Spotted at a personal celebration:
The smiling faces of attendees at the event.

Chasing Zero: An Executive Discussion About Reducing Harm

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For some healthcare executives, “zero harm” may seem like a far-fetched goal. All providers hope to minimize unnecessary harm, but for some, the idea of eliminating it entirely may seem unlikely or even impossible. Modern Healthcare Custom Media sat down with healthcare leaders who have partnered with The Center for Transforming Healthcare to implement high reliability processes within their organizations on their journey toward zero harm, a goal they believe is worth striving for.

What is the safety culture at your organizations? How have you emphasized avoidance of harm, and how have you used change management principles to do that?

Dr. Patrick O’Shaughnessy: Safety culture is paramount. It’s foundational if you’re going to embark on a high-reliability journey. When CHSLI started our journey to high reliability, we realized we had real opportunity to make improvements in this area, to decrease the vertical power distance and to make sure that every team member felt comfortable coming forward to discuss safety — not just when things were going well, but also when there were opportunities for improvement. You have to consider how you can work to get people across the organization to feel comfortable to come forward with concerns about safety, and then celebrate that, because it lets you know where you need to improve.
Rob Curry: It’s not just applying performance improvement tools, but rather about developing a culture where everyone buys into the idea that reducing errors is, in fact, possible. It should start with governance support. Our board changed our mission statement purposefully, to reflect that we are going to commit to our communities of about a million people that we are going to offer safe care. Our mission statement says: “Emanate Health exists to help people keep well in body, mind and spirit by providing quality health care services in a safe, compassionate environment.” It used to simplify say, “in a compassionate environment,” but at the beginning of our journey we added the adjective “safe” to signal to our employees, our physicians and our communities that we mean it.

Dr. J. Michael Henderson: My belief is you don’t really get to a culture of safety until you’ve dealt with employee and patient engagement. I view those as the two foundational pillars of a culture of safety. If you don’t have engaged employees, it’s really hard to have a good culture of safety. The journey toward zero harm is built on trust, respect and communication, and to me, those are the three pillars of employee and patient engagement.

Anne Marie Benedicto: When we talk about engaging employees to encourage reporting, we have to ask ourselves: is it easy to report? Is there a feedback loop, so the problems they report turn into improvements that everyone can experience? That’s part of what maintains a safety culture — making it easy for people to do the right thing.

How important is it to encourage the reporting of errors and patient harm? What best practices can you share from your organizations?

AMB: That’s how your system learns. You hope that most of the errors aren’t so significant that they could bring harm to the patient, staff or visitors, but we don’t know our vulnerabilities if we don’t report. What happens when you actually hurt someone? Does that mean you punish the person, even when it is a system issue? If they want to be truly safe, an organization must have that conversation before that happens so that employees understand the reporting process and how leadership will react and respond.

PO: We don’t just measure significant safety events and precursor safety events — we also track near-miss events. The near-miss event rate is a great way to get your pulse on the true culture of safety the organization has. When you see your near-miss event rate go up, you take notice. We used to say, “Fortunately, that event did not reach the patient,” and you took it off the grid. Now we’re saying, “Hey, wait a minute — from a process standpoint, let’s look at this and let’s learn from it, so that there is no possibility of future harm.”

RC: I think the near-misses are even perhaps more important than the infrequent harmful events. We really support that in our environment by making it easy for anyone to report. They can do so anonymously, even though may not because they trust the organization and the culture.

JMH: You’ve also got to make it easy for them to report the event. If it’s tedious and difficult and there’s no feedback, there are many barriers to encouraging the frontline staff to report and give you the pulse of what’s really going on.

Where do you suggest healthcare executives start in their journey to zero harm?

JMH: Healthcare is notorious for having a punitive culture with its hierarchy of physicians, nurses and support services. I’m a surgeon and I remember that era well, so I think a lot about what has happened in the last decade to get beyond that. We have to think about how we intentionally change that hierarchy into teamwork.

RC: I agree. The journey begins with working to change processes, not to blame people. When you change the processes to get better outcomes, then the people
involved feel better and encouraged. Then there is a level of trust in an organization too, because they see the results.

PO: I think there is now a bigger emphasis on team-based care, where people are working as an integrated delivery system representing each microcosm of where care is delivered. It involves us realizing that we stand a better chance of giving that patient the outcome they deserve if we work collectively, and we accept that we’re going to make mistakes. Every human being can make a skill-based error one out of every 1,000 times. But if you’re cross-checking me and I’m cross-checking you, those odds go from one in 1,000 to one in a million. That’s powerful.

AMB: The three of you talk about safety from an improvement culture. You are leading robust process improvement and you have improvement capability so you can actually measure reliably changes in safety. I actually think that’s one of the least discussed aspects of building a safety culture — the ability to measure it. That ensures that it’s not just that people are feeling like things are going well, but rather there’s actual proof that that’s happening.

In transformation efforts at your organizations, how did leadership play a role in shifting processes and gaining buy-in from employees? How can other organizations get started?

RC: Prior to our journey, we were pretty siloed between departments and roles, and silo mentality can often get in the way of process improvements. If you’re only looking at single causes, there is not really a good analysis being conducted. I think the challenge we had was getting people to get out of their silos, and to trust that working together is going to result in improved processes and reduced harm, which it did. In the first wave of our Six Sigma training supported by the Center, we put six teams together, each with six diverse representatives. All of a sudden, now these people have to interact, define the problem, measure it, analyze, improve and control. They’re starting to be empowered by this process, to work together and collaborate because they want to be successful, and they want to have an end result that says, statistically speaking, “we improved this.”

JMH: It wasn’t until my third year at UMMC that our chasing zero campaign really kicked off. It was built on what I call the “building blocks,” which were setting goals to close performance gaps, data-driven improvement work, and a transparent scorecard. Everyone knew what was happening and could see progress, and just showing that is a strong judgment of when an organization is ready to take on the more challenging stuff to get to zero. For organizations that haven’t done it yet, you’ve got to ask that question, “Are we ready?” UMMC was ready, and leadership agreed. The worst you can do is kick something like that off too quickly and cause it to backfire.

PO: Leadership support is critical to ensuring a successful go-live, as well as sustainability. In healthcare, we are great at getting new projects off the ground: we get a great new initiative going, we get some improvement, and then something else bubbles up and we see decay. Whether it is budget challenges or another new program, people get distracted and stop spinning that plate on the stick and start spinning something else, and the plate eventually falls. For CHSLI culturally, that was a huge challenge. What we did was we took high reliability principles and we said, this is our operational chassis for everything that we’re doing. This is not a project or initiative — it is a cultural organizational transformation into who we are becoming. If this is our core, and this is where we’re going after, everything is going to correlate to that. It’s in our strategic plan, and we talk about it at every board meeting. It is that important, and we don’t confuse people with different initiatives. It all bakes into that one plan. All the goals and all the initiatives align in that format, because burnout is a real thing that affects
the sustainability of zero harm. The journey never ends — if and when you do get to zero, now you have to maintain it, right? This work never ends, and refinement and course correction are paramount to sustain the gains and overcome challenges ahead.

**AMB:** A hospital is super complicated — one of the most complicated organizations on earth — and that multiplies at the health system level. You have micro-cultures in there. If for instance, people say that respectful interactions are one of our core values, that may be problematic, because respect is going to mean different things in the operating room versus the back office. People need to talk about what that means, so it’s not a squishy word. Those are the types of conversations that build trust. Leadership is challenged to initiate those conversations and start to understand how respect as a norm weaves through your organization, even if it is operationalized in different ways.

Some healthcare leaders don’t believe it’s possible to achieve zero harm. How do you respond to this?

**PO:** The key difference is understanding zero preventable harm versus zero errors. We’re not saying you’re going to be error-free, right? We’re going to always make errors, but how do we mitigate, trap them and prevent them from reaching the patient? It doesn’t mean we’re all at zero across everything we do, but we have reached zero in many key quality areas, while other indicators have been dramatically improved.

**RC:** I’m so passionate about this issue that when I meet with colleagues I say, “Have you started the journey toward high reliability?” Some are more or less in denial. You can’t eliminate all harm, it’s just a natural situation in healthcare. But you’re not going to change the frequency of harm if you don’t start a journey. I say, “If you don’t try and do something, you’re obviously not going to succeed and you’re going to fail.” Success speaks volumes. I tell naysayers that when we started, our preventable harm was 237 reportable cases, and it was down to 43 this past year.

**JMH:** I like to ask, “Have you been a patient recently, or a patient’s family member? How much harm is acceptable to you in that case?” You’ve got to make them stop and think about it. What is an acceptable number if it’s not zero?

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About the Joint Commission Center for Transforming Healthcare

As a high-reliability partner, the Joint Commission Center for Transforming Healthcare works with organizations across the care continuum, to help them design and strengthen their own systems and structures to achieve reductions in harm on their journey to high reliability. Created in 2008 as a nonprofit affiliate of The Joint Commission, the Joint Commission Center for Transforming Healthcare creates products and services that promote and develop high reliability in health care, including the Targeted Solutions Tool® for Hand Hygiene, Safe Surgery, Hand-off Communications, and Preventing Falls, and the Oro® 2.0 High Reliability Self-Assessment web-based tool.

The Center’s leading assessment tools enable senior leaders to evaluate their readiness for high reliability health care, identifying key information about strengths and opportunities. No matter where an organization is on its journey, the Center’s Robust Process Improvement® method, blending Lean Six Sigma and formal change management, ensures organizations are equipped with a sustainable program that generates engagement and results long after launch.

With strong leadership and a partner like the Center, organizations that implement high-reliability principles can reach safety goals they once believed unattainable – and address issues long considered unsolvable.

For more information, visit the Center for Transforming Healthcare website at www.centerfortransforminghealthcare.org