

Spring IDN Summit & Expo

April 20-22, 2010

2:45 – 4:00 pm

Strategic Management Track

Positive Deviance: Liberating the secret change agents in your organization

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“Insight, I believe, refers to the depth of understanding that comes by setting experience, yours and mine, familiar and exotic, old and new, side-by-side and learning by letting them speak to one another.”

-Mary Catherine Bateson

Road Map

1. PD primer
2. PD in healthcare, e.g. healthcare-associated infections (HAI's): process and outcomes
3. *Distinguishing features of PD
4. *Other healthcare applications of PD in healthcare
5. *Wicked problems in your world that might be ripe for PD
6. Conclusion

The **POWER** of Positive Deviance



Solutions before our very
eyes

The Premise:

In every community there are certain individuals whose **uncommon practices/behaviors** enable them to find **better solutions** to problems than their neighbors who have access to the **same resources**

Sternins Introduce PD, Vietnam 1991

Childhood Malnutrition

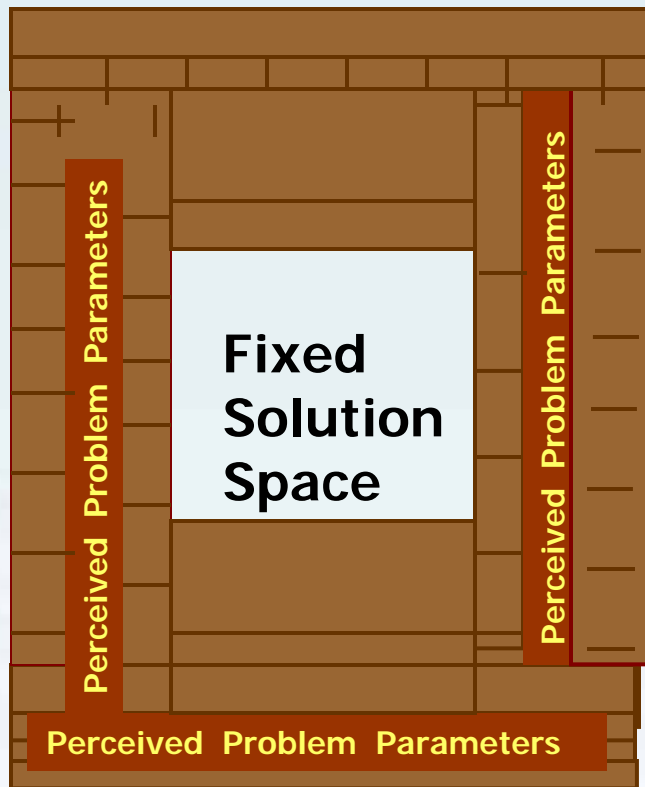
www.positivedeviance.org



Traditional vs PD Problem Solving Approach

Traditional

Flows from problem analysis towards solution



Positive Deviance

Flows from identification and analysis of successful solution to problem solving

Expanded
Solution
Space

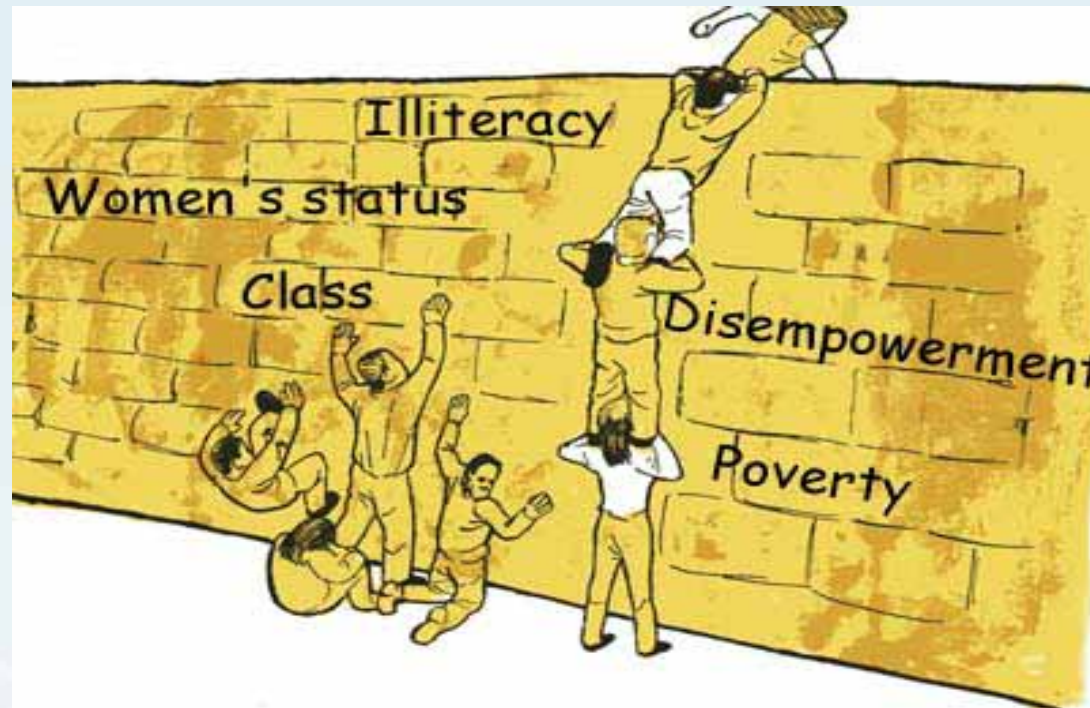
PD: Focus on practice rather than knowledge



“It’s easier to ACT your way into a new way of THINKING,
than to
THINK your way into a new way of ACTING”

PD enables us to act **TODAY**

...



The presence of Positive Deviants demonstrates that it is possible to find successful solutions TODAY before all the underlying causes are addressed!

PD in healthcare

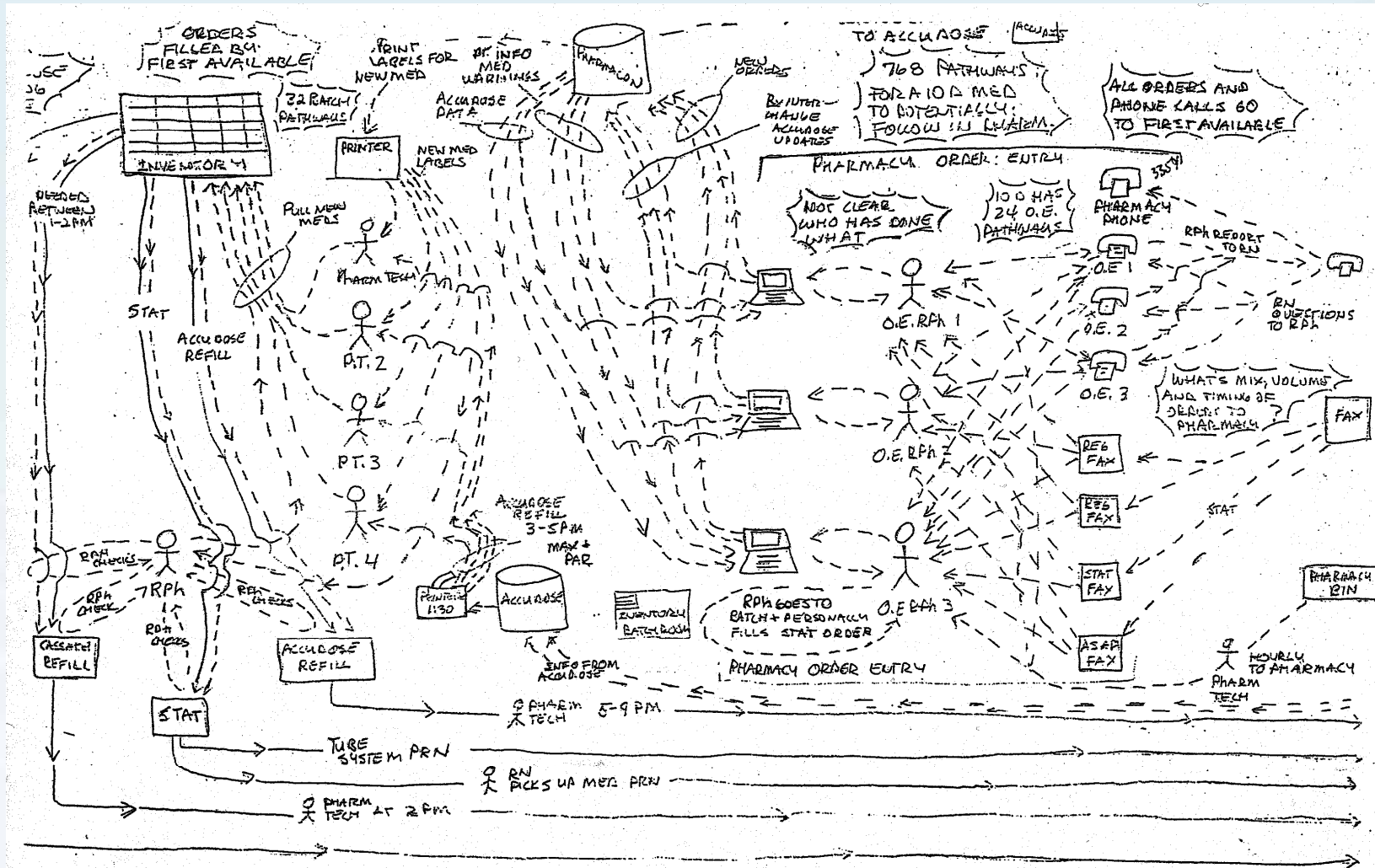
Why Positive Deviance for preventing healthcare acquired infections (HAI's)?

- Because traditional education, best px, PDSA, lean and regulation & enforcement alone have achieved only modest, transient success which has failed to spread within and among hospitals
- Because HAI's represent a complex problem requiring both technical and behavior/social change.
- Because solutions to MRSA and other HAI's already exist in every hospital !

The "system"

...for ordering/administering Tylenol 3.

How much more complex is MRSA prevention?!

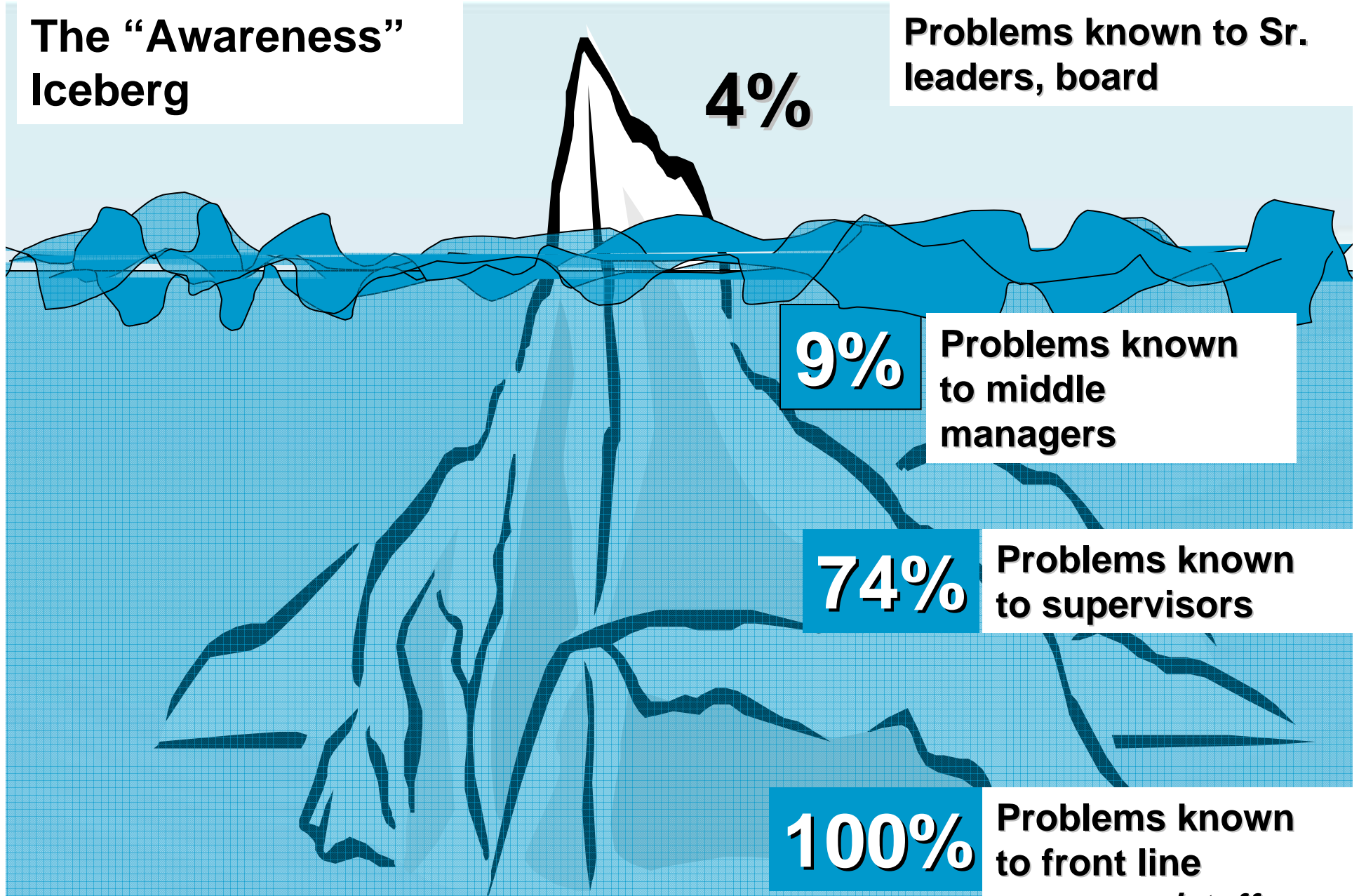


Have you ever asked yourself: *Who knows best...

- How, when & where transmissions of resistant bacteria are taking place?
- How to prevent these transmissions?

*How **the "system"** works & how to improve it

The “Awareness” Iceberg



Problems known to Sr. leaders, board

4%

9%

Problems known to middle managers

74%

Problems known to supervisors

100%

Problems known to front line managers/staff

This internationally acclaimed study conducted by Sidney Yoshida, was initially presented at the International Quality Symposium, Mexico city, 1989. It indicated how management's failure to understand its processes and practices from the perspective of its customers, suppressed the company's profits by as much as 40%.

Leadership: powerful, few.
Make decisions about how work
is done

**Business
as usual**



Middle managers:
implement decisions

Front line workers- experts at the
work they do: **carry out decisions**,
rarely engaged in deciding HOW
work is done

So who knows best? Could it be... the “touchers?”

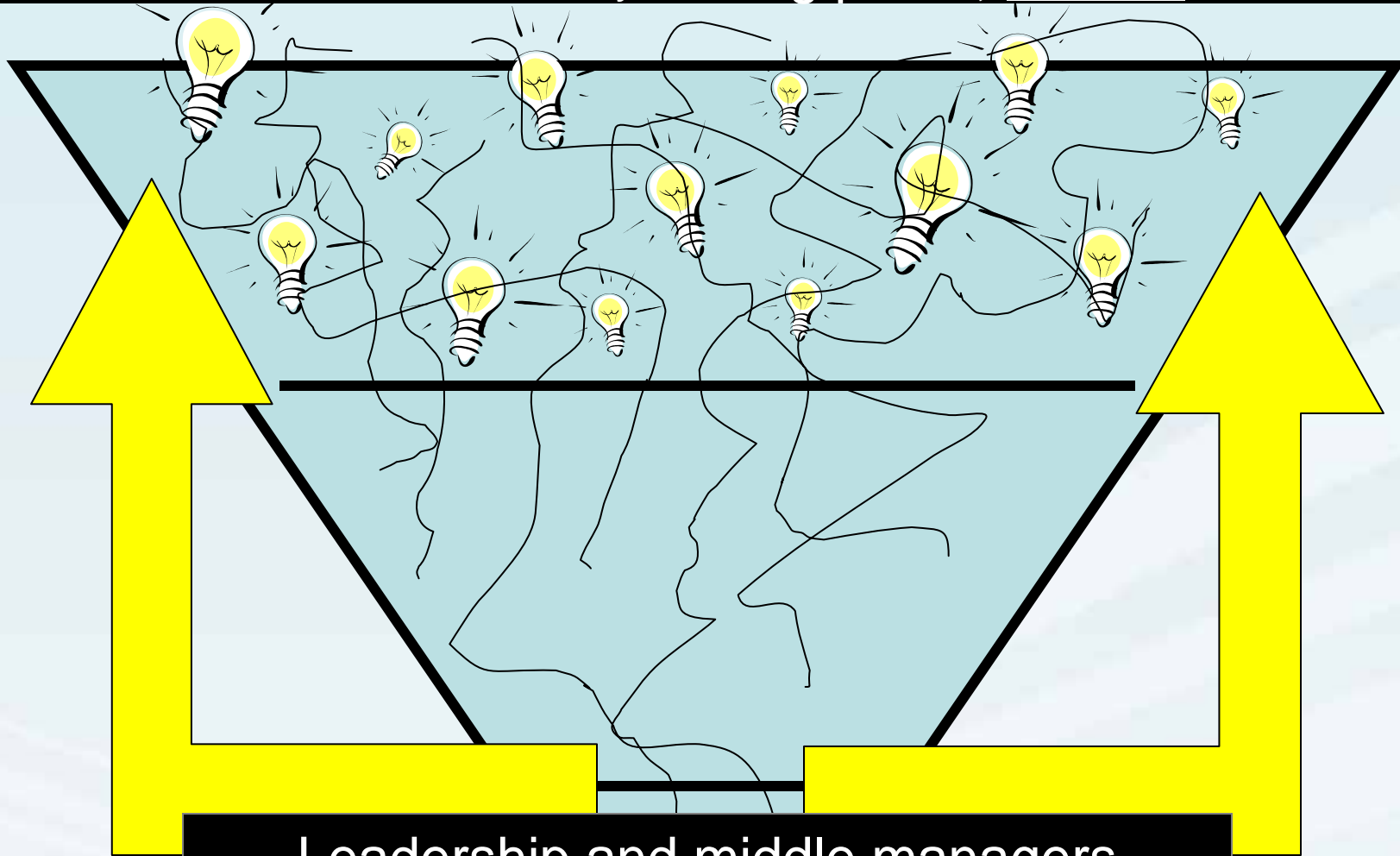
The people who have direct patient contact and touch them with hands, clothing and equipment are clearly in the best position to know how, when and where (MRSA) transmissions occur in their work area and how to prevent them.

Unlikely suspects found in places rarely visited are the secret **world experts on preventing HAI's .**

Infection Prevention is **Everyone's** job!

*In general, lots of people are **smarter** than
a few people...
especially **front line staff***

Front line workers: experts at the work they do, decide HOW to do work, & foster self-discovery among peers; owners



Leadership and middle managers support and filter ideas, and remove barriers for implementation of practices

PD

from front-line workers

So...the questions we must ask ourselves are:

- How are we going to unleash the solutions from the “touchers?”
- What are we going to do once the transmission sites and causes have been exposed and solutions have been proposed by those who know best?
- What can we start doing today to address these issues?

Positive Deviance Steps

Discern & Disseminate

Design & Do

Discover

Define & Determine

Define & Determine: *Kick-Offs*



- Day 1—Kick-Off (2-3 hours)
 - Senior Leader Introduction
 - MRSA overview
 - Personal Stories
 - *Reflection*
 - The Positive Deviance (PD) Story
 - *Reflection*
 - Examples of PD used for MRSA
 - *Reflection*
 - Invitation to Volunteer Meeting
- Day 2—Volunteers Meet
 - Organize for action
 - Launch Expanded Discovery and Action Groups
 - Plan Measurement
 - Plan Communication

Volunteers meet after the Kick Off



Discovery & Action Dialogue

Be genuinely curious – the answers are in the room



Discovery & Action Dialogues

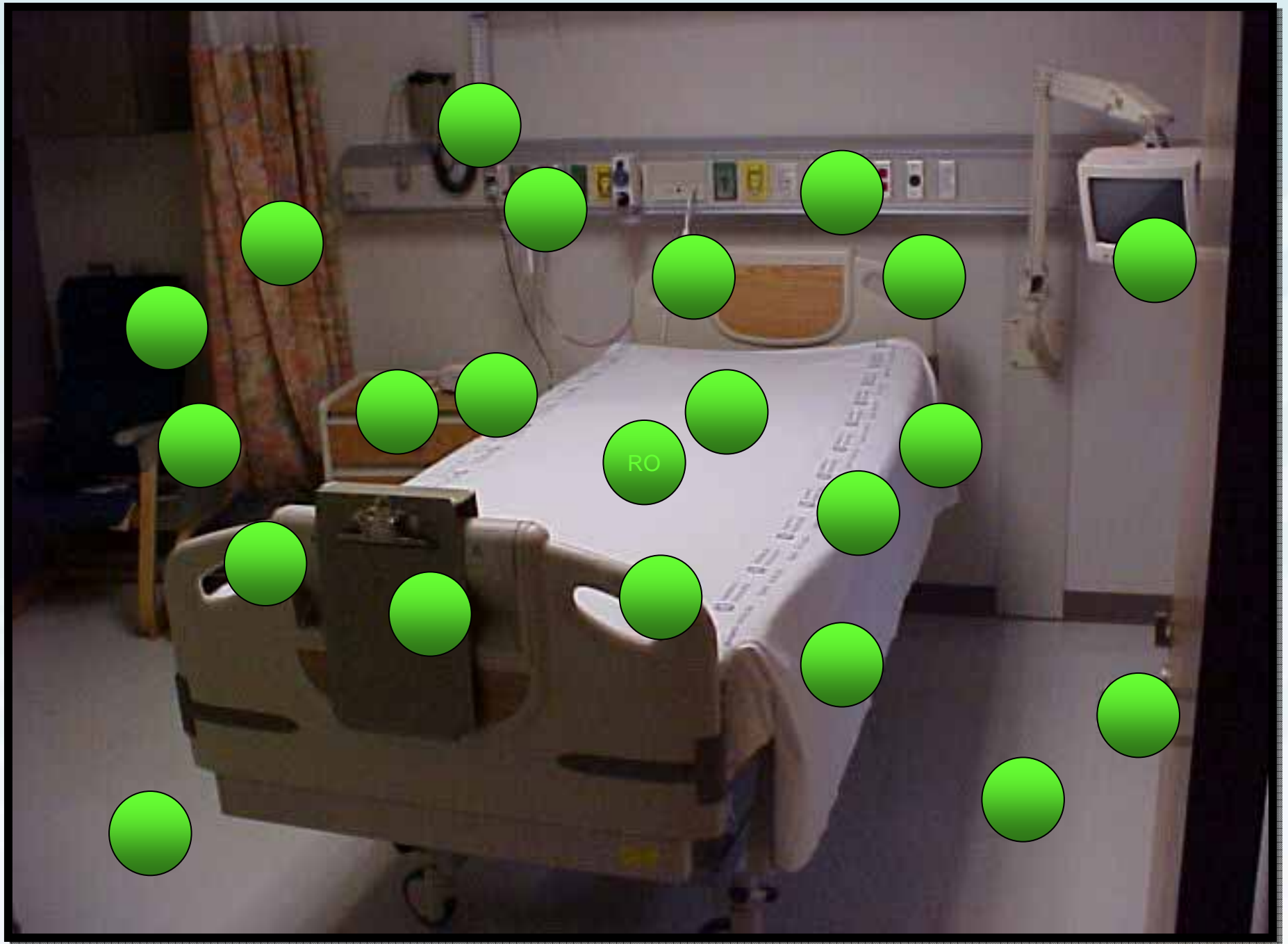
Facilitator starts with basic questions

- How do you know whether your patient has MRSA or carries the MRSA germ?
- In your own practice, what do you do to prevent spreading MRSA to other patients or staff?
- What are the barriers that prevent you from doing these things all the time?
- Is there anyone or any unit that has a way of doing things that enables them to overcome these barriers?
- Do you have any ideas about getting rid of barriers?
- What would it take to make that happen here?
- What seems possible to you now? Who should be involved?
- Who wants to help make it happen?

Design & Do

Front line staff act on and own their solutions



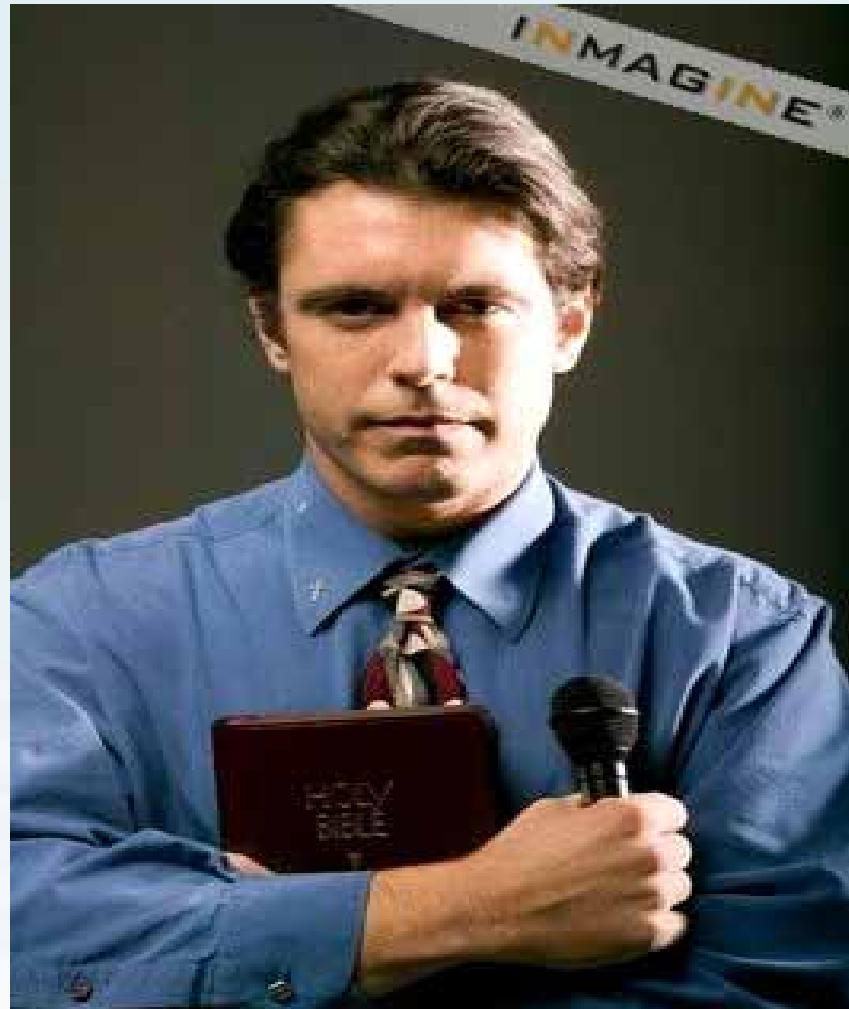


Staff owned/operated Solutions



Dedicated stethoscopes, thermometers, tourniquets and disposable blood pressure cuffs in isolation rooms

Before & After Bible Hygiene



Transporting MRSA Positive Patient





● Daily cleaning items: ● For room turnover, clean all daily items and:



Created by EMS and Infection Control staff

“We dance around in a ring and suppose, while the secret sits in the middle and knows.” — Robert Frost



What PD Tells Us – *that is different*

Solutions imported from external sources – result in a “social” immune response in the same way our bodies reject foreign bodies.

Best Practices “imported” from the outside are not as durable or scalable as local best practices discovered from the inside.

Buy-In vs *Ownership*

* **Buy-In:** Someone else has developed the idea, made the decision, designed an action plan and then asks and needs the staff to implement it.

Ownership: Front line staff develops the idea, makes the decisions, designs the action plan and acts on it.

* Buy-in is the opposite of ownership and a danger signal that tells you that your development and implementation process are missing the essential ingredient of involving everyone who needs to be.

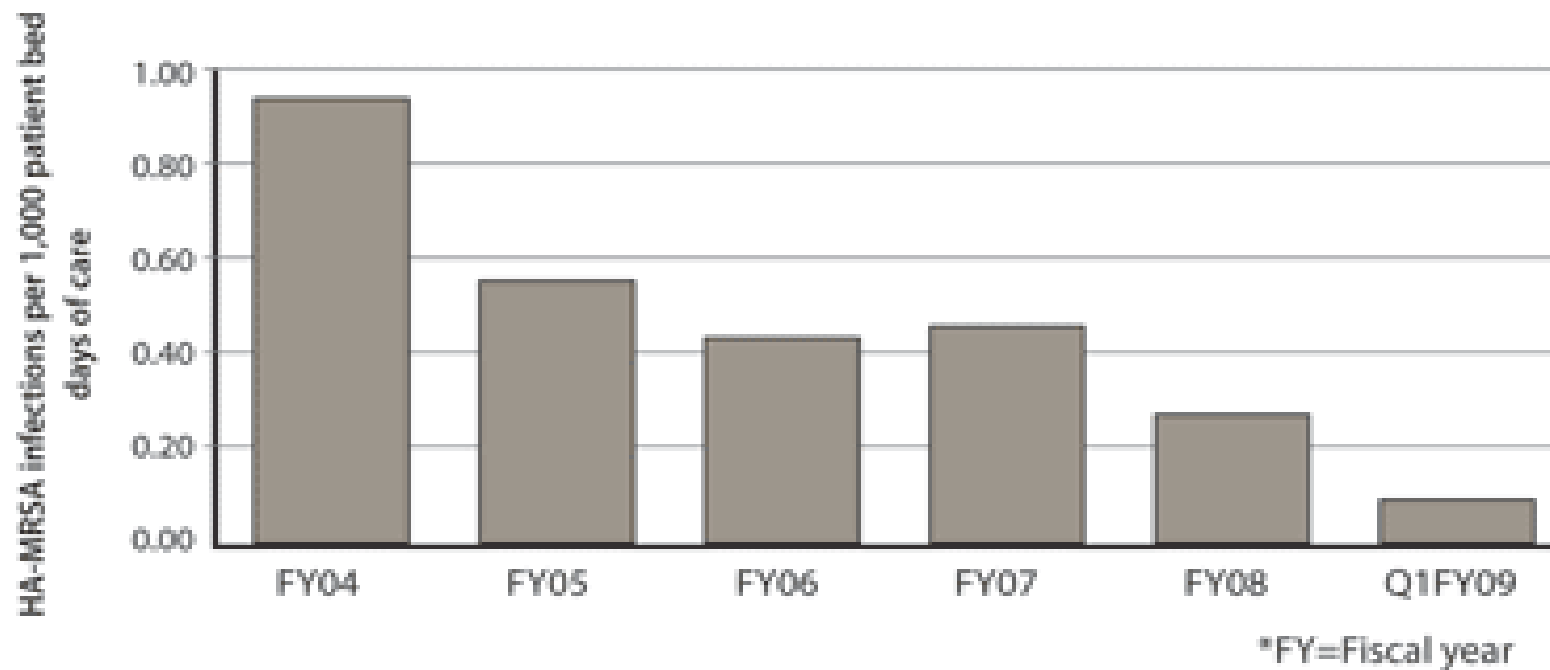
Discern - Performance Grid

Front line efforts are “bathed” in data

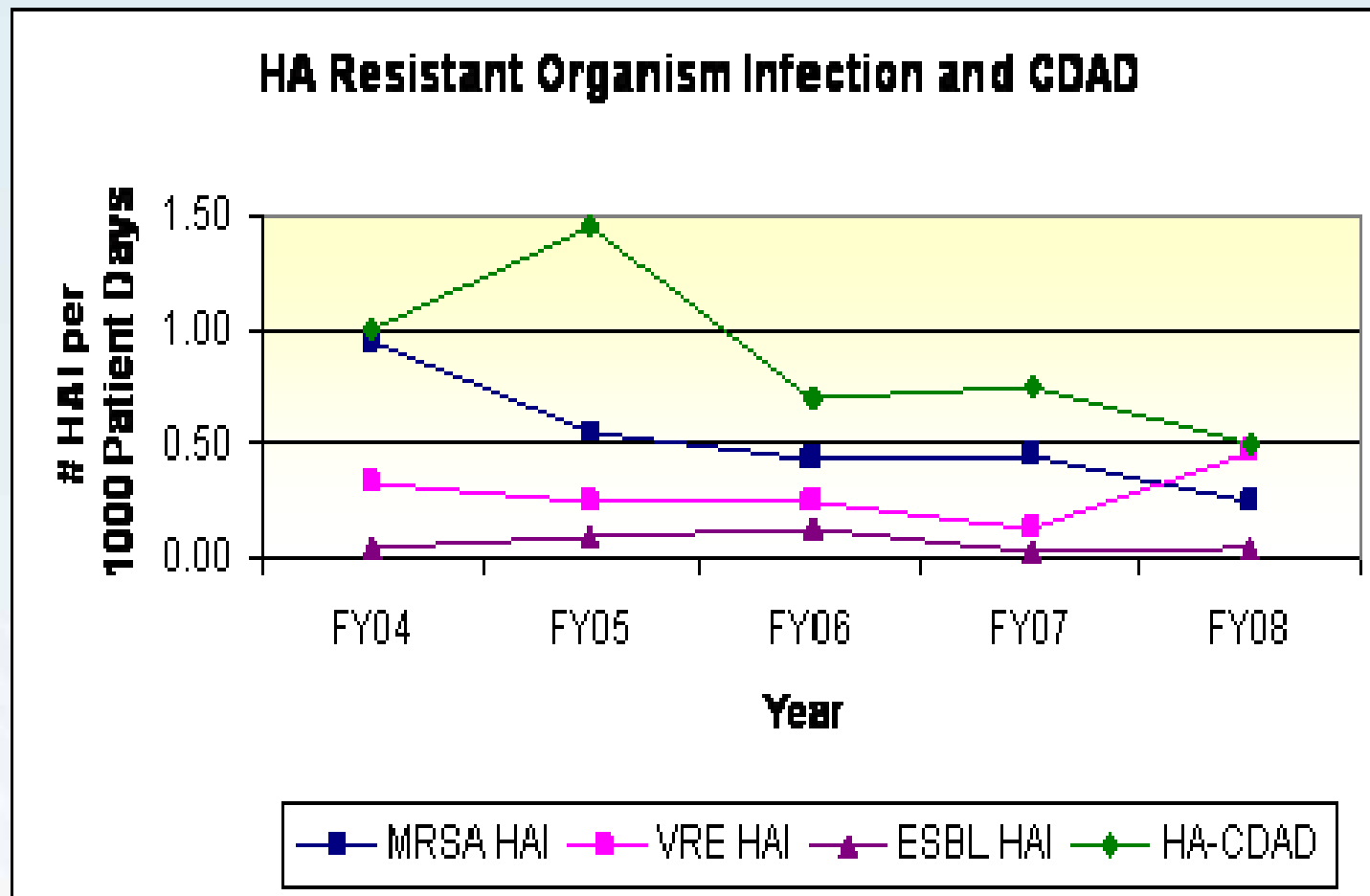
Unit	Nares Culture Rates-Adm.	Nares Culture Rates-D/C	Hand Hygiene Adherence	Contact Precaution Adherence	HA-Transmission Rates	HA-Inf. Rates

VAPHS HA MRSA Infection Rates

HA-MRSA infections reported in Pittsburgh VA Healthcare System



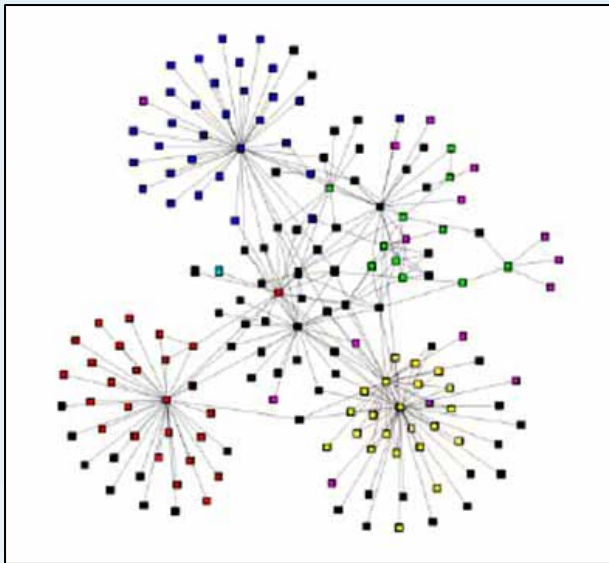
VAPHS-UD MDRO Infection Rates



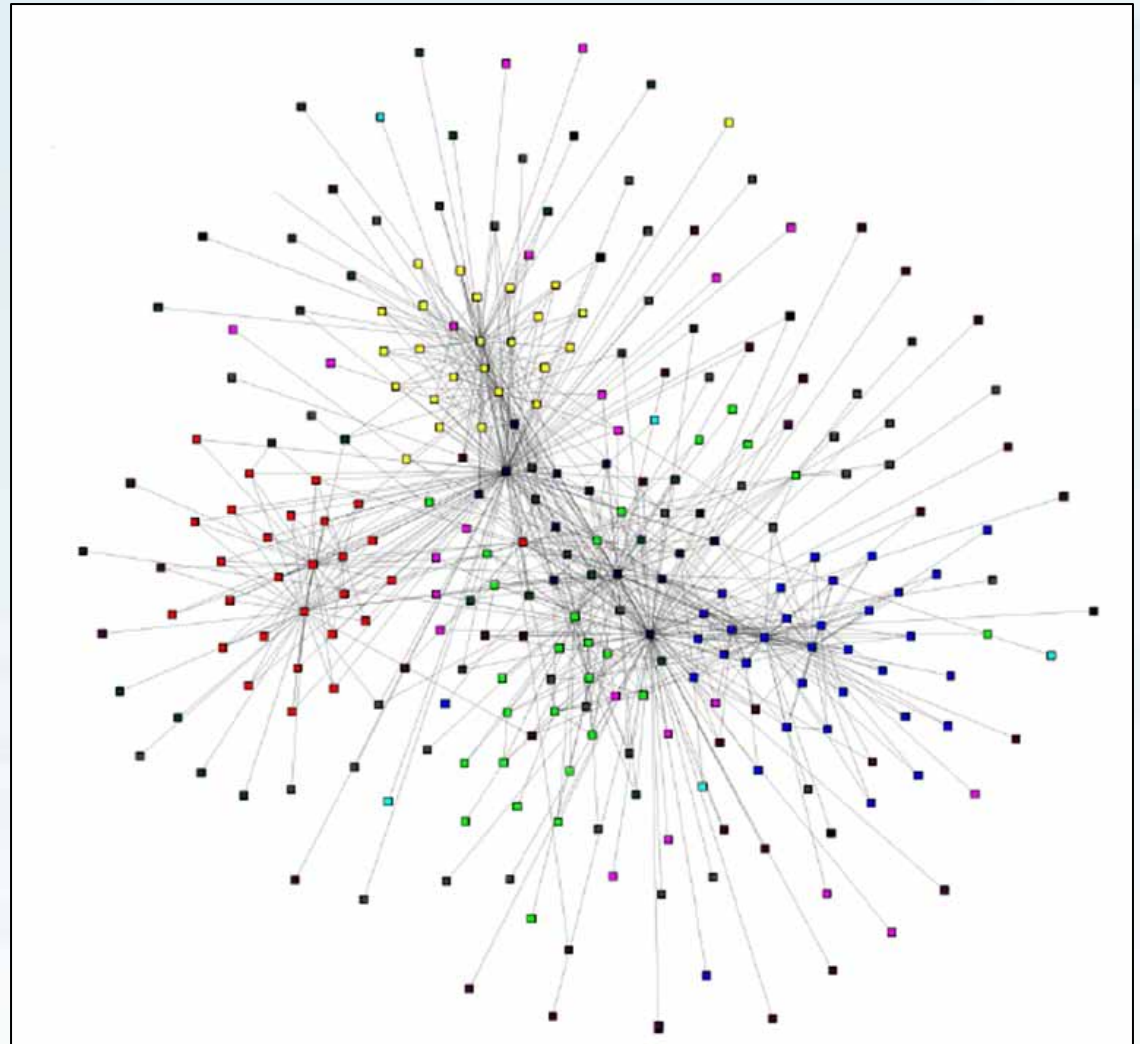
PD ~ a Network Phenomenon

VA Pittsburgh

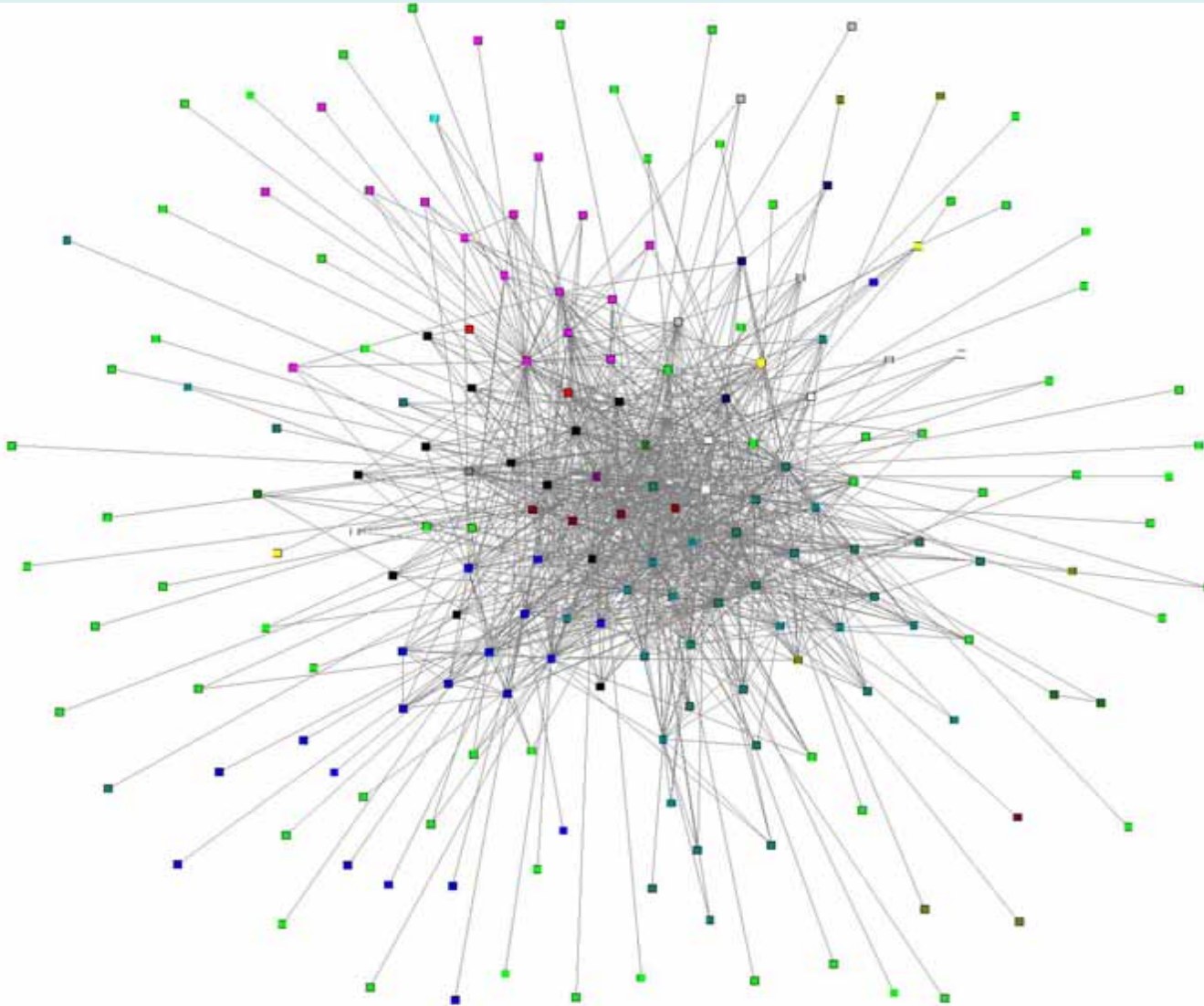
2005



2007



Potential Network





Robert Wood Johnson Foundation

Disseminate

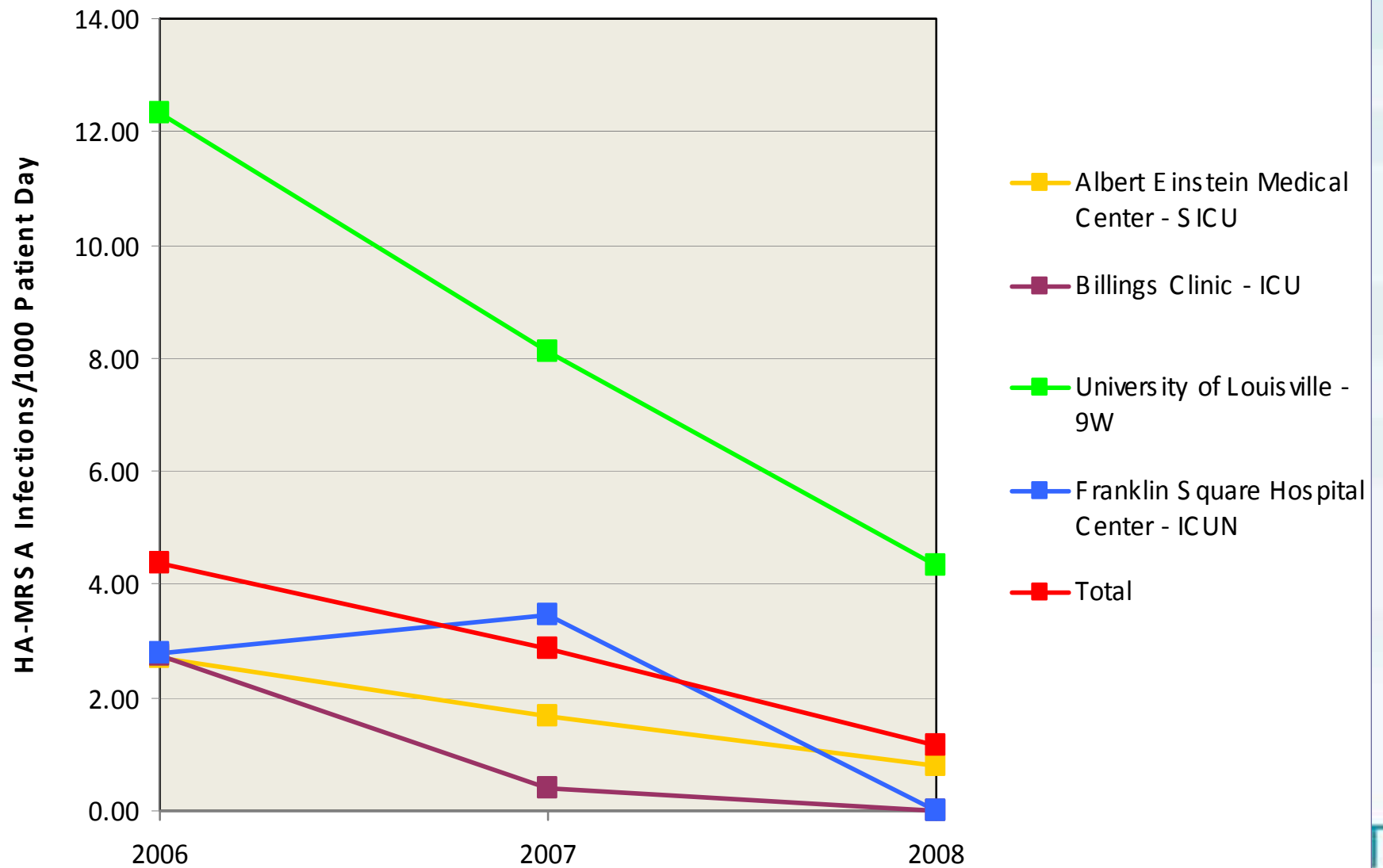
**Reducing MRSA Infections by Using
the Positive Deviance Approach to
Behavior and Social Change**

**“While national rates of MRSA HAI’s go up,
RWJ/Plexus PD beta site rates are going down.”**

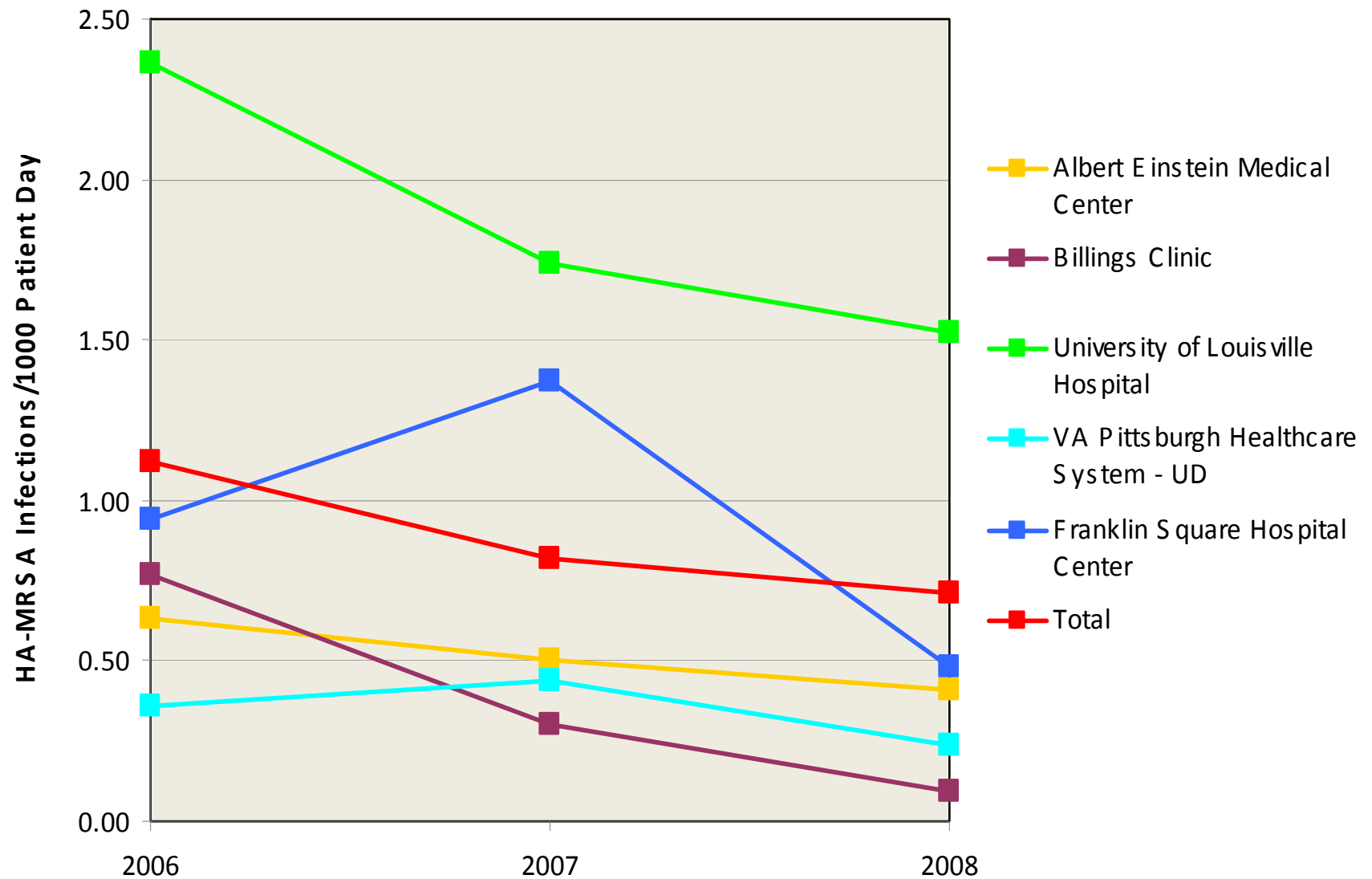
John Jernigan, MD, MPH



Pilot Unit Healthcare Associated MRSA Infection Rates /1000 Patient Days - Plexus Beta Sites



Hospital-Wide Healthcare Associated MRSA Infection Rate/1000 Patient Days - Plexus Beta Sites



Acknowledgments

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- Margaret Toth, MD, CQO, Delmarva Foundation
- Robert Wood Johnson Foundation
- Beta Site Coordinators and Staff

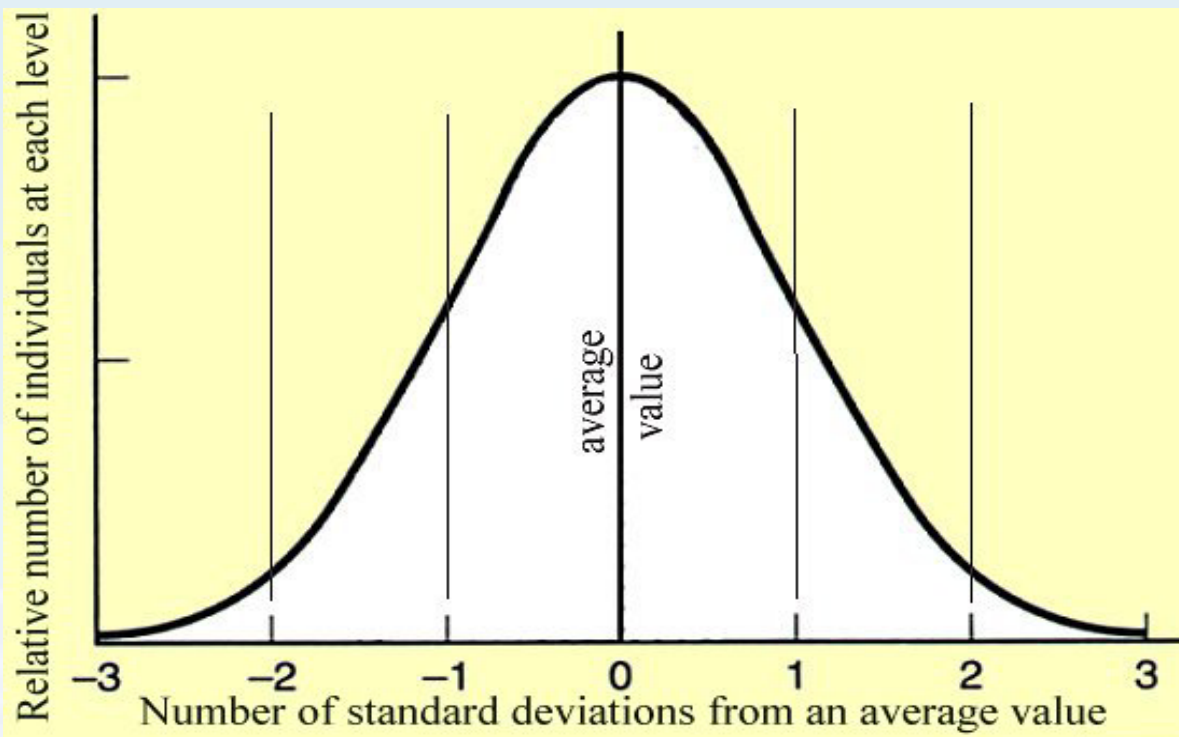
Small Group Discussion

- **Salient features of PD**
- **PD differs from current QI**

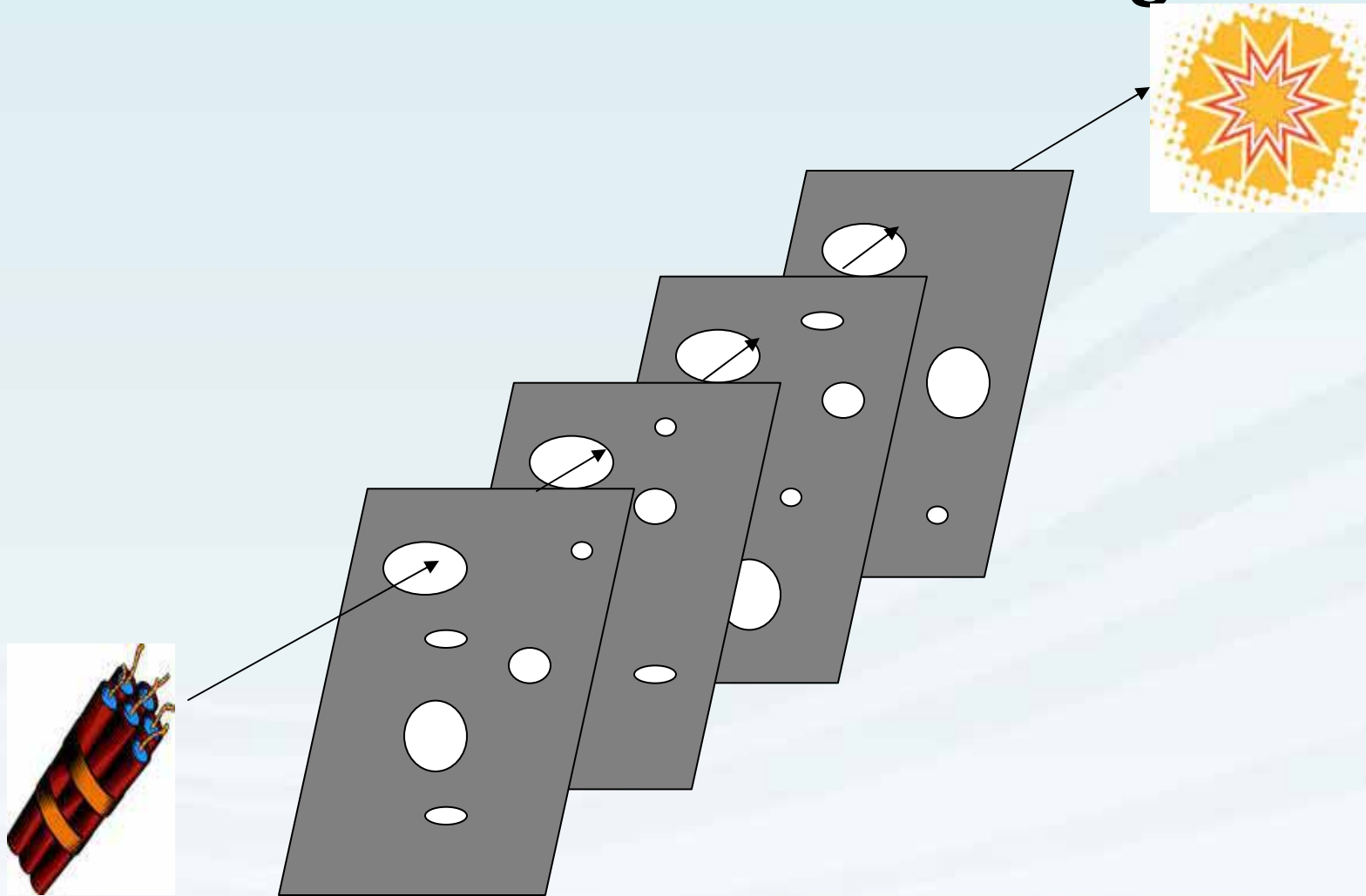
Questions

- What are the similarities, differences between your current QI strategies and Positive Deviance?
- What are some complex challenges that require behavior change in your hospital(s) that may be ripe for PD?

Bell Curve



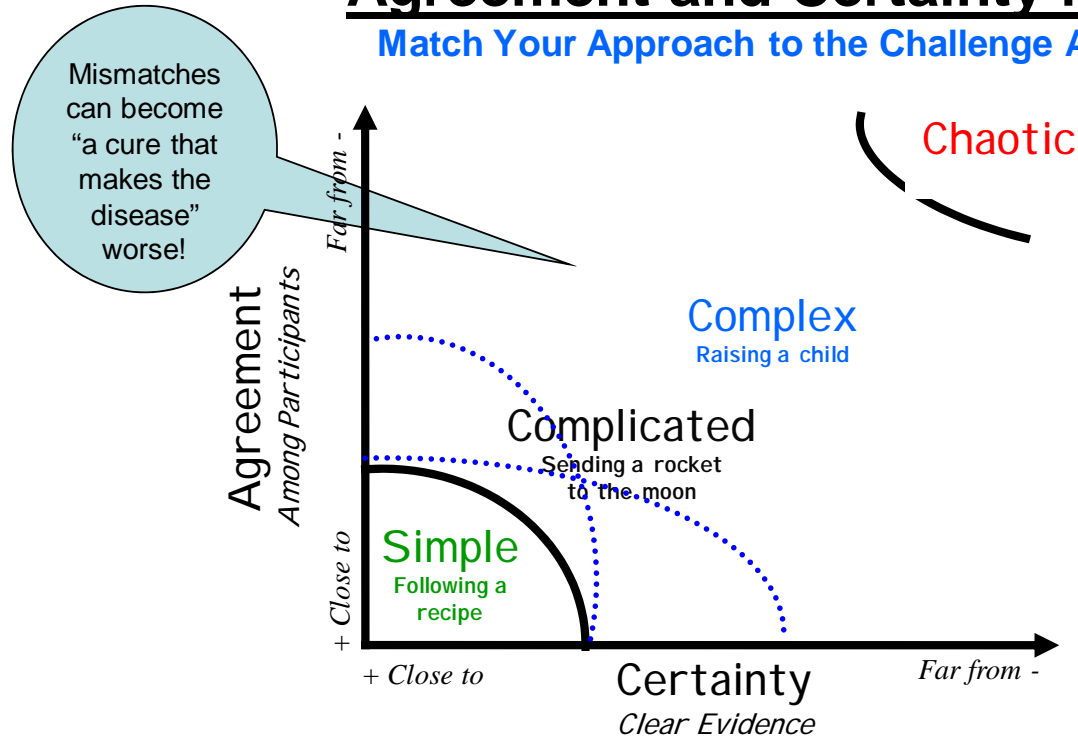
James Reason's Swiss Cheese Diagram



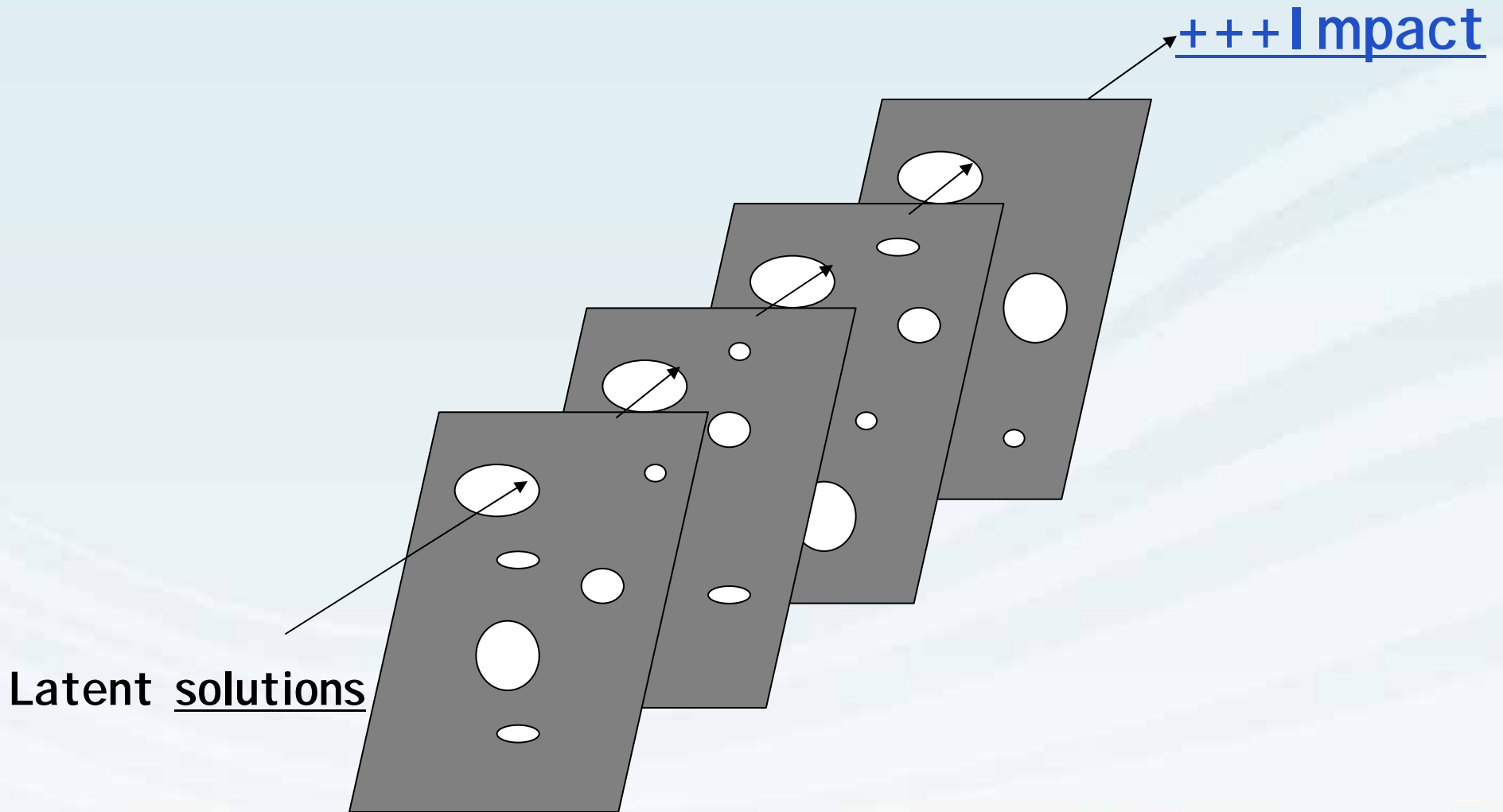
Brenda Zimmerman: Complexity and Creativity in Organizations

Agreement and Certainty Matrix

Match Your Approach to the Challenge At Hand



Reason's diagram Redux



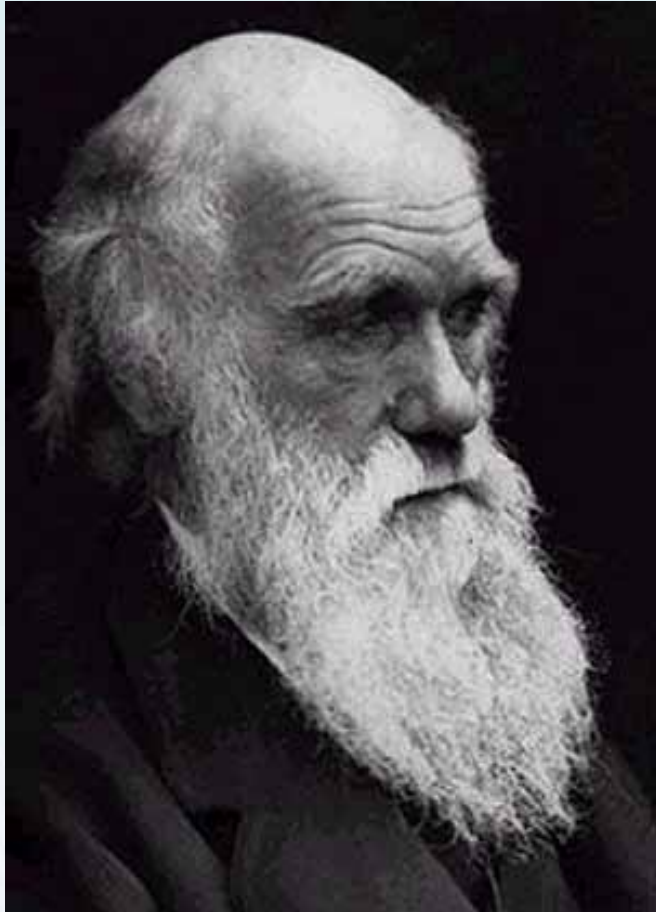
Quality Improvement and Patient Safety Science Rich Repertoire of Approaches

- **Defect-based:** Team-based Process Improvement (IHC), Rapid Cycle Improvement (IHI), Lean, Six Sigma, TPS, etc.
- **Asset/Strength-based:** complex adaptive system science, e.g. PD, appreciative inquiry, etc.

*Not an either/or proposition but both/and

The great opportunity in healthcare today

- 1. Develop an epistemology of approaches to improvement that includes defect-based and strength-based strategies that are currently available.**
- 2. Understand the nature of the challenges we face; problems can have simple and complicated technical aspects as well as complex dimensions which require behavior change.**
- 3. Educate and train healthcare professionals to be able to define the problem in all of its dimensions, draw from the rich current repertoire of improvement strategies and apply the appropriate sociotechnical solution(s).**



“It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most **adaptable to change.”**

Charles Darwin

Thank You

NOT KNOWN