Leading to Zero: Advocate Health Care’s Plan to Eliminate Harm Starts at the Top
By Diana Mahoney

Safety huddles. Checklists. Alerts. Event reporting. Error transparency. The language of High Reliability that is familiar to complex, high-hazard domains such as commercial aviation and nuclear power is making its way to health care, promising to change the culture in which physicians and front-line care providers deliver care every day. As with any other fundamental change in health care, however, the transformation will only be sustainable if senior leaders own the process, according to James Skogsbergh, president and CEO of Advocate Health Care and chair of the American Hospital Association’s (AHA) board of trustees.

In a keynote presentation at Press Ganey’s 13th Annual HPI Safety Summit in Chicago last month, Skogsbergh, together with Advocate colleagues Dr. Lee Sacks, executive vice president and chief medical officer, and Dr. Rishi Sikka, senior vice president of Clinical Transformation, explained the role of mindful leadership in the journey to Zero Harm and how the Illinois-based health system has successfully employed its own safety culture transformation.

“Safety culture transformation has to start with the leaders, including the CEO and board of directors. Unless your leaders are trained, molded and expected to lead in a High Reliability manner, the culture won’t sustain front-line interventions,” Skogsbergh explained.

Speaking from his perspective as chair of the AHA board of trustees, Skogsbergh has seen “a ton of good work” at the national level focused on enhancing patient safety, including such efforts as the AHA’s Health Research & Educational Trust–administered Hospital Engagement Network, part of the Department of Health and Human Services’ Partnership for Patients initiative, and the AHA’s and National Patient Safety Foundation’s (NPSF) adaptation of a transformative patient safety curriculum developed by the NPSF’s Lucian Leape Institute.

“This steadily increasing focus on and transparency around safety is all really good news, but the importance of leading to safety—the role of leadership on the journey—has yet to take the main stage,” Skogsbergh said. “If we are going to truly shift the culture of health care organizations toward High Reliability, senior leaders have to establish zero safety events as the moral imperative of the organization and make that the target of their collective focus.”

The concept of patient harm also has to become visible, and personal—both of which contribute to culture shock, according to Skogsbergh. “For a long time, senior leaders of health care organizations, including our own, were virtually unaware of the flawed systems that contributed to patient harm, and of the harm itself, because the events that were reported were confidentially investigated and managed,” he explained. “We were insulated and protected by our own processes.”

This changed for Advocate beginning in 2010, following a medical error that resulted in the death of an infant. “A 60-fold overdose of sodium was inadvertently put into the infant’s IV. His death was the result of our failure to pay attention to detail, have a questioning attitude, validate and verify,” Skogsbergh said. “His death was devastating, and we are still pained by that experience, but even that, on its own, was not sufficient to really launch a large-scale culture change until we changed the mindset of leaders, including myself, that harm is the cost of doing business in highly complex systems.”

This change in mindset occurred, Skogsbergh said, when two of the organization’s leaders brought the details of the organization’s collective harm to the leadership team in the form of patient stories. “Once that harm became visible to us, there was no turning back. We could no longer consider unintended serious harm as the cost of doing business, so we brought our leaders together from across the organization and asked the question, ‘Is it possible to create a deliberate road map to eliminate serious harm?’”

AT A GLANCE
- Illinois-based Advocate Health Care began transforming its safety culture in 2012 by methodically training every leader in the organization, from unit and department managers up to the C-suite, in High Reliability practices.
- With senior leaders engaged, the transformation team shifted its focus to the sharp end of care through its four-year plan to create High Reliability units by training physicians and front-line associates across the organization, one unit at a time.
- Year-to-date, the organization has seen a decrease of more than 40% in its reported Serious Safety Event Rate, with several sites posting decreases of 60% to 70%, and significant improvement across multiple AHRQ Culture of Safety measures.
The answer, it seems, is yes, but the road is not easy, nor does it end. The Advocate leadership team created its strategic safety plan, with the goal of zero harm events, and “never looked back,” Skogsbergh said.

“It was interesting to note that when the completed plan was submitted, there was no analysis on the financial impact on the organization. This intentional omission was spot-on,” said Skogsbergh. “It sent a message that we’re not talking about cost. We’re talking about the care of patients. No one argues with that message, because patients deserve to receive care that is free from harm. Without exception, our leadership team understood that our ability to provide care was not a business imperative, but a moral one.”

In order to make meaningful progress on the safety culture transformation, Advocate’s transformational change team had to overcome significant cultural barriers to change across the system leaders, including the following.

- **Shock:** “Hearing about the collective harm was unbelievable to many leaders,” Skogsbergh said. “We’re a top-decile performer and one of the top systems in the country, so when we found out that a serious safety event was occurring once every 1.5 days in our system it was hard for people to wrap their heads around that.”

- **Mindset:** “At the start of our safety journey in 2011, the collective mindset was that patient harm was an unfortunate cost of doing business in a complex system, and site leaders hesitated when it came to reporting events, almost as if each was a personal failure,” explained Skogsbergh. “Shifting this mindset required helping leaders recognize the need to change and gradually infusing new information to change their way of thinking.”

- **Fear:** This was the most significant barrier, Skogsbergh said. “We were encouraged to talk about safety events, but there were voices in our heads telling us not to out of fear: fear of loss of reputation, fear of litigation.” Overcoming this fear took longer than it should have, he said, noting that for the first few months of the journey, the Serious Safety Event Rate (SSER) wasn’t readily visible. It didn’t take long, however, to make the SSER a “true north” metric that sits on top of the performance scoreboard as a public and visible commitment to mindfully leading to safety.

**Leading to Safety from the Inside Out**

Initiating the safety journey required establishing a “why” and keeping it simple, Dr. Sacks explained. “Just telling people what they had to do would not work. We needed to inspire everyone to join us on the journey by establishing a big, visible ‘why’ for our work and communicating it from the inside out,” he said. “Our ‘why’ was the patient harm rate—the fact that there were 300 serious safety events per year—and our vision was to go from 300 to zero. There was no way we could say any number of patients harmed was acceptable.”

The next step was to devise the plan, message its importance and secure buy-in across the organization, starting with the leaders, Dr. Sacks said, noting that while there are “dozens and dozens” of individual tactics, the overall plan was devised around four key strategies.

1. Position safety as fundamental to care, call it out, make it visible and make sure everyone hears about it all the time.
2. Require leader ownership of patient safety, rather than delegating it to a single team or individual.
3. Empower front-line associates and physicians to address safety issues.
4. Engage patients and loved ones on this journey.

Of these, leader ownership, as noted, is a lynchpin. Toward this end, Advocate spent 18 months training every leader in the organization, from unit and department managers all the way up to the executive team. “We aligned all leadership teams, identified and assigned readings and implemented tools along the way so that leaders could demonstrate their commitment to High Reliability,” said Dr. Sacks.

In addition, in partnership with Press Ganey’s HPI consultants, “we delivered 12 two-hour sessions on various aspects of High Reliability leadership,” Dr. Sacks said. “Each session had assigned pre-readings, homework and a tool or method, such as a daily safety huddle, that could be implemented so that we could visibly demonstrate safety commitment.”
Shifting the Lens to the Front Line

In addition to changing culture at the leadership level—which provides the soil and foundation for safety efforts to take root, according to Dr. Sikka—effecting measurable change requires bringing that same model of behavior to the people who deliver care daily.

“We’ve done this by creating the High Reliability unit,” Dr. Sikka explained. “Over the past two years and continuing over the next two years, we are going unit by unit every three to four months at every one of our hospitals, teaching all the associates the science of High Reliability and error-prevention techniques that they can use daily, and we teach them a method to see problems and solve problems,” he said. “The way we accomplish this ambitious agenda at the unit level—the sharp end of care—is by designating safety champions in every unit, as well as a cadre of folks who are advancing safety in the unit.”

The designated safety champions, physician partners and departmental managers participate in the training to become the coaches that “move the microcultures,” Dr. Sikka said.

The unit-by-unit High Reliability training is scheduled for completion in 2018, after which “we’re going to start it all over again,” said Dr. Sikka. “The idea is that there is no end. Learning always continues.”

In the meantime, ongoing assessment and evaluation of the journey’s progress indicates that the road map the team is following is, in fact, leading toward zero.

“From when we started to where we are now, we have almost doubled the identification of safety events in the organization, including doubling physician reporting of events over the past year,” Dr. Sikka said. “This is key, not just in terms of understanding the data. Being able to identify events earlier means you can work them up and resolve them faster.”

With respect to the organization’s SSER, following a predicted initial increase of reported events, Advocate has seen a year-to-date decrease of more than 40% across the organization, with several sites posting decreases of 60% to 70%, Dr. Sikka reported.

The culture of safety across the organization has also improved measurably. In 2012, the organization’s Agency for Healthcare Research and Quality (AHRQ) Culture of Safety performance placed it at the 57th percentile nationally. By 2015, it had risen to just under the 75th percentile, and an early look at 2016 data appears promising for additional improvement, Dr. Sikka said.

Performance on the individual components of safety culture shows significant gains across the board. For example, Feedback and Communication about Errors rose from the 68th percentile to the 90th; Communication Openness increased from the 40th percentile to the 84th; and Non-Punitive Response to Error—“the foundation of a just culture,” according to Dr. Sikka—rose from the 34th percentile to the 80th.

Taken together, these outcomes confirm that the answer to the question posed early in the Advocate Health Care safety journey—Is it possible to create a deliberate road map to eliminate serious harm?—is a clear and resounding “yes.”