On the Same Page

Our Quality Action Plan
August 6, 2010

In the May 20, 2010 edition of On the Same Page, I shared the main themes of our strategic plan. With respect to our clinical mission, the first and foremost goal is to strive for the highest-quality, safest experience for every patient. Put differently, UF&Shands must be built around the patient experience. Quality and safety are of critical importance. Unless we get this right, we will not reach our research, educational or financial goals.

We have set a five-year goal for top-10 status in quality and safety among hospitals participating in the University HealthSystem Consortium (UHC). Our strategies for achieving this goal include partnership between HSC faculty and Shands; alignment between clinical programs and facilities; and, most important, establishing a culture of quality and safety that extends to every member of our hospital and Health Science Center community, both in Gainesville and Jacksonville.

We already get a big part of the patient care piece right. I have had the pleasure of making quality rounds for several months with Dr. Timothy Flynn, professor of surgery and interim senior associate dean for clinical affairs. The spirit and dedication of the doctors, nurses and others who are taking care of our patients at Shands has been truly uplifting for me, and I have heard many heartfelt expressions of appreciation for this care from our patients. We also have deep talent and clinical capability — important elements for supporting improvement.

Every single person — nurses, ward clerks, physicians, administrators, parking valets, residents, cooks, painters, therapists, transport team members, technicians — anyone who wears a Shands or UF badge, whether they have direct patient contact or not, must be an important part of the goal to deliver perfect care every time. Everyone at NASA knew they were working to put a man on the moon; everyone working at Shands and UF needs to feel the same way about delivering safe and effective patient care.

We are already making significant progress in the key areas of mortality, safety and access. About 20 percent fewer patient die at Shands than would be expected based on their medical risk as estimated by UHC prediction models. The number of patient safety incidents has declined by 25 percent over the past year, and we are committed to continued improvement. In the coming weeks, we will be making major announcements regarding patient access, beginning with our employees at Shands and at UF.

Our overall objective is to ensure that every patient receives exactly the right care, every time.

In this spirit, and under the Forward Together theme of the UF&Shands Strategic Plan, a retreat of UF faculty and Shands hospital managers and administrators on the topic of patient care quality and safety was held on June 19. More than 150 attendees heard presentations from national experts on their experiences in improving quality at their institutions, and then broke up into working teams that made recommendations in eight specific areas.

We devised an action plan based on the teams' recommendations, which were listed and subsequently voted upon by all attendees. We also took into account the results of a survey of faculty and staff perception of patient safety, and the recommendations of the Institute for Health Care Improvement, which assessed our institution. This plan, as follows, represents the synthesis of Dr. Kayser Enneking, chair of anesthesia and chair of the Shands Board Quality Committee, with input from board members and retreat attendees:

1. **Put patients first**
    - Design care processes around the patient
    - Improve access and timeliness for the patients we serve
    - Appoint patients and /or their families to our patient safety committees, advisory groups and focus groups
    - Organize an Employee as Patient forum

We often forget how scary and frustrating being a patient can be. We must always focus on the patient first. We will give them a voice so they can be heard throughout our organization in our meetings, in our classrooms and on our wards. An Employee as Patient forum will help us focus and organize our efforts. Appointing patients to our patient safety committees will drive patient safety improvement at a faster rate. Putting the patient in the center of every conversation about process changes the dialogue and provides common ground for all of us.

2. **Increase transparency about patient safety across our organization**
    - Post on each unit the cumulative number of "Safe Days" since a patient harm event occurred on that unit
    - Patient safety and care improvement data will be posted on hospital screen savers.
    - Improve information sharing and lessons learned regarding infections and other patient safety events.

Transparency is about showing what we are doing well and where we have opportunity to improve. We have many bright areas of excellence in our system. We need to connect these pools of excellence so all patients receive seamless, high-quality care. It is difficult to improve unless we know the points from which we are starting.

Perhaps one of the most valuable products of transparency is the ability of the organization to learn continually. We believe that multidisciplinary review of patient safety reports will yield a wealth of ideas for process improvement. Providing feedback to the reporter will encourage more reporting as they see the improvements in patient care that they helped initiate.

3. **Recruit a Chief Quality Officer**

There is a science to making large gains in patient safety and quality. We will identify the right person to lead our efforts. Does this mean this is the person responsible for our patients' safety? No — this is everyone's job. But having an expert should help galvanize our efforts. We expect to have this position filled in the next six months. With the recruitment of a Chief Safety and Quality Officer we will be able to continue to evolve our quality workforce. This was identified by both the IHI and our retreat participants as an area of opportunity.

4. **Align goals, effort and incentives around patient care outcomes**
    - Align performance goals of Health Science Center and hospital leadership
    - Include quality metrics in all performance evaluation systems, including the faculty compensation plan and hospital staff evaluations.
    - Establish a reward system throughout UF&Shands aligned with safety and quality outcomes.

We need to row the boat with our oars in synch. Alignment between goals, effort and incentives around clinical outcomes will ensure that our focus on the patient first is a priority at all levels of the organization.

5. **Develop the skill sets of our Physician Directors of Quality (PDQs) and other champions**

We have a secret weapon: the cadre of dedicated people who really want to do this better. We will strive to provide all of our safety champions with the tools they need to help us effect change. The science of how to bring about change in patient care quality and safety is evolving and exciting. Topics for workshops of the PDQ and hospital champions will include Reliable Design, "Plan Do Study Act" Methodology, Project Management, Data Boot Camp, Facilitation Skills, Root Cause Analysis, Change Theory, and Human Factors in Process Design. A job description for the PDQs will be written and applied uniformly across the organization

6. **Develop Interdisciplinary Clinical and Academic Programs (ICAPs)**

These ICAPs — in Cancer, Cardiovascular Medicine, Children's and Women's Health, Neuromedicine, Organ Transplantation and Peri-operative Medicine — will be charged with improving the patient care experience throughout the continuum of care and across departments. Each interdisciplinary team will manage the entire operation and budget of their specific area of patient service, with a focus on safety and quality. We fully expect that achieving safety and quality goals will lead, quite naturally, to improved operational functionality and financial performance.

7. **Leadership Rounding**

Visible leadership support of the patient safety and quality transformation is essential. Everyone in the organization needs to have the opportunity to show us how we can do things better and what barriers exist to doing this. Leadership rounding has been identified by every high-performing organization in American health care as one of the most effective strategies to move the Culture of Safety.

We have many areas of truly superb patient care within our institution. On a quarterly basis, individuals and teams with stellar performance on a particular metric will be identified, allowing us to reward high achievers and shine light on areas of excellence within the organization.

8. **Develop a funding mechanism for small projects related to patient safety and quality**

These grants, administered through the Shands Board Quality Committee, will enable us to try out good ideas and small tests of change. We will solicit ideas from any interdisciplinary group that has a good idea about patient safety and quality. Any idea that puts the patient first and improves care will be evaluated for funding. We will make details of this program available by the second quarter of this year.

We are now assigning responsibility for each element of this action plan to members of the UF&Shands leadership team and are developing metrics and benchmarks against which our progress will be measured. This information will be posted on the Forward Together website as it becomes available.

Some of you have a job title that says “quality.” Most of you do not. The goal is for each individual in our organization to make a personal resolution and commitment to define your personal goal each day as delivering quality as Job 1, and contributing to improving system quality. We are making tremendous strides already, and will surely continue to do so with a shared purpose and focus.

Forward Together,

David S. Guzick, MD, PhD