NEW CLINICIAN LEADERSHIP PROGRAM

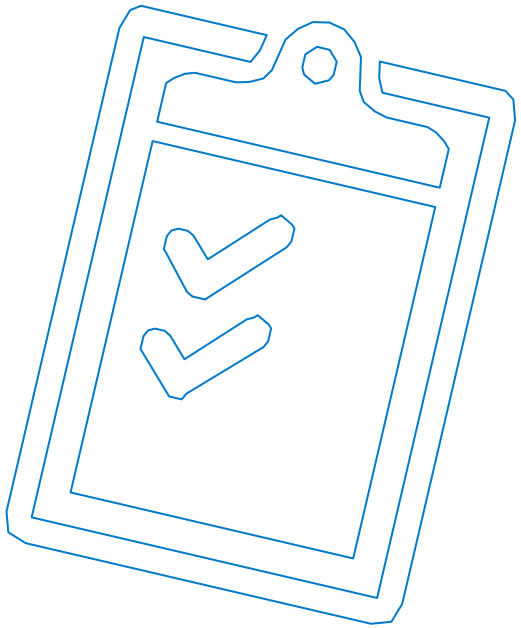
WELCOME

October 2019

Learning Objectives

By the end of these sessions, you will better be able to:

1. Build awareness of what it means to be a clinician leader at Aurora, and enhance ability to be a team leader
2. Get to know and build relationships with other clinicians within the Aurora Health Care Medical Group
3. Identify resources for professional development and leadership opportunities
4. Build awareness of our Purpose: We Help People Live Well, as well as build alignment with our Values: Excellence, Compassion, & Respect



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CME Designation and Accreditation

Aurora Health Care is accredited by the Wisconsin Medical Society to provide continuing medical education for physicians.

Aurora Health Care designates this live activity for a maximum of 13.25 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

You may claim your credit after completing the online evaluation. Your attendance and credits will be assigned through the CPD Learning Platform. You can access your certificate and transcript by logging onto https://cpd.aurora.org. Credits are usually assigned within 30 days.

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Disclosures

The planners and speaker(s) have indicated that there are no financial relationships with any commercial interests to be disclosed.

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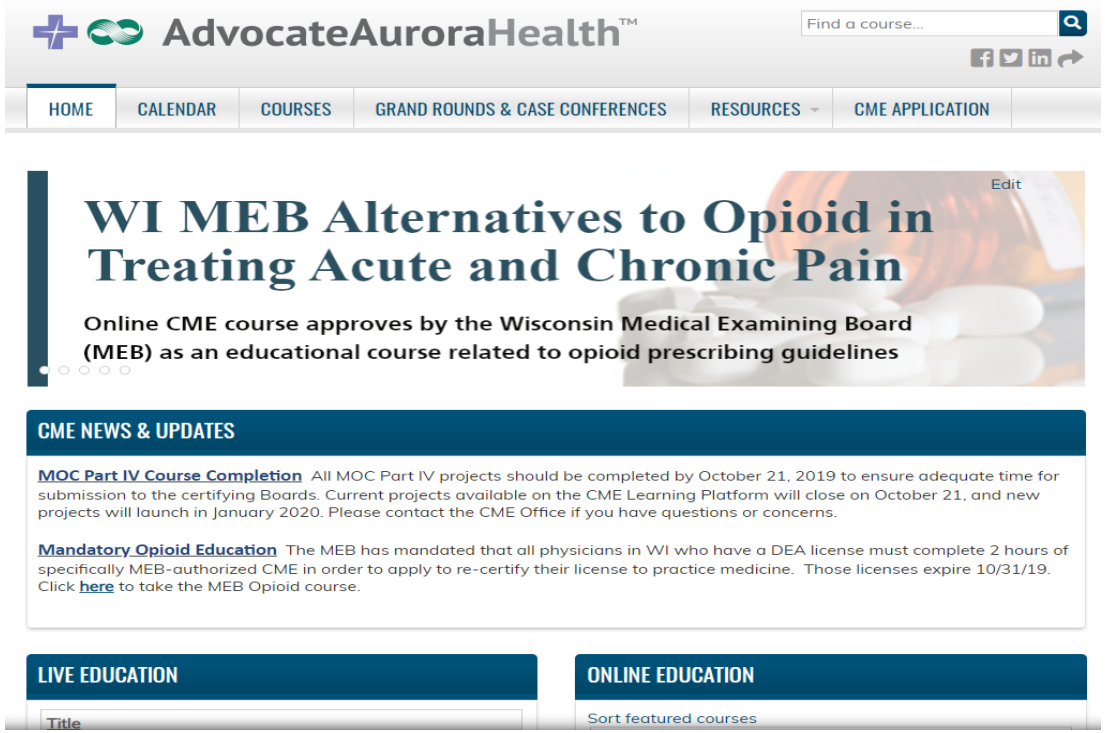
CME Learning Platform

https://cme.advocateaurorahealth.org

Track your CME credits and register for upcoming CME courses on the **CME Learning Platform**.



Stop by the table outside to pick up a handout to learn more about the **CME Learning Platform** and what it can do for you!

Please contact the CME Office at cme@aurora.org if you have any questions.

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Schedule Overview – Day 2

1. WELCOME/RECAP
2. PATIENT SAFETY/HIGH RELIABILITY
3. ACTIVITY: COMMUNICATION SIMULATION
4. CASE STUDY SCENARIOS: WHAT WOULD YOU DO?
5. LUNCH
6. EPIC OPTIMIZTION
7. RESOURCES WALKTHROUGH
8. LEADERSHIP OPPORTUNITIES
9. INTERACTIVE Q&A & WRAP UP DAY 2

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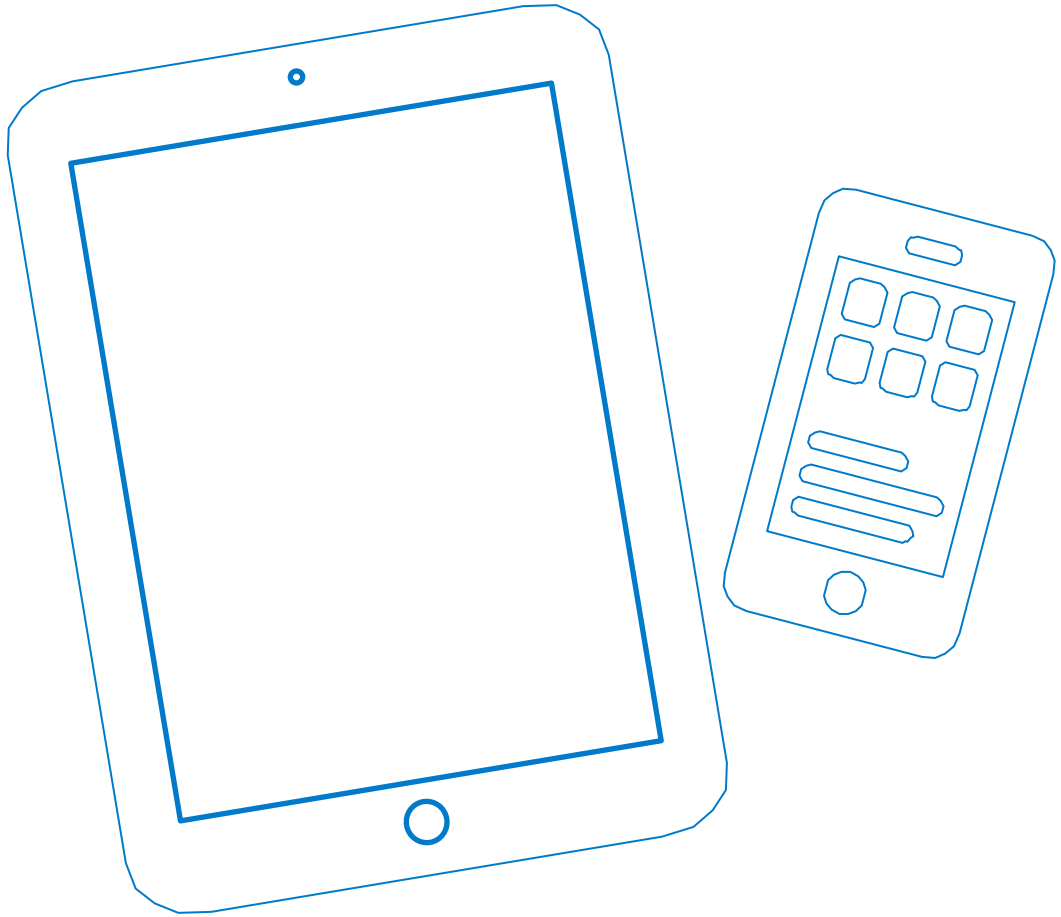
Reminder to silence your electronics please!



However be ready to use your smartphone to submit questions about any of the topics that we discuss.

Today, input the best safety catch you have ever witnessed or been responsible for.

Website: https://advocateaurora.cnf.io

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Patient Safety / High Reliability

“We Are First and Foremost, A Safe Clinical Enterprise”

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Safety Story

Cal Sheridan's Journey With Jaundice and Kernicterus

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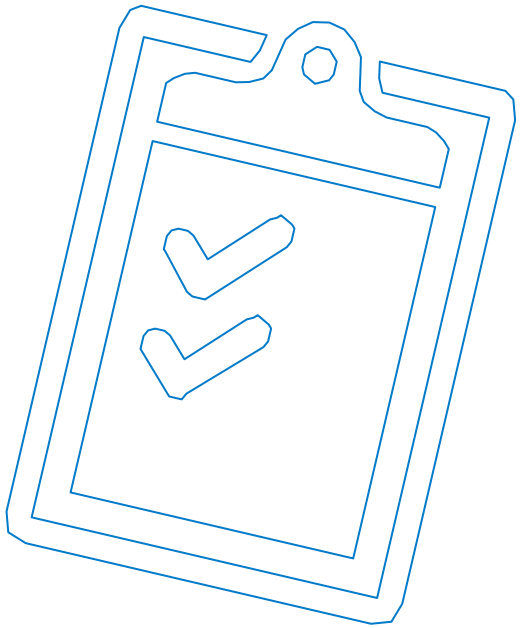
Overview

- Scope of Problem
- What is a High Reliability Organization
- Culture
- Models of Safety
- Types of Safety Errors
- Safety Behaviors



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STAND UP IF…

- YOU have suffered harm as a patient at a hospital or other care facility (an infection, fall, delayed diagnosis causing delay in treatment, other …)
- A FAMILY MEMBER has suffered harm in a hospital or other care facility
- A FRIEND or COLLEAGUE has suffered harm in a hospital or other care facility

The Prevalence of Medical Errors

Medical Errors are Third Leading Cause of Death in the U.S.

10 percent of U.S. deaths are due to preventable medical mistakes.

- Second only to heart disease and cancer
- In 1999 the IOM estimated between 48,000 and 95,000 preventable deaths per year
- Research now says medical error is responsible for over 400,000 deaths in the United States annually

A Shift in Thinking

Bad Apple Theory

- People who make mistakes are poor performers
- System performance is assured by removing poor performers

Systems Thinking

- All people are fallible and experience errors
- System factors are the majority cause of error
- Reliable outcomes can be obtained using the right mix of people and process

High Reliability:
What is High Reliability

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Principles of High Reliability

The exceptional patient experience is the sum of all outcomes and interactions

High Reliability Culture				
Safety	+	performed as intended reliably over time	=	**No harm**
Quality	+	performed as intended reliably over time	=	**Clinical excellence**
Service	+	performed as intended reliably over time	=	**Respectful & compassionate experience**
Team Member Focus	+	performed as intended reliably over time	=	**Engagement of resilient teams**

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Definitions

- **Reliability:** A probability that a system will yield a specified result: expressed as ratio (e.g. 99%) or frequency (1 per year)

- **High Reliability Organization (HRO):** An organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity

Most simply put, high reliability is…

‘The capability to perform to the highest standard, consistently over time’

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Five Principles of HRO's

One: Preoccupation with Failure

Two: Sensitivity to Operations

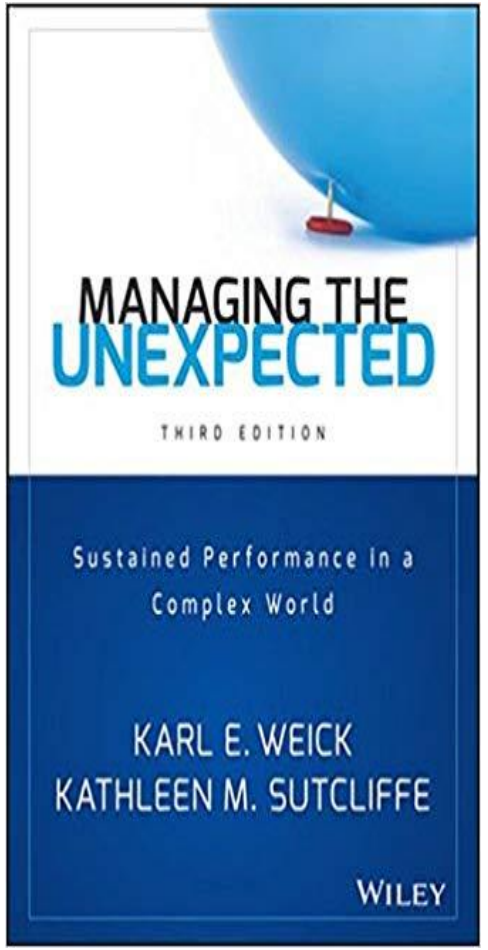
Three: Reluctance to Simplify

Principles of ANTICIPATION

Four: Commitment to Resilience

Five: Deference to Expertise

Principles of CONTAINMENT



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Five Principles of HRO's

One: Preoccupation with failure

- Regard small, inconsequential errors as a symptom that something is wrong
- Spend time identifying activities we don't want to go wrong
- Discuss what to look out for with members of your team and the oncoming team
- Take the time to attend to important details

Train for Failure

Five Principles of HRO's

Two: Sensitivity to operations

- Leaders get out and look for the holes in the Swiss cheese
- Give real time guidance and resource allocation
- We have a good 'map' of each other's talents and skills within the department

Five Principles of HRO's

Three: Reluctance to Simplify *Interpretations*

- We discuss alternatives regarding how to go about our normal work activities
- We think before we act, and if we are making an assumption, we check with others before proceeding
- We're not afraid to ask questions and voice safety concerns

Five Principles of HRO's

Four: Commitment to Resilience

- Because we are aware of what's going on around us, we identify errors as they occur, and correct them before they get worse and cause more harm
- We talk about mistakes and ways to learn from them
- When errors happen, we discuss how we could have prevented them

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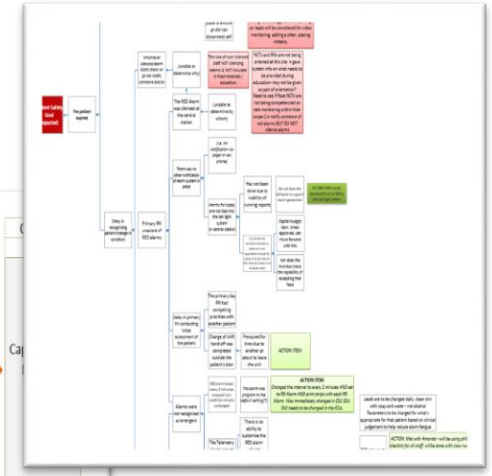
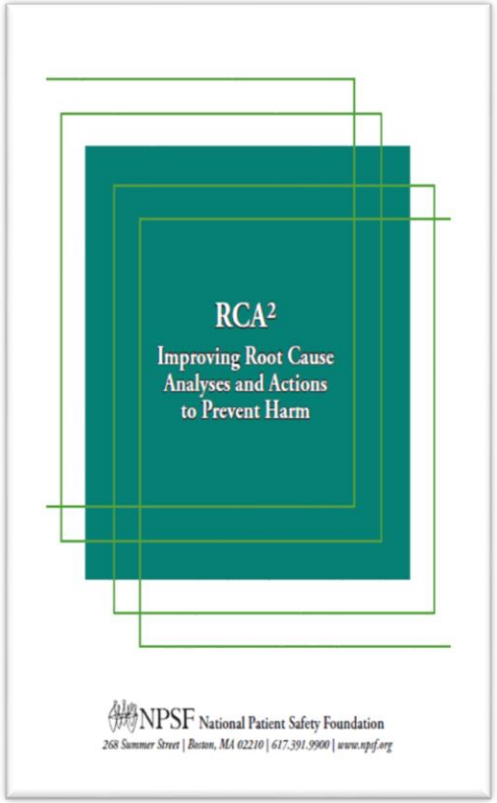
When errors happen, we discuss how we could have prevented them…

- Story telling and lessons learned
- Enhanced cause analysis
- Event transparency





Self
Leading
Clinical Practice
Teams

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Five Principles of HRO's

Five: Deference to expertise

- We don't hesitate to share our expertise
- We take advantage of the unique skills of our colleagues
- When a crisis occurs, we rapidly pool our collective expertise to resolve it
- Rather than a team of experts, we are an expert team

Huddle Video

Hierarchy of Reliability Culture

Think your way into a new way of acting

Challenge:
Maintaining urgency for and monitoring change

Act your way into a new way of thinking

Challenge:
To re-construct from tactics to principles

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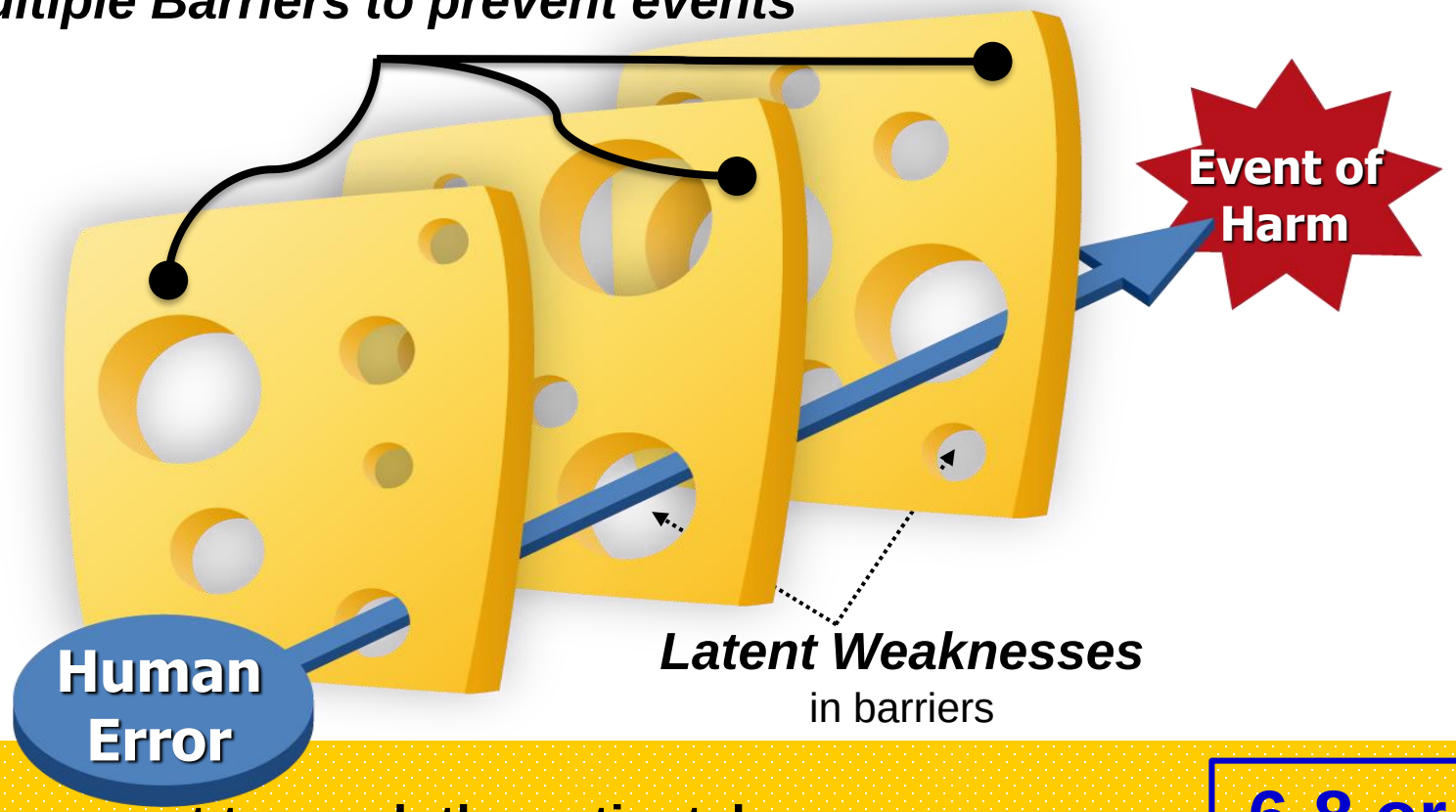
How Harm Events Happen

Multiple Barriers to prevent events



For an event to reach the patient, how many latent weaknesses in the barriers have to be breached?

6-8 or more

Reliability Culture

Healing Without Harm
Don't Hurt Me, Heal Me, & Respect Me

Will

Reliability Science
Knowledge and understanding of human error and human performance in complex systems

Means

Design of **Structure**

Design of **Work Processes**
Lean, Six Sigma

Design of **Culture**
Behaviors for Error Prevention, Red Rules, CRM

Design of **Policies & Protocols**
Focus & Simplify

Design of **Technology & Environment**
Electronic medical record, barcode technology, smart pumps

Leadership
Reinforce & Build Accountability for performance expectations and Find & Fix system problems

Execution

Behaviors
of Individuals & Groups

Exceptional Outcomes
Healthcare That Is ***Safe*** – Zero Events of Harm
Timely, Effective, Efficient, Equitable & Patient Centered

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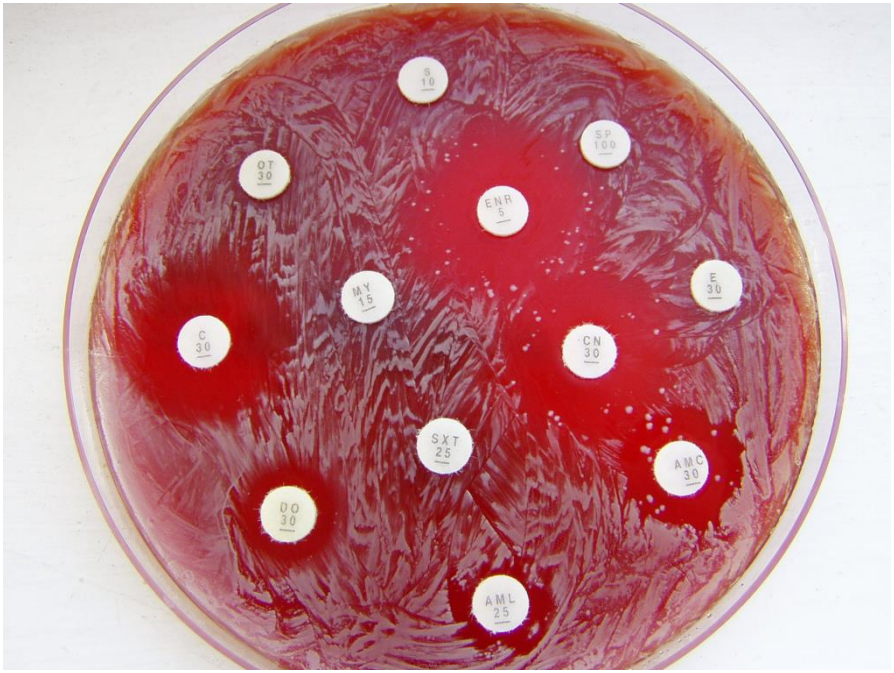
High Reliability Behaviors and Tools for Providers

High Reliability Behaviors and Tools for Providers



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Just ok is not ok

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Leaders and Teams

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High Reliability:
Power Distance

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High Reliability:
Team Work in Health Care

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High Performing Teams Need Psychological Safety

“Over two years we conducted 200+ interviews with Googlers (our employees) and looked at more than 250 attributes of 180+ active Google teams. We were pretty confident that we'd find the perfect mix of individual traits and skills necessary for a stellar team -- take one Rhodes Scholar, two extroverts, one engineer who rocks at AngularJS, and a PhD. Voila. Dream team assembled, right?

We were dead wrong. Who is on a team matters less than how the team members interact, structure their work, and view their contributions. So much for that magical algorithm.

We learned that there are five key dynamics that set successful teams apart from other teams at Google”…

39 re:Work

Psychological Safety was <u>far and away</u> the most important element of what makes effective teams.

[The five keys to a successful Google team]

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Role of Clinical Leaders

- **You** as the physician or advanced practice clinician are viewed as the clinical leader of your team
- **You** are critical in creating and sustaining an environment of psychological safety
- Fostering psychological safety and high team performance is critical to create resilience in teams

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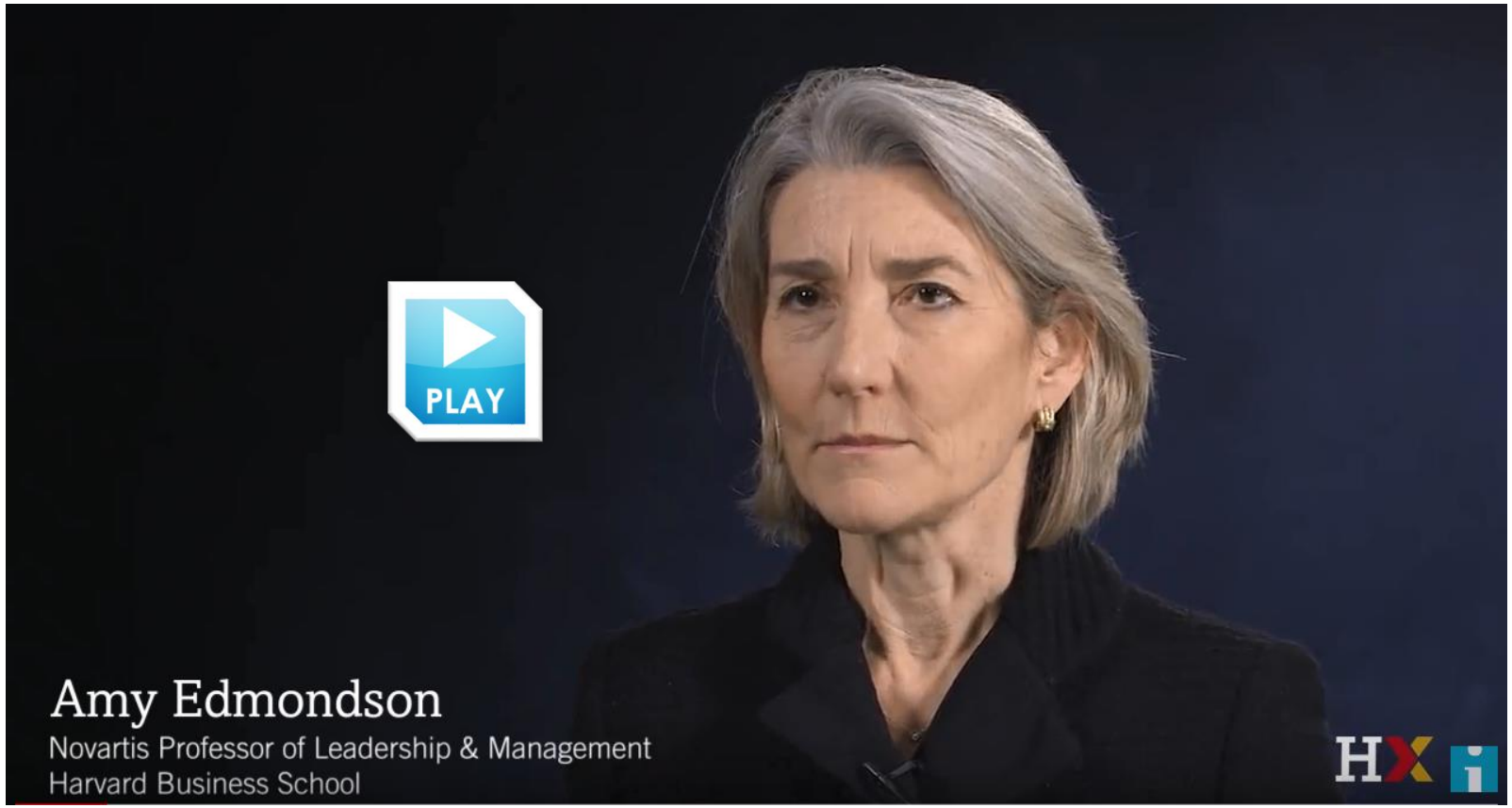
Why is Psychological Safety Important in Healthcare?



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Break for Discussion

With your neighbor(s) identify positive – and not so positive – examples of teams you have been on that had psychological safety.

5 minutes

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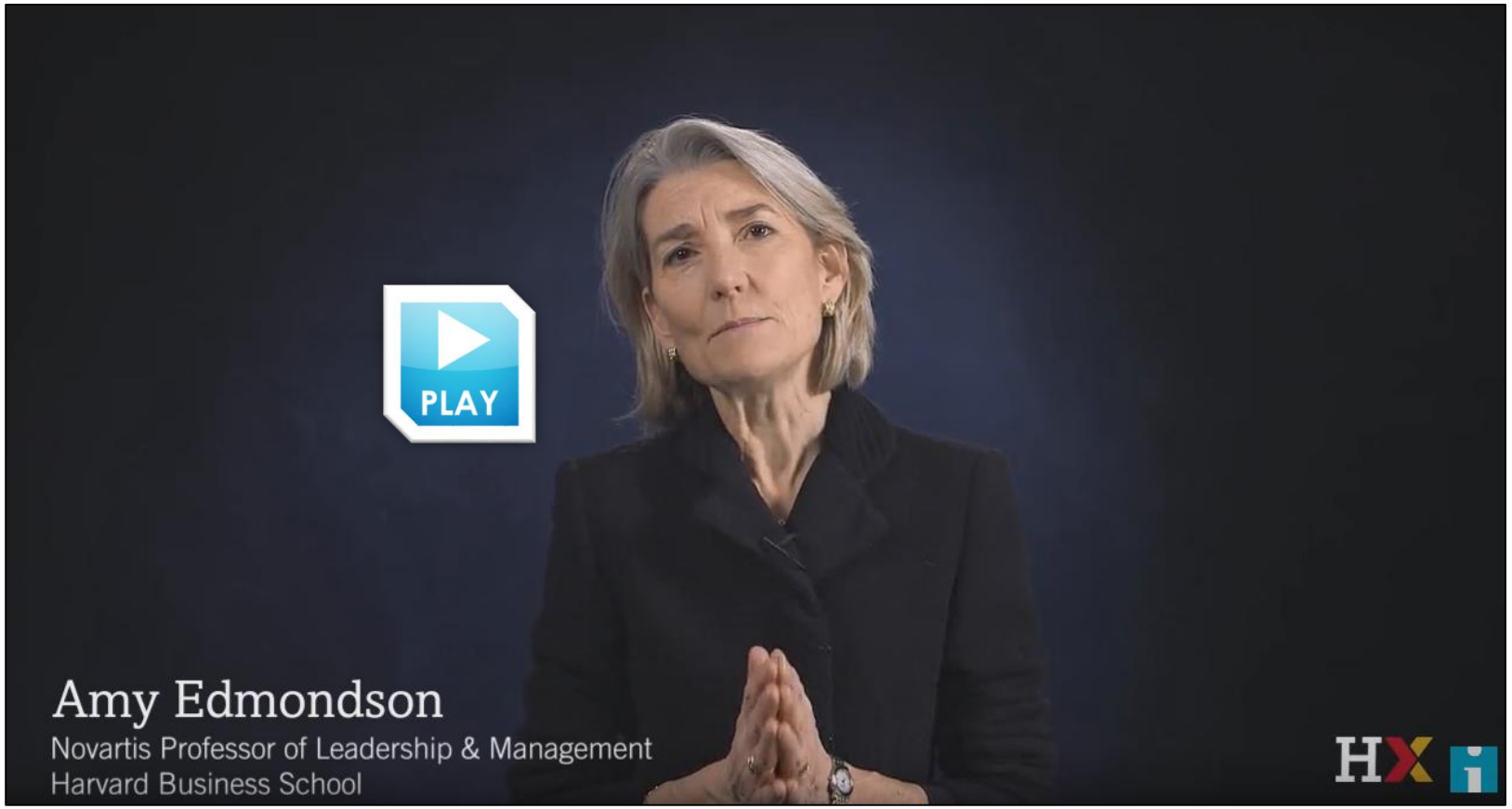
Why is Psychological Safety Important in Healthcare?

- Learning
- Risk Management
- Innovation
- Job Satisfaction/Meaning

What You Can Do?



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Break for Discussion

- With your neighbor(s) identify two opportunities in your clinical work when you can use these skills
- Describe why you think it will make a difference

5 minutes

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Behaviors You Should Use and Model

- Framing of the work
  - Describe the meaning of the work
  - Remind people of the nature of the work → highly complex, safety impact
- Model fallibility and invite input
  - Ask for input by name to decrease barriers to providing feedback
- Reward the messenger
  - Actively thank those for bringing key feedback and speaking up

High Reliability:
Errors We Can Control

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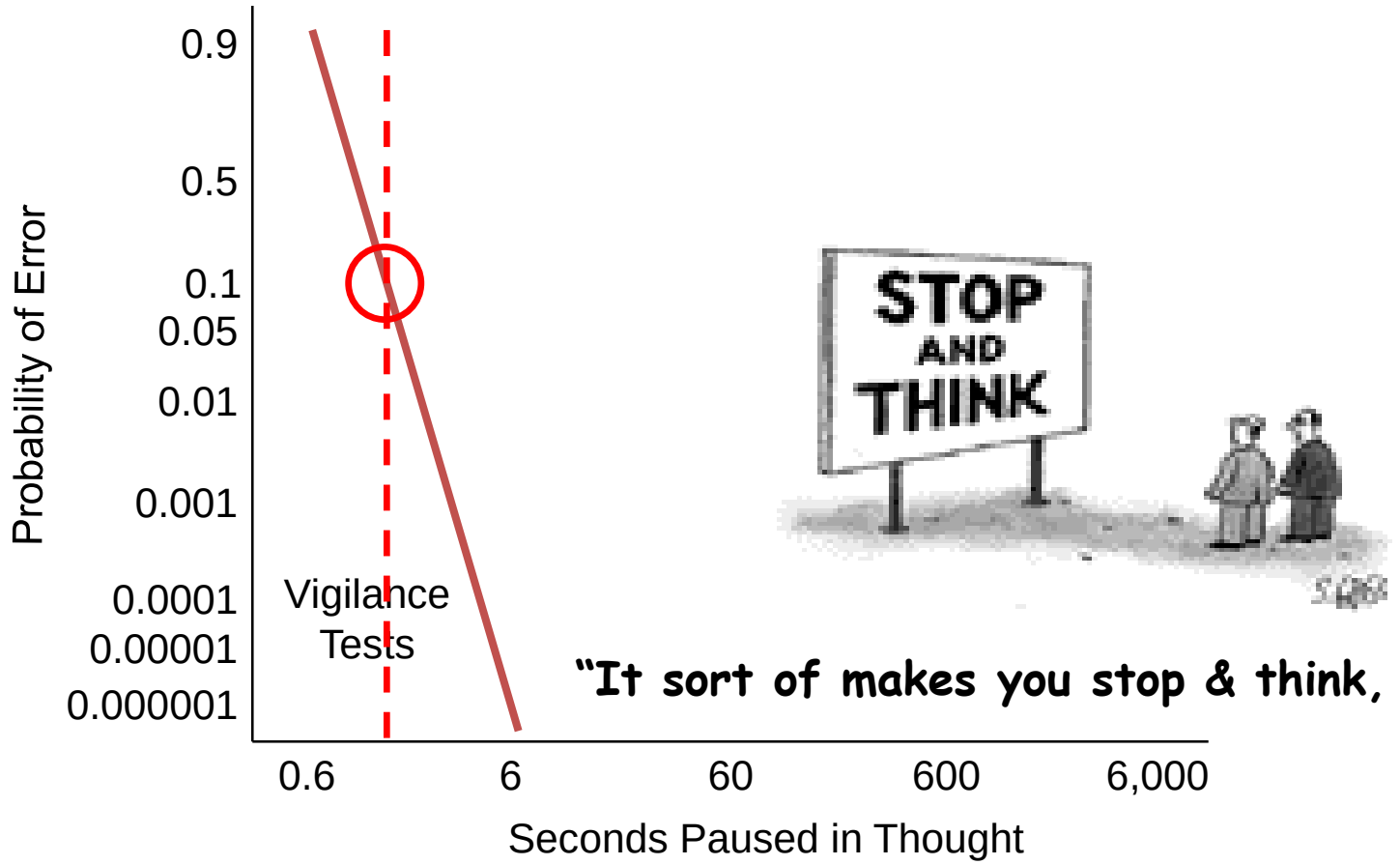
Self-Checking With STAR* (Stop, Think, Act, & Review)



"It sort of makes you stop & think, doesn't it?"

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OPERATION BREAKTHROUGH
PATIENT SAFETY
BEST OF THE BEST

* Jefferson Center for Character Education

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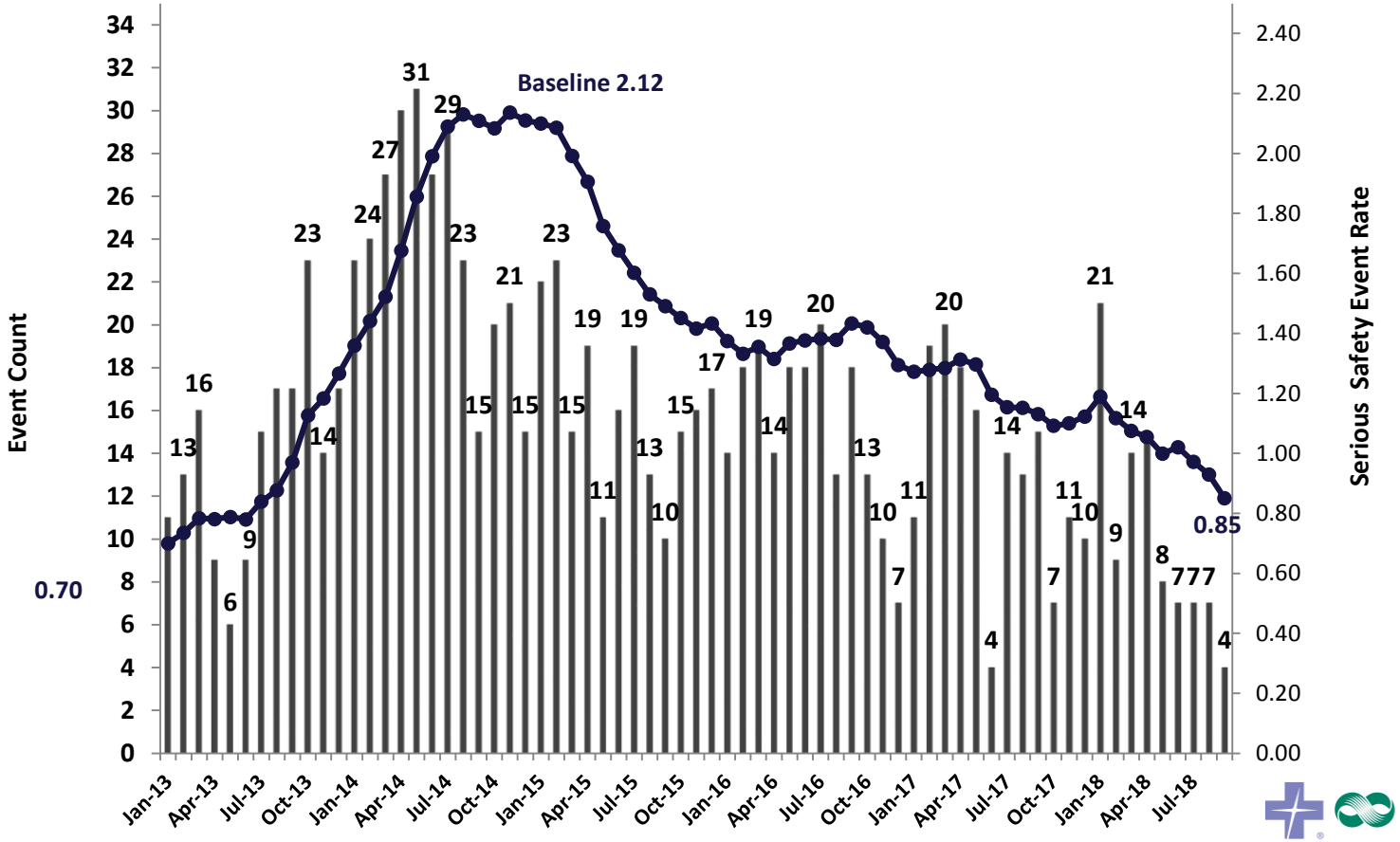
Illinois Safety Measure – October 2018

Advocate Hospital Serious Safety Event Rate (SSER)
Rolling 12-month rate per 10,000 APD
January 2012 through September 2018
Data Pulled on 10/16/18



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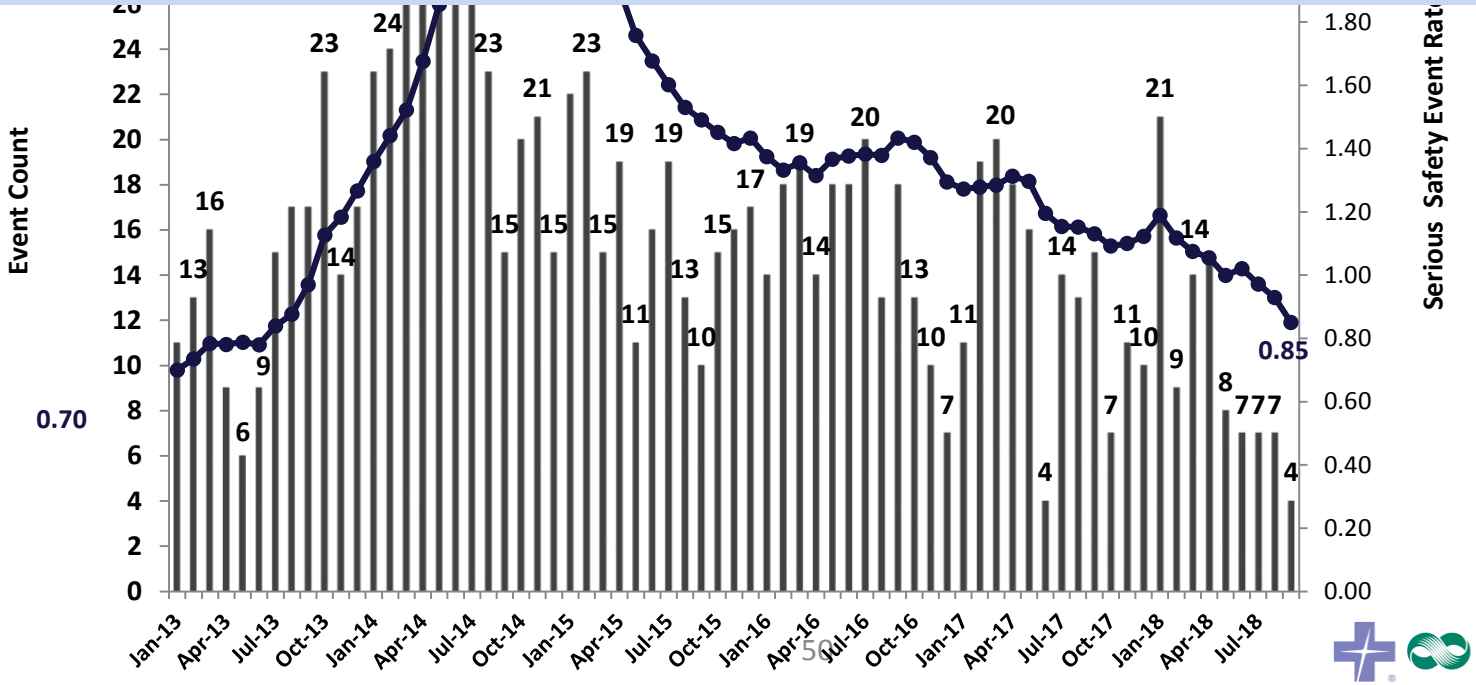
OUR INTENT AS WE ROLL OUT AND CHANGE CULTURE – INCREASE REPORTING TO DEVELOP NEW AND MORE ACCURATE BASELINE



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Summary

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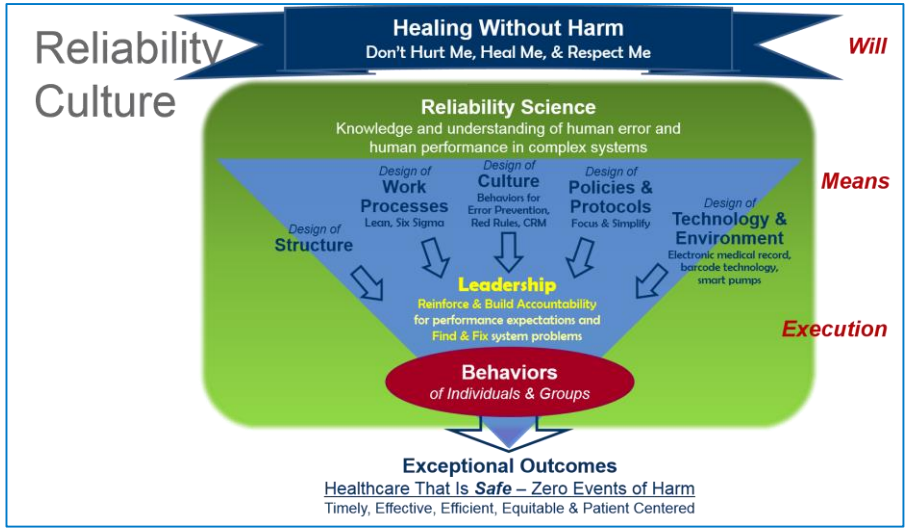

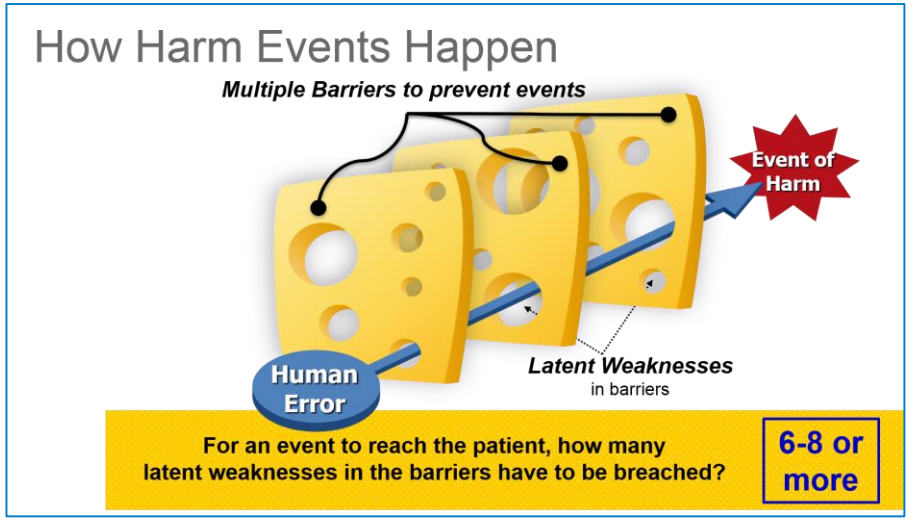

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Questions?

Conferences I/O:
https://advocateaurora.cnf.io

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