20 Years After To Err is Human

Observations from Where the Work is Done

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VALUE CAPTURE

Front Line of **Patient Care**

Our approach to lawmaking, regulating, and assessing for quality still bears qualities of "1,000 miles from the cornfield thinking."

Fixing is hard

"Farming ~~looks~~ mighty ~~easy~~

when your plow is a pencil

and you are 1,000 miles

from the cornfield."

– President Dwight D. Eisenhower

In the **Cornfield**

Glimmers of hope, but mostly pieces and parts

How Far **Have We Come?**

Focus on leader-led improvement and management systems to close the gap.

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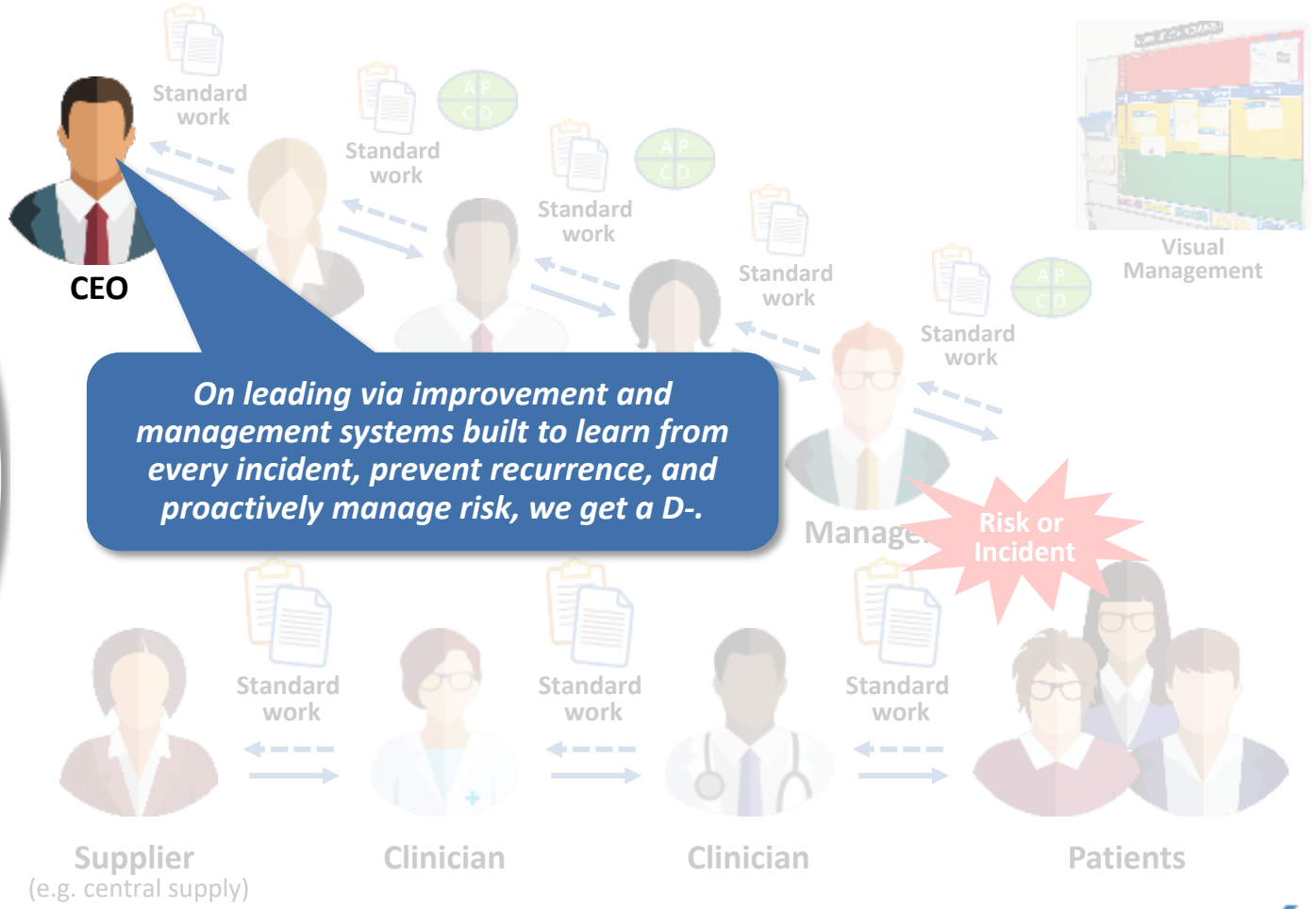
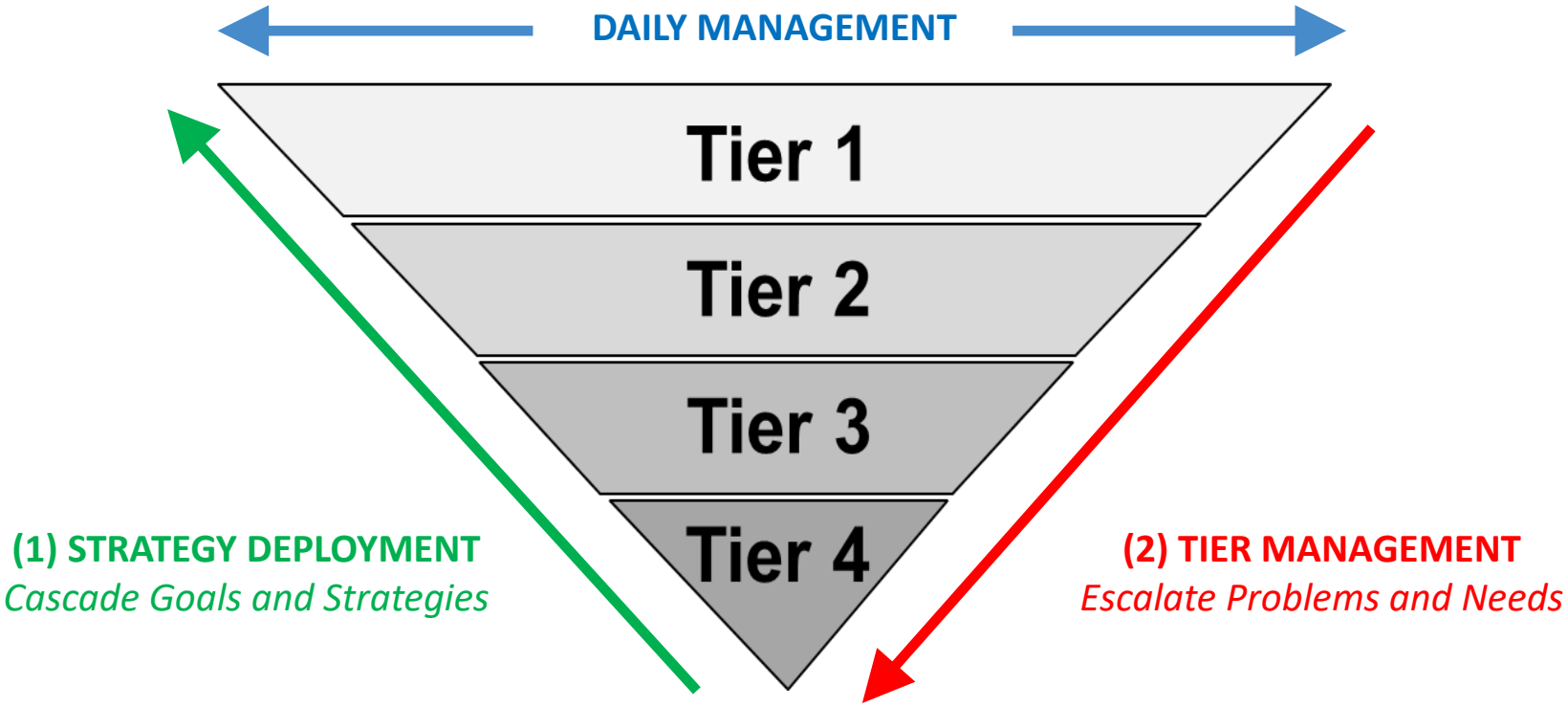


"What determines how great a healthcare organization will become is how well its leadership system creates a culture of excellence and safety, improves the enterprise system and effectively implements best practices."

Change Healthcare Organizations from Good to Great
American Society for Quality, 11/2005

Operational Excellence Daily Management System



Close the Gap

What questions would catalyze action?

If continuous learning from incidents were in place, what would each level know?

- ✓ Three incidents or near-misses in my area this week were…
- ▪ Here's how I participated in problem solving, what I learned about the cause, and how we have changed our process to prevent that cause from recurring here…
- ✓ The incidents this week that occurred across our ambulatory operations to people doing similar work to me were…
- ▪ And here's what we learned about the cause and how we changed our process to prevent them from recurring here…
- ✓ By the way, here is an incident that occurred this week elsewhere in the US to people doing similar work to me and what I learned about the cause and how we changed our process to prevent it from recurring here…
- ✓ Finally, I'd love to show you my high risk task of the day and how we prep, observe, and debrief it each and every day.
- ✓ Who's that? That's our director observing the manager coach us so she can coach him to continue to develop us as problem solvers.

Clinician

Close the Gap

What questions would catalyze action?

If continuous learning from incidents were in place, what would each level know?

- ✓ Can I show you the design and operation of our integrated improvement and management system, where each front line team member is continuously learning from and acting to prevent recurrence of incidents and near misses in their area, across the health system, and across the country?
- ✓ I'd love to show how through my standard work I anchor the system. My key roles include…

- I coach my direct reports to ensure that problems are being identified, investigated, and actually solved **THROUGH THE OPERATIONAL HELP CHAIN**, with support from our safety experts.
- I make sure barriers are being broken and resources allocated to support problem solving, on a daily basis.
- I make sure safety is embedded in every strategy and capital decision we make.
- I am visible and checking at least 2 levels down and on the front line to confirm that our problem solving and prevention systems are working as intended. This means monitoring for consistent daily ideal behaviors.
- I make sure that **DEVELOPING PEOPLE** to be strong scientific-method based problem solvers is embedded in each leader's work, at every level, every day.