Spotlight On Success: CaroMont Health Embraces High Reliability

Several years ago, CaroMont Health embarked on a journey toward high reliability, seeking to incorporate the principles of safety culture and Robust Process Improvement® throughout its entire enterprise. "Our board and senior leadership had read landmark articles by Drs. Mark Chassin [MD] and Jerod Loeb [PhD][1,2], which made a compelling case for a safety-focused culture that anticipates and prevents errors," says Todd R. Davis, MD, vice president of medical affairs, quality and patient safety officer for CaroMont Health. "In discussing these articles, it became clear that pursuing high reliability was the right thing to do for our patients."

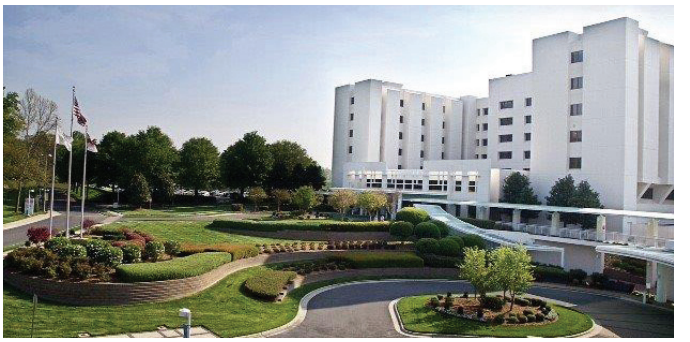
Organization Facts: Located in Gastonia, North Carolina, CaroMont Health is an independent, non-profit, community health system comprised of a 435-bed hospital along with clinics, physician offices, long term care facilities, hospice, ambulatory surgery centers, and diagnostic services.

Project Description: CaroMont Health is working to become a highly reliable organization, establishing a culture of safety and Robust Process Improvement throughout all its settings.

Outcomes: Since beginning this initiative, the organization has seen a drop in patient mortality, enhanced staff satisfaction, and fewer preventable safety events. The health system is continuing to strive for greater reliability, relying on leadership commitment and staff involvement to drive success.

Assessing the Current State

Early in its journey, CaroMont wanted to get a full understanding of its culture and any areas that needed attention. "The Chassin and Loeb articles* speak of an organizational self-assessment, and we decided to use this tool to get a sense of our existing environment and where we needed to improve," says Bonnie Faust, vice president, Patient Care Services, chief nursing officer for CaroMont Health. "We had more than 150 people complete the survey, including board members, physicians, nurses, and other direct care staff. During the process, we educated respondents on high reliability concepts and encouraged people to complete the survey honestly and thoughtfully. After compiling the results, it was evident that we needed to get started making some changes."



CaroMont Health, Gastonia, North Carolina

Providing Multifaceted Training

One area in which CaroMont invested was interactive, hands-on training that teaches the elements of a safety culture and shifts the environment to one of reliability, error prevention, and strong communication. The following are three specific training programs the organization offers:

Just Culture. This discusses the importance of accountability but also the need to recognize that system issues—rather than human flaws—are usually the underlying cause of errors. "We have incorporated the training's principles into our human resources and peer review policies, ensuring that all employees and physicians know their responsibilities and what they will be held accountable for," comments Faust.

Team Training. This course outlines a formalized process that enables more collaborative team conversations, helping groups work together and feel safe bringing up concerns. Some things on which this training focuses include time-outs, debriefing, and rounding.

Crucial Conversations. This critical program shows individuals how to communicate difficult information. "The training aims to remove hierarchy barriers that typically exist in health care," says Davis. "So, for example, after taking the training, a housekeeper can feel safe in telling the CEO that he or she must wash his or her hands. The course teaches communication skills and demonstrates how to share and receive information respectfully, ensuring that both parties in a conversation leave the interaction feeling valued. It also

* The Chassin and Loeb articles are available at the following links: http://content.healthaffairs.org/content/30/4/559.full?ijkey=UoA7j1SNli6pQ&keytype=ref&siteid=healthaff and http://www.jointcommission.org/assets/1/6/Chassin_and_Loeb_0913_final.pdf.

explains ways to create trust in communication."

These three educational offerings address safety culture at the organizational, team, and individual levels, helping staff, leadership, and physicians appreciate how safety impacts every aspect of their work. CaroMont uses a "train the trainer" approach when delivering education, having several staff members go through intense offsite training and then bring their knowledge back to the organization.

Maintaining Strong Leadership

Committed leadership underpins CaroMont's high reliability efforts, with the board, CEO, and other senior leaders ready and willing to allocate resources, redesign processes, and hold themselves accountable for establishing, sustaining, and promoting a safety culture. "Throughout the past few years, safety has become part of our DNA, and leadership works diligently to make sure everyone in the organization understands that preventing harm is our highest calling," comments Faust. "Our corporate goals center around this idea and we try to put systems in place that foster a collaborative and safety-focused environment."

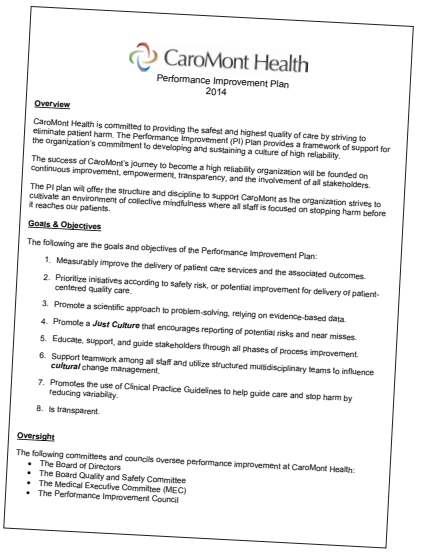
Getting Commitment from the Medical Staff

Another key component to CaroMont's program is a fundamental commitment from the medical staff to monitor and mandate a certain level of physician behavior and communication. "About four or five years ago, the medical staff began working with physicians to stress the importance of appropriate and collaborative communication, emphasizing the principles of high reliability," says Davis. "In some cases, physicians required coaching or additional training, and in others the decision was made to sever ties with the physician because he or she was not willing to fully commit to our safety goals. Having this degree of engagement from the medical staff was crucial in establishing and sustaining a culture in which the staff feels comfortable approaching and interacting with physicians."

Retooling Performance Improvement

According to Chassin and Loeb, Robust Process Improvement is an essential element to a highly reliable organization. To that end, CaroMont took a close look at its performance improvement processes and revamped them to better reflect a safety focus. "Previously, we had a 15-page document that outlined our approach," says Davis. "While well-intentioned, it was complex, unapproachable and not all that effective. It was more of a treatise rather than a working document that could drive improvement. We involved all levels of the organization in reviewing the document, going through at least 12 evolutions. We even included community members, allowing us to capture the patient perspective. As a result of these efforts, we generated a 2-page performance improvement document that serves as a flexible and working tool, guiding how we elevate performance and maintain a safe environment." (*See* this document on pages 17–21 in the online version of this newsletter.)

CaroMont Health's complete performance improvement document is available in the online version of this newsletter.



CaroMont Health

Performance Improvement Plan
2014

Overview

CaroMont Health is committed to providing the safest and highest quality of care by striving to eliminate patient harm. The Performance Improvement (PI) Plan provides a framework of support for the organization's commitment to developing and sustaining a culture of high reliability.

The success of CaroMont's journey to become a high reliability organization will be founded on continuous improvement, empowerment, transparency, and the involvement of all stakeholders.

The PI plan will offer the structure and discipline to support CaroMont as the organization strives to cultivate an environment of collective mindfulness where all staff is focused on stopping harm before it reaches our patients.

Goals & Objectives

The following are the goals and objectives of the Performance Improvement Plan:

1. Measurably improve the delivery of patient care services and the associated outcomes.
2. Prioritize initiatives according to safety risk, or potential improvement for delivery of patient-centered quality care.
3. Promote a scientific approach to problem-solving, relying on evidence-based data.
4. Promote a ***Just Culture*** that encourages reporting of potential risks and near misses.
5. Educate, support, and guide stakeholders through all phases of process improvement.
6. Support teamwork among all staff and utilize structured multidisciplinary teams to influence ***cultural*** change management.
7. Promotes the use of Clinical Practice Guidelines to help guide care and stop harm by reducing variability.
8. Is transparent.

Oversight

The following committees and councils oversee performance improvement at CaroMont Health:

- The Board of Directors
- The Board Quality and Safety Committee
- The Medical Executive Committee (MEC)
- The Performance Improvement Council

Measuring Success

Since CaroMont started down this path, it has seen some positive results. "Every year, we conduct an employee survey to gauge how our staff feels about the organization," says Faust. "One of the survey questions deals with how safe employees feel our organization is. In the last year, we have seen a significant gain in this area, which we are very proud of. This shows that the staff feels we are making a difference and that safety is a priority for our organization."

In addition to the staff survey, CaroMont regularly reviews a number of other metrics, including outcomes, patient experience, and cultural indicators. "Our patient mortality rate has dropped 25% in the past 18 months, despite an increase in patient acuity," says Davis. "We also experience less safety events, and our quality scores are rising. Although our reliability efforts are not the sole driver behind these results, we do feel they are contributing significantly to improved performance."

Moving Forward

High reliability is not a short-term goal, and CaroMont Health is committed to the long haul. "We are still at the beginning stages of this work, and we have a ways to go," says Davis. "The reality is that you never fully achieve high reliability: It is something you always strive for, being mindful that a safety culture is an organic part of day-to-day activities. In the end, this is something that most employees want—to take away the barriers to reliable care and work together to improve outcomes and keep patients safe." TS

Figure 1. CaroMont Health Performance Improvement Plan

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(*Appendix A*)

Clinical Practice Guidelines

The selection and implementation of clinical practice guidelines is designed to help practitioners improve the quality of care by building systems and processes designed to reduce errors and support CaroMont's goal to become a High Reliable Organization (HRO).

Sources of clinical practice guidelines may include:
1. Professional Societies
2. Regulatory Agencies
3. Nationally recognized organizations such as the IHI and AHRQ.

Methods for Assessing Performance

At the foundation of CaroMont Health's commitment to become a HRO is the assessment of performance. To monitor the effectiveness and progress of advancing toward high reliability the Board of Directors, Senior Leaders, and Physician and Clinical Leaders will annually review CaroMont's development in relation to the organizational maturity within the following domains:

1. Leadership
2. Culture of Safety
3. Process Improvement

CaroMont will use the findings of the review to develop specific goals, then design and measure, and continually reassess outcomes and comparative data to improve and enhance performance.

System Metrics

Clinical and administrative leadership will identify system metrics that measure the following:

1. Adverse events
2. Clinical outcomes
3. Effectiveness of all operational systems
4. Patient and family experience
5. Safety and reliability

Performance Improvement Methodology

The foundation of CaroMont's approach to clinical and organizational improvement is a collaborative and robust ***Lean Six Sigma*** model. The tools of ***Lean*** and ***Six Sigma*** provide a systematic process to uncover the specific threats to safety and process failures. This structured approach is founded upon the principles of ***Plan-Do-Study-Act***.

A3 Thinking is a proven and powerful means of aligning both ***Lean*** and ***Six Sigma***. This technique provides a consistent reporting mechanism for root-cause problem solving, progress updates, and monitoring and sustaining world class results. (*Appendix B, C*)

Change management is critical and leadership's role as a cultural enabler is to encourage and empower employees in "relentlessly striving for the goal of zero patient harm".

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Appendix A

Oversight Committees and Councils

The Board of Directors commits CaroMont to a culture of safety and high reliability. Its members have ultimate oversight of all the performance improvement activities and results throughout the organization. The Governing Board holds senior leadership and clinicians accountable to continually reduce harm and improve performance.

The Board Quality and Safety Committee ensures quality and safety is an integral component of the governance and management processes of the organization by reviewing and reporting CaroMont's safety and quality results to the Governing Board. The Board Quality and Safety Committee evaluate and recommend system priorities to CaroMont clinical and administrative leadership to support the mission and strategic plan. The membership of the committee includes four members of the Governing Board, four senior medical staff members and four senior administrative leaders.

The Medical Executive Committee (MEC) assures the highest level of safe and quality care is provided, and reports to the Board Quality and Safety Committee. The MEC oversees all clinical care and supporting processes throughout the organization. The MEC reviews findings, activities, and opportunities for improvement in organization-wide functions, processes and outcomes. It provides oversight to all medical staff committees including Credentials, Peer Review, Grievance, the clinical function of Service Lines, and the clinical service contracts.

The Performance Improvement Council supports all organization efforts of safety, quality, and performance improvement and reports to the MEC. The PI Council ensures clinical practice guidelines and evidence based care are implemented to reduce harm and generate better patient outcomes. The PI Council helps identify priorities and system vulnerabilities and evaluate the effectiveness of improvement initiatives for Service Lines and Clinical Divisions to focus on. As patient care is a team obligation and the responsibility of every person working at CaroMont Health, the PI Council membership includes clinical and administrative leaders, and at least one community member.

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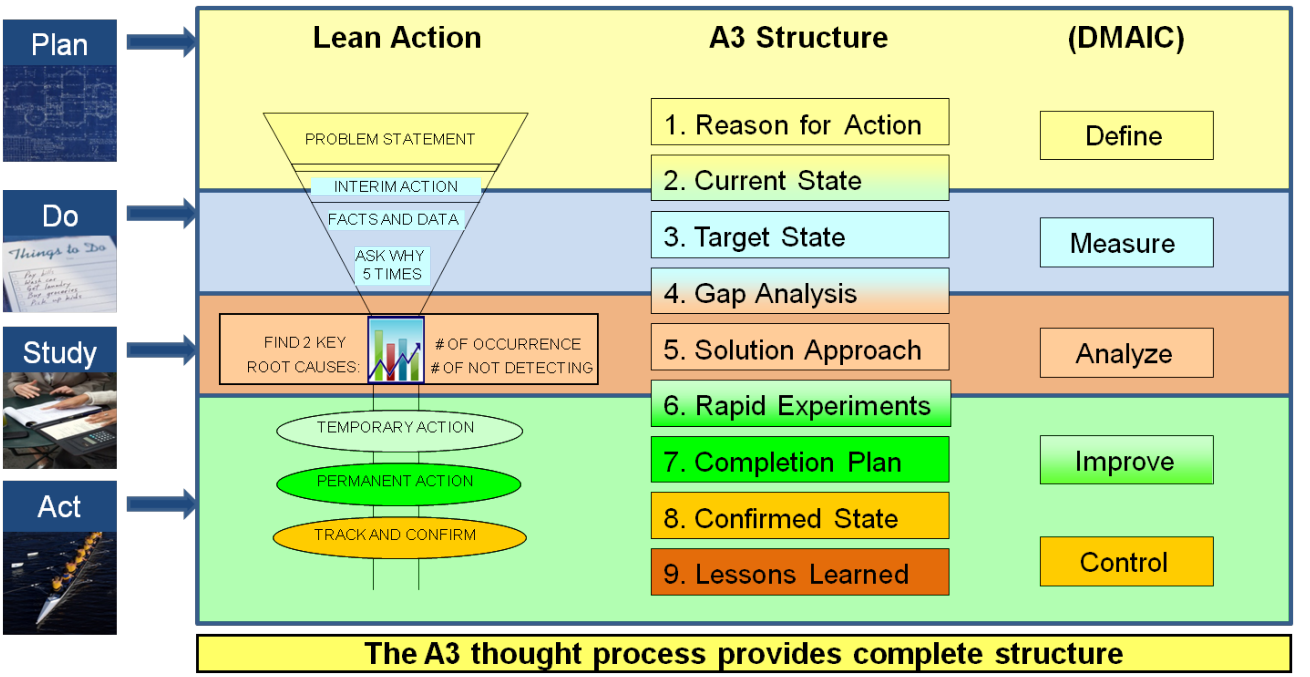
Figure 1. CaroMont Health Performance Improvement Plan (continued)

Appendix B

Lean Six Sigma Approach



Appendix C

Key Concepts

- PDSA – Plan-do-study-act (a continuous cycle of improvement)
- HRO – High Reliability Organization (strives for zero patient harm)
- Six Sigma – Reduce process variation.
- Lean Philosophy – Identify and eliminate process waste and create customer value.
- A3 – Simply refers to an 11X17 inch page size. The concept is an all inclusive one pager.

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Figure 1. CaroMont Health Performance Improvement Plan (continued)

A3 Template

1. Reasons for Action	4. Gap Analysis	7. Completion Plans
2. Initial State	**5. Solution Approach**	**8. Confirmed State**
3. Target State	**6. Rapid Experiments**	**9. Insight**