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More We than Me

Using Positive Deviance to Engage Everyone

By Prucia Buscell

> When a group of individuals becomes a "we," a harmonious whole, they have reached as high as humans can reach.
>
> —*Albert Einstein*

Maureen Jordan is the administrative director of respiratory care at Albert Einstein Medical Center. She is a self-described *type A* personality who likes to get things done, so she thought it was ridiculous when colleagues acted out the transport of a critically ill patient as an improvisation exercise and asked her to take notes. The action involved a nurse, a physician, an escort service employee, a ventilator, an oxygen tank, a stretcher and a creatively noncompliant "patient" played by Dr. Jerry Zuckerman, Einstein's medical director of infection prevention and control. "I was amazed," Jordan said months later, "I saw so many things that could cause infection and cross contamination. I made a list of all the things that needed to be addressed. And we had fun."

Jordan's list and discussions that followed among escort employees and other frontline staff involved in transporting patients from one location to another in the hospital produced a new policy. Then there was an in-service for the staff. "But since they generated it themselves, we didn't need to sell it," she said. Neither the federal Centers for Disease Control and Prevention (CDC) nor the Society for Healthcare Epidemiology of America (SHEA) has a policy on who should wear gowns and gloves during a transport, explained Dr. Jeffrey Cohn, chief quality officer for the Albert Einstein Healthcare Network in Philadelphia, so it made sense for Einstein staff to work out one for their own environment.

While colleagues were working on protecting patients during transports, another escort service employee was devising a creative solution to another problem. Jasper Palmer demonstrated with a showman's flair how to don a gown and gloves then quickly slide out of the gown, twirl it around his right arm and stuff it into a glove. He compressed the bulk of the personal protective gear worn when tending isolation patients into a wad the size of a baseball. "You don't have to have overflowing trash bins," he said.

Jordan and Palmer are among the hundreds of the people at Albert Einstein Healthcare Network in Philadelphia who have joined SMASH, an organization-wide effort to fight MRSA (Methicillin Resistant *Staphylococcus Aureus*) and other virulent infections that are afflicting hospital patients across the country. In dozens of small ways, Einstein's successful efforts are embodied in triumphs and insights that emerged from countless cultural collisions and negotiations. Those encounters, many unexpected and unplanned, some subtle and some contentious, have generated new and altered relationships, practical innovations, changes in language, and some impressive outcomes.

Dorothy Borton, a thoughtful woman with a gracious bearing, never liked being considered an enforcer. She is an RN with more than 30 years of clinical experience in infection prevention, and she remembers the way it used to be when she walked onto a hospital unit. "People would make a great

show of doing things the correct way, but I got the sense that as soon as I walked away, their actions would change," she said. "If you asked them two years ago who is in charge of infection control, they would say it's the infection control professionals. Now it's recognized that every person in the facility regardless of individual role—the janitor, the finance officer, the direct care giver, patient or visitor—plays a part in preventing infection."

That is a big difference. Borton enjoys seeing employees throughout the hospital working together now as a team, and she is especially pleased that infection control professionals are now viewed as a resource, not as police. "It's been fun working with individuals, seeing them grow, and seeing unlikely leaders become advocates and champions," she said. The transition had its discomforts—for her and her colleagues, it meant doing more asking than answering. It also meant giving up some control and becoming comfortable with new and evolving responsibilities.

These changes emerged from a journey that Albert Einstein Healthcare Network (AEHN) began in 2006. Albert Einstein, a nonprofit organization with 6,000 employees and several major facilities and outpatient centers in the Philadelphia area, embarked on a new infection fighting strategy based on a dialogic method called Positive Deviance (PD). It has changed relationships and workplace habits among countless health professionals and other employees. And, it got results. The incidence of healthcare acquired MRSA and other infections has been reduced significantly. The idea is that PD, which does not rely on new drugs or technology, encourages the kinds of cultural changes that help people consistently adhere to practices known to fight infections.

"We had talked about connecting more with what is happening on the front lines, and getting a much greater sense of engagement and ownership among those who are on the front lines," explained Dr. Cohn who connected AEHN to a project developed by Plexus Institute in collaboration with the Positive Deviance Initiative. "PD as a tool is all about the front lines. I was convinced if we could learn to do this well, it would be in complete alignment with our transformational work."

Positive Deviance

Positive Deviance (PD) bridges the gap between what healthcare workers know and what they do (Singhal et al., 2010). They know the evidence based infection reduction protocols but they do not always follow them. The PD approach focuses on how to foster reliable adherence to known infection prevention precautions at all times by everyone who comes in contact with patients and their environment. Patients do not develop MRSA infections unless the germ is transmitted to them and they become colonized. Of those who do become colonized with MRSA bacteria, 30 percent will develop MRSA infections. So the key to preventing infections is preventing transmissions. Every front line healthcare worker, and that includes doctors, nurses, aides, therapists, housekeepers, and all support service staff, have countless opportunities to transmit bacteria from patient to patient. They also are the very best onsite experts on how to prevent transmissions in their own work.

PD is based on the idea in every community there are individuals or groups who are solving problems better than colleagues who have exactly the same resources. Using PD, eliminating MRSA infections will come from acknowledging the expertise of frontline staff and eliciting a sense of ownership of the problem and its solution from all the staff members who come in contact with patients. Once they discover and own solutions, they will carry them out. As Dr. Zuckerman described it, "People don't turn their backs on things they create."

Introducing Positive Deviance

To kick things off, Einstein invited several hundred executives, managers, and department heads as well as doctors, nurses, and support staff to a PD session. Attendance was open to everyone. It was also completely voluntary. Dr. Cohn shared his own wrenching MRSA story. Some

Change Grows out of Ownership

And ownership is *NOT* the same as buy-in

There is an important distinction between ownership and buy-in. These words are not interchangeable and they are not synonymous.

Ownership is when you own or share the creation and refinement of an idea, a decision, an action plan, a choice; it means that you have participated in its development, that it is your choice freely made.

Buy-in is the exact opposite: someone else, or some group of people, has done the development, the thinking and the deciding, and now they have to convince you to come along and buy-in to their idea -- so that you can implement their idea without your involvement in the initial conversations or resulting decisions. Aiming for buy-in creates lukewarm, pallid implementation, and mediocre results.

PD helps you create true ownership and avoid the pitfalls of buy-in.

When it comes to solving intractable socio-technical behavioral problems in systems the notion of buy-in is just not useful – people in the system need to own the new behaviors.

Anytime you or someone around you thinks or talks about buy-in beware! It is a danger signal telling you that your development and implementation process is missing the essential ingredient of involving all who should be included.

With its emphasis on Discovery and Action with usual and unusual suspects, PD offers a powerful means of avoiding the wasted time and mediocre results affiliated with buy-in.

years earlier, when he was a practicing oncologist, he treated a college professor in his 50s who had been diagnosed with a serious but treatable cancer. The prognosis was years of remission. Instead, the man died of lung failure resulting from a blood stream MRSA infection that he almost certainly got through an IV line put in place for chemotherapy. "It was devastating for the family, and as the doc who had embarked him on this treatment, I felt horrible," Dr. Cohn said. Next, an Einstein board member told of his experience with a *staph aureus* infection. Dr. Zuckerman outlined what MRSA bacteria is and does. Einstein's new quality manager, Dr. David Hares, an internal medicine physician who recently earned an MBA at the University of Michigan and had served an internship with a biotech company trying to develop a MRSA treatment, recounted the numbers of people MRSA sickened and killed. Then Jerry Sternin (Sternin 2010) and his colleague and wife Monique Sternin shared their experience with PD in global health work and early efforts to apply it in U.S. healthcare. As the session ended, Dr. Cohn invited anyone interested in volunteering to help in a new fight against MRSA to come to a session at 9:00 a.m. the next day.

"We were very nervous," Dr. Cohn recalled. "Would anyone show up?" A circle of a dozen chairs initially went unoccupied as a few people straggled into the room a little after 9:00 a.m. "Einstein time," scoffed several doctors who noted that meetings often start late. Eventually, some 50 doctors, nurses, aides, administrators, housekeepers, and clergy were among those who brought more chairs to join the circle. The conversations started that day would grow into a concerted effort involving hundreds of people. Pilot projects began in four units, and people who work with patients in numerous capacities throughout the hospital began to re-examine their own roles and the way they worked with others to prevent infections.

"I think we were able to see some complexity principles at work in that first hour or two," Dr. Cohn said in retrospect. "There was self organization and people without a clear agenda saying: How do we proceed? How do we make sense of this next task? Within 30 to 40 minutes, people had self organized into subgroups." Some would be short lived, such as a group that worked on early logistics, and other groups would continue working on such issues as measurement, communication, and support for the pilot units.

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Early Skeptics

Despite dedication and enthusiasm, the initiative did not come together with magical ease or speed. Many were skeptical then, and Dr. Cohn conceded some still are.

Dr. Zuckerman became the physician champion for SMASH. That's an acronym for Stop MRSA Acquisition and Spread in our Hospitals, the name staff members voted to call the PD/MRSA initiative. Dr. Zuckerman was an early skeptic:

> I asked where is the evidence, where is the science? The science and the guidelines tell us what we should all be doing for infection prevention and control. However, despite universal knowledge of best practices, healthcare workers routinely fail to follow them. PD is a very different process. It strives to invoke behavioral and cultural changes. It focuses on the how to implement best infection prevention practices, an area that infection control professionals have struggled with for a long time.

Despite his qualms, Dr. Zuckerman was swayed by the preliminary reduction in infection rates. He recognized that the PD approach had contributed to increased cooperation and teamwork and involvement of front line staff. He observed, "We've made more progress on this in the last six months than we have in the last 14 years."

When Should We Start? How about Now?

The efforts unfolded differently in each unit that got involved. In a 46-bed medical surgical unit, the nurse manager Gene Spross, RN, had been going to SMASH meetings early on. She intuitively liked PD, but wondered if it could work in her unit, with its 80 employees in two physically separated sections. Still, she kept learning. She said,

> My staff knew something exciting was going on, and they wanted to be part of it. They were honest when they met with Dr. Hares, the project leader —they said we know we don't always do everything we should. Dr. Hares asked, when do you think you could start this process? Four or five answered 'how about right now'!

SMASH participants go out of their way to help each other. Spross added, "When one unit is successful it motivates other units. So they step up and do it, and those who have already worked on it will support them."

Regular Meetings and Butterflies

As part of the PD process, Discovery and Action Dialogues, or D&ADs, as they came to be called, were scheduled as needed on the units (see Discovery and Action

Dialogue Worksheet). Some dialogues were spontaneous one-on-one exchanges. Some were short bursts of engagement among staff members and mentors. The idea was to talk about an issue, discover whether anyone has already come up with uncommon strategies to address it, and if not, then create an action plan that is as concrete as possible. Volunteers are sought to see that specific steps are carried out. No ideas are ridiculed or dismissed. Ideas are "butterflies" to be examined with care and treated gently. In one D&AD with respiratory therapists participants worried that the pens they carried in and out of the rooms might be vectors for transmissions, so pens were to be purchased to keep in isolation rooms. One participant reported that during a D&AD with her staff, a medical clerk came up with the idea of having a pink sheet on all patient bedside charts that showed MRSA status and swab-in, swab-out data *(see page 18)*.

D&ADs were to become central to PD work in other hospitals. They allowed for community discussions and elicited a host of suggested solutions. In addition, brief facilitated conversations alleviated the need for big meetings that were hard to schedule in a hectic environment where people work shifts covering 24 hours.

Dr. Cohn, Dr. Zuckerman, Borton, or Dr. Hares generally attend regular Friday meetings where staff from pilot units discuss their progress with prevention, barriers to prevention, and possible solutions. The sessions are open, and members of several units and support services are invited or attend on their own. After months of practice, discussions at the Friday meetings flow easily, with partners in conversation augmenting each other's observations and proposals. Coaches from Plexus Institute often participate in regular conference calls about PD and infection issues.

Dr. Zuckerman says that the use of PD and D&ADs has permeated other initiatives: "Our urinary tract infection group finds out from front line people what some of the problems are, and they are being very inclusive, working with a bottom up approach, and incorporating those ideas into clinical areas and projects."

Nothing about Me without Me

"The complexity of taking care of patients, of hundreds of interactions every day, in a complex environment, that's where PD comes into play," said Dr. Zuckerman. "With the traditional approach, leadership gets an idea of what's wrong and imposes a solution. The natural reaction is that won't work for us. PD is about people in the community identifying the problems you cannot see from the outside, and coming up with novel ideas that work for them, right there. It is about community ownership. Because solutions are community driven, they are likely to be accepted.

"If the discussion involves another person or another group, they have to be brought in," Dr. Zuckerman continued. "That's how you expand the community. If you don't know how a room is cleaned, you bring in housekeeping." Employees from several departments, including food services, radiology, patient transport, and therapy became vigilant infection fighters and found multiple ways to remove barriers to their own consistent vigilance. In fact, Dr. Cohn notes that some of the people Jerry Sternin called "unusual suspects," the people who have not traditionally been invited to work on infection control, are among Einstein's "heroes." "Environmental Services [housekeeping] and transport have folks who care passionately and have tremendous pride in the role they can play in preventing infection," Dr. Cohn said. "The people in the Storeroom where supplies are kept have played important roles."

The PD approach acknowledges the expertise of those who do the work. It is also flexible enough to address new issues and revisit old ones. As it turned out, there were still more questions about the best methods for in-house transports.

Can SMASH Achievements be Sustained?

When the question was raised at a regional meeting, several Einstein employees were indignant. Of course infection control vigilance will last, several insisted, because they will make it last. It is their process.

The plans for a network-wide SMASH program offer some insights on maintaining an effort. The decision had many roots. Doctors making rounds were noticing SMASH units were better than others at having personal protective gear available, and staff more consistently followed hand hygiene and isolation precautions. Spross and several other nurses were beginning to think SMASH should be universal. Dr. Hares and Dr. Carlos Urrea, another quality management physician, and Borton, the infection control nurse, were starting conversations with additional units. Dr. Cohn said a joint decision was reached in the spring of 2007 to expand the initiative. "We all looked at what we were doing, and uncovering, and the value of making all these previously invisible MRSA patients visible, and knowing our patient population and we knew it was the right thing to do,"

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Discovery and Action Dialogue Worksheet

Question Purpose	Generic MRSA Questions	Your Questions
Affirm the participant's knowledge of the problem/challenge. Provide opportunities to get thoughts and questions out on the table.	What do you know (or think) about MRSA? How do you know when one of your patients has MRSA or is colonized with MRSA?	
Focus on personal practices rather than on what other people do or don't do. Recognize the participant's knowledge of what they are supposed to do.	What do you do in your own practice to keep from transmitting MRSA?	
Identify the barriers and constraints to the desired behavior. Why can't you? (which gets at identifying the barriers), rather than Why don't you? (which sounds judgmental).	What prevents you from doing that 100% of the time?	
Establish that practicing the desired behavior (and getting around any barriers) is possible. Identify the existing uncommon successful strategies that enable some individuals to overcome barriers or issues. Identify the enablers and supports that make the desired behavior easier or more likely.	Do you know of anyone who always does what is recommended to prevent the spread of MRSA? Or any place where everyone seems to be able to do it all the time? How do they get around these barriers? Are there times when you are able (or better able) to do what you are supposed to do to prevent MRSA transmission? How are those times different from the times when you are not able to do it?	
Provide an opportunity for participants to generate and share new ideas for enabling the desired behavior.	Do you have any other ideas about how we can do better about preventing MRSA transmission here? Or make practicing the recommended behavior easier/likelier?	
Identify action steps with target dates and a mechanism for reporting back. Recruit volunteers for each action step. Capture ideas that don't yet have an identified action plan or volunteer.	What would we have to do here to implement that idea? Would anyone from this group volunteer to help with the next steps?	

Dr. Cohn said. "Then the state mandated MSRA testing for high risk patients. We have a lot of people from long term care, or chronic renal failure, who would be viewed as high risk. It just made sense."

As Dr. Hares put it, "It was a desire, not a decision. It was a request from people who were a part of SMASH, who said we have something good and we have to share it. It was discussed, and expressed, and shared with others, and that's how the desire became a decision."

There was some initial resistance, he said, "But the beauty of PD is the concept of unusual suspects. If the usual suspects are too busy, or unconcerned, move to the next person. And eventually the usual suspects will comply because someone asks them to. People resist, then they get sucked into a big movement. Nothing was ever imposed. People find their own way."

Several Einstein staff members think that changed relationships and a sense of ownership will support continuation of newly developed infection control practices and behavior. Jordan offered a similar observation, and cited her own personal changes. Dr. Hares observed that because of continual work-related conversations, people from different units and occupations communicate more freely. "More people know each other on a first-name basis," he commented.

Even language has changed. Several Einstein employees have noticed that people at all levels of the organization address each other more respectfully, and that speech is more inclusive. Most respond politely to reminders about MRSA prevention practices, no matter the source. Borton noted that nurses offer reminders graciously, and doctors tend to be pleasantly unflummoxed.

"If you are in a meeting and you say you have a story to share, you are no longer the crazy guy," Dr. Hares said. "They are a part of what we do today. Even a vice president told a story about something that she experienced, and how she solved it, and it was a springboard for discussion." Another newly frequent phrase is "I don't know, let's ask," Dr. Hares added. And butterflies? A new metaphor, it doesn't signify queasy stomachs or flighty socializing, but rather inspiration, ideas, and practical solutions. "When we talk about butterflies we mean ideas that are floating over the middle of the table," explained an Einstein nurse at a meeting of healthcare professionals. "When there is a butterfly, someone has to catch it, not strangle it, or squash it, but catch it and work on it." Several staffers have favorite butterfly stories.

Leadership has changed too, Dr. Hares noted, and more attention is paid to attitudes on the front lines. Hospital executives recently approved a switch from hand gel to foam in dispensers throughout the building despite additional expense, even though the cleaning power of both products is the same. But people like the foam better, Borton said, because it dries faster and doesn't feel as sticky. "The feeling was if it is more acceptable to staff, they will use it more frequently and we will have improved hand hygiene," she said. In the past, expense alone would have been an obstacle to change.

Dr. Zuckerman summarized the change with the observation, "now there's more 'we' than 'me'."

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