PATIENT SAFETY ALERT™
A quarterly supplement on best practices in safe patient care

Early results of Leapfrog hospital survey promising

Nearly half of institutions contacted provided replies

In mid-2001, a total of 525 hospitals in six regions around the country were invited to complete a web-based patient survey by the Business Roundtable's The Leapfrog Group in Washington, DC.

Now, the first returns are in, and The Leapfrog Group's top official says she is encouraged by what she sees.

"Overall, the results are very promising," said **Suzanne F. Delbanco**, PhD, executive director, during a press briefing held Jan. 17, 2002. "Nearly half of the hospitals that we invited to take the survey submitted responses (241, or nearly 48%). That's an enormous achievement."

53% meet standards

What's even more exciting, she added, is that of the hospitals that responded, 53% already met at least one of Leapfrog's standards for three key safety practices: The use of computerized physician order entry (CPOE); staffing intensive care units (ICU) with intensivists; and evidence-based hospital referral.

By practice, the results broke down as follows:

- Of the responding hospitals, 3.3% have instituted CPOE.
- About 10% of the responding hospitals have fully implemented the intensivist model, and another 18% indicated plans to enlist intensivists by 2004.
- In terms of specific volume recommendations, 12% meet Leapfrog's recommended level of annual experience for coronary artery bypass graft; 31% for coronary angioplasty; 21% for abdominal aortic aneurysm repair; 20% for carotid endarterectomy; 15% for esophageal cancer surgery; and 22% have neonatal ICUs that meet Leapfrog's recommendations.

The six targeted regions include urban hospitals in Atlanta, California, East Tennessee, Minnesota, St. Louis, and Seattle-Tacoma-Everett. Three of the six regions (California, East Tennessee, and Minnesota) reported having at least one hospital with a fully implemented CPOE. Five of the six (California, East Tennessee, Minnesota, St. Louis, and Seattle) have at least one hospital that has fully implemented the ICU physician staffing or intensivist practice.

The greatest impact

The three standards were selected because, according to Leapfrog members, the greatest impact could be made on patient safety in the shortest period of time. If implemented, nearly 60,000 lives could be saved each year and more than half a million serious medication errors could be prevented, the group claims.

"CPOE has been shown to reduce serious medical errors by more than 50%. Staffing intensive care units with intensivists has been shown to reduce the risk of patients dying in the ICU by more than 10%. Appropriate referrals for high-risk procedures and conditions can reduce the risk of a patient dying by at least 30%," Delbanco declared.

Private industry is an integral part of this effort, and companies have their own incentives for participating, noted **Charles R. Lee**, chairman and co-CEO of New York-based Verizon Communications.

"We have two standpoints. First, we care about our employees and our retirees, and their

dependents, and their families," he said.

"The other one is the whole matter of quality. Quality is a never-ending journey. You're never satisfied with the current results; you always want to get better and do better. It's a standard practice in big corporations. We hope that we can, over time, develop relationships with some of the institutions that are involved in the medical profession to move them forward."

Sharing the information

Now that Leapfrog has this survey information, the next step is to share it with specific stakeholders. "Our members are going to share it with their employees, retirees, and dependents, through internal communications like newsletters, benefits materials, and corporate web sites," Delbanco said.

She also noted that Leapfrog, with the help of the Portland, OR-based Foundation for Accountability, has created a consumer test and tool kit that members, health plans, physicians, and others can use and customize to educate consumers. The hospital information is being made available to the public on the group's web site www.leapfroggroup.org.

Delbanco noted that sharing these results fulfills a commitment not only to consumers but also to the hospitals that took the time to complete the survey.

"Sharing this information is only part of what we're doing with hospitals," she added.

"In some cases, our members will offer financial incentives to hospitals to implement the Leapfrog practices, as well as other types of reward and recognition," Delbanco said.

Such strategies are, of course, intended to engender change at the institutional level, which is critical to the success of Leapfrog's efforts. The survey information "is only significant if people change behavior," noted **John Rother**, director of policy and strategy for the Washington, DC-based American Association of Retired Persons (AARP).

"It's only significant if the hospitals respond not only to a request for information but start to implement these changes to save lives." **(Some institutions and health care organizations already have; see article, at right.)**

It's also important for all of us, as patients and family members, to pay attention to the information and make decisions based on it, Rother noted.

"Do not send your parent to a hospital that's refusing to give this kind of information," he warned. "Do not send a family member to a hospital for an operation where we know that another hospital in your area does it better — a lot better. These choices are life and death decisions."

[For more information, contact:

- ***Suzanne F. Delbanco**, PhD, Executive Director, The Leapfrog Group, c/o the Academy, 1801 K St., N.W., Suite 701-L, Washington, DC 20006. Telephone: (202) 292-6713.*
- ***Charles R. Lee**, Chairman and Co-CEO, Verizon Communications, 1095 Avenue of the Americas, New York, NY 10036.*
- ***John Rother**, Director of Policy and Strategy, AARP, 601 E. St., N.W., Washington, DC 20049. Telephone: (202) 434-3704. E-mail: jrother@aarp.org.]* ■

Putting safety principles into practice

Incentivizing safety efforts

When it comes to safety, theory is nice but results are better. Two panelists at the Leapfrog Group press briefing reported how they have given teeth to safety principles with transformative initiatives.

Michael A. Stocker, MD, MPH, CEO of Empire Blue Cross and Blue Shield in New York City, described an innovative incentive program being undertaken in his area.

"We represent about 100,000 employees and dependents in the New York City area," he said.

Making it worth the effort

"Those hospitals that meet the computerized physician order-entry (CPOE) standard and the enclosed ICU [intensive care unit] standard will receive a 4% bonus on all income that we provide to them if, in fact, they fulfill these standards. We are actually going to send a check quarterly to the CEO to make the point to the hospitals in the area." In the second year, a 3% bonus will be provided, and a 2% bonus will be paid in the third year, he added.

Why is Empire Blue Cross and Blue Shield doing this? "From its inception, what we really

liked about The Leapfrog Group's standards is the fact that they are evidence-based," Stocker noted.

"The evidence is simply overwhelming; one large company estimates that one or two of their employees died because of medical errors every day, including retirees and dependents," he said.

Because the standards are evidence-based, he continued, "Everybody can intuitively understand what it means if you have a volume standard, what enclosed ICUs mean, if you have intensivists [who] are available and [CPOE]. Second, it can be done anywhere. You could do this all across the country, and our hope, of course, is that's what's going to happen."

CPOE implementation

At Cedars-Sinai Health System in Los Angeles, CPOE is about to become a reality. "We've been working on it for about two years, and it's set to go live in May of this year," reported **Michael L. Langberg**, MD, FACP, chief medical officer and senior vice president for medical affairs.

The medical executive committee at Cedars-Sinai passed a motion in January that basically would suspend a physician's ability to practice in the institution if the physician was not certified competent in his or her ability to use the CPOE system by the time it goes live.

"The reason for doing this is not punitive," Langberg explained. "It's a very strong belief in the marriage of a physician order-entry system with clinical decision support. So at the time physicians submit an order to the hospital, they will have available to them all the important information to make the best judgment or choice for their patients.

"Once we establish that standard, all patients and all physicians will have to be involved in that kind of support in real time," he said.

[For more information, contact:

- ***Michael L. Langberg**, MD, FACP, Chief Medical Officer and Senior Vice President for Medical Affairs, Cedars-Sinai Health System, 8700 Beverly Blvd., Suite 2211, Los Angeles, CA 90048. Contact: Grace Cheng. Telephone: (310) 423-3510. E-mail: grace.cheng@shs.org.*
- ***Michael A. Stocker**, MD, MPH, CEO, Empire BlueCross and Blue Shield, 11 W. 42nd St., 18th Floor, New York, NY 10036. Contact: Deborah Bohren. Telephone: (212) 476-3552. E-mail: Deborah. bohren @empireblue.com.]* ■

Safety tool stresses education and action

Tragedy transforms facility into industry model

Two tragic medication errors seven years ago prompted Dana-Farber Cancer Institute in Boston to undertake what CEO **Jim Conway** calls "a journey of change."

That journey has led to industrywide praise and recognition, including the recent awarding to Conway of one of the two inaugural Individual Leadership in Patient Safety Awards from the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance.

Among Conway's most notable accomplishments was the development of a patient safety self-assessment tool that encourages executives to initiate improvements proactively rather than to wait for the occurrence of adverse events to force action.

In early 1995, Dana-Farber discovered that two patients had received massive chemotherapy overdoses. As one of those patients was Betsy Lehman, a well-known health reporter for the *Boston Globe*, the events received extensive media coverage, including 28 front-page stories in the *Globe*. The question on everyone's lips seemed to be, "How could such a bad thing happen at Dana-Farber, and to such an informed patient?"

This led to what Conway calls "a journey of change for our leadership and staff." Naturally, he says, Dana-Farber carried the burden of these events, but that was not enough.

"It was also our responsibility to learn all we could about why our system failed," Conway says. The events, he says, took on significant power, driving health professionals across the country to learn about medical errors.

"It's mentioned in the first sentence of the executive summary of the [Institute of Medicine] report [*To Err Is Human*]," Conway notes. "It was not only a sentinel event, but a seminal event."

The development of the safety tool grew out of the ongoing process of change. "Myself, the chief of nursing, the staff, the directory of pharmacy, the director of risk management, and others have all spoken on the subject extensively," Conway notes.

"We get two common questions from health care leaders. The first is, 'In the absence of high-profile events, how do you create the tension for

change?' The second issue we hear is something like this: 'You would never catch my boss standing in a public forum and talking about *our* stuff!' We have talked a lot about the gap between excellence and perfection," he explains.

It was not surprising then that last November, the Joint Commission asked Conway to give a talk at its annual meeting on leadership and patient safety. "In preparation for that talk, we had conversations with our trustees and executive leadership, as well as with our staff," he says.

"We asked ourselves, 'What are the things we do that work and seem to make sense, and that lead to success?'" Conway then put up a posting on the National Patient Safety Foundation listserv, asking if health care professionals believed their organizations' leaders "got it" when it came to patient safety.

"We got a number of comments from people who said they did, and they told us what they do," Conway reports. "Then we went and looked in the literature. We spoke with people like [the Institute for Healthcare Improvement's] Don Berwick and [Harvard University's] Lucian Leape, and asked what they thought."

Dana-Farber also consulted two other groups: a state coalition of 20 organizations dedicated to improving patient safety, and their patients.

The result was the patient safety tool, which has been given the title, "Strategies for Leadership — Hospital Executives and Their Role in Patient Safety."

It is divided into four basic sections:

- **Personal Education.**

How do you educate yourself? What books and articles have you read? Do you take courses? Do you understand the facts of your organization?

- **Call to Action.**

What are you doing to establish a framework for safety in your facility? What policies and procedures have you put in place?

- **Practicing a Culture of Safety.**

How do you do this every day?

- **Advancing the Field.**

What do you do outside of your institution to support others?

The tool is presented in the form of a questionnaire, with "Y" and "N" boxes next to each of the 42 questions. The American Hospital Association in Chicago has put its imprimatur on the tool and has distributed it to hospital executives. In the cover letter, Conway notes: "To be sure, having a number of checks in the 'Yes' column of the self-assessment is far more significant than having none. But identifying a plan to move some checks from 'No' to 'Yes' could be equally significant."

Clearly, he says, some "Y's" are more important than others, but that can vary from institution to institution.

"The question to ask is, 'How can I move in my organization from No to Yes?' It is an opportunity to step back and reflect," Conway says. "We propose that you not only reflect with yourself, but with a group of other people before checking off the box."

The Dana-Farber program actively involves patients and family members at all levels of institutional planning; this is what helps keep safety at the forefront of all Dana-Farber activities, he adds.

"We have patient and family advisory councils in both adult and pediatric care," he says. "They sit on most of our operational committees — at the board level on our quality committee. [They leave if the board goes into executive session.] We share error rates with patients, and slips and falls. When we go through the Joint Commission survey, they are involved."

Nearly instant feedback

By actively engaging patients and families in the process, Dana-Farber can get almost instant feedback. "We can implement a new system today, and the next day a patient can say, 'The infusion room is too crowded,' or 'The construction project is making the staff uncomfortable,' or 'When I was admitted they couldn't find my records,'" he explains.

"Our patients are experiencing care in ways that none of us do, and to the extent our processes are not working, they can tell us — and quickly. Sure, we do statistical surveys, but the results often come in two or three months later. We want our patients to pick up a phone and give us a call."

Out of a tragedy have come some very good things indeed. Today, Dana-Farber sees nearly three times as many patients as it did in 1995.

"Not only has our volume grown, but our research has grown; the center is vibrant," Conway says. "Our story is the story of how an institution took a tragic situation and used what it learned to leverage the whole organization to a better place."

[For more information, contact:

*• **James Conway**, CEO, The Dana-Farber Cancer Institute, 44 Binney St., Boston, MA 02115. Telephone: (866) 408-3324. E-mail: Dana-Farber ContactUs@dfci.Harvard.edu.]* ■