(SOUNDBITE OF INTRO MUSIC)

KATE BASTINELLI, HOST:

Welcome to *Perspectives*. I'm Kate Bastinelli from the Greater New York Hospital Association. I'm joined by my GNYHA colleague Kendall LaSane, who will be interviewing Dr. Jason Golbin, Executive Vice President and Chief Medical Officer at Catholic Health. We'll be exploring the importance in building a culture of safety within hospitals and health systems and how to foster collaboration between the organization, staff, and patients.

Let's get started.

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DR. JASON GOLBIN:

Good morning, so nice to be here with you.

KENDALL LASANE:

Thank you again for joining us. If you could just please introduce yourself and share your current role in any previous related roles.

GOLBIN:

So, my name is Jason Golbin. I'm the Executive Vice President and Chief Medical Officer here at Catholic Health on Long Island. We're an integrated, faith-based health system. Six hospitals, three nursing homes, home care, hospice. We have about 16,000 employees here on Long Island and we're the third largest employer here on Long Island. My background is in pulmonary critical care and sleep medicine. I went to medical school on Long Island actually, but grew up in Staten Island. Can't get rid of that accent. From there, I did residency internal medicine at Lenox Hill Hospital, along with the chief resident year, followed up by fellowship and pulmonary and critical care medicine at Mayo Clinic out in Rochester, Minnesota. Quite an experience for a hardcore New Yorker to spend three years in Minnesota, but really incredible place. The way medicine should be. From there, I came back to Long Island and worked in private practice. I was tapped to become the Chief Medical Officer at Saint Catherine Hospital up in Smithtown in 2013. My boss at the time, and the person who hired me, was Doctor Patrick O'Shaughnessy, who is now our President and CEO and moving our organization at a pace we've never seen before. He was taking on progressive responsibility in the organization and wanted a little more assistance in the quality front, and he developed a position called the System Chief Quality Officer, which had never existed before, and in 2017 I became the first System Chief Quality Officer here until 2021, and was again blessed to become the System Chief Medical Officer here at Catholic Health.

LASANE:

Thank you, Doctor Golbin. If you could just describe how you became interested in quality and patient safety. What was your path to this work?

GOLBIN:

That's a great question. So, I had some experience but very minimal with systemic level or systematic level change as Associate Director of the ICU at Good Samaritan Hospital in Bayshore. But it wasn't really until I came over to Saint Catherine's that I understood the challenge and dynamics of organizational-wide change. First week actually, Doctor O'Shaughnessy said to me, "So Jason, what are you doing about readmissions here? I see that your congestive heart failure readmissions are in the 25th percentile." That challenge engaged me in the ability to change care not just for the patient sitting in front of me, but the population as a whole in the hospital. And now, from the system point of view, really looking, branching all over Long Island and beyond as we continue to expand. This was magnified in 2015 when we began our journey to high reliability, which we've been focused on now for over 6 years. We looked first at a common cause analysis with three years of data and we found that we had a significant number of what we defined as serious safety events – events of harm that occurred because of commission (something we did wrong) or omission (something we missed), including a number of deaths. Those are patients that didn't return home to their family that should have, in our opinion, returned home to their family. Multi-focused around procedural areas, and we set a goal that we were going to reduce that by 80% in five years with the eventual goal of zero harm. That is where we are headed and we have made great progress. The way we did that is that we defined first and foremost patient safety was our core value as a system, and we built out what we call The Daily Patient Safety Principles. We trained everybody in the organization using a train-the-trainer model in partnership with our colleagues at Press Ganey, all staff and all credentialed medical staff (that includes every physician and every APP). We actually made it a condition of credentialing here at Catholic Health to be trained in safety and error prevention. As far as we knew, that hadn't been done anywhere else in the United States. It is being done now. We've actually shared that nationally.

LASANE:

Thank you. And as you know, Doctor Golbin, the Institute of Medicine's report to errors human was released in 1999. It really outlined the importance of reducing medical errors that you've described by designing safer health systems. It had an outsized impact on patient safety by bringing the culture of silence around preventable medical errors to light. In your opinion, what has been the biggest shift in how quality and safety are viewed within health care organizations since then?

GOLBIN:

So that was in 1999, and here it is, right, where we're almost in 2023 and still fighting the good fight. So when I was a resident at Lenox Hill, there was a VP for Medical Affairs and he introduced me and my Co-Chief Resident to that book. It was the first time that I had been exposed to that. We didn't discuss that in medical school and my goal as a resident really was to do no harm, right? To deliver great care to my patients. But I never thought anywhere beyond that. But here I was now as a Chief Resident managing 100

residents, and it made me question and look at the way we deliver care in a different way. Spoke to the cost of harm. Again, something not anywhere on my radar at that point. What I learned was that most of the errors were systemic in nature rather than individual failing, but it's taken many, many years, I believe, to move that into the common culture, the common language of our hospitals. And I don't just mean our hospitals, I mean hospitals nationwide really. It wasn't until mid 2015-16 that you saw this higher reliability journey start to take off. We were an early adapter, I believe, to what everybody is doing. But that's not dissimilar in my brain when I think about evidence-based medicine. You can see, they say an article will come out and it will have a game-changing piece of data. But it takes 5, 10, 12 years to actually implement that in common practice, and that's always a challenge. But I think the biggest game changer as a result of the error human report has been the higher reliability journey. I think that's what's making the difference across the nation. And certainly has made a tremendous difference in our health system.

LASANE:

And there continues to be a culture of blame that influences conversations about hospital quality and safety. Why is it important that we move away from a culture of blame in the way that you've described for systemic change?

GOLBIN:

We work very hard to avoid that culture, blame. That's not the right answer for how to improve health care in 2022 and 2023 and beyond. We follow the teaching of just culture, and we've embedded that throughout our health system. So, in just culture, when somebody makes a mistake, meant to do the right thing and just literally did the wrong thing by mistake, we console that person. We recognize that chances are there was something systemic that allowed that mistake to happen. There was a hole in the Swiss cheese that allowed that to penetrate, and we console that person. If somebody makes what we call an at-risk error, which is, in the terminology, normalized deviance. I use the example of “Everybody’s speeding on the highway, so I'm gonna speed too.” Well, that doesn't make it OK. The rules say you have to drive it this, just cause everybody else is speeding doesn't mean you should. Well, we coach that person. And, essentially, of course, sometimes when the police officer pulls you over, and you can't say, “Everybody else was going 75, so was I.” He may coach you as well, that you really can't do that. However, the biggest harm and the biggest risk in our building is reckless care. Somebody who, despite knowing the rules, knowing the right thing to do for our patients, does the wrong thing. Does something reckless. Really, truly conscious disregard. Then we remediate or punish that person. I hate to use the term punish, but that is just culture. And we follow that. We've embedded that through the health system. All of our HR colleagues work with our leaders to make sure we follow that algorithm, if and ever we do have an event that needs to be handled in this way.

LASANE:

So, as you described Dr. Golbin, many of the issues that arise in patient safety are preventable. How can we best position individuals in leadership positions to contribute to building a culture of safety?

GOLBIN:

So for us, we believe it all starts with leadership. Each and every one of our leaders have to live and breathe quality, safety and experience. And again, you'll hear me say it over and over again. Every patient. Every encounter. Every time. We put the patient at the center of everything we do. And if you do that, every patient, every time, you never do wrong. Actually, Joint Commission has come to believe that leadership is accountable too. And as you know, when Joint Commission comes in and they do a deeming survey, if they find an error, they usually also attribute that error to leadership. Because leadership is accountable for whatever happens in those buildings. The way we do it is we recruit for that passion. We recognize and look for that passion. You may not know everything about that specific job, but if you have passion for accountability, leadership, quality, safety, and experience, we can then train you around the specifics. We train and support, and we recognize and reward for success. That's very, very important. We've developed a number of metrics of success that we reward around. First is our zero harm awards. So when we have a campus, or a unit, or an outfit that has zero harm for 12 month consecutive period, we recognize that and we celebrate that with our board. And we call it our zero harm awards, and we've had more and more of those as the years have gone on. Really incredible. We celebrate individual accomplishments that our leaders recognize on the campus. We call them the golden key moments, when someone does something special to elevate the experience or the safety of our program. Recognize that person, or that unit, or that group of people for what they did, and we give them a golden key based on our golden keys to ICARE behavior. The last thing I think that's really important to make sure our leaders are all on is that we cascade our goals. Up and down through the organization. So, everybody is rowing in the same direction. We make sure there are not too many goals, but it's important to know that quality, safety, and experience are first on the list for everybody in our health care system. That is the most important goal. Before the dollars, before the operational metrics, it's quality, safety, and experience. And we thank Doctor O'Shaughnessy for putting that at the front of everything we do.

LASANE:

And you touched on this as well, that patient safety includes an emphasis on preventing errors and learning from errors that do occur. Can you tell us a little bit more about the tools and educational initiatives that you have implemented with physicians, clinical staff, and non-clinical staff, to improve patient experience?

GOLBIN:

So, when we started with our higher reliability journey, we did a common course analysis that we discussed a little earlier. And what we found is that we needed a set of daily behaviors, of daily principles, of what we expect from our staff, our physicians, our leaders. Again, every patient, every time, around supporting that culture of safety. And we teach everybody who comes into our organization. They take our daily patient safety principle error prevention course. So let me give you some examples. The first one would be speak up and use what we call CUS. CUS is 3 letters that represent concerned, uncomfortable, and stopped the line. So, we empower our staff. If something doesn't look right, if something doesn't feel right, it doesn't matter who you are in the building. It doesn't matter what your job is. We reduce that power distance and we empower that staff to say, “I'm concerned that something doesn't seem right here.” If they don't get the response they want, they say, “I'm uncomfortable.” And then ultimately, anybody can stop the line. You've

heard the famous stories, that “Any way you can stop the line” at the Toyota. They stop the buzzer to stop in any era. It's the same thing in the hospital. We've had numerous examples since we put this in place back in 2015, 2016, where even somebody that's not clinical will stop the line of the clinical operation. Say, “Wait a second, are you sure?” And it doesn't matter if they're right or wrong. We reward them and thank them for stopping the line and being concerned about putting our patients first. We teach how to communicate clearly using 3-way repeat back and read back. We ask clarifying questions. We use S bar for handoffs. Certainly, everybody who's clinical knows S bar. What's the situation? What's the background? What's the assessment? And what's the recommendation of the requests? This way it's very clear communication, up and down the chain of command. And then we want you to have a questioning attitude. We want and encourage that people question and qualify and validate and verify that the information they have, the information they're acting on, the information they're sharing, is accurate. And lastly, we support and follow evidence based guidelines up and down throughout the organization. Built-in, of course, to our electronic medical record.

LASANE:

And just thinking about the shift that there's been in safety culture toward also prioritizing patients and their families as part of the health care experience. What steps should leaders take to foster collaboration between the organization, patients, and their families?

GOLBIN:

I'm so pleased we got to this. This is where I've developed quite a passion. Let me back up and tell you that when I came to work for Doctor O'Shaughnessy in 2017 as the System Quality Officer, the first thing he did was do an assessment of quality and safety across the organization. And what we saw was not an issue necessarily around quality safety, but it was around the experience of our patients. It was not uniformly excellent around the organization. Certainly, we had pockets of excellence. We had other pockets where patients were perceiving, right? Because it's their perception. That's all that matters. That their experience was not the experience that they wanted. That it should have been. We had high performing areas and low performing areas. Well, I said, “OK, patient experience, that's not me. That's nursing.” And of course, that's not correct. We did the same thing that we did with safety. We partnered with Press Ganey. We did a common cause analysis, and what we found looking across the organization is that there was no uniform set of behaviors that were expected when you were a member, an employee, or a physician, or an APP within Catholic Health. What are the behaviors that we expect? And how often should we do them? So, we built out, similar to daily patient safety principles, the daily patient experience principles. We called it our golden keys to ICARE behavior. So ICARE was in our mission and value statement. It stands for Integrity, Compassion, Accountability, Respect, and Excellence. And we assign standardized behaviors for each of those topics that we expect everybody to follow. I'll give you some examples. For Integrity, introduce yourself, make eye contact, smile, use a patient’s preferred name. For Compassion, we spent a great deal of time teaching around empathy. Here in medicine, we tend to be problem solvers. We want to fix everything right away. And sometimes, patients are still in the “Hold on, you're not even hearing me.” I always tell the story that as a pulmonologist, I thought I did a great job clinically whenever I had to, unfortunately, make a diagnosis of lung cancer. Before the patient even came into the office, I had everything lined up. I had gotten the pathology results. I had spoken to the surgeon. I had spoken to the

ecologist, and I had everything set. So, 1,2,3, there would be no pause. I would have my patients tucked in and taken care of and getting the appropriate treatment. And I would share this with them and I wouldn't stop and I wouldn't empathize and say, “I'm sorry. You have lung cancer.” But I already arranged everything. “Here's the surgeon you're gonna see, here's the...” What I didn't realize is, they were probably still stuck on, “I have what?” And I think that was a huge learning experience for me, many, many years into my career. Nobody had ever taught me how to empathize before. I was good at sympathy. I was good at action. But I wasn't good at empathy. And we've seen that organizationally as we've taught this culture of patient experience. So we taught this and we continue to teach, just like safety. When you come on to work here at Catholic Health, you have to have a safety curriculum and you have to have an experienced curriculum. These things all tied together on a higher reliability journey. We actually said that to be a truly highly reliable organization, you have to hit on quality, and safety, and patient experience, and employee engagement. We hold everybody accountable and put it into everybody's leadership goals. Again, cascading up and down, throughout the organization, to make sure experience is as integral to what we do as is quality and safety.

LASANE:

And in your opinion, what other support is needed to adequately prepare the workforce to contribute to building a safety culture?

GOLBIN:

So there you go, right? So 2022, I think more than any other year, has taxed our people. It's always been a challenge for staff and healthcare. And then COVID came. And in my humble opinion, I certainly was optimistic we'd be further out of it in 2022 than we had been. And what we've seen is that we continue to struggle with COVID at any given day, and our staff has been challenged by three years of COVID, among the issues that you see in America. We have the great resignation, you have burnout. So much of our focus for 2022 has focused on the employee engagement piece of that puzzle. We're working on having an engaged, enthusiastic, empowered workforce. It actually makes living that higher reliability mission more critical than ever. Done a ton of work around resilience with our HR partners across the organization. And I am super pleased that today I will publicly say we are on-boarding our first ever Vice President for Clinician Resilience and Well-Being. We have asked this physician to build a baseline assessment of, “Where are we with that clinician well-being?” And then we're going to build out a systemic program to mirror what we've done with the rest of our higher reliability journey.

LASANE:

And what is one lesson you've learned from building a culture of safety that other health care leaders should know?

GOLBIN:

I would say higher reliability really works. I think COVID put it to the test. So here we are, overwhelmed, certainly in New York, and we were just the first three months of COVID. March, April, and May of 2020

were unlike anything we'd ever seen. But I think it was a higher reliability training and culture that allowed us to persevere and return so many patients safely back to their family. Let me give you some examples. There's five principles of being a high reliability organization. The first one is preoccupation with failure, meaning every small error is important and can aggregate to larger catastrophic areas. An example of how we put preoccupation with failure into place during COVID is that we stood up, tell the ICU in the matter of two to three weeks. Something that normally takes an organization, I would say, one to two years to implement safely, we stood up in two to three weeks. Our ICUs were overwhelmed. Our staff was getting sick themselves, was having trouble maintaining the amount of hours needed to take care of all these patients. And we said, “Wow, we can't have any failure. We can't have any small error,” because each small error aggregates up. So we stood up, tell ICU across the system, that remediated and let us calm the waters and those ICUs without any small errors. Next principle is reluctance to simplify. Complex principles or processes cannot and should not be oversimplified. Some things are complex in health care. An example of this during COVID was our ambulatory care workflow. Our office stayed open, but we had to develop very, very complex workflows with a million boxes on the flow chart to make sure our patients and our staff were safely provided for as we care for patients in the office. The third principle is sensitivity to operations. So, we know that operations drive results, but small changes upstream can lead to large changes or problems downstream. So, we built from scratch operational dashboards. We had never had before such situational awareness around the organization about where the patients were, how do we move the patients? How do we make sure we get the care and the supplies to where the patients need it? Here we just never had that level of operational situation awareness. We built, also from scratch, the fourth principle of high reliability. Healthcare is resilience. Never quit. Never, as the Navy seals say, never ring the bell. So, we did the same thing. We needed to move hundreds of patients over those three months between the organization, actually out to the city and back from the city. Some incredible movement had to be done. We built what we called Catholic Health Air Traffic Control. We called it Care Traffic Control. And it was all virtual. And lastly, probably one of the most applicable during COVID is the principle of deference to expertise. Just because you're the leader doesn't mean you know the most about the issue or the problem. And you certainly saw that during COVID, so we adapted and collaborated with the medical nursing staff in ways we had never done before. Our whole anesthesia staff, remember there was no elective surgery. A whole anesthesia staff, both the physicians and the CRNAs, came out into the ICUs and built out ICU collaboration teams. We saw the same thing around critical care nursing dyads, where we had med surge nurses joining a critical care nurse to help take care of all these critical care patients, with the critical care nurse at the lead. The collaboration and the deference expertise we saw during COVID, to me, just proved the point that high reliability health care is the only way to proceed.

LASANE:

What continues to motivate you despite the obstacles?

GOLBIN:

I read a book once by Angela Duckworth. It's called Grit. It's an amazing book, and she defines grit as passion times perseverance. And I said, "Wow, that's it. That's the bullseye.” And I think that's what it is. You have to have passion to succeed in health care, but it's not easy. It's not just passion. You need perseverance to do it. Day in and day out. To me, that's the driving force.

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BASTINELLI

Thank you for joining us today. Until next time, this has been Perspectives.