Patient Safety Coaches in the Ambulatory Setting: Improving Patient Safety Culture

HPI Patient Safety Summit 2014

Aaron West, patient safety manager, Novant Health medical group
Today’s Agenda

- Introduce Novant Health and Novant Health medical group
- Review the Novant Health medical group patient safety coach program
- Discuss challenges and barriers to program implementation
- Share successes and lessons learned
- Look ahead at the next steps in our journey
- Open discussion and questions
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**1,215 physicians**

**390 clinics**

Physicians recognized by NCQA* for excellence in diabetes care: 246

Physicians recognized by NCQA* for excellence in caring for those with heart conditions or stroke: 207

**1,690 overall providers**

**6,495 employees**

All numbers are approximate and reflect the medical group as of Jan. 2014

*NCQA = National Committee For Quality Assurance

**Includes physicians and allied health providers
2014 Novant Health medical group patient safety aims

1. Reduce safety events

Reducing safety events in our practices will occur through these initiatives:

- Patient Safety Reporting Initiative: assessed and improved safety event reporting through anonymous and non-punitive approach with select group of practices (6) compared with other like practices (27).
- Aggregating and using safety event reporting to better understand trends and opportunities
- Improvement workgroups where greatest opportunity exists
  - Medication Safety workgroups (anticoagulation safety and antibiotic stewardship)
  - Falls prevention (Q4 2014-Q1 2015)

2. Improve patient safety culture

Improving patient safety culture is occurring through these initiatives:

- Refined and adjusted safety behaviors and error prevention tool education for ambulatory care setting
- Repeated AHRQ Medical Office Survey of Patient Safety Culture with an emphasis on:
  - Communication openness
  - Communication about error
- Established patient safety coaches in every practice location by the end of 2014.
Foundations of the Novant Health medical group patient safety coach program:

Review common language and high reliability principals
“We are what we repeatedly do. Excellence then is not an act, but a habit.”

- Aristotle
Why is Culture Important?

Culture

Shared values and beliefs of individuals in a group or organization

= Shared values & beliefs

Our behaviors

Outcomes
Culture Change Methodology

In order to change culture we must:

**Step 1: Set Expectations**

Define Safety Behaviors & Error Prevention Tools proven to help reduce human error

**Step 2: Educate**

Educate our staff and medical staff about the Safety Behaviors and Error Prevention Tools

**Step 3: Reinforce & Build Accountability**

Practice the Safety Behaviors and make them our personal work habits
1. **Practice with a Questioning Attitude**
   A. *Stop, reflect & resolve in the face of uncertainty*

2. **Communicate Clearly**
   A. *Use SBAR-Q to share information*
   B. *Communicate using three-way repeat backs & read backs*
   C. *Use phonetic and numeric clarifications*

3. **Know & Comply with Red Rules**
   A. *Practice 100 percent compliance with red rules*
   B. *Expect red rule compliance from all team members*
   C. *If compliance with a red rule is not possible, stop action until any uncertainty can be resolved*

4. **Self-Check: Focus on Task**
   A. *Use the STAR technique*

5. **Support Each Other**
   A. *Cross-check and assist*
   B. *Use 5:1 Feedback to encourage safe behavior*
   C. *Speak up using ARCC – “I have a concern”*
Influencing Behaviors at the Sharp End

Adapted from R. Cook and D. Woods, *Operating at the Sharp End: The Complexity of Human Error* (1994)

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Design of Culture

Design of Work Processes

Design of Technology & Environment

Design of Structure

Design of Policy & Protocol

Behaviors of Individuals & Groups

“You have to manage a system. The system doesn’t manage itself.”

W. Edwards Deming

"A bad system will DEFEND a good person every time."

W. Edwards Deming

Outcomes

“You have to manage a system. The system doesn’t manage itself.”

W. Edwards Deming
Five Principles of HROs

Three Principles of Anticipation

Preoccupation with Failure
Regarding small, inconsequential errors as a symptom that something’s wrong

Sensitivity to Operations
Paying attention to what’s happening on the front-line

Reluctance to Simplify
Encouraging diversity in experience, perspective, and opinion

Two Principles of Containment

Commitment to Resilience
Developing capabilities to detect, contain, and bounce-back from events that do occur

Deference to Expertise
Pushing decision making down and around to the person with the most related knowledge and expertise
NH medical group patient safety coach

Job function:
• Facilitate patient safety culture and good habit formation
• Includes both clinical and non-clinical staff members, but is not designed to be a leadership role
• Observe, reinforce and provide real-time feedback for safety behaviors and positive patient safety culture

Job qualifications:
• Caring and patient-centered attitude
• Good communication skills
• Team-oriented

Duties and responsibilities:
• Attend the initial 2-hour training session
• Attend monthly patient safety coach meeting
• Know and model First Do No Harm (FDNH) safety behaviors and error-prevention tools
• Build positive habits for safety behaviors using 5:1 feedback to peers
• Communicate patient safety / FDNH information to leaders and staff members
• Collect and report staff patient safety concerns to leaders through normal reporting structure
• Share safety stories at staff meetings
• Encourage safety event reporting by peers and leaders
• Assist practice leadership with quality improvement planning activities/projects
Implementation plan and timeline
The action plan/timeline

- Q1-2 2013- Reviewed the acute setting safety coach program and adjusted for ambulatory setting:
  - Role of the coach
  - Training materials
  - Monthly meetings
- Q2-4 2013- Established a pilot program of 50 practices (provider based) with coaches
  - Initial training sessions
  - Monthly safety calls
- Q2-Q4 2013- Required all 50 coaches to conduct a small improvement plan for their practice using PDSA methodology
- Q4 2013- Created a patient safety coach “registry” and tracking methodology
The action plan/timeline (cont.)

- Q1 2014 – conducted Survey Monkey to assess progress. We learned that most coaches:
  - were equally distributed front office and clinical
  - preferred more interactive telephonic/web-based meetings
  - suggested focus on a monthly topic (i.e. safety behavior)
  - were “volunteered” for the role with little input
  - were not comfortable with improvement planning and PDSA methodology

- Q1–Q2 2014 – Adjusted program according to survey feedback:
  - Revised monthly meeting format and added additional opportunities for participation (5 per month)
  - Added training sessions in each market (12 opportunities)
  - Removed the requirement to conduct a practice improvement plan

11/4/2014
Novant Health: Patient Safety Coaches in Ambulatory Setting: Improving Patient Safety Culture
The action plan/timeline (cont.)

- Q2 2014 – Call for Patient Safety Coaches in all NHmg practices. Request was made through:
  - Email blasts
  - Newsletters
  - Practice manager meetings

  Response Rate 60%

- Q2-Q3 2014 - Additional training sessions offered across all markets (15 opportunities)

- Q2-Q3 2014  Engaged coaches in AHRQ patient safety culture survey (participation and result sharing)

- Q3 2014 - Second call for coaches was made – focused email to practice managers who did not respond – Response Rate: 90%

- Q4 2014- Follow up phone calls to managers that have still not responded to request. Goal: 100%

- Q4 2014 – Survey Monkey #2 of all coaches to determine progress and next steps
Challenges, Success, and Lessons Learned
### NHmg Practices with vs. without Patient Safety Coaches*

#### AHRQ Patient Safety Culture Survey 2014

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<td>% Positive Responses Px Without Coach</td>
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<td>59%</td>
<td>-6%</td>
<td>54%</td>
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*average of all practice responses*
Challenges and Barriers

- Safety events in ambulatory setting are different than acute, requiring a different understanding. We harm patients differently.
- Practices are very busy and have competing priorities/staffing issues affecting:
  - Monthly call attendance
  - Initial training
- Coaches are often assigned to meet a requirement (versus meet a need)
- Managers are reluctant to delegate the task and seek diversity of opinion
- Safety behaviors must be “translated” to be relevant for setting (i.e. specialty specific)
- Safety event reporting is still seen as punitive and time consuming
- Providers are still removed from the conversation about patient safety culture and the role of the coach
Successes and Lessons Learned

- Translating safety behaviors for ambulatory setting is crucial (make it personal and relevant)
- Story sharing and transparency with focused attention, encouragement, and deliberate practice is possible
- Validating and honoring the value of the patient safety coach role is very powerful
- Recognizing that managers need to see the value of the coach and “what’s in it for me” allows co-ownership
- Engaging coaches in dialogue on calls is important
- Focusing on Fair and Just Culture principals is essential
- Shifting away from regulatory point of view to “it is the right thing to do” reduces friction
- Continuously reminding coaches of the power of 5:1 feedback and their role as models of behaviors (vs. enforcers of rules) eases pressure
- Emphasizing moral authority over formal authority removes barriers and eases anxiety
Next Steps
Next Steps

- Begin taking attendance on monthly calls
- Develop better metrics to understand impact of coaches
  - Safety events
  - Patient safety culture
- Highlight “positive deviance” and success stories from practices
- Encourage connections and networking among coaches
- Tie patient safety work to Novant Health Population Health initiatives.
  - Care coordination
  - Care transitions
  - Patient and family engagement
- Work with managers and coaches on quality improvement activities
The framework for patient safety has been built...

The coaches are in place,

They have the tools and know how to use them,

What can we accomplish with when we all work toward a shared goal of ZERO HARM?

Timelapse of the Amish raising a giant barn in under 10 hours by Christopher Jobson
Thank you

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