Lean Toward Zero Patient Harm

"The Toyota Way," "Lean"—we've all heard the terms and been exposed to the buzz. We know that the Toyota Production System model is admired and emulated the world over by management experts and gurus. But it's not news—it's not the latest-and-greatest—so, why should we care now? Here's why: The Toyota Way, or Lean, *works.* Its effect in helping healthcare organizations and entire health systems improve patient care, reduce errors, increase patient and staff satisfaction and more is well-documented—indeed, proven. Why, then, wouldn't we want to know all about it?

> *Lean has emerged as a potent tool to help healthcare leaders provide smoothly operating, patient-centered care free from errors.*

Derived from the waste-reduction, just-in-time management philosophy implemented in Japanese car manufacturing in the 1930s and 1940s, Lean has since emerged as a potent tool to help healthcare leaders provide smoothly operating, patient-centered care free from errors. In healthcare, waste is conceived as anything that doesn't add value. In *patient-centered* healthcare, value is regarded as only those items and services a patient would willingly pay for out of pocket. The waste to be eliminated, then, comprises unnecessary wait times, lengthy travel between service centers, redundant forms to complete and staff to inform, all manner of inefficiencies and, most particularly, errors and injuries in patient care.

At ACHE, through the [Leading a Culture of Safety Blueprint](#) jointly developed by ACHE and the IHI Lucian Leape Institute, we're extremely focused on helping our members transform their institutions and agencies into high-reliability organizations founded on a culture of safety. Implementation of Lean is one surefire way to move your hospital or health system closer to

the goal of zero patient harm.

ACHE members have access to the second edition of *[The Toyota Way to Healthcare Excellence: Increase Efficiency and Improve Quality with Lean,](#)* by John Black (with David Miller and Joni Sensel). This new edition provides detailed information regarding the implementation of Lean in the massive Saskatchewan provincial healthcare system as well as reports and historical perspectives from three leaders who have implemented Lean in U.S. health organizations for a decade or more.

What do these leaders want us to know? [Dr. Gary Kaplan, CEO](#) of [Virginia Mason Medical Center](#) in Seattle and chair of IHI Lucian Leape Institute, is one of the earliest Lean healthcare pioneers. In his foreword to the second edition, Kaplan is effusive. He professes that at Virginia Mason, Lean has led to: "…significant improvements—contributing to at least a 50 percent reduction in time, space, or the need for other resources. In areas of major focus, we've seen defects go to nearly zero. We've experienced improvements in the hospital length of stay, patient wait times to see a doctor, face-to-face time for patients with their physicians, time to get lab results, and even time to get the bill sent out.…Lean works!"

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Kaplan promises that healthcare executives can "create a better, safer, more efficient, and higher quality healthcare system if we are willing to embrace these new methods and are truly willing to lead."

Partnering for Safety

As healthcare executives, we are all aware of and striving toward the broad and common goal of reducing preventable harm to patients. But did you know that the Centers for Medicare & Medicaid Services (CMS) have your back? Yes, lest we think we are doing it alone, the team at CMS would like us to be aware of the strides they are making to innovate for patient safety.

Using a systems approach, the Partnership for Patients (PfP) is a CMS initiative that focuses on education and advocacy to make advances in quality improvements, spread best practices, and promote reduction in preventable injury and subsequent readmissions.

> *"Aligning toward a common goal fosters synchronized communications, leverages broader perspectives, and promotes a higher likelihood of success."*

Why a systems approach? "Explicit effort to think about systems is necessary for organizational learning and innovation because humans tend to concentrate their efforts and understanding on those parts of the system for which they are directly accountable," explain the authors of [Partnership for Patients: Innovation and Leadership for Safer Healthcare](#) (Journal of Healthcare Management: May/June 2017 – Volume 62 – Issue 3 – p 166–170). The authors—Patrick Conway, Shelly Coyle and Nancy Sonnenfeld—are members of the CMS Quality Improvement and Innovation Group (QIIG). This team believes that systems thinking can help eliminate harmful events and lead to efficient innovations in healthcare.

PfP employs a multipronged strategy to reach toward successful innovation. The program consists of partnership among the QIIG

and its contractors, as well as collaborators from the federal, state, and local levels and private entities. To achieve change, the PfP has introduced incentives and penalties in reimbursement that are aligned with its goals as well as creating programs that focus on reducing hospital-acquired illnesses and injuries and subsequent readmissions.

The authors recognize the essential role of hospital executives in collaboration with the PfP. Considering the many demands on healthcare leaders, they propose that a systems approach is required to achieve real and sustainable improvement. Some methods they support are described below.

> *"Declare bold aims; make strong, public commitments; and expect the same from your partners."*

Patient and Community Engagement

The PfP encourages healthcare executives to listen to and share openly with their patients and community. Opportunities for exchange and honest communication improve trust between parties and foster the development of a more patient-centered culture.

Making the Rounds

Leaders who make daily or weekly rounds, visiting patients and frontline staff, will learn more about the workings of their organizations while communicating a commitment to those in their care. PfP recognizes that a workforce who feels heard and valued will produce better results for their patients.

Partner Power

True to its name and mission, PfP values and promotes the power of partnerships. PfP welcomes collaboration with organizations aligned to the mission of improved patient safety and believes in the old adage "strength in numbers." For instance, the authors suggest that an initiative

incorporating diverse hospital departments like Nursing, IT and Environmental Services together might achieve more than one could accomplish alone. "Aligning toward a common goal fosters synchronized communications, leverages broader perspectives, and promotes a higher likelihood of success," they write. "Declare bold aims; make strong, public commitments; and expect the same from your partners."

ASA/ACHE Podcast on Establishing a Patient Safety Culture

(Click [here](#) for link to podcast)

Brought to you by the American Society of Anesthesiologist and the American College of Healthcare Executives

Featuring:

- Jane Easdown MDCM, MHPE
  Professor of Anesthesiology
  Vanderbilt University Medical Center

- M. Michael Shabot, MD
  Executive VP & System Chief Clinical Officer
  Memorial Hermann Health System

- Butch Uejima, MD, MMM, FAAP, CPHRM
  Chief Medical Officer
  Chairman, Dept of Pediatric Anesthesiology and Perioperative Medicine
  Nemours/AI duPont Hospital for Children

Professor of Anesthesiology and Pediatrics
Sidney Kimmel Medical College
of Thomas Jefferson University

In collaboration with ASA and ACHE, this podcast discusses leadership's role in establishing a patient safety culture that extends beyond a grassroots conversation. Adoption of high-reliability safety by senior leadership and board members is an absolute requirement for success. Patient safety culture must be clearly supported as a key mission by the governing board. The 25-minute Q&A-format discussion provides perspectives from clinical and administrative viewpoints.

A Marathon to Patient Safety

We've said it here before: [leading for safety is a marathon, not a sprint!](#)

Like all good marathoners, we're prepared for the long haul and are determined to go the distance. With that in mind, it may not surprise you that it has been a full year since the ACHE, in partnership with the [National Patient Safety Foundation's Lucian Leape Institute](#) (NPSF LLI), released [Leading a Culture of Safety: A Blueprint for Success](#).

Perhaps in that time you have reached the first milestones in your marathon, or maybe you're just now tying on your shoes and adjusting your bib—either way, there is still a long way to go in your organization's journey to zero patient harm. It might be the right time now for a little inspiration: read ["Partnering to Lead a Culture of Safety,"](#) by [Gary Kaplan](#), [Tejal Gandhi](#), [Deborah Bowen](#), and [Charles Stokes](#), for a refresher on why the ACHE has teamed up with the NPSF LLI to help you and your executive-team colleagues learn to lead a

culture of safety in your organization. You may wish to think of the ACHE and NPSF LLI as your distance-running coaches for this long journey.

According to the authors, these coaches have determined that the essential first step in your marathon toward safe, high-quality healthcare is to build a safety culture in your organization. And, they say, the only way to transform a culture is to start with strong, committed leaders who convey urgency. "Without urgency, there can be no change, because the status quo is a powerful inhibitor," they caution.

"Absent a true culture of safety, improvements…are difficult to sustain. Absent strong leadership, a culture of safety is difficult to develop and nurture," write the authors.

Leaders must also commit to transparency in all organizational transactions and communications, and create a workable, reliable process for addressing safety concerns. To assure these priorities can be achieved, it is essential to engage all leaders: from the CEO to the trustees to the front-line clinical and administrative managers. "Strong leadership is…shared leadership," Kaplan and his co-authors write.

Our coaches have adopted the belief of the LLI that "Safety needs to be much more than just another priority; it must be embraced as a core value of an entire organization—in fact, as a moral and ethical imperative in healthcare."

If you haven't done it yet, it's time: tie on those running shoes and get moving. The authors agree, "…there is no better time to begin than now. It is the duty of healthcare leaders to protect their patients and their workforce and to aim for zero preventable harm."

Lead for Safety

What can you, as a healthcare executive, do to aid your organization's transformation into a [high-reliability organization](#) that delivers safer care and saves lives? Whether you're a middle manager or a member of the C-suite, there is a role for you in building a [culture of safety](#) that leads toward error-free care.

In [*The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization,*](#) [John Byrnes, MD, and Susan Teman, RN,](#) use a straightforward, no-jargon approach to show leaders how to embrace, communicate, model and reward safety as they guide the transformation into a high-reliability organization. Published by ACHE, *The Safety Playbook* dovetails perfectly with the partnership effort of ACHE and the [IHI/NPSF Lucian Leape Institute](#) to increase the focus on and commitment to safety by today's healthcare executives.

Commit to Safety

According to Byrnes and Teman, "every level of a high-reliability organization needs to be aligned with safety as a core value." From the board to physicians, to staff on the front-lines, each person is responsible for achieving zero patient harm. It starts at the top: with unwavering commitment by the trustees and executive leadership. This commitment is reflected in the inclusion of safety at the core of the strategic plan and in the dollars invested to train and motivate the entire organization.

Build a Just Culture

One of the foundations of a high-reliability organization is the establishment of a just culture—one that distinguishes between system and individual failures. A just culture is a

culture of transparency and respect, where errors are reported and the first question asked is, "Why did this happen?" rather than, "Who did this?"

Byrnes and Teman promote the flattening of hierarchy as an essential step in the progress to a just culture, and they provide the "Call Me Bob" campaign as a case study. Taking a cue from the airline industry where the cockpit crew refer to each other by first names to encourage candid communication, Dr. Robert (Bob) Connors, president of Helen DeVos Children's Hospital in Grand Rapids, Michigan, launched the "Call Me Bob" campaign to encourage a first-name-only approach among staff members and physicians. The goal of such initiatives is to eradicate the perception that speaking up to a senior staff member is equivalent to challenging authority. In a high reliability organization, it is essential that a nurse feels empowered to question a decision by a physician, and a junior staff member feels safe reporting an error.

Executive safety leadership actions

Some leadership techniques suggested by Byrnes and Teman to achieve a flattened hierarchy and build a just culture include:

- Practice executive rounds. Make a habit of regular visits to patient care units, initiating two-way communication and building approachability and trust with staff. During these visits share your commitment to the organization's mission and values, in particular to safety, and gather important information from the front lines in patient care
- Sponsor and champion cause-analysis capabilities (find-and-fix exercises) and the resulting system improvements. Believe in the organization as a system of continual learning and improvement, and share that conviction with all members of the staff
- Communicate. Share safety data in a relatable manner;

> make the data transparent and tell stories to personalize it; share safety metrics within individual units

Learn more in *[The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization](#)*, *available on the ACHE's Publication page.*

Imagine Your Hospital with Zero Harm

As healthcare leaders, we all want to create and sustain a [culture of safety](#) in our organizations. This goal is so crucial and timely that [ACHE](#) and the [Institute for Healthcare Improvement/National Patient Safety Foundation Lucian Leape Institute](#) are partnering to increase the focus on and commitment to safety.

Transforming vision into reality can seem a task so enormous and expensive, however, that we put it off, or we nibble around the edges—instead of jumping in with the full commitment required to ensure success.

Enter the team of [John Byrnes, MD](#), and [Susan Teman, RN](#). These experts in healthcare safety have given us a playbook of common sense strategies and real-world tactics that hospitals and health systems can employ now to begin or continue making the transition to harm-free care.

In *[The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization](#)*, Byrnes and Teman draw from their experience in helping hospitals and health systems transform into [high-reliability organizations](#) that

deliver safer care and save lives. Throughout the book, they scatter examples and case studies from their successes, including one children's hospital that cut serious safety events by 90%. They write, "No more children have died because of medical harm at that hospital (p. xxii)."

> *Medical errors are the third leading cause of death in the United States, accounting for approximately 250,000 deaths per year.*

That is quite the testimony in a healthcare environment that is suffering, quite frankly, a patient safety crisis. Medical errors are the third leading cause of death in the United States, accounting for approximately 250,000 deaths per year ([Cha 2016](#); [James 2013](#)).

In the preface, Byrnes implores us to "imagine your hospital with zero errors," and then he, together with co-author Teman, proceeds to provide a practical guide to building a safety program that will eradicate preventable errors in your hospital, for your community and even for your own family.

Learn more in *[The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization](#),* available on the ACHE's Publication page.

Leading for Safety and Its Favorable Side Effect: Reduced Readmissions

Leading a culture of safety in your organization will enable you to check off another goal on your to-do list: reducing the

readmission rate.

At this year's [Congress on Healthcare Leadership](#), participants had two opportunities to hear from forward thinker and strategist [Josh Luke, PhD, FACHE](#). Dr. Luke is founder of the [National Readmission Prevention Collaborative](#) and author of *[Readmission Prevention: Solutions Across the Provider Continuum](#),* published by [ACHE](#).

Luke's book is a must-read for healthcare leaders at every level of the continuum and is a best-selling book from [Health Administration Press](#). In it, Luke provides tactics, tools, and resources that executives at acute-care and post-acute care facilities and agencies can implement immediately to reduce unnecessary hospital readmissions.

According to Luke, moving away from the pre-[ACA](#) volume-based model of care to a value-based model boils down to delivering care that is patient-centered. "Those who are willing to lead the charge to transform their organization to a patient-centered delivery model must be creative in identifying and using resources to achieve their goals in a cost-effective way," says Luke, and he identifies and elaborates on readmission prevention tactics that you can put into action now.

Brief perspectives written by healthcare experts appear throughout the volume, offering viewpoints on preventing readmissions at various levels of care:

- Hassan Alkhouli, MD, Chief Medical Officer, [Garden Grove (California) Medical Center,](#) contributed "A Hospitalist's Perspective on Readmission Prevention," in which he states: "Most cases [of unplanned rehospitalizations] are the result of systems failures in ensuring appropriate transition to another source of care."
- In "Advancing Excellence in America's Nursing Homes:

Tracking Tool and Resources for Safely Reducing Rehospitalizations," [Adrienne Mihelic, PhD,](#) Senior Biostatistician for Telligen Healthcare Intelligence, offers a look at the "Advancing Excellence Safely Reduce Hospitalization" package, which includes talking points; fact sheets for residents and family, staff, and nursing home leadership; data tracking tools; and recommended interventions to improve the transition processes.

- [Sarah Thomas](#), writing when she was Rehabilitation Specialist and Legislative Affairs Liaison at Hallmark Rehabilitation in San Francisco, prepared a perspective entitled, "Rehabilitation Is Vital in Readmission Prevention," in which she focuses on assessing the level of care a patient needs to function safely in a transitional environment. She summarizes, "Consistent communication, collaboration, and continuity of care are needed to reduce the rate at which patients return to the hospital."

Luke's core safety message focuses on three elements:

1. Communication between responsible parties at all layers of care
2. Assessment of the patient's ability to transfer to the next level safely
3. Creating extra layers of safety: Ensuring the ability of the next level to provide for the patient safely

He reflects that the ultimate goal of healthcare is to return the patient safely to his or her home environment. Luke says, "Caretakers at all points of care now start their patient evaluation with one basic question: Can we discharge this patient home safely and confidently?"

Journal of Healthcare Management: Safety Collection

Check out the "Safety" collection from the *Journal of Healthcare Management*. Articles include:

- Patient Safety Climate A Study of Southern California Healthcare Organizations
- Creating a System of Consistent Safety in the Froedtert & Medical College of Wisconsin Health Network
- The Three-Legged Stool: Why Safety, Quality, and Equity Depend on Each Other
- Partnering to Lead a Culture of Safety
- and so much more

Why Safety and Quality Depend on Equity—and Vice Versa

How can safety and quality care in our healthcare institutions depend upon equity?

It has long been true that every patient deserves safe and high-quality care, but today's diverse population demands that we focus now on eliminating healthcare disparities in our institutions, according to Jack Lynch, FACHE, president and CEO of Main Line Health (MLH), Bryn Mawr, PA, in a recent article in the *Journal of Healthcare Management* (*J Healthc Manag.* 2017 Sep/Oct;62(5):298-301).

What is the connection between equity and the delivery of safe

and quality care? Past research has demonstrated a simple fact accepted by healthcare leaders today: patients identifying as racial minorities or LGBQT face increased risk for adverse safety events in our healthcare system. With our population rapidly diversifying—according to the [US Census Bureau (2017),](#) minorities will make up 54% of the American population by 2050—we must commit now to an unequivocal pledge of safety and quality care for every patient. Falling short of this, we will risk providing suboptimal care for fully one of every two patients who seek our assistance.

According to Lynch, the pledge to achieve equity at MLH is built on three mandates:

- Commitment to the [STEEEP principles](#) (to deliver care that is Safe, Timely, Efficient, Effective, Equitable and Patient centered)
- Education for cultural competence
- Organizational culture that rewards employees who take a stand for safety

"As healthcare leaders, we must address disparities in care with the same intensity and passion with which we have unequivocally embraced patient safety and quality," Lynch says.

Unmistakably STEEP

One patient at a time—that's how they meet the challenge at MLH, according to Lynch. While inequities in the country's healthcare system lead to disparities in patient care, healthcare leaders cannot and should not consider this problem insurmountable, in Lynch's view. By adopting the National Academy of Medicine's STEEEP principles and holding all employees accountable for ensuring that each patient receives care that is safe, timely, efficient, effective, equitable and patient centered, MLH is committing to achieve their vision of equitable care for all by 2020.

Culturally correct

When ethnic disparities in patient safety occur, often they can be traced to a lack of cultural competence—a blend of cultural knowledge, attitudes, skills and resources—on the part of the healthcare providers (Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2010, p.S116). Healthcare leaders today have a moral and financial imperative to invest in cultural competence education for their staff.

AT MLH, managers participate in a Diversity, Respect and Inclusion workshop over 2 days; the hospital intends to roll out similar training to all staff in 2019. In his article, Lynch mentions several national organizations that can help healthcare organizations improve their teams' cultural competency. One such resource is the ACHE's *Leading a Culture of Safety: A Blueprint for Success,* which helps leaders build a safety culture grounded in trust, respect and inclusion.

Speaking up for safety

"At MLH, we have worked diligently to create a culture in which everyone feels empowered and encouraged to speak up for safety and 'have each other's back,'" says Lynch, though he shares that the organization, like others, has much work to do. Such an environment is an essential precondition for patient safety. Human error is unavoidable in healthcare, as everywhere. For this reason, healthcare leaders must cultivate a culture of respect and trust, where staff members feel empowered and emboldened to admit to, to report, and to stand up to impending error.

"If we can establish trust and respect in our organizations, we can then be sure every healthcare worker will be that much more committed and sensitive to providing compassion, respect, and an equitable experience to every individual who gives us the privilege to serve and care for them," promises Lynch.

Jack Lynch was a key speaker at the [2018 Congress on Healthcare Leadership](#), which just wrapped up in Chicago. Join us as we lead with intent, [lead for safety](#) and lead toward zero harm.

How To Lead For Safety

There is nothing more important for healthcare providers than ensuring the safety of their patients and workforce. And, ACHE is committed to catalyzing healthcare leaders around safety.

We contacted three of our nation's leading safety experts, [Tejal K. Gandhi, MD, CPPS](#), Chief Clinical and Safety Officer at Institute for Healthcare Improvement and President of its NPSF Lucian Leape Institute; [John "Jack" Lynch III, FACHE](#), President/CEO of Main Line Health; and [Doug Salvador, MD](#), Vice President of Medical Affairs at Baystate Health. Each of them emphasized that the journey to a zero-harm environment begins with creating a safety culture.

"A culture of safety is the foundation for all work, from day-to-day operations and care to improvement initiatives in safety and beyond," offers Gandhi.

But, culture often remains unchallenged because it's seen as the way things have always been. According to Salvador, there is a mountain of evidence linking disrespectful and dismissive behavior by healthcare providers to the harm of patients. For this to change, Lynch stresses that there can be no compromise on quality of care and patient safety. It must be "embedded as a non-negotiable," a core value for all healthcare organizations.

How To Get Started

"The most important first step is to measure the safety culture in your organization using a validated safety culture survey instrument," says Salvador. This includes leadership, communication and interactions right at the front lines. Often, this is where cultural issues exist but are never talked about.

Gandhi points out that it is nearly impossible to sustain improvement without a clear vision for the future. Leaders should set the vision and model aligning behaviors to demonstrate an expectation of trust and respect across all levels of an organization. Lynch agrees. For an organization to lead for a culture of safety, it must also "ensure a supportive, inclusive and respectful environment so that each member speaks up for safety … and feels empowered to do so."

ACHE, in partnership with the IHI/NPSF Lucian Leape Institute, launched *Leading a Culture of Safety: A Blueprint for Success*, including an organizational self-assessment and best practices to help healthcare leaders build a sustainable culture of safety. "Though creating a culture of safety is not easy, our new tool, provides a framework for leading an organization toward the ultimate goal of zero harm," says Gandhi.

Common Obstacles Faced By Organizations

Lynch reminds healthcare leaders to expect challenges—and embrace them. These are essential to discovering an organization's strengths and weaknesses, and how to make necessary improvements. He suggests, "Leaders must be relied upon by all levels of staff … to address changes when they need to be made," especially when focused on error prevention

and safety.

It's also important to remember changing organizational culture is an "ongoing journey," indicates Gandhi. Salvador suggests leading these shifts in culture can be "extremely hard and often lonely." He emphasizes that support for creating a culture of safety has to come from the top because "setting new expectations for safe behaviors will be met with push-back from powerful places."

Learn More About How To Lead For Safety

ACHE is committed to supporting the Leading for Safety journey for all healthcare leaders. As a result, it is offering a variety of learning opportunities, including:

- ***Creating and Sustaining A Culture of Safety***, a Hot Topic Session at the [2018 Congress on Healthcare Leadership](#) providing practical strategies for driving change at every level of the organization. Led by Tejal K. Gandhi, MD, CPPS; John "Jack" Lynch III, FACHE: and Doug Salvador, MD.
- [Leading for Safety: A FREE Three Part Webinar Series](#), which provides a deeper dive into the principles and practices of the *Blueprint*.
- [High Reliability Boot Camp](#), pre-Congress one-day program that provides an in-depth look at the organizational requirements and tools needed to launch a high-reliability journey, with the ultimate goal of zero harm. Led by [Michael Shabot, MD](#), President of the Joint Commission; [Mark R. Chassin, MD](#), EVP and System Chief Clinical Officer, Memorial Hermann Health System; and [Gary R. Yates, MD](#), Partner at Press Ganey Associates.
- Additional events at the Congress (March 26-29), including a [luncheon keynote](#) by renowned leader [Peter J. Pronovost, MD, PhD, FCCM](#), SVP, Johns Hopkins Medicine,

and Director of its Armstrong Institute for Patient Safety and Quality.