

# LEADERSHIP ENGAGEMENT TOOLKIT



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## OUR JOURNEY

The Department of Defense (DoD) has been on a journey to transform the Military Health System (MHS) to a high reliability organization (HRO). In HROs, the entire workforce shares a single-minded focus on identifying potential problems and high-risk situations before they lead to an adverse event.

## THE MHS HRO MODEL

The MHS has adopted its HRO Guiding Principles.

Leaders engagement - at all levels – is critical to success. Leaders focus their attention on where errors have occurred—in order to learn from these events—and on what could go wrong—in order to prevent future harm events. The Guiding Principles are based on those used by organizations that aim for high reliability and are tailored for the MHS and its journey toward high reliability:

- ▶ First, Do No Harm
- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Reluctance to Simplify
- ▶ Commitment to Resilience
- ▶ Constancy of Purpose
- ▶ Respect for People
- ▶ Fostering a Culture of Safety

Taken individually, each principle may improve elements of the health care delivery system; however, collectively they form the foundation for an HRO, and are critical enablers for the MHS to achieve its strategic goals of the Quadruple Aim— Improved Readiness, Better Care, Better Health, and Lower Cost.

*Appendix A* has a more complete description of the Guiding Principles and examples of associated leading practices.

*Appendix B* offers a more detailed description of the essential elements of an MHS HRO.

Leadership commitment is the keystone to an HRO. Seventy-five to eighty percent of all initiatives that require behavior change fail in the absence of leadership managing that change.<sup>1</sup>

Engaged and committed leadership drives culture change, staff trust, and better processes resulting in zero preventable patient harm.

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<sup>1</sup> McChesney, C., Covey, S., & Huling, J. (2012). *The 4 Disciplines of Execution: Achieving Your Wildly Important Goals (4DX)*. New York City, NY: Free Press.



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## ENGAGEMENT STRATEGIES: EXECUTIVE AND PHYSICIAN LEADERS

### *About These Engagement Strategies*

The MHS is not the first health system to travel this path. We have an opportunity to learn from others.

This compendium of Executive and Physician Leadership Strategies was adapted from The Joint Commission Resources/Hospital Engagement Network “Patient Safety Initiative: Hospital Executive and Leadership Strategies.”<sup>2</sup>

This Leadership Engagement Toolkit constitutes a set of evidence-based tools that have been used successfully in health care settings across the nation.

These strategies can and should be used to meet your local organizational needs. Implementation of the full suite of Engagement Strategies will likely accelerate your transformational change toward high reliability. Implementation demands an investment in training, information, technology, money, time, and effort – and so a sequential approach to implementation is recommended.

The return on this investment is profound. Evidence demonstrates that patient safety programs pay for themselves in direct cost savings, increased patient and family satisfaction, improved staff satisfaction, and ultimately, in the quality of life that is sustained or enhanced through the reduction of harm.<sup>3</sup>

These strategies present best practices in military treatment facilities (MTF) Executive Leadership Strategies (Part 1) and Physician Leadership Strategies (Part 2). The strategies focus on:

- ▶ What are the Practices?
- ▶ Why use the Practices?
- ▶ How to “Instructions for Conducting the Practices”.

There are several guides to the strategies that would enhance the implementation of these strategies at the Service and MTF level. The accompanying “How to Guide” suggests a comprehensive roll-out, communications plan, coaching and mentoring and measures of success.

<sup>2</sup> Note. Adapted from “Patient Safety Initiative: Hospital Executive and Leadership Strategies,” by The Joint Commission Resources Hospital Engagement Network, 2014. Copyright 2014 by The Joint Commission Resources. Adapted with permission.

<sup>3</sup> HHS Press Office. (2014, December 2). Efforts to improve patient safety result in 1.3 million fewer patient harms, 50,000 lives saved and \$12 billion in health spending avoided. Retrieved from <http://www.hhs.gov/news/press/2014pres/12/20141202a.html>.



# PART 1. MTF EXECUTIVE LEADERSHIP STRATEGIES

## INTRODUCTION

### ***Expectations of MHS Leaders***

For the MHS to function as a high reliability organization, there are expectations of its leaders.

These expectations include a relentless commitment to patient safety, zero tolerance of preventable harm, and development of a shared culture of safety throughout the organization. Leaders are expected to incorporate the MHS HRO Guiding Principles (*Appendix A*) into all decision-making processes and messages. Leaders are expected to establish the infrastructure, policies, programs, and staff training necessary to implement and sustain the essential elements of a highly reliable MHS.

These expectations include the following leadership best practices:

- 1. The executive leadership team and all its members are personally involved.*** They fully participate, individually and collectively, in patient safety initiatives, and stay informed of initiatives' progress. Patient safety cannot be delegated; it cannot be isolated to an office, a committee, or individuals, with results simply reported up the chain of command.
- 2. The commitment of leaders is absorbed and reflected throughout the organization – a “culture of safety.”*** Everyone has leadership roles when it comes to safety. A best practice demands participation at all levels—including all levels of leadership, clinical practitioners, and all employees and contract service-providers—in a committed partnership with patients and their families.<sup>4</sup>
- 3. Critical to high reliability is a commitment to achieving zero preventable patient harm through the use of effective process improvement tools.*** Essential to improving the performance of care processes is the systematic learning, adoption and implementation across the organization of proven tools and techniques. Examples include Lean Methodology, an organizational approach to remove waste from the system, and Six Sigma tools that focus on reliability and reducing variation within a system. About 65 percent of sentinel events can be attributed to poor or ineffective communication among health care teams. Thus, a focus on teamwork tools and implementation strategies are critical.
- 4. The hospital and ambulatory leadership teams learn and adopt the best evidence-based practices in patient safety.*** An enormous amount of research, experimentation, learning, and documentation of best practices in patient safety is occurring and easily accessible through webinars, workshops, academic journals, and trade publications. The MHS Patient Safety Analysis Center is here to help curate and communicate external information for the benefit of the entire MHS.

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<sup>4</sup> Reason, J. (2000). Human error: models and management. *British Medical Journal of Quality and Safety*, 320(7237), 768-770.



Go to the Patient Safety Program (PSP) website: <http://www.health.mil/dodpatientsafety> to learn about:

- ▶ The Basic Patient Safety Manager (BPSM) course:  
[Access BPSM course information](#)
- ▶ Toolkits, online courseware, self-study materials, patient safety data summary reports and forums available through the Patient Safety Learning Center (PSLC):  
[Access Patient Safety Learning Center](#)
- ▶ TeamSTEPPS® training, implementation and sustainment:  
[Access TeamSTEPPS® information](#)
- ▶ Webinars and Speaker Series:  
[Access Webinar Series information](#)

To learn more about courses offered through the Joint Medical Executive Skills Institute (JMESI), ongoing coaching and simulation exercises to support Patient Safety/Quality/Process Improvement (PS/Q/PI) scenarios grounded in evidence-based practice, contact the PSP at [patientsafety@dha.mil](mailto:patientsafety@dha.mil)

### ***Safety Leadership Best Practices***

The MTF Best Practices on the following pages have been shown to reliably produce results associated with safe patient care. They emphasize the establishment and use of cross-functional, non-hierarchical, and cohesive teams working together with patients and their family members to provide the safest care possible for each and every patient.

We encourage MTF leaders to carefully consider each best practice: How does a given practice fit into the MTF's existing patient safety structures, strategies, and programs? How might a practice heighten the visibility and sponsorship of existing efforts of the organization's commitment to patient safety?

The best practices are based on recommendations from the National Quality Forum, the Institute for Healthcare Improvement, the Health Research and Education Trust (HRET) of the American Hospital Association, Joint Commission Resources, the Research Division of The Joint Commission, and other notable practitioners, researchers, and institutional leaders in the field of patient safety, such as Paul Batalden, MD (Geisel School of Medicine, Dartmouth Medical School), Allan Frankel, MD (Safe and Reliable Healthcare), and Peter Pronovost, MD and colleagues at Johns Hopkins University.



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## BOARD ENGAGEMENT IN PATIENT SAFETY

*One of the most important interventions for hospital leadership in developing a hospital safety program is to get the hospital's Board involved with safety and quality.<sup>5</sup>*



### What is the Practice?

Establish a standing Board-level committee on patient safety and quality improvement, with goals, metrics, and regular reviews with military treatment facility (MTF) executives. In the Military Health System (MHS), the Board-level committee may be the MTF executive-level committee, for example, the Board of Directors, Executive Steering Committee, etc. At a minimum, this Board would include the Commander, Deputy Commander, Chief Medical Officer, Chief Nursing Officer, Chief Administrative Officer and Senior Enlisted Advisor.

### Why Use the Practice?

- ▶ A clear conceptual understanding of quality and patient safety is essential to board engagement.
- ▶ The Board needs to understand the differences between quality and patient safety and work with the organization on improving both pathways.
- ▶ The Board's commitment to quality and safety reinforces its value as an essential ingredient of the organization's culture.

- ▶ The Board can reinforce safety behavior at all levels.
- ▶ Aligns the Board and the leadership team around the MHS, Service, and MTF strategic goals for patient safety and quality.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
- ▶ Sensitivity to Operations
- ▶ Fostering a Culture of Safety

### Instructions for Conducting the Practice

#### Increase the Board's Quality Literacy

- ✓ Educate the Board on salient patient safety and quality issues.
- ✓ Ensure the Board members are proficient in competencies relative to patient safety (PS), quality (Q), performance management (PM), and performance improvement (PI).
- ✓ Consider adding PS and Q experts to the Board.
- ✓ Use retreats for having in-depth dialogue on quality and safety improvement projects.
- ✓ Have Board members attend PS and Q conferences.
- ✓ Consider adding a Board member who comes from a high reliability organization (HRO) who has executive responsibility for quality in his/her organization.



### Frame an Agenda for Patient Safety and Quality

- ✓ Initiate discussion between the Commander (and Deputy Commander) on the status of PS and Q.
- ✓ Ensure that quality and safety on the Board agenda gets equal billing with other agenda items.

### Engage in Quality Planning and Focus and Provide Incentives

- ✓ Create a vision for PS and Q for the MTF with long-term outcome measures and goals.
- ✓ Ensure the PS and Q measures, which the Board reviews, are assessed regularly and presented in a manner that a non-clinical member can understand.
  - Integrate the measures into the overall Board performance.
- ✓ Additional Guidance:
  - Review the hospital's PS and Q plan and ensure it is aligned with the overall strategic plan.
  - Link performance evaluations of Commanders and Deputy Commanders to PS and Q measures.
- ✓ Implement a feedback loop up and down the chain of command to communicate appropriate information, expectations, gaps, etc.

### Patient-Centeredness

- ✓ Share patient stories at Board meetings to further increase focus on patient-centeredness.
- ✓ Ensure that patients are involved in improvement by having patients participate on improvement committees and projects.
- ✓ Encourage the appointment of at least one patient member to the Board in accordance with established Federal Advisory Committee Act rules.

### For More Information

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<sup>5</sup> Whittinton, J. (2006, July). Key Issues in Developing a Successful Hospital Safety Program. Retrieved from <http://webmm.ahrq.gov/perspective.aspx?perspectiveID=27>.



## SAFETY CULTURE DEBRIEFING

*The Commander, Deputy Commander, Chief Medical Officer, Chief Nursing Officer, Chief Administrative Officer and Senior Enlisted should be directly involved in the application of the knowledge that has been generated through the measurement of culture.<sup>6</sup>*



### What is the Practice?

At least annually, leaders should assess the organization's patient safety (PS) and quality (Q) culture using a survey tool that is selected with consideration of validity, consistency, and reliability in the setting in which it will be applied, and that is conceptualized around domains that are applicable to performance improvement initiatives/efforts such as teamwork, leadership, communication, and openness to reporting. The results of the culture survey process should be documented and disseminated widely across the enterprise in a systematic and frequent manner. The interventions component of this safe practice will be satisfied if the survey findings are documented and have been used to monitor and guide performance improvement interventions.

### Why Use the Practice?

- ▶ Ability to target areas for improvement.
- ▶ Studies show positive correlations between a high culture of safety score with higher staff retention because of higher morale, lower burnout, and less absenteeism.<sup>7</sup>

### High Reliability Guiding Principles include:

- ▶ Sensitivity to Operations
- ▶ Constancy of Purpose
- ▶ Fostering a Culture of Safety
- ▶ Commitment to Resilience

### Instructions for Conducting the Practice

The Military Health System (MHS) uses the Agency for Healthcare Research and Quality Culture Survey every 3-4 years. In alternate years, surveys such as the TeamSTEPPS® Teamwork Perceptions Questionnaire (T-TPQ) are available and look at staff perceptions of patient safety. The T-TPQ looks at domains of leadership, communication, teamwork, and staff comfort in speaking up. See *Appendix C* for the T-TPQ.

Measurement of the culture of safety by itself is not enough. The results must be fed back to the organization to stimulate discussions about areas of weakness and solutions for improvement. Since culture resides at the local level, it is important to discuss the results by departments, units, and roles. Focusing on group-level data depersonalizes the discussion and fosters actionable ideas for improvement in the context of the local realities of care delivery. More than simply a measuring stick, feedback to respondents at the work-unit level can actually be the first step in improving culture. Leadership needs to provide a structure for reviewing the results with frontline caregivers and managers to identify specific areas of concern, and obtain insights and recommendations on how to address the issues.



### To get started on using the survey results:

- ✓ Identify the top 2-3 dimensions and develop action plan themes.
- ✓ Do a comparative analysis of previous results and select one area for improvement.
- ✓ Additional guidance:
  - For action plans, build in defined actions, measures, and lines of accountability. Include a system for leaders to monitor progress toward action plans.
  - Include a system for identifying and mitigating barriers and challenges to progress.
  - Teach frontline leaders how to use the data from the survey, including: 1) seeking staff interpretation of findings, 2) seeking staff solutions to identified issues and problems, and 3) facilitating the creation of staff-built, unit-level work plans based on their ideas for improvement.

### For More Information

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1. Joshi, M., & Hines, S. (2006). Getting the board on board: Engaging hospital boards in quality and patient safety. *The Joint Commission Journal on Quality and Patient Safety*, 32(4), 179-187.
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<sup>6</sup> Note. Adapted from “Safe Practices for Better Healthcare 2006 Update: A Consensus Report,” by the National Quality Forum (NQF). Copyright 2006 by NQF.

<sup>7</sup> Johns Hopkins University. (n.d.). Center for Innovation in Quality Patient Care. Retrieved August, 2015, from Johns Hopkins Medicine: [http://www.hopkinsmedicine.org/innovation\\_quality\\_patient\\_care/areas\\_expertise/improve\\_patient\\_safety/culture/improving.html](http://www.hopkinsmedicine.org/innovation_quality_patient_care/areas_expertise/improve_patient_safety/culture/improving.html)



## SAFETY LEADERSHIP ROUNDS (ALSO KNOWN AS WALKROUNDS™)

*Organizations across the world, to include the Military Health System, are using the WalkRounds program as a mechanism to engage senior leaders in an effort to improve the reliability of care in their organization.<sup>8</sup>*



### What is the Practice?

Safety Leadership Rounds are conducted in patient care departments such as the emergency department, medical-surgical floors, and the operating room, as well as in ancillary departments such as the imaging and laboratory areas, as well as ambulatory clinics. Senior leaders go to the department weekly and conduct informal conversations with staff members about safety issues. Safety Leadership Rounds provide a method for leaders to talk with frontline staff about safety issues in the organization and show their support for safety practices.

### Why Use the Practice?

- ▶ Staff who trust that they can share safety and quality concerns with their leaders, without reprisal, has been demonstrated to contribute to a culture of patient safety, whereas staff who feel intimidated or have been disciplined for speaking up will not become fully engaged in the culture of safety.
- ▶ Demonstrates commitment to safety.
- ▶ Fuels culture for change pertaining to patient safety.

### High Reliability Guiding Principles include:

- ▶ Sensitivity to Operations
  - ▶ Deference to Expertise
  - ▶ Constancy of Purpose
  - ▶ Fostering a Culture of Safety
- ▶ Provides opportunities for senior executives to learn about patient safety.
  - ▶ Identifies opportunities for improving safety.
  - ▶ Establishes trusting relationships and lines of communication about patient safety among employees, executives, and managers.

### Instructions for Conducting the Practice

#### Ground Rules

- ✓ Military treatment facilities (MTFs) should decide whether or not to announce the time and place of Safety Leadership Rounds, and the decision should be agreed to by senior leaders and managers.
  - Senior leaders establish and publish a rounding schedule that includes dates, units to be visited, and approximate times of the visit.
- ✓ Organizations should reassure employees that all information discussed in Safety Leadership Rounds is confidential.
  - A mechanism to address leadership follow-up and feedback on action items received from staff should be established.



## Who Should Conduct Safety Leadership Rounds?

- ✓ All “C-suite” (Senior) Leaders, usually including the Commander, Deputy Commander, Chief Medical Officer (CMO), and Chief Nursing Officer (CNO), Chief Administrative Officer and Senior Enlisted Advisors. Individual leaders should conduct or participate in the rounds at least quarterly, though more frequently is encouraged.
- ✓ Senior leaders should commit to conducting Safety Leadership Rounds at a minimum of once per week and for a minimum of one year, with no cancellations.
  - Leaders need to identify and implement a mechanism to follow-up or give feedback to staff on any issues/actions identified during the rounds process.
- ✓ Members of the senior executive team can rotate for easier scheduling, but every senior leader should perform a Safety Leadership Round every week.
  - The make-up of the rounding leadership team may rotate among the senior leaders so that 2-3 leaders are rounding at a time. Leaders typically spend about 15-20 minutes/unit and visit 2-3 units in one rounding session.
  - Leaders should consider inviting patients and their families to the rounding team.
- ✓ The Institute for Healthcare Improvement (IHI) Patient Safety Leadership WalkRounds™ process and questions (pages 4-5 of the tool) are at Appendix D.

## Sample Questions

- ✓ “Have there been any near misses that almost caused patient harm but didn’t?”
- ✓ “Is there anything we could do to prevent the next adverse event?”
- ✓ “What specific intervention from leadership would make the work you do safer for patients?”
- ✓ “How are you engaging patients and families in their care?”

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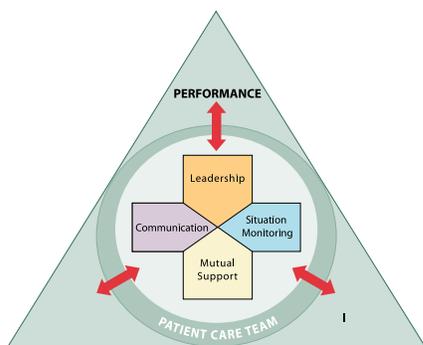
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## TEAMWORK TRAINING AND SKILL BUILDING

*The Commander and senior administrative leaders should be directly involved in ensuring that the organization implements the activities detailed in the specifications of the Teamwork Training and Skill Building safe practice.<sup>9</sup> This includes preparing and determining readiness for a teamwork initiative, training and implementing, and coaching and sustaining any gains.*

*Highly effective frontline teams are a hallmark of all High Reliability Organizations (HROs) and a core mechanism through which the HRO Guiding Principles can be put into practice. These well-trained operational teams repeatedly scan their environments for clues of emerging problems, constantly communicate to share information across team members, and swiftly adapt to changing demands. They continually learn through structured debriefs and real-time collaborative problem-solving, deferring to those with the most expertise regardless of hierarchy. They drive safety culture from the bottom up by maintaining a profound mutual respect and trust, by holding one another accountable for speaking up about identified safety risks, and by quickly adjusting to contain them.*



### What is the Practice?

The Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) program, developed jointly by the United States DoD Patient Safety Program (PSP) and the Agency for Health Care Research and Quality (AHRQ), is a systems approach to teamwork, which includes: 1) Assessment, 2) Training and Implementation, and 3) Coaching and Sustainment.

### Why Use the Practice?

- ▶ Care has become fragmented, necessitating successful team communication to prevent system failures.
- ▶ Organizations are treating sicker patients at ever faster rates with treatments that are becoming increasingly complex.
- ▶ Failure of teamwork and communication has been consistently cited as a primary root cause in approximately 65 percent of sentinel events reported to The Joint Commission.<sup>10</sup> In a systematic review of emergency department closed claims, fundamental teamwork behaviors would have prevented or mitigated the adverse event in 43 percent<sup>11</sup> of reviewed cases.

### High Reliability Guiding Principles include:

- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Constancy of Purpose
- ▶ Fostering a Culture of Safety

- ▶ Research shows that 20 percent of a successful teamwork initiative will come from effective preparation. Approximately 10 percent of success will come from an effective learning intervention (e.g., training), and 70 percent of success will come from identification and mitigation of organizational barriers in order to apply the information into daily practice.

### Instructions for Conducting the Practice

- ✓ Leadership should be actively involved in all aspects of teamwork for a successful initiative that improves patient safety and quality.
- ✓ Leaders should set the expectation and hold staff accountable for staff working as multidisciplinary teams.



- ✓ Leaders should participate in the identification of a change team and physician champion to monitor and ensure implementation of the tools.
- ✓ Leaders should supply resources to develop an implementation plan that includes a review of data, teamwork aims based on the data and opportunities for measurement and evaluation.
- ✓ Leaders should provide opportunities for initial training to all leaders and staff, both clinical and nonclinical. They must sustain a cadre of trainers to ensure ongoing training for staff.
- ✓ Leaders should model the expected behaviors of teamwork.
- ✓ Leaders should model the Guiding Principles of high reliability, for example, “deference to expertise,” rather than hierarchy.
- ✓ Leaders should provide resources to monitor use of the tools throughout the military treatment facility (MTF), as well as to identify and mitigate barriers and challenges, and to impact teamwork on patient safety and quality.
- ✓ Leaders should monitor implementation plan progress and impact on patient safety and quality. This may be done through several mechanisms that include, 1). During Senior Leadership Rounds, discuss implementation of the tools and strategies, impact on patient safety and quality, lessons learned and challenges, 2). During Board Engagement in Patient Safety meetings, discuss progress toward the implementation plan and any impact on patient safety as well as any barriers and challenges to wide-spread implementation and sustainment of the tools and strategies.

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<sup>9</sup> Note. Adapted from “Safe Practices for Better Healthcare 2009 Update: A Consensus Report,” by the National Quality Forum (NQF). Copyright 2009 by NQF.

<sup>10</sup> The Joint Commission. (2013, February 7). Sentinel Event Data - Root Causes by Event Type. The Joint Commission. Retrieved May 10, 2013 from: [http://www.jointcommission.org/Sentinel\\_Event\\_Statistics/](http://www.jointcommission.org/Sentinel_Event_Statistics/).

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## DAILY SAFETY BRIEFING

*“How can any of us be “too busy” to be involved in delivering reliable care to our patients?”<sup>12</sup>*  
*-John Toussaint, CEO, ThedaCare center, Appleton, Wisconsin*



### What is the Practice?

The Daily Safety Leadership Briefing is a 15-minute meeting of the C-Suite Senior Leaders with all department and unit leaders of the organization. The military treatment facility (MTF) Chief Patient Safety and Quality officers should be included. A three-point agenda is used:

1. **Look back:** Significant safety or quality issues from the last 24 hours.
2. **Look ahead:** Anticipated safety or quality issues in the next 24 hours.
3. **Follow-up:** Status reports on issues identified today or days before.

### Why Use the Practice?

- ▶ Shared situational awareness.
- ▶ Heightened risk awareness.
- ▶ Early identification and resolution of problems.
- ▶ Demonstrated staff follow up on issues, assuming that their resolution is well communicated.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
- ▶ Reluctance to Simplify Interpretations
- ▶ Sensitivity to Operations
- ▶ Respect for People
- ▶ Fostering a Culture of Safety

### Instructions for Conducting the Practice

A senior leader facilitates the meeting, typically via conference call or in person. All other senior leaders and all operational leaders participate. The meeting occurs in the morning with an “everyone checks-in” expectation.

When safety-critical issues are identified, the MTF must have a mechanism for tracking issues and their resolution.

The following are examples of questions that the leader can ask during the Daily Safety Briefing to promote a risk-averse mindset and risk-averse actions in others:

- ✓ “What events/issues came up in the last 24 hours?”
- ✓ “What immediate, remedial actions did you take?”
- ✓ “Are events/issues similar to this happening in other departments or units?”
  - “Could events/issues such as this happen in other units or departments?”
- ✓ “What other areas does this issue impact?”



- ✓ What are some possible patient safety and quality issues that may occur in the next 24 hours?
- ✓ What would you do to prevent patient safety and quality issues in the future?
- ✓ “How are you preparing your team for potential issues or events that might occur?”
- ✓ “What error prevention behaviors should be used?”
- ✓ “How was the patient/family involved in the event, or how could their involvement prevent another such occurrence?”
- ✓ “How will we communicate our decisions that we have made today?”

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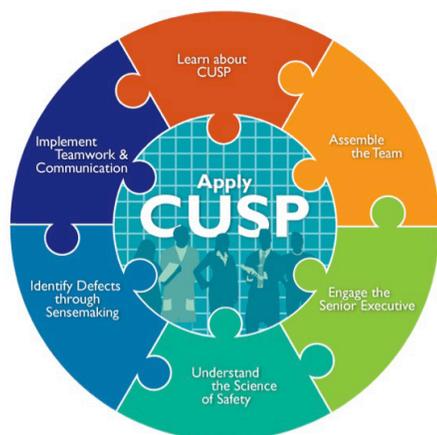
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## SENIOR EXECUTIVE ADOPT-A-WORK UNIT (ALSO KNOWN AS COMPREHENSIVE UNIT-BASED SAFETY PROGRAM [C.U.S.P.]

*The keys to program success are the active role of an executive advocate and staff's willingness to openly discuss safety issues on the units.<sup>13</sup>*



### What is the Practice?

Adopt-a-Work Unit is a five-step program that pairs a hospital executive with a care unit to change the unit's workplace culture—and in so doing brings about significant safety improvements—by empowering staff to assume responsibility for safety in their environment. This is achieved through education, awareness, access to organizational resources, and a toolkit of interventions. Adopt-a-Work Unit works because it recognizes the central importance of culture in sustainable patient safety improvements. Since culture is local, it must be targeted at the unit level, with support at the organizational level.

### Why Use the Practice?

- ▶ Educates and improves awareness about patient safety and quality of care.
- ▶ Empowers staff to take charge and improve safety in their workplace.
- ▶ Creates high-trust partnerships between units and executives to improve organizational culture.
- ▶ Provides resources for unit improvement efforts.

### High Reliability Guiding Principles include:

- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Constancy of Purpose
- ▶ Respect for People
- ▶ Fostering a Culture of Safety

- ▶ Provides tools to investigate and learn from defects.

### Instructions for Conducting the Practice

- ✓ Train and coach staff in the science of safety. Provide this training to all members of a unit (i.e., to anyone who spends more than 60 percent of his/her time working on the unit).
- ✓ Engage staff to identify defects. Ask each staff member to answer a simple, two-question survey: 1) “How is the next patient going to be harmed on this unit?” and 2) “How can we prevent this harm from occurring? Also find potential areas of improvement based on review of incident reports, claims, and sentinel events.
- ✓ Senior executive partnership/safety rounds. Perform monthly safety rounds in which the executive interacts with staff on the unit and discusses safety issues with them. All staff should be invited to attend.
- ✓ Continue to learn from defects. Use the “Learning from Defects” tool to address the top risks identified by the team.
- ✓ Implement tools for improvement. The safety team members highlight several priority areas needing improvement and use the many tools in the public domain to address them.



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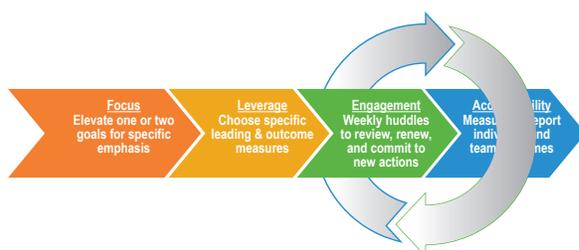
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## EVIDENCE-BASED PRACTICES OF EXECUTION

*The first discipline of execution is to focus your finest effort on one or two goals instead of giving mediocre effort to dozens of goals.<sup>14</sup>*



### High Reliability Guiding Principles include:

- ▶ Reluctance to Simplify Interpretations
- ▶ Sensitivity to Operations
- ▶ First, Do No Harm
- ▶ Commitment to Resilience
- ▶ Fostering a Culture of Safety

### What is the Practice?

Use a disciplined, structured approach for implementing and executing patient safety strategies, including:

- ▶ Focus
- ▶ Leverage
- ▶ Engagement
- ▶ Accountability

### Why Use the Practice?<sup>15</sup>

- ▶ Seventy-five to eighty percent of all initiatives that require people to change behavior, fail.
- ▶ Implementing complex changes requires extraordinary discipline.
- ▶ It enables focused improvement efforts at the unit level to maintain the highest priority and not to get lost in the “whirlwind” of the daily work flow.
- ▶ It enables leaders to assess organizational resources and capabilities to advance performance improvement.

### Instructions for Conducting the Practice

- ✓ Review existing data and information for opportunities to improve and to establish goals. Examples may include, but are not limited to: Hospital Acquired Infections, Readmissions, Falls, Adverse Drug Events, etc.
- ✓ Elevate one or two goals for specific emphasis.
- ✓ Decide on a measurable result and a time for when it is to be achieved.
  - Identify performance improvement models as needed.
  - Investigate all best practice literature and solutions to understand the scope of the issue and gap analysis (For example, if studying Surgical Site Infections (SSI), investigate the national solutions available on The Joint Commission’s Targeted Solutions Tool (TST).)



- ✓ Select the leverage points that will move results toward the goal.
- ✓ Create leading measures of action on the leverage points (e.g. a scoreboard).
- ✓ Ask team members to commit to actions that will move the levers.
- ✓ Hold weekly meetings/huddles with the team to review, renew, and commit to new actions.
  - Identify and share lessons learned, throughout the military treatment facility (MTF), Service, and Military Health System (MHS) as appropriate.

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## PART 2. PHYSICIAN LEADERSHIP STRATEGIES

### INTRODUCTION

Physician engagement and participation are critical elements to any health care delivery organization's efforts to improve the safety of care. While we understand that all clinicians and staff should be considered leaders in patient safety, quality, and process improvement and that most, if not all, of these “physician leadership” strategies would apply to all clinicians, the focus of this toolkit is on physicians. As Taitz, Lee, and Sequist suggested, “most physicians are ill equipped to lead patient safety initiatives, and many physicians struggle to optimally contribute to patient and quality improvement efforts that lead to safer, high quality care for their patients.” Physicians represent leadership in health care and help set the norms for an organization.

As frontline providers, physicians' patterns of behavior and level of engagement influence the views and expectations of nurses and other clinical care providers. Thus, it becomes very important to have them connected to any effort designed to improve clinical care. Without engagement and alignment, variation in care provision cannot be addressed and substantive, lasting improvement cannot be guaranteed.

Physician engagement is one of the more difficult aspects of safety culture to address because of the inherent complexities of the physicians' interactions within a health care organization. Due to the historically autonomous nature of physician practice, it can easily become disassociated from the organization's operational and strategic goals. With this in mind, we often find that the lack of physician involvement in quality endeavors reflects such factors as competing demands, wariness of loss of autonomy to corporate structures, an absence of compensation for participation, and lack of formal training and knowledge in quality improvement work.

### ALIGNMENT WITH ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)

The critical importance and complexity of engaging physicians as leaders for all safety and quality initiatives are reflected in the Accreditation Council for Graduate Medical Education (ACGME) multi-year efforts to restructure physician residency training. In 1999, ACGME released a set of six General Competencies for all physician residents, regardless of specialty. The General Competencies focus on preparing physicians to practice medicine in the increasingly complex health care delivery system and primarily address patient safety and quality improvement skill sets.

In 2009, ACGME began redesigning its accreditation system around educational outcomes based on the six General Competencies. This “Next Accreditation System (NAS),” began phased implementation in 2012 and included: 1) the development of specialty-specific learning milestones as a framework to assess resident and fellow performance and progression within the six General Competencies, and 2) the establishment of the Clinical Learning Environment Review (CLER) Program to assist graduate medical education (GME) training sites in creating optimal clinical learning environments for residents' achievement of the six General Competencies. The CLER Pathways to Excellence consist of a series of measurable activities and expectations designed to engage resident and fellow physicians in learning to provide safe, high quality patient care. The CLER Pathways identify trainee, faculty and facility leadership behaviors, and activities around the



six General Competencies. Implementation of the physician leadership strategies presented in this section will assist Military Health System (MHS) GME sites comply with ACGME accreditation requirements and recommendations by providing an opportunity for 1) Program Directors and faculty to engage in the practices, and 2) Aligning improvement projects and requirement for fellows and residents.

The aim of this set of strategies is to provide organizations with a framework to guide current and future efforts to increase physician engagement, wherein they are working “to reduce unjustifiable variation in care.”(p. 724) We use “working” to refer to the larger picture of physicians as an integral part of the multidisciplinary health care institution. Physicians play an integral role in serving as a de facto source of leadership guidance within the clinical environment. To this end, physicians must 1) play a key and active role in contributing to the establishment of organizational goals and objectives; 2) assume “ownership” of the health care delivery process to ensure favorable outcomes, and 3) demonstrate, through behaviors, their commitment to unit-based and organizational quality and safety objectives.

### **For More Information**

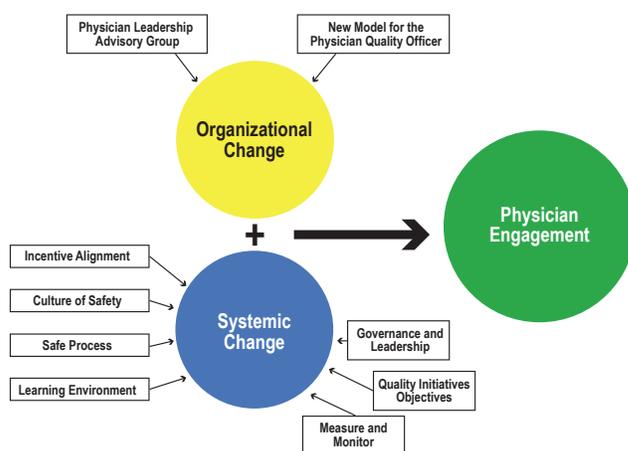
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## THE TWO ELEMENTS OF CREATING CHANGE: ORGANIZATIONAL AND SYSTEMIC COMPONENTS

As illustrated in Figure 1,<sup>16</sup> creating change in the realm of physician engagement for a health care system requires that we focus our efforts not just on organizational change, but on reshaping and developing the systemic elements that can help or hinder physician engagement in quality and safety efforts.

**Figure 1. Organizational and Systemic Components in Physician Engagement**



The **organizational** changes that can be made per Figure 1, include the following:

- ▶ Creating a Physician Leadership Advisory Group.
- ▶ Developing a new model for the Physician Quality Officer.
- ▶ Creating the Physician Compact (a commitment made with each physician) to formalize expectations.

The **systemic changes** that can be made per Figure 1, include the following:

- ▶ *Establishing* a Culture of Safety.
- ▶ *Redefining* the Learning Environment.
- ▶ *Promoting* Governance and Leadership.
- ▶ *Establishing* Quality Initiative Objectives.
- ▶ *Ensuring* Safe Processes.
- ▶ *Maintaining* efforts to Measure and Monitor.

The **expected benefits**<sup>17</sup> of increasing physician engagement: through improved physician engagement in quality and safety, we aim to achieve the following four objectives:

1. **Improve** clinical outcomes.
2. **Reduce** malpractice risk.
3. **Improve** patient satisfaction.
4. **Improve** physician satisfaction and decrease physician burnout.

NOTE: All references to “physicians” includes dentists and other licensed providers.

<sup>16</sup> Birk, S. (2009). Models of physician engagement: community hospital employs physicians to address local needs. Fort Hamilton Hospital establishes a structure to give physicians a clear voice. *Healthcare Executive*, 24(6), 34-6, 38, 40.

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## MEDICAL LEADERS BUILD PATIENT SAFETY STRUCTURES: THE BASICS

*While advances in biomedicine are awesome, progress in patient safety and quality of care has proven slow and arduous. One factor contributing to the labored progress is the paucity of physician leaders who can help advance the science and practice of quality and safety.<sup>18</sup>*



### What is the Practice?

Leadership, including medical staff leaders, ensures the engagement of the physician body as partners with hospital executives and staff in building patient safety structures. These efforts are concurrent with the ongoing development of a safety culture that is designed to identify opportunities for reducing harm. Physicians and licensed providers experience various challenges in working within complex systems, given the many error-prone processes, regardless of the size and type of hospital. In order to advance the science and practice of quality and safety in hospitals, medical staff leaders' engagement and activation in systematic process improvement is critical to success.

### Why Use the Practice?

- ▶ To reduce harm across the patient care experience.
- ▶ To eliminate preventable errors.
- ▶ To create a system of high reliability and patient safety.
- ▶ To create an infrastructure of multispecialty leaders for are responsible and accountable for providing high-quality patient care.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Fostering a Culture of Safety
- ▶ Constancy of Purpose

### Instructions for Conducting the Practice

- ✓ At Headquarters (i.e., Military Health System (MHS) and/or Service):
  - Identify patient safety, quality, and performance improvement competencies for leadership levels.
  - Include aspects of personal commitment to patient safety to reduce harm, professional credibility, quality improvement, knowledge and skills, problem solving prowess, and communication and teamwork skills.
  - Identify current availability of learning opportunities.
  - Identify best practices for physician educational opportunities.
  - Develop and launch learning opportunities for physician leaders.



- ✓ At the military treatment facility (MTF):
  - Appoint a Patient Safety Officer (PSO).
  - Appoint a Chief Medical Officer (CMO) (may be the same as the PSO).
  - Establish budgets for the CMO and PSO offices.
  - Establish clear lines of accountability.
- ✓ Identify lead physician champions for large volume or high risk patient populations (e.g., surgery, anesthesia, orthopedics, cardiovascular, pediatrics, obstetrics, emergency services, general medicine, oncology).
- ✓ Create a Physician Leadership Advisory Group (or equivalent of) composed of lead physician champions, to be facilitated by the CMO. Routine agenda items should consist of:
  - Review of annual patient safety goals.
  - Review of quarterly initiatives/objectives, with alignment of strategic goals and dashboard metrics.
  - Evaluation and assessment of clinical performance.
- ✓ Ensure:
  - Oversight and facilitation of the organization’s agreement with the physician body.
  - Maintenance of organizational rules of engagement and mutual expectations with hospital executives regarding a safety culture and quality improvement initiatives. The engagement compact should include a Code of Conduct emphasizing the promotion of a positive and supportive safety culture, signed by both hospital leadership and physician leaders.
- Creation of a safe venue for reporting concerns.
- Provision of a structured approach to patient safety education for new physicians, dentists, residents, fellows, hospitalists, and medical students.
- Facilitation of transparent reporting and disclosure of data among physician staff.
- Evaluation of physician satisfaction with quality initiatives and the monitoring of outcome data.
- ✓ Educate physicians across the organization in the principles of the science and practice of quality and safety and cost-efficient care, value- versus volume-based reimbursement methods, and unit-based team building methods to ensure a changing mindset for multidisciplinary care providers.
- ✓ Consider re-naming the Mortality and Morbidity (M&M) Conference to the “Patient Safety and Quality Improvement Conference,” reflecting shift in focus from “shame and blame” to “what worked, what did not work, and what will we do differently next time.”
  - Invite multidisciplinary teams to the Patient Safety and Quality Improvement Conference (to be held at least quarterly) for discussion and resolution of issues that are system and communication related.



- Maintain efforts to measure and monitor clinical performance and the prevention of adverse events.
  - Align data to departments and teams to enable tangible connections between their systematic processes and the defined patient safety concerns.
- ✓ Create and/or revamp incentives, as appropriate (MTF-level):
    - Consider performance-based bonus or compensation structure.
  - ✓ Facilitate recognition of successful performance initiatives.
  - ✓ Identify leadership opportunities for successful performance.
  - ✓ Establish a planning process for succession of safety and quality physician champions.

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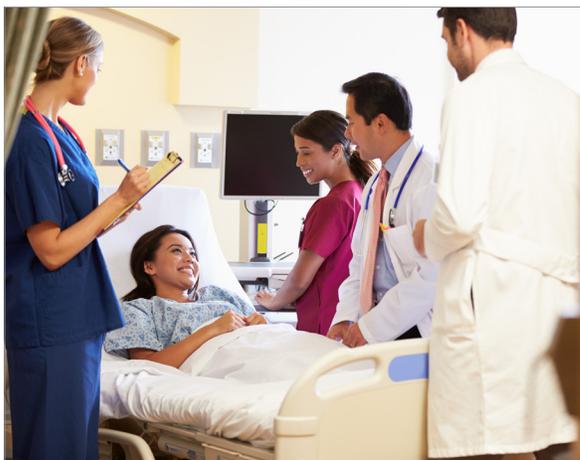
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## IMPROVING PHYSICIAN AND PATIENT COMMUNICATIONS AT THE BEDSIDE

*Common to all such interactions is the desire for trustworthy information (often from an individual clinician) that is attentive, responsive, and tailored to an individual's needs.<sup>19</sup>*



### What is the Practice?

Patients experience many caregivers communicating and providing clinical care throughout their inpatient stay. The benefit of having the multidisciplinary team, including the physician, discuss the care plan for each specific patient at the bedside provides coordinated information for all. This encourages discussion and patient questions for clarity and understanding, representing a tailored approach to meet the individual patient needs. In addition, it improves teamwork and engages both the patient and the family.

### Why Use the Practice?

- ▶ Reinforces a patient's care plan in front of the entire team.
- ▶ Provides a mechanism for other physicians, nurses, pharmacists, and social workers (as appropriate) to confirm and understand, plan, and provide input.
- ▶ Provides a direct mechanism for patient and family engagement in their own care.
- ▶ Links to patient satisfaction survey scores to demonstrate effectiveness.

### High Reliability Guiding Principles include:

- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Respect for People
- ▶ Fostering a Culture of Safety

- ▶ Includes patients and family members in rounding process.
- ▶ Increases communications.

### Instructions for Conducting the Practice

- ✓ A designated person caring for the patient assesses the physician rounding patterns and establishes the time for the team communication.
- ✓ A designated person records the key actions for the care plan documentation.
- ✓ Language uses easily understandable terms; non-English-speaking patients have the appropriate interpretation resources present.
- ✓ Pictures and teaching materials are used (as appropriate) for the topic and needs of the patient.
- ✓ Patients and families are encouraged to ask questions and participate in the discussion.
- ✓ Using teach-back, patients are asked to summarize (if they are capable) what they heard.
- ✓ SBAR (Situation Background Assessment Recommendation) is a technique used for prompt and appropriate communication in the health care organizations.<sup>20</sup>



- ✓ **TEAM UP**<sup>21</sup> (**T**eam Together, **E**ducate Yourself, **A**sk Questions, **M**anage Your Medications, **U**nderstand Changes in Game Plan, **P**rovide Your Perspective) is a simple tool for patients to understand the type of questions and actions they should initiate or ask to improve their health care.

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## PHYSICIAN INVOLVEMENT IN UNIT-BASED HUDDLES

*Patients want to be treated like responsible adults capable of assimilating information, asking informed questions, and having reasonable expectations.<sup>22</sup>*



### What is the Practice?

A multi-disciplinary team huddle is a short, quick, energetic, stand-up planning meeting that is held at least daily in the work area of each team and is facilitated by a team leader. The huddle provides a brief time for quick questions and information sharing within each team. In 15 to 20 minutes, each team member is given the opportunity to receive and share information that is vital to the performance of the team. The patient can be an active participant. Unit-based huddles traditionally focus on the top priorities for a group of patients with each interdisciplinary staff member sharing their updates.

### Why Use the Practice?

- ▶ The multidisciplinary team provides the collective wisdom of all team members focused simultaneously on the needs of the patient.
- ▶ The huddle team may choose to invite the patient to participate in their care.
- ▶ This approach provides a unified approach and assures the patient that the “team” is providing care for them.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Fostering a Culture of Safety

\* The “huddle” in this strategy refers to a multidisciplinary team planning session. In the TeamSTEPPS® language, it is considered a “Brief.” The Patient-Centered Medical Home (PCMH) language refers to “Huddles.” In this context, this would be the unit-based planning. This could be used in the inpatient or ambulatory settings.

### Instructions for Conducting the Practice

- ✓ Ask for the presence of all care team members (for example, physicians, dentists, nurses, technicians, social worker, pharmacy) at a set, regular time.
- ✓ Communicate each member’s role for the patient to understand.
- ✓ Emphasize specific goal(s) and measureable result(s) that are highly relevant to work flow and patient care.
- ✓ Communicate each member’s responsibilities.
- ✓ Create a scorecard or evaluation tool to assess progress.
  - Compare performance between units (or with specific patient populations) to foster teamwork.
- ✓ Use evidence-based best practices to guide the care and treatment plans.
- ✓ Discuss team disagreements privately and not in the presence of the patient as appropriate to the situation.



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## THE ROLE OF PHYSICIAN CHAMPION IN PATIENT SAFETY MEETINGS

*The role of leaders is to define and communicate the purpose of the organization clearly and establish the work of practice teams as being of highest strategic importance. Leaders must be responsible for creating and articulating the organization's vision and goals, listening to the needs and aspirations of those working on the front lines, providing direction, creating incentives for change, aligning and integrating improvement efforts and creating a supportive environment and culture of continuous process improvement that encourage and enable success.<sup>23</sup>*



### What is the Practice?

Physician leaders have a number of different roles in the patient safety meetings (e.g., Quality Councils, Executive Committee of the Medical Staff (eCOMS), Morbidity & Mortality (M&M), etc.). They help identify and prioritize needs, and they can help obtain resources, referrals, and respond to changes in the patient and the environment. Physicians also help to optimize the performance of teams that provide various services with a shared aim to improve the safety and quality of care. In the leadership role, they support and recognize the coordination of work across all services to sustain the improvement.

### Why Use the Practice?

- ▶ The changes in health care are rapid and unrelenting. The leadership of the physician can bring harmony and cohesion to the continuous process improvement efforts.
- ▶ There is an interdependence of multiple roles that physician leadership can influence to achieve measureable results.
- ▶ Physicians support accountability to the individual patients, while also assuming responsibility for leading the team.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
- ▶ Sensitivity to Operations
- ▶ Deference to Expertise
- ▶ Fostering a Culture of Safety

### Instructions for Conducting the Practice

- ✓ Select physician leaders who are positive role models.
  - Specifically seek out local opinion leaders (i.e., practitioners identified as influential by other practitioners).
- ✓ Use a multidisciplinary approach:
  - Encourage physician involvement early.
  - Respect all members of the team.
  - Create a standardized agenda.
  - End each meeting with a '3W Action Plan' (What, Who, When).
- ✓ Discourage "shame and blame" and encourage participation and openness.
- ✓ Focus meetings (M&M, quality improvement, etc.) on system issues and opportunities.



- ✓ Emphasize specific goals and measurable results that are highly relevant and actionable.
  - Incorporate a performance improvement model (e.g., ‘PDSA’ (Plan, Do, Study, Act) cycles to rapidly assess progress and address pitfalls.

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## HARM-REDUCTION ROUNDING CHECKLISTS AND EVIDENCE-BASED GUIDELINES

*A checklist is a type of informational job aid used to reduce failure by compensating for potential limits of human memory and attention. It helps to ensure consistency and completeness in carrying out a task. Evidence-based guidelines use the best available evidence regarding the effectiveness, risks, and cost of a medical procedure before implementing the procedure in clinical practice.<sup>24</sup>*



### What is the Practice?

A harm reduction checklist is a tool to aid caregivers in the review of all important aspects of care. Benjamin Taylor, MD, MPH (University of Alabama, Birmingham) has provided the medical intensive care unit (ICU, or MICU) rounding checklist (*Appendix E*), which he and his colleagues created to address the prevention of patient harm across the board. The Joint Commission Resources Hospital Engagement Network (JCR HEN) adapted this ICU checklist to create a non-ICU checklist (at *Appendix E*) to enable physicians to address the reduction of all-cause harm in other care settings.

Evidence-based guidelines are designed from an examination of current evidence within the paradigm of evidence-based medicine. Clinical guidelines identify, summarize, and evaluate the highest-quality evidence and most current data about prevention, diagnosis and prognosis, therapy (including dosage of medications), risk/benefit, and cost-effectiveness.

### Why Use the Practice?

- ▶ Checklists are built off of risk awareness intelligence. They provide a systematic approach to check the predictable root causes that risk patient safety in order for those risks to reduce harm to the patient.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
  - ▶ Sensitivity to Operations
  - ▶ Deference to Expertise
  - ▶ Fostering a Culture of Safety
- ▶ Guidelines are designed to standardize medical care, increase quality of care, and reduce several kinds of risk (to both the patient and health care provider), and to achieve the best balance between cost and medical parameters.

### Instructions for Conducting the Practice

- ✓ Checklists can be very helpful in the promotion of safety culture, but should be developed carefully with constant feedback from the clinical environment:
  - Consider physicians' daily professional practice requirements and demands for time in balancing other duties.
  - There must be a predefined problem for which the checklist is the right tool and is perceived as being the right tool for solving the problem.
  - Ask: “Are preventable adverse events, such as The Partnership for Patients list of readmissions and nine hospital-acquired conditions (i.e., surgical site infections, ventilator-associated pneumonias, central line-associated bloodstream infections, catheter-associated



urinary infections, pressure ulcers, injury due to falls and immobility, adverse drug events, obstetrical adverse events, and venous thromboembolisms) being prevented in my organization, or are they a consistent issue?”  
If you continue to see harm in each of these areas, this checklist tool might work well for your multidisciplinary teams.

- Stakeholders must have input in the process (and particularly the revision) but quality assurance of the checklist is the responsibility of administration.
  - The checklist must be short and easy to use, with a clear, easy-to-read font.
  - It must be made (or adapted) by the physicians within the organization who will use it.
  - An influential person within the organization should lead the implementation effort.
- ✓ Guidelines that are evidence-based enable physicians to have the best available evidence regarding the effectiveness, risks, and cost of a medical procedure before implementing the procedure in clinical practice. Components are:
- Policies based on clinical evidence.
  - Estimate of the magnitude of treatment options.

- Analysis of recommendations and potential outcomes for treatment.

- ✓ Provide concise, evidence-based best practice pocket guides/reminders for common hospital-acquired conditions.

### For More Information

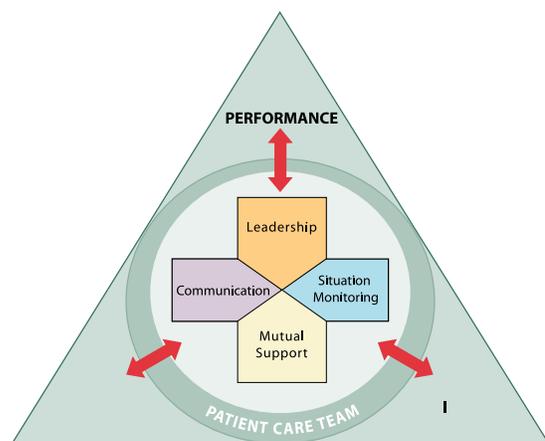
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## MULTIDISCIPLINARY TEAM TRAINING AND SKILL BUILDING

*Teams perform better than collections of individuals. In any situation requiring a real-time combination of multiple skills, experiences, and judgment, teams (as opposed to individuals) create superior performance.<sup>25</sup>*



Highly effective frontline teams are a hallmark of all high reliability organizations (HROs) and a core mechanism through which the HRO Guiding Principles can be put into practice. These well-trained operational teams continually scan their environments for clues of emerging problems, constantly communicate to share information across team members, and swiftly adapt to changing demands. They continually learn through structured debriefs and real-time collaborative problem solving, deferring to those with the most expertise regardless of hierarchy. They drive safety culture from the bottom up by maintaining a profound mutual respect and trust, by holding one another accountable for speaking up about identified safety risks, and by quickly adjusting to contain them.

### What is the Practice?

Successful organizations in a wide variety of industries recognize multidisciplinary teams as the unifying principle for operational excellence. Team interaction is collegial rather than hierarchical. Each team member has an obligation to speak up if a question of safety is apparent. Communication is highly valued. Team decision-making is focused on patient safety as the priority.

### High Reliability Guiding Principles include:

- ▶ Reluctance to Simplify Interpretations
- ▶ Deference to Expertise
- ▶ Respect for People
- ▶ Fostering a Culture of Safety

### Why Use the Practice?

- ▶ The primary purpose of the multidisciplinary team is to achieve consensus with patient safety in the inclusion of expertise from various professionals.
- ▶ Teams are to function as a unit, not individuals, to attain complex patient safety needs.
- ▶ A high degree of involvement and communication among the team members positively influences patient outcomes.

### Instructions for Conducting the Practice

- ✓ Use of existing teamwork training tools (e.g., TeamSTEPPS®).
- ✓ Champion teamwork; create the culture where team members use the tools and role model the tools.
- ✓ Participate in the organizational preparation of teamwork:
  - Participate in the change team and assist in setting the expectation, reviewing data, identifying goals and aims.
  - Participate in multi-disciplinary training and monitor implementation and use of the tools.



- Participate as a coach to identify and mitigate barriers to successful teamwork, evaluate the impact of teamwork on patient safety, quality and performance improvement, and sustain any gains.
- ✓ Institute team-building activities to encourage care providers to work together, improve communication, and reduce errors as a united force rather than group of individuals.
- ✓ Evidence-based
  - Optimizes use of resources.
  - Resolves conflicts and barriers.
- ✓ Communicate goals and message in multiple ways to multiple groups of providers. All are encouraged to participate.
- ✓ Create an atmosphere where:
  - Teams operate in an informal, comfortable, and relaxed atmosphere.
  - Team members feel free to express their opinions.
  - Leadership functions shift depending on the circumstances and needs of the group and skills of the members.
- ✓ Resolve conflicts and improve information sharing.
  - Eliminate barriers to quality and safety.

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## PHYSICIAN LEADERSHIP OF POST-ADVERSE EVENT DEBRIEFS

*An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient. A potential adverse event carries the potential for injury. Many, but not all, adverse events are preventable. Those that are preventable, or those that are preventable and result only in the potential for harm, are considered errors. Thus, errors may or may not result in adverse events, and adverse events may or may not be the result of errors.<sup>26</sup>*



### What is the Practice?

Most errors arise not from the aberrant behaviors of an individual, but rather from systemic and often predictable organizational factors. Physician leaders, along with other members of the multidisciplinary team, are almost always in the best position to assess what went wrong with internal systems and processes following an adverse event. These internal investigations are designed to ask the question, “Why? Why? Why?” in a sequence of complex processes that are examined.

### Why Use the Practice?

- ▶ Adverse events require a multidisciplinary approach when being addressed. Physicians, who represent leadership in the clinical realm, are integral to future efforts to improve the system.
- ▶ Identifying lessons learned from the review of adverse events will create safer environments by limiting the potential for errors within the system.
- ▶ Creating a culture of safety enables staff to feel safe in reporting errors and confident that action will be taken to address the errors and system improvements.

### High Reliability Guiding Principles include:

- ▶ First, Do No Harm
- ▶ Commitment to Resilience
- ▶ Deference to Expertise
- ▶ Fostering a Culture of Safety

### Instructions for Conducting the Practice

- ✓ Conduct the debrief at the earliest possible time after the event is identified. This may be immediately after the event, at the end of the shift, or at the end of the day.
- ✓ Discourage “shame and blame” and encourage reporting of adverse events and errors.
- ✓ Gather and discuss information surrounding the adverse event from multidisciplinary sources using a structured agenda.
- ✓ Focus goals on needs of the patient with system improvements.
  - Identify gaps in performance and patient safety.
- ✓ Allow all team members to discuss process, areas of concern, and recommendations. Describe steps that will be taken to prevent recurrence of adverse event.
- ✓ Consider using components of the TeamSTEPPS® debriefing tool to guide the event.
- ✓ Address “second victim” effects on involved health care providers.<sup>27</sup>



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## MANAGING RESISTANCE

*A major challenge in transitioning to the health care system of the 21st century...is preparing the workforce to acquire new skills and adopt new ways of relating to patients and each other.<sup>28</sup>*



### What is the Practice?

In today's health care setting with advanced technology and expanding knowledge, physicians have less direct control over many of the decisions that affect their patients; they often work in collaboration with scores of staff in support of the clinical effort. This dynamic can cause stress and resistance, which inhibit teamwork and the collective, interdisciplinary efforts necessary to reduce harm and improve patient safety. Education, physician role models, and policies help to build a positive approach.

### Why Use the Practice?

- ▶ Physician contributions toward safe, effective delivery of care can be substantial if effective roles are realized.
- ▶ The priority is for providers to make the right clinical decisions and then execute the diagnostic and treatment plans without delay or error in collaboration with others.
- ▶ The guarantee of safe care involves the quality of the providers involved, the information available to them, and the redesign of systems that support the effort and the ability of the organization to evolve rapidly along with medical knowledge and technology.

### High Reliability Guiding Principles include:

- ▶ Sensitivity to Operations
  - ▶ Reluctance to Simplify
  - ▶ Commitment to Resilience
  - ▶ Fostering a Culture of Safety
- ▶ Creating buy-in for organizational change is difficult, especially for high-level care providers such as physicians, who are used to well-established and autonomous practice patterns.

### Instructions for Conducting the Practice

- ✓ Investigate physician and staff reluctance to change or to be engaged in patient safety initiative.
- ✓ Clarify their perception of facts/reality related to the change.
- ✓ Focus on evidence-based practices and data to support decisions as needed.
- ✓ Provide dedicated support to make it easier for them to participate.
- ✓ Highlight/create incentives.
- ✓ Focus on relationship with peers and team members.
- ✓ Review physician roles and responsibilities at the senior level:
  - What are the expectations at the senior level?
  - What are the goals for physician engagement?
  - What are the measurement data for hospital-acquired conditions?



✓ Use established approaches and tools to enhance teamwork and collaboration and, resolve conflict: A collaborative engagement approach is “Connect and Correct” which allows teams to build trust and address the problem.

- To “Connect” or build trust, a good tool to use is **PEARLA**.
- **Presence**: Focus on the person and the conversation.
- **Empathy**: Consider what is going on for the other person.
- **Acknowledge**: Reflect on what you hear. Acknowledge what matters to him/her.
- **Reflect and Reframe**: Notice his/her response; consider a reframing statement.
- **Listen openly**: Listen to what he/she is saying below the surface.
- **Ask**: Ask questions to clarify and build trust.
- To “Correct” or address the problem and resolve conflict, a good tool to use is **DESC**:
  - **Describe** the behavior and be specific.
  - **Explain** the impact.
  - **Seek** alternatives and agreement.
  - **Clarify** consequences.

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## APPENDIX A. HIGH RELIABILITY ORGANIZATIONS: PRINCIPLES AND EXAMPLE PRACTICE<sup>29</sup>

**Constancy of Purpose (First, Do No Harm): Constant and proactive focus on what can go wrong; using failure and near-failure to gain insight into the strengths and weaknesses of the system.**

### *Practices/Behaviors*

- ▶ All members of the health care team first consider potential risks and benefits of every clinical decision and action and commit to “first do no harm”.
- ▶ Treat any lapse as a symptom that something is wrong with the system that could have severe consequences if separate small errors happen to coincide.
- ▶ Conduct frequent incident reviews; report errors no matter how inconsequential.
- ▶ Elaborate near-miss experiences for lessons learned. Learn from failures and near-failures.
- ▶ Learn from mistakes through swift processing.
- ▶ Establish leadership practices that create a culture of trust, e.g., encourage questioning, reward those who report errors/mistakes.

**Sensitivity to Operations: Constant awareness of leaders and staff about the state of the systems and processes that affect patient care, enabling timely identification of errors and processes for improvement.**

### *Practices/Behaviors*

- ▶ Encourage ongoing concern with the unexpected.
- ▶ Identify and correct holes in the system’s defenses against failures—e.g., imperfections in supervision, reporting of defects, engineered safety procedures, safety training. Establish policies and evidence-based safe practices to enable timely identification of errors and improvement opportunities.
- ▶ Stay attentive to frontline operations. Executive and physician leaders practice strategies to engage frontline such as unit huddles and leadership safety rounds.
- ▶ Establish activities that encourage trust. Refusing to speak up out of fear of punishment creates a system that knows less than necessary to remain effective.
- ▶ Ensure effective frontline team performance by maintaining situational awareness of the “big picture” of current operations. Provide everyone with detailed real time information on what is happening and instruct everyone to be on-call to do whatever the ongoing operation demands.

<sup>29</sup> High Reliability Organization Task Force. (2015, September). The High Reliability Organization Task Force Report: A Resource Guide for Achieving High Reliability in the Military Health System.



- ▶ Communicate, communicate. Integrate frontline team practices that improve communication, e.g., team huddles, pre-procedure briefs, structured handoffs.
- ▶ Promote early identification of problems so actions can be taken before the problems become substantial.

**Deference to Expertise: Listening and responding to system/process experts, regardless of rank, position, or title.**

*Practices/Behaviors*

- ▶ Establish patterns of decision making that “migrate” to expertise.
- ▶ Differentiate between normal, high-tempo, and high-risk/emergency operations and clearly signal in which mode operating:
  - Decisions come from the top when it is “normal.”
  - In high-tempo and high-risk/ emergency situations, push decision making down and around—decisions are made on the frontline and authority migrates to the people with the most expertise, regardless of their rank.
- ▶ Allow decisions to migrate up as well—dependent upon accountability, responsibility, uniqueness of problem, environmental characteristics.
- ▶ Establish clear signals through practices like team huddles and pre-procedure briefs that inform everyone when migration [to expertise] is crucial and when it is not.

Reluctance to Simplify: The avoidance of simplistic explanations for risks or failures and a commitment to delve deeply to understand vulnerabilities, especially when these involve human factors.

*Practices/Behaviors*

- ▶ Avoid simple explanations for failures and near misses. Take deliberate steps to create more complete pictures, to “see more.”
- ▶ Encourage “boundary spanners” who have diverse experience and perspectives. Include physicians and other frontline “operators” in Root Cause Analysis and Failure Modes and Effects Analysis activities.
- ▶ Interact and communicate. Generate hypotheses about what is going on, what can be done, what are long-term system-wide consequences of proposed actions.

**Commitment to Resilience: Ability to maintain or regain a dynamically stable state to continue operations after a major mishap and/or in the presence of continued stress.**

*Practices/Behaviors*

- ▶ Develop capabilities to detect, contain, and bounce back from inevitable errors; be mindful about errors that have already occurred and correct them before they worsen and cause more serious harm; manage the unexpected.
- ▶ Ensure frontline operations personnel have appropriate training and deep knowledge of the



technology, the system, their coworkers, themselves, and resources.

- ▶ Place a premium on operations experts—personnel with deep experience, skills of recombination, and training; when situation outside “normal” boundaries occur, these knowledgeable people self-organize to provide expert problem solving.
- ▶ Mentally simulate worst-case conditions and practice “emergency situation and procedures” drills.
- ▶ Implement frontline teamwork skills and tools to optimize ongoing dynamic situational awareness, problem solving, and adaptation to changing demands.

**Respect for People: Demonstrating courtesy and respect toward everyone, and truly valuing their contributions; also valuing people’s ability to learn, think and solve problems, and challenging them supportively to perform at their peak ability.**

*Practices/Behaviors*

- ▶ Listen to understand and connect with others.
  - Keep your promises.
  - Express gratitude.
  - Walk in their shoes.
- ▶ Speak up.
- ▶ Grow and develop.
- ▶ Be a team player and share information.
- ▶ Build capability around you by coaching and contributing to a learning environment and trusting culture.
- ▶ Actively participate in improving processes and solving problems.
- ▶ Be accountable for the results as well as the processes that achieve them.

**Collective Mindfulness: Sensitivity to the environment; collective mindfulness is a heightened state of involvement or being, at the unit level. Ability of everyone within the organization to consistently focus on that which has the potential to cause harm, recognizing emerging problems earlier, and managing them more decisively before they escalate.**

*Practices/Behaviors*

- ▶ Pre-operatively, people spend time identifying activities they do not want to go wrong.
- ▶ In handoffs or reports to oncoming staff, people discuss what to look out for.
  - People seek alternative perspectives and are encouraged to express different opinions.
  - People feel free to bring up problems and tough issues.
- ▶ People interact often enough to build a clear picture of what is happening here and now.



- People have a good “map” of each other’s talents and skills.
- ▶ People consistently work to improve their competence and develop new response repertoires.
- ▶ People are aware of each other’s unique skills and knowledge and when problems arise take advantage of the unique skills of their colleagues.
- ▶ When a crisis occurs, people rapidly pool their collective expertise to attempt to resolve it; people have access to a variety of resources whenever unexpected surprises crop up.

**Preoccupation with Failure: Constant and proactive focus on what can go wrong, and using failure and near failure to gain insight into the strengths and weaknesses of the system. Encourage reporting of errors, learn from near misses, wary of potential liabilities of success – complacency, temptation reduce margins of safety, drift to auto processing. Helps de-stigmatize failure supporting resilience.**

*Practices/Behaviors*

- ▶ Have a shared attentiveness.
- ▶ Trust one another.
- ▶ Empowerment to frontlines through:
  - Huddles.
  - Brief/Debriefs.
  - Encourages Patient Safety Reporting.
- ▶ Encourage a learning environment to help identify what is working right.



## APPENDIX B. ESSENTIAL ELEMENTS OF A HIGHLY RELIABLE MILITARY HEALTH SYSTEM<sup>30</sup>



### A. LEARNING FROM LEADING PRACTICES IN HIGH RELIABILITY ORGANIZATION (HROs)<sup>31</sup>

From December 2014 to April 2015, the HRO Task Force conducted a literature review and coordinated site visits and briefings from experts in established HROs and high-performing civilian health care organizations moving toward high reliability, as well as from other relevant subject matter experts. The goal was to identify HRO leading practices relevant to the Military Health System (MHS) environment. There is a vast amount of theoretical and empirical information available on the topic of high reliability. The literature review included peer-reviewed articles on high reliability, case studies of how organizations apply high reliability theories and practices to their work, and lessons learned from previous high reliability transformations.

<sup>30</sup> High Reliability Organization Task Force. (2015, September). The High Reliability Organization Task Force Report: A Resource Guide for Achieving High Reliability in the Military Health System.

<sup>31</sup> High Reliability Organization Task Force. (2015, August). The High Reliability Organization Task Force Report: A Resource Guide for Achieving High Reliability in the Military Health System.



Some caveats are in order when reviewing leading practices from civilian HROs. When developing a framework for the MHS to become an HRO, the unique features of the MHS have to be considered. It is a global, comprehensive, integrated, yet federated system that includes combat medical services, peacetime health care delivery that promotes medical readiness and a ready medical Force, public health services, medical education and training, and medical research and development. As one of the largest health care systems in the United States, with total spending of more than \$49 billion in Fiscal Year (FY) 2014,<sup>32</sup> the MHS includes both a direct care component, composed of DoD-operated and staffed health care facilities (military treatment facilities, or MTFs), and a purchased care component operated through TRICARE regional contracts. In FY 2014, through its direct care component DoD operated 56 hospitals, 360 ambulatory care clinics, and 262 dental clinics, employing 67,577 civilians and 86,039 military personnel.<sup>33</sup>

As an organizational entity, the MHS is matchless in that it is structured and operationalized through an extensive array of statutory requirements, instructions, policies, and guidelines of DoD, the Military Departments (or Services, to include Army, Navy [including Marine Corps], Air Force), TRICARE, and the Defense Health Agency (DHA). Moreover, it does not operate on a traditional reimbursement system as found in the civilian sector, and is subject to congressional authorization and appropriation processes that direct its activities and use of resources.

These distinctions are crucial when reviewing the principles and leading practices of other health care systems noted for their high reliability. Nonetheless, much can be learned from how high-performing health care organizations operationalize the principles of high reliability in their daily operations.

## B. ESSENTIAL ELEMENTS TO ACHIEVING HIGH RELIABILITY

### 1. Leadership Commitment to Zero Preventable Harm<sup>34</sup>

Leadership commitment is the keystone to an HRO. In literature reviews and in discussions with industry leaders, the theme of the centrality of leadership commitment to an organization's success as an HRO is a constant thread. It must be the first step and serves as the basis for a culture of safety and continuous process improvement. Leaders must have a shared understanding that the journey to become an HRO may take several years and it must be a top priority of every leader. This commitment must begin at the most senior levels of leadership and be supported by the same level of commitment at all levels of management.<sup>35, 36</sup>

<sup>32</sup> Figures are for FY 2014 as projected that year. See: Department of Defense Health Agency. (2015). Evaluation of the TRICARE Program: Access, Cost, and Quality. Fiscal Year 2015 Report to Congress.

<sup>33</sup> Ibid.

<sup>34</sup> High Reliability Organization Task Force. (2015, August). The High Reliability Organization Task Force Report: A Resource Guide for Achieving High Reliability in the Military Health System.

<sup>35</sup> Chassin, M. R., & Loeb, J. M. (2011). The Ongoing Quality Improvement Journey: Next Stop, High Reliability. *Health Affairs*, 30(4), 559-568. Retrieved from <http://dx.doi.org/10.1377/hlthaff.2011.0076>

<sup>36</sup> Frankel, A. S., Leonard, M. W., & Denham, C. R. (2006). Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability. *Health Services Research*, 41(4 Pt 2), 1690-1709. Retrieved from <http://dx.doi.org/10.1111/j.1475-6773.2006.00572.x>



Engaged and committed leadership leads to organizational culture change, acceptance of HRO principles, increased frontline staff trust in leadership and HRO processes, and achieving zero preventable harm. Frontline trust is the ultimate arbiter of success in leader commitment and culture change. Zero preventable harm is the ultimate indicator for a successful journey to an HRO.<sup>37</sup>

## 2. Establishing a Culture of Safety

The U.S. Agency for Healthcare Research and Quality (AHRQ) defines a safety culture in the following way:

“The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.”<sup>38</sup>

The Joint Commission (TJC) officers Chassin and Loeb described specific initiatives that health care organizations can take to reduce errors and improve patient safety in a highly reliable fashion.<sup>39</sup> Key components of these efforts include commitment of organizational leadership to patient safety and a goal of zero harm, development of a functional culture of safety throughout the organization, and widespread deployment of process improvement tools.

In a mature HRO, safety is not only everyone’s business; it is everyone’s first priority. In an HRO, “Workers exhibit enough trust in their peers and the organization’s management that they routinely recognize and report errors and unsafe conditions. This trust is established when the organization eliminates intimidating behavior that suppresses reporting, acts in a timely way to fix the problems reported by workers, and communicates these improvements consistently to the individuals who reported the problem in the first place.”<sup>40</sup> Commanders and leaders set the tone for a culture of safety for both patients and staff, and commit to improvement, with a goal of zero harm.

## 3. Continuous Process Improvement

Process and performance improvement are the systematic approaches used by organizations to eliminate both actual and potential access, safety, and quality events and help guide organizations in the development of effective solutions. Robust process and performance improvement practiced by every member of the team at every level enables health care organizations to avoid common failures. Effective programs are data driven and rely on accurate reporting and analysis of events. Practicing high reliability science enhances an organization’s capacity to create near fail-safe processes.

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<sup>37</sup> Chassin and Loeb, op. cit.

<sup>38</sup> Organizing for Safety: Third Report of the ACSNI (Advisory Committee on the Safety of Nuclear Installations) Study Group on Human Factors. Health and Safety Commission (of Great Britain). Sudbury, England: HSE Books, 1993. Available at: <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult1.html>

<sup>39</sup> Chassin and Loeb, op. cit.

<sup>40</sup> Ibid.



In addition, change management is a systemic approach that must be used alongside process and performance improvement to help an organization accept, implement, and sustain improvement. Effectively integrating the use of process improvement tools and change management into daily practice equips the organization to eliminate harm to those served and improve their care experience.

#### 4. Patient-Centered Culture, Transparency, and Patient Engagement

Patient-centeredness is a leading practice among highly reliable health care organizations. Effective care is generally defined by or in consultation with patients rather than by tools or standards established and used by providers only. Research by Bechtel and Ness suggests that a truly patient-centered health care system “must be designed to incorporate features that matter to patients—including ‘whole person’ care, comprehensive communication and coordination, patient support and empowerment, and ready access. Without these features, and without consumer input into the design, ongoing practice, and evaluation of new models, patients may reject new approaches such as medical homes and accountable care organizations.”<sup>41</sup> A patient-centered culture is also foundational to the MHS Quadruple Aim.

The MHS Review cited the importance of transparency and the Secretary of Defense endorsed the MHS Review recommendations regarding transparency in his October 1, 2014 memorandum. The Transparency Initiative Group was created to develop a framework for MHS transparency in four domains: clinician-to-clinician, clinician-to-patient, with the public, and through national and regional collaboratives. It is also tasked to (1) implement the Secretary’s request to make all currently available aggregate statistical quality, patient safety, and access data at the military treatment facility (MTF) level available on health.mil, and (2) identify measures for public reporting of quality, patient safety and access data, based on input from several sources. The Transparency Initiative Group is pursuing avenues to increase patient engagement at the enterprise level to heighten awareness of existing public information and to engage beneficiaries to further inform DoD transparency initiatives.

#### 5. Putting the Guiding Principles into Practice through Teamwork

Highly effective frontline teams are a hallmark of all HROs and a core mechanism through which the HRO guiding principles can be put into practice. These well-trained operational teams continually scan their environments for clues of emerging problems, constantly communicate to share information across team members, and swiftly adapt to changing demands. They continually learn through structured debriefs and real-time collaborative problem solving, deferring to those with the most expertise regardless of hierarchy. They drive safety culture from the bottom up by maintaining profound mutual respect and trust and holding one another accountable for speaking up about identified safety risks and quickly adjusting to contain them.

#### 6. Common Knowledge Base

The Task Force focused on defining and standardizing a comprehensive approach to learning within the MHS. Informed by the literature on high reliability, and complemented by numerous site visits, external partners, reviewers, and consultations with organizations that have achieved recognition as HROs, the Task Force learned that a common characteristic of these organizations is the establishment and nurturing of an organization-wide culture of continuous learning. DoD’s

<sup>41</sup> Bechtel C, Ness DL. (2010) If you build it, will they come? Designing truly patient-centered health care. *Health Aff (Millwood)*. 2010 May; 29 (50): 914-20. doi: 10.1377/hlthaff.2010.0305.



ongoing commitment and growth of the MHS as a learning organization will require: (1) markedly expanding a cadre of clinical experts/leaders in patient safety/quality/ process improvement (PS/Q/PI); (2) preparing the entire clinical workforce with the knowledge and skills required to implement high reliability, safety, and quality science at the frontlines of patient care; and (3) developing visionary, innovative leaders with the attributes and skills necessary to foster a learning culture.

## 7. Assessment Strategies

Transformation to an HRO requires that the MHS implement measurement strategies to assess progress toward high reliability as well as provide leaders and frontline staff with actionable information to drive continued advancement. To facilitate improvements, assessments must measure not only the desired end-results of high reliability but also the supporting structures and behaviors believed to be necessary to produce those results. To ensure a coordinated and comprehensive approach to improvements, HRO measures should also align with and facilitate the success of strategies and products adopted by the organization.

## 8. Organizational Enablers for Appropriate and Supportive Infrastructure

The central tenets and practices of high reliability require a supportive organizational environment in order to deliver their expected benefit. The following subsections briefly address basic framework and infrastructure issues central to promoting high reliability: organizational structure and governance; physical infrastructure such as information technology and facilities (to include logistics); the role of strategic communications in permeating high reliability throughout the enterprise; and the importance of forming and retaining strategic partnerships.

### a. Organizational Structure and Governance

Each of the organizations the Task Force studied developed an organizational structure that evolved over time to support their enterprise-level efforts. Each had a responsive and responsible organizational structure for decision making and oversight, and their structure clearly empowered members of their organizations to take actions or develop plans to eliminate harm and improve reliability. In addition, these successful organizations fostered synchronized collaboration and communication among groups and bidirectional information flow from the most senior leaders to the frontline staff. The MHS leadership has recognized the importance of a streamlined organizational structure and governance and the need for improvement within the MHS. As a first step, in his January 16, 2015 memorandum “Military Health System Governance Organization Registration Process,” the Assistant Secretary of Defense for Health Affairs (ASD/HA) directed that all groups provide copies of their charters within 60 days. As well, the MHS has several ongoing efforts to review and revise the roles and responsibilities of the highest-level MHS groups (i.e., those with Flag or General Officer members), and to streamline all committees and work groups to enhance the effectiveness of the MHS Governance structure.



## b. Health Care Information Technology

Multiple experts identified health information technology (HIT) as one of the critical components of a high-performing health care organization.<sup>42,43</sup> High-performing health care organizations have integrated medical devices with their electronic health record (EHR) and with other devices in order to provide staff with more complete, synchronized information about a patient's condition, enabling early awareness of potential risks.<sup>44</sup> HIT systems also improve the ability to present data and provide analytical assessment of information that enables staff to identify process improvement opportunities, monitor the impact of initiatives and pilot programs, sustain new processes through automation, and share these processes with others. Additionally, as patients become more likely to leverage digital platforms for communication and visit locations that support digital platforms, online appointing, and virtualized care, a robust HIT capability can support the migration of patient-centered care to participatory medicine.

The MHS recently announced the award for a next-generation EHR, led by the Defense Healthcare Management System Modernization (DHMSM) Program Office. Deployment of the new EHR should begin in Calendar Year 2016 and be completed no later than Calendar Year 2022. Once fully deployed, the modernized EHR will eliminate many of the risks created by having separate inpatient and outpatient EHRs. However, the experience of other large health care systems has shown that deploying a new EHR requires a significant organizational commitment and transformation, with well-documented risks during the transition period. Simultaneously deploying a new enterprise EHR and committing to transforming how care is delivered within the organization can create both opportunities and challenges. Successfully synchronizing these two enterprise-wide change efforts will enable faster improvements and mitigate the risks of deploying a new EHR.

## c. Health Care Facilities

Although health care delivery is rapidly evolving to leverage virtual options such as patient portals and asynchronous communication, the majority of MHS direct care will continue to be delivered in dedicated MTFs for the foreseeable future. Because of the well-documented impact of the built environment on the quality, safety, and efficacy of care<sup>45,46</sup> and on the attitudes and

<sup>42</sup> Porter, M.E., & Lee, T.H. (2013). The strategy that will fix healthcare. *Harvard Business Review*, 91(10): 50-70.

<sup>43</sup> Glickman, S.W., Baggett, K.A., Krubert, C.G., Peterson, E.D., Schulman, K.A. (2007). Promoting quality: The healthcare organization from a management perspective. *International Journal for Quality in Health Care*, 19(6) 341-348.

<sup>44</sup> Karsh, B.T. (2004). Beyond usability: Designing effective technology implementation systems to promote patient safety. *Quality and Safety in Health Care*, 13(5): 388-394. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743880/pdf/v013p00388.pdf>.

<sup>45</sup> Ulrich, R.S., Zimring, C., Zhu, X., et al. (2008). A review of the research literature on evidence-based healthcare design. *Health Environ Res Des*, 1:61-125.

<sup>46</sup> Ulrich, R., Quan, X., Zimring, C., Anjali, J., Choudhary, R. (2004). The role of the physical environment in the hospital of the 21st century: A once-in-a-lifetime opportunity. Designing the 21st Century Hospital Project. Retrieved from: [https://www.healthdesign.org/sites/default/files/Role%20Physical%20Environ%20in%20the%2021st%20Century%20Hospital\\_0.pdf](https://www.healthdesign.org/sites/default/files/Role%20Physical%20Environ%20in%20the%2021st%20Century%20Hospital_0.pdf)



morale of staff, patients, and visitors,<sup>47,48</sup> facilities and the built environment are an enabler of improved reliability and performance for the MHS. Health care organizations that have achieved the highest levels of quality and safety use clear standards, standard workflows, and standard workspace design to help minimize risks when medical personnel work in multiple facilities.

DHA's Facilities Shared Services (FSS) is a jointly staffed, multidisciplinary, shared service supporting Army, Navy, Air Force, and DHA facilities requirements. DHA FSS personnel collaborate with clinical and operational experts both within and outside the MHS to ensure that DoD medical facilities reflect leading practices with respect to their planning, design, construction, and operation. The DHA FSS maintains and employs a comprehensive set of guidance documents that serves as the criteria to shape new MHS facilities. This guidance includes criteria that govern space and equipment planning, standard room templates, and detailed technical criteria.

The current overarching guidance for construction of MTFs followed by the MHS was provided in Section 2714 of the Fiscal Year 2010 National Defense Authorization Act, which cited the May 2009 report of the Defense Health Board as the source that defined a "World Class Military Medical Facility." This report established the principles used by the FSS, in the design of MTFs that support the unique needs of military personnel and their families.<sup>49</sup> The standards for renovations and new construction include evidence-based design (EBD) and industry leading practices, which revolve around six domains for a World-Class Medical Facility: Basic Infrastructure, Leadership and Culture, Processes of Care, Performance, Knowledge Management, and Community and Social Responsibility.

As the MHS transforms how it delivers health care delivery and increases transparency, it will be important for facility experts to systematically engage with clinical and operational leaders from within and outside the MHS, as well as patients and families.

#### **d. Strategic Communications**

Communication across the MHS enterprise to achieve success in the adoption of the HRO guiding principles will require extensive efforts. The transformation toward becoming an HRO represents a fundamental change in the approach to day-to-day performance for every member of the organization, from the most senior executive leaders to frontline health care providers to administrative staff and patients. Moving toward high reliability means that every member of the MHS will center his or her efforts on service to the patient, with a goal of zero harm through behaviors such as alerting to potential problems before they occur and

<sup>47</sup> Hamilton, D.K., Orr, R.D., & Raboin, W.E. (2008). Organizational transformation: A model for joint optimization of culture change and evidence-based design. *Health Environments Research and Design Journal*, 1:40-60.

<sup>48</sup> Kizer, K.W. (2010). What is a world-class medical facility? (2010). *American Journal of Medical Quality*, 2:154-156.

<sup>49</sup> Department of Defense. Military Health System. World-Class Facilities. Retrieved from: <https://home.facilities.health.mil/knowledge-center-topic-areas-introduction-to-world-class>



employing standard work practices to reduce undesired variability across the system. Strategic communications are critical to increasing stakeholder awareness and understanding, eventually leading to acceptance and ultimately ownership as individual behaviors change to support the desired culture. A strategic communications framework is necessary to support ongoing communication for all initiatives in addition to the deployment of change management strategies across the enterprise. The use of communications tools and tactics along with targeted change management approaches informed by stakeholder and communications analyses can be a driving force in support of this effort.

While the HRO vision exists across the enterprise, it is also critical to acknowledge the unique cultures and approaches to change within each Service and the DHA. Each of these entities has its own independent communications operation and will tailor communications approaches as deemed appropriate.

#### **e. Strategic Partnerships**

The MHS Review contained several action items that called for the establishment of strategic partnerships to assist the MHS in improving patient safety, quality care, and access. MHS Governance has embarked on a process to establish initial partnerships with the National Academy of Medicine (formerly the Institute of Medicine) to join its Roundtable on Value & Science-Driven Healthcare. In the work to develop initial near-term partnerships, MHS Governance approved notional guidance for the strategic development effort. This guidance outlines that a strategic partnership is a relationship that supports one or more MHS objectives through learning, knowledge sharing, skills development, and enhanced problem solving. Strategic partnerships have the potential to affect system-wide performance improvement and/or catalyze transformative change. Strategic partnerships also allow the MHS to share and learn from established leaders in areas of importance to the MHS—a partner does not have to look like the MHS to be valuable to the MHS. These partnerships provide additional tools and options to support Service-specific initiatives at the enterprise, MTF, or clinic level. Many of the tools and current partnerships established by the Services that are being considered at the MHS level will provide enhanced capabilities and improve capacity for inter-Service collaboration.

### **9. Enabling Improved MHS Patient Safety and Quality through the Purchased Care Component**

The MHS Review found disparities in the availability of safety and quality data in both the direct and purchased care components.<sup>50</sup> More than 65 percent of MHS health care dollars are spent on purchased care, with beneficiaries often shifting back and forth between the two components. Thus it is critical that the MHS remain committed to improving performance in both the direct and purchased care components. During summer 2014, the TRICARE Regional Offices (TROs) developed recommendations to strengthen existing monitoring of clinical quality and patient safety within purchased care. They reviewed current requirements, determined gaps, and developed improvements/enhancements to the requirements for consideration in future contracts to place appropriate emphasis on the importance of patient safety and quality of care. These contractual considerations—along with opportunities for the MHS to align with the Centers for Medicare & Medicaid Services and the Office of Personnel Management on payment reforms that focus on value rather than volume—will help assure that all MHS beneficiaries receive highly reliable care, regardless of where that care is received.

<sup>50</sup> Department of Defense. (2014). Military Health System Review: Final Report to the Secretary of Defense. Retrieved from: [http://www.defense.gov/Portals/1/Documents/pubs/140930\\_MHS\\_Review\\_Final\\_Report\\_Main\\_Body.pdf](http://www.defense.gov/Portals/1/Documents/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf)



## APPENDIX C. TeamSTEPS® TEAMWORK PERCEPTIONS QUESTIONNAIRE (T-TPQ)

**Instructions:** Please complete the following questionnaire by placing a check mark [✓] in the box that corresponds to your level of agreement from Strongly Agree to Strongly Disagree. Please answer every question and select only one response for each question. The questionnaire is anonymous, so please do not put your name or any other identifying information on the questionnaire.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Team Structure						
1.	The skills of staff overlap sufficiently so that work can be shared when necessary.					
2.	Staff are held accountable for their actions.					
3.	Staff within my unit share information that enables timely decision making by the direct patient care team.					
4.	My unit makes efficient use of resources (e.g., staff supplies, equipment, information).					
5.	Staff understand their roles and responsibilities.					
6.	My unit has clearly articulated goals.					
7.	My unit operates at a high level of efficiency.					
8.	My supervisor/manager considers staff input when making decisions about patient care.					
9.	My supervisor/manager provides opportunities to discuss the unit's performance after an event.					
10.	My supervisor/manager takes time to meet with staff to develop a plan for patient care.					
11.	My supervisor/manager ensures that adequate resources (e.g., staff, supplies, equipment, information) are available.					
12.	My supervisor/manager resolves conflicts successfully.					
13.	My supervisor/manager models appropriate team behavior.					
14.	My supervisor/manager ensures that staff are aware of any situations or changes that may affect patient care.					

PLEASE CONTINUE TO THE NEXT PAGE →



		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
<b>Situation Monitoring</b>						
15.	Staff effectively anticipate each other's needs.					
16.	Staff monitor each other's performance.					
17.	Staff exchange relevant information as it becomes available.					
18.	Staff continuously scan the environment for important information.					
19.	Staff share information regarding potential complications (e.g., patient changes, bed availability).					
20.	Staff meets to reevaluate patient care goals when aspects of the situation have changed.					
21.	Staff correct each other's mistakes to ensure that procedures are followed properly.					
<b>Mutual Support</b>						
22.	Staff assist fellow staff during high workload.					
23.	Staff request assistance from fellow staff when they feel overwhelmed.					
24.	Staff caution each other about potentially dangerous situations.					
25.	Feedback between staff is delivered in a way that promotes positive interactions and future change.					
26.	Staff advocate for patients even when their opinion conflicts with that of a senior member of the unit.					
27.	When staff have a concern about patient safety, they challenge others until they are sure the concern has been heard.					
28.	Staff resolve their conflicts, even when the conflicts have become personal.					
<b>Communication</b>						
29.	Information regarding patient care is explained to patients and their families in lay terms					
30.	Staff relay relevant information in a timely manner					
31.	When communicating with patients, staff allow enough time for questions					
32.	Staff use common terminology when communicating with each other					
33.	Staff verbally verify information that they receive from one another					
34.	Staff follow a standardized method of sharing information when handing off patients					
35.	Staff seek information from all available sources					



## APPENDIX D. INSTITUTE FOR HEALTHCARE IMPROVEMENT (IHI) LEADERSHIP WALKROUNDS™ TOOL

For complete tool, go to:

<https://www2.aap.org/visit/Walkrounds.pdf>

## APPENDIX E. HARM ACROSS THE BOARD REDUCTION CHECKLISTS<sup>51</sup>

**Figure 1. Harm Across the Board Reduction: ICU Rounding Checklist**

Rounding Physician: \_\_\_\_\_ Date: \_\_\_\_\_

**Purpose:** To eliminate patient harm that is preventable. This tool will be designed by physicians within hospitals to reflect their priorities for harm reduction during daily rounds with the multidisciplinary team within their service specific area.

Category	Checklist Options	Notes Action
<b>Infection Prevention</b>	<ul style="list-style-type: none"> <li>▶ Antimicrobials—day number, stop date, bug and sensitivities</li> <li>▶ Central venous lines (C.V.L.s):               <ul style="list-style-type: none"> <li>– Central venous line #1 Proper insertion? Can it be removed?</li> <li>– Central venous line #2 Proper insertion? Can it be removed?</li> </ul> </li> <li>▶ Foley catheter? Can it be removed? (Do not leave in just to monitor urine output in a patient who can void)</li> </ul>	
<b>Medication Safety</b>	<ul style="list-style-type: none"> <li>▶ Review medication list—needs?</li> <li>▶ Steroids—taper or stop?</li> <li>▶ D.V.T. prophylaxis for everyone; ulcer—for patients with mechanical ventilation, sepsis, burns, and head injury/stroke</li> <li>▶ Vaccines – Flu or Pneumococcal?</li> <li>▶ Sedation Needs – Discontinue?</li> </ul>	
<b>Bedside Safety</b>	<ul style="list-style-type: none"> <li>▶ Pressure Ulcer Assessment and status?</li> <li>▶ Fall prevention measures in place</li> <li>▶ Physical Therapy, Ambulation?</li> </ul>	
<b>Physiologic Safety</b>	<ul style="list-style-type: none"> <li>▶ Vital Sign Stability – Shock Work up?</li> <li>▶ Ventilated patient—H.O.B. elevated 30 degrees? Awaken today? Spontaneous breathing trial today?</li> <li>▶ If A.R.D.S. patient, is V.T. 6 mL/kg ideal wt (5 ft tall 50 kg, 6 ft tall 75 kg scaling linearly) and is Ppl 30 cm H2O or less.</li> <li>▶ Day number of intubation? Have we started nutrition and are we at tube feeding goal?</li> <li>▶ Glucose control less than 180 mg/dl?</li> <li>▶ Code Status Addressed?</li> </ul>	
<b>Preparation for Hand-Off to Next Care Setting</b>	<ul style="list-style-type: none"> <li>▶ Transfer Plan?</li> <li>▶ Care team in place for handoff?</li> <li>▶ L.T.A.C. candidate?</li> </ul>	

<sup>51</sup> Provided courtesy of Benjamin Taylor, MD, MPH, Assistant Professor, and Chief Quality and Patient Safety Officer, University Hospital, University of Alabama at Birmingham School of Medicine. The checklist may be adapted for use with acknowledgement.



**Figure 2. Harm Across the Board Reduction: Non-ICU Rounding Checklist<sup>52</sup>**

Rounding Physician: \_\_\_\_\_ Date: \_\_\_\_\_

**Purpose:** To eliminate patient harm that is preventable. This tool will be designed by physicians within hospitals to reflect their priorities for harm reduction during daily rounds with the multidisciplinary team within their service specific area.

Category	Checklist Options	Notes Action
<b>Infection Prevention</b>	<ul style="list-style-type: none"> <li>▶ Antimicrobials—day number, stop date, bug and sensitivities</li> <li>▶ Central lines:                             <ul style="list-style-type: none"> <li>– Central venous line #1 Proper insertion? Peripheral I.V.? Can it be removed?</li> <li>– Hemodialysis shunt care?</li> </ul> </li> <li>▶ Foley catheter? Can it be removed? (Do not leave in just to monitor urine output in a patient who can void)</li> </ul>	
<b>Medication Safety</b>	<ul style="list-style-type: none"> <li>▶ Review prophylaxis list—needs?</li> <li>▶ Antibiotics: Check ID/susceptibilities, Day number? Stop date?</li> <li>▶ Steroids—taper or stop?</li> <li>▶ Prophylaxis—V.T.E. risk assessment for everyone</li> <li>▶ Mechanical versus pharmaceutical prophylaxis?</li> <li>▶ Ulcer—for patients with mechanical ventilation, sepsis, burns, and head</li> <li>▶ Vaccines—Flu or Pneumococcal?</li> <li>▶ Sedation Needs—Discontinue?</li> </ul>	
<b>Bedside Safety</b>	<ul style="list-style-type: none"> <li>▶ Pressure Ulcer Assessment and status?</li> <li>▶ Fall prevention measures in place</li> <li>▶ Physical Therapy, Ambulation?</li> </ul>	
<b>Physiologic Safety</b>	<ul style="list-style-type: none"> <li>▶ Vital Sign Stability past 24 hours: If S.B.P. &lt; 90, M.A.P. &lt; 65, or H.R. &gt; 130, shock workup been considered?</li> <li>▶ Have we started nutrition and are we at tube feeding goal?</li> <li>▶ Glucose control less than 180 mg/dl?</li> <li>▶ Code Status Addressed?</li> </ul>	
<b>Preparation for Hand-Off to Next Care Setting</b>	<ul style="list-style-type: none"> <li>▶ Transfer Plan? Family Updates? Discharge Date?</li> <li>▶ Readmission Risk?</li> <li>▶ Patient and Family Education?</li> <li>▶ Care team in place for hand off?</li> <li>▶ Primary Care Provider? Follow up appointment?</li> <li>▶ Special Equipment Needs?</li> <li>▶ Home Health, Skilled Nursing or L.T.A.C. candidate?</li> </ul>	

<sup>52</sup> Adapted by Joint Commission Resources from “ICU Rounding Checklist” (Figure 1, page 26).



## APPENDIX F. HOW TO GUIDE

### INTRODUCTION

#### PURPOSE

This How to Guide supplements the Leadership Engagement Toolkit (Engagement Strategies) resource. It was designed to assist military treatment facility (MTF) leaders in structuring their organizations for successful implementation, sustainment, and impact of the Engagement Strategies.

#### LEADING CHANGE

The Engagement Strategies are evidence-based leadership practices intended to facilitate and accelerate organizational transformation toward a culture of safety and high reliability. More than 70 percent of all major transformation efforts falter because organizations fail to take a consistent holistic approach to change and to engage their workforce effectively.<sup>53</sup> MTF leaders can substantially increase the likelihood of successful adoption, sustainment, and impact of the Engagement Strategies by implementing them within the context of a structured change management approach. John Kotter's 8-Step Process for Leading Change is one commonly used and highly regarded model for accelerating transformational change. Grounded in years of research and internationally recognized as seminal work in the field of change management, the 8-Step Process provides leaders a practical approach for inspiring and creating sustainable change at all levels of their organization. (Table 1)

**Table 1. Kotter's 8-Step Process for Leading Change (Accelerate's, 2014)<sup>54</sup>**

Kotter's Steps	Leadership Role
1. Create a Sense of Urgency	<ul style="list-style-type: none"> <li>▪ Craft and use a significant opportunity as a means for exciting people to sign up to change their organization.</li> </ul>
2. Build a Guiding Coalition	<ul style="list-style-type: none"> <li>▪ Assemble a group with the power and energy to lead and support a collaborative change effort.</li> </ul>
3. Form a Strategic Vision and Initiatives	<ul style="list-style-type: none"> <li>▪ Shape a vision to help steer the change effort and develop strategic initiatives to achieve that vision.</li> </ul>
4. Enlist a Volunteer "Change Workforce"	<ul style="list-style-type: none"> <li>▪ Raise a large force of people who are ready, willing and urgent to drive change.</li> </ul>
5. Enable Action by Removing Barriers	<ul style="list-style-type: none"> <li>▪ Remove obstacles to change, change systems or structures that pose threats to the achievement of the vision.</li> </ul>
6. Generate Short-term Wins	<ul style="list-style-type: none"> <li>▪ Consistently produce, track, evaluate and celebrate volumes of small and large accomplishments—and correlate them to results.</li> </ul>
7. Sustain Acceleration	<ul style="list-style-type: none"> <li>▪ Use increasing credibility to change systems, structures and policies that don't align with the vision.</li> <li>▪ Promote and develop staff members who can implement the vision.</li> <li>▪ Reinvigorate the process with new projects, themes and volunteers.</li> </ul>
8. Institute Change	<ul style="list-style-type: none"> <li>▪ Articulate the connections between the new behaviors and organizational success, and develop the means to ensure leadership development and succession.</li> </ul>

<sup>53</sup> Kotter International (n.d.). Retrieved September 2015, from <http://www.kotterinternational.com/the-8-step-process-for-leading-change/>.

<sup>54</sup> Adapted from "Kotter's 8-Step Process for Leading Change—Accelerate's expanded scope version", 2014.



## CONTENT AND FORMAT

This How to Guide applies key principles from Kotter’s 8-Step Process to facilitate MTF leaders’ implementation of the Engagement Strategies as an essential part of their journey toward high reliability and the goal of zero harm to patients. The Guide includes three sections:

- ▶ Getting Started – The Rollout
- ▶ Equipping Leaders as Coaches and Mentors
- ▶ Evaluation – Making and Measuring Progress

Each section presents high level strategic guidelines, suggested leadership activities, and resources.

## GETTING STARTED – THE ROLLOUT

### SELECTING ENGAGEMENT STRATEGIES FOR IMPLEMENTATION

The Engagement Strategies foster and reinforce key behaviors necessary for organizational performance improvement, advancement toward high reliability, and creation of a culture of safety and continuous learning. By implementing these Engagement Strategies, MTFs can advance across all five MHS High Reliability Organization (HRO) Domains of Change identified by the HRO Task Force. Table 2 shows the relationship between each Engagement Strategy and the five HRO Domains of Change.

Although implementation over time of the full suite of Executive and Physician Leader Engagement Strategies in most MTFs will likely accelerate the Military Health System (MHS) transformational change toward high reliability, no MTF is expected to implement all Engagement Strategies simultaneously. Some of these strategies may already be underway and need to be “hardwired” into the DNA at your MTF. Because implementation of each leadership practice entails an investment in time and resources, a phased sequential approach is recommended. The following guidelines are provided to aid MTF leaders in their selection of the Engagement Strategies for initial implementation:

- ▶ Consider each Engagement Strategy in terms of its possible contribution to the organization’s ability to achieve its goals related to getting to zero patient harm.
- ▶ Consider selecting two to three Engagement Strategies for Executive Leaders and two to three for Physician Leaders to begin engaging leaders at multiple levels.
- ▶ Leverage MTF patient safety and quality data to guide selection.
- ▶ Use Table 2 (Matrix of Leadership Engagement Strategies and HRO Domains of Change) as a guide to identify Engagement Strategies that will best facilitate your organization’s advancement across the five domains of change.
- ▶ Consider how each Engagement Strategy could support your organization’s existing patient safety and quality improvement initiatives.



**Table 2. Matrix of Leadership Engagement Strategies and HRO Domains of Change**

Leadership Engagement Strategies	High Reliability Organization Domains of Change																									
	LEADERSHIP COMMITMENT					SAFETY CULTURE					CPI			FRONTLINE TEAMWORK			PATIENT-CENTERED CULTURE									
	Facility Executive Leadership	Department/Clinic Leaders/ GME Faculty	Frontline Leaders	Quality Strategy	Quality Measures	Information Technology	Trust	Accountability	Identifying Unsafe Conditions	Strengthening Systems	Assessment	Transparency—Dissemination Internal	Methods	Training	Spread	Appropriate Staffing	Trust & Respect	Situational Awareness	Effective Communication	Adaptability & Resilience	Respect/Cultural Competence	Transparency to Patient/Family and/or the Patients Involved in System Design	Care Delivered when Needed	Effective Communication	Patients are Members of Care Team	
<b>EXECUTIVE LEADERS</b>																										
Board Engagement in Patient Safety	X			X	X		X			X	X											X <sup>1</sup>	X <sup>1</sup>			
Safety Culture Debriefing	X						X			X	X															
Safety Leadership Rounds	X	X				X	X	X	X		X											X <sup>1</sup>				X <sup>1</sup>
Teamwork Training & Skill Building	X		X			X	X	X	X						X	X	X	X	X	X	X	X			X	X
Daily Safety Briefing	X	X	X					X	X		X															
Senior Adopt-a-Work Unit	X					X	X	X	X		X															
Best Practices of Execution	X	X									X	X		X												
<b>PHYSICIAN LEADERS</b>																										
Medical Leaders Build Patient Safety Structures		X	X	X	X	X	X				X		X									X <sup>1</sup>				
Improving Physician & Patient Communications at the Bedside			X												X	X	X	X	X	X	X	X		X	X	X
Physician Involvement in Unit-based Huddles			X			X									X	X	X	X	X	X	X <sup>1</sup>	X <sup>1</sup>				X <sup>1</sup>
Role of Physician Champions in Patient Safety Meetings		X	X	X		X	X				X															
Harm-Reduction Rounding Checklists & Evidence-Based Guidelines			X					X	X																	
Multidisciplinary Teamwork Training & Skill Building			X			X	X	X	X						X	X	X	X	X	X	X	X			X	X
Physician Leadership at Post-Adverse Event Debriefs			X			X	X	X	X								X		X							
Managing Resistance			X			X	X																			

<sup>1</sup>Applies only if facility chooses to include patients and family members in the strategy.

## LEADING CHANGE - STRUCTURING YOUR ORGANIZATION FOR SUCCESS

Common barriers and enablers to organizational change are well described in the literature. Table 3 presents evidence-based organizational success factors that enable change and some leadership activities that foster them.

Please see Table 3 on next page.



**Table 3. Structuring Your Facility for Success: Organizational Success Factors and Related Leadership Activities<sup>55</sup>**

Success Factor	Example Leadership Activities to Establish Success Factor
<b>1</b> Align the initiative with the organization's mission, vision and values	<input type="checkbox"/> Visibly and clearly map new behaviors, tools and strategies that will be part of the change to the organization's mission, vision, and values. <input type="checkbox"/> Align all stakeholders around the "change vision". <input type="checkbox"/> Role model and send the single message that the change matters to caregivers and their patients.
<b>2</b> Provide organizational support	<input type="checkbox"/> Provide adequate people, time, and resources. <input type="checkbox"/> Establish an organization-wide communication campaign about the change. <input type="checkbox"/> Build in support such as policies, procedures, and practices that align with the initiative goals and establish a supportive work climate. <input type="checkbox"/> Lead by example: set an expectation for role modeling and mentoring from the executive suite to frontline leaders. <input type="checkbox"/> Hold all accountable for achieving the stated goals. <input type="checkbox"/> Promote involvement of all stakeholders.
<b>3</b> Engage leadership at all levels	<input type="checkbox"/> Communicate to leaders at all levels of the organization the importance of change for the organization and the pivotal role they play in ensuring success. <input type="checkbox"/> Actively engage supervisors and frontline leaders as training instructors, coaches, mentors for the change.
<b>4</b> Prepare for staff education and training	<input type="checkbox"/> Ensure adequate time and resources for staff education and training. <input type="checkbox"/> Communicate the relevance and importance of the education and training. <input type="checkbox"/> Set the expectations for high performance and good outcomes.
<b>5</b> Create a plan	<input type="checkbox"/> Ensure an action plan is developed for the change initiative.
<b>6</b> Facilitate application of newly trained skills on the job	<input type="checkbox"/> Provide trainees ample and timely opportunities to practice their learned new skills on the job and/or through periodic refresher training. <input type="checkbox"/> Ensure supervisors reinforce new behaviors on the job Establish accountability system for resisters.
<b>7</b> Engage frontline champions to drive implementation of the change	<input type="checkbox"/> Engage the "go-to" staff. <input type="checkbox"/> Foster innovation. <input type="checkbox"/> Provide champions executive and administrative support.
<b>8</b> Prepare the organization for continuous learning on the job	<input type="checkbox"/> Ensure appropriate selection and training of supervisors, frontline champions, and/or peers to act as coaches to frontline staff. <input type="checkbox"/> Ensure staff members have access to other performance support resources such as job aids, communities of learning, and related virtual learning opportunities.
<b>9</b> Establish partnerships and collaborations.	<input type="checkbox"/> Establish inter- and intra-organizational networks, collaborations, and partnerships to share ideas, lessons learned, and resources.
<b>10</b> Measure the effectiveness of the change effort on multiple levels.	<input type="checkbox"/> Ensure valid evaluation methods and metrics that assess impact, monitor barriers to change, and identify opportunities for continuous improvements.

<sup>55</sup>Almeida, S.A., King, H., & Salisbury, M.L. (2013). Teamwork improvement in health care: A decade of lessons learned every organization should know. In E. Salas, S.I. Tannenbaum, D. Cohen, & G. Lathan (Eds.). Society for Industrial & Organizational Psychology Professional Practice Series - Developing and enhancing teamwork in organizations: Evidence-based best practices and guidelines (pp.298-330). San Francisco, CA: Jossey-Bass.



## EQUIPPING LEADERS AS COACHES AND MENTORS

### BACKGROUND

Coaching is a strategy to facilitate change. Coaching can insure the successful execution, sustainment and improvement of the Leadership Engagement Toolkit. Contained below are Benchmark elements critical to a successful initiative. Over time, these elements will help to achieve the performance status of a high reliability organization and the broader-based mission of the MHS: to achieve excellence in the patient, provider and staff experience of care.

### COACHING BENCHMARKS

The “full engagement of healthcare leaders in patient safety efforts is a powerful force in cultural change toward achieving reliable care”.<sup>56</sup> Coaching as both a strategy and a tool to engage healthcare leaders and their teams in highly reliable processes comprises six key benchmarks:

#### **Benchmark #1 – Establish coaches as essential to the mission of executing transformational healthcare strategies.**

The coach assumes the responsibility of applying a standardized process to systematically guide those they coach towards success by:

- ▶ Engaging a transformational process.
- ▶ Establishing partnerships with leaders and frontline providers of care.
- ▶ Enrolling members in a reliably active learning environment.
- ▶ Working together with leaders and their teams as they work together to achieve a specific goal or practice change.

Coaching empowers executive and physician leaders to influence their staff to take an active role in improving the functions of their environment.

#### **Benchmark #2 – Insure coaching is evidence-based and standardized.**

Coaching is a credentialed practice with competencies organized into four basic categories:

- ▶ Communication.
- ▶ Managing Relationships.
- ▶ Performance Improvement Management.
- ▶ Executing Strategies.

<sup>56</sup> Frankel A., Graydon-Baker, E., Nepl, C., Simmonds, T., Gustafson, M. & Gandhi, T.K. Patient Safety Leadership WalkRounds. TM Jt Comm J Qual Saf. 2003; 29(1): 16–26. Retrieved May 10, 2013.from: <http://patientsafety.unc.edu/documents/LeadershipWalkRounds.pdf>.



**Benchmark #3 – Insure coaching occurs as a structured process.**

Choosing an effective coaching model and establishing coaching roles and responsibilities must fit the needs and existing culture of the organization. Broadly all models focus on four common elements:

- ▶ The relationship between coaches and the person being coached.
- ▶ Providing a structure in which the leader can identify clear goals.
- ▶ Gaining awareness to identify meaningful, strategic actions that lead to the desired change.
- ▶ Reviewing outcomes to discover, learn and make adjustments made with a commitment to follow-up and review new outcomes.

**Benchmark #4 – Insure coaching, is accessible and responsive to the needs and dynamics of healthcare.**

Choose a coaching design that matches the internal resources, time and coaching skill-base of the organization. Potential options include:

- ▶ Establishing or leveraging coaches internal to the organization.
- ▶ Engaging resources external to the organization.
- ▶ Collaborating and coordinating to achieve a combination of the two.

**Benchmark #5 – Establish a coaching program that is strategic.**

(Refer to Table 2 for general information on success factors for change).

- ▶ Assign an executive sponsor.
- ▶ Choose a best-fit coaching model and design matched to your organizations culture and needs.
- ▶ Invest in programs of coaching skills practice (simulated settings) and on-going learning and credentialing.
- ▶ Commit to personally pay attention.

**Benchmark #6 – Insure proper resources and require on-going learning for coaching staff.**



## EVALUATION - MAKING AND MEASURING PROGRESS

### BACKGROUND

It is important that military treatment facilities (MTFs) evaluate the effectiveness of the Engagement Strategies to determine if their implementation is producing the desired impact... and if not, why not. Well-designed measurements will provide MTF leaders and frontline staff with actionable information to optimize the effectiveness of the Engagement Strategies, identify and remove barriers to implementation, and continually improve and adapt the strategies to best accommodate local needs and resource availability.

Measurement is foundational to achieving High Reliability. HROs are “information-rich,” constantly attentive to all forms of data and information that provide insights into potential risks and opportunities to close safety gaps. The importance of measurement for reducing preventable errors and harm is pervasive throughout the high reliability literature and across national standards and recommendations for patient safety and healthcare quality.

### CHARACTERISTICS OF AN EFFECTIVE ENGAGEMENT STRATEGIES EVALUATION PLAN

#### #1 – Includes Families of Measures

It is important to assess not only the desired outcomes/results of the Engagement Strategies, but also the organizational behaviors and infrastructures needed to produce those end-results. Therefore, the evaluation plan should include a “family of measures”—structure, behaviors, and results—that will allow MTFs to answer “if we are not achieving our desired results...why not?” Failure to achieve positive results could be due to failure to implement the Engagement Strategies as intended (behaviors) or lack of supportive organizational structures.<sup>57</sup> Table 4 presents families of measures and assessment tools and techniques MTFs could use to design their Engagement Strategies evaluation plan. The best combination of measures and tools will depend on the strategies selected for implementation and on MTF local factors such as targeted outcomes, measurement expertise, and resource availability.

Please see Table 4 on next page.

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<sup>57</sup> See also Table 3. Structuring Your Facility for Success.



Table 4. Families of Measures, Tools, and Techniques for Evaluating Engagement Strategies<sup>58</sup>

Type of Measures & Description	Options for Measurement Tools & Techniques
<p><b>Structure / Input Measures:</b> <i>Do we have the infrastructure needed to successfully implement and sustain the Engagement Strategies?</i></p> <p><u>Consider</u><sup>1</sup>:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stakeholder commitment</li> <li><input type="checkbox"/> Communication strategy</li> <li><input type="checkbox"/> Implementation plan</li> <li><input type="checkbox"/> Training</li> <li><input type="checkbox"/> Implementation support – coaching, job aids, frontline champions</li> <li><input type="checkbox"/> Supportive policies and procedures</li> <li><input type="checkbox"/> Measurement systems and expertise</li> <li><input type="checkbox"/> Time and resources</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> “Organizational Success Factor” Checklist<sup>1</sup></li> <li><input type="checkbox"/> Informal discussions with stakeholder groups</li> <li><input type="checkbox"/> Checklist of competing priorities</li> </ul> <p><u>Existing Quantitative Measurement Tools:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Leapfrog Hospital Survey -National Quality Forum [NQF] Safe Practices Section</li> <li><input type="checkbox"/> ACGME CLER Pathways (for Graduate Medical Education [GME] sites)<sup>2</sup></li> </ul>
<p><b>Behavior / Process Measures:</b> <i>Are we implementing the Engagement Strategies as intended?</i></p> <p><u>Consider:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Are Strategies implemented as described?</li> <li><input type="checkbox"/> Are the right people involved?</li> <li><input type="checkbox"/> How often is the <i>Strategy</i> used?</li> <li><input type="checkbox"/> Are best practices for that <i>Strategy</i> in place?</li> <li><input type="checkbox"/> Is the <i>Strategy</i> customized to meet MTF needs?</li> <li><input type="checkbox"/> Are patients included?</li> <li><input type="checkbox"/> Are there any barriers to implementation?</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Direct observation</li> <li><input type="checkbox"/> Leadership reports</li> <li><input type="checkbox"/> Questionnaires – leaders, frontline staff, patients</li> <li><input type="checkbox"/> Interviews of leaders, frontline staff, patients</li> </ul> <p><u>Existing Quantitative Measurement Tools:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Leapfrog Hospital Survey -NQF Safe Practices Section</li> <li><input type="checkbox"/> TeamSTEPPS<sup>®</sup> Teamwork Perceptions Questionnaire (TTP)</li> <li><input type="checkbox"/> ACGME CLER Pathways (for GME sites)</li> </ul>
<p><b>Outcome / Results Measures:</b> <i>Did we achieve our desired results from implementation of Engagement Strategies?</i></p> <p><u>Consider:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient harm events</li> <li><input type="checkbox"/> Patient outcomes</li> <li><input type="checkbox"/> Patient satisfaction</li> <li><input type="checkbox"/> Culture of safety</li> <li><input type="checkbox"/> Frontline teamwork</li> <li><input type="checkbox"/> Targeted outcomes for Service- or MTF-specific patient safety initiatives</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Informal feedback from leaders, frontline staff, and/or patients</li> <li><input type="checkbox"/> Structured interviews of leaders, frontline staff, and/or patients</li> <li><input type="checkbox"/> Outcome measures for Service- or MTF-specific patient safety initiatives</li> </ul> <p><u>Existing Quantitative Measurement Tools</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient Safety Reporting System (PSR)</li> <li><input type="checkbox"/> Partnership for Improvement metrics</li> <li><input type="checkbox"/> Patient satisfaction surveys</li> <li><input type="checkbox"/> Tri-Service Safety Culture Survey</li> <li><input type="checkbox"/> T-TPQ</li> </ul>

<sup>58</sup> Accreditation Council for Graduate Medical Education (2014). CLER Pathways to Excellence. Retrieved from: [https://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER\\_Brochure.pdf](https://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf)



## #2 - Incorporates Stakeholder Input

Stakeholders, such as frontline leaders and staff, patients, process improvement experts, can contribute significantly to the evaluation plan by providing ideas, resources, expertise, general support, and insights into potential barriers to the evaluation process.

## # 3 - Leverages Existing Initiatives and Measures

To produce credible and valid results, evaluation does require a thoughtful and scientific approach; but it does not need to be complicated, time-consuming, or resource-intensive. Below are some approaches to keeping evaluation simple, while maintaining its scientific validity and credibility.

- ▶ Integrate the Engagement Strategies into existing patient safety initiatives. The Engagement Strategies will likely facilitate almost any patient safety or high reliability improvement initiative. Integration will advance the existing initiative, while providing an established evaluation structure to assess the impact of the Engagement Strategies.
- ▶ Align the Engagement Strategies evaluation plan with existing validated DoD measurement tools (see Table 4). Leveraging these existing measurement tools would provide a scientifically valid, time-efficient, and feasible framework for evaluating implementation of the Engagement Strategies.
- ▶ Simplify Existing Tools –Use Questionnaire Dimensions of Interest. Dimensions are groups of questionnaire items (questions) that were designed to collectively assess a specific element. MTFs could make their Engagement Strategies evaluations simpler and more time-efficient by periodically administering only those questionnaire items in dimensions that map directly to their Engagement Strategies outcomes of interest.

## #4 - Considers Organizational Success Factors

The same organizational factors that impact the success of the Engagement Strategies implementation effort also directly affect evaluation activities. It is important to consider the organizational success factors presented in Table3 when designing the evaluation plan and, where possible, structure for success upfront before launching the evaluation plan.

## #5 - Comprehensive

A well-constructed evaluation plan will markedly enable the measurement process and prevent wasted time and resources by providing a feasible roadmap, assigning accountability, and identifying potential barriers and mitigation strategies. The plan can be very simple, but should include at a minimum:

- ▶ Aim(s) – what you hope to achieve with implementation of the strategy.
- ▶ Measures – family of Structure, Behavior, Outcome/Results measures.
- ▶ Data analysis plan.
- ▶ Results feedback plan.
- ▶ Roles and Responsibilities.
- ▶ Potential barriers to measurement and mitigation strategies.



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## RESOURCES

- ▶ Available through Defense Health Agency/Patient Safety Program:
  - The Engagement Strategies will be available on line at <http://www.health.mil/dodpatientsafety> and through the Service Patient Safety Representatives.
  - Three high-level webinars will be offered, with recordings maintained on the Patient Safety Learning Center. These webinars will support implementation teams with more detailed guidance for operationalizing the concepts and strategies contained in this How to Guide.
  - Interested Communities: leadership sessions to support the implementation of engagement strategies.
  - Consultation specific to coaching models and practice designs.
  - External coaching resources: coaching outside the MTF (DHA resource).
  - Additional resources accessible at <http://www.health.mil/dodpatientsafety>
- ▶ ACGME General Competencies, CLER Program, Milestones, and related information available at <http://www.acgme.org/acgmeweb/tabid/83/ProgramandInstitutionalAccreditation.aspx>
- ▶ AHRQ Hospital Survey Toolkit including Survey forms, Items & Dimensions, and User's Guide is accessible at <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html>
- ▶ Achieving High Reliability in the Military Health System Resource Guide, The High Reliability Organizational Task Force Report, September 4, 2015.
- ▶ Leapfrog Hospital Survey, results, and related information accessible at <https://leapfroghospitalsurvey.org/>
- ▶ National Quality Forum (NQF). Safe Practices for Better Healthcare—2010 Update: A Consensus Report. Washington, DC: NQF; 2010. Available at [http://www.qualityforum.org/Publications/2010/04/Safe\\_Practices\\_for\\_Better\\_Healthcare\\_%E2%80%93\\_2010\\_Update.aspx](http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx)
- ▶ TeamSTEPPS® Teamwork Perceptions Questionnaire (T-TPQ) available at <http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/reference/teampercept.html>
- ▶ TRICARE Inpatient Satisfaction Surveys (TRISS) Report of Findings accessible at <http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/TRICARE-Patient-Satisfaction-Surveys/TRICARE-Inpatient-Satisfaction-Surveys>
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