CLARITY White Paper

Crushing the Silos: A Leadership Imperative to Ensuring Healthcare Safety in the Era of Healthcare Reform

In this new age of healthcare reform and the coming together of Accountable Care Organizations we have both an opportunity and the need to Crush the Silos that might well be impeding a fully engaged focus on reducing harm and enhancing patient safety.

Since the IOM Report in 1999, *To Err is Human,* followed by the second of the IOM Reports in 2001, *Crossing the Quality Chasm*, healthcare has struggled with ways to enhance patient safety by focusing on structural design of the healthcare system and the culture of safety that needs to permeate that system. As studies [1,2] have shown, while the rhetoric has grown and effort has been great, the results generally have been meager in terms of true change. We now have additional accreditation and regulatory standards and more activity around data collection and public reporting, and plenty of internal discussions on change … but to say we have fully engaged the healthcare organization in a new way of thinking about Patient Safety is probably a stretch. In this new age of healthcare reform and the coming together of Accountable Care Organizations we have both an opportunity and the need to *Crush the Silos* that might well be impeding a fully engaged focus on reducing harm and enhancing patient safety.

Silos prevail in healthcare on both macro and micro levels. On the macro level there are departmental silos: Nursing, Medicine, Quality, Patient Safety, Risk Management, etc. … not to mention Finance and Human Resources. On a micro level, within each of these areas exist additional silos, for example in Quality we have internal and external quality management and in Medicine and Nursing we also have quality programs and peer review. And when it comes to data collection … each of these areas is collecting a set of data that from their individual perspective is both unique and necessary. Our very infrastructure is designed to fragment our services and create multiple, competing agenda.

This situation is daunting in itself, but our systems of care grow more complex each year with multiple services, new technology and many healthcare sites that make up a healthcare system. And, within this healthcare system there is the expectation that daily work needs to be completed at an accelerated pace and in cost efficient ways adding stress to an already strained organization.

The result of this fragmentation and complexity is evident in how healthcare providers tend to approach patient safety situations as 'special cases' instead of looking more holistically at the processes that led to that situation and looking at where these processes exist to create the conditions for more than an isolated event. A case in point … how many organizations complete a Root Cause Analysis on a sentinel event, develop an action plan and then feel good that it has been addressed … until the same situation erupts in another part of the organization? It is essential that we break away from this isolated incident approach and focus our energy on coming together to determine how to best manage the structures that need to support enhanced clinical outcomes in a safe environment across the system of care.

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A recent study reported by Milliman, Inc. [3] indicates that medical error is continuing and that it is doing so at great cost to the US economy. As reported by Milliman, in their measurement of a medical claim data base for a large insured population, they estimated that 6.3 million injuries occurred in the US in 2008 and of those 1.5 million were associated with medical injury. In their report they also estimated that these injuries resulted in a cost of $19.5 billion … mostly in increased medical costs of providing additional services and prescriptions to these injured individuals, but also included in this number were $1.4 billion related to increased mortality and $1.1 billion related to lost productivity in days missed from work. The study did not take into account potential medical malpractice lawsuits or settlements that might well have added another $10 billion to the cost of these injuries. There can be little argument that something needs to change.

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To create change it is important to have a clear vision of where it is we wish to go … in today's environment of healthcare reform we need to create fiscally sound and clinically excellent organizations to benefit the communities we serve. As the industry moves toward Accountable Care Organizations, this needs to be the central vision. How do we begin to bridge the gap from our current reality to this vision? It begins creating a culture where the organization and its professionals have a preoccupation with failure [4] so that complacency is thwarted and a bright light is shone on how it is better to work together toward success than to repeatedly fail as individual departments or professionals.

Many tools exist to help with the changes in attitude that are necessary to heighten vigilance and awareness. There are assessments to perform and Lean Black Belt seminars to attend and consultants to engage … but the real tools need to be ones that impact the total organization from the top down and bottom up. These tools include real-time data and analytical tools in the hands of professionals who can respond quickly … from event data captured across the organization in real-time to foster internal transparency of organizational processes and a sharp focus on impediments to patient safety … to clinical support systems and the adherence to Evidenced Based Care protocols … to the financial incentives that reward professionals for the organizational successes that are defined by our patients' experiences. Finally at the foundation of all of this lies the leadership within our organizations that will insist on c*rushing the silos* that keep us from working together and who can inspire excellence through collaboration, and governance that will demand to be central to the quality of care being provided to the communities their organization serves. At this time it is a cultural imperative that healthcare leadership creates a corporate vision for excellence.

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In this age of Healthcare Reform, the most basic reform will need to come in our mindset and mental models [5]. In the seminal work of Peter Senge, mental models are defined as "deeply ingrained assumptions, generalizations,

or even pictures or images that influence how we understand the world and how we take action". If we have a chance at success we must first be willing to obliterate our current models so that we can achieve the vision and truly *re – form* our organizations into financially sound healthcare safety zones for our patients, visitors and staff.

So, to begin our transformation we need to start 'at home' by crushing our organizational silos and recreating in its place an organizational fabric that supports change and protects our patients along with the technology to support real time knowledge, evidence based care and accelerated intervention as appropriate to sustain excellence. Attention to an isolated event provides limited insight … attention to the work of a department provides limited influence … attention to the total processes and events of the enterprise of care provides the opportunity to fully see into the whole organization and systematically and fundamentally change healthcare delivery.

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