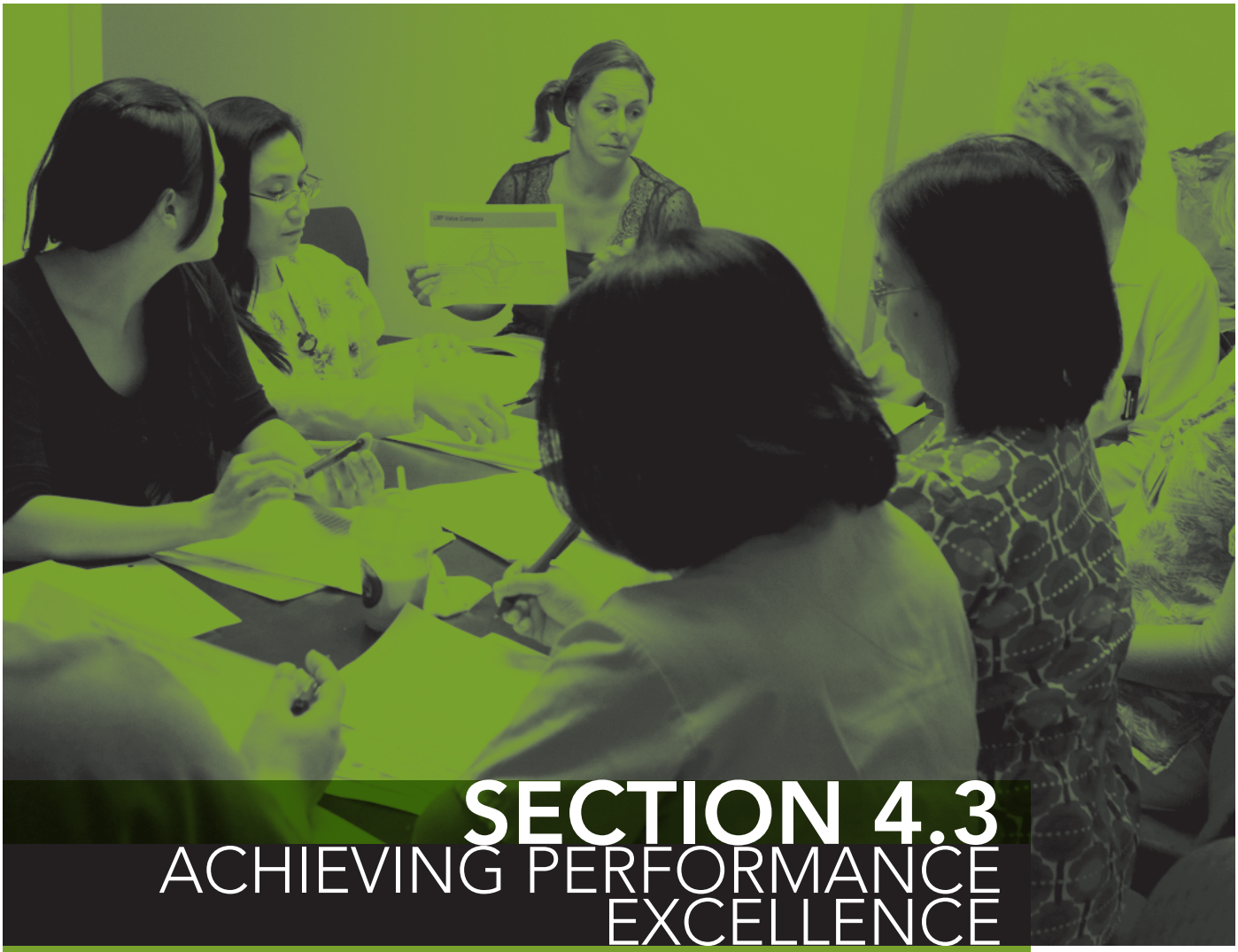


SECTION 4.3
ACHIEVING PERFORMANCE EXCELLENCE

SPONSOR AND LEADER | **RESOURCE GUIDE FOR UBTs**

LABOR MANAGEMENT PARTNERSHIP

COMPETENCY TOOLS: ACHIEVING PERFORMANCE EXCELLENCE

Introduction

Performance excellence is the overarching umbrella that encompasses the various systems, processes and tools we use at Kaiser Permanente to:

1. **Improve clinical outcomes**
2. **Eliminate waste**
3. **Become more member/patient focused**
4. **Reduce costs**
5. **Reach the highest quality service**
6. **Make Kaiser Permanente the best place to work**

Performance improvement is a process that helps us reach excellence in each of these areas. It is a way we can apply continuously and consistently to reach our goals.

Key Tip!

Creating a performance excellence culture takes careful planning, execution and commitment. As a sponsor/leader, it is your role to help develop this culture and engage your team in performance excellence work.

As a sponsor and leader, engage your team in performance excellence work:	
[✓]	Learn and apply standard performance excellence tools and methodology
[✓]	Communicate with staff regularly on progress of improvement work and “where we are”
[✓]	Provide tools and resources
[✓]	Have the will to change the current system and execute ideas that will improve the system
[✓]	Reinforce that performance excellence is everyone’s work and not seen as a separate “side” activity or singular event

This section on Performance Excellence provides basic tools to help you coach and guide co-leads through lead performance excellence efforts within their teams. Get support from local and regional resources, such as improvement advisers, UBT implementation consultants or other UBT leads, quality and learning departments, to name a few.

Performance Excellence

TOOL: Creating a Performance Excellence Culture

Key Tip!

Performance excellence sponsors and leaders partner with their union representatives to make UBTs work!

As unit-based teams engage in performance improvement work, they help build a culture of performance excellence.

All levels of employees at KP have accountability for improved practice and performance. When staff are engaged in the process of improvement, the entire process becomes more meaningful.

The culture of an organization is a collection of behaviors, attitudes and values that form a pattern over time.

How Will You Know When You Have a Performance Excellence Culture?	
[✓]	When performance excellence behaviors are regularly observed in staff
[✓]	When performance excellence tools and training are used regularly by frontline staff
[✓]	When performance excellence values are clearly communicated by walking the talk
[✓]	When relevant data and information is made readily available to frontline staff
[✓]	When performance excellence work is routine and becomes "core" to the day-to-day duties
[✓]	When thinking is no longer *"It's not my problem," "I did my part"* and *"I'm done"*
[✓]	When performance excellence language is commonplace and not a "foreign" concept
[✓]	When there is a climate of trust and open sharing toward performance excellence

TOOL: Performance Excellence Behaviors

High-performing organizations share six key qualities. Part of the process for achieving performance excellence at Kaiser Permanente is developing and maintaining these attributes. As a sponsor of unit-based teams, focus on developing these capabilities in yourself, your co-leads and within the overall organization.

Leadership Priority Setting	» Leadership team engaged and aligned » Sets clear priorities based on vital few breakthrough performance areas » Priority areas focus on clinical, financial, employee and member/patient indicators
View the System as a Process	» Organization leadership teams identify core business processes » Aligns improvement priorities based on vital business needs
Measurement Capability	» Set outcomes and improvement process metrics for key areas » Establish performance targets to achieve best in class/national best » Use balanced scorecard system to make process performance a priority
Learning Organization	» Surface best practice based on evidence of performance » Share, learn and spread performance capability across enterprise » Focus on top-down and bottom-up execution
Improvement Capability	» Create improvement infrastructure and staff » Able to execute from testing through spread of practice at all levels » Unified internal methodology for improvement representing multiple methods » Improvement skills applied immediately to improvement priority
Engagement and Culture	» Leaders walk around and understand local level work » Communicate often and visibly about how the improvement efforts of staff connects to organizational priorities » Use of improvement training to teach staff about system mission and priorities, create safe space to explore and learn

Source: Performance Improvement Institute **kpnet.kp.org/qrrm/perf_imp/imp_inst/imp_inst_index.html** (KP Intranet only)

TOOL: Systems Thinking and Organizational Learning

As unit-based teams focus on performance improvement work, they will make changes to processes and procedures that can have a ripple effect throughout the organization. An essential part of your role as a sponsor is the ability to step back, look at the big picture and assess the impact of decisions and changes on other parts of the organization. This ability, called Systems Thinking, approaches problem solving by looking at the interaction of all the parts that make up the system and how improvements in one area of a system can adversely, or beneficially, affect another area. Doing so promotes organizational learning and helps break down silos.

Key Tip!

Significant improvements can be achieved in health care when unit-based teams consider how changes affect the entire system. As a sponsor of unit-based teams, coach co-leads to incorporate Systems Thinking into their small tests of change, and even their day to day work!

Benefits of Systems Thinking:

1. Able to deal more effectively with complex problems
2. Prevent significant negative events
3. Prevent harm to member/patients
4. Increase staff morale
5. Get away from assignment of blame
6. Solve problems that seem unsolvable or revise ineffective solutions
7. Innovation encouraged at every level

THREE STEPS OF SYSTEMS THINKING	
Identify the Problem	» Step back and consider the problem within the bigger system » Focus on patterns of behavior over time, rather than a single event » Focus on the specific system within the organization's control that is responsible for performance issues » Reach agreement on what the problem is before moving to solutions
Brainstorm Solutions	» Look for the cause of the problem or inefficient workflow » Understand feedback loop and ongoing process that reinforces the problem » Take advantage of collective brain power of the group to solve the problem » Try to create a list of different possible solutions
Do a Reality Check	» Evaluate feasibility of the solutions to see if they are realistic » Conduct small tests of change to see if an improvement can be made (RIM)

Source: Institute for Healthcare Improvement **www.ihi.org**

Performance Improvement

TOOL: Understanding Rapid Improvement Model (RIM)

The **Rapid Improvement Model** has been adopted by the LMP and the National Performance Improvement and Execution Department as an effective quality improvement methodology. RIM+ is a tried-and-tested approach to achieving successful change improvement. This model offers the following benefits:

1. Simple approach that anyone can apply
2. Reduces risk by starting small
3. Used to help plan, develop, implement and sustain change
4. Achieve big gains from small rapid tests of change
5. Eliminate time wasting and dangerous work-arounds/ unwritten rules
6. Accomplish your department's goals and improve its performance

Developed by Associates in Process Improvement (API) **www.apiweb.org**

SETTING GOALS
What are we trying to accomplish?

Improvement requires setting goals that are time-specific, measurable and define the specific population of members/patients that will be affected. Goals for improvement should be aligned with department/regional goals and the Value Compass.

ESTABLISHING MEASURES
How will we know that change is an improvement?

This question focuses specifically on what your team will measure, how you will measure it, and how you will know that the change is really an improvement.

SELECTING CHANGES
What changes can we make that will result in improvement?

All improvement requires making changes, but not all changes result in improvement. Organizations must identify changes that are most likely to result in improvement.

TESTING CHANGES

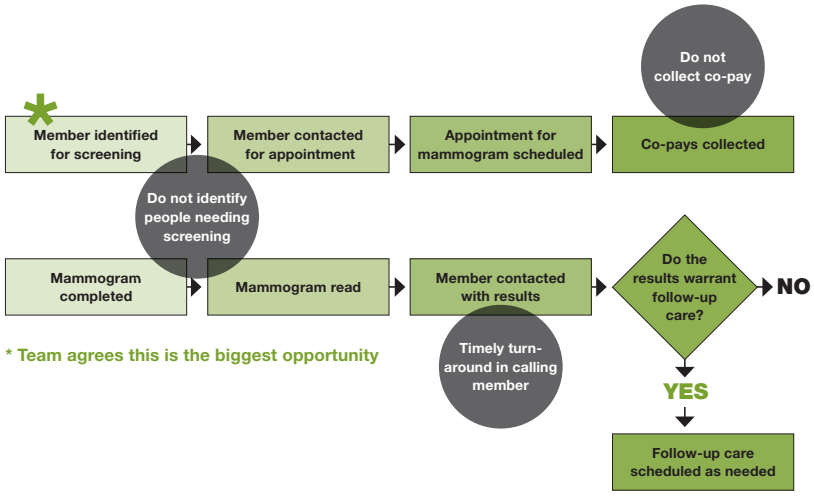
The Plan-Do-Study-Act (PDSA) cycle is a quick way to test change in a real work setting—plan it, try it, observe the results and act on what is learned. PDSA is the scientific method for action-oriented learning.

TOOL: Understanding Process Mapping

Key Tip!

Remember, there are always at least three versions of the map: **what you think it is, what it actually is and what you would like it to be.** The point of process mapping is not the map itself, but understanding the flow of information and material in order to make process improvements.

Once your teams know what performance improvement project to work on, they can begin the process of identifying potential areas of improvement. A process map will help them do this. As a sponsor, you can help co-leads coach their teams in completing a process map and ensuring a focus on the member/patient.



Do a Quick Walk-Through of Entire Process	» Provides a sense of flow and sequence of steps » Document the amount of time it takes to complete the process » Pretend you are staff or a member/patient experiencing the problem
Draw the Process by Hand	» Follow actual pathways of materials and information » Materials—which ones, why and how and when they are used » Information—how people know what to do and when » Use pencil so you can make changes as needed » Get feedback from those who do the work of the process
Gather Information Relevant to Each Step	» Can be data or stories—use data tool to collect relevant current-state information » Rely only on information you or your team collect personally » Verify facts to clearly understand the current state
Map the Process Yourselves	» Do this even if you have information from other people or departments
Decide What You Would Like the Process to Be	» In a perfect world, what would it look like? » Be creative and be realistic! » Use this to determine what small tests of change to make » Focus on one area at a time

Source: Performance Improvement Institute **kpnet.kp.org/qrrm/perf_imp/imp_inst/imp_inst_index.html** (KP Intranet only)

TOOL: Setting Goals

Once teams have identified what they want to work on using a process map, they need to clarify their goals. An organization will not improve without a clear and firm intention to do so. The first step in the Rapid Improvement Model is to set a goal by answering the question, ***"What are we trying to accomplish?"***

EXAMPLES:

1. **Inpatient:** reduce ventilator-associated infections by 25 percent in the ICU West within ten months.
2. **Outpatient:** Increase by 25 percent the annual testing of HgbA1C in diagnosed diabetes patients in the South City Clinic within six months.
3. **Non-clinical:** Improve staff satisfaction service scores by 5 percent in the registration department in the next six months.

Key Tip!

The SMART technique does not just apply to RIM goals. Try using this approach for yourself. In one sentence, see if you can make your own goals SMART!

S M A R T	MEANS	ASK YOURSELF
Specific	Goal is specific, concrete and well defined	» Do you know exactly what you want to accomplish? » Can you summarize the thought?
Measurable	Outcome can be measured	» Are you able to assess your progress? » How will you know when you've reached it?
Actionable	Goal is something you can act on	» Is your goal something you have power over? » Is the goal dependent on others?
Realistic	Goal or objective is realistic and chance of success is good	» Is your goal doable within your current situation? » What things might prevent you from achieving your goal?
Time-bound	Goal or objective has a specific end-time for achievement	» What is the deadline for completing your goal? » What is the frequency you are assessing?

Source: Performance Improvement Institute **kpnet.kp.org/qrrm/perf_imp/imp_inst/imp_inst_index.html** (KP Intranet only)

TOOL: Establishing Measures

The more specific a goal is, the easier it will be to test with the Plan-Do-Study-Act cycle. Try coaching your co-leads to develop SMART goals with their unit-based teams.

Once teams have a goal, they need to figure out what measures, or metrics, are needed to track their progress. Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement. This answers the question, ***"How will we know that a change is an improvement?"***

Tips for Measuring Data

- Plot data over time
- Seek usefulness, not perfection
- Use sampling
- Keep it simple
- Integrate collection, display and analysis into the daily routine
- Use qualitative and quantitative data

THREE TYPES OF MEASURES	
Outcome Measures (voice of the member or patient)	How is the system performing? What is the result? » Tied directly to goal statements » Can be time, clinical outcome, financial or satisfaction
Process Measures (voice of how the process works)	Are the parts/steps in the system performing as planned?
Balancing Measures (viewing system from different directions/dimensions)	Are changes designed to improve one part of the system causing new problems in other parts of the system? » What happened to the system as we improved outcome and process measures?

Three Types of Data:

Accountability

Reporting Purposes

- Specific data
- Agencies
- State/federal regulators

Research

Beyond Doubt

- Lots of data
- Prove hypotheses
- Statistical

Improvement

Just Enough to Learn

- Limited data
- Small samples/tests of change
- Changes incorporated, as needed

TOOL: Selecting Changes

While all changes do not lead to improvement, all improvement requires change. The ability to develop, test and implement changes is essential for any individual, group or organization that wants to continuously improve. As a sponsor/leader, work with your co-leads to ensure that change efforts teams tackle are in line with regional/national goals and work toward the four points on the Value Compass, with the member/patient at the center.

EXAMPLES OF POSSIBLE CHANGES TO TEST	
Producer/Patient Interface	To benefit from improvements in quality of products and services, the patient must recognize and appreciate the improvements
Focus on the Product or Service	Although many organizations focus on ways to improve processes, it is also important to address improvement of products and services
Improve Work Flow	Improving the flow of work in processes is an important way to improve the quality of goods and services produced by those processes
Optimize Inventory	Inventory of all types is a possible source of waste; understanding where inventory is stored in a system is the first step in finding opportunities for improvement
Eliminate Waste	Look for ways to eliminate any activity or resource in the organization that does not add value to an external customer.
Focus on Variation	Reducing variation improves the predictability of outcomes and helps reduce the frequency of poor results
Error Proofing	Redesigning systems makes it less likely that people will make errors. One way to error-proof a system is to make the information necessary to perform a task available in the external world, not just in one's memory. Write it down or make it inherent in the product or process
Change the Work Environment	Changing the work environment itself can be a high-leverage opportunity for making all other process changes more effective
Manage Time	Organizations gain competitive advantage by reducing the time to develop new products, waiting times for services, lead times for orders and deliveries and cycle times for all functions in the organization

Source: Institute for Health Improvement **www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove** (KP Intranet only)

TOOL: Testing Changes—Plan, Do, Study, Act (PDSA)

STEP 1: PLAN
Plan the test or observation, including a plan for collecting data

- State the objective of the test
- Make predictions about what will happen and why
- Use a baseline—create one, if needed
- Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)

STEP 2: DO
Try out the test on a small scale.

- Carry out the test
- Document problems and unexpected observations
- Begin analysis of the data

STEP 3: STUDY
Set aside time to analyze the data and study the results.

- Complete the analysis of the data.
- Compare the data to your predictions
- Summarize and reflect on what was learned

STEP 4: ACT
Refine the change, based on what was learned from the test

- Determine what modifications should be made
- Prepare a plan for the next test

Once a team has mapped a process, set a goal, developed measures and a data collection plan and selected changes, the next step is to test those changes. The **Plan, Do, Study, Act (PDSA)** cycle is a quick way of improving work processes that allows teams to rapidly test on a small scale, where a little risk taking is encouraged, and failures are considered ok because we learn from them.

As a sponsor, you can coach your co-leads to:	
[✓]	Think big. Test small
[✓]	Survey the team on how the change is working
[✓]	Understand controlled failure is ok—it's a chance for the team to learn
[✓]	Debrief the failure so it is a learning experience, not a humiliation. (Ask, *"What did we learn? How could we have done this differently? What will we do now?"*)
[✓]	Celebrate success early and often!

Source: Performance Improvement Institute **kpnet.kp.org/qrrm/perf_imp/imp_inst/imp_inst_index.html** (KP Intranet only)

TOOL: Implementing and Spreading Change

After testing change on a small scale, learning from each test and refining the change through several PDSA cycles—including testing the change under varying conditions, on different shifts and with different staff—the change may be ready for **implementation** on a broader scale. Implementation is the final step and involves building the change into the organization and possibly revising documents and written policies.

AS A SPONSOR, UNDERSTAND WHY TEAMS NEED TO TEST BEFORE IMPLEMENTING CHANGE:

1. Increases degree of belief that change may work
2. Documents expectations and learnings
3. Builds a common understanding of what good looks like
4. Evaluates costs and side-effects for changes
5. Explores theories and predictions
6. Tests ideas under different conditions
7. Learn and adapt in real time

Spread is the process of taking a successful implementation process and replicating that change or package of changes in other parts of the facility or other regions. There are several models of spread used with success at KP: the IHI Breakthrough Series Collaborative Model, the IHI Framework for Spread and the KP Wave Model all share the following common characteristics:

Leadership	Setting the agenda and assigning responsibility for spread
Set-Up for Spread	Identifying the target population and the initial strategy to reach all sites in the target population with the new ideas
Better Ideas	A description of the new ideas and evidence to "make the case" to others
Communication	Methods to share awareness and technical information about the new ideas
Social System	Understanding the relationships among the people who will be adopting the new ideas
Knowledge Management	Observing and using the best methods for spread as they emerge from the practice of the organization
Measurement and Feedback	Collecting and using data about process and outcomes to better monitor and make adjustments to the spread progress

Source: Institute for Health Improvement **www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove** (KP Intranet only)

Metrics

Measure Improvement at KP: A Guide for the Perplexed

A key aim of unit-based teams is to improve performance on one or more of the four points of Value Compass: Quality, Service, Affordability, Best Place to Work. Performance measurement helps us answer the question: how do we know that what we are doing is making things better?

UNDERSTANDING METRICS

Metrics are like a dashboard in your car. They tell you how you're currently operating in a number of areas. By tracking your metrics over time, you can determine if the changes you are making are really an improvement and whether the improvement is large or small.

If the metric improves, does that mean our performance is getting better?

In general, the answer is "yes," but not always. You should be careful about paying too much attention to short-term fluctuations in your metrics. Every metric has a certain degree of random variation built into it. In most cases, the long-term trend is a better indicator of a team's performance.

Source: LMP Metrics and Analytics

TOOL: Performance Measurement Glossary

Baseline	First set of measurements before testing a change. Provides a marker to show which areas are doing well and which need improvements.
Control Group	Unchanged variable (clinic or region) that can be used to compare progress against to see if improvement is due to change or something else unrelated.
Metrics (or Measure)	Number linked to some aspect of performance. Most metrics are expressed as a ratio or percentage of one number to another. **Example:** We give our members a survey to find out how many are satisfied with their primary care visits. One hundred members fill out the survey and 80 of them report being satisfied. That means that 80 percent (i.e., 80 out of the 100) are satisfied.
Numerator	First or top number in a ratio. Some tests of change may want to see this number increase to show improvement. **Example:** We would want the number of patients, 80, who report they are satisfied to go up.
Denominator	Second or bottom number in the ratio. Some tests of change may want this number to decrease to show improvement. **Example:** We want to improve the number of female patients screened for cervical cancer. Women with hysterectomies should not be included. Including them is understating our true performance.
Threshold	Usually corresponds to the bare minimum of performance that is considered acceptable on a measure.
Target	Desired level of performance on a metric—good level of performance obtainable through strong effort. **Example:** We want 90 percent of our patients satisfied with their primary care visit. This is our "target" level of performance for this measure.
Stretch	Considered to be a very good level of performance achieved through particularly focused effort. In some departments or medical centers, certain types of rewards or recognition may be attached to these different levels of performance.

Source: LMP Metrics and Analytics

TOOL: What is Your Team's Metrics Strategy?

Don't forget… any time you plan a test of change, make sure you identify and collect the metrics to let you know if your change is having a positive impact. This is important for your clinic but also very important if you want to share with others what you're doing.

Few organizations can measure and track as many indicators of organizational performance as Kaiser Permanente. While the national team tracks many of your clinic's metrics, you may need additional metrics or metrics on a more frequent basis. Once you've identified which metrics you want to track, you'll need to develop a plan to actually get the metrics. Your local or national project manager can assist with this plan.

Identify Existing Reports	» Clinic manager may already receive these reports » Sometimes, quality or membership satisfaction information is posted on regional websites or accessible through the Panel Support Tool or POINT.
Designate Someone to Gather Metrics and Bring to Team Meetings for Review	» May need to talk with sponsors about requesting local analyst to help » Having an analyst as part of the team (even if they can't attend every meeting) can be very helpful!

Where to Get Performance Measurement Data

People can find data to measure performance from three general places:

1. **Reports:** Most common source. Created by KP regional offices and many medical centers. No additional resources are needed to generate the data, but existing data may not have exactly what you need.
2. **Raw Data:** Even if KP doesn't have an existing report on the metric you need, the data may be available in a computer system and can be extracted by someone with the right programming skills. This is generally more complicated and expensive than using existing reports. The potential benefit is that you may be able to construct precisely the metric you need.
3. **Self-Collected:** In cases where no data currently exists in a report or database, you may want to consider collecting the data yourself. For example, KP currently does not have a computer system that records whether patient care staff are washing their hands regularly. Before constructing your own data collection tool, check with other teams and departments doing similar work to see if they have already created something.

Source: LMP Metrics and Analytics

TOOL: Value Compass Reports

Below is a brief summary of the types of reports that may be available to you, organized by domain of the LMP Value Compass. These reports are usually generated by a regional or medical center office that deals with performance reporting. However, there may be different staff—and in some cases even different departments—involved in the production of the various reports.

SERVICE	
Inpatient Satisfaction (HCAHPS)	A standard survey used by KP's hospital regions to measure member/patient satisfaction. The questions are very detailed and cover all major aspects of the hospital experience. The data are available in a national database known as AVATAR, which has many powerful reporting and analysis features.
Outpatient Satisfaction	There is no current standard survey in use that can be compared across regions. All KP regions measure outpatient satisfaction and ask questions about things, such as: the totality of the experience, making the appointment through the registration process and the encounter with the physician or other provider.
Appointment Operations Data	For outpatient service, getting an appointment in a timely fashion is a key driver of member/patient satisfaction. Most regions maintain a significant reporting and analysis capability in this area, including booked-to-seen intervals, appointment backlog, etc.
QUALITY	
Outpatient Quality	There is a national set of outpatient quality measures that all major health plans use known as HEDIS (Healthcare Effectiveness Data and Information Set). These measures include measures of primary prevention (e.g., cancer screening), chronic disease management (e.g., hypertension control) and resource utilization (e.g., referral rates for certain procedures).
Inpatient Quality	There is a national set of inpatient quality measures that all hospitals use known as JCAHO Core Measures (JCAHO—pronounced jay-co—is the national accrediting body for hospitals). These measures include things like effective care for heart attack victims and surgical infection prevention.

Source: LMP Metrics and Analytics

TOOL: Value Compass Reports (continued)

* AFFORDABILITY	
General Financial Performance	Department financial performance is usually available from a medical center controller or finance department. This would include things like the department's spending compared to its budget. In many cases, this data can be broken down to highlight spending on particular items (e.g., supplies, etc.), which could be the focus of performance excellence activities.
Efficiency/ Productivity	Existing reporting on efficiency and productivity tends to vary across regions, medical centers and departments, such as finance or operations. Some large departments, such as pharmacies or call centers, may also have their own internal reporting capabilities.
Revenue Collection	Finance or other departments are generally the best source for information and reporting on co-pay collection, billing and other aspects of the revenue cycle.
Membership Growth	Marketing and Sales departments are generally the best source of information on membership growth and retention
BEST PLACE TO WORK	
People Pulse	The single best source of information about employee perceptions of our work environment is the annual People Pulse survey, which is used in all regions. The large number of questions allows departments to track various aspects of employee engagement and satisfaction. However, since PP is only conducted once a year, it is hard to use it for rapid cycle performance improvement. In most cases, PP data can be obtained from regional HR departments.
Workforce Development	There is now a national Workforce Development Dashboard. It includes data on recruitment, demographic and retention metrics. Data is not completely comparable across regions due to different HR information systems.
Workplace Safety	Because of federal reporting requirements, KP has data that are available across regions. All regions except Hawaii report through the Workplace Injury Information System (WIIS). Contact your local HR department for more information about how to gain access to this information.

* This compass point encompasses a wide range of activities aimed at improving efficiency, revenue collection and membership growth. Depending on what aspect of affordability is being measured, reporting in this area can vary widely across regions, medical centers and departments.

Source: LMP Metrics and Analytics

TOOL: Coaching Co-Leads on Use of Metrics

As a leader in the organization, you may be in the position of responding to question from UBTs about what they should measure or how they can get access to data. Here are some questions you can work through together to help them focus their efforts.

What is Your Overall Goal?	Before jumping into the question of metrics, be clear on the team's performance excellence goal. If the goal is closely aligned with one of the points on the Value Compass, there may be an existing metric to measure progress toward that goal.
Are We Currently Measuring That Goal?	When the team has a clear idea of the goal, investigate whether any of KP's existing performance measures are a good fit for that goal. If not, would it make sense for the team to adjust the goal so they can take advantage of existing reporting systems?
Can We Measure Things that Drive the Outcome?	In some cases, it may be more appropriate to measure certain "drivers" that affect the outcome rather than the outcome itself. For example, month-to-month data for strokes and heart attacks will often be too variable to be a reliable measure of the team's performance. Instead, encourage them to focus on key drivers of the outcome (e.g., effectively controlling hypertension) and measure and track those.
Is the Measure "Good Enough?"	Just because a measure isn't exactly what you are looking for doesn't mean it can't be helpful. Even if a measure shows a more muted impact in distilled, departmental data, that may be the feedback you need to justify continuing the activity and perhaps refining the measure.
Is the Target Reasonable?	You want a target that stretches the team and encourages it to perform at its best—not one so hard it becomes a source of discouragement. Try looking at the three best-performing teams or departments in your medical center or region and aim for their level of performance. As a leader, you can provide an important "reality check" to teams so that they don't set their sights too low or too high.
How Do We Communicate to the Team About The Metrics?	Everyone on the team should understand how the metric works and how they can work to improve it. Your teams may need your help in connecting with the right kind of analytic staff within your medical center who can explain the metrics the organization is using.

Source: LMP Metrics and Analytics

Other KP Cultures

TOOL: Creating a "Just Culture"

Having a workplace culture that is **JUST** further promotes performance excellence by establishing a sense of fairness, openness and trust. In a **Just Culture**, people are encouraged to share valuable work information, discuss acceptable and unacceptable behavior openly and learn from mistakes.

Leaders understand that staff will make mistakes. You can help unit-based teams learn from their everyday experiences and demonstrate a Just Culture by:

1. Understanding the **how** and **why** of mistakes or errors
2. Providing **fair treatment** to individuals who make errors, regardless of the outcome or frequency
3. Demonstrating a firm intolerance for **intentional** risk-taking behavior
4. Conducting a thorough examination of the facts, events and circumstances
5. Determining what needs to be done with regard to the behavior—managers make the ultimate determination and labor may have to defend them

Tips for Demonstrating a Just Culture:	
[✓]	Model Just Culture behaviors—staff learn from your example
[✓]	Communicate the message about Just Culture and set the tone
[✓]	Rounding—keep your finger on the "pulse" and be visible to staff, be in the know
[✓]	Performance reports drive performance excellence work—share them with your staff
[✓]	Maintain consistency in fairness
[✓]	Make performance excellence a part of your staff meeting agenda
[✓]	Use incentives for staff to reward them for practicing Just Culture behaviors

Source: Patient Safety University **kpnet.kp.org/qrrm/patient/toolkits/culture/culture_index.html** (KP Intranet only)

TOOL: Creating a Culture of "Safety"

Injuries in the work unit impact morale, attendance, service, performance and quality of care. Frontline participation in the identification and elimination of hazards is a foundation of the organization's comprehensive approach to safety.

What Does a Culture of Safety Look Like?

1. At Kaiser Permanente, safety is a core business and personal value.
2. All injuries and all safety incidents are preventable: the goal is zero.
3. Line managers are accountable for the safety performance of their employees.
4. All employees are accountable for working safely.
5. Prevention is more effective and sustainable than "post-injury" management.
6. Safety feedback and observation are everyone's responsibility.
7. Employee involvement is critical.
8. Employees must receive appropriate training.
9. Managers are responsible for ensuring that the systems, equipment, training and support allow employees to work safely.

REMEMBER, FOSTERING A CULTURE OF SAFETY HELPS PROMOTE:

1. A safe work environment
2. An acceptance of responsibility for personal safety
3. An acceptance of responsibility for the personal safety of others
4. Increased organizational pride and a stronger sense of team

Strong Leadership	» Visible, demonstrated commitment » Clear, meaningful policies and principles » Challenging goals and plans » High standards of performance
Appropriate Structure	» Everyone is responsible for injury reduction and safety » Active engagement by people who do the work » LIne management accountability » Supportive safety staff » Integrated committee structure » Performance measurement and progressive motivation
Focused Processes and Actions	» Thorough investigations and follow-up » Effective audits and re-evaluation » Effective communication processes » Safety management skills

Source: National Workplace Safety

Notes