

Are You Infected?

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The title of this article may lead you to believe that it is about healthcare-associated infections (HAIs), but the theme concentrates on leadership. As it turns out, the article is about both. The power of the human spirit, our values, and the force magnifier of social networks are untapped resources we can leverage to bring the care back to health care and the trust back to the public trust. It may seem odd to combine the concepts of leadership and fighting HAIs in one writing; yet, leadership is as contagious as the pathogens that strike our patients.

Whether you are a governance board member, chief executive officer (CEO), administrator, physician leader, or frontline caregiver, there is much we can learn about leveraging our talent to combat the enemies of patient safety who never sleep.

HEALTHCARE-ASSOCIATED INFECTIONS AND LEADERSHIP: BOTH IN CRISIS

Make no mistake; the term *healthcare-associated infections* may sanitize the name of what they are, but the reality is the same. We give these infections to our patients—we ARE responsible for them. They are reaching crisis proportions. In fact, HAIs have helped move medical-related harm from the eighth leading cause of death in the United States, reported by the Institute of Medicine in 1999, to third, when studies showed that approximately 1.7 million infections occur annually in the United States. This translates to roughly 4.5 infections per 100 admissions and a total of 98,987 deaths per year. A 300-bed hospital with 15,000 admissions will have 775 per year. The cost has been estimated at \$4.5 billion to \$6.5 billion each year.¹

Hospital leadership is in crisis as well. Leadership failure has been cited as a major cause and one of the fastest growing causes of sentinel events.² Communication failure among administrative leaders, midlevel managers, and frontline caregivers regarding quality goals is a major problem.³

Leaders Paint Their Values Through Their Behaviors

Leadership is similar to the spread of infectious disease. It is a contagious phenomenon, positive or negative. Verbal and especially nonverbal communication are vital. We all know what it is like to meet people and be in an organization that has a vibrant energy where people have a twinkle in their eye, lightness in their heart, and really enjoy working together—we just don't see it in hospitals very often.

If values were paint, the behaviors of leaders are the daily brush strokes on the canvas of the organization. Behaviors are far more important than rhetoric—the true stories and narrative of those behaviors define who we are. The question is— what are you painting? Are you “playing the role” or being a role model?

With the advent of multimedia transmission over the Internet, we have become a viral society where ideas, rumor, and facts travel in an instant beyond the walls of a room, conversation, or organization. Transparency is not an option.

THE ENEMIES THAT NEVER SLEEP

AIDS of the Corporate Soul—A Diabolical Design

Almost by magic, AIDS attacks the immune system and spreads through the very core processes its host uses to combat disease. The virus infects the victim's operating system. It uses white blood cells, which are supposed to detect and fight foreign invaders, and is able to trick the immune system into producing more and more virus particles.⁴ In an organization, the symptoms of an unhealthy

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culture and the often self-induced injuries that create it are as contagious as the drivers that create a positive one. In his book, *How the Mighty Fall and Why Some Companies Never Give In*, released in the spring of 2009, Jim Collins, famed business author, charts the rise and fall of great companies and states, “Whether you prevail or fail, endure or die, depends more on what you do to yourself rather than on what the world does to you.” He establishes the “hubris of success” and the “undisciplined pursuit of more” as the first 2 stages of downfall. In the third stage, he says that there is “denial of risk and peril,” followed by a stage of “grasping for salvation,” leading to “capitulation, irrelevance, or death.” We are certainly not unfamiliar with these patterns in hospitals and other health care organizations. The big question is: How do you know when you are slipping into a failure trajectory?⁵

HAIs... The Cost of Doing Business?

Communication is as much a vector of successful leadership as it is a vector of leadership failure. David Gergen tells us, in *Eyewitness to Power*, that communication by symbols is particularly important for a leader.²⁷ For instance, when leaders communicate that deaths related to HAIs are a “cost of doing business,” even when they know such infections are destroying the lives of families in their community, it sends a clear message, symbolically, to the frontline—no amount of rhetoric or value statements on the walls can reverse this message. Like AIDS, moving through a body, communication of harmful values moves through the corporate organism of a hospital workforce with light speed.

The Immune Defense System of the Status Quo

Most of us can resonate with the humorous quote of Congressman Dana Rohrabacher, who says, “Bureaucracy is the best device known to man that can turn entrepreneurial energy and financial resources into solid waste” (oral communication, June 27, 2009). Yet, there is something else regarding bureaucracies that is important to the discussion of patient safety. A major property of bureaucracies is that they instinctively defend their survival. Social Darwinism is alive and well in our hospitals today. Many nursing leaders admit that “we eat our young” when something bad happens, which is so graphically depicted in the story of Julie Thao, a nurse criminally indicted for the death of her patient, which occurred because of human error compounded by system failures.⁶

We Eat Our Young

We know that many typical hospitals experience preventable deaths; yet, our collective behaviors to protect how we do things pose a formidable enemy to transformative improvement. Denial is the first stage of grief, often quoted from Kubler-Ross.⁷ We grieve when we know we are not what people think we are or when we do not really live up to our press releases.

HAIs Never Sleep

Surgical-site infections, those associated with central lines, urinary tract infections, ventilator-associated infections, and in-

fections from multidrug-resistant organisms will continue to plague our hospitals 24 hours a day, 7 days a week, and 365 days a year.

The Bugs That Never Sleep

The only way we will be able to prevent such infections is through transformative leadership and an absolute change in culture. “Business as usual” will just not stem the tide. This will be an ongoing war, and it is a war of attrition. The losers will not have the staying power and will not establish stable systematic approaches that can continuously hold them in check once they are reduced.

PEOPLE POWER—INVISIBLE FORCES OF HUMAN NATURE

Our core values are an invisible force of human nature that can be leveraged for transformation of organizations.

Values Genetics

In a prior article, we have defined the Values Genetics Model to help clinicians understand how human values are tightly coupled to the behaviors that they produce and the performance that is delivered.⁸ The collective behaviors of the individuals within an organization define its culture. Briefly, if core values are thought of as genes, then their expression as traits would be behaviors. Values drive behaviors, and behaviors drive performance. The strength of the expression is mediated by choice—conscious and unconscious choices. Such choice is heavily impacted by the values of the host organization, of which individuals are members.

The FUDGE Factors: Fear, Uncertainty, Doubt, Greed, and Envy

The FUDGE factors are very powerful instincts that we, as leaders, must combat and overcome in those we lead. In past articles, we have discussed them in terms of the barriers to excellence. When possible, we must convert this negative energy into positive motion toward our goals for better care.⁹

It is clear that the corporate values DNA of an organization, like a hospital, can be mapped, but the question arises: Can we do values reengineering and seize victory from the jaws of defeat when a culture is failing? Leaders must determine how they can leverage our values to fight HAIs through changes in the behaviors of caregivers and administrators. Governance boards are the corporate conscience and the keepers of the values’ flame. Administrative leaders must put the systems in place to make sure that conscious and unconscious choices of behavior are clear and make the tough courageous decisions that, in the short term, might seem to put an organization’s reputation in harm’s way, like publicizing infection rates to mobilize the troops to combat them.

Infectious Leadership

According to leadership expert, Michael Watkins, “For good or ill, the senior leadership of every organization is infectious.

By this, I mean that leaders' behaviors tend to be transmitted to their direct reports, who pass them on to the next level, and so on down through their organizations. Over time, they permeate the organization from top to bottom, influencing activity at all levels. Eventually, they become embodied in the organizational culture, influencing the types of people who get promoted and hired into the organization, creating a self-reinforcing feedback loop—either positive or negative."¹⁰

We asked Rick Boothman, chief risk officer for the University of Michigan, about the contagious nature of leadership and values-grounded communication. He is the father of the "principled approach" to risk management, malpractice, and disclosure. He states:

"Fear chills the best intentions. Health care professionals know what to do, but are afraid. Great leaders recognize fear and never let it win. They use their positions to make a principled culture safe. They inspire us with word and deed to want to do the right thing. And once it starts?"

"It rolls through an organization like a summer thunderstorm, cleansing everything in its path."

"I'm often asked how hard it was to push the University of Michigan Health System to pursue a principled approach and it makes me laugh. Once a nurse or physician knows it's ok, you often can't shut them up!" (oral communication, June 26, 2009).

Rosabeth Moss Kanter,¹¹ famed business guru and expert in change management shares, in her book and articles, about how "change masters" lead successful transformations of organizations. She says of leaders:

"Leaders must wake people out of inertia. They must get people excited about something they've never seen before, something that does not yet exist."

She goes on to say "The theme provides the setting for a story that—has come to life, to raise aspirations and inspire action."

It is precisely this kind of change that hospitals will need to transform their mind sets and cultures regarding hospital-acquired infections to ones of vigilance and accepting nothing less than zero infections.¹¹

We must move from infection control to infection prevention and "chasing zero." Our national stakeholders are demanding it, including The Leapfrog Group, the Centers for Medicare and Medicaid, The Joint Commission, the Institute for Healthcare Improvement, and the Agency for Healthcare Research and Quality.¹²

The 3 T's of Leader Engagement

We have referred to the 3 T's of leader engagement—truth, trust, and teamwork—in prior articles. Truth is the currency of the mind—facts, quantitative evidence, and the numbers are

critical to win the battle of the mind. Trust is the currency of the heart—emotion, empathy, compassion, and faith. When we can help people make that 18 inch connection between the heart and the head, we can mobilize action that puts the hands to work through teamwork. Teamwork provides the gears that magnify the actions of a group to deliver sustainable results that exceed what the individuals can do separately.¹³

STORY POWER AND SOCIAL NETWORKS

Story Power

Heath and Heath,¹⁴ authors of *Made to Stick*, say that we get people to act on our ideas by telling stories. They state that the most powerful formula for transmitting an idea that sticks can be remembered by the acronym SUCCES:

*Simple Unexpected Concrete Credentialed,
Emotional Stores.*

Such stories likely leverage certain neurophysiological pathways that activate us and stimulate both attention and memory retention. This must explain the impact of the *Josie King Story*, a video about an 18-month-old who died the preventable death of a systems failure at Johns Hopkins, one of our greatest US hospitals. This 9-minute video story is now being used by almost 2000 hospitals worldwide. Our preliminary research findings reveal that thousands of lives have been saved, and hundreds of thousands of dollars have been raised for patient safety through the use of this video.¹⁵

Social Network Power

Metcalfe's law refers to the power of computer networks in which the power of a network grows logarithmically as the number of computer nodes grows arithmetically. The unprecedented explosion of Internet-driven social networks and the power of grassroots coalitions that have huge political impact certainly resonate with this principle as described below.

The success of the presidential election of 2008 demonstrates the enormous impact that can be generated by applying story power through social networks.

PUBLIC NARRATIVE POWER—STORIES OF SELF, US, AND NOW

This author recently had the rare opportunity to participate in one of the most powerful methods that can be used by leaders, organizers, and frontline foot soldiers in the quest of achievement—the *public narrative*. The Harvard Advanced Leadership Initiative,¹⁶ founded by Rosabeth Moss Kanter, cited above, was established to provide a small group of seasoned entrepreneurs from around the world with the best of Harvard's experts and knowledge assets to spawn ventures to tackle big social problems in health care, education, and social sectors.

As 1 of the 14 fellows in this program, this author was honored, humbled, and inspired by the opportunity to spend a workday developing a public narrative with Marshall Ganz, an acclaimed educator at the Harvard Kennedy School of Government. Our day was a rollercoaster ride of concept briefings, small group work sessions with bright young facilitators armed with stopwatches, and frequent, fast, whole-group sessions filled

with episodes of rare personal vulnerability of global leaders getting in touch with their past, present, and future.

Ganz states that the practice of leadership is

“Enabling others to achieve purpose in the face of uncertainty.”

He says that this requires engaging the heart, the head, and the hands: motivation, strategy, and action (oral communication, June 11, 2009).

Public Narrative—A Leadership Art

Ganz is the architect of Camp Obama, the program that inspired and developed a frontline field force of campaign volunteers through a process that helped propel a new president into office and rewrote how political campaigns will be run forever. This son of a rabbi typically begins his introduction of public narrative by referring to the biblical story of Moses being called by God: “Who is calling me, why these people, and why now at this place?” (oral communication, June 11, 2009).¹⁷

Ganz states that, through narrative, we can articulate the experience of choice in the face of challenge, thus sharing the values that enable us to manage the anxiety of agency, as well as its exhilaration. In his introduction of the concepts, he defines them as processes through which individuals, communities, and nations make choices, construct identity, and inspire action. Ganz says that leadership is (oral communication, June 11, 2009),

“Inspiring action across cultures, faiths, professions, classes, and eras.”

According to Ganz, public narrative is a leadership art. Through it, leaders learn to draw on narrative to instruct and inspire.

The Self, Us, and Now Stories

Marshall Ganz designed the public narrative as a process to learn how we could reclaim our capacity to articulate, draw courage from, and act upon our public values, and as a way to translate our values into action.

He teaches that “Public narrative is composed of 3 elements: a *story of self*, a *story of us*, and a *story of now*. A story of *self* communicates who I am—my values, my experience, why I do what I do. A story of *us* communicates who we are—our shared values, our shared experience, and why we do what we do. A story of *now* transforms the present into a moment of challenge, hope, and choice.” He goes on to say that leadership requires engaging others in purposeful action by mobilizing the feelings that can facilitate it to challenge feelings that inhibit it (oral communication, June 11, 2009).

Just like a day at Camp Obama, our day with Marshall Ganz was filled with many sessions, composing our stories of *self*, *us*, and *now*; our goal was to identify how we could pull from our own core, the collective motivation we have to get others to move with us to a common vision.

The SELF Story

In small groups, we were each given no alternative but to deliver a 2-minute presentation of our own “story of *self*”—with only 5 minutes of preparation. Embarrassingly, we revealed private moments of pain and joy that, many times, brought tears to our eyes and smiles to our lips. Although we had worked together for months, we had newfound revelations about what made us tick. Firm, incisive questions and challenges by our facilitators distanced us from pat answers and pushed us to reveal why we are motivated to serve others. In the words of Hansueli Maerki, from Switzerland, one of our fellows who is the recently retired IBM chairman and general manager of IBM Europe/Middle East/Africa, “Going through the process of public narrative was like the successful search for myself, finding the roots of why I like to be leading others to a common goal” (oral communication, June 11, 2009). Running like Swiss trains, we moved back and forth between conference rooms and offices, marveling at the discipline of the day, sharing our stories and refining them with every telling, realizing and wondering what campaign volunteers must have experienced through the same process. We began to feel an excited tension developing, like a coiled spring.

The US Story

After a full-group session of reviewing our own stories, we were led through the process of developing our “*us*” story. We were taught that a “story of *us*” communicates the values a couple, family, community, movement, nation, and/or faith-share. One of our fellows, retired marine Maj Gen Charles Bolden, an astronaut, and now the newly appointed leader of the National Aeronautics and Space Administration, reflected on the power of the Marine core values of honor, courage, and commitment when he pulled out of his wallet a card he carries that embodies them during preparation of our *us* story. Stories drawn from shared experience can evoke the values developed through life experiences. These stories became what Ganz describes as a “moral resource” the group could call upon to face new challenges. Again, we shaped, sharpened, and shortened our stories against the pacing stopwatch and a colleague putting up warning fingers when we were a minute away from our cutoff. We critiqued each other, now collectively working toward a powerful oneness that we, as a small subset of a team, could relate to. We presented this to the larger group through a very disciplined process, again first sculpting fog, then shaping play dough, then finally, our message held its shape to the probing questions of our facilitators, led by Marshall Ganz, the genius of the process. This message had risen from the vulnerability of our personal private experiences to reveal our core.

The NOW Story

When we assembled for the third time into our small groups, we knew the drill: 5 minutes to compose our message and then *go*. A “story of *now*” communicates values at stake in an urgent challenge with which we are confronted now, a source of hope that can inspire us to step up to that challenge, and the choice we must make about how to act. We were challenged to think about what would happen if our envisioned goal was not met. What were the consequences? We were taught that the choice offered should promise a specific outcome and require collective action and that it begins with an action each individual can take now. When we returned to the full group, we found we had gained momentum because we had discarded generalizations and nailed specifics.

The Self-Us-Now Story

When we put it all together, we had tempo and energy. We linked our own calling, the calling of our community, and the call to action. We were concise and powerful. We could call on that inner drive of our life, that purpose for working together, and the urgency of now to invite others to join an authentic quest that we believed in. In the words of Shelly London, a world-class communications expert and one of our fellows, “Public narrative is a tool much like a telephoto lens on a camera. It allows you to focus your field of vision exactly where you need it to be—one unified action.”

We then could speak from the heart and make a compelling request of someone to join our work in a tight, compact, and moving message. The tuning forks of our hearts could set off resonance in the hearts of those we needed to recruit and compel to act.

Our Advanced Leadership Initiative group started to become a team that day and it is now just beginning its own journey. And the story of the success of the Obama campaign has been written into the history books.

David Gergen, an advisor to four presidents, and co-chair of the Harvard Advanced Leadership Initiative, cited above, states that he had learned a tremendous amount about the great leadership of Ronald Reagan. He writes in his book, *Eyewitness to Power*, that “Ronald Reagan pretended to be a non-politician, a citizen who happened to run for office, a Mr. Smith comes to Washington. But behind that thin veneer, he was pretty darn good at politics too, and that was an important - and indispensable - ingredient in his leadership.” As Joseph Alsop once observed about the Presidency, “Rule 1, at any rate in America, you have to be a good politician in order to get the chance to be a great statesman.” Hospital leaders need to be good politicians in order to be great CEOs. This requires dedication to delivering on the core values, painting those values every day, and also being great communicators, as shown in the leadership of Ronald Reagan. We used Ronald Reagan as a good example of leadership both to balance the example we have demonstrated above regarding President Obama, and also to recognize the fact that great leaders need to be great communicators.²⁷

*The story of your success with HAIs
and other quality*

...and patient safety challenges is yet to be written.

*It will become part of the narrative of your
organization, whether you write it or not.*

WHAT IS YOUR PUBLIC NARRATIVE?

Health care leaders and caregivers reading this must ask themselves whether they have a “calling” or a job. Do they want to leverage the power of people, stories, and their social network to take on our big challenges or not?

Clearly, most organizations will not have undergone the rigorous process we did developing a *self-us-now* story and refining it down to 5 minutes; however, many have a loose narrative from which to start a discussion. Others may be starting from scratch. You know you are starting from scratch if the board and leadership team need to consult a brochure or plaque on the wall to recall the values, vision, or mission statements.

A sobering reflection is the thought mentioned above—if you do not write your narrative, it will likely be written by someone else, whether you like it or not.

Board Members

Do you have a calling, OR is your board member designation just another merit badge on the tunic of your resume?

- Can you call on your *self* story to explain why you are serving, articulate an *us* story of collective focus on quality, and are you communicating a *now* story of urgency to the administrative leadership team? Your community is counting on you to hold this team accountable.
- You are the keeper of the flame of core values. You are the conscience of the organization. In the case of HAIs, are you doing enough to make sure your hospital is doing enough?
- Do the values of the organization clearly have a resonance across those with whom you have contact with in the organization? Do you undertake “walk-arounds” at the organization and directly interact with the staff, or are you largely a visitor to the board room reviewing financials and prepackaged materials about the quality measures of the organization? Great hospitals share the “good, the bad, and the ugly” with their boards. The bad and the ugly are considered treasures for improvement and opportunities for greatness. Are yours?
- The *National Quality Forum Safe Practices for Better Healthcare—2009 Update* is now a nationally endorsed set of standards that defines a blueprint for governance and administrative leaders. Have you committed your organization to adopt them, as have many organizations, such as Catholic Healthcare Partners, a multihospital network based in Cincinnati, Ohio, one that has taken safety seriously?¹⁸
- You might consider a board retreat that is focused on uniting you with the administrative leadership team, clinical leaders—both doctors and nurses/care providers, around your public narrative.

You represent a community that knows we have a crisis regarding HAIs. Can you honestly communicate that your hospital is doing everything it can to “chase zero?” If not, it is a good place to start taking your values out for a “test drive.”

Chief Executive Officers

Do you have a calling, OR is it just a leadership job? Have you delegated away the opportunity to ignite high performance through the core values of your talent?

- Do you have a *self* story from which to draw to inspire your operating team and the troops at the—frontline? Does your *us* story unify everyone in the organization and give them a collective identity as a team?
- Is your *now* story tied to reality and a catalyst for daily action? Your consolidated *self-us-now* story can be the litmus test for tough decisions. “The core values of your organization,” in the words of Ann Rhoades, international people systems expert, “must jump off the wall through the actions of leaders” (oral communication, July 5, 2009). Have you built them into your leadership guidance system?
- You, more than anyone, must ensure that your leadership team “paints those values through their behaviors” on the canvas of every meeting, with every interaction, every day.
- Have you created an environment of anxious excitement and anticipation of achievement that can be as contagious as the flu, spreading from person to person, invisibly, or is your organization experiencing a “depression flu,” dwelling on budget cuts and the negative side of our challenges. You create the

- tone of your organization. In the words of Dr Gary Kaplan, the CEO of Virginia Mason Hospital, “You are sending signals in everything you do” (oral communication, December 1, 2007).
- In the case of HAIs, if the CEO does not own them, no one owns them. The CEO must lead a multifront war on the status quo. The time for incremental improvement is over—policy makers, purchasers, and now, consumers are demanding transformation.
 - Have you put together a values-grounded transformation plan like Dr Chris Olivia, CEO, West Penn Allegheny Health System, has done for his hospital system?
 - As the chief executive of your organization, you hold within your span of control the ability to involve patients and families in the operations and leadership of the organization. The 2009 update to the NQF Safe Practices for Better Healthcare, Chapter 9 entitled “Opportunities for Patient and Family Involvement,” provides a leadership blueprint for you addressing involving patients. Insights are also provided for each practice as to how to accomplish this.¹⁸ Great organizations involve patients and families in all they do, such as the Dana Farber Cancer Institute in Boston, with great results. The ball is in your court.
 - Consider developing the leadership art of the public narrative and convening your leadership team around clear messages that help shape the identity of the organization toward a common purpose that is grounded in your mission. Take on hospital-acquired infections as an example, and consider leveraging the social networks within the hospital.

It is you who have the greatest responsibility to set off the tuning fork in the hearts of the people you lead—without yours going off, how are you going to do it?

Chief Operating Officers and Administrative Leaders

- Do you have a calling *OR* is it just an operations job? Does the tyranny of the budget dictate your future?
- Camp Obama drove its clear messaging down to the precinct level. Are you driving your messages of transformation down to the unit level in your hospital?
 - Are you painting the values of the organization through your behaviors? Operations is where the rhetoric meets reality.
 - Upper and mid-level managers report to you. Do you take the weak position of saying “I hire good people and let them do their jobs” while your every message is about short-term cost containment. The message of “no margin – no mission” means “MARGIN IS THE MISSION.” Your managers can only serve one master and if bucks trump everything, you have sealed your future.
 - Have you engaged your quality and safety leaders and charged them with prioritizing the safety improvement opportunities that can convert inefficiencies into better outcomes while dropping money to the bottom-line like readmissions, adverse drug events, HAIs, and hand-offs between units and care settings? Most chief operating officers do not know that the revenue of readmissions and treatments of adverse drug events are “red ink” and loss leaders.
 - Consider doing what Dr Bill Rupp, CEO of the Mayo Hospital in Jacksonville, Fla, has done in a number of hospitals. Insist on posting infection rates on the doors and walls of units experiencing them. After spending a few weeks reprinting and posting them, the staff will quit taking them down, and when infection rates improve through this transparent competitive culture shift, your staff will start assuming a new identity and self-esteem. It happens like this all over the

country. And we know of no organization where this provoked a response from the dreaded malpractice bogeyman—the mythic risk that so many administrators have clung to that indulges hiding leadership failure.

Midlevel managers have been found to be the weakest link in the command chain and require the most mentorship on performance improvement and the opportunities to convert inefficient processes between departments into better care and economics. It is time to consider using good old-fashioned inspiration, mentorship, and leadership to help them move from being monitors of budgets to becoming social entrepreneurs who lead. It will be you who will have to give them more to listen to than the drumbeat of the profit-and-loss statement. They look to you as conductor of your hospital orchestra.

Chief Financial Officers and Financial Teams

Infections are no longer the cost of doing business. Patient safety investments are no longer about return on investment (ROI). They are about SIB – Stay in Business.

- If you haven’t found out that your quality leaders, patient safety officers, and nursing leaders are the Chief Revenue Preservation Officers of the hospital; then you are in for a real shock with health care reform.¹⁹ Meet with them and ask them whether they think they have enough resources to fight their battles.
- Soccer moms, senators, congressmen, and the press all understand when someone gets an infection from coming to your house. The payers have the bug now and you’d better make sure you do not fail to green-light high impact patient safety investments like those necessary to reduce infections. Just take a look at your marketing budgets and the cost of your last crisis management experience. How much was the fully loaded cost of repairing your hospital’s image. If you have an infection problem today that has not yet been in the press, get ready to write some checks.
- Shorting investment in infection prevention is like not paying for oil changes in a fleet of vehicles. Deferred maintenance is a time bomb.
- Finally, the *self-us-now* story approach might sound to the highly analytic and finance crowd like just another pack of psycho-babble; however, consider two things: first, the huge financial support in dark green dollars that the Obama campaign generated from people who had little to give; second, consider your own career path. If you want to grow, lead, motivate, and move beyond crunching numbers, you will need to build leadership skills. Communication is the centerpiece of those skills and the public narrative is about as fast a crash course on those skills as you will ever take. If you can’t tell it, you can’t sell it. If you can’t sell it, they won’t buy it. And if they don’t buy it, you will miss out on the excitement of truly leading people.

It is our belief that the next generation of great leaders may come from the ranks of our chief financial officers and finance leaders who will monetize and show us how to generate the value from our values.

Patient Safety and Quality Leaders

With the advent of real pay-for-performance and quality-focused health care reform, the role of quality leaders is evolving from one of little authority and a lot of auditing to one becoming the “chief revenue preservation officer.”¹⁹ Authority and accountability are growing. And there will be growing pains to this evolution.

- Do you have a real calling, or is it just another quality job? Your organization will be calling on you to help shape your collective identity: your new *us* story in quality, whether you call it that or not. No hospital will be able to survive the “no outcome, no income tsunami” without a solid quality platform that is well directed to surf the new waves. It will take courage to stand up to the status quo and those who defend it.²⁰
- Are you prepared to “eat crow” regarding your past improvement plans that have not made zero HAIs your target?
- Can you leverage the “3 Ts of Leadership Engagement”?¹³ You, more than anyone, must communicate the “truth” regarding your patient safety performance—the numbers, metrics, measures, and opportunity demonstrated by the evidence. You must leverage patient stories to appeal to the heart and build respect for the “trust” patients have in us. You must become an expert in the third T, teamwork, by developing the teams to tackle challenges such as reducing the infections we give patients when we care for them.
- Have you met with the infection control leaders and professionals? Do they know the seriousness of the required transformation of their role? Do they have the resources? Are HAIs posted so everyone on a unit can see them to follow the progress? Are leaders keeping staff aware of the daily vigilance necessary to prevent HAIs, or are they cowed by the fear of transparency? Are they caving to the myth of malpractice risk—the friend to the status quo? You have to be the supportive spokesperson for your leaders, if they get it, and their challenger if they don’t.
- Finally, if you are keeping a finger on the national pulse, you must put real impact into the *now* story of your organization. Health care typically moves at glacial pace. The requirements to reduce adverse events are going to evolve at a rate that is nothing short of breathtaking, taking many organizations by surprise. It is your job to keep yours ahead of the curve.

You have a wonderful opportunity to use what Joe Nye,²¹ author of *The Powers to Lead*, describes as “soft power,”—that ability to attract people to your mission. High-performance care is coming into its own, and you can lead it, follow it, or get out of the way. We recommend that you step up and lead. You can be the champion of the *now* story.

Physician Leaders

Whether they are independent or employees of an organization, it is time for physicians to step up and be responsible. We know that the most precious thing we have ever been given is the sacred trust of our patients. It has always been our job to honor it.

- It is no longer acceptable to complain about hospital administrative decisions or practices when you are not taking the lead on attacking infections that we give our own patients.
- It is time to serve the calling and be part of the solution and not part of the problem. Physician behavior and inertia are major barriers to developing high-performance hospital care. The resistance to change and negative attitudes that can ripple through a medical staff are more infectious and virulent than the most aggressive pathogen.
- Gone is the myth of the genius “silo savior,” who is the prima donna procedural or diagnostic maestro to whom we have to pay homage. Medicine has become a team sport, and there are enough well-trained procedural stars and diagnosticians coming up through the system who have great hands and great minds WHO ARE team players. As Bill Rupp, cited earlier, has taught us: “Doctors need to learn the science of teamwork

so that they can practice the art of medicine” (oral communication, March 10, 2009). The old guard will have to get with the program or be out of it, because continuity of care will be a priority of health care reform, and episode-of-care payment frameworks are going to demand team play.

- The positive energy that can build within an organization when the medical staff become champions for change is incredibly infectious. It is no small wonder that the first rule of transformation is to find physician champions. No small wonder, either, that the critical requirement of champions is enthusiasm.
- In the end, it is the physician’s pen and, now in the information age, their keystrokes that still define the majority of what occurs to patients in a hospital. And yet, as Dr Don Berwick, president and CEO of the Institute for Healthcare Improvement says, “We need to act as if we were guests in the patients’ lives” (oral communication, March 13, 2009).

Physicians need to learn the value of communicating through the 3 Ts mentioned earlier; they have a terrific opportunity to put the *self-us-now* story together because their relationships span the entire patient experience. When the tuning fork in their hearts goes off, everyone can feel it.

Infection Control Department Leaders and Control Professionals

The evolution of health care, with new demands of transparency, pay-for-performance, and the pressures created by the great successes of initiatives such as the Institute for Healthcare Improvement 100,000 Lives Campaign, has created a perfect storm for infection control department leaders. Their departments were funded, structured, and operate to detect infections. Few have been in the business of performance improvement. The best recommendation we can make is to embrace the change and get in front of the parade.

- Develop deeper and more collegial relationships with patient safety officers, performance improvement teams, and nursing leaders.
- Learn about the new best practices and successful initiatives. *The National Quality Forum Safe Practices for Better Healthcare—2009 Update* provides a great start.¹⁸ The HAI compendium,²² the most harmonized and referenced assemblage of HAI knowledge yet created, provides a terrific resource from which to draw.²²
- Recognize that you are going to be called into some very tense discussions. For instance, when soon-to-be-released reports demonstrate that surgical skin preparation solutions that may be more expensive than what you are currently using in your operating rooms dramatically drop the rate of surgical site infections, you will be in those discussions. Be prepared and stay tuned to the evolving literature. Tune up your knowledge about the cost of infection-related products; if you don’t, you may find yourself in a very hot seat.
- Embrace the supplier community that is now leveraging information that they are gaining from their customers. Many now have more actionable information than academic research study groups who now have less research funding.
- Look at what has been defined as AIIMS—Automated Infection Identification and Mitigation Systems. These health information technology systems provide terrific decision support for prevention of infections. They will move infection prevention specialists from audit mode to action mode where they need to be.²³
- Finally, look to a future of innovation and *real* reengineering of care. Leading international experts such as Denise Murphy,

nurse, quality leader, and steadfast champion of patient safety, believes that in the future we will be working side by side with human factors engineers and reworking care processes with an end-to-end solution approach to adverse events (oral communication, July 2, 2009). Get ready. You will be a player in that future game.

It is a good news–bad news situation for you. The good news is that you will be in the spotlight... the bad news is that you will be in the spotlight! Unless you make a vocational paradigm shift, you will soon find yourself in front and at the center on the patient safety stage; however, there will be a new audience of the chief operating officer, chief financial officer, and CEO who will not be shy about asking tough questions.

Pharmacy Leaders

Our leaders of hospital pharmacies and their staff probably know more about adverse events in our hospitals than most other silo service verticals. They have a terrific opportunity to exert new leadership influence and can have a huge impact on the performance of a hospital. Our message to you is consistent with the new National Quality Forum Pharmacist Leadership Structures and Systems Safe Practices,¹⁸ which we were honored to help compose. It is time to assume the authority and accountability for performance outside the walls of the pharmacy. As we identify new pathogens and infection-related scenarios (and they will arise), pharmacists will almost always be involved. They should be monitoring the literature and policy makers' decisions.

- Antibiotic stewardship is designed to optimize antimicrobial therapy administered to hospitalized patients, to ensure cost-effective therapy and improve patients' outcome while containing bacterial resistance. This will be increasingly important to protect the community from even more formidable pathogens than we have today. Pharmacists can partner with the safety and quality leaders to take the lead here; however, they need the sponsorship of the "C-suite." Again, leadership is a make or break proposition.
- As we face more pandemics such as avian flu and other population-related community infections, it will be important that in the future our pharmacy leaders are in the game and that they help with the tough decisions that may have to be made when demand exceeds capacity in a crisis.

Our experience is that hospital pharmacists are wonderfully motivated professionals who will resonate with a values-grounded leadership platform. They are people whom great hospitals always engage as champions. To quote an expression from the motion picture, *The Replacements*, "When the game is on the line, winners want the ball." Our game is on the line, and our message to pharmacy leaders is to speak up and ask for it, and our message to hospital administrators—give them the ball... you can count on them.

Nurses

The career life picture of today's hospital nurse is not pretty. Low compensation, modest authority, little autonomy, and workload that explodes with cost cuts explain why more than 40% of nurses plan to leave the profession in the next 2 years.^{24,25} Just at the time when we most need them, we are not developing, inspiring, and supporting our key talent pool. Until robots replace nursing care, we are dreaming if we think that technology alone is going to get us out of the current health care crisis. It is these unsung heroes who are the final mile of our health care delivery highway. No one would argue against the concept that our nurses are called to serve. Even the most

mercenary of us cannot explain why nurses hang in, taking care of patients every single day. Our message is to nursing leaders and to the other leaders mentioned above:

- Our best and most motivated nurses are easy targets to be lured away to industry and other jobs. Don't let this happen! The average nurse is in his/her late 40s, feeling disenfranchised, and ready for a change. Make them the target of your *self-us-now* story. We must remobilize and inspire what Ann Rhoades, cited above, would call our "A" players—those who live the values of the organization every day, providing the life blood of a hospital to their patients—love, compassion, caring, that spirit that spells safety and inspires the trust of patients and caregivers.
- Nursing leaders have a "break-out" opportunity to recast the role of their constituents as the champions of high-performance care: the players who can turn inefficiency into outcomes and bottom line. Some of our nursing leaders have assumed a victim persona without offering an alternative. Now is the time to show where the faults are in the system and to demonstrate how nurses can address them with a little resource support and frontline leadership.
- Joy Peters, RN, MBA, is a nursing leader who captures the essence of what our hospital leaders need to hire, reward, promote, and reinforce. She naturally exudes the *self-us-now* story as she takes you for a tour of her unit at Allegheny General Hospital, demonstrating, with enthusiasm, the changes that nurses have made to their equipment, processes, and approach to making patients safer. Her infectious enthusiasm for performance improvement has even earned her various nicknames including "Joy-ota," acknowledging her championship of approaches such as Toyota production methods. She is the "A player" role model that nurses must compare themselves to. We all know of great nurses, however, all too often, where the "tall poppy syndrome" kicks into gear as a reaction to such players in unhealthy cultures. Tall poppy syndrome is a pejorative term used in the United Kingdom, to describe what is seen as a populist-leveling social attitude. It is seen as a societal phenomenon in which people of genuine merit are criticized or resented because their talents or achievements elevate them above or distinguish them from their peers.²⁶ Only leaders can prevent this from occurring.
- We need to invest in our nurses, teach them to lead, lead them better, and inspire them. They are our diplomats to our patients, doctors, and the communities we serve. We owe them a *self-us-now* story that we can back with real action and give them a chance to pull out of the slump that market forces have created.
- To operations leaders, we suggest that you consider the mental operating system of a nurse and many nursing leaders. They have been selected, trained, and told, throughout their careers, that they must take orders and translate them into action through compassion and care. They have not been taught the aggressive skills of street-fighting over budgets. You cannot expect them to weigh in and duke it out with those who excel at such skirmishes. Too often, this writer has seen nursing leaders bullied and beaten up by the operations and finance players who know how to play tough. Too often, the "wins" for finance or operations teams over budget issues with nursing leadership spell quality and safety failures and "losses" for hospitals. In the future, with changes that will come with reimbursement, this is going to be lethal to the bottom line and to survival. Ask the right questions and do your homework with regard to nursing staff and coverage issues. Review the National Quality Forum Safe Practices that address nursing and direct caregivers¹⁸—your blueprint has been written.

- To nurses, we recommend that they combat the learned helplessness that leadership experts say is crippling in a culture. Holding a “pity party” over lack of respect or autonomy will not prevent infections and, as mentioned above, a self-defeatist attitude can become contagious and as dangerous as the worse multidrug-resistant bug.

In conclusion, both HAIs and leadership are contagious. We can tap the power of the human spirit, and our values, and leverage the force magnifier of social networks. We can put the care back into health care and the trust back into the public trust.

Our friends in politics have given us some good lessons. We must take the time to build our public narrative, define our identity, and then paint our values through the brush strokes of our behaviors. Healthcare-associated infections provide a wonderful place to start.

The question is... Are you infected?

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Chairman