Learn Global, Act Local, and Be Vocal

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In this first issue of the 2011 edition of the *Journal of Patient Safety*, it is important for us to stop and take a look in the mirror as we chart our course for the journal and our own leadership trajectory. It is time for us to challenge ourselves to do whatever we can to accelerate improvement in patient safety because our fight against health care harm is intensifying. Complexity and fragmentation are increasing. And yet, in the face of fewer resources, the battle lines have never been more clear—they are leadership, practices, and technologies.

We know that the high-performance care envelope where care is safe, effective, equitable, timely, efficient, and patient-centered is at the intersection of engaged leaders who ensure adoption of safe practices that deliver predictable outcomes and the careful aggressive adoption of technologies that enable and empower the leaders and practices.

The close of the decade marks the seventh year for the *Journal of Patient Safety*, and 10 years after the Institute of Medicine Report, *To Err Is Human*.[1] The question is, where are we in the fight against health care harm and what can we do to have transformative impact through the journal and through our own services as champions for patient safety?

WHERE ARE WE AND WHAT CAN WE DO?

The largest purchaser of health care in the world, in fact the largest purchaser of anything on the planet, is our own Centers for Medicare & Medicaid Services now led by one of the greatest contributors to global health care, Dr Don Berwick. We now pay more than US $800 billion a year for care that has ranked us 37th in the world by the World Health Organization. Most recently, a study of primary care physicians in 11 countries revealed that, although the United States spends far more on health care than the other countries in the study, US primary care physicians continue to lag well behind in health information technology capacity, are the least likely to have arrangements for after-hours care, and report few incentives or targeted support for improving primary care.[2] In 1968, Medicare and Medicaid cost US $303 per beneficiary. By 2009, it cost US $8872 per beneficiary…an increase of 2150% (Paul McGann, MD, Deputy Chief Medical Officer, CMS, oral communication, December 1, 2010).

Thomas Zeltner, MD, who led Switzerland's health care system for 19 years before his recent retirement, was one of the most respected health ministers in the world. During his tenure, Switzerland delivered better outcomes for 7.5 million Swiss citizens at 60% of US cost, with an annual growth rate in cost of 2.1%. He states that many in the world are puzzled by the fact that of the US $4.3 trillion per year spent on health care in the entire world, that 60% is spent by the US and that we seem paralyzed to change our trajectory. Dr Zeltner says, "doctors and caregivers from all over the world want to come to the U.S. to learn from American institutions, and take back innovations that they can put to work at home" (Dr Thomas Zeltner, oral communication, January 9, 2011). The reason is that we in the United States have islands of procedural and technical greatness in a sea of dangerous systems failures. It is our systems failures to which we must direct our attention. Dr Zeltner goes on to say, "despite the greatness of many specific areas of know how, the world is aware of the US' very flawed systems or non-systems of care."

Just in the last quarter of 2010, we have had 3 very important reports on the health of our systems.

The first was by the Office of Inspector General,[3] which selected a nationally representative random sample of 780 Medicare beneficiaries discharged during October 2008. Physician reviewers determined whether an adverse event occurred using a Global Trigger Tool instrument and determined whether the event was on the NQF list of Serious Reportable Events or the Medicare list of hospital-acquired conditions, what the level of harm was to the patient, and whether the event was preventable. The findings of this study were:

- **An estimated 13.5% of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays.** Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, approximately 1 (13.5%) in 7 experienced an adverse event.
- **An estimated 1.5% of Medicare beneficiaries experienced an event that contributed to their deaths,** which projects to 15,000 patients in a single month.

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- **An additional 13.5% of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm.** In addition, 28% of beneficiaries who experienced adverse events also had temporary harm events during the same stay.
- **Physician reviewers determined that 44% of adverse and temporary harm events were clearly or likely preventable.**
- **Hospital care associated with adverse and temporary harm events cost Medicare an estimated US $324 million in October 2008.**

The second study was recently published in the *New England Journal of Medicine*,[4] which communicated the lack of improvement in safety during 5 years in the progressive state of North Carolina. This study, authored by Christopher Landrigan, MD, used the same Global Trigger Tool measurement method originally developed by Dr David Classen, and further developed by Dr Classen and the Institute for Healthcare Improvement, revealed that minimal improvement had been generated during a 5-year period. It is my view that efforts in North Carolina had impact; however, the complexity and fragmentation of care that has naturally evolved with increasing financial pressures are trends that we all are fighting that may not be apparent. Nonetheless, the results of this excellent study should be sobering to health care and community leaders.

The third study by Schoen et al[2] and the Commonwealth Fund revealed that, although the Untied States spends far more than other countries do, it lags way behind in health information technology capacity, is least likely to provide after hours care, and has few incentives for improving primary care. Furthermore, the United States does not lead in use of teams. Clearly, these 3 features directly impact patient safety and quality of care. We have much to learn from others.

Globally, we find that many Organizations for Economic Co-operation and Development countries are experiencing similar rates of harm and that patient safety issues are not uniquely a problem of the United States. In fact, many leaders around the world are experiencing the same problems, yet innovation is breaking out in pockets everywhere. However, the voices of their champions are only heard through informal, poorly functioning old social networks, personal communications and much delayed traditional publications.

Leading patient safety experts, researchers, health care CEOs and their teams, and consumers all tell us that we must act now to prevent health care harm. Our incremental improvement is just not enough. We are just not delivering enough impact on even the most common and well-understood adverse events. So what can we do?

The answer is that we must write our own story of success, or it will be written without us; and without considerable effort, it will not have a happy ending for our professions or our patients. Every story has victims, villains, a crisis, heroes, and a resolution. It is time to write our own story, reject the chains of habit and learned helplessness, and do what we know is right for our patients, our caregivers, and our communities.

LEARN GLOBAL

First, we must "learn global," meaning we must look for best practices beyond the borders of our country and even beyond the boundaries of our industry sector. Terrific impact is being generated in countries like Scotland under the leadership of people like Derek Feeley, the acting director general of health, who reports a wonderful reduction in adverse events across the entire country. Their guiding declaration that introduces the summary of their results says it all: "There will be no avoidable injury or harm to patients from health care they receive, and an appropriate clean and safe environment will be provided for the delivery of health care services at all times" (Derek Feeley, oral communication, December 21, 2010).

Although we have adopted practices from other industries like aviation, there are many other sectors that have much value to share. For instance, breakthrough work in leadership pioneered by the Barry-Wehmiller Corporation, which has more than 49 successful acquisitions in manufacturing, has had an enormous impact on fulfillment of their workers that has translated into extraordinary organizational performance. Robert Chapman, their visionary CEO, who has merged the Toyota Lean methodology with their leadership model, says of health care: "Healthcare professionals NEED to be cared for themselves…for them to deliver *total* care, they need to feel that their leaders believe that their lives and well-being are every bit as important as their patients" (Robert Chapman, oral communication, January 11, 2011).

Chapman and his teams have shown that when leaders take on the responsibility for real fulfillment of employees during the time spent with them, it makes them better mothers, fathers, spouses, and/or family members. The extraordinary performance of their plants and organizations in the United States, Italy, United Kingdom, Belgium, Germany, Hungary, and India is "irrefutable" (Robert Chapman, oral communication, January 11, 2011).

ACT LOCAL

- The second thing we can do is "act local." In each of our own home organizations, we must directly address our own performance gaps. We must also build a bridge to span the vast expanse from the shore of awareness to the shore of action. The superstructure of such a bridge is through the other 2 As: accountability and ability. We must take personal accountability for the changes necessary in our behavior that should be made for transformation; and we must invest in the ability of those who need new skills to affect those changes. The urgency of health care harm demands that everyone from the top to the bottom of an organization act now. In the words of Gary Kaplan, MD, CEO of Virginia Mason, recently named by the Leapfrog Group as the Hospital of the Decade, "Leadership is not a noun…it is a verb."[5] There are great people serving as servant leaders at the frontline every day; no one reports to them, yet they lead by example. Kaplan also provided a window into great governance boards at the top of the organization in his acceptance speech when he stated, "Now many CEOs ask me, 'How do you manage your board?' And I look at them and say, what are you talking about? Our board members hold our feet to the fire…they give us the voice of the patient in the board room every single day" (Gary Kaplan, oral communication, November 30, 2010). Tom Van Dawark is the former chairman of the board of directors of Virginia Mason. He was a member of the board and strategic planning team during the design and execution of the strategic plan that set the stage for the hospital to assume its current national leadership position. Now a global governance leadership champion, he tells us, "Virginia Mason found that the input from our board members, who had safety and quality competencies outside health care, was very beneficial. Bringing experiences from outside health care, and not being 'burdened' with 'we've always done it this way,' these board members took a different perspective when asking why the accident occurred, why the intended corrective actions would be beneficial, and how we were monitoring the revised procedures when in place." He shares that, "our health care organizations need to focus upon industry wide safety and quality expertise and enhance board

safety deliberations by placing members with such expertise on safety and quality focused committees" (Tom Van Dawark, oral communication, January 11, 2011).

Dr David Classen, one of our nation's real leaders in patient safety, cautions us that, "It is critical that we stop being seduced by our current delusions that patient safety is easy based on inadequate and token measurement systems…it is time to dig into the detail" (David Classen, oral communication, January 11, 2011).

BE VOCAL

- We can no longer give in to the chains of habit that allow us to silently watch processes which have evolved over time harm patients and caregivers. Baby elephants are trained to believe that the chains around their legs are immovable—and they never forget. This learned helplessness to move beyond the chains that are used to control them for the rest of their lives, keeps them in one place, even when attached to objects that they can easily move with great power as adults. Sound familiar? In their book, *Switch*, which addresses transformational change, Dan and Chip Heath share with us the metaphor of the rider, the elephant, and the path. They tell us that we must inform the rider (the logical mind), motivate the elephant (the heart), and define the path (the new direction).[6] We must move the rider (or the mind) with logical arguments based on solid research comprised of clear facts, figures, patterns, and assessments. And we must motivate the elephant (or the heart) by calling on the emotions of passion, joy, and fear because it is the heart that gets things done. Together, the head and heart can move the hands to action. In a recent conversation, Dan Heath expressed the critical importance of decision making best practice, the topic of their next book. The Heath brothers have taught us how to be better storytellers, and now they will help us become better decision makers.
- Dr Stephen Swensen, the highly respected leader of quality for the 22 Mayo hospitals, reflects what a values driven decision making is all about: "At Mayo Clinic we have a litmus test for all decisions: the needs of the patient come first. It changes everything when we see all our work through that lens. For instance, Mayo's five Education Deans leading our 3,000 some students and residents see their job as improving patient care, not educating the next generation. That mindset leads to practices, for instance, that require residents to demonstrate competency in our simulation center before placing a central line in a patient. Who would want it any other way?"

Ann Rhoades, the people systems guru, cofounder of JetBlue Airways, and author of the recent book, *Built on Values: Creating an Enviable Culture That Outperforms the Competition*,[7] has shared with us that, "leaders drive values, values drive behaviors, and behaviors define our culture." She has challenged us to believe that our values should be "off the wall" and that we should not just have them posted in our lobbies but lived each day by our leaders—the voice of example is the loudest voice of all.

OUR CHARGE

It is a joy taking the helm of the *Journal of Patient Safety* because it is a truly successful publication that is, in no small part, due to the terrific leadership of Dr Nancy Dickie. She has served as editor-in-chief through the typically challenging period of any start up enterprise. To her we owe a great debt of thanks. Now, we must do justice to her work and the many contributors to its success by making sure we can help suppliers, providers, and purchasers of health care receive actionable information that can save lives, save money, and deliver value to the global communities we serve.

To step up to the challenges our readership will have to face in the decade ahead, we are going to serve them by implementing 5 strategic initiatives:

- **Scientific rigor:** We are going to intensify the scientific rigor and communicative effectiveness required of authors submitting articles to make sure that every submission is of the highest caliber.
- **Translational research:** We are going to prioritize publication of articles that are of translational nature *now*—those that translate research and leadership insights into information that inspires action to reduce patient safety events that cause harm and suffering to patients AND caregivers.
- **Multimedia and new media**: Because we will be vigilant about the first 2 initiatives, we will leverage multimedia and new channels such as social media networks to communicate our messages. We *must*, however, produce articles that are of extraordinary quality by traditional standards or these media will be interpreted as promotional and diminish the core value of the content. We need articles by and for the next generation of healthcare leaders-students. These must be delivered through their preferred learning channels.
- **Global expansion:** We will expand our quest for submissions beyond country borders and beyond our industry boundaries, as excellence knows no such limits. We are in a shrinking global community that needs to leverage every bit of innovation we can find…and communicate it as rapidly to all as fast as possible.
- **Full value chain focus:** We will expand the domain of our focus to embrace the entire healthcare value chain throughout the channels of care: from suppliers through providers to purchasers. From suppliers who produce products, services, and technologies that they sell to caregivers and their facilities who deliver care services, to private, government, and consumer purchasers. This means articles should be written by and for consumers. All own a piece of patient safety and need a voice to join the quality choir.

In a recent conversation with Dr Lucian Leape, the father of the patient safety movement, he challenged us to make sure we emphasize the importance of hospital leaders. "They need to own patient safety," and he underscored the critical nature of 6 focus areas in safety being pursued by the Lucian Leape Institute. These are medical education reform, active consumer engagement, transparency, integration of care, restoration of joy in our service, and safety of the health care workforce (Dr Lucian Leape, oral communication, January 10, 2011).

Care providers no longer can arrogantly believe that their science is better than that of their trading partners or that conflicts of interest only lie with suppliers and purchasers. We need to take the issue of conflicts of interest head-on and create safe harbors for collaboration, because technology suppliers and health care purchasers have a treasure trove of data we can use to save lives.

As we close the last decade and begin the next, we need to serve everyone from the servant leader at the frontline "Who," as Bob Chapman has said, "deserves to be treated with as much care as we treat our patients," to the governance board member who needs to be equipped, not with all the right answers, but with the questions they need to ask to keep hospitals on course.

Our villains are not bad people but bad systems. Our victims are both patients and caregivers. The crisis is clear and the resolution will happen with you—those of you who are humble

enough to "learn global," disciplined enough to "act local" and brave enough speak up and "be vocal."

It is time—your time and the journal's time to build our bridge from awareness to action. We owe it to our families, our colleagues, and our patients.

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We want to acknowledge you and your institution for your current efforts in patient safety. We hope you enjoy this article and find it useful in your future work.

Sincerely,

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Chairman