Affinity Group Session: Supervisors and Guests

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@HarvardCEPR • #SDPconvening
Who is CEPR?

MISSION

To increase the effective use of quality evidence in education.

STRATEGY

Diagnose ➔ Intervene ➔ Evaluate ➔ Influence

MODELS

• Develop data-use capacity
• Generate relevant and accessible evidence
• Build a community driving evidence use

SDP INPUTS

• Place data talent in agencies
• Train data talent to run mission-critical analyses
• Strengthen SDP network of supervisors and fellows
## What you might get from the fellowship

<table>
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<tr>
<th>Increased Analytic Capacity</th>
<th>Improved Strategic Data Use</th>
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<td>Better Data and Data System Quality</td>
<td>Productive Collaboration and Communication</td>
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SDP Fellowship Timeline Refresher

**Year One**
- Orientation
- Winter I
- Convening I
- September Workshop

**Year Two**
- Winter II
- Convening II/Graduation

**Fellowship Workshops**
- Alumni Mentors
- Working Groups
- Webinars
- Faculty Advisors
- Capstone Working Groups
- Webinars

**Ongoing Fellowship Support**
SDP Fellowship: What’s on the immediate horizon?

Cohort 7 (2015-2017)
Graduation (Fellows and Supervisors)
July 17-18

Cohort 8 (2016-2017)
September Workshop (Fellows only)
September 2017

Cohort 9 (2017-2019)
Orientation (Fellows and Supervisors)
Week of October 23, 2017
Today’s session

• Be thoughtful
• Be honest
• Be reflective
Children’s B Case

- Leadership Changes
  - Dr. Eric Knox comes on board as Director of Patient Safety in 2001; performs well and wins trust, but leaves in 2002 to return to retirement at his wife’s insistence
  - Dr. Glenn Billman, formerly Director of Patient Safety at Children’s in San Diego, replaces Knox, and is highly respected, passionate about safety, and effective as a leader
  - CEO Brock Nelson retires, and is replaced by Dr. Alan Goldbloom, former COO of Hospital for Sick Children in Toronto, who has considerable passion for patient safety
SAFE to SAFEST

• Adds “strategic thinking” to SAFE framework and acronym, which includes
  • Leadership Development program
  • Lean Process Improvement initiative
  • Center for Care Innovation and Research
  • Participation in multi-hospital collaborative focused on quality and safety in Minnesota
“The Way We Do Things Around Here”

- Safety is seen as part of the DNA of the hospital
- Training in safety expanded -- including all new hires
- Safety learning reports rise and involve about 40 focused review per year
- Chain of Command instituted to ensure assistance always available for safety
- Rapid Response Teams implemented
- Family Advisory Council
- Awards
- New Technology
  - Electronic Medical Records
  - Smart Pumps
  - Bar Coding
- Disclosure expanded (with no increase in legal action, in frequency or magnitude)
Q: How do you become a learning organization?

(a) You declare yourself a learning organization

(b) You humbly embark on a long journey of

• building collective learning capabilities,
• identifying performance and opportunity gaps, and
• systematically tracking results...
The leader’s job

Creating shared urgency about an opportunity or performance gap

+ Creating a climate of “psychological safety”

+ Building and supporting a team-based infrastructure for experimentation and learning
Julie Morath & Children’s Hospital

- **Creating shared urgency**
  - A compelling vision: 100% patient safety
  - The power of inquiry

- **Building psychological safety**
  - Institute “blamefree reporting”
  - Anticipate the “worse before better” effect

- **Empowering a team-based learning infrastructure**
  - Patient Safety Steering Committee
  - Safety action teams
  - Good catch logs
System-wide patient safety reports
psychological safety is created by *local* leadership

- **Being accessible**
  - “[He’s] in his office, always just two seconds away. He can always take five minutes to explain something, and he never makes you feel stupid.”

- **Inviting input**
  - “[the team leader] gave us a talk about what [the change] is about, the kind of communication he wanted, what results he hoped for, and told us to immediately let him know of [any ideas or concerns we had]”

- **Modeling fallibility**
  - “The team leader has created an atmosphere where that happens. He’ll say, ‘I screwed up. My judgment was bad in that case’.”

- **Clarity about what constitutes punishable misconduct**

source: Edmondson
Paradox: Clarity about punishment creates safety

*Julie Morath’s “Blameworthy Acts”*

- Reckless behavior
- Disruptive behavior
- Disrespectful behavior
- Knowingly violating standards
- Working way beyond your boundaries
- Failure to learn over time
Learning vs. Accountability

• Leaders must achieve a delicate balance between stimulating learning and maintaining accountability
  • You can’t simply choose to stress learning OR accountability; it’s not either one or the other – organizations need both
  • In addition, one doesn’t always have to come at the expense of the other
  • However, balancing the tension between two is very difficult
  • Managing the tension requires close attention to several critical processes:
    • Performance management system
    • Budgeting process
    • Monitoring and control processes
    • Hiring process
    • Management development programs
Psychological Safety and Accountability (Edmondson)

- **High Psychological Safety**
  - **Low Accountability for Demanding Goals**
    - Apathy (low energy)
    - Politics
  - **High Accountability for Demanding Goals**
    - Anxiety
    - Limited collaboration

- **Low Psychological Safety**
  - **High Accountability for Demanding Goals**
    - Comfort zone
    - High performance
  - **Low Accountability for Demanding Goals**
    - Productive collaboration
“The point of educating instead of blaming seems to me very important. For nothing stultifies one more than being blamed. Moreover, if the question is, who is to blame?, perhaps each will want to place the blame on someone else, or on the other hand, someone may try to shield his fellow-worker. In either case the attempt is to hide the error and if this is done the error cannot be corrected.”

Mary Parker Follett (1868-1933)
What about your organization?

• Is yours a learning organization? How do you know?

• Do people feel safe to take risks? Speak up?

• What systems/infrastructure do you see supporting these efforts? Hindering them?

• Are the parameters of what constitutes appropriate/”safe” behavior clear and transparent?

• What if any next steps might you take to help enhance learning in your organization?