A DISCUSSION GUIDE
For Teachers and Facilitators

Good News…How Hospitals Heal Themselves

A Documentary Report for Public Television
and a Resource for Healthcare Professionals and Hospital Leaders

2006

See Also the Companion Book:

The Nun and the Bureaucrat—How They Found an Unlikely Cure for America's Sick Hospitals

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DISCUSSION GUIDE
for

Good News…How Hospitals Heal Themselves

Suggestions for the discussion leader. In addition to this Discussion Guide for the video documentary, *Good News…How Hospitals Heal Themselves*, the book *The Nun and the Bureaucrat…* was designed to accompany, enrich and enlarge the material in the documentary. Relevant chapters in the book, noted below, offer the discussion leader many suggestions for starting the sharing process if participants don't immediately begin responding to questions. At the end of each chapter in the book is a list of the chapter's main ideas.

Before Viewing the Documentary

To get participants ready for a discussion, you might begin by reading the first few paragraphs from the Preface of The Nun and the Bureaucrat, as follows:

> Every lawmaker, civic leader, employer and informed citizen knows four facts about healthcare: (1) healthcare is the biggest domestic problem they face; (2) healthcare financing costs are spiraling out of control; (3) many millions of Americans have no health insurance; and (4) these leaders do not agree or know how to fix these problems.
>
> More and more Americans are aware of another four facts: (1) that personal and family healthcare costs are crippling; (2) that as hospital patients they are not the center of attention; (3) that hospitals are dangerous places because hospital-acquired infections are among the top five causes of death in the United States; and (4) that people feel helpless about this and have no idea what to do to improve the situation.

Many hospital administrators, physicians, and nurses know four additional facts: (1) that most American hospitals are sick; (2) that they are crippled by inadequate and outdated management practices, unnecessary duplication of services and astounding waste; (3) that hospitals generate many avoidable, often deadly, mistakes—including countless “near misses,” that is, mistakes that almost happened; and (4) that it is in hospitals where the turnaround in healthcare costs and safety must begin.

And like any great change, the turnaround will begin with a new idea. The documentary offers a story—told by doctors, nurses and hospital administrators—of how a new idea, called “systems thinking” helped to transform the way they understood and organized their work and allowed them to dramatically improve over sixty sick hospitals, saving lives while reducing costs and suffering.

Before viewing the beginning of the documentary, it may be helpful to get a sense of participant attitudes about hospitals and health care in the United States in general. Your questions need to be adapted to the different participants. For example, as an opening question, you might ask:

Hospital patients or their family members:

• Have you or a close family member spent time in a hospital in recently? Or visited a hospital emergency room? Describe your experiences. Which experiences would you list on the positive side? Which on the negative side?

Lawmakers, civic leaders, or employers:

• When you think of American hospitals in the light of your employees or constituents, what kinds of thoughts, worries or concerns come to mind?

Participants who are hospital administrators, doctors, nurses or other hospital personnel:

• When you think of your hospital and the patients you serve, what kinds of thoughts, worries and concerns come to mind?

NOTE: View first portion of the documentary. Stop the film before beginning the Emergency Room story.

Opening *[See Chapter 1: Where We Started: Symptoms of Sick Hospitals.]*

• The premise of this documentary is that many American hospitals—as hospitals—are sick. It claims that hospitals cause unnecessary infections, pain and sometimes death, that there are avoidable errors, mistakes, waste, and high costs. Are these symptoms really clear signs of sickness in health care?

• Can you recall any statistics about hospitals mentioned in the documentary, so far, that surprised you or upset you?

Complexity *[See Chapter 2: The Biggest Challenge We Faced: Complexity.]*

• What does the documentary mean by “complexity”? What conditions are making the healthcare system more complex?

• Hospital personnel in the documentary target complexity as a major source of their sickness. How can growing complexity contribute to a hospital’s sickness?

• Hospital personnel say hospital management methods are out of date, and that’s why ever-increasing complexity creates such

problems. Do you think that's true? What are some out-of-date hospital management methods?

The Lost Patient *[See Chapter 3: The Most Surprising Challenge We Faced: The Lost Patient.]*

• Hospital personnel claim that hospitals have lost sight of the patient, that the patient is no longer the primary focus of everyone in the hospital. What are some signs that care of the patient is not the first consideration of everyone in health care?

Waste *[See Chapter 4: The Most Pervasive Challenge We Faced: Waste.]*

• What are some areas of waste reported in the documentary that seem important to deal with? Why?

Importance of Data *[See Chapter 10: How We Learned to Cooperate and Share Data.]*

• Both hospital systems studied in the documentary reported that sharing data among hospitals aided and hastened their improvement. Are you surprised to discover that U.S. hospitals in general don't share data with one another? Why wouldn't they want to?

SHOW NEXT SECTION OF THE DOCUMENTARY

NOTE: View the documentary through the Emergency Room story (Stop before Leadership).

Emergency Room Story *[See Chapter 6: Systems Thinking and Continual Process Improvement.]*

• What were some elements of the Emergency Room story that caught your attention?

• Why wouldn't encouraging hospital staff in the ER to work harder and faster have been enough to make the 30/30 program succeed?

• A Florida hospital tried to reproduce the 30/30 program in its ER. They put up signs announcing the program and promised free movie tickets to any patient that wasn't under active care in 30 minutes. Do you think this program succeeded? Why or why not?

• What struck you most about how the hospital successfully instituted the 30/30 program?

SHOW NEXT SECTION OF THE DOCUMENTARY

NOTE: View the documentary through the end of the New Eyes section (before Toyota).

Leadership *[See Chapter 12: What Our Leadership Learned.]*

• As these healthcare systems are healing themselves, how crucial do you think the leadership role is? When is it especially important? In the beginning? During the transformation?

• What are some of the most important qualities or functions of leadership in healing a sick or broken organization?

Systems Thinking *[See Chapter 6: Systems Thinking and Continual Process Improvement.]*

(Note to discussion leader. Systems thinking is the core of the healing transformation of these two hospital systems; the new systems-thinking mindset should be emphasized throughout the rest of the discussion.)

• From the section of the documentary you have just viewed, how would you describe the new mindset they are calling systems thinking?

• How does systems thinking differ from the way most people today think? Why is it so essential to any successful organizational transformation in the 21st Century?

• What is a "process"? What is systems thinking's approach to fixing a broken process or improving a healthy one? How is this approach different from traditional approaches to problem solving?

• The documentary narrator said that just as the different scenes in a movie work together to create a successful film, so the different processes in a hospital should work together to create a successful healthcare system. Are you familiar with any systems that are made up of a number of different processes? *(If participants are slow to respond, you may give some examples of your own. For instance, a wedding event is a system made up of many different processes. An automobile is a system made up of many different processes. And so on.)*

New Eyes *[See Chapter 9: Walking Around With New Eyes.]*

• Many of the hospital personnel in the documentary described learning systems thinking as a way of getting "new eyes." What are some of the processes in a hospital that these doctors, nurses, and pharmacists could see with new eyes that their old eyes couldn't see?

SHOW NEXT SECTION OF THE DOCUMENTARY

NOTE: View the documentary and stop at the end of the Five Whys Technique.

Toyota Solution *[See Chapter 7: Toyota Solution: What We Learned from the Toyota Production System: Focus on the Customer/Patient.]*

• The documentary claims that the Toyota Production System proved to be the best prescription and medicine to heal a hospital. How might you explain to someone what that claim means?

The Customer/Patient *[See Chapter 8: What We Learned from the Toyota Production System: Focus on the Customer/Patient.]*

• Toyota taught the healthcare personnel that the hospital's customers are their patients. What are some ways that Toyota regards its customers that would help hospitals treat their patients more safely?

• How would you describe or define a *customer,* in general? How would you describe a *supplier*, in general?

• Can you describe how in any complex system involving a lot of employees, almost every employee is an internal customer of other employees, and is at the same time an internal supplier of other employees? Is this internal customer/supplier relationship especially important in health care? Why?

The Five Whys Technique *[See Chapter 14: Finding Root Causes of Problems.]*

• Can anyone explain how the Five Whys technique works to find the root cause of a problem?

SHOW NEXT SECTION OF THE DOCUMENTARY

NOTE: View the documentary and stop at the end of the Malcolm Baldrige Quality Awards.

Blame *[See Chapter11: Blame: The Root of All Evil and Chapter 9: Walking Around With New Eyes.]*

• Why was it important for the healing of these hospitals to make blame go away?

• Why is it important for all employees to feel free to report errors and "near misses"?

- For a systems thinker, how do identifying errors or near misses help the continual improvement of a process or a system?

Continual Quality Improvement *[See Chapter 6: Systems Thinking and Continual Process Improvement.]*

- Do you think that every process in a hospital can be improved?

- The healthcare people we studied believed that every process could be improved, not only once but again and again. They claim that there is no such thing as a perfect process. Do you agree? Why? Or why not?

- How does reporting errors and mistakes relate to a commitment to continual improvement?

Malcolm Baldrige National Quality Awards *[See Chapter 18: Self-Assessment with the Baldrige Criteria.]*

- Has anyone here heard of the Baldrige Quality Award? Tell us about it.

- What are the Baldrige criteria and why were they so important to the transformation of the SSM Health Care system?

SHOW NEXT SECTION OF THE DOCUMENTARY

NOTE: View the documentary again and stop at the end of the Wheelchair story.

The Front Line *[See Chapter16: Empowering Front-Line Workers.]*

- What are some differences between solving problems on the front line and solving problems by long-term research?

- What are some advantages and benefits of each approach?

• Describe some front-line problem-solving techniques these hospital personnel learned from their systems training from Toyota or CQI. Discuss examples that were shown in the documentary.

The Wheelchairs *[See Chapter 11: How We Became Systems Thinkers.]*

• List some of the issues and concerns in the wheelchair problem. Start with the different groups of employees that had an interest in solving this problem.

• Consider each of these interest groups in turn. For each group, ask: How would the final solution of the wheelchair problem be incomplete or less successful if this interest group hand not been involved in the problem-solving process?

SHOW NEXT SECTION OF THE DOCUMENTARY

NOTE: View the documentary and let it play to the end.

The Doctors *[See Chapter 17: Removing Barriers Between Doctors and Hospitals.]*

• What were some of the concerns—or reasons for resistance—doctors had about wholeheartedly supporting the transformation of these healthcare systems?

• Why would doctors resist? Why weren't they immediately converted to systems thinking and a commitment to continual improvement?

Toward Perfection *[See Chapter 13: Going for the Theoretical Limit.]*

• Is it unreasonable to expect any hospital to attain the ideal—the theoretical limit—in things like no mistakes, no unnecessary infections, no unnecessary deaths, no medication errors, no pharmacy errors, etc.? Why were both healthcare systems aiming for perfection in all these areas?

• If you had go to a hospital for a serious illness or operation, would you tend to choose a hospital where healthcare personnel were striving for perfection, or another hospital where employees had more reasonable expectations of themselves?

(Focus on Patients) *[See the opening paragraphs of Chapter 3: The Most Surprising Challenge We Faced: The Lost Patient.]*

• Why did focusing on achieving "perfect patient care" make the difference between success and failure in the transformations of these hospitals? Would they have done just as well if they had put their focus on "increasing profit" or "eliminating waste" or some other goal? Why or why not?

• Do you have any final thoughts about the state—and possible future—of health care in this country after viewing this documentary?

• What about a system's mindset? Is it useful?

• What about the conventional wisdom that says if something "ain't broke, don't fix it?"

• How difficult is it to start questioning procedures that worked in the past?

• Is it possible to solve problems without describing them?

• What would it require to begin to acquire "new eyes?"