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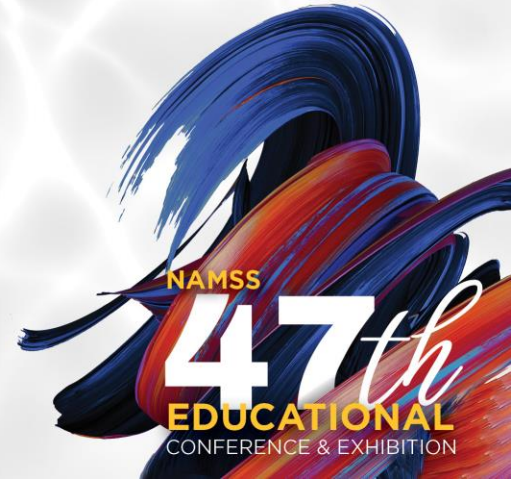
NAMSS
47th
EDUCATIONAL
CONFERENCE & EXHIBITION
Orlando, Florida | September 10 – 13, 2023

Building Better:
Setting the Foundation
for the Future of the Profession

The Role of the Medical Services Professional in a High Reliability Organization

NAMSS 47th EDUCATIONAL CONFERENCE & EXHIBITION

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POLL QUESTION

On a scale of 1 to 5, how much do you know about High Reliability?

Objectives

➢ Define what is an HRO and its relevance to healthcare

➢ Demonstrate how HRO principles relate to credentialing and privileging

➢ Outline the benefits of HRO practices in credentialing

What Is An HRO?

➢ Certain industries face the possibility of catastrophic, life or death, events everyday.

➢ High Reliability practices are proven to provide consistent, positive outcomes.

➢ High Reliability Organization(HRO) introduces safety behaviors and error prevention tools, if practiced as **habits**, will reduce error and prevent events that can harm our patients and workforce.

High Reliability principles are used in high-risk, complex, dynamic environments -- like nuclear plants, aircraft carriers, wildfire operations, air traffic controllers -- where there is constant risk of catastrophic failure.

A **high reliability organization** is an organization, that despite operating in a *high stress, high-risk* environment continually manages their environment *mindfully*, adopting a constant state of vigilance resulting in the fewest number of errors.

How Do HROs Operate?

HROs work and train for zero accidents

HROs share many properties with other high-performing organizations including:

* highly trained-personnel
* continuous training
* effective reward systems
* frequent process audits and;
* continuous improvement efforts

What are HRO Principles?

Preoccupation with Failure

➢ Never satisfied that they have not had an accident for many months, or even many years

➢ Always alert to the <u>smallest</u> signal that a new threat to safety may be developing

HRO Principles

Reluctance to simplify

➤ There is no one-size-fits-all "best practice" solution

➤ Resist the temptation to simplify the observations, as the threats can present themselves in many different forms

➤ Recognize the risk of "painting with broad strokes" and failing to dig deeply enough to find the ***real*** source of a particular problem

HRO Principles

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HRO Principles

Sensitivity to operations

➢ Recognize that the earliest indicators of threats to organizational performance typically appears in small changes in operations

➢ Each employee pays close attention to the operations and maintains awareness as to what is or isn't working
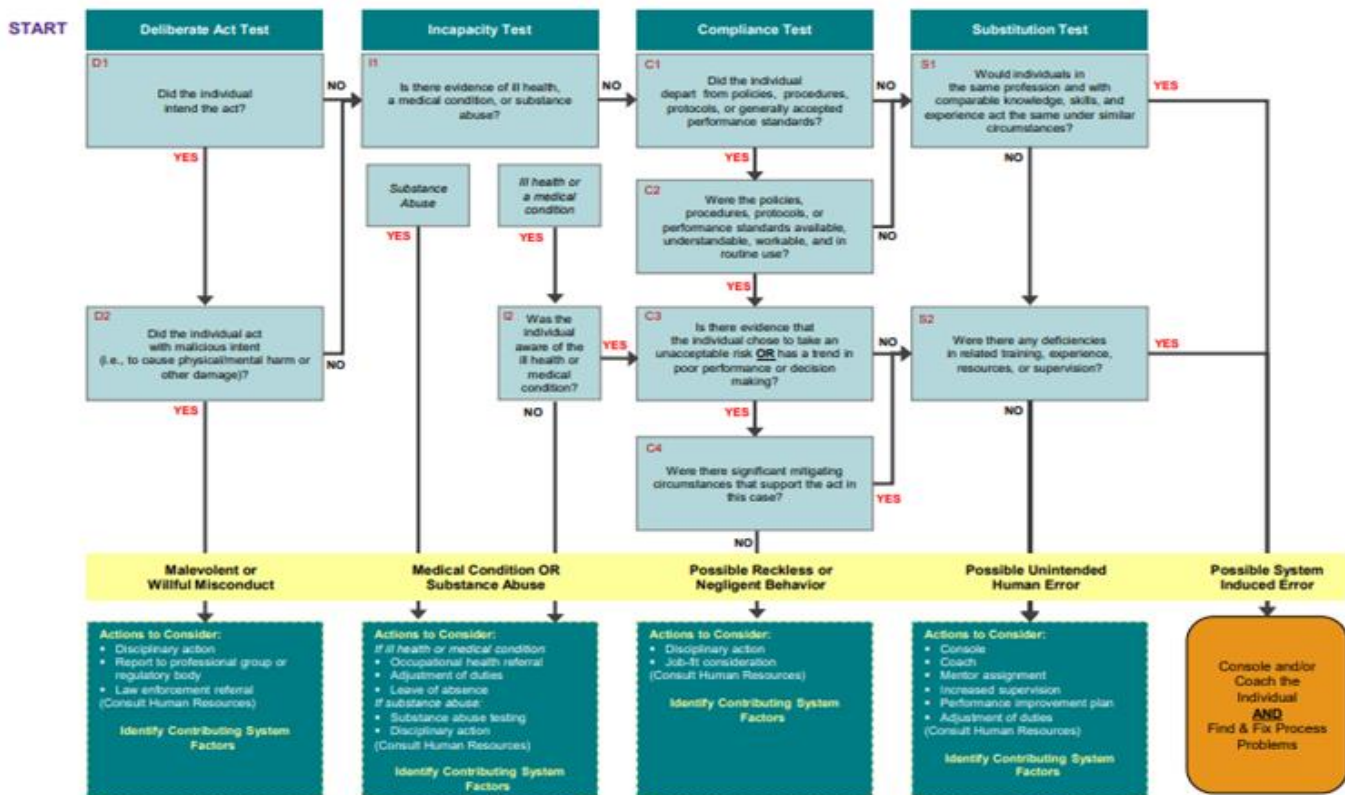
HRO Principles

Commitment to resilience

➢ Recognize that despite all precautions, errors will occur, but errors should not be allowed to disable operations

➢ Use Just Culture when assessing errors and actions

JUST CULTURE DECISION GUIDE

Adapted from James Reason's *Decision Tree for Determining the Culpability of Unsafe Acts* and the *Incident Decision Tree* of the National Patient Safety Agency (United Kingdom National Health Service)

START

Deliberate Act Test	Incapacity Test	Compliance Test	Substitution Test

D1 Did the individual intend the act? — NO →
I1 Is there evidence of ill health, a medical condition, or substance abuse? — NO →
C1 Did the individual depart from policies, procedures, protocols, or generally accepted performance standards? — NO →
S1 Would individuals in the same profession and with comparable knowledge, skills, and experience act the same under similar circumstances? — YES →

D1 YES ↓
C1 YES ↓
S1 NO ↓

Substance Abuse — YES ↓

Ill health or a medical condition — YES ↓

C2 Were the policies, procedures, protocols, or performance standards available, understandable, workable, and in routine use? — NO →
C2 YES ↓

D2 Did the individual act with malicious intent (i.e., to cause physical/mental harm or other damage)? — NO →

I2 Was the individual aware of the ill health or medical condition? — YES →

C3 Is there evidence that the individual chose to take an unacceptable risk OR has a trend in poor performance or decision making? — NO →

S2 Were there any deficiencies in related training, experience, resources, or supervision? — YES →

D2 YES ↓
I2 NO ↓
C3 YES ↓
S2 NO ↓

C4 Were there significant mitigating circumstances that support the act in this case? — YES →
C4 NO ↓

Outcomes

Malevolent or Willful Misconduct	Medical Condition OR Substance Abuse	Possible Reckless or Negligent Behavior	Possible Unintended Human Error	Possible System Induced Error
Actions to Consider: • Disciplinary action • Report to professional group or regulatory body • Law enforcement referral (Consult Human Resources) **Identify Contributing System Factors**	**Actions to Consider:** *If ill health or medical condition* • Occupational health referral • Adjustment of duties • Leave of absence *If substance abuse* • Substance abuse testing • Disciplinary action (Consult Human Resources) **Identify Contributing System Factors**	**Actions to Consider:** • Disciplinary action • Job-fit consideration (Consult Human Resources) **Identify Contributing System Factors**	**Actions to Consider:** • Console • Coach • Mentor assignment • Increased supervision • Performance improvement plan • Adjustment of duties (Consult Human Resources) **Identify Contributing System Factors**	Console and/or Coach the Individual **AND** Find & Fix Process Problems

HPI | PRESS GANEY

HRO Principles

Deference to expertise

➢ Identify individuals who best know how to resolve the threat, even if they are not the highest ranking

➢ Surround yourself with people who know more than you do – defer to them

➢ Insert yourself in issues where you can assist

HRO = Collective Mindfulness

An HRO is "an environment of *'collective mindfulness'* in which all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the org and when they are easy to fix."

~(Weick and Sutcliffe 2007)

HRO Challenges

➤ Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day

➤ Hospitals find improvement difficult to sustain, and they suffer "project fatigue" because so many problems need attention

The Center for Transforming Healthcare

➢ High Reliability introduced into healthcare by TJC's Center for Transforming Healthcare

➢ Created in 2008, the center has aligned with healthcare facilities to help facilities develop:

  ➢ Leadership commitment to zero harm

  ➢ Sustainable safety culture

  ➢ Robust process improvements

What is the MSPs role in HRO?

As we looked into this very important initiative, we realized:

➤ The characteristics of High Reliability Organizations could also apply to credentialing and privileging

➤ HRO's "collective mindfulness" should also include the processes that examine the practitioners who provide patient care

Why High Reliability Credentialing (HRC)?

➢ Assists in assessing gray areas and overlapping processes

➢ Credentialing risks are greater than ever, and more public than ever!

➢ New credentialing technology, more on the horizon

➢ More pressure on MSDs to expand scope of services

In the current shifting credentialing landscape, we don't want to lose sight of the real reason we care so much about what we do…

Keeping patients safe (zero harm)

HRC Princip

- **Embrace C**
- Be resilient ... their training, ex ... reliable means to re ...
- Promote sk ... asis with a 90-day a ...
- Learn from

we've always done it this way

HRC Principle #2

➢ **Comm...**

  ➢ Don't...

  ➢ Don't... and FIX IT

  ➢ If one... view your error

  ➢ Focus... nment

  ➢ Don't...

HRC Tips

- Follow checklists - the checklist system can help fine tune the credentialing and privileging process by eliminating human error and ensuring thorough verification of credentials

- Adapt your credentialing framework to "bullet proof" your processes

- Use your team's expertise, encourage problem sharing and solutions

- Expert may not be the one in charge, listen to your front line

- Encourage open and frank discussions

HRC Cool Tools!

Six Sigma Uses "DMAIC"
To Improve the Outcomes of Processes

Define → Measure → Analyze → Improve → Control

- **Define:** Who are the customers? What is critical to the quality of the process?
- **Measure:** How can we measure exactly how well the process is performing?
- **Analyze:** What are the most important causes of the defects?
- **Improve:** How do we remove the causes of the defects?
- **Control:** How can we maintain the improvement?

The Joint Commission

SBAR Tool
(Situation Background Assessment & Recommendation)

Parkland
Clinical Informatics

Topic: Date of Review: Stakeholder(s):	
Situation *A concise statement about the problem*	
Background *Pertinent brief information related to the situation*	
Assessment *Analysis and options considered -what you found/think)*	
Recommendation(s) *Action recommended- what you want)*	
Figure 1.1	
Figure 1.2	
Figure 1.3	
Next Steps:	
Completion target date:	

Leadership Model for High Reliability
Department Daily Safety Huddle

Parkland

Daily Safety Huddle Agenda

Current Census		Admits Last 24 hours		Surgical Cases		Procedures	

Isolation Patients: Contact		Contact (+)		Airborne		Droplet		COVID (+)	

Days Since Last Safety Event	Days Since Last Patient Fall with Injury	Days Since Last Employee Injury	Days Since Last WPV Event	Days Since Last Visitor Injury

High Risk Readmissions / DC Planning Issues:

Huddle Purpose:
- Focused on today's operations
- Identify and proactively problem solve any barriers
- Close communications loops
- Build energy/engagement with the team to prepare for the day

Keep Huddles: *Fast – Focused – Proactive - Positive*

1. **Safety Moment and/or Celebrations**
   - Share recognition and promote teamwork
   - Share gratitude and any related ICARE value moments
   - Acknowledge efforts and examples of excellence
   - Acknowledge any safety champion events

2. **Look Back:** Follow ups from yesterday
   Provide updates/resolutions to follow up item from the day before.

3. **Look Forward:** Prepare for today and look to tomorrow
   - What do staff need to know to prepare the day?
   - Are there any quality/safety or high-risk issues?
   - Any operational barriers? Any staff concerns?
   - Anything new to report for the day?
   - Any issues anticipated for tomorrow?

4. **Gemba Results:** Go where the work is happening to observe
   - What were yesterday's results?
   - Quick problem-solving
   - How can we course correct to avoid a miss today?
   - *Think prevention!*

5. **Follow Up:** Start-the-Clock Items
   - Are there any issues that may impact other departments?
   - Any high-risk situations needing support?
   - Any operational, equipment, IT challenges or needs?
   - Any issues impacting patient flow?
   - Any quality/safety concerns?

Self-Assessment of HRO Characteristics
Source: *Managing the Unexpected*, Karl E. Weick and Kathleen M. Sutcliffe

To deal with the unexpected, HROs create a mindfulness infrastructure. Mindfulness is a rich awareness and a capacity for action that jointly facilitates a capability to discover and manage unexpected events before they escalate into crises and catastrophes. The five HRO principles that make up the mindfulness infrastructure are below in no particular order as all five are interconnected and critical.

SCORING: FOR EACH ITEM THAT YOU CHECK OFF, GIVE YOURSELF 3 POINTS

Principle 1: PREOCCUPATION WITH FAILURE
Regarding small, inconsequential errors as a symptom that something is wrong. Operating with a chronic wariness of the possibility of unexpected events that may jeopardize safety by engaging in proactive and preemptive analysis and discussion.

In practice, this means as leaders in our Department /Organization we:
- ☐ We treat near misses and errors as information about the health of our system and try to learn from them.
- ☐ We make it hard for people to hide mistakes of any kind.
- ☐ People are inclined to report mistakes that have significant consequences even if nobody notices.
- ☐ Managers seek out and encourage bad news.
- ☐ People are rewarded if they spot problems, mistakes, errors, or failures.

Principle 2: SENSITIVITY TO OPERATIONS
Paying attention to what is happening on the front line. Ongoing interaction and information-sharing about the human and organizational factors that determine the safety of a system as a whole

In practice, this means as leaders in our Department /Organization we:
- ☐ Pay attention daily to what is happening & who is readily available for consultation if something unexpected arises.
- ☐ Should problems occur, someone with authority to act is always accessible/ available, especially to people on the front lines.
- ☐ Supervisors readily pitch in whenever necessary.
- ☐ We have access to resources if unexpected surprises crop up.
- ☐ Managers constantly monitor workloads & can obtain additional resources if the workload starts to become excessive.

Principle 3: RELUCTANCE TO SIMPLIFY INTERPRETATIONS
Encouraging diversity in experience, perspective, and opinion. Taking deliberate steps to question assumptions and received wisdom to create a more complete and nuanced picture of ongoing operations

In practice, this means as leaders in our Department /Organization we:
- ☐ Encourage people to take nothing for granted and have a questioning attitude.
- ☐ Encourage people feel free to bring up problems and tough issues.
- ☐ Do not criticize/attack people when they report information that could interrupt operations.
- ☐ Encourage people to express different views of the world.
- ☐ Generally, deepen our analyses to better grasp the nature of the problems that arise.

Principle 4: COMMITMENT TO RESILIENCE
Developing capabilities to detect, contain, and bounce back from errors that have already occurred, before they worsen and cause more serious harm

In practice, this means as leaders in our Department / Organization we:
- ☐ Encourage people to use their knowledge in novel ways.
- ☐ Are concerned with building people's competence and ability to vary their response to problems.
- ☐ Encourage staff to have a number of informal contacts that they use as necessary to solve problems.
- ☐ Encourage people learn from their mistakes.
- ☐ Ensure our people have the skills to act on the unexpected problems that arise.

Principle 5: DEFERENCE TO EXPERTISE
Pushing decision making down and around to the person with the most related knowledge and expertise. During high-temp operations, decision-making authority migrates to the person or people with the most expertise with the problem at hand, regardless of rank.

In practice, this means as leaders in our Department / Organization we:
- ☐ Know who has the expertise to respond if something out of the ordinary happens and seek them out.
- ☐ Value expertise and experience over hierarchical rank.
- ☐ Go to the most highly qualified people, regardless of rank, to make the decision if something unexpected occurs.
- ☐ Typically "own" a problem until it is resolved.
- ☐ Obtain expert assistance when something unprecedented occurs that we do not know how to handle

SO HOW DID YOU SCORE?

	Points (3 points for each check)	For each Principle
Principle 1: Preoccupation with Failure		15 pts – Excellent! Keep up the good work and continue to build strong habits
Principle 2: Sensitivity to Operations		-----
Principle 3: Reluctance to Simplify Interpretations		10 pts – Not Bad... look for opportunities to become more mindful
Principle 4: Commitment to Resilience		-----
Principle 5: Deference to Expertise		5 pts – Definite room for improvement. Continue to focus on developing mindfulness skills

What does a daily huddle look like?

- Leadership (VP, Director, 4 managers – 10-15 minutes)

Date	Team	Safety St⌄	Last 24 hours	Next 24 hours	Start the Clock	Other Comments
8/14/2023	Delegated		No Issues	No Issues (CAC)		
	Ops		No Issues	CRED report		
	Support Services		No Issues	Prepping for MEC		
	Tech					
	Director	X	PRC Presentation	Review Project Tracker		
	VP		OTO privileges (meeting to finalized)	Presentation for PSQM & MEC; Outcome of Dr. Chang		
8/16/2023	Delegated		Group2 planning	Meet w/Ken regarding roster request for PCHP		
	Ops		provider wi/suspended privs			
	Support Services	X	e-vote sent out	e-vote to go out tp CC for DoP in time for MEC		
	Tech			S-bar		
	Director					
	VP		Report for NTP/RTP			

HRC Principle #3

Anticipate Disaster!

➤ Every employee at every level in a high reliability organization is encouraged to constantly think of ways their work processes might break down
➤ Employees are encouraged to share their concerns for potential failures, which can help create best practices across departments
➤ Document for the future
➤ Imagine every provider you credential will be involved in a high-profile legal negligent case
➤ Do you have the documentation to support all decisions made regarding privileging?

Could you demonstrate a **total picture** of the individual, as well as the choices/decisions that were made during the credentialing process?
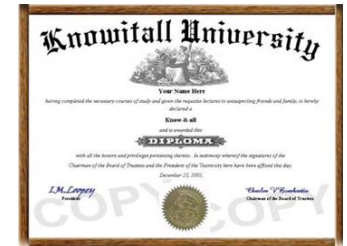
Yes/No

Are you so sure?

HRC Principle #4

➢ Always "Be On" but know when to let others shine

  ➢ No matter how many years experience, no one person can know everything…surround yourself with those that do!

  ➢ Be a Life-long learner, but be sure to share that knowledge

HRC Principle #5

Don't Let Technology Over-Simplify

➢ Technology allows us to build in speed and accuracy

➢ However, technology does not have a "gut instinct"

➢ Use technology to increase transparency

  ➢ Track your metrics!

# Initials	# Reappt.	# of Denials
# MoPs	# of Temp Privs	# Waivers
# NTP/RTP	#FPPE/OPPE	TAT

HRO Lingo

- **CUS**
  - Voice a CONCERN
  - State I am UNCOMFORTABLE
  - This is a SAFETY Concern
- **3 Way** repeat back and read backs
- Handoff with **SBAR**
- Validate and Verify (this is were **MSPs excel**!)

HRO Lingo

- **STAR**
  - <u>S</u>TOP: Pause for at least 2 seconds
  - <u>T</u>HINK: Consider your action and concentrate
  - <u>A</u>CT: Carry out the task
  - <u>R</u>EVIEW: Make sure you got it right
- Cross-check (yourself and others)
  - Double-check your work
  - Be willing to ask for help "Can I get a cross-check"?
 - Have someone else's back by offering a supportive cross-check

It's Going to Take Work…Lots, but it's worth it

➢ Safety cultures are harder to maintain than to create

➢ It takes a full commitment from ALL team members

➢ Building consistent reliability into programs such as privileging and verification helps to sustain the safety culture

Seems like a lot of work, why should I?

- Improves organizational effectiveness – we need to think outside our office walls and participate in organizational task forces

- Improves organizational efficiency – what do we lend to the organization as a whole? How are we viewed by leadership?

- Improves customer satisfaction – Who are our customers? Are they all satisfied – if not why not?

- Improves organizational culture – What an opportunity to change the perception of credentialing!

- Improves compliance – robust regulatory compliance, improved outcomes

WHAT IMPROVEMENT (REALLY) LOOKS LIKE

What is the worst that can happen?
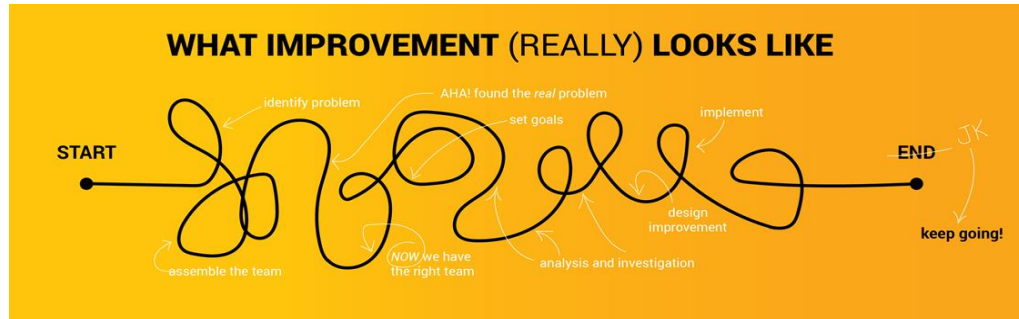
Above all else, employees at high reliability organizations remember their purpose. They do worthwhile work and feel as though they can make a difference within their organizations.

Resources

- http://www.jointcommission.org/assets/1/6/Chassin_and_Loeb_0913_final.pdf
- https://education.ochsner.org/img/uploads/events/Chassin_QualitySummit.pdf
- http://www.beckershospitalreview.com/hospital-management-administration/5-traits-of-high-reliability-organizations-how-to-hardwire-each-in-your-organization.html
- http://www.centerfortransforminghealthcare.org/hro_portal_main.aspx
- http://www.memorialhermann.org/about-us/quality-report-high-reliability-healthcare/
- https://www.studergroup.com/resources/articles-and-industry-updates/insights/january-2017/building-high-reliability-organizations-(hros)-in

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