NAVIGATING YOUR WAY TO HIGH RELIABILITY

Thursday, March 15, 2018

HURON | Studer Group A HURON SOLUTION

PRESENTER

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Today's Objectives

1. What is High Reliability
2. Learning from Others
3. Why Healthcare?
4. Key Considerations and Characteristics
5. Tools and Tactics
6. Pitfalls and Challenges
7. Wrap Up / Q&A

What is High Reliability?

- High reliability is the ability to operate in complex, high-risk environments for extended periods without serious accidents or catastrophic failures.
- HRO is a commitment and journey toward the pursuit of predictable, error-free operation.

HRO Definition

An HRO is an organization that succeeds in continuously avoiding catastrophes in a high-risk environment where human errors can be expected due to complexity, but avoided due to collective mindfulness and standardized process performance.

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Human Errors

Human errors can be…

- *Expected* due to complexity
- *Avoided* due to mindfulness and standardized process performance.

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How Safe is US Aviation?

1990 – 2001 (9,300,000 fights per year)
129 deaths = 13.9 deaths per million flights

2002 – 2010 (10,000,000 fights per year)
18 deaths = 1.7 deaths per million flights

2011 – 2017 (10,500,000 fights per year)
0 deaths = 0 deaths per million flights

Path to "Zero Harm"

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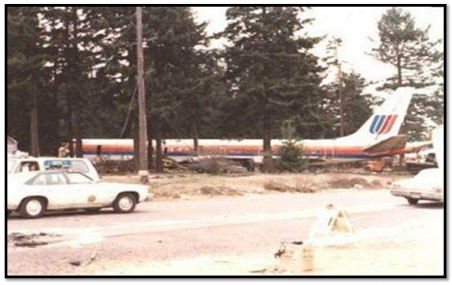
United Airlines 173 – The Need for Change



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Disruptive Change is Here

- On any given night, 2 million people are staying in other people's homes around the world on Airbnb
- Airbnb now has 4 million listings worldwide
- That's more than the top five hotel brands combined.

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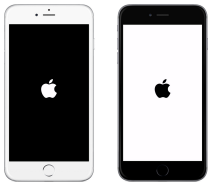
Disruptive Change is Here

UBER



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You Are Being Challenged

- The time for leaders has come.
- Contentment with the past is no longer an excuse for apathy or unacceptable behavior.
- Disruption in healthcare is knocking at the portal of our generation.
- *Question: What are you going to do about it?*

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Key Components of Change

1. Innovation
2. Communication & Teamwork
3. Flat Hierarchy
4. Safety
5. Process Improvement

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The Five Characteristics

1. Preoccupation with Failure: Constant mindfulness of safety and risk
2. Commitment to Resilience: Immediate event recovery and analysis
3. Sensitivity to Operations: Resource and operation flexibility
4. Deference to Expertise: Knowledge and experience is highly values
5. Reluctance to Simplify: A focus on being "right" not "fast"

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Why HRO?

May 12, 2016
US News

Medical Errors Are Third Leading Cause of Death in the U.S.

10 percent of U.S. deaths are due to preventable medical mistakes.

October 2, 2017
ScienceDaily

21 percent of Americans report personal experience with medical errors

The public believes errors result from systemic problems and that both health professionals and patients have a role in improving patient safety.

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Annual Inpatient Admissions

- 35,000,000 per year
- 1 in 100 chance of death by medical error
- 1 in 3 chance of medication error

Medical Errors Are Third Leading Cause of Death in the U.S.

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"To err is human, but to persevere in error is only the act of a fool."

– Marcus Tullius Cicero

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SETTING THE STAGE FOR SAFETY

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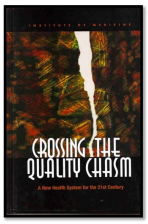
The Six Aims for Improvement

Health care should be:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable



These aims are not new….yet American healthcare fails far too often with respect to these aims, despite enormous cost and dedication and good efforts of millions of American health care workers."

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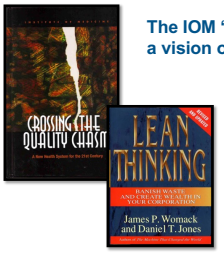
Do Not "Copy and Paste"



The IOM "Chasm" Report only gives us a vision of where to go.

"I think Lean gives us the path to get there..."

- **Process Improvement Framework**
- **Tools and Problem-Solving Skills**

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Random Acts of Lean

Value-Stream Mapping	Improve Efficiency	Mixed-Model Designs
Workplace Organization (5-S)	Healthcare execution systems	Drum/Buffer/Rope
Six Sigma	Hejunka Scheduling	RFID/Bar Code Strategies
Visual Management	Standard Work	Flow Rate Management
Total Preventive Maintenance	Rapid Improvement Events	Cellular Concepts
Balanced / Lean Scorecard	Operational Method Sheets	Rationalization Practices
Kaizen Events	Changeover Optimization (SMED)	Demand-Driven Metrics
Theory of Constraints	Case Sequencing	Flexibility Practices
Workouts	DMAIC	Process Mapping
Kanban	Production Preparation Process	Velocity Analysis
Changeover Optimization (SMED)	Process Balancing Tools	Mistake-Proofing (Poka-Yoke)
Case Sequencing	Electronic Kanban Methods	Benchmarking Practices
Reduce Waste – 7 Wastes	Green Belts, Black Belts	

A Common Problem

- Pockets of improvement are not tied or affect bottom line
- Primarily focused on micro areas with micro results

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Over 70% of Transformations Fail

Across the healthcare spectrum, over 70% of change and transformation initiatives fail.

Understanding why strategies fail is important to avoiding these pitfalls and achieving success.

Beer and Nohria (2000); Conference Board report; press analysis.

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Why Organizational Change Does Not Sustain

1. Dots are not connected consistently to purpose, worthwhile work and making a difference
2. Do not achieve critical mass
3. Absence of an objective accountability system
4. Leaders do not have the training to be successful
5. Too many new behaviors introduced at once – need of sequenced approach
6. No process in place to re-recruit the high and middle performers and address low performers
7. Inability to spread & standardize best practices
8. Failure to have leaders "always" do desired behaviors

Source: *Organizational Change Processes In High Performing Organizations: In-Depth Case Studies with Health Care Facilities. Alliance for Healthcare Research. 2005.*

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5 Elements of Successful Change

Shared Vision	+ Skills / Training	+ Incentives	+ Resources	+ Action Required	=	Successful Change
X	+ Skills / Training	+ Incentives	+ Resources	+ Action Required	=	Confusion
Shared Vision	+ X	+ Incentives	+ Resources	+ Action Required	=	Anxiety
Shared Vision	+ Skills / Training	+ X	+ Resources	+ Action Required	=	Gradual Change
Shared Vision	+ Skills / Training	+ Incentives	+ X	+ Action Required	=	Frustration
Shared Vision	+ Skills / Training	+ Incentives	+ Resources	+ X	=	False Starts

Adapted from Knoster, T., Villa, R., & Thousands, J. (2000). A framework for thinking about systems change.

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Think, plan and act differently

1. A Culture of Leadership
2. Innovation and Transformation Strategy
3. Change Management Platform
4. Process Improvement Engine

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Culture and Leadership Model

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A Culture of Leadership

All levels of leaders must be committed to high reliability. The strategic planning and implementation must be owned, supported and driven by:

- Administration
- Directors and Managers
- Physicians
- Nurses
- Board Members
- Community
- Patients
- Family Members

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HRO PITFALLS

Normalization of Deviance

"A slow drift away from the norm toward catastrophic failure"

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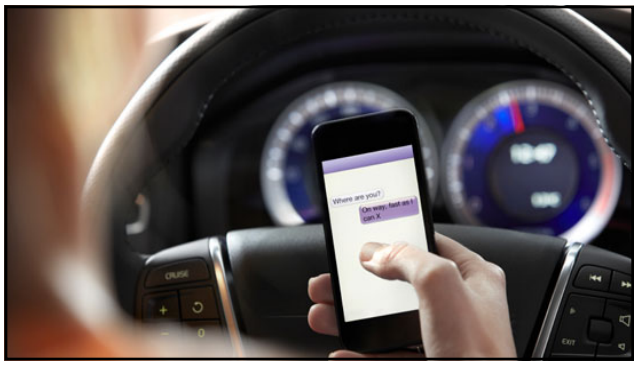

- This temperature was 15 degrees colder than any previous launch
- The air temperature at liftoff, 11:38 a.m. EST, was 36 F
- In writing: no launches to occur below 53 F

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The Normalization of Deviance

A slow drift toward catastrophic failure

- Complacency
- Shortcuts
- What we permit, we promote
- The illusion of communication

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The single biggest problem with communication is the illusion that it has taken place – *George Bernard Shaw*

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How to Prevent It

1. Awareness
2. Organizational Design
3. Recurrent Training
4. Auditing Practices and Policies
5. Standard Operating Procedures
6. Hardwiring Assertiveness

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High Reliability Pitfalls

Scope Creep
- Any change not in the original plan
- Often done with the best intentions
- Can cloud focus and cause delays
- Major challenge for leaders – knowing when to raise the flag

Hope Creep
- Not having a clear view of the end state
- Just going through the motions and hoping someone knows
- "We'll catch up next week. I don't have time now."

Effort Creep
- Mistake the finish line for the start of the "stickiness" phase of the project
- 80%+ complete… and then it stalls out

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The Path to HRO

Question:

"How do we build a predictable, repeatable process?"

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Great Leaders Know…

80%

- **80% of the work** in managing successful Process Improvement has nothing to do with the tools and everything to do with perceptions
- **People are "prisoners of their own experience"** unleashing their creativity takes careful pre-planning prior to any team activity

90%

- **90% of the time this pre-planning never happens**, which causes false starts and deflated demeanor

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THE "STICKY INDEX"

Understanding Team Readiness

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"Sticky Index" Where do you score?

To make changes "stick", self-score your team's current performance.

1 = We have issues 5 = We're top-notch

Issue	Sample Score	Your Score
Continued removal of waste and non-value added activities	1	?
Built-in quality through "stop and fix" mentality	2	?
Discipline in root cause problem solving	3	?
Ongoing improvement through employee empowerment	2	?
Ability to execute…period	4	?
Total:	12	?

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"Sticky Index:" Where do you score?

To make changes "stick", self-score your team's current performance.

1 = We have issues 5 = We're top-notch

Issue	P1	P2	P3	P4	P5	P6	P7	P8	Avg. Score
Continued removal of waste and non-value added activities									
Built-in quality through "stop and fix" mentality									
Discipline in root cause problem solving									
Ongoing improvement through employee empowerment									
Ability to execute...period									
Your total score									

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"Sticky Index:" Where do you score?

To make changes "stick", self-score your team's current performance.

1 = We have issues 5 = We're top-notch

Issue	P1	P2	P3	P4	P5	P6	P7	P8	Avg. Score
Continued removal of waste and non-value added activities	2	3	2	1	1	3	2	1	
Built-in quality through "stop and fix" mentality	3	3	1	1	1	2	1	2	
Discipline in root cause problem solving	2	1	3	1	1	1	1	2	
Ongoing improvement through employee empowerment	2	2	1	1	1	1	1	2	
Ability to execute...period	2	3	2	2	1	1	1	3	
Your total score	**11**	**12**	**9**	**6**	**5**	**8**	**6**	**10**	

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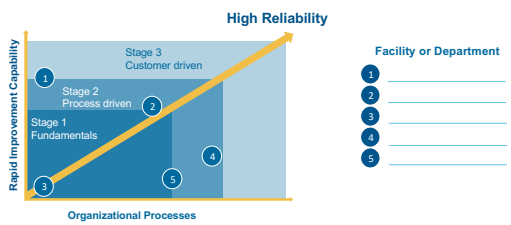
Aligning Capability and Culture



Facility or Department

1. _____
2. _____
3. _____
4. _____
5. _____

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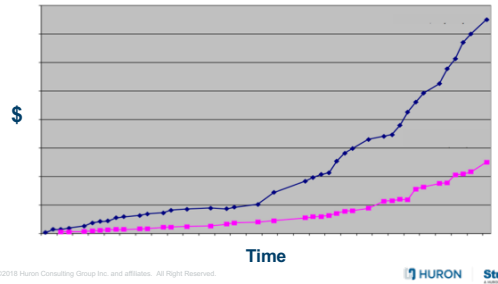
High Reliability in Action



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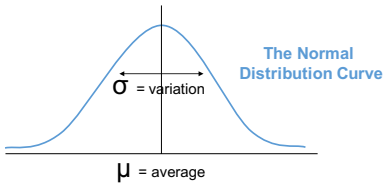
Stop Chasing Averages

Variability recognizes that processes do not produce identical results every time (inherent in nature)



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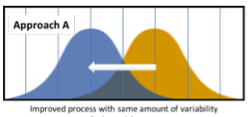
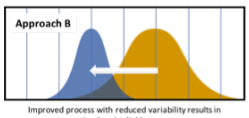
Attack Variation, Not Averages



Improved process with same amount of variability results in at-risk outcomes



Improved process with reduced variability results in sustained and reliable outcomes

- **High levels of variability increase levels of risk.**
- **Improved process with reduced variability results in sustained and reliable outcomes.**

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Creating Predictability

An HRO has an organization-wide headset that is focused on creating predictability and process consistency.

Excellent People + Broken Process = Average Results

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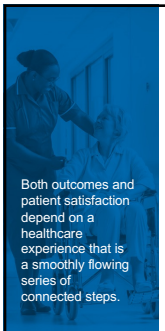

Both outcomes and patient satisfaction depend on a healthcare experience that is a smoothly flowing series of connected steps.

Cultural Influence

Consider the process of patient care

- From a cross-functional viewpoint
- Instead of individual departments

HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems

jiffy lube

Get past the trees to see the forest!

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What Consumers Buy

1 French Fries

2 Big Mac

3 Shakes

4 Egg McMuffin

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The Voice of the Customer

1 Consistency

2 Speed

3 Toys

4 ID by Kids

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Changing to Meet Demand

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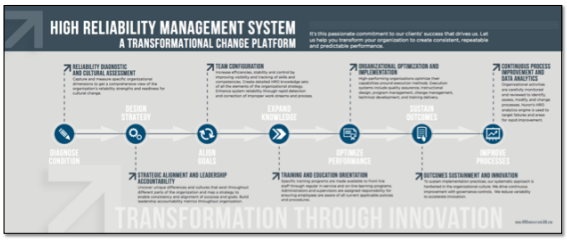
A Transformational Change Platform



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What is High Reliability?

- High Reliability: The condition of constant and persistent mindfulness within an organization to achieve safe, predictable and repeatable outcomes.
- High Reliability Organization (HRO): An HRO is an organization that succeeds in continuously avoiding catastrophes in a high-risk environment where human errors can be expected due to complexity, but avoided due to collective mindfulness and standardized process performance.

Predictable Behavior + Reliable Process = Sustained Culture of Excellence

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2018 SCHEDULE OF EVENTS

Learn more at **StuderGroup.Com/Conferences**

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- **The Engagement Conference** Minneapolis | Apr. 10-11
- **High Reliability Strategy Workshop** Minneapolis | Apr. 10-11
- **Excellence in the Emergency Department** Minneapolis | Apr. 10-11 • Las Vegas | October 16-17, 2018
- **Leadership and Improvement Conference** Toronto | May 2-3, 2018
- **What's Right in Health Care®** Nashville | Aug. 21-23, 2018
- **The Physician Summit** Las Vegas | Oct. 16-17
- **The Evidence-Based Leadership Conference** Las Vegas | Oct. 16-17

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Error Is Inevitable

Recognizing human limitations

- Limited memory capacity
- Limited mental processing capacity
- Negative effects of stress (Tunnel vision)
- Negative influence of fatigue
- Other physiological factors
- Limited ability to multitask
- Flawed teamwork

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Hallmarks of a HRO

1. Team Briefings
2. Team Debriefings
3. Situational Awareness
4. Assertiveness
5. Decision Making
6. Teamwork and Leadership
7. Conflict Management
8. Standardized Communication

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1. Team Briefings

- Announce the briefing
- Describe the current situation
- Share meaningful background information
- Ask for team input
- Discuss next steps
- Review contingency plans
- Encourage monitoring and cross-checking

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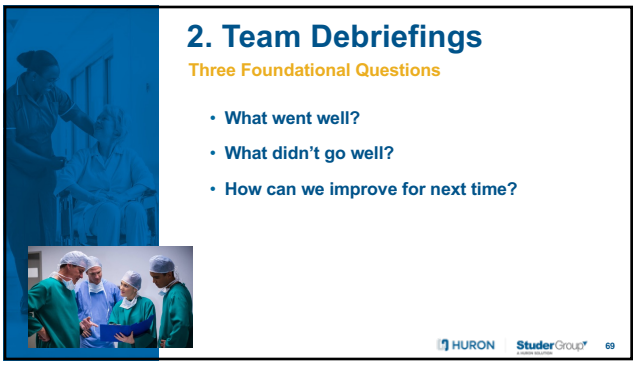

2. Team Debriefings

Three Foundational Questions

- What went well?
- What didn't go well?
- How can we improve for next time?

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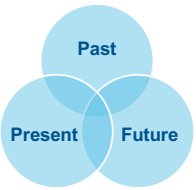
3. Situational Awareness

Provides for a shared understanding of:

- Past
- Present
- Future



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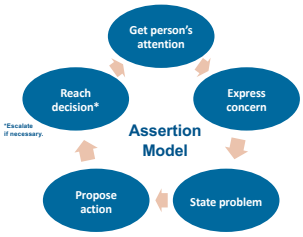
4. Assertiveness



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5. Decision Making

7-step decision-making process

1. Define the problem
2. Collect the data and evidence
3. Develop possible alternatives
4. Evaluate, weigh, sift, discuss
5. Choose best alternative given constraints and realities of the situation
6. Execute
7. Review and modify as needed

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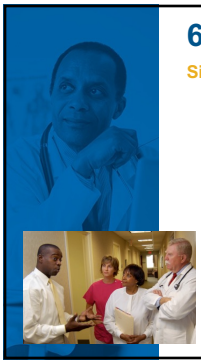

6. Teamwork / Leadership

Six Characteristics of a High Performing Team

1. Consist of two or more individuals
2. Each member has a specific role and members interact to achieve a common goal
3. Teams make decisions
4. Teams have specialized knowledge and skills
5. Teamwork functions by task interdependency
6. Every team needs a leader

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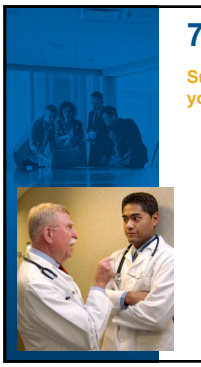

7. Conflict Management

Successful conflict management depends on your ability to:

- Manage stress while remaining alert and calm
- Control your emotions and behavior
- Pay attention to feelings as well as spoken words
- Be aware of and respectful of differences

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8. Standardized Communication

Three techniques

- Assertion
  - Team members speaking up and stating concerns
- Closed-loop
  - The receiver responds verbally to the sender by confirming that the request has been understood and is being carried out
- SBAR
  - Situation; Background; Assessment; Recommendation

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Obstacles to Predictability

- Cumbersome information technology systems
  - Multiple log-in screens
  - Different software apps needed to get to data
- Worker frustration
  - Cultural toxicity and tension
    - Nurse-to-nurse, nurse-to-physician, admin-to-nurse
    - And so on…and so on…
  - Empowerment
  - The "I Love Lucy" dilemma
- Normalization of deviance
  - Inadvertent errors and oversights that can increase patient risk

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CRITICAL PLAYERS

The Leadership/Stakeholder Worksheet

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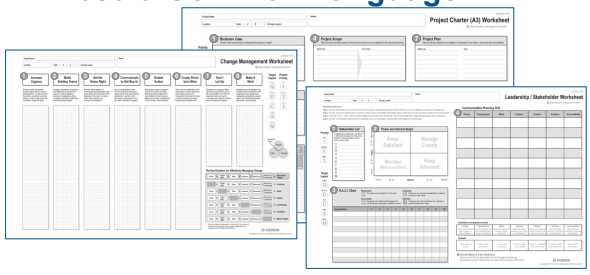
Embed a Common Language



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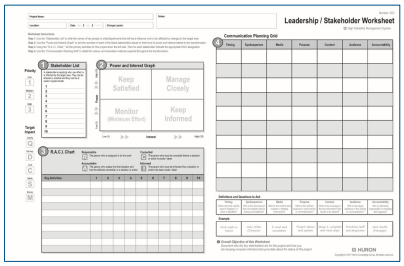
Who Can Impact This Project (for Better or Worse)?

HRO Project Management Tool Number: 003



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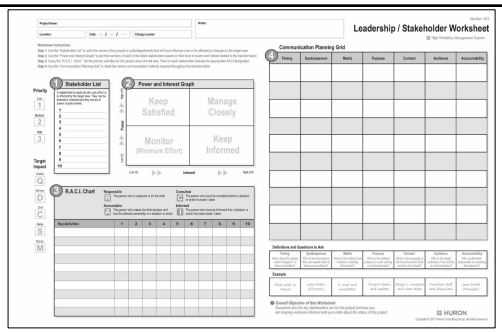

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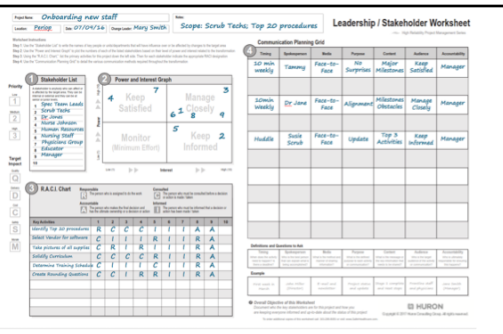

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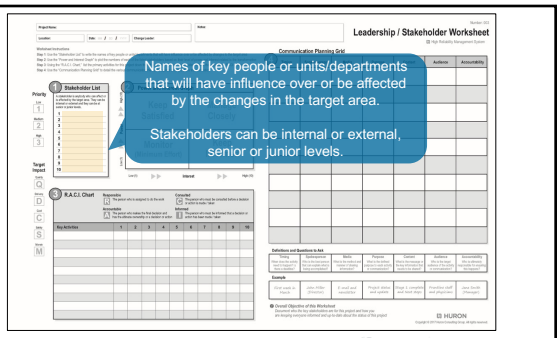
Leadership / Stakeholder Worksheet
Communication Planning Grid
Names of key people or units/departments that will have influence over or be affected by the changes in the target area.
Stakeholders can be internal or external, senior or junior levels.
1 Stakeholder List
2 Power and Interest Graph
3 R.A.C.I. Chart
4
Keep Satisfied
Manage Closely
Monitor (Minimum Effort)
Keep Informed
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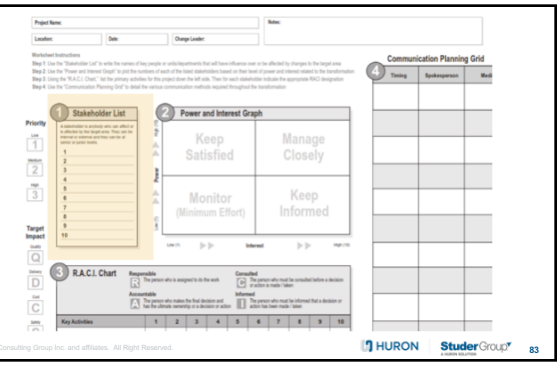
Communication Planning Grid
1 Stakeholder List
2 Power and Interest Graph
3 R.A.C.I. Chart
4
Keep Satisfied
Manage Closely
Monitor (Minimum Effort)
Keep Informed
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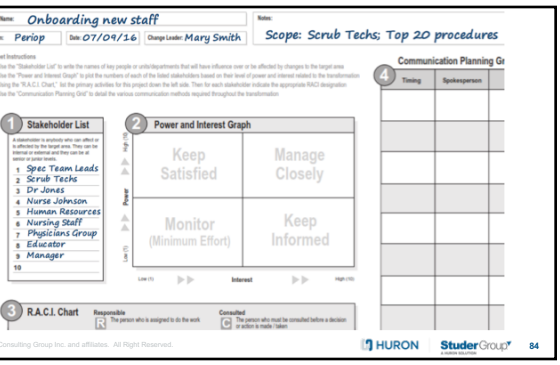
Project Name: Onboarding new staff
Location: Periop
Date: 07/09/16
Change Leader: Mary Smith
Notes: Scope: Scrub Techs; Top 20 procedures
1 Stakeholder List
1 Spec Team Leads
2 Scrub Techs
3 Dr Jones
4 Nurse Johnson
5 Human Resources
6 Nursing Staff
7 Physicians Group
8 Educator
9 Manager
10
2 Power and Interest Graph
3 R.A.C.I. Chart
4
Keep Satisfied
Manage Closely
Monitor (Minimum Effort)
Keep Informed
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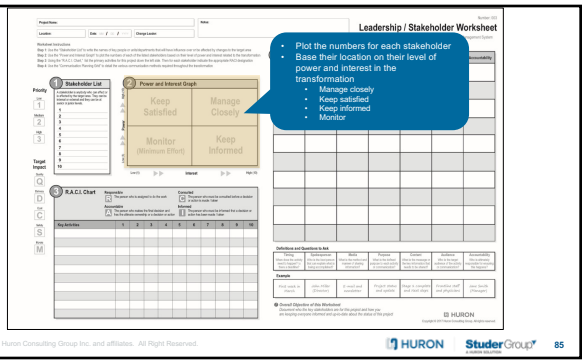
Leadership / Stakeholder Worksheet
Keep Satisfied
Manage Closely
Monitor (Minimum Effort)
Keep Informed
Plot the numbers for each stakeholder
Base their location on their level of power and interest in the transformation
Manage closely
Keep satisfied
Keep informed
Monitor
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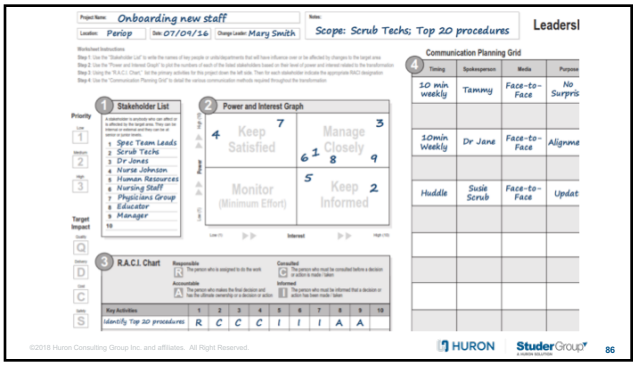
Project Name: Onboarding new staff
Location: Periop
Date: 07/09/16
Charge Leader: Mary Smith
Scope: Scrub Techs; Top 20 procedures
Leadersl
Stakeholder List
Spec Team Leads
Scrub Techs
Dr Jones
Nurse Johnson
Human Resources
Nursing Staff
Physicians Group
Educator
Manager
Power and Interest Graph
Keep Satisfied
Manage Closely
Monitor (Minimum Effort)
Keep Informed
R.A.C.I. Chart
Identify Top 20 procedures
R C C C I I I A A
Communication Planning Grid
Timing
Spokesperson
Media
Purpose
10 min weekly
Tammy
Face-to-Face
10min weekly
Dr Jane
Face-to-Face
Huddle
Susie Scrub
Face-to-Face
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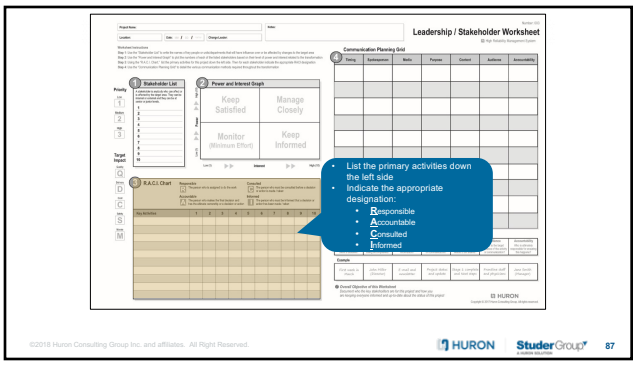
Leadership / Stakeholder Worksheet
Communication Planning Grid
List the primary activities down the left side
Indicate the appropriate designation:
Responsible
Accountable
Consulted
Informed
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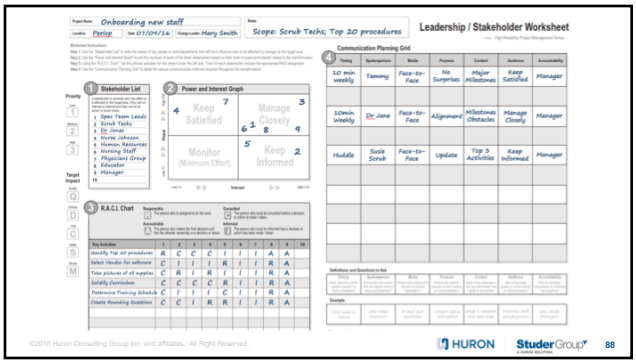
Onboarding new staff
Scope: Scrub Techs; Top 20 procedures
Leadership / Stakeholder Worksheet
Communication Planning Grid
Stakeholder List
Power and Interest Graph
R.A.C.I. Chart
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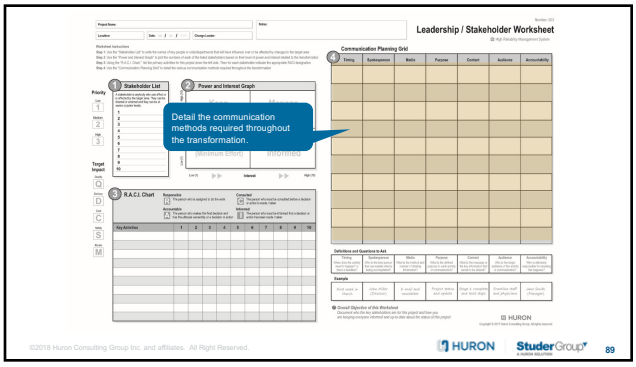
Leadership / Stakeholder Worksheet
Communication Planning Grid
Detail the communication methods required throughout the transformation.
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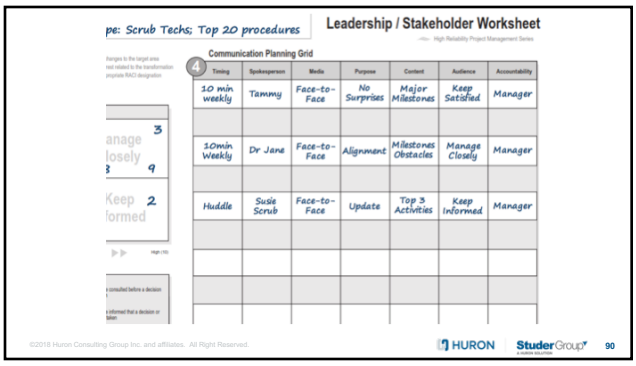
Leadership / Stakeholder Worksheet
Communication Planning Grid
10 min weekly
Tammy
Face-to-Face
No Surprises
Major Milestones
Keep Satisfied
Manager
10min Weekly
Dr Jana
Face-to-Face
Alignment
Milestones Obstacles
Manage Closely
Manager
Huddle
Susie Scrub
Face-to-Face
Update
Top 3 Activities
Keep Informed
Manager
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PROJECT CHARTER

Setting Yourself Up for Success

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Project Communication

Failure to communicate effectively is often the greatest threat to project success.

Communication is the oil that keeps projects running smoothly.

Stakeholders

- Who needs to know what, when (how often) and how?
- Constant effective communication among everyone involved
- Formal, informal, written, verbal

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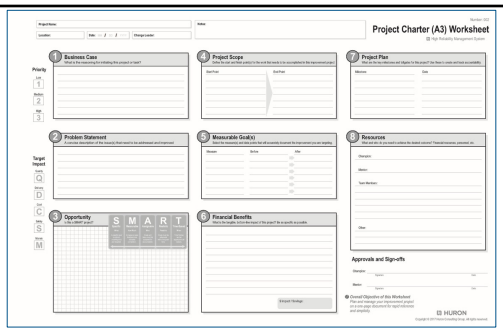

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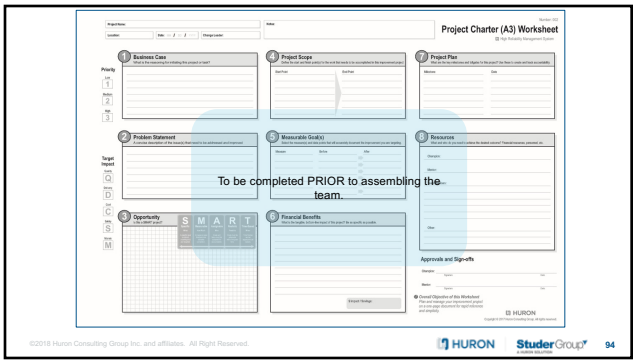
Project Charter (A3) Worksheet
To be completed PRIOR to assembling the team.
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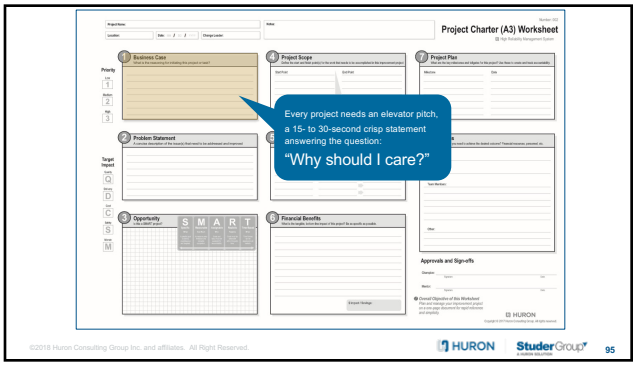
Project Charter (A3) Worksheet
Every project needs an elevator pitch, a 15- to 30-second crisp statement answering the question:
"Why should I care?"
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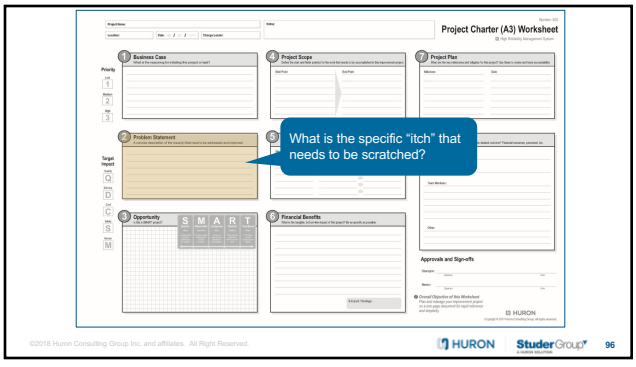
Project Charter (A3) Worksheet
What is the specific "itch" that needs to be scratched?
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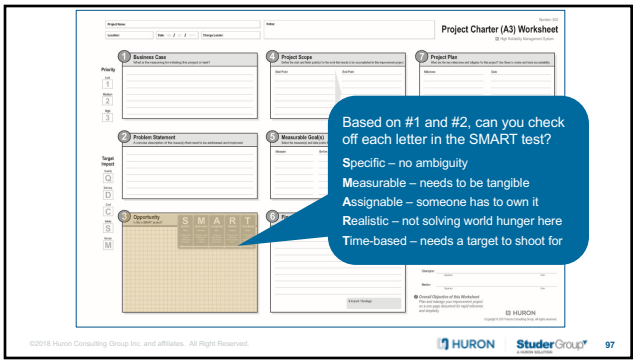
Project Charter (A3) Worksheet
Based on #1 and #2, can you check off each letter in the SMART test?
Specific – no ambiguity
Measurable – needs to be tangible
Assignable – someone has to own it
Realistic – not solving world hunger here
Time-based – needs a target to shoot for
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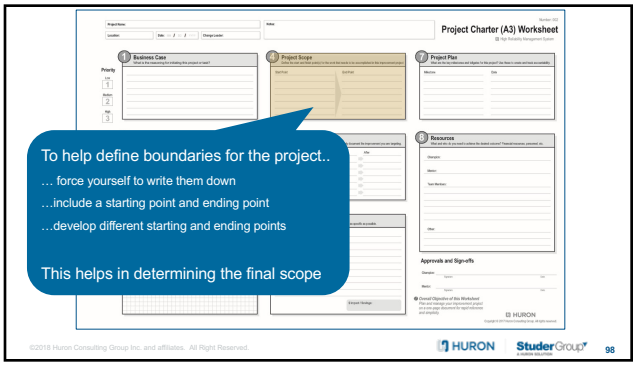
Project Charter (A3) Worksheet
To help define boundaries for the project..
… force yourself to write them down
…include a starting point and ending point
…develop different starting and ending points
This helps in determining the final scope
Approvals and Sign-offs
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Project Charter (A3) Worksheet
Although it may feel premature, force yourself to write down possible measures.
Back of the napkin BEFORE
Back of the napkin AFTER
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Project Charter (A3) Worksheet
You must understand the difference between
Hard Savings
and
Soft Savings
Force yourself to identify a savings category and calculate projected savings
S M A R T
Approvals and Sign-offs
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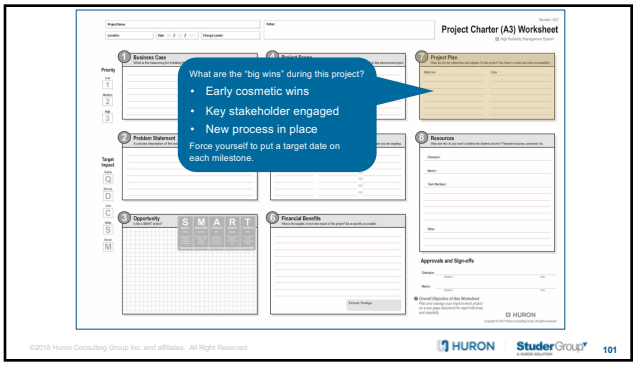
Project Charter (A3) Worksheet
What are the "big wins" during this project?
• Early cosmetic wins
• Key stakeholder engaged
• New process in place
Force yourself to put a target date on each milestone.
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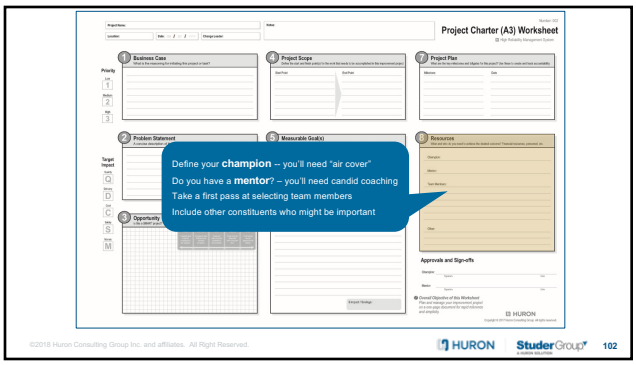
Project Charter (A3) Worksheet
Define your champion -- you'll need "air cover"
Do you have a mentor? – you'll need candid coaching
Take a first pass at selecting team members
Include other constituents who might be important
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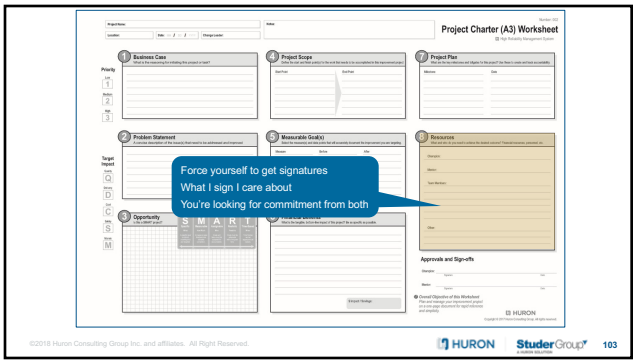

You Are Being Challenged

- The time for leaders has come.
- Contentment with the past is no longer an excuse for apathy or unacceptable behavior.
- Disruption in healthcare is knocking at the portal of our generation.
- *Question: What are you going to do about it?*

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Evaluation Forms on Table

"Spring into Quality" Symposium
Feedback and Evaluation

Thank you for your comments and feedback!

- Please fill out
- Leave on table

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HIGH RELIABILITY STRATEGY WORKSHOP

Minneapolis | Apr. 11, 2018

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- Teamwork
- Highly Reliable Leadership
- Fixing Broken Processes
- Cultural Transformation
- Communication Strategies
- Change Management
- Planning an HRO Journey
- Science of Reliability

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Thank You

Dave Marshall

dmarshall@huronconsultinggroup.com

720-989-1043

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