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Leapfrog Group jumps at chance to give consumers health care info

Consumers and hospitals benefit from public information

Consumers have more information available to them to when purchasing dishwashers than they do to find a good hospital. That, says **Suzanne Delbanco**, PhD, is part of what inspires her work as executive director of The Leapfrog Group in Washington, DC, an assembly of 100 employers working to improve patient safety and help consumers make more informed hospital choices.

In January, the group released the results of its first hospital survey, covering 248 hospitals in six regions. **(For results, see chart, pp. 28-29.)** The group asked responding facilities for information on their use of computerized physician order entry (CPOE) systems, whether they use intensive care specialists, and the volumes the facilities have for several specific procedures, including:

- coronary artery bypass graft surgery (CABG);
- coronary angioplasty;
- abdominal aortic aneurysm repair;
- carotid endarterectomy;
- esophageal cancer surgery;
- high-risk deliveries and the availability of neonatal intensive-care units (ICUs).

"The biggest surprise in the survey results was the willingness of facilities to participate," says Delbanco. "Especially since this is a new initiative."

She also was impressed with the number of hospitals that either met Leapfrog standards, or had plans to implement them in the near term. "In urban areas, it is clear that there is a choice of hospitals for consumers that will have these safety practices," says Delbanco.

Despite the few regions covered, the results of the survey were on par with national estimates, Delbanco says. "There are about

10% of respondents that have intensivists, and between 2% and 5% that have CPOEs."

While consumers certainly will benefit from having this information available, the benefits also will accrue to hospitals, says **Michael Langberg**, MD, FACEP, chief medical officer and senior vice president for medical affairs at the Cedars-Sinai Health System in Los Angeles.

"We are a community hospital and believe deeply that we have an accountability to the community," Langberg says. "Having reliable and responsible data to gauge the effectiveness of our institution makes us better."

Secondly, Langberg continues, having comparative data out there and available for all to see has, in the experience of a variety of industries, "added energy to quality improvement efforts. Knowing the information is being made public provides yet another impetus to us to make improvements. We have to face the information, look at it, and find ways to do better."

Fewer variations on a theme

Langberg says being able to see competitor data will help his system see where the mean is, where Cedars-Sinai stands compared to the mean, and what variations there are in performance. "We know that this kind of data assists in eliminating variations in care between institutions and moving the average to the positive side," he says. Langberg cites New York as an example, where information on CABG procedures was made public. Without any regulatory effort, hospitals worked to eliminate performance differences within a couple years.

Within his system, there already are changes taking place that will alter what consumers see on the Leapfrog charts in the future. "We are focusing on CPOE and are due to implement it fully and go live in May," says Langberg.

Like Delbanco, Langberg was most surprised by the number of institutions willing to provide this data to Leapfrog. "In California, 44% of the hospitals that were asked participated. There are an awful lot of surveys [hospitals] have to fill out, and this one was voluntary, so I think the participation was great."

The first results charted by Leapfrog are for the participating hospitals as of Dec. 31, 2001. Among the key findings:

- **CPOE:** While only 3.3% of hospitals currently have CPOE, another 30% indicated they have plans to have it in place prior to 2004, and three of the six regions have at least one hospital that has fully implemented it.
- **ICU physician staffing (IPS) or ICU intensivists:** Of the hospitals submitting responses, 10% have intensivists staffing their ICUs. An additional 18% of responding hospitals indicated plans to implement the practice fully by 2004. Five of the six regions have at least one hospital that has intensivists on staff.
- **Evidence-based hospital referral standards:** Although this standard specifies that patient referrals should be based on either publicly reported risk-adjusted outcomes or hospital volume, Leapfrog only is reporting volumes at this time. Of the submitting hospitals, 12% meet the recommended level of annual experience for coronary artery bypass graft surgery. A third — 31% — meets the coronary angioplasty volume recommendation, 21% meet the recommendation for abdominal aortic aneurysm repair, and a fifth reached recommended volumes for carotid endarterectomy. Fifteen percent meet the esophageal cancer surgery volume recommendation, and 22% have neonatal ICUs that meet Leapfrog specifications. In each of the volume standards, at least one hospital in every region meets the recommendations.

Coming soon to a PC near you

Leapfrog will now update the information monthly. And Delbanco says that as the results are released, more and more hospitals are opting to complete the survey and add their data to the list. "There are big spurts of hospitals working on this for our future updates," she says. "I think

COMING IN FUTURE MONTHS

- Technology update
- Info on top 100 hospitals
- Really simple real-time data
- Developing data management skills

as more hospitals realize that their peers think this is important data, more will participate."

In addition to increasing the data from regions already covered by the survey, Leapfrog will begin adding regions aggressively. Another 10 - 15 regions are due to be added in March. And the group already is looking at additional safety practices for inpatient and outpatient settings to add to later iterations of the survey.

The process for adding those data elements also is changing. "In the past, we went around to patient safety and quality improvement gurus around that country," she explains. "We asked them, 'What are the antilock breaks, airbags, and seatbelts for the health care industry?' They came up with a short list that we knew consumers could understand and that hospitals could put in place. We had strong evidence that this could make a difference."

In the future, however, there are formal partners that will help Leapfrog to develop ideas. They include the Joint Commission on Accreditation of Healthcare Organizations, the National Quality Forum, the National Committee on Quality Assurance, and the Agency for Healthcare Research and Quality. **(See news brief on p. 36.)**

"They'll help us think through the next options. But our first goal is to cover the whole country with the survey we have," Delbanco says. But she estimates that will take a couple more years. "The more people who get their feet wet, the more we learn, and the easier it is for others to follow."

Langberg thinks that all of the standards Leapfrog espouses are leaps, and any movement toward them is a success for the hospital or health system reporting the attainment. "I don't think anyone expects 100% of hospitals to have met these standards," he says. "They are big goals to reach, and personally I was pleasantly surprised by the numbers that met individual components of these goals."

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• *To see the complete data for each region, visit The Leapfrog Group web site at www.leapfroggroup.org.]* ■

NRMI data impacts care on many different levels

Moving with the times makes data more relevant

For more than 11 years, the National Registry of Myocardial Infarction (NRMI) has been collecting data on heart attack patients around the country. It is one of the largest patient registries in the world, with information on more than 1.8 million patients and 1,600 hospitals, says NRMI project manager **Kathee Litrell**, PhD, RN.

"This is a prime example of providing value-added services for the cardiovascular community," she says. "We provide frequent feedback for hospitals to assess their own practices, as well as information on how heart attack patients are being taken care of. We have aligned what we do to the needs of our customers."

Recently, Litrell shared what NRMI — funded by biotech company Genentech in South San Francisco, CA, but run independently of the company — does with others interested in and involved in patient registries at a conference on the subject. She says among the things NRMI does particularly well is changing with the times. "Every iteration of NRMI changes as guidelines change," she notes. "We keep current with what people should be tracking — whether it is aspirin use, the use of ACE inhibitors and beta blockers, or how many patients get primary PTCA [percutaneous transluminal coronary angioplasty]. All of these therapies show survival benefit and are tracked for all hospitals in our study."

Hospitals using the data can look at those elements for their state, the nation, or just for like hospitals. "We provide ample benchmarking opportunities," says Litrell. **(For more on the data elements collected by NRMI, see box on p. 30.)**

Knowing that the work of creating a registry never is finished also is one of the key elements to making one successful, according to Litrell. "It is critical to listen to customers and see what they perceive as their needs and then go out and meet them." For instance, NRMI recently heard from pharmacists that they wanted information on every drug therapy collected by the registry. "So we went out and developed a report," she says.

When customers said they wanted the ability to capture data electronically, NRMI implemented

Continued on page 29

Initial Survey Results By City or Region

Atlanta

- Fifty-two percent of invited hospitals (16 of 31) responded to the survey.
- Fifty-six percent have fully implemented at least one of Leapfrog's recommended patient safety practices.

Of the hospitals responding:

- None has fully implemented computerized physician order entry (CPOE), but six say they plan to by 2004.
- None has fully implemented the intensive-care unit (ICU) physician staffing practice, but three say they plan to staff intensivists by 2004.

Evidence-based hospital referral:

— Four meet the coronary artery bypass recommended annual volume.
— Four meet the coronary angioplasty volume recommendation.
— Three meet the abdominal aortic aneurysm repair volume recommendation.
— Three meet the carotid endarterectomy volume recommendation.
— Two meet the esophageal cancer surgery volume recommendation.
— Six meet Leapfrog specifications for neonatal intensive-care units (NICUs).

California

- Fourty-four percent of invited hospitals (150 of 338) responded to the survey.
- Responding hospitals account for an estimated 60% of total discharges from hospitals invited to participate in the survey (this statistic is not available for other regions).
- Fifty-two percent of hospitals in California submitting responses have fully implemented at least one of Leapfrog's recommended patient safety practices.

Of the hospitals responding:

- CPOE: Six have fully implemented CPOE, and 33 say they plan to implement CPOE fully by 2004.
- IPS: 14 have fully implemented the IPS practice and 13 say they plan to staff intensivists by 2004.

Evidence-based hospital referral:

— Ten meet the coronary artery bypass recommended annual volume (many California hospitals voluntarily report outcomes data for this procedure — see www.HealthScope.org).
— Thirty-nine meet the coronary angioplasty volume recommendation.
— Twenty-five meet the abdominal aortic aneurysm repair volume recommendation.
— Twenty-four meet the carotid endarterectomy volume recommendation.
— Twenty-three meet the esophageal cancer surgery volume recommendation.
— Thirty-two meet Leapfrog specifications for the NICU.

East Tennessee

- Ninety-two percent of invited hospitals (23 of 25) responded to the survey.
- Fifteen — 65% — of hospitals in the region submitting responses have fully implemented at least one of Leapfrog's recommended patient safety practices.

Of the hospitals responding:

- CPOE: One has fully implemented CPOE, but 12 say they plan to implement CPOE by 2004.
- IPS: One meets the IPS practice, and six say they plan to staff intensivists by 2004.

Evidence-based hospital referral:

— Five meet the coronary artery bypass recommended annual volume.
— Eleven meet the coronary angioplasty volume recommendation.
— Ten meet the abdominal aortic aneurysm repair volume recommendation.
— Nine meet the carotid endarterectomy volume recommendation.
— Three meet the esophageal cancer surgery volume recommendation.
— Five meet Leapfrog specifications for the NICU.

Minnesota

- Sixty percent of invited hospitals (28 of 47) responded to the survey.
- Thirty-nine percent of hospitals in Minnesota submitting responses have fully implemented at least one of Leapfrog's recommended patient safety practices.

Of the hospitals responding:

- CPOE: One has fully implemented CPOE and nine say they plan to implement CPOE by 2004.
- IPS: Five have fully implemented the IPS practice and nine say they plan to staff intensivists by 2004.

Evidence-based hospital referral:

— Four meet the coronary artery bypass recommended annual volume.
— Ten meet the coronary angioplasty volume recommendation.
— Four meet the abdominal aortic aneurysm repair volume recommendation.
— Five meet the carotid endarterectomy volume recommendation.
— Six meet the esophageal cancer surgery volume recommendation.
— Three meet Leapfrog specifications for the NICU.

St. Louis

- Three percent of invited hospitals (one of 31) responded to the survey.
- That hospital has fully implemented the ICU physician staffing practice and meets five of the volume standards.

For the one hospital responding to date:

- CPOE: It does not meet the CPOE standard, but it plans to implement CPOE by 2004.
- IPS: It does meet the IPS standard.

Evidence-based hospital referral:

— It meets the coronary artery bypass recommended annual volume.
— It meets the coronary angioplasty volume recommendation.
— It meets the abdominal aortic aneurysm repair volume recommendation.
— It meets the carotid endarterectomy volume recommendation.
— It does not meet the esophageal cancer surgery volume recommendation.
— It meets Leapfrog specifications for the NICU.

Seattle-Tacoma-Everett

- Ninety-two percent of invited hospitals (23 of 25) responded to the survey.
- Fifty-seven percent of hospitals in the Seattle area submitting responses have fully implemented at least one of Leapfrog's recommended patient safety practices.

Of the hospitals responding:

- CPOE: None has fully implemented CPOE, but 12 say they plan to implement CPOE by 2004.
- IPS: Three have fully implemented the IPS practice, and 12 say they plan to staff intensivists by 2004.

Evidence-based hospital referral:

— Four meet the coronary artery bypass recommended annual volume.
— Nine meet the coronary angioplasty volume recommendation.
— Eight meet the abdominal aortic aneurysm repair volume recommendation.
— Five meet the carotid endarterectomy volume recommendation.
— Three meet the esophageal cancer surgery volume recommendation.
— Five meet Leapfrog specifications for the NICU.

Source: The Leapfrog Group, Washington, DC.

such a feature. Now users say they want a data analysis tool so that hospitals can analyze data for subpopulations that aren't part of the NRMI's routine reports — older women, for instance. As of April, Litrell says, that feature will be added to NRMI.

For those who want to avoid duplicate data collection and reporting, NRMI has altered its database so that it is will be available to users for reporting core measures to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Final verification by JCAHO is anticipated before hospitals have to start reporting core measures data in July.

Data Collected by NRMI

- Demographics and Medical History
- Event Timeline
- Presentation Characteristics
- Transfer-In
- Reperfusion Strategies
- Reasons Reperfusion Strategies Not Utilized
- GP IIb/IIIa Inhibitor
- Other Procedures
- Stroke
- Clinical Events
- Medication/Therapies
- Contraindications to Key Therapies
- Information on Discharge
- Discharge Status

Source: NRMI, South San Francisco, CA.

There isn't a cost for any of the routine quarterly reports on all of the acute myocardial infarction (AMI) measures. For some of the extra reports or new services, there are fees, although Litrell says they are nominal — about $50 for data diskette services, for example. "This is just a great partnership for us with cardio hospitals," she says.

What makes a good registry is having information that applies to a large number of hospitals and collecting data that they can use, Litrell says. "Any hospital that sees a lot of AMIs and provides cardiac services will be interested in this data," she notes. "If the focus is women's health, maybe they aren't interested. But otherwise, it offers great opportunities."

Looking at the trends over time can show just how much having this data available can impact patient care. Since NRMI began in 1990, median door-to-drug times have decreased from 60 to 34 minutes. Many hospitals now are within the national goal of treating patients in less than 30 minutes. As health care organizations become more efficient and effective at treating patients with AMI, hospital lengths of stay have become shorter, with patients receiving reperfusion treatments such as thrombolytic therapy, primary PTCA, and early coronary artery bypass graft surgery benefiting the most.

And hospitals also have been successful at using risk-reduction therapies for coronary artery disease for secondary prevention of future cardiac events. One reason: improved use of several important medications within the first 24 hours after diagnosis. **(For more on these successes, see graphs on p. 31.)**

Hospitals have used the data to improve several key areas of operation, Litrell says, from decreasing the time from onset of symptoms to hospital arrival and treatment, to increasing the use of beta-blockers by creating critical pathways.

"The data has been important because it has increased awareness in the hospitals of all the key therapies that an AMI patient should receive — not just the drugs [Genentech] produces, but all the class-one indications for AMI," she says. "It even looks at glycoprotein 2b/3a inhibitors. And knowing where you stand compared to national, state, and like hospitals helps to drive quality improvement and improve the impact you have on patients."

There have been other efforts to influence AMI treatment, she continues. "In the early 1990s, HCFA did a project where they did a one-time review of charts. But doing that and getting a report later doesn't necessarily have an impact on how you treat patients. We provide routine feedback. And with our new data analysis feature, you can check where you are whenever you input data."

The data from the registry also has influenced research. There are more than 50 studies and more than 100 abstracts based on the NRMI, Litrell says. "Because the database is so large, you can look at areas that are hard to view in a randomized control trial — minorities and women, for example. I know that we have helped hospitals and the whole cardiovascular community with the publications we have generated."

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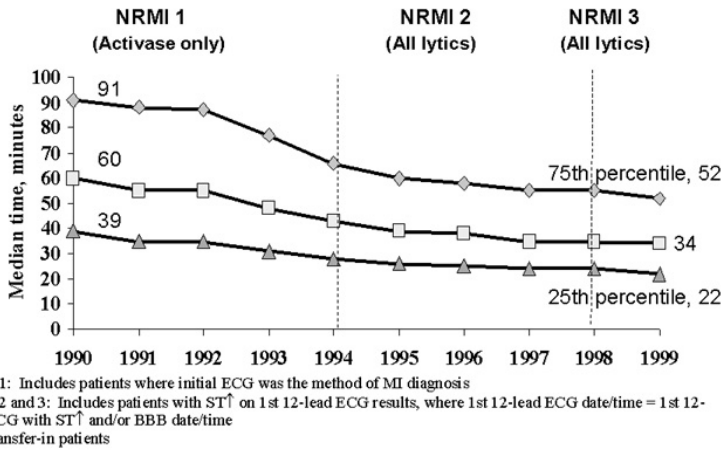
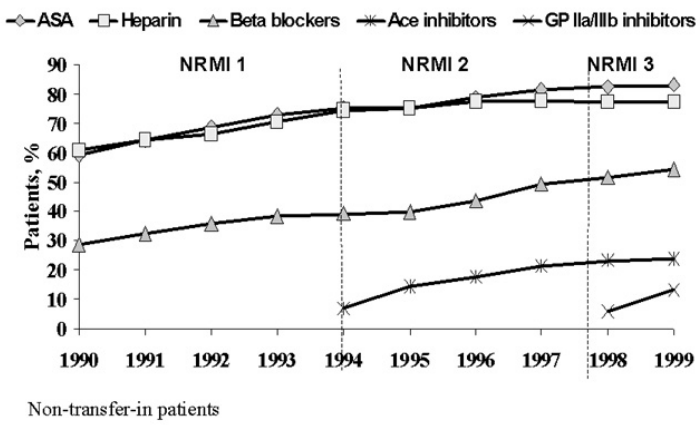
A schedule change brings peace to rural Montana OR

It took selling, but block usage improves efficiency

For four years, **Mary C. Seitz**, RN, worked as an operating room (OR) nurse at the 45-bed Northern Montana Hospital in Havre. And for four years, there was a lot of down time, she says. "Staff were scheduled from 6:30 a.m. to 3:30 p.m., and after that, there was a call crew on." But physicians



Source: National Registry of Myocardial Infarction, South San Francisco, CA.



Source: National Registry of Myocardial Infarction, South San Francisco, CA.

supposedly tied up, only to have the slots canceled later."

The haphazard scheduling even caused problems for staff who had to clean and restock the ORs for the next procedure, says Seitz. "They had to make sure that the equipment was right for the next surgeon coming in." It was, Seitz concluded, an extremely inefficient way to operate operating rooms.

After four years, Seitz was made operating supervisor and was delighted when the two top producing surgeons approached her and asked her to take a crack at creating a block schedule for the rooms. "I'd never even heard of block scheduling," she says. "But I had thought that using the room in solid chunks of time would be a good thing." She called friends at other hospitals and asked what they did. She researched the idea on the Internet, making particular use of the Association of perioperative Registered Nurses web site (www.aorn.org).

"I created a mock schedule on paper over the course of a couple weeks," Seitz says. "I figured out how much operating time each physician had each year and averaged out their weekly working minutes in the OR. The biggest producers got the best time slots."

There were three operating rooms in the hospital that were open full time five days a week. "But from my calculations, I knew we could really do what we were doing in two rooms," she says. That would leave the third room open for emergent cases. "There were times when physicians would get bumped out of their time because we had an emergency coming in. But with the new schedule, we could leave a room open just for those cases."

Such a change also could help the anesthesia team. "We have three nurse anesthetists on full time, and this would let the third person be available for the emergency room, X-ray, or obstetric

didn't schedule their cases to fill all the slots for the three operating rooms during the scheduled OR time. Instead, there were a lot of after-hours operations. "They were working until all hours of the night because the physicians wanted to stay in their offices."

For the four years she worked as an OR nurse, physicians used the operating rooms on a first-come, first-served basis. "Whatever doc called first got the perfect time for him," Seitz explains. "They would schedule times before they had cleared it with the patients. We had a lot of rooms

sedations. They all would never be tied up at once based on the OR schedule."

Physicians were given days — or partial days — when they were in surgery. Rather than running from office to hospital and back again, they had complete blocks of time when they used the ORs. "It was a hard idea for the office staff at first," Seitz says. "They were used to scheduling the docs on a piecemeal basis. Now they had to have surgery days or surgery afternoons. It was a harder idea for them to grasp than I thought it would be."

Nice idea, but . . .

While on paper the ideas looked grand, Seitz still had to sell the new scheduling system to the physicians, OR staff, and office staff. "I had no idea what a ruckus this would raise," she says. "Two physicians wanted it and seven others weren't happy at all."

At the first meeting to float the idea, Seitz presented all the statistics she had gathered. "They questioned every bit about their time," she recalls. Seitz asked all who came to that initial meeting to provide feedback. If a physician didn't call, write, or e-mail her, Seitz made it a point to contact him or her. "The only ones who didn't show up were low producers, and even though I tried repeatedly to get their input, they never communicated with me about it," she notes.

After letting the physicians mull over the statistics and offer criticism, Seitz created a sample block schedule, got more comments, and provided training for the OR and office staff.

"One of the benefits we were looking for was a reduction in turnover time," she says. "I wanted it done in less than 30 minutes." In a big city, that might seem a long time, but the nurses have to do the turnover themselves at Northern Montana Hospital. There are no specific turnover teams. By creating blocks of time that were all orthopedic or all laparoscopic, some efficiency immediately was achieved. "It really minimized equipment issues for us. There was no moving beds or equipment every time a surgery ended."

When, during training, the OR staff said they couldn't meet the 30-minute goal, Seitz showed them how. "It really helped that I was a working manager," she notes.

She then introduced a three-month trial of the schedule, holding monthly meetings so that rules could be tweaked and concerns aired. For instance, Seitz learned that there had to be open times specifically inserted into the OR schedule. "You can't just create a complete schedule months in advance. You have to have some blank spots in case something comes up."

If physicians were out of town on their scheduled day, rather than waste the eight hours by leaving the OR empty, that block opened up for general use by all the doctors on a first-come, first-serve basis. Open days were freed for that purpose three days in advance of a day when nothing was scheduled. "That solved the problem of nonemergent, but urgent cases," says Seitz.

One problem that arose during the three-month trial was physicians stacking their schedules to inflate their average weekly OR minutes. "Every single procedure they could schedule and do was scheduled and done," she says. But, Seitz notes, inflation of estimated surgery times stopped. "The physicians follow themselves in a block schedule," she says, explaining that there is no point in saying a 60-minute procedure is going to take 90 minutes because the only people the physicians would shortchange would be themselves.

After the initial trial period, the statistics were reviewed, and they continue to be evaluated periodically. "The funny thing was that the physicians who had the most problems with the idea in the first meeting never told me they were wrong or that it was a great idea. But they certainly got really quiet."

Seitz now works in the office of one of the surgeons, but the hospital has kept intact the block scheduling that she implemented more than two years ago. The whole idea was something of a fluke, but once it got rolling, Seitz says, it seemed to solve a whole host of problems. For instance, in the recovery room, there was no one scheduled for after hours. If a surgery came in and the call team was requested, a nurse had to be pulled from somewhere else in the hospital to be in recovery.

Overtime was cut. An overstaffing issue was addressed. Salary figures declined. Utilization was more efficient. "But that wasn't the goal at all," Seitz says. "I thought morale was low and that doing something at 7 p.m. when we had sat for hours drinking coffee earlier was silly."

Still, the numbers speak for themselves: productivity has increased 15%, and two ORs are used at 57% for an 80-hour week, compared to 28% when all three were in use for 120 hours per week. Overnight stays by patients are less frequent, with many often released the evening after surgery.

The success, Seitz says, is credited in part to having senior administrative staff such as the nurse director and CEO backing her, and doing it

verbally in front of the physicians. Having two of the nine physicians on her side also helped. "You can't do this if no doctor wants it," she says.

Physicians are scientists, and Seitz said having the data available to determine which doctors did what in the operating rooms helped convince some of the skeptics. "They had to really think about how much time they needed in the OR," she says. "And I also think it made them reevaluate what they wanted their practice to be."

Lastly, she says that being a working manager was important. "I think a lot of managers will hate me for saying that. But I worked every day in the OR. I got in there and did it with the staff. I think that helped them learn and understand that I wasn't doing something that would make their lives more difficult."

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See an MD in 30 minutes or your money back

A unconventional idea that works for a NJ hospital

It almost sounds like an ad for a popular pizza chain — 30 minutes or your money back. But for more than three years at CentraState Hospital in Freehold, NJ, the emergency department (ED) has been promising patients that they will see a nurse within 15 minutes and a doctor within 30 minutes (15/30) or they don't pay. Amazingly enough, it's working. Fewer than 10 patients have had their bills waived, says **Michael Jones**, MD, FACEP, FAAEM, chairman of the department of emergency medicine at the 240-bed facility in central New Jersey.

The idea was the brainchild of the head of the Robert Wood Johnson Health Network, with which CentraState is affiliated. "I told him that even Domino's [Pizza] didn't do this any more, but he was insistent," says Jones. "I can tell you I had three or four sleepless nights over this."

But the more he thought about, the more Jones thought it could work. "There are artificial lulls and booms in an emergency department," he explains. "The peaks and troughs are created by the registrar and triage nurses. Unless you have a bus accident, you don't have multiple patients descend on you between 9:15 and 9:30 a.m. They trickle in. So now we have a program where as they come in, we get them into the department."

At first, it was tough. By the time a nurse had seen the patient, physicians had only seven or eight minutes to get to him or her. Triaging was taking too long. So the hospital created an abbreviated triage sheet, and triage is now done at the bedside. Registration occurs at the bedside as well, in 90% of the cases. In the other 10%, a family member does it at the front desk.

Jones says that there is a strong belief that there just aren't enough emergency department physicians and that a three- or four-hour wait is just the norm. "But in New Jersey, at least, it's illegal for a patient not to be seen within three hours," he says. "And this is still broken on a routine basis."

If there is a manpower issue, then Jones says EDs should just beef up their staff. "I guarantee you that if you do this, more patients will come," he says. And he should know. The ED at CentraState instituted a pediatric ED program at around the same time the 15/30 program started. "Usually, the emergency pediatricians were in the call room watching television. So we created scripts for them and when we needed help, we got them involved as patient greeters."

One day, however, Jones was called in his office and asked to be a greeter. "I asked where the peds docs were. But they were swamped. We added a service and the patients came. I never want to hear it uttered that if an emergency department adds more docs, they won't have the patient volume to pay for it. I guarantee that if a facility goes to a 15/30 program like us, they will take patients from other facilities. We have patients come to our ED from all over the area." Indeed, he says, patient volume in the ED has increased by around 11% per year since the program's inception in 1998.

Jones has put his money where his mouth is and has increased staffing. Where once there were six physicians, now there are 15 physicians and four nurse practitioners. To free the physicians up for more time to see patients, there is a scribe program to handle some of the administrative paperwork that was eating into patient time. "An added bonus is that the people who do that work not only cost less per hour than the doctors, but they make sure the documentation is correct."

Greeters no longer are needed in the ED. Patients typically see the physician who will be treating them. The initial meeting, which satisfies the 30-minute rule, may only consist of a physician ordering labs, "but the patient feels more comfortable knowing a physician knows something about

their condition," says Jones. "I think, too, that it's important to prevent an initial negative impression created by a prolonged wait. No matter how nice the nurse or docs are, after a three-hour wait in a waiting room, it's going to be hard to overcome a bad feeling."

And when the deadlines aren't met? Jones says he told the doctors that it has to be a team effort, and that all the docs on the team were to pay $50 into the hospital library fund every time the 30-minute deadline wasn't met — regardless of which physician was responsible for the delay. "The first time it happened, I was on. I whipped out my $50 and they all realized it was for real."

Jones gets a report when the deadline isn't met and reviews the charts with the treating physicians. The patient advocate and nurse manager are also involved, and the billing company is called and told to erase the bill. "It just isn't submitted to the insurance company," he says. The two other hospitals in the network that the idea was foisted upon have dropped the program, but Jones is a true convert. "We really make this work," he says.

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CQI 'business as usual' is no help for patient safety

Traditional approach weak on anticipating errors

Ever since a landmark report by the Institute of Medicine in Washington, DC, both health care quality managers and oversight agencies have been placing a greater focus on patient safety. However, observers say, addressing patient safety improvement with a traditional continuous quality improvement (CQI) approach may not be the way to go.

Some say the fault lies within CQI itself, while others blame inadequate implementation, but they all agree that "business as usual" is not the way to improve patient safety. "CQI mechanisms to control risks have not been entirely successful because CQI does not allow for human error," says **Patrice L. Spath**, of Forest Grove, OR-based Brown-Spath & Associates. "CQI expects people to be infallible."

"If we look at quality as it has been implemented in the past, we won't be successful in reducing patient errors," adds **Monica C. Berry**, BSN, JD, CPHRM, president of the Chicago-based American Society for Healthcare Risk Management (ASHRM).

"The whole notion of quality in the past has become the *idea* of doing it, so it became an end rather than a means. In whole process of 'just doing it' what has happened over time is that we have gotten lost in that process and fallen down in the implementation."

Spath asserts that in the health care setting there are two distinct aspects of CQI, each of which has its shortcomings. One affects the culture of the organization, the other relates to CQI project work.

On the cultural side, she says, organizational commitment is lacking. "What has happened is that a lot of administration leaders saw CQI as synonymous with Joint Commission requirements and pushed it down to people lower in the organization," she explains.

"They gave it to the quality manager, or perhaps to the risk managers, and expected individual managers in each department to improve their processes. Quality managers knew what to do; they had the ownership, but they didn't have the power to effect organizational change

like senior leaders do. Nor did they have the same power to make others accountable."

When it comes to actual process improvement, says Spath, a lack of training combined with an inherently flawed approach create a formula for failure. "Most of our managers are people who moved up into management from on-line positions and did not get the training they needed in how to improve processes," she declares. "Second, the solutions were not necessarily the best fixes in terms of improving patient safety; a lot of the focus was on improving the efficiency of process."

Any number of CQI projects have been undertaken to improve outpatient testing, or reduce waiting times, to improve patient flow in the organization, to get test reports out more quickly, or to improve customer service, Spath notes. "What we didn't do is look at the mistakes that could be made in that superefficient model that can result in patients not getting the right test, for example," she offers.

"Let's say an old lady comes into radiology for an IVP [intravenous pyelogram]. She's checked in and she sits down. Another lady is scheduled for abdominal X-rays, and sits down without checking in. The radiology tech calls the name of the first lady, who doesn't hear him, and the second lady stands up. The tech puts her in the dressing room, and does an IVP on the wrong person. So, one patient did not do what we expected them to, and the radiology tech did not check the patient's ID. We didn't ask 'What if?' questions during the process, because CQI just doesn't include that focus on human error."

So what CQI has given us, she concludes, are more efficient processes, but not necessarily error-resistant processes.

Effective or not, CQI and patient safety improvement are stuck with each other, says Berry. "Quality and risk management are joined at the hip," she asserts. "Neither one will be successful without a commitment to approach problems in a collaborative way."

Spath offers a number of suggestions for supplementing CQI to make patient safety improvement initiatives more effective. "There are techniques like reduced reliance on memory, simplifying the process — not something we have traditionally looked at," she says.

"The Joint Commission wants us to evaluate the culture of the organization as it relates to patient safety — to measure the commitment throughout the organization and then to take appropriate action. This is not something we did as part of [total quality management]."

Leaders must establish quality and safety standards and hold their people to them, Spath says. "The quality manager's role should be that of facilitator; they should serve as an in-house consultant," she explains.

"They will gather up the data to see if standards are being met, to look at aggregate information to identify opportunities for improvement. They should generate ownership to provide a support function, but not to make it happen. By taking on all the responsibility for quality, everybody else in

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the organization relinquishes it. We can't take on the responsibility for patient safety."

Rather, she advises, upper managers should build constant patient safety improvement into a list of performance expectations for all employees.

Berry would like to see the whole CQI process streamlined. "We've gotten caught up in the length of the process; it takes forever to get from phase one to that phase where you monitor the implementation," she explains. "That length of time is something we don't have when it comes to changing patient safety initiatives."

How can we cut the project time down? "We need to look at things and develop a much more rapid cycle," Berry recommends. "I believe that was probably part of the Joint Commission requiring root-cause analysis to be completed within 45 days."

In the final analysis, says Spath, any CQI project must impact patient outcomes and satisfaction. "What this is really getting at is, are we really making the patient any healthier? That's the real lynchpin between quality and risk," she says. "Leaders can no longer ignore their responsibility." ■

NEWS BRIEF

JCAHO signs agreement with the Leapfrog Group

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, has signed a partnership agreement with The Leapfrog Group and will provide input on the group's future patient safety initiatives. "The Joint Commission welcomes this opportunity to collaborate with the purchaser community in support of patient safety," says **Dennis S. O'Leary**, MD, president of the Joint Commission.

"The Leapfrog Group's work symbolizes the priority accorded to patient safety by those key stakeholders — purchasers, accreditors, and health care providers — who will eventually have the greatest impact in making improvements happen."

In the first major collaboration effort between the two parties, the Joint Commission has begun work with Leapfrog leaders to pursue the identification of a specific set of ICU-related outcome and process measures. These measures may eventually be used to supplement or even replace the current Leapfrog measures that recommend that hospitals have board-certified or board-eligible intensivists. **(See this month's cover story on the Leapfrog Group and its efforts.)** ■