PODCAST 124:
HABITUAL EXCELLENCE LEADERSHIP

By Mark Graban

Former US Treasury Secretary, and former CEO of Alcoa, Secretary Paul O'Neill joined The Lean Blog Podcast to share his unique perspectives into healthcare and continuous improvement.

Secretary Paul O'Neill, Founder and Non-executive Chairman
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Back in episode 124 of the Lean Blog Podcast, my guest was former US Treasury Secretary Paul O'Neill, founder of Value Capture, and the former CEO Alcoa, whose innovative and principled leadership made Alcoa one of the safest workplaces in the world.

Secretary O'Neill shared his thoughts on patient safety and healthcare, explaining he has been interested in health and medical care research since he began working for the federal government in 1961. At that time, working in the Veteran's Administration (VA), he was tasked with introducing and applying operations research ideas to the department's work including delivering health and medical care through 212 different VA hospitals around the country. In his next government position, in the Office of Management and Budget, O'Neill was responsible for advising the Director and the President on issues of health and medical care. This coincided with the enactment of Medicaid.

O'Neill said he never lost his interest and involvement in health and medical care issues when he eventually left the government to become the President of The International Paper Company, or when he went on later to Alcoa.

 "In fact while I was still the Chairman and CEO of Alcoa in 1997, I was asked to be a cofounder of something called the Pittsburgh Regional Health Initiative. I accepted that responsibility because I believed that it was possible, as I had found it was possible at Alcoa with an articulation of the right set of values, to help organizations to accomplish a level of performance that most people would have said was impossible," O'Neill said.

When his focus on employee safety improvement was initiated at Alcoa, the company was already in the top third of U.S. companies for avoiding injuries. Their injury rates are now 30 times lower than hospitals, O'Neill said. He believes it is possible to achieve worker safety in health and medical care that's 30 times better than it is today, but it requires the right leadership and the articulation of goals at the "theoretical limit" (zero harm and zero injuries).

Alcoa University and Dr. Richard Shannon

"I thought, when I was at Alcoa, that we should share our expertise in achieving remarkable levels of performance with a community. And so we created something called the Alcoa University, and Dr. Richard Shannon came to one of our sessions. He was so intrigued with the idea of applying ideas of continuous learning and continuous improvement with an established goal at zero injuries to patients, that he then set out to import these ideas into his work at the Allegheny Medical Center, where he had responsibility for three intensive care wards."

Dr. Shannon, who I should note was my guest in episode 127 of the Lean Blog Podcast, had 1754 patients move though those three ICUs in the 12-month period before the course. 39 got an infection during care, with 19 patients dying.

After the course, Allegheny General Hospital started infection prevention efforts, focusing on identifying what had happened if there was an infection through the following:

- get all people involved in the delivery of care—nurses, doctors, technicians, and custodians— participating in the effort,

- get them observing how the care is done;
- come to agreement with all about how they would do the work;
- do it the same way every day.

After about 18 months working in this way they once again began tracking results over the following 12-month period. During that year following their 18 months of work, over 1850 patients were seen but just one infection occurred, and nobody died.

"[Dr. Shannon's] results were very consistent with my own experience at Alcoa; that when we got people to practice good ideas and to learn from every instance of anything going wrong, that the process (whatever it was) got better and better and better."

To Err Is Human

But despite success at Alcoa, Allegheny General Hospital and other places like the University of Pennsylvania, ThedaCare, and Virginia Mason Medical Center, adoption of these methods and mindsets lags.

"Since 1999, when the Institute of Medicine's famous study was published, called T*o Err Is Human*, we've accomplished, on a national basis, practically nothing in terms of reducing things gone wrong in the delivery of health and medical care," O'Neill said. "As straightforward as these ideas are, leadership in health and medical care institutions around the country have not grabbed these ideas and implemented them, which is, frankly, unbelievable when it's so clear that the benefits are not only in significantly better outcomes for health and medical care, but significant cost reductions at the same time. I believe, having

observed the practice of caregiving around the country in a lot of different venues, that if we could get these ideas practiced every day in every caregiving institution in the United States, we could have an enormous improvement in outcomes for patients, and we could save a trillion dollars a year out of the current $2.7 trillion we're spending on health and medical care. That would be unbelievably positive for our society."

O'Neill said the problem is that while many are designated as leaders, very few of them articulate goals and then help their staff acquire and practice the skills to succeed.

"It's really hard to find people in leadership positions who understand the idea of 'habitual excellence,' which means a leader should expect every aspect of his organization to perform at the known level of possibility. Having that kind of leadership and a leadership that is not about punishing or blaming people, but about using every single instance of anything gone wrong as a basis for organizational learning, is really critical."

Medical Malpractice System Alternatives

O'Neill explained that one pushback to habitual excellence as the idea that perfection is unachievable and an organization can't set goals that many would perceive to be unachievable.

"I found, in my own early days at Alcoa, when people told me that about workplace safety, then I said to them, 'OK, if you don't want to have a goal of zero, then let's go around and find out who wants to volunteer to be hurt to make sure we reach our goal of somebody being hurt,'" O'Neill said. "To aspire to less [improvement] than

[reaching] zero is to excuse every single one that happens rather than learning from them and figuring out a way to introduce practices that take away the possibility [of infections]."

The second pushback to habitual excellence is the current medical malpractice system. By reporting each instance of error, the fear is that the records will create, facilitate and aid malpractice lawsuits.

O'Neill explained the thinking needs to shift toward combining both the fact that people do get hurt, with the injuries and illnesses caused by the same set of circumstances over and over again can be fixed by understanding what went wrong. To do that, a transparent system where everything gone wrong is observed, documented, and shared on a real-time basis in every day in every healthcare giving institution is necessary.

In order to take away the fear of transparency because of the threat of lawsuits, O'Neill argues the notion of medical malpractice should be abandoned. Instead, when an individual is injured as a consequence of a medical intervention, the case should be then turned over to a board of experts to judge the economic loss associated with the injury, and award that individual that economic loss without any lawyers involved and without any trying to hide the injury. This type of system would remove the economic cost associated to the individual events.

Politics and Habitual Excellence

"I've been advocating to the government that they should implement a system where every care giving institution in the nation is required to hook up to the internet at 8 o'clock in the morning local time, wherever you are, and report on the internet every instance of a newly identified patient acquired infection, every case of a patient fall, and every case of a medication error," O'Neill said. "First of all, it would be shocking to the people and secondly, I think it would spur action to bring those numbers down quickly." There are far too many medication errors that occur every day, as O'Neill said.

O'Neill also urges Boards of Directors at healthcare institutions, hospitals, and nursing homes ensure the day-to-day operational leader is supportive of the idea of establishing theoretical limit goals for everything that goes on in their institutions.

"I think if Boards of Directors urge the people who are day-to-day responsible for care delivery, it might provide some stiffening of the backbone of people who are supposed to lead institutions to habitual excellence."

The full interview with Secretary O'Neill is still available at www.leanblog.org/124.

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