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Sustaining Innovative Change

Healthcare is not a highly reliable industry, which may result in unacceptable harm to patients, visitors, and staff that is costly and unsustainable. Although we have made great strides in the past 20 years, there is still much work to be done to create reliable systems in healthcare. This requires a transformational mindset and the development of innovative solutions that have not been tried before.

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key points

- Although we have developed many innovative solutions to reduce harm in healthcare over the past 20 years, patient safety metrics are virtually unchanged.
- All healthcare organisations are challenged with sustaining change because we do not yet have reliable cultures, systems, and processes.
- In addition to reducing harm, high reliability in healthcare will improve financial health.
- To become highly reliable, organisations must transform the way they structure improvement.
- Five suggestions are outlined to help organisations to get started on an innovative, transformational journey.

The Future of Continuous Improvement in Healthcare

Healthcare workers and leaders are naturally innovative. When the Institute of Medicine (IOM) report, To Err is Human, became a catalyst for change in 1999 (IOM 2000), we began applying this skill set to quality and safety improvement. Since then, healthcare organisations have focused on many different initiatives, including:

- Evidenced-based, Clinical Practice Guidelines
- Cross-Organisational Collaboratives
- Shared Governance
- Disease-Specific Certifications
- Patient Experience
- Electronic Health Records (EHRs)
- Lean/Six Sigma and Continuous Improvement
- Culture of Safety, Just Culture
- Pay for Performance
- High-Reliability Organisations (HRO)

Over the past 20 years, in every sector of healthcare, intelligent and passionate people have worked tirelessly to improve the safety of their staff, patients, and visitors. While some organisations are further ahead than others, everyone has implemented several or all the initiatives listed above in some respect, especially since financial incentives are now frequently associated with quality and safety outcomes. So, why, then, did the National Academies of Medicine (NAM) report in 2021 that patient safety is at a standstill (NAM 2021) after we spent two decades innovating change?

Healthcare truly has transformed in many ways in the recent past, and we have come very far in these twenty years, but the industry has struggled to sustain improvements over time. This is because the cultures, systems, and processes that we have created only work well under certain conditions. Our hard-won efforts fall apart when uncontrollable stress is introduced into the system, stress that might come in the form of a leadership change, a staffing crisis, or a global pandemic. Regardless of the cause, at some point, something is going to happen that requires a shift in

priorities, and we need to create reliable systems that can tolerate that stress without breaking down.

High-reliability organisations (HROs) build their processes to withstand inevitable stress. They make it easy to do the right thing and hard to do the wrong thing. Sadly, no healthcare organisation in the world is highly reliable, and millions of people die or suffer permanent harm every year due to unintentional medical errors. Aviation, nuclear power, and other high-risk industries are far safer than healthcare, and would never tolerate the level of harm that patients, families, and staff experience daily.

Everyone agrees that healthcare safety is imperative, and nobody wants to see harm come to patients, visitors, or health workers. In addition, the relationship between financial health, patient safety, and care quality is clear: patients who receive good care experience lower complication rates and, thus, a lower cost (Slawomirski et al. 2017). With financial pressures at an all-time high for healthcare leaders, organisations can't afford not to become more highly reliable.

The Problem

To add to the above stated, all healthcare organisations today have some version of the same problems:

Reimbursement for healthcare services has increasingly become tied to specific outcome metrics, such as mortality, medication errors, central-line associated bloodstream infections (CLABSI), patient satisfaction scores, and many, many more. In response, organisations have created teams or committees to oversee the improvement of one specific metric. These teams spend countless hours working to move a single data point, and although they may be successful in the short-term, sustaining change becomes very difficult because they didn't address all care issues across the continuum for the patient with that specific problem. For example, teams focusing on reducing central line infections tend to emphasise the implementation of the evidence based CLABSI bundle but stop short of assessing all aspects of the care of the patient requiring an intravascular device.

- *Improvement teams roll out change inconsistently, making it difficult for the frontline to keep up*

  In most organisations, because the teams described above do not communicate and collaborate well, the improvements they implement are introduced in a fragmented way. Perhaps one team revises a policy, another creates an order set, and yet another implements a new protocol that is not built into the Electronic Health Record (EHR) because it was not a priority for IT. This creates inconsistent processes for locating information for the frontline and makes an already complex environment even more difficult to navigate safely.

> Our hard-won efforts fall apart when uncontrollable stress is introduced into the system, stress that might come in the form of a leadership change, a staffing crisis, or a global pandemic

- *Improvement occurs in silos: the right hand doesn't know what the left hand is doing, thus creating a "patchwork quilt" of improvement*

  Healthcare is complex, and leaders are challenged with many competing priorities. As a result, new teams and committees are constantly being created on top of the groups that have historically existed. These teams are often unaware of what the others are doing, resulting in duplication of efforts and costly inefficiencies.

- *Improvement teams are generally created to focus on a specific metric, resulting in gaps in care processes for related patient groups*

- *Leaders have too many competing priorities, preventing a laser focus on strategic goals*

  Healthcare leaders are overwhelmed and are burning out just as fast as the clinical teams they manage. Siloed improvement efforts often result in additional complexity for them as much as their teams, with new audits, meetings, and inefficient administrative tasks continually added to their workload. Although

many organisations have created formal leadership development programmes and succession plans, the ability to fully embody leadership principles is overshadowed by the constant diversion of a leader's attention from one problem to another.

- *The improvement process itself has become incredibly complex and difficult to manage*

  A continuous improvement mindset has become the norm, and healthcare organisations have generally adopted some framework for improvement, such as Plan-Do-Study-Act (PDSA) or Define-Measure-Analyze-Improve-Control (DMAIC). However, most have not applied that framework to the actual process of improvement. There is generally no one person, department, team, or committee who has oversight of all improvement work, leading back to the first problem identified above: the right hand doesn't know what the left hand is improving.

The past 20 years have brought great progress in performance improvement, but it is time to innovate further. Leaders must now continue their efforts to build strong safety cultures in their organisations but must also change the way they structure improvement. The ability of an organisation to innovate in this way is critical to becoming highly reliable, which will result in the sustainment of change, improved financial health, and better patient outcomes.

To create reliable systems, healthcare organisations must be willing to fundamentally change their entire approach to improvement and be tenacious

Five Innovative Solutions

Innovation is hard and requires strong leaders who can set a vision for the future, encourage creative solutions, and design teams that foster ongoing collaboration. To create reliable systems, healthcare organisations must be willing to fundamentally change their entire approach to improvement and be tenacious - a transformation such as this takes time, patience, and persistence.

Luckily, healthcare workers are naturally innovative. If we are ever to reduce harm in healthcare, leaders must harness the power in their organisations and design new solutions that have never been tried before, such as:

- *Eliminate the silos among improvement teams*

  Organisations can begin this work by completing an assessment of the current state of improvement workflows. Consider creating an actual status map and outline how many committees and teams are presently meeting and define the purpose for each. Quantify the cost of this improvement work by including the number of members, their average hourly wage, and the total hours spent on this team or committee. Next, identify gaps in the process and examine where there is duplication or overlap, where there are organisational needs that are not being addressed by any team, and how many teams are just meeting because they always have, rather than for a specific purpose. This exercise will help senior leaders to combine, condense, or eliminate committees and teams as appropriate.

- *Create teams that focus on improving the care of a patient population, not an individual metric*

  Measurement of outcomes is still critical but consider how many you can combine if you focus on patient populations instead. For example, a team focusing on "The Care of the Patient with Congestive Heart Failure" across the continuum could analyse the proper utilisation of heart failure guidelines, readmission rates, mortality rates, health equity trends, and patient satisfaction scores all in the same team. Ensure that the right stakeholders are involved in this team to address care issues across the continuum, as experienced by the patient, rather than through the eyes of a particular clinician group.

- *Make it easy for the frontline to know what to do*

  Leaders need to create systems and processes that are easy to follow in cultures that are supportive and helpful when changes occur. Start again with a current state assessment. For example, in the care of a patient with heart failure, examine how many documents and instructions are in place across all

care departments: are they easily retrievable and easy to follow? Do some departments have different expectations than others? Because there are so many policies, procedures, protocols, order sets, etc., in most organisations, getting a handle on this generally takes several years, but start with a handful of the patient populations discussed above.

- *Empower leaders to effectively manage innovative change*

  Understanding the actual workload of leaders is difficult and will likely require shadowing to develop a clear picture of the current state. Identify where there are unreasonable expectations: creating workflows that only allow high performers to be successful will never result in the development of collaborative teams across the organisation, as 60% of any population are middle performers. In addition, examine your leadership development programmes and create opportunities to validate (not just teach) leadership skills and behaviours.

- *Establish a single visual process for the management of ongoing safety, quality and service improvement*

  Many organisations have a difficult time differentiating between strategy and business as usual. Since the improvement of patient care workflows should always be continuous, it can't also then be strategic. Create a global calendar of improvement that is aligned with education, regulatory, and other programmes that allow for the review of the care of specific patient populations every one to three years. The design of this new structure to manage improvement work then becomes strategic and should be built into annual plans to ensure that the right resources are made available.

The suggestions listed above do not require significant investment in technology and are not cost-prohibitive. However, this is transformative work that requires strong leaders with a long-term vision and a thorough understanding of change management principles. Identify the early adopters in your organisation and just begin to have a conversation: what of the above rings true? What are some innovative approaches that might work for you?

Conclusion

It will not be easy to create reliable care systems, but every healthcare organisation has what it takes: intelligent, hard-working people with the skills to innovate and lead collaborative change. It will be challenging work, but creating safer systems can no longer be optional in healthcare. And with today's financial pressures, we can't afford not to try.

Conflict of Interest

Donna Prosser is a full-time employee at Vizient, Inc. ■

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