Organizing and Leading for High Reliability

What We Heard	Suggestions
High-reliability organizations (HROs) are organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures. HROs have five characteristics: • Preoccupation with failure • Reluctance to simplify interpretation • Sensitivity to operations • Commitment to resilience • Deference to expertise	• Practice persistent mindfulness. • Plan for success. • Take advantage of existing groundwork.
Manage the expected to manage the unexpected. Safety culture can be measured at the following levels: • Unmindful • Reactive • Systematic • Proactive • Generative	• Link safety and reliability to organizational strategy and resources. • Define safety culture. • Incorporate human factors and reliability science into improvement methods.
Framework for clinical excellence is an interweaving of culture and learning systems. Culture contains: • Psychological safety • Accountability • Teamwork and communication • Negotiation Learning systems contain: • Transparency • Reliability • Improvement and measurement • Continuous leadership	Implement a continuous learning system that cycles through the components below: • Collecting information • Analyzing information • Identifying actions • Assigning accountability • Ensuring feedback
Standardize clinical processes. Even the best-designed systems will not work 100 percent of the time. Expect failures and prepare for unexpected failures.	Standardize clinical processes by: Design • Implement content based on accepted medical evidence and where appropriate • Establish processes based on systems Customization • Implement processes based on data, learnings or changes in evidence Utilization • Required use always with clinical “opt out” • Variances used for possible redesign/improvement

What We Heard	Suggestions
Move from Safety 1 to Safety 2. Safety is the ability to succeed under varying conditions. Recognize that you cannot change the culture but you can change things that will change the culture.	Change your mindset from negative to positive. Safety 1 –Manifestations of safety are the adverse outcomes. • Few things as possible go wrong • Reactive response to risk • Humans add risk • Identify cause • Failure effect mode Safety 2 –Ability of a system to sustain required operations under both expected and unexpected conditions. • As many things as possible go right • Proactive and anticipate • Humans are resources • Understand what goes right to learn what can go wrong • Understand conditions where variability cannot be controlled
Principle 5: Start the journey toward high reliability Take advantage of existing groundwork (e.g., standard tools, response systems, etc.). Plan for success: pick a topic and location with receptiveness to change and a champion.	Become a learning organization. • This has no end point! Move to reliable processes and responses first. • Understand what is expected • Prepare to be proactive and less reactive Recognize it as a journey.

Community Collaboration in Readmissions

What We Heard	Suggestions
Be curious about data! Dig into the patient cases.	• Use both Big Data and Little Data to drive results. • Learn which groups are readmitted at a higher rate-these are the groups you will TARGET with special effort. • Ask patients AND providers.
Be introspective and humble – what can we do differently (not "the patient was noncompliant!")?	• What you are learning on a day-to-day basis? Take a dive. • Slice and dice by payer, diagnosis, disposition, etc. • Interview! Be part of the readmissions challenge with HRET HIIN. • Get people in the same room. • Learn what everyone has to offer. • Learn what everyone's frustrations are. • Start with one issue and go from there.
AQAF and AlaHA • Uses RCA Standardized Tool for readmissions • CHF – common readmission among patients – develop a specific CHF protocol	How to get started in your hospital: • Readmission penalties. • Post-acute providers want to make sure they work with hospitals. • Improving communications. • Include all players – include emergency services. • Disrupt the ordinary process of automatic readmissions. • Know who was recently discharged (ex: flag). • Identify person and process for ED to get support to determine patient's disposition.