your staff can write, you know, it's been two days, three days, four days – or the clerk or whoever is going to do this. And then there are actually little tips. So instead of just saying it's been two days or five days, there are little tips to remind the nurse or the clinician about some helpful things you can do to prevent it from happening.

We're going to provide these laminated to you. So within the next few weeks, you're going to get an order sheet -- we only can do a one-time order – and you're going to let us know how many you need and the different categories because we can't encourage you more than if you want to get frontline staff involved and you want to try to get them using these, there couldn't be any better way to get awareness going on the units – to just get them using them. And it doesn't make any difference whether it's the clerk updating them or a nurse champion or whoever you want. For those who are offsite, there's a brochure in your packet and there's a brochure on the website; and you can take a closer look at them. But basically, they're all around the room here; and they basically all look like this.

Okay, and then the other thing we'll say is obviously connect the dots with finance. And if you ideally have a person in your finance department that can work with quality and do business case analysis, that's great.

And then the last point he'll make is leadership at the bedside – empowering the patient. And what he's talking about, again, is the important part of the clinicians taking care of the patients, being the leaders, having situational awareness, knowing when to prevent things from happening – when to speak up; and that part is really important.

So that's the message, our work on building capacity and on what Ben would say; and I'm going to turn it back over to Bob.

Nancy, thank you. I thought that was fantastic in terms of really connecting the dots. It was brilliant, and I can tell you personally I love these No Harm Across the Board ideas as a way to, again, engage everyone. I'm going to take you back to our HEN, so I thank you for the opportunity to steal that; but it does get to what we're trying to do. And I think just to step back a little bit, why are we talking about this? This is the question people ask me. We are committed already. We've already signed on. You deliver care every to people; I don't. So, why these commitments? What's the point of it? So here's one answer; first of all, I'm not CMS so I'm not directing anything. You could not invite me back to New York, so that's okay.

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You know, number one is as I think you've seen, it is today easier in every organization, not hospitals, to go project by project. I mean, it's easier. We have teams that are that way, and we can let them go. We're talking about safety systems and then really foundational work to make all the other stuff work well. And so these systems are really key. The commitments around these really will drive the improvement, I think, to where we want it to be to make it easier for the work we do and for our patients. So I think that's the why we're trying to get this.

The work is fantastic. When I look at your results, it's impressive – decrease in early elective deliveries by 36% for about 75 affiliate hospitals; decrease in CLABSI, VAP, SSI. It's great stuff; we should be very proud of it and knowing what impact we're having. There are still opportunities – whether it's falls or CAUTI or others where these system implementations might help us to accelerate that.

So this is an opportunity, I think, for all of us to kind of reinvigorate, kind of renaissance the Partnership for Patients. Great activity going on, great improvement – but how do we take it to the next order? And we all are talking about reliability, so we're talking about the next level of reliability. It's an important piece, and I just thank you for kind o bearing with us as we just kind of go through some of these things in terms of thinking about how do we go from where we are to where we're going in terms of this No Harm Across the board or accelerating change – whatever, again, makes the most sense to your organization.

Just a couple of other lessons – as you can see, when you focus on a portfolio of work and not the projects, it changes kind of the conversation. It raises the goals for improvement because it's not just getting CLABSIs below 1 or 0.5 for thousand line days; it's reducing all harm, from our 30 or 40 per thousand days down to 10 or 20. And it's really, again, these safety systems.

So just to talk about some of these commitments – and I think you guys have come up with a great set of thoughts – just a terrific set that can change the way we provide care in terms of improving. Teams – we know it's all team sports these days. It's how do we work together in teams? We have to learn how to do that in many ways because we weren't trained that way; so it's how do we do teams? Hard stops – you know, I was actually a little skeptical of hard stops in early elective deliveries. I heard that and I felt, "Well, mandates don't always work. And it just doesn't make sense." And we like that it makes a difference. You know, it really – again, whether it's like a checklist approach or a hard stop approach, that intervention makes a significant difference.

Checklists themselves – and we'll talk about the safe surgery checklist – but clear outcomes from the work, very process-oriented but gets to the care delivery.

Protocols – and we'll talk specifically around VTs and VAPs for that sort of work. Evidence-based protocols – we've been talking about for a while. How do we implement them reliably?

And patient engagement – I think as Nancy said, this is not contrary to what Bob has talked about. Patient engagement is an important part of our process and our stakeholders. So it's not necessarily a double check error reduction, it's how do we engage all stakeholders in this effort?

So those are five commitments we're talking about. And I would encourage you to think through these as we're going to kind of tag team on the next five to talk about some of the examples of these commitments and then get to some questions with everyone. You know, what's worked in thinking about these commitments? You're working on them. What hasn't worked? What can we learn from each other? And then the fun part of action planning in terms of all of us.

So I will turn it over for the next couple of minutes.

I apologize for the popping up and down. Okay, so we're going minimize that by standing up here together. And just to reiterate what Maulik said, we looked at what we've done for the last year and a half; we have about another six to seven months in this contract period and in our focus period that we set forth for you all and have an opportunity really to accelerate and build on what you've already done. So we put our heads together here at NYSPFP, and came up with five things that – like Maulik said – you may or may not already be doing in some capacity, but that we want to refocus our efforts around. So how can we reinvigorate what you're already doing to maximize and accelerate and transform our outcomes?

So number one, if you want to, in your packets there are actually two forms that we're going to be using over the next 20 minutes. What you see on your slides, we actually have it in a form-based (inaudible); and you can probably read it better. And then there's actually a worksheet that looks exactly like it except it gives you the ability to add in your ideas and your thoughts about where you can potentially go in the next 30-60 days or so forth.

Okay, our first commitment that we would like you to really take a look at is the idea of expanding your interdisciplinary team to include a clinical pharmacist to reduce adverse events. So the first question is, "Of all the clinicians available, why are we saying pharmacy?" We have, over the last year and a half in terms of working with PFP, reading the literature and keeping up-to-date – and in fact on the train ride on the way down, I got a notice by PFP that one of the big systems in the country had tremendous success using pharmacists at medications. We're just bombarded with how effective it is to pull pharmacists into the care process.

And there are a couple of areas where we think it's really paying off, and you can see that there's a selection there. Using pharmacists and medication reconciliation, both on admission but particularly at discharge to review the meds and more importantly to resolve the discrepancies, has it been extremely effective. If you go to any of the pharmacy associations or the Safety Medication Institute, you will see study after study looking at pharmacists getting involved and really being able to reduce readmissions; and I think that that's extremely important. If your organization doesn't feel like it can handle that cost of that redesign or it can't handle it effectively, the pharmacist doesn't necessarily need to be involved with every patient. And if you want a barometer, perhaps having the pharmacist involved with the high-alert drugs as we're talking about in our project – the anticoagulants, the insulins, the opiates and probably (inaudible) would be a great idea.

The other piece is that we have learned that – and we'll say pharmacy-driven anticoagulation teams and insulin teams – but again, they're not always pharmacists. Sometimes they're hospitalists; sometimes they're adult advanced nurse practitioners or some sort of combination. But the idea of having

hospitalwide protocols for medication management in these high-alert drugs with a system to promptly respond to when there's a change in the lab work or a change in nutrition or whatever is just stellar. It becomes not even trying to reduce adverse drug events; it just becomes trying to provide really good care, and the quality is the byproduct of that. So one of things we would like you to look at is how you can look at bringing pharmacy into some redesign systems in your organization.

Okay, number two – and I am really lucky to be able to talk about this one because I think once in a blue moon in all of the quality work that you all do and that we do, we come across quality improvement interventions that give us an opportunity to act like a light switch. You put them into place, you put a policy into place, and almost overnight you can see a change in your outcomes and the way that people are practicing medicine. And a hard stop really gets us that opportunity.

And among the focus areas that we're talking about for the Partnership for Patients, we have the opportunity to place hard stops in three areas and a soft stop in one related area. And I really urge you all, if you do not have these in place already to think about going back and making them a hard-wired policy in your hospitals. I think – no, I know – that hospitals that have done it see a marked drop in their related rates – like I said, almost overnight.

The first is around early elective deliveries, and we've seen it time and time again. You put a hard stop policy in place where you can't schedule those elective deliveries unless there's an obstetrical or a medical indication, and you see your EED rates go down. Some hospitals have chosen a soft stop – having a review of having sort of a yield sign when the scheduling occurs. That works as well, but it can't be said about an actual hard stop policy.

Second is around catheter-associated UTIs. A hard stop to make sure that there is a medically necessary or medical indication for inserting a catheter, especially in the emergency department, is critical. We're in the middle of a statewide pilot right now, which many of you are implementing at your hospitals and already, in just the last four weeks, seeing real improvements in what happens in your emergency departments related to catheter insertions.

I hope we hear from hospitals that have been doing this and are seeing these results. Again, we've seen a big drop in utilization for catheters. We're not there yet with the infections; but if you don't have a catheter in, you don't get an infection. So it's kind of difficult to make a case for putting an unnecessary catheter in.

Related to CAUTIs, a soft stop in place for timely discontinuation of catheters is also another opportunity for us. And I say it's a soft stop because we have a bit of a limitation – both in our state as well as nationally – around nurse-driven or nurse-initiated protocols. And so we encourage hospitals – and again, I'd love to hear from hospitals that have done this – to have nurse-driven protocols where the physician is brought in – the empowered nurse brings in the physician to make a decision about discontinuing catheters.

And then lastly, a hard stop around medication management, and specifically around implementing processes that make sure that any discrepancies in the medication reconciliation process are resolved prior to discharging a patient from the hospital. Again, this really obviously has a lot to do with medication

safety; but also in your readmission prevention activities and provides a real opportunity around improvement.

The third commitment that we'd like you to think about – and, you know, we've talked a lot about this in the New York State Partnership for Patients because it is our approach. So CMS has asked us to reduce SSIs – surgical site infections – but we made a very conscious decision to in our overall approach not looking at these clinical focus areas as projects and looking at it more holistically and systemwide. We thought it was important to look at SSIs from the bigger perspective of OR safety. And I think looking at it that way gives us an opportunity around a couple of different issues that or concepts that we've talked about today.

One is teamwork. We've found that in looking at OR safety instead of surgical site infections, we've been able to bring the entire perioperative team to the table; and that's been really, really transformative for our work -- and I know your work as well. The surgeons, the anesthesiologists, the quality improvement specialists, the infection preventionists, the infectious disease physicians – they're all at the table. And when they're all at the table, we move away from just trying to prevent SSIs and looking at the entire perioperative -- that contained episode – as an opportunity to prevent other complications – not just wrong site surgeries, not just those acute errors, but errors beyond that, harm beyond the perioperative setting, going into CAUTIs, reducing falls because of immobility, looking at pressure ulcers related to the surgery and adverse drug events, VTE, all of it – pretty much everything that is on our Partnership for Patients list you can address in that perioperative setting, and it's really critical to have an effective set of checks and balances, which the surgical safety checklist gives us.

So our focus is around the brief and the debrief, and a full brief and debrief with the entire surgical team. That surgeon needs to stay in the OR for the debrief, and I know that's been a challenge for many of you. So we'd like to take another look at that and share what works. So that's number three.

Thank you. I totally agree. That's so powerful to have that central surgical team up there and their ability to do a debrief and cover everything.

The fourth one is on ventilators. We talked a little bit earlier about moving to ventilator-associated events. That is primarily why we put this up into the five top areas of commitment, There is a belief that as we delve into VAEs, we're going to delve into some very important patient safety issues beyond just developing pneumonia – certainly in terms of oxygenation. But the two things – the innovations that we're working on – in VAT or VAE also have extremely broad effects. If we reduce the sedation in patients on ventilators or eliminate it – both are possible, we have hospitals in this room doing it – and we get those patients up walking, even at first if you're dangling them and getting them to the bed, that's still more activity, eventually walking – there's unprecedented rewards from that – not only from a ventilator-pneumonia safety perspective, but the literature shows that significant decreases in mortality, delirium, all of the post-traumatic stress syndromes that come out of critical care stays -- it's just incredible. So we're asking you to really take the challenge of VAE on, really take the challenge of sedation and mobility on, and really be on our journey to learn with us what we're going to find about other opportunities within VAE.

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And the last one it you've heard a lot about, but I want to address it, and that's the integration of the patient safety practices into the nursing care delivery system. And again, most of you are doing a version of it. I think the challenge here is to really look at how well you're doing it, and are you really optimizing these practices to get the most out of them both from, frankly, from an equality perspective but from an efficiency perspective and from a patient satisfaction perspective. The literature really reflects that these practices really actually help in all areas.

So for example, are you doing the side rounds in the morning? Do you have two nurses introducing themselves to the patient, involving the patient in the conversation? Do you have a whiteboard up there where you're actually doing the care plan for the day? Are you using whiteboards? Are the patient and family using the whiteboard? Are the physicians? More importantly, you're trying to get a multidisciplinary discharge plan together. Is the discharge planning team all using the whiteboards?

And my favorite example is for all of us who do patient teaching and we don't have the family with us, if the family's phone number is up on the whiteboard and you call the family, they can at least look into the teaching over the phone. So there are just all kinds of ways.

And the other things that we all know and we continue to encourage you to get really good at is various forms of purposeful rounds – certainly hourly rounds, looking at goals in pressure ulcer preventions and a variety of other things (inaudible) to the symptom management, and patient satisfaction is incredibly effective. A lot of you have already seen the results of that. So we encourage you to really take a look at the effectiveness of rounds. It seems like it's overwhelming and expensive, but actually it can be a lot more efficient if you have a real organized approach to doing some of these rounding things.

So those are our five commitments, and we're going to turn it over to Maulik.

Thank you very much.

I have to just take a little time on these commitments because I think they're fabulous. Just working back a little bit, change of shift reports at the bedside – I'm on the board of a hospital that's doing it and going housewide. It takes a little bit of skill and experience in how you do it, but they'll tell you it's making a big difference in term of communication, in terms of staff satisfaction, and in terms of patients and families engaged.

Whiteboards can be used many, many ways. I can just tell you one story. Several years ago when our daughter was in the hospital, it became a fun activity for our daughter to have the nurses come in, use the whiteboards. They had contests with each other – who could take up more space on the whiteboard. They gave our daughter a couple of ideas. She was on O_2 and they said, "Okay, when you don't feel well, have someone put a checkmark on the whiteboard." It was a way for them to gauge how much they could drop the oxygen level or so. Many ways – this was more fun than anything else – but I can tell you, it made a difference in terms of communication.

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Purposeful rounding – that makes a difference for sure. And I know that's a challenge with all the work we have today. But every hour/two hours going in, using the whiteboard, having the communication, engages again in the plan.

Last week I was with a CFO at a hospital in Ohio – about 350 beds – with three or four of us also; and we were talking about patient engagement, some of the strategies. And the CFO said, "You know, the best thing we've done in the last year is this daily goal sheet. We give it to patients. We don't always get it right on that day or get what we need done, but just the fact that everybody knows you might be going down for an imaging study, or you might be doing this, or perhaps this might happen later today, makes a difference." People like knowing what's going on. Unfortunately, it doesn't always get honored; but even just setting the expectation makes a difference and again, puts the whole care team on knowing, "What are our daily goals for today?"

And then again, I think teach-back in other things. I've seen teach-back work really well. I've visited hospitals where they do it so well, and it makes a difference in readmissions and it makes a difference in medication and it makes a difference in many of our topics – so just some of the ways to think about that.

Working back, I do again just want to say hard stops, checklists – these are protocols that make an impact when put in reliably and consistently. So maybe we can combine these next couple of questions for us for those on the line as well as for those in the room. We have a couple set. One is we know you're putting in systems today. What's working? What's not working well? What can we offer or learn from each other?

The second then is you've got the action planning worksheets; and I already see some people filling it out, so we're going to pick on you. But try to take some time maybe to think about that. This is not a mandate; this is not a thing; this is a how do we, as a group, come together on this work? Most of my job I love is working with hospitals and our partners at the State Hospital Association and others to make improvement happen. The other part is I sometimes go to Washington D.C. and talk about some of the challenges we have. And it's always great to start and end with the results that we have for our patients. And it's been tremendous.

So this is our way to kind of say, I'd say, we're all authors in the national improvement story. We are the authors. You're the authors; all I'm doing is writing the preface, I think, and some other things. But you're the authors. We're halfway through the book, and now the plot thickens. We've gone through the book, we've got the characteristics, we know progress is (inaudible). Now the question is, "How do we acceleration? How do we get to that conclusion that everybody is going to say, that's a best seller?" And I think that's where we're at today. You're leading this charge. So how do we get from the project level to all the other system-level and implementation to get to accelerating improvement?

So we'll try with some mics and also on line to say, "Are there any questions or comments on this?" We have a few.

Hi, I'm Kelly from St. Luke's-Roosevelt Hospital. Your posters for Do No Harm so to speak, have you anything addressing the operating room specifically – i.e., universal protocol or preventing retained foreign items?

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So for those on the line because I'm not sure if you would have heard, the question was: "Do you have anything around the posters for the OR?" Not in the OR, but we have one for each condition. But that gives us an idea. We could do a checklist-type poster; one limitation of that is that hospitals like to customize it, and in fact the checklist is meant to be customized. So we'd need to put some thought into it, and we'd love your feedback.

I would be willing to bet, though, there's a hospital that has one in this state. How can we share?

Is Stanton Island here or on the line? I know I've just recently spoken to them about their poster. And I know others have it as well; that was just one example.

Hi, Sam (inaudible) from the Maimonides -- I'd like to expand on a couple of items, and then I'll have to weave a couple of things together. From our own experience, it has to do with procedural safety, surgical safety. We had a real issue at Maimonides a few years ago. Our surgical mortality rate was quite high. And in 2009, a new Chief of Surgery was appointed; and he made it his overarching goal to reduce unnecessary or avoidable deaths. We put into place everything that everyone has talked about; and at the present time, our surgical mortality has been reduced by around 60% from (inaudible). And I would say most of that has to do with culture change, adoption by the chairman, the department and all the senior leaders, by a certain turnover in personnel, which is natural when a new administration comes in.

But one thing we've done that I haven't heard today is a real concentration on pre-operative case assessment and doing the right operation for the right case – patient selection for the operation. Many of us have (inaudible) where we discuss cancer cases. We have a mandatory presentation of all elective cases at our cancer center. Every elective cancer case must be presented to a committee. We generalize that down to our cardiac surgery department. Every elective cardiac surgery case, non-emergency, has to be presented to a committee. All valve cases have to have two attendees in the room. And as of this year, we've generalized the preoperative mandatory assessment to every inpatient going for surgery. If it's not an emergency case, an internist – a hospitalist, one of Dr. Wachter's people – will come and assess that patient. If the time interval between the decision to do the case and the actual performance of the case is say 12 hours or less, that patient will get a separate set of eyes for that evaluation.

This makes a lot of things highly inconvenient for the doctors, but much more convenient for the patients. And I think I would offer that as object lesson for people to consider.

Those are just terrific, terrific examples. And you said it so well, generalized. I mean, we're talking about systems; so you're putting in the system across different service lines, across different areas, and it's just wonderful.

Fundamentally – and it's not the gravity of the case. If it's just a lymph node biopsy but on an inpatient, in other words somebody sick enough to be an inpatient today for some other reason, and if it's a minor operation, it's the patient situation not the gravity of the operation that dictates whether a preoperative assessment needs to be done – and we're doing that.

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Just for the people on the line I'm going to summarize this quickly. Basically what happened is that Maimonides went full throttle implementing just about everything that we talked about and recognized a 60% reduction in mortality. But what they're throwing out as a challenge to us is that they've also now moved some of their process improvement to the preoperative area where they're assessing the need for surgery, the type of surgery and all that type of thing, and also assessing the patient's readiness for surgery and are they prepared.

So I think that's excellent. And Dr. Dillinger in one of his tutorials touches on that a little bit as well.

Nancy, I think that that idea of using numerators on the frontline is fantastic because the data that's coming from the billing data and late into (inaudible) versus the CMS – we can't trust the data, and the physicians don't buy into it. And we cannot get unit-specific or patient-specific data to support our outcomes at this point – at least we can't where I work. And that is a fantastic idea. It is a fantastic idea because everyone on the team can participate in identifying a case and counting the numbers. And they can't deny it if they all put their own numbers in. And we know it isn't going to get into the billing data because we know that's totally inaccurate. So that's a problem, that we cannot keep using the billing data for all of these hospital-acquired and patient-safety indicators.

Thank you, Lori.

For those at home, Lori actually did a fabulous job of actually bringing up a couple of other reasons why the posters and having the frontline staff be involved – the realness and accuracy of the data, and the real timeness of it and ownership by the staff.

And thank you, Lori, because those are all true.

That's a great point. I would just say – I have a math degree, so I love numbers. I think it really does engage everybody. And again, we're not trying to write a JAMA article; we're trying to show improvement over time in the right way.

(inaudible)

When it's your own data, it's more accurate for sure.

(inaudible)

Hi, I'm Sheila Robinson from Queens Hospital Center. Going back in terms of the perioperative checklist, I think it would be a great suggestion if you include the brief and debrief. That would help with decreasing medical errors and improving communication. And by going back, we'll make sure that is being done.

So I have a question back to you or to the group. I think hospitals are trying to implement an effective brief and debrief but are challenged by it. Some people say they have time constraints and pressures to start the surgery at a certain time and end at a certain time. So what are some strategies? What are some hospitals doing around making sure the preoperative brief and then especially the debrief with the whole team in the room happens?

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Well, the first thing that we did at Queens Hospital Center was that we made sure that our perioperative team – everyone was trained in Team Steps, so they understand the value of it. That's how we got them to do the briefs and debrief.

Others? How do you keep the surgeon in the room? I'm just going to ask it.

Sheila (inaudible) from Maimonides --- we had a wrong site surgery 13 years ago, long before patient safety became the vogue. And that was our first root cause analysis. And we found 14 issues that we thought were working that weren't working. And one of the things that we started then and continued to do – and of course the time out and the briefing have changed and evolved over time – is senior leadership does observations in the OR. And we show up, we get in greens, we put on masks and the hats and we say hello to everybody. And it's not just so much the policing activity that it was early on; it's the coaching activity that happens now. And it has opened up also the (inaudible) for the entire perioperative staff to ask a lot of other questions about lots of other stuff that they're concerned about. So we continue to do that periodically, and it's fun. We have fun, and the staff is beginning to ask why we don't go back as often as they would like.

Great story.

That's a great one.

I encourage you all to remember the webinar from the North Short talk, and I think Dr. Welsh talked about the debrief and the idea of having it earlier – don't wait till the end of the surgery. Perhaps just when you're ready to close the case, you could do a debrief then. Everybody's in the room. It will allow you enough time to look at what went well and what didn't go well, and also enough time to maybe get a little bit more care planning about the whole picture of that patient. And I think they're doing it.

And I think just to build on the system's part, where can you do debriefs? It's not in just one area – so whether it's post fall, whether it's in OR – I mean, think about that as where can we do these? It's a great method to what we're trying to do.

We've also taken the debriefings when something bad happens and taking into consideration that there are two victims in an error and really focusing on the staff that's been involved. They have to continue taking care of patients. How do we help them continue and address their concerns and thoughts and feelings about what happened? So you have to work with patients and families, and you have to work with the staff as well.

Wonderful.

Any more questions? Do we have any online?

No questions online.

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So I will thank everyone for allowing me to join. You've got great leadership in New York; it's a privilege to work with them. And I encourage you to think through these commitments as a way to continue to revitalize, energize the improvement we're going on. I know you'll talk about when you want them handed in and all that stuff. But again, it's transparency; it's working together; and it's getting to the results at a higher level. So thank you for the opportunity just to have the conversation.

Thank you, Maulik.

Okay, so you do have the team planning worksheets in your folders which we did not get to and we will not get to. And those of you online have them electronically. Your project managers will be reaching out to you, and we would like to have these completed over the next couple of weeks so that we can have you set 30-, 60- and 90-day targets that may be too high to achieve – but that's okay. Any progress forward is I think going to be very positive, and we're hoping the five commitments make sense to you as well as they do to us. So your project managers will be in touch. And thank you so much for those of you who have shared. We hope to hear from others as well offline. Thank you.

That was just terrific. I just want to formally thank Maulik, Nancy and Dana for putting that part of the program together. It's been so important for us to engage you and to hear from you. And for those of you who have shared the lessons you've learned over the course of your careers, and more recently with regard to safety, thank you so much. And it's really so important to be transparent with one another so that we can all move in the same direction.

So now we are getting close to the end. And I had this terrible feeling before when I heard that rumbling upstairs that it was collective stomach growl, and you will soon be released and can have lunch. But before we do that, we really want to engage around the very important topic of leadership in quality improvement – engaging clinicians and practitioners alike in this journey and really making them an impactful part of your sustainable teams.

So to do that, we are really pleased to have Dr. Jeremy Boal with us. And Dr. Boal began his career at Mount Sinai Center in 1994. And now he's come full circle and has returned to Mount Sinai, where he will be leading the system as the Chief Medical Officer for the Mount Sinai Health System – so congratulations. But in between, he has been engaged in some very impressive activities at North Shore LIJ where he held the position of Chief Medical Officer and also led some terrific quality improvement initiatives and had some great results in the area of infection prevention and also reducing mortality due to sepsis. But importantly for this segment of the program is really improving relationships with clinicians and engaging clinicians as you lead these quality improvement initiatives.

So, Jeremy, please come to the podium. Thank you.

I am honored to get to spend a little bit of time with you even though it is just before lunch, and I think most of you are watching the weather as well and wondering how you're going to get out of here if it starts raining. It really is an honor to get to spend time with you. I'm not up here as an expert in any way. I'm up here as a colleague, as somebody who is humbly trying to do the same things that you are doing every day.

And just to get my story out of the way, when I was an intern at the University of Minnesota, I had been up for about 36 hours; and it was a Friday, and I was signing my patients out to the team that was going to be covering. And just before we left for the weekend – I was off for the weekend, it was one of these rare events where you got two days off in a row – there was a patient of mine who had heart failure who was a little bit fluid overloaded, and we decided to increase a diuretic on that patient – furosemide. And so I wrote the order for the slightly increased dose of furosemide on that patient, and I went home feeling very good about myself as an intern.

And came back on Monday and found out that another patient had died. And I didn't understand why the patient had died; I wasn't expecting it, and I actually pulled the chart for medical records and reviewed it and realized to my horror that I had written the order on the wrong patient. I had actually taken a patient who had been on extraordinarily high doses of furosemide who had very bad kidney failure and reduced that person's dose to a very, very low dose. And that patient had developed hyperkalemia, a high potassium level, and had arrested.

So that was my introduction to the patient safety movement. And back then, like most people who have had errors in their practice, it was all my fault in my mind. The two patients had the same name, and there were no warnings on the charts. There were no work hour restrictions. There were no checks and balances. There were no pharmacist who said, "Hey, doc, I don't know why this dose is incredibly low on this patient who has very bad renal failure. Are you sure you're doing the right thing?" No nurse picked it up either. We were all working in our silos. There were no team rounds back then.

So I tell that story to you today because I think it's important that when we talk about engagement and we talk about why we do this and why we're all sitting in this room and why we beat our heads against a wall every day when we go back to our hospitals is because it doesn't just impact on the patients that we care for. I think it impacts us on an incredibly personal level. Nobody goes into health care to turn a patient. Nobody goes in to stand by when somebody suffers a pressure injury which, by the way, is a very, very traumatic event. We treat it like a statistic; but if you've ever had one, you can imagine what it must feel like to be immobilized and not be able to do anything about it and to have your skin integrity break down and to get an infection and the like. It's the same with line infections and blood clots. It's the same with delays and treatment. Those are very, very serious events; but we treat them as just built into the system – as part of the bureaucracy of health care and the chaos of medicine.

We make excuses for our region; we do it all the time, right? It's tougher here. There's less family support. We have more poverty. Health beliefs, language barriers – you name it, we've got an excuse for why our results aren't as good. I guarantee you for every patient in the communities that we serve who are part of those statistics, they don't care about any of that. And I think in our hearts we don't really care about it either. I genuinely think that each one of us feels accountable when somebody has a readmission that they don't need to have or dies in an ICU on tubes and drains and ventilators when three admissions ago it was obvious that they had a terminal illness, and we just need somebody to have a discussion with them and their family about benefit and burden of care.

So I think ultimately the reason that I'm talking about these things is that we know – and I think you know – that all these terrific ideas that we've heard about today, whether it's purposeful rounding or following checklists – we love checklists, they work -- but none of them work unless people are truly engaged in the

work. Right now in our region in every one of our hospitals, there's a timeout procedure going on where everybody is going through the motions – right now in your hospitals, in my hospitals. I can guarantee that. I can guarantee you right now somebody is inserting a line, and the nurse who's supposed to be there making sure everything goes right is being handed a bundle sheet at the end of the procedure because he or she is at a desk doing other work and assigning their part. I guarantee that's happening; it's rampant throughout our system.

Part of it is because we have a set of old beliefs about change, and we have to develop a new set of beliefs and a new set of questions that we ask. But part of it also is that we accept these things and we tolerate them and we don't believe many times in our heart of hearts that we can create a system or an environment where that never happens, where the folks on the unit would never allow that to happen. They'd hold each other accountable so that when we're not looking, it's happening anyway. That's what engagement is about. It means everybody in the organization is engaged in the why – why this matters. And everybody from the very top down makes it a priority and never cuts corners.

This is brutally hard. Even us, the so-called experts, struggle with this every day. In our hospitals, we have everything. We have the whitewall – docs talk about the whitewall, nurses working in a silo. We have physician disruptive behavior that we don't deal with because they bring volumes into our buildings, right? We've got the untouchables. We've got the really nasty unit receptions who nobody will cross, right? And by the way, if you pick up that phone you get yelled at; and if you don't pick up that phone you get yelled at, right? So what does that say about the patient? What does that look like to the patient and the family member and everybody else?

So underlying all of this – the secret sauce to all of this is this issue of engagement. And we've had a lot of discussions about this; and why I'm so glad I get to talk to you about it today is because I don't think we talk about it enough. We accept. Every employee in every hospital knows if the folks at the top really care about safety and quality. They know; intuitively, they can feel it. So all of these things that we're talking about, they're just bureaucracy unless we actually are committed to it, unless we live it -- we actually demonstrate it in the way we behave as well. Otherwise it's just bureaucracy. You'll get the forms back; you'll get the bundles completed. All those things will be done, and we won' see the kind of improvement we need to see.

And by the way, zero is possible. And that's heresy for physicians to say, but it really is. And we have to believe it.

So everyone takes the limits of his own vision, her vision, for the limits of the world. You guys have heard of Roger Bannister. Who was he?

(inaudible)

There you go. So Roger Bannister was a medical student, believe it or not, when he crushed the four-minute mile barrier. Now, for hundreds of years before he did that – probably thousands of years – there was a genuinely fixed belief that it was impossible. Psychologically humans couldn't run faster than four minutes; our bodies would break down. That was a fixed belief, and nobody beat the barrier. How many

people beat it the year after he did it? Thirty-seven. How many people beat it the year after that? Three hundred. Nobody beat it prior to him doing it.

Think about all of our fixed beliefs about what's possible. I guarantee you they're holding us back. Whether it's about we don't believe people can work together as well as they need to; we don't believe we can get to zero; we don't believe that we can get to 100% reliability; we don't believe that we can hold disruptive physicians accountable and end up in a better place at the end of the day. There are all sorts of things we just take for granted; we just have fixed belief. Our region – that's a fixed belief. "We can't do as well as Minnesota." It's nonsense; we can do as well as Minnesota.

"Great works are performed not by strength, but by perseverance." The vast majority of times when we engage in these efforts, we attack them with strength; and then we go on to something else. How many cycles have lived through? This is all about perseverance.

I'm going to tell you a brief story that I think illustrates this. And it also I think illustrates why this issue of engagement is so critical. There's a hospital in this region that has a large population of adult cystic fibrosis patients because their sister hospital has a very big pediatric cystic fibrosis program. And in that hospital, they received a complaint letter from a parent. And the letter said, 'I have two daughters. I know I'm going to outlive both of them. I know that health care is complex, but I have to tell you about what happened to my daughter when she came into your hospital.

She's now an adult. She was pregnant, so she came in on the adult side for respiratory difficulty. And it was a miracle that she didn't die as a result of the care that she received." And he detailed what the care was like. Every single person involved in the care thought they were going the right thing, but the system just wasn't designed to deliver optimal care to somebody with cystic fibrosis. What does it take? If you're a patient with cystic fibrosis at home, you're doing everything you can already to for yourself. You're taking your antibiotics; you're using your inhalers; you already have a mini hospital at home. You have to take your pancreatic enzymes just at the right time so that you can digest your food. You have to have more calories than normal because the work of breathing is so excessive that you become malnourished very quickly.

When a patient like that comes into the hospital, unless you actually build the system around them, the odds of them getting that care – even equal to what they get at home – are zero; and now they're sicker than when they were at home. They need better care.

So there was a doc in this case who had just done some training in improvement science. Now, she wasn't a Ph.D.; she wasn't an industrial engineer. But she learned enough about mapping process and about working patients – I know that came up earlier – and she, on her own, found a nutritionist, a pharmacist, a nurse, a unit receptionist and a few other folks who had interacted with this person during her prior hospitalization. And she asked them to work with her on coming up with a better system. And she asked the dad to participate in the process.

And she had never done this before, and we had never done this before. And they had decided that they were going to meet weekly and actually try to figure out how to fix this for her and for every other patient. So how did they become experts in cystic fibrosis? They asked this patient and the next ten patients who

came to the hospital to keep a diary of what happened to them. When did they get their antibiotics? When did they get their pancreatic enzymes? When was the first time that they got their respiratory treatment? And what they found was that the mean time to what we would consider the "right care," getting everything on time was 30 hours. It was nobody's fault. It was not any individual's fault. It was that the system of care wasn't designed around patients with cystic fibrosis.

So they kept meeting as a group every week and said, "Well, how can we fix this? We can't change the whole system; we're not at the top, and it's too complex. We can't fix the entire pharmacy system and the antibiotic ordering system and the respiratory therapy system. So they just iterated; they constantly talked and worked and experimented. And eventually, they figured out that they can give the patients full control of their medications because these are patients who are experts in their care. They can work to the regulatory and infection control issues of giving them their own medication box. They can work through the MAR issues of making sure the nurses know what was taken and what wasn't so that the nurses are on board and the docs know what's going on.

And through that process, to this date, they've gone about two years now without any patient not getting to perfect care within two hours. And that tiny little team is still meeting. And when a patient shows up on another unit – they've created a system where the patients are all showing up on the unit because they know how to do this – that team goes to that other unit and educates that other unit on how to provide that perfect care. It is achievable; that's just one example of it. When you break it down into its component parts, it's achievable. And what kept this all going was engagement. They felt an obligation to that patient and to that father to do the right thing. And they're reminded every time they get together.

Now, that patient passed away. Her sister is still alive. And the father has obviously never recovered. But this team is so connected with that family and their experience of care, they'll never give this up. They'll do this for the rest of their careers; and I don't have to worry about it, and it's not on a dashboard anywhere. So think about that when you think about how do we create sustainable change and how do we create engagement in a way that allows the frontline staff to own the problem and feel the rewards of achieving that solution for it?

"If we're going to achieve results never before accomplished, we must expect to employ methods never before attempted." So think about that CF example, and think about how we create an environment where everybody in the organization is liberated to do that kind of work – that kind of experimentation – because the answers are not just in checklists, I can promise you that. If it was – we've all implemented checklists, right? – we wouldn't be having CLAB infections; we wouldn't be having wrong site surgeries. That's just the first part of it.

"We must either find a way or make one." This is one of my favorite quotes from Hannibal. So quality improvement is not about just applying known techniques. It's actually about committing to solving the problem. Those ideas and those techniques are important; they're a roadmap for us. But they're really just the tip. The hard work is actually sitting down every week and figuring out, "How do you embed this into the organization?" And if there is no solution set, you've got to come up with one. Don't wait for somebody else to invent the bundle around emergency room care for patients with neutropenia; it may not be out there. But that may be a problem you have to solve. You've got to come up with that bundle, and you've got to test it.

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"In truth, people can generally make time for what they choose to do. It's not really the time, but the will that is lacking." What do you guys think about that? Or are we all going to go back and say, "You know what: There's just no time for this." We have other priorities, right? A lot of people around us view this as this is competing with all the other responsibilities we have.

Memorial Hermann Healthcare System, which is a very large, very successful system and an incredibly safe system although by no means perfect, they decided that their core value was going to be safety. Not a core value – the core value. And that if they focused on safety, if they communicated it – top-down, side-to-side, bottom-up – that everything else would fall into place because that's teaching the principles of high reliability and how to understand processes and not accepting when people get hurt and taking responsibility and all those things. So this is as much about priority setting as anything else. I think you guys recognize that as much as I do.

"If you can't describe what you're doing as a process, you don't know what you're doing." And this is up there just to remind us that – I suspect that you all agree on this one as well. We don't know how to do this, and I say that humbly. Many of us are just learning the signs of performance improvement. We're learning how to map processes. We're learning how to interpret a run chart and a control chart. Right now in many of our hospitals in our region, there are not just executives but quality management leaders and quality management staff and CMOs and others who are looking at bar charts and misinterpreting data. I guarantee it. And they're chasing common cause variability, and they're stressing people out about random variation; and they're even missing the signal that's hidden in all that noise.

We have to become not Ph.D. scientists, but we have to become facile enough that we don't waste time and waste energy; and we know how to focus on what's important. We've got to know the basics. We have to know it well enough that we have credibility so that we can teach it to others – and I mean everybody. On nuclear submarines, there are 21-year-old kids who are managing to prevent those things from running into underwater volcanos looking at run charts. If they can do it, there isn't a single person in our organizations who can't do that. We just have to get comfortable with the idea that we're not experts yet. We have to become experts, and we have to make sure that everybody else understands the basics of performance improvement.

To me, that's not restricting; that's actually liberating. If we understand that, then we can apply our creativity and our enthusiasm and our will to solving problems. If we don't, we're going to chase things that aren't really broken or we'll pat ourselves on the back for things that aren't really fixed. And we're guilty of both.

"Quality is everybody's responsibility." And I think you guys recognize this. If we think that we can solve this problem without engaging everybody, we don't have a chance in hell. When the environmental services employee walks into a patient's room and sees that the tray table is pushed to the side and the remote control for the TV is on the floor, and it's the third time in a week they've seen that and they know that that creates a risk for that patient in terms of falling because maybe they'll try to get out of bed to get it or they'll trip over it getting out of bed, and pulls the (inaudible) cord and says, "We have a problem here." And everybody participates in solving it so that you don't just keep seeing it. It's not enough to pick it up and put it on the table, but we actually have to decide we're going to solve this problem so nobody

experiences it, that's what it looks like. It doesn't happen very much in health care, but you'll know it when you see. You'll know it when everybody in the entire system – including legal and finance and everything else – understands that this is their responsibility, wherever they find it.

And the last thing is, "The lure of the distant and the difficult is deceptive. The great opportunity is where you are." Just like that cystic fibrosis situation, you don't have to work hard to look for a place to get started. There is more than enough in what we learned about in the PFP Requirements and Mandates to actually get started. And when staff bring you a problem, let them solve it with you. Let them solve the problem that's right in front of them with you because it is right in front of us and it's all around us.

Virginia Mason Hospital – you guys have heard about that, I'm sure. They're a small hospital. Yes, they're different; yes, they're in the Northwest. They've built this into the system; every single person in the hospital is constantly working on two things: doing their job and improving it. And to date, they've done over 900 – call it what you want – Microsystems Lean, Six Sigma, performance improvement – it doesn't have to have a name; it's not complex; it's not rocket science but process-oriented improvements. That hospital went from mediocre to Leapfrog's Hospital of the Decade – highest quality, lowest cost -- the value equation that we're all trying to solve. And the way through that was by involving everybody in the process.

Right now, there's more awareness in the C-Suite about the importance of these things than there ever was before, in my opinion. Transparency, P for P, value – we've all got to get costs down because the revenue model is changing. There's never been a better time to convince people in the organization that this is actually a way through it. This isn't in competition with our other goals; it's actually a way through it – is to embed improvement into everything we do.

That's all I've got. Listen, I'm very excited to have a chance to work with you guys and best of luck.

(inaudible) questions. If not, I just want to say that was an absolute terrific way to end what was, I hope, a very inspiring morning. There are no words that I could say in closing that said it better than you did through your illustrations and your own personal story and your quotes. Kathy and I and all of our speakers today – I want to thank them – but we all wish you well on this journey. We're with you. We will stay at it. Don't ignore those e-mails inviting you to yet another webinar because you may learn something. And bon appetite.