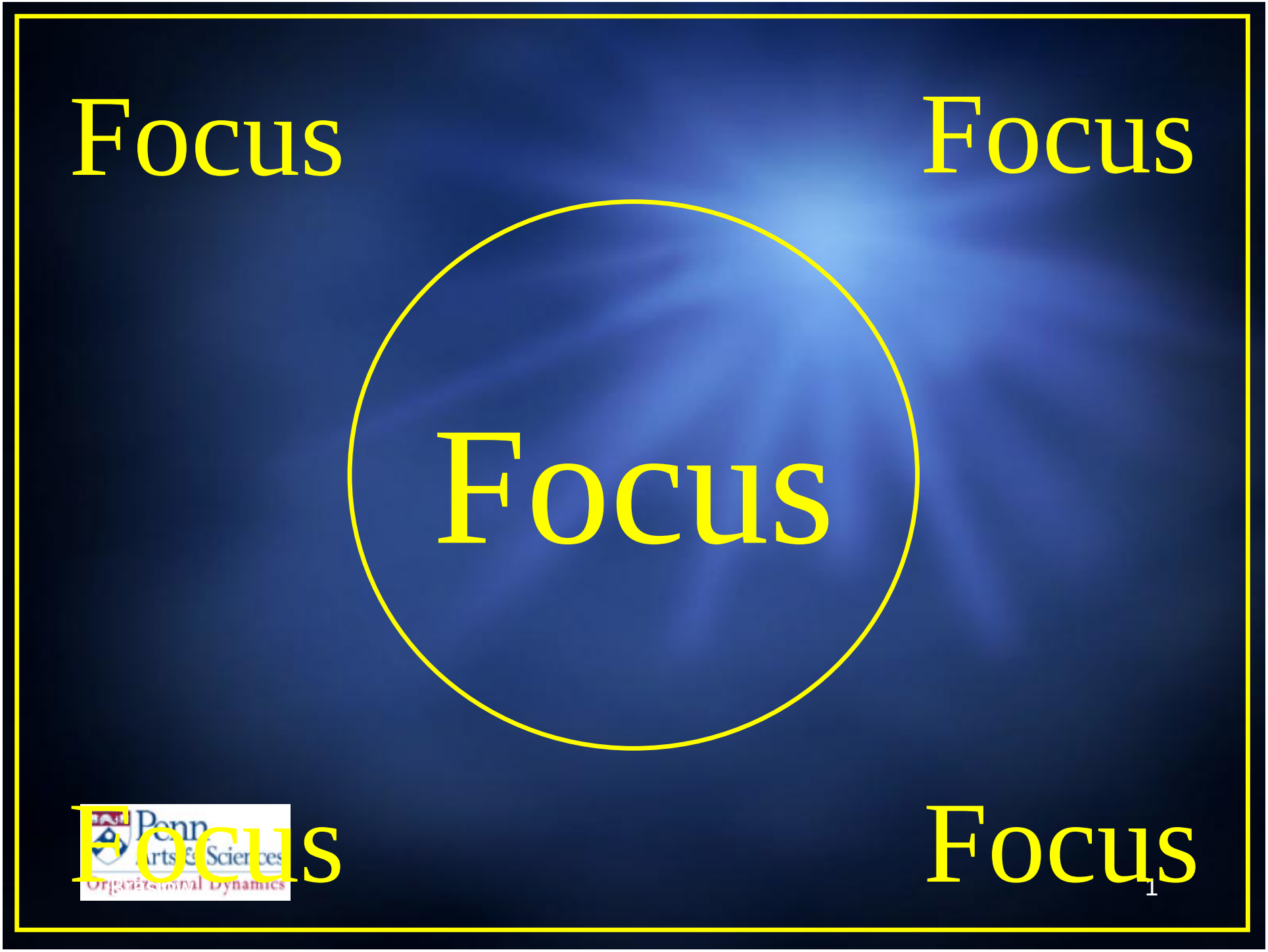
Focus
Focus
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Update from the

University of Pennsylvania Special Task Force on Rethinking the System of Survival for Sudden Cardiac Arrest:

~~Our Best Practices~~ → Our Best Processes

Allan Braslow
Visiting Scholar

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Disclosures

Univ. of Pennsylvania:
I am a visiting scholar in Organizational Dynamics, and a member *of Special Task Force on Reframing the System for Survival for Sudden Cardiac Arrest.*

Goodman Research Group:
I have been a Co-PI for evaluations of AHA, ARC and NSC emergency care programs [funded by AHA, ARC and NSC].

Braslow & Assocs.
I co-invented and defined in the literature:
Video-Directed, Self-Instructional (VSI) CPR practice-while-watching learning method [funded by Laerdal].

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Outline for this morning...

- Who we are . . .
- *Our Processes*
  - *Thinking Systemically vs Thinking Analytically*

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Who we are . . .

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Rethinking the System of Survival for Sudden Cardiac Arrest

History of the Task Force and Project

In 2007, Dr. Larry Starr, who has been involved in cardiac and emergency care research for more than 25 years, posed this question: "Why after 40 years of enormous energy and resources is the Sudden Cardiac Arrest (SCA) survival rate low, very low — too low? Are we doing the 'right' things?" When colleagues Dr. Allan Braslow and Frank Poliafico visited him as part of a meeting with Dr. Lance Becker who had recently come to Penn to direct the Penn Center for Resuscitation Science, he offered a new framework to think about the SCA survival problem. **READ MORE...**

Special Task Force

- Benjamin Abella
- Jean (Will) Bail
- Matt Dane Baker
- Lance Becker
- Danny Benau
- Nicholas Bircher
- Allan Braslow
- Robert T. Brennan
- Kathleen G. Burke
- Ted Crites
- Mike Fink
- John M. Field
- Keith Griffiths
- Dave Gaieski
- Ward M. Hamilton
- Eugene Janda
- Guy Knickerbocker
- Mary E. Mancini
- Raina Merchant
- E. E. (Chip) Miller
- Vinay M. Nadkarni

Dr. Guy Knickerbocker Visit: July 8, 2010

JAMA. 1984 Jun 15;251(23):3133-6. Landmark article July 9, 1960: Closed-chest cardiac massage. By W. B. Kouwenhoven, James R. Jude, and G. Guy Knickerbocker.

- View the invitation and the attendee list.
- View photo of Dr. Guy Knickerbocker and Dr. Kathy Burke, School of Nursing
- Listen to the audio presentation. Please note that this is a large file, and depending on your Internet connection, it might take some time to start playing

Penn Researchers Host Meeting to Explore Systems Approach for Improving SCA Survival: April 29, 2011

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A social systems laboratory that is *"rethinking the system for sudden cardiac arrest survival"* with interdisciplinary representatives from medical and organizational groups and societies, device manufactures, hospital and EMS systems, academic departments, and other stakeholders.

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Task Force Question

Why after 40 years of enormous energy and resources is the Sudden Cardiac Arrest (SCA) survival rate low, very low —too low?

Are we doing the “right” things?

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- Organizational Coaching
- Organizational Consulting and Executive Coaching
- Practitioner/Development and Change
- Projects, Programs, and Portfolios
- School of Nursing Minor in Organizational Dynamics of Healthcare Systems
- Sustainable Development

Writing Workshops

Because the discipline of writing for academic purposes is based on skills that are not common to business writing and because the writing process is central to learning in this program, Organizational Dynamics offers a series of free workshops facilitated by Dr. Steven Freeman and Dr.

Dynamics. Applied.

Sudden Cardiac Arrest is a Wicked Problem. It's a Mess.

Read More >> Project Website.

2011-2012 ALUMNI PROFILES

Click here to complete the **2011-2012 Alumni Profile survey**.

COMMUNITY PROFILES

We are updating our community profiles page. Here are examples of profiles for two recent graduates: Peter Galasinao and Jake Silverman..

Meet our students and alum. To submit information for your personal profile, send a request to dynamics@sas.upenn.edu.

What's New

CALENDAR OF IMPORTANT ACADEMIC DATES

For a list of important events see the new Bulletin Page.

IMPORTANT DYNAMICS UPDATES

FALL 2012 COURSE REGISTRATION IS NOW OPEN!

Fall 2012 Semester Registration is open. Here is a list of Fall classes. Fall classes begin Wednesday September 5.

Students from departments or schools at Penn other than DYNM, click here for information about how to register for a DYNM course.

LOOKING FOR THE LOCATION OF THE CLASSES YOU REGISTERED FOR?

Go to your Penn Portal or click here.

ALL NEW STUDENT ORIENTATION

New student orientation for Fall 2012 will begin at 6:00pm on Tuesday, September 4. Click here for details

35 Years, 50 faculty and scholars, 500 adult students, 17 domains of Organizational Dynamics

- Anthropology
- Design and Planning
- Economics
- Education
- Engineering
- English
- Government
- Health Care
- Humanities and Languages
- Human Resources
- Law
- Management
- Organizational Science
- Philosophy
- Political Science
- Psychology
- Sociology

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We deal with Wicked Problems (Messes)

We have a 35-year international track record of success in business, industry, healthcare and government using *Systems Thinking (Thinking Systemically).*

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Organizations that have applied

Penn's Thinking Systemically

Approach

to Dissolve Messes

and Improve Outcomes:

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American Airlines
AMA
ALCOA
ARMCO Latin America
Anheuser Busch
AT&T
Bell of Pennsylvania
The Boeing Company
Briggs and Stratton
Canadian Pacific
Chrysler
Dubai government
Dupont
Eastman Kodak
Eli Lilly
EPA
Exxon
Federal Reserve Bank
Ford Motor Company
General Electric
General Motors
IBM
Imperial Oil Canada
IRS
Johns Hopkins Hospital
Kaiser Permanente
Koop Foundation
Marriott International
Metropolitan Life
Mexico City govt
NASA/Goddard and JPL
NIH
Natl Library of Medicine
Natl Science Foundation
Oracle
PanCanadian Petroleum
Pentagon
Sun Microsystems
Southwest Airlines
Union Carbide
UK Health Service
US Air Force
US Army
US Navy
US Steel
White House

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What is Thinking Systemically ?

- Thinking Analytically
- Thinking Systemically

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Thinking Analytically

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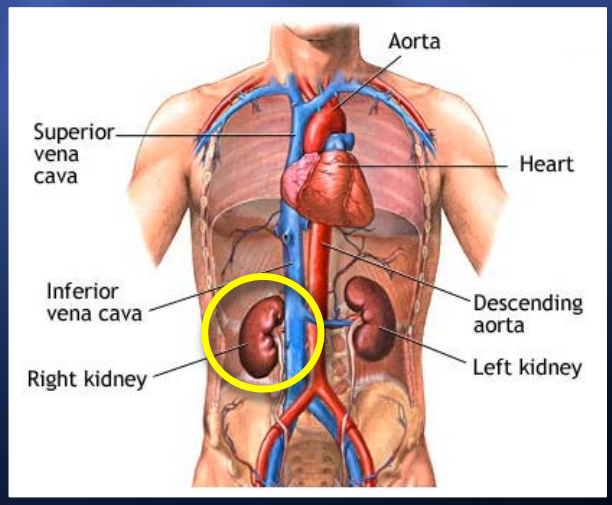
Thinking Analytically is a way of Thinking about a Problem

1. The problem is in the parts, so break it down (analyze)
2. Search for a root cause



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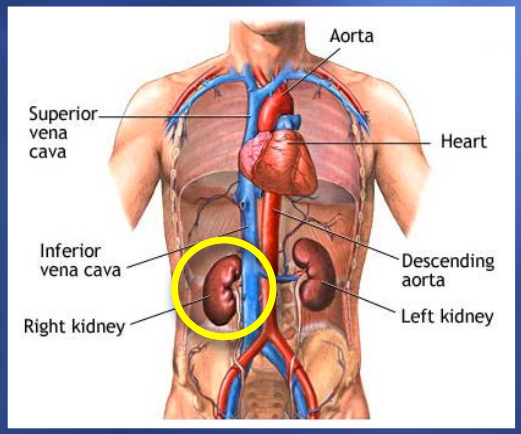
Thinking Analytically is a way of Thinking about a Problem

3. Replace or fix the bad part



4. Problem solved!

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Similarly...

But... is it that simple?

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Issues/Limitations with Best Practices

- Generally, a best practice focuses on 1 element or procedure. But ramping up one element does not necessarily have positive impact on the whole system; rather, it can have no or negative impact.

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Issues/Limitations with Best Practices

- Generally, if you find a procedure (or BP) that works in one community and is said to work in another community – upon inspection you find that the BP in the second community has 10-20 or more steps added to it to accommodate it (to make it work) in the other community.

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Issues/Limitations with Best Practices

- They are imposed, made to fit
- Sustainability?

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Thinking Systemically

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Thinking Systemically is Another Way of Thinking about a Problem: Different Assumptions

1. The problem cannot be broken down into parts.
2. You have to search and understand the forces outside the problem.

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Thinking Systemically is Another Way of Thinking about a Problem

3. You have to understand how the whole system is currently designed; how it functions or fails to function as desired.
4. Create a redesign

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- In Thinking Systemically, the System is the entire community with all its subsystems, organizations, users and stakeholders.

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- This is not a system. The Chain of Survival is a metaphor (or some refer to it as an algorithm or an additive process).
- The system that brings about a positive or negative patient outcome is more than this.
- The "links" above are sort of end-points in a whole series of things that need to come together.

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Smoking ⟶ Heart Disease

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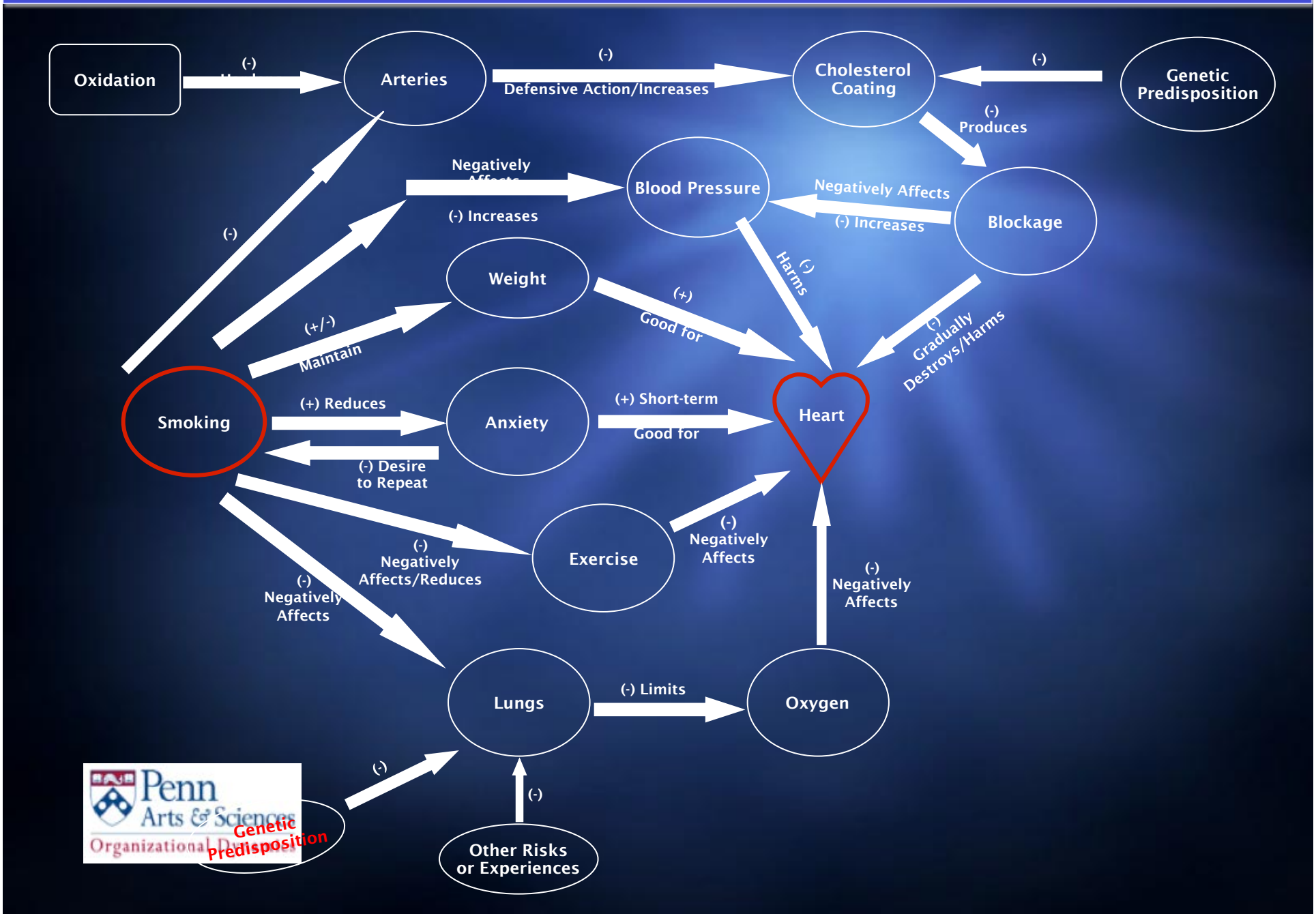
Systemic Relationship Between Smoking and the Heart



The system for survival for SCA is a complicated system and differs from community to community.

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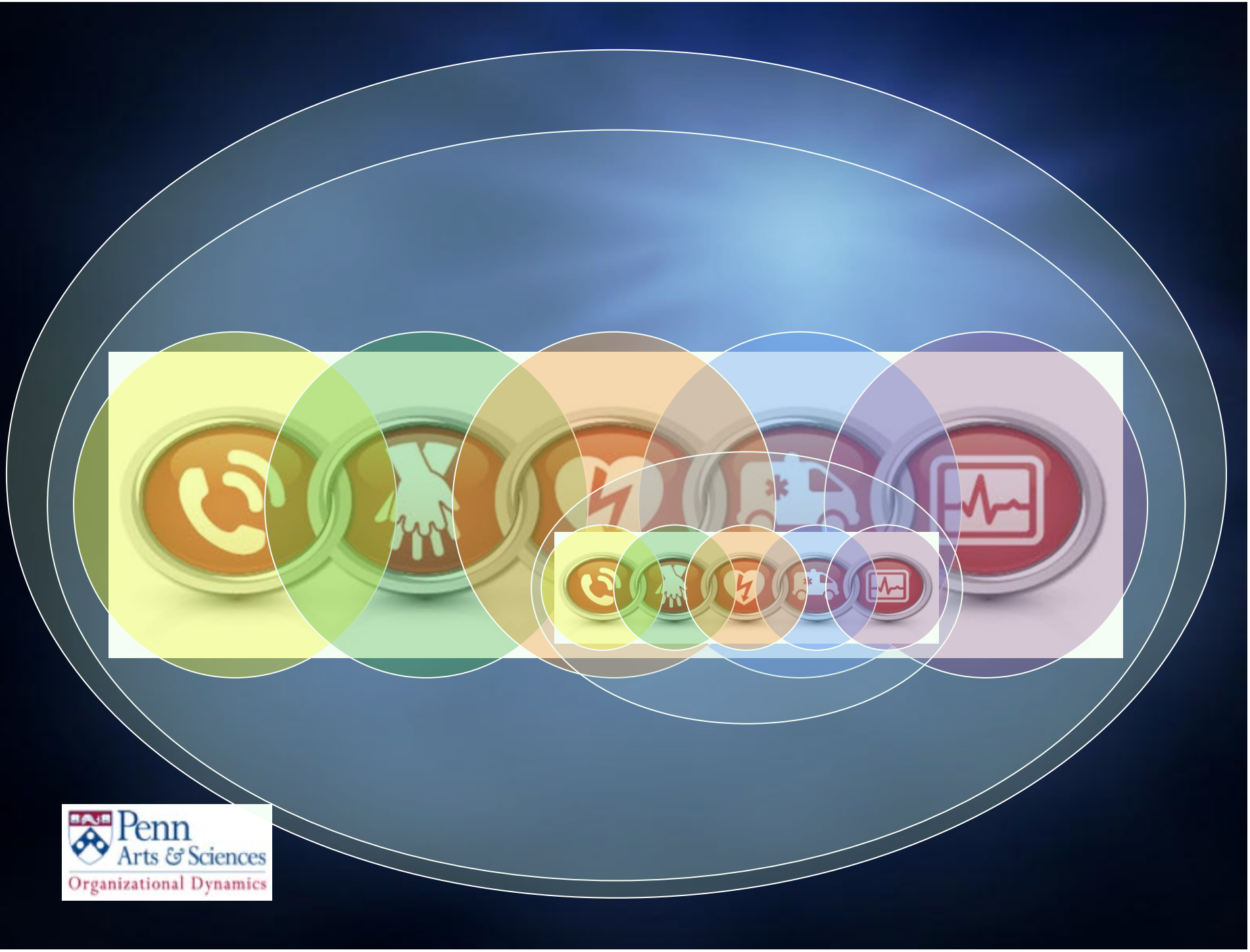
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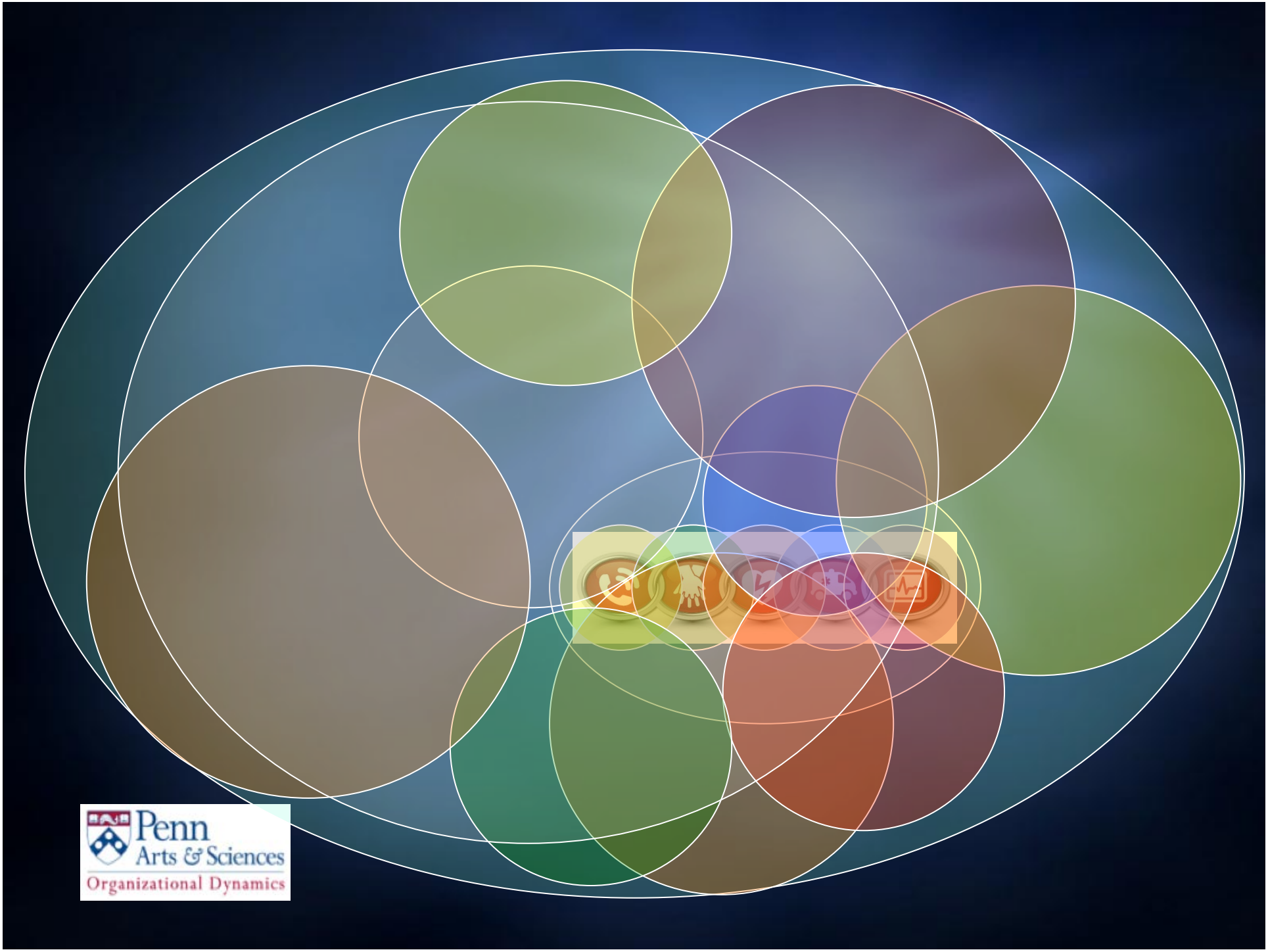
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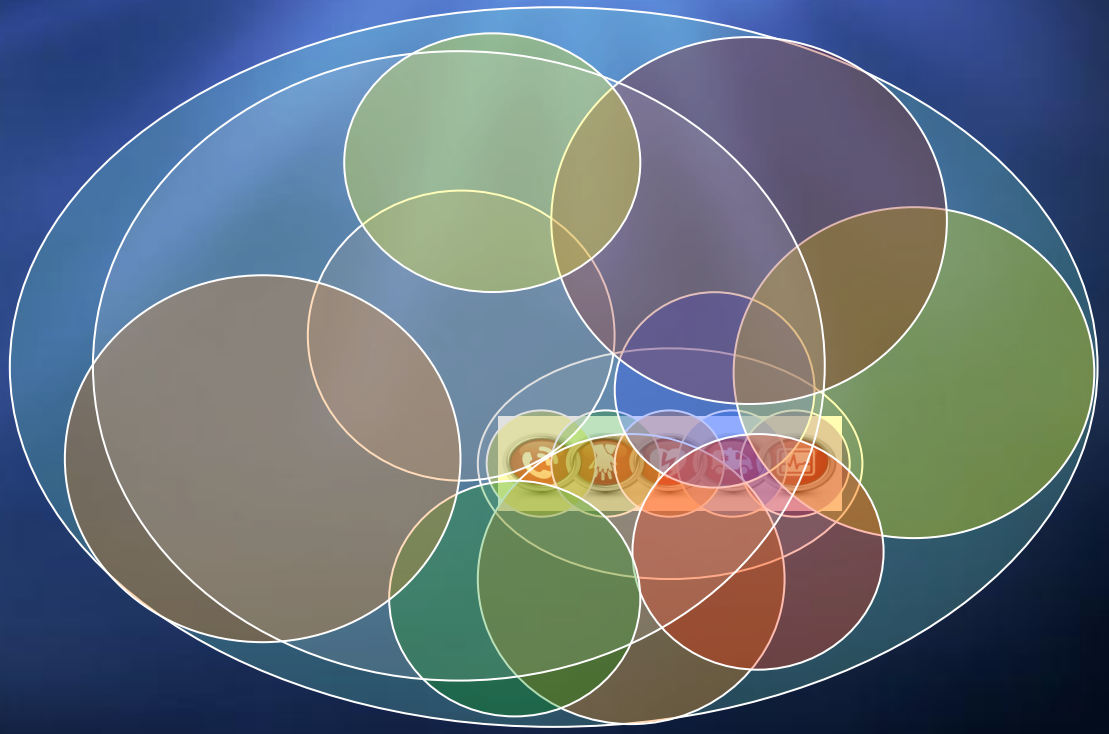
- Each community has a different culture(s), work ethic, financial resources, governance, politics, socioeconomic conditions, psychology…



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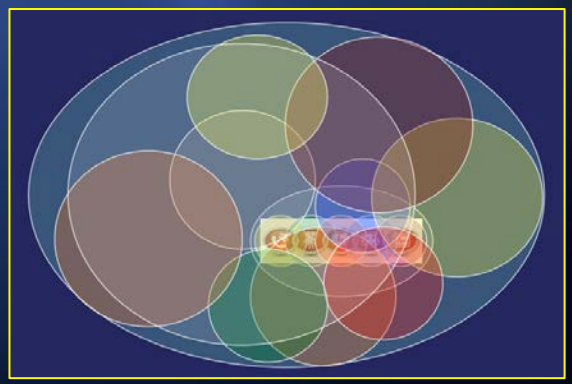
The system for survival for SCA is a complicated system and differs from community to community.



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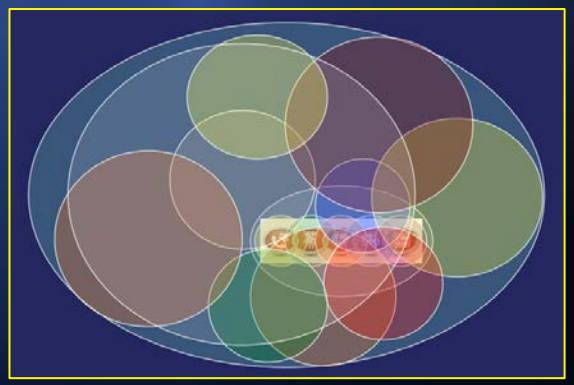
- Each system is looked at as unique (different from the system in the next county or state) – which is how it really is in the real world.
- *They don't do it like we do it.*



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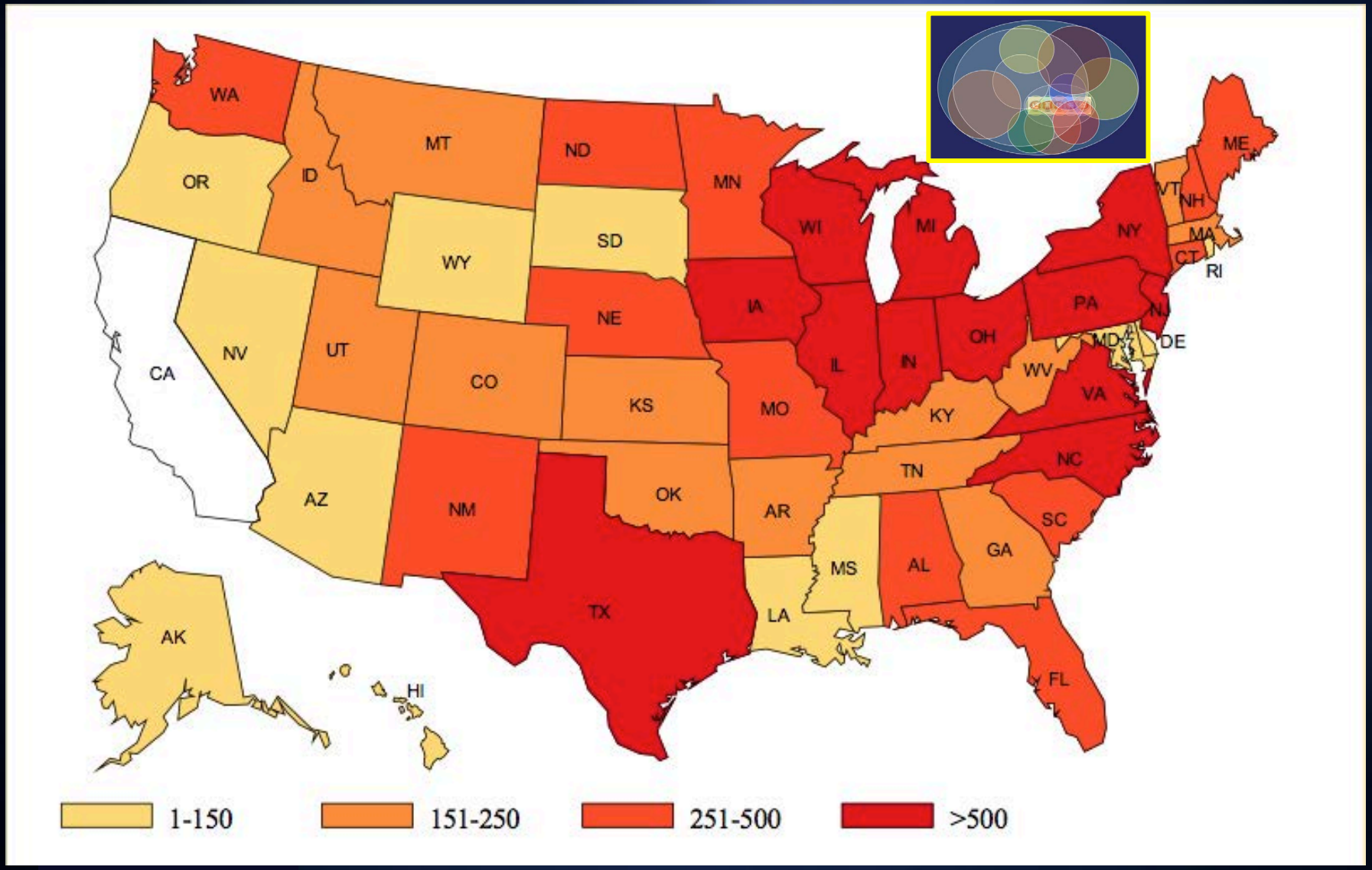
Approx. 19,000 Licensed EMS Agencies



Source: 2011 Natl EMS Assessment Report
UNC Chapel Hill

Our Processes…

Using the framework that systems are quite different/unique,

- *We* do <u>not</u> design or dictate or import the necessary changes:

T*he Expertise is the Stakeholder Community*

The Design is Done by the Users

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Our Processes…

Mess Formulation (Dx)

The users, doers, stakeholders look at the whole system, the whole Mess – not parts or elements, because problems in parts are generally *symptoms* of a much larger system problem overall.

- An example please, Allan . . .

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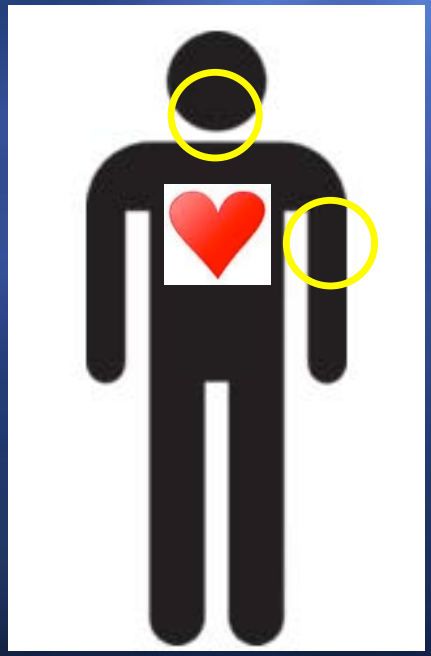
Are these the real problem,
or are they *symptoms* of the problem?



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Our Processes…

Mess Formulation (Dx)

- We facilitate and help figure out the problem.
- We listen to them *(this is working, this is not working, etc.)*
- All statements are important, but in complexity, the problem is commonly not what the org. thinks it is. The words and descriptions are too simple to fully appreciate the problem.

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Our Processes…

Mess Formulation (Dx)

- Until MF is performed, most organizations do not realize that holding on to their original vision is contributing to their failure. Once they give up the original vision, they realize that that was the core of the problem.
- They realize that all of the problems (symptoms) emerged from holding on to their primary vision or principle.
- They can't see it ahead of time. They don't know what the problem is until they have kind of gone all the way through the MF.

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Our Processes…

Idealized Design

- A Design Team of stakeholder/users creates an Idealized Design to *Dissolve* the Problem(s)
  - This means that they redesign the system so that the problems cannot exist.
  - They don't fix and solve – they redesign/alter so the problem cannot occur.
    - They "start from scratch."

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Our Processes…

Idealized Design

- The ID is based on what is desired if those who are part of the problem (stakeholders) could have what they want rather than merely improving what already exists in the current state.
- AND they start with their desired outcome.

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Backcasting (Start with what you want)

Our Processes…

And then…

- We say "Let's now figure out what we can do about it – how closely can we approach the idealized design? And what resources do we need to approach it?
- Then the stakeholders say "In order to do these kinds of things… (and they work together to implement the design).

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Summary

- Who we are . . .
- *Our Processes*

Please join us!

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Google: Penn SCA Survival

braslowa@gmail.com

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