Your Personal Quality Leadership Plan

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Session Objectives

- Assess your current level of readiness to lead in quality improvement
- Detail the sequence of improvements necessary with respect to:
  1. Creating your mentor and coaching opportunities
  2. Increasing your self-awareness and mindfulness
  3. Making a strategic commitment to quality
  4. Assessing current gap between desired and observed performance
  5. Developing a structural and measurement model to close gap
  6. Developing influence strategies for individuals and groups
  7. Creating a High Reliability Organization by mastering sustainable culture change

The paradox

The best thing you can do is to just start measuring things.

A journey of 1000 miles starts with a single step - you have to start somewhere!

The worst thing you can do is to just start measuring things.

Being 1000 miles off course starts with no destination – you have to have a plan!

Remember this?

Ease of access!

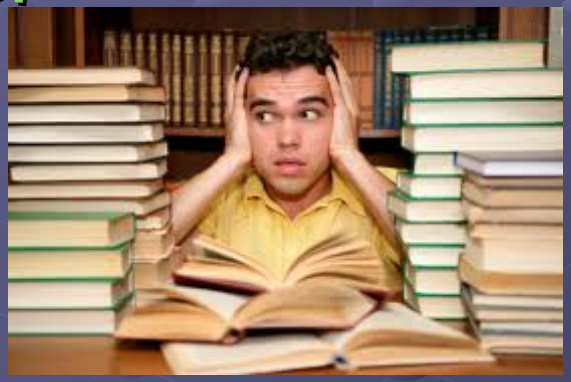
Medical errors!

CMS Core Measures!

Joint Commission Accreditation!

GME!

Outcomes!



Patient satisfaction!

Physician cancellations!

Clinical Outcomes!

Cost effectiveness!

National Patient Safety Goals !

Physician Credentialing!

Hand Sanitization!

Time for me and my family!

Which culture are you creating?

Your checklist

1. Get a mentor/coach
2. Increase your self-awareness / mindfulness
3. Make a strategic commitment to quality
4. Assess current gap between desired and observed performance
5. Develop a structural and measurement model to close gap
6. Develop influence strategies for individuals and groups
7. Create a High Reliability Organization by mastering sustainable culture change

1. Get a mentor / coach

- Who in your organization is a good leader who can assist with your personal leadership development plan?
- Who is a quality / high reliability content expert who can help you learn?

Don’t skip this step – biggest predictor of success!

2. Increase Self Awareness and Mindfulness

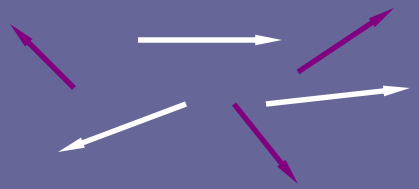
- Spend time every day thinking about quality:
  - Where are our biggest opportunities?
  - Are we walking the talk?
  - Are we doing the right things and doing them right?
  - Are we one the path to a high reliability organization?
- Mentor others – answering their questions clarifies your thoughts
- “Just don’t do something, stand there!”

3. Make a Strategic Commitment to Quality

- Am I engaging the exec team and the board?
- Are financial and quality focus areas balanced?
- Are we tactical or strategic in how we do things?
- Which Baldrige level best describes us?
- Are we “big picture” or “analysis paralysis”?
- Am I trying to do this on my own instead of leading the organization?

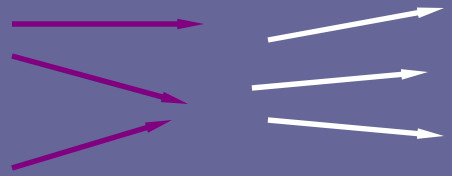
Baldrige Example

(1) Reacting to Problems



The hospital just seems to react all the time. Each clinic designs its own check-in system. No two are alike.

(2) Early Systematic Approach



The family doctors in one building get together and share ideas. Now all primary care clinics have the same system.

(3) Aligned Approach

Someone realizes that the medical specialty and surgical clinics could adopt that system as well. Now all hospital clinics have the same system.

(4) Integrated Approach

The COO realizes that non-clinical units like financial advising and even the cafeteria can benefit. Now all waiting areas in the hospital for any service have comparable processes.

4. Map Desired vs Observed Performance

- Go back to the MSW model and fill it out for your organization
- Pay most attention to Must Do and Should Do lists
- Weekly website visits:
  - Institute for Healthcare Improvement (IHI)
  - Agency for Healthcare Research & Quality (AHRQ)
  - Center for Medicare and Medicaid Services (CMS)
  - The Joint Commission (TJC)

Must Do examples

- Joint commission preparation
  - National Patient Safety goals
  - Physician credentialing and peer review
  - Disruptive physician policy and procedure
- CMS
  - Core measures
- Patient Safety
  - Medical error, patient injury and infection harm tracking
  - Error disclosure policies and procedures
  - Root cause analyses
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Credentialing and privileging-related physician performance assessment

Should Do examples

- Monitoring system-wide mortality and morbidity
- Leapfrog survey
- Targeted cost-effectiveness analyses
- Specific patient satisfaction surveys
- Development of physician leadership structure
- System efficiency (e.g., LOS, ED throughput)
- Physician satisfaction
- Service line performance measures
- At least one *Failure Modes and Effects Analysis*

Want to Do examples

- What are the issues you think are important?
- What would engage your passion for change?
- What does your executive team want to see?
- Are there specific cultural attitudes about quality and safety that need to be addressed?
- What's the "one big thing" that would make your institution great if you could just do it?
- What's your pet project that you've been dying to do?

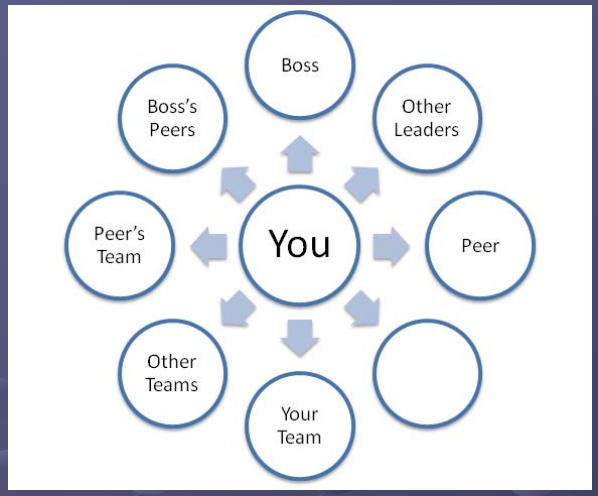
Again, Your Priorities

- Primary targets
  - Mortality and morbidity outcomes
- Secondary targets
  - Effectiveness and efficiency
  - Doing right things and doing things right
- Tertiary targets
  - Satisfaction, access and equity

5. Structural and Measurement Models

- What is your model?
- How are you going to measure what you model?
- How will you manage what you measure?
- How will you be sure it stays managed?
- How will you create permanent sustainable change, aka high reliability?
- Remember the goal: HRO Culture of Safety

6. Develop Influence Strategies

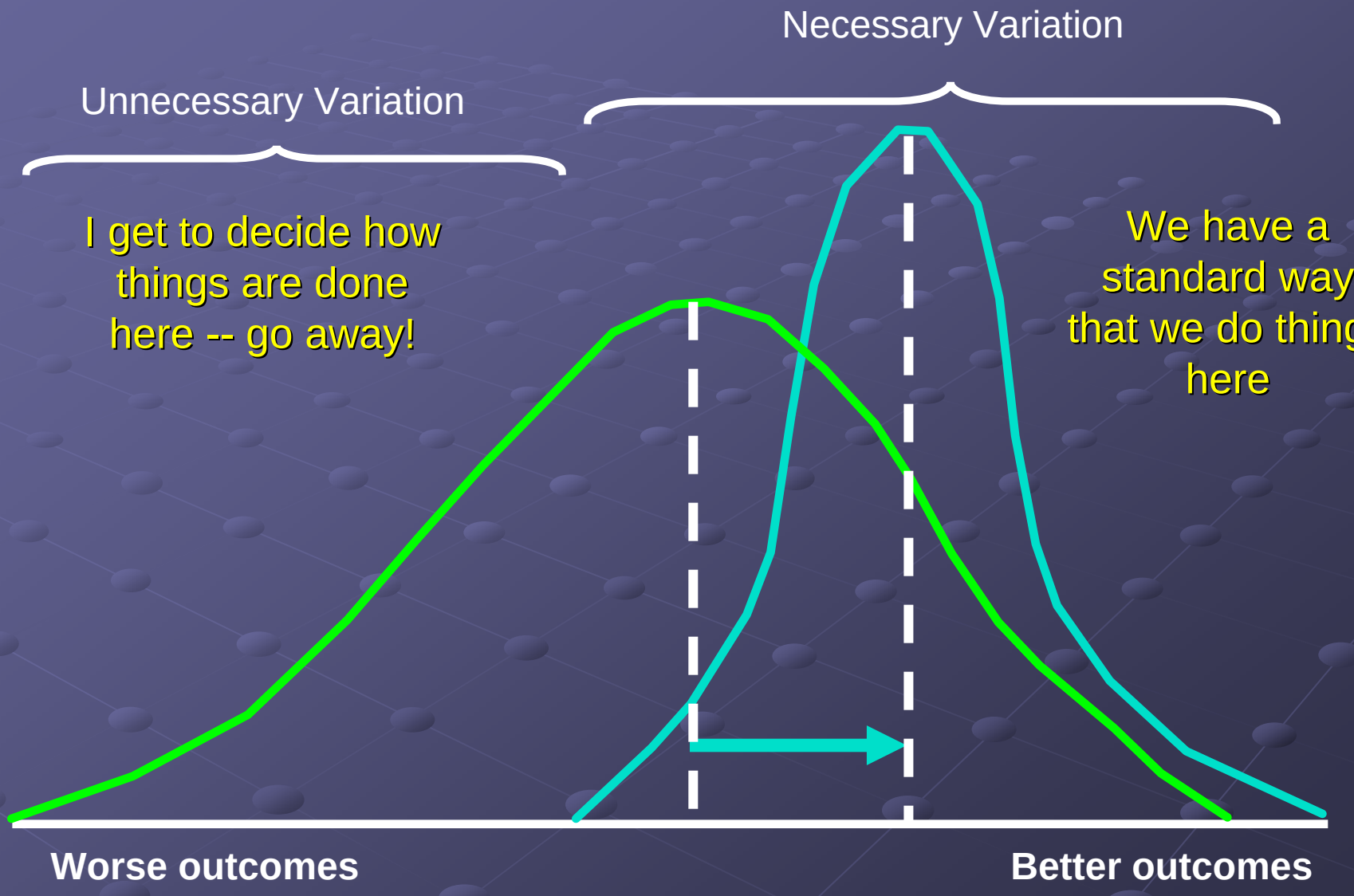


- Know what to do, then know how to get it done
- Don't become a transactional leader
- Become a transformational leader who inspires change
- Create alignment with the vision by aligning personal and organizational incentives
- See resistance as a competing values problem to solve

7. The HRO Culture of Safety

- Begin with the end in mind – envision the HRO culture of the future
- Do the AHRQ Culture of Safety
- Again… again… again…. until the culture changes
- If you can't change the people, change the people
- HRO's continually decrease unnecessary variance – it's an asymptotic PDSA process

Necessary vs. Unnecessary Variation




HOSPITAL SURVEY
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Database Report
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PATIENT
SAFETY

Final Approach Checklist

- ❑ I have a mentor and content expert
- ❑ I work on increasing self-awareness daily
- ❑ I am strategic – my exec team and board will “get it”
- ❑ I have a vision and know the O/E gaps
- ❑ I know what to measure and how to manage it
- ❑ My priorities are clear – I have a plan for change
- ❑ I can create sustainable change using influence
- ❑ I can manage resistance to change
- ❑ I know what a HRO looks like and how to get there
- ❑ I am never satisfied with where I am

What are you going to do?

Behind every new CMO is a great administrator