

# Healthcare Benchmarks and Quality Improvement

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## Collaboratives grow, even among traditional health care competitors

*Rivals become allies in search for new ways to improve quality*

Something's happening in the world of quality improvement that might not have been thought possible 10 years ago. In ever-growing numbers, hospitals that once thought of each other only as competitors are joining forces to attack the major quality improvement challenges they all face.

For quite some time, facilities have recognized the value of one specific type of collaboration — benchmarking — but this is something else entirely. The collaborative model, which many credit the Cambridge, MA-based Institute for Healthcare Improvement (IHI) with creating, involves even greater interaction and sharing among facilities.

### **Number of advantages for using model**

There are a number of advantages to the model, explains **Jonathan Sugarman, MD**, CEO of Qualis Health, the quality improvement organization (QIO) for Washington, Alaska, and Idaho.

"One of the benefits comes from the fact that when collaboratives are conducted using [IHI's] breakthrough series model, it is based on the best evidence as it exists," he explains.

"It usually starts with an expert panel identifying a set of

## Key Points

- The IHI-pioneered concept already is generating positive results.
- Participants gain access to panels of experts and evidence-based best practices.
- Challenges seen in sustaining change once collaborative has been disbanded.

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change concepts, which if implemented, will result in improved care. So just to get involved in a collaborative gives you access to experts on evidence of what works in real-world settings, as well as access to different kinds of knowledge than you could accumulate just through a literature search," Sugarman notes.

Qualis Health was one of the prime movers in a 56-hospital collaboration sponsored by the Centers for Medicare & Medicaid Services (CMS) to prevent surgical infections. **(For more information, see related story, p. 99.)**

The second benefit of a collaborative is that it provides a QI team with all the tools it needs to improve, Sugarman adds.

"That includes not just the necessary cognitives on science, but the QI managerial — and

sometimes even political — tools you need to engage practitioners around clinical problems," he says.

"These tools address, for example, how to implement change, the role of measurement, and the distinction of measures for improvement vs. research. It provides a sweep of tools," Sugarman points out.

Finally, the collaborative model is a multiorganizational, multi-institutional endeavor. "One of the most common responses from collaborators who are asked what they like most is the opportunity to interact with their peers and colleagues at institutions trying to deal with similar issues," he observes.

"They learn quite a bit from each other about effective activities. When they are struggling, it's good to see that others are as well; also, when something works, they can see how someone else has used it as well," Sugarman adds.

"People from one institution, for example, get flow sheets from another institution, which they are then free to adapt or adopt." This, he explains, embodies one of the mottos of the collaborative model — "Sharing seamlessly and stealing shamelessly."

### ***A surprising level of sharing***

**Regina Berman**, director of process improvement at Hackensack (NJ) University Medical Center, a large teaching hospital, already is a believer; her facility is participating in the IHI's "100,000 Lives Campaign" collaborative. **(See related story, p. 101.)**

"Our medical staff have come to realize how the transparent sharing fosters learning," she notes. "They've actually been surprised at the level of sharing, because in the old days, it never existed. In the old days, it was very competitive. Not only that, you simply didn't share your defects for fear of lawsuits or losing market share."

**E. Patchen Dellinger**, MD, professor and vice chairman of the department of surgery and chief of the division of general surgery at the University of Washington, Seattle, was a lead participant in the Qualis/CMS collaborative; and while he appreciates its initial success (the surgical infection rate was cut by 27%), he does have concerns about the ability of collaboratives to sustain improvement.

"I retain an underlying caution regarding the process, in that I think it's very possible to participate in a collaborative, achieve a good portion of

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Editor: **Steve Lewis**, (770) 442-9805, ([steve@wordmaninc.com](mailto:steve@wordmaninc.com)).  
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, ([brenda.mooney@thomson.com](mailto:brenda.mooney@thomson.com)).  
Editorial Group Head: **Coles McKagen**, (404) 262-5420, ([coles.mckagen@thomson.com](mailto:coles.mckagen@thomson.com)).  
Managing Editor: **Russell Underwood**, (404) 262-5521, ([russ.underwood@thomson.com](mailto:russ.underwood@thomson.com)).  
Senior Production Editor: **Ann Duncan**.

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For questions or comments, call **Steve Lewis** at (770) 442-9805.

the changes desired, then see it slip away as the collaborative ends,” Dellinger observes.

That does not, however, diminish his appreciation of the process itself. “Personally, as someone who led that particular collaborative and a regional that followed and traveled to 10 state collaborations around the country as an outside speaker, I can tell you the collaborative process is an energizing, generally upbeat, positive experience for those involved. It really helps an organization kick-start improvement,” he adds.

Sugarman says he is aware of the potential problem noted by Dellinger. “Typically, collaboratives are time-limited,” he concedes.

“However, in some cases, things continue on. We in Washington state started a statewide collaborative in 1999 on diabetes. We are now starting its fifth iteration and have expanded it to include adult preventive services and cardiovascular disease.”

*(Editor’s note: We hope the articles in the rest of this month’s Healthcare Benchmarks and Quality Improvements will give you a clearer understanding of exactly what collaboratives are and how they work, and the opportunities available for you to get your own facilities involved in such initiatives.)* ■

## Hospitals collaborate to reduce surgical infections

*QIO-led program cuts rate 27% in one year*

Fifty-six hospitals from 50 states and U.S. territories, collaborating to improve surgical care, significantly cut the rate of surgical infections for more than 35,000 patients in a yearlong, nationwide effort sponsored by the federal Centers for Medicare & Medicaid Services (CMS) and led by Qualis Health, the quality improvement organization (QIO) for Washington, Alaska, and Idaho.

### Key Points

- Quality improvement organization (QIO) trains other QIOs and participating QI professionals.
- Initiative emphasizes rapid testing, then spread of small changes.
- Teams typically include QI managers, nurses, and physicians.

The 44 hospitals that provided data throughout the collaborative reduced their surgical site infection rate by 27%. The results were published June 23 in *The American Journal of Surgery*.

Conducted in 2002-2003, the National Surgical Infection Prevention Collaborative also involved 43 QIOs working under contract to CMS.

A major cause of preventable morbidity and mortality in hospitals, surgical-site infections complicate an estimated 780,000 operations each year. Research has shown that compared to similar-risk patients undergoing the same surgery, a patient who gets a surgical-site infection is twice as likely to die, five to six times more likely to require readmission, and likely to stay in the hospital twice as long.

The costs of these complications may range from \$30,000 to \$50,000 per major surgery.

The collaborative emphasized rapid testing of small changes in the work of surgical teams, then incorporating successful modifications into routine care.

Surgical teams from the national collaborative hospitals joined staff from state-based QIOs at a series of two-day learning sessions with Qualis Health over the course of a year.

Most of the teams came from large, urban hospitals, although some small, rural institutions participated as well.

Between sessions, the teams worked with their local QIOs and communicated frequently with each other to share information about implementing improvements, barriers encountered, and lessons learned.

All teams in the collaborative agreed to focus on improving performance on three processes that CMS uses as national quality measures:

1. administration of antibiotics within 60 minutes of surgical incision;
2. use of appropriate antibiotics;
3. discontinuation of antibiotics within 24 hours of the end of surgery.

Most of the teams also worked on improving performance on one or more of the following: control of glucose levels during surgery, avoiding hypothermia during surgery, use of supplemental oxygen during surgery and recovery, and clipping rather than shaving the surgical site.

Over the course of the collaborative, the median performance of participating hospital teams improved on all process measures. The overall infection rate fell more than a quarter, from 2.3% in the first three months of the collaborative to 1.7% in the last three months.

Hospitals participating in the collaborative began with a higher-than-average performance on this measure: a median 70% rate of administering antibiotics within 60 minutes of incision. By the end of the collaborative, median compliance had risen to 92%.

Recent research shows, for example, that patients receive antibiotics in the 60 minutes prior to surgical incision — a key technique for avoiding infections — only a little more than half the time.

Training in the adoption of successful interventions identified in the National Surgical Infection Prevention Collaborative subsequently was conducted over the past three years by QIOs in every state.

### ***Multiple goals sought***

There were multiple reasons for doing the collaborative, explains **Jonathan Sugarman, MD**, CEO of Qualis Health. “The first was to kick off an effort to prevent surgical infections and to try this [collaborative] method at the national level,” he says. “But another was to provide QIOs the ability to learn how to implement the collaboratives.”

This, Sugarman says, was a nontrivial undertaking. “It requires a lot of content knowledge, a lot of structure, involving what works and what does not in these groups,” he explains.

“This involved training for QI professionals. There was additional time spent with the QIOs — they had some coached practices and asked questions,” Sugarman notes.

“The goal was to develop in each state a hospital that could participate in a statewide collaborative that would be facilitated by them.” Almost every hospital that was asked to participate did so, he says.

There are a couple of key requirements for setting up a collaborative, Sugarman continues.

“Since they are not in and of themselves research, you tend to focus on the implementation of evidence-based practices,” he adds. “There has to be an actual set of changes that are known to be effective.”

“It’s a fairly structured event,” adds **E. Patchen Dellinger, MD**, professor and vice chairman of the department of surgery and chief of the division of general surgery at the University of Washington, Seattle, the lead facility in the cooperative.

“Our national collaborative was preceded by a two- to three-day meeting run by IHI [the

Cambridge, MA-based Institute for Healthcare Improvement, credited with pioneering the collaborative model] to get everyone up to speed [on the collaborative process]. Qualis, the functional arm that ran it, was of course already very experienced in this process,” he explains.

“At the same time, however, Qualis was teaching the other QIOs how to run collaboratives, with the goal of going back to their regions and running their own,” Dellinger adds.

During the training session, there was much talk about how to begin change with small units, and then achieving “spread” — engaging more physicians, more patient groups, and so forth, he says.

“Once you’ve done that, you must hold your gains,” Dellinger continues. “In my personal observation, change is difficult, but you can do it; and the IHI model helped us get going. Spread is more difficult; and holding gains is more difficult still.”

### ***The model for improvement***

The collaborative’s efforts to improve delivery of antibiotics at the appropriate time offer perhaps the clearest example of the “model for improvement,” which is based on beginning with tests of small changes. It also was one of the best-documented and best-studied aspects of the evidence on which the initiative was based, he notes.

There have been a number of papers on the subject over the past 10 years, culminating in one two years ago on about 34,000 Medicare patients across the nation, which showed appropriate antibiotic delivery was accomplished in the average hospital less than 60% of the time, Dellinger adds.

“That’s not because docs did not know what to do, or they didn’t give the right order; it happens because it is a very complicated process, and hospitals do not focus on the mechanisms of delivery happening in the same way every time,” he points out.

When Dellinger’s collaborative focused on the issue, for example, the teams typically would include a nurse, a QI professional, sometimes a surgeon, and sometimes an anesthesiologist.

“They would diagram the process — what happens between when a surgeon orders the antibiotic and when it’s given,” he explains.

“They would document what could make this process go wrong. Then we’d talk to ‘Dr. Smith,’ and tell him, ‘Here’s what we think we need to

## Need More Information?

For more information, contact:

- **E. Patchen Dellinger, MD**, Professor, Vice Chairman, Department of Surgery; Chief, Division of General Surgery, University of Washington Medical Center, 1959 N.E. Pacific St., Seattle, WA 98195-6410. Phone: (206) 543-3682.
- **Jonathan Sugarman, MD**, CEO, Qualis Health, 10700 Meridian N., Suite 100, Seattle, WA 98133. Phone: (206) 364-9700, or (800) 949-7536. Fax: (206) 368-2419. E-mail: jonathans@qualishealth.org.

happen to make things right.”

At that point, Dr. Smith's patients would be tracked for six weeks or so. If the change did not work, another change would be tried. "We'd do a couple more tests, and if the process worked, then we'd take all four colorectal surgeons in our hospital," Dellinger continues. "Then we'd do it for every surgeon, and that's how to achieve spread."

One of the keys strategies for many hospitals was giving responsibility to the anesthesiologist, since he is in a very good position to judge when it is the right time to give the antibiotic.

"This worked for a lot of hospitals but not all of them. Others decided to use the nurses in the OR; this emphasizes that the same solution does not work for every facility," he observes.

### **Ongoing contact with QIOs**

Another key to success was the ongoing contact between the QIOs and participating facilities, Dellinger says. "There were three learning sessions over 12 months, as well as an Outcomes Congress," he reports. "At each learning session, there were content experts lecturing, basically sharing what the evidence showed. There were also human factors experts — one from IHI and several from Qualis. They talked about how to do the small change tests and so forth."

After that, he notes, the meeting would break into small groups where hospitals would share their experiences. "We shared what worked and what didn't, so there was a lot of cross-pollination," Dellinger says. "Also, there was an e-mail list to which all participants in the collaborative could write questions, and the content experts

could answer and share those answers with the list. There were also conference calls at least once a month."

Anecdotally, he says, "The impression I had, as well as a number of people from Qualis and the teams themselves, was that having an active clinical physician, preferably a surgeon, involved in the team was also very important. They are the captain of the ship, so if a surgeon went back and sold a concept to a colleague, this was *very* helpful."

### **States reap the benefits**

Following the national collaborative, QIOs and participating facilities went back to their own states to foster more regional efforts. "Qualis subsequently ran one for Washington, Idaho, and Oregon in which we got 30 to 40 hospitals to participate," Dellinger reports.

"The results were quite good, in fact quite comparable to the national collaborative," adds Sugarman. "In many cases, those organizations active in the national collaborative continued as mentors."

QIOs in more than 30 states report hospitals taking part in the training have gone on to show significant improvement. For example: 26 hospitals participating in California increased the proportion of surgical patients receiving antibiotics within one hour of incision from 73.8% to 84.3%.

In Colorado, 16 hospitals increased the proportion receiving antibiotics within one hour of incision from 62% to 88%; in Maryland, 16 hospitals went from 72% to 91.9%.

Nineteen hospitals in New Mexico went from 47.6% to 68%, and in Texas, 42 hospitals went from 61% to 84%. ■

## Early '100,000 Lives' participant sees benefits

*Facility sees dramatic reductions in ventilator use*

One of the better known ongoing collaborations in the United States is the Cambridge, MA-based Institute for Healthcare Improvement's (IHI) "100,000 Lives Campaign," whose goal is to save 100,000 lives through targeted QI interventions by June 14, 2006. The campaign, launched in January 2005, features "Six Changes That Save Lives":

- Deploy rapid response teams (called when a

## Key Points

- Ongoing history of QI efforts lays excellent foundation for collaborative.
- Small test changes part of processes leading to improvement.
- Rapid response teams catch small problems before they become large ones.

patient seems to be losing ground but isn't yet a true emergency).

- Deliver reliable, evidence-based care for acute myocardial infarction (AMI).
- Prevent adverse drug events (ADEs).
- Prevent central-line infections.
- Prevent surgical-site infections.
- Prevent ventilator-associated pneumonia (VAP).

To date, more than 2,300 hospitals have enrolled in all 50 states, accounting for about 50% of all U.S. hospital beds, according to IHI. If all U.S. hospitals joined, says IHI, 183,000 lives could be saved every year.

One of the early adapters, Hackensack (NJ) University Medical Center (HUMC), a teaching hospital in northern New Jersey with nearly 700 beds, already has started reaping the benefits.

"It's incredible," says **Regina Berman**, director of process improvement. "It goes to the concept that a group mind is better than a single thought. We have a brain trust — some of the best minds in the country — to sit down with to share. They include great scientists, operations people, and pharmacists. We are benchmarking and sharing collaborative data all over the place."

### ***A good foundation laid***

Berman notes that one of the reasons why the program has been effective so quickly is that HUMC already had laid a strong foundation. "We've been part of the IHI network for some time, because we are a 'Pursuing Perfection' [another IHI initiative] hospital," she explains.

"In December [2004], we were down at the annual forum and heard Don's [Berwick, head of IHI] kickoff speech [on the campaign]. It was quite impassioned and very moving, so we signed up immediately," Berman adds.

HUMC already had worked at reducing AMI mortality and, in fact, had some of the lowest rates in the country, she reports.

"We focused on our systems for patient care by starting to work with first responders to transmit vital information even before the patient arrives," Berman relates. "Plus, thrombolysis used to be the

## Ventilator Associated Pneumonia Infections Per Device Days

Source: Regina Berman, Hackensack (NJ) University Medical Center.

## Need More Information?

For more information, contact:

- **Regina Berman**, Director, Process Improvement, Hackensack University Medical Center, 30 Prospect Ave., Hackensack, NJ 07601. Phone: (201) 996-2000.
- **Institute for Healthcare Improvement**, Cambridge, MA. For information on the 100,000 Lives Campaign, go to [www.ihl.org/campaign](http://www.ihl.org/campaign).

gold [clot-busting] standard; now, we do angioplasty." HUMC also was part of the [Centers for Medicare & Medicaid Services] demonstration project, "and were in the top decile in each category," she adds.

HUMC already has deployed its rapid response team. "Our understanding is that it should be the senior rehab nurse, a critical care person, who leads the team, because others feel more comfortable calling them," Berman observes. "In some cases, you can use physicians, but we feel nurses may be reluctant to call a physician-led team."

There are clear benefits to a rapid response team, she continues. "Sometimes, you have an intuitive sense of a change in patients — they just do not look good; they are anxious, but you do not have objective data yet," Berman explains. "A nurse may hesitate to call a doctor, but if they can call and say 'I'm worried' and someone will come, it tends to help capture a downward spiral more quickly."

Berman says that typically, from the time a patient is perceived to have a change in status to the time he or she actually expires, there is about an 8- to 12-hour window. "So the idea is to catch that change as early as you can," she asserts.

### Ongoing QI efforts

One of the areas in which HUMC has seen dramatic improvement, and in which there is a slight overlap with the start of the 100,000 lives campaign, involves VAP infections. (See graph, p. 102.) "It's what we call our 'ventilator bundle,' says Berman — five steps every day at exactly the same time. "We've not only been able to prevent pneumonia, but we get our patients off the ventilator more rapidly."

When the initiative began in October 2004, she recalls, "We might have had 12 patients on ventilators in the ICU." Now, Berman points out, "There may be one or two."

A similar approach is being used regarding central lines and avoiding bloodstream infections — keeping patients connected for as short a time as possible. "We want them connected as long as they need to be, but not one second longer," notes Berman. Success in this area involves proper technique and preparation of the site before the line is inserted. "We're creating a video for the staff to show them the best technique," she says.

Another evidence-based practice HUMC is adopting involves surgical infection prophylaxis. "The evidence suggests that instead of shaving patients, you should use a clipper," Berman notes. (See article on surgical infections, p. 99.) "Patients used to be shaved the night before surgery, and when they got nicks, bacteria got in them. Now, no one gets shaved until they are up in the OR and antibiotics have been started."

Finally, HUMC is working on further improvements in medication reconciliation, to help prevent ADEs.

"The concept here is to do everything we can to include a call to the patient's pharmacy for a complete and accurate list [of the medications the patient is on]," Berman explains. "Throughout their stay, changes are updated electronically, so we can ensure when they go home, they know exactly what to take, how often, and who to check with to make any changes."

Part of that effort, she adds, is to try to get patients to take more responsibility for compliance. "For our heart patients, we've created pillboxes and created a sample of what a day looks like," she adds. "We'll take simple approaches to see what works to make things better."

Joining the 100,000 lives project involves no fee, and paperwork is minimal, according to IHI. (For more information, see box, above left). ■

## Proactive staff help avert patient safety crisis in OR

*Hydraulic fluid in barrels labeled 'Klenzyme'*

A group of alert instrument technicians at Wake Forest University Baptist Medical Center in Winston-Salem, NC, averted disaster when they discovered that several barrels of liquid labeled "Klenzyme" turned out, in fact, to contain hydraulic fluid.

Wake Forest hospital officials say a quality

## Key Points

- Quality improvement program encourages employees to proactively report situations.
- Greasy feel, wrong color in liquid spurs employees into action.
- When staff have concerns, key phrases will automatically stop a process.

improvement program that encourages employees to proactively report situations that cause them concern may have been instrumental in avoiding the potentially serious consequences.

“Certainly, there is an emphasis on employees and workers being empowered to say something isn’t right and look into it,” notes spokeswoman **Karen Richardson**. “That’s what enabled them to catch the problem so quickly.”

### A ‘greasy feel’

On Dec. 13, 2004, when two loads of surgical equipment at the facility were washed, they came out with what was described as a “greasy feel.”

“Two instrument techs were running these loads and immediately said, ‘Something’s not right here,’” Richardson says. “They looked in the barrel labeled Klenzyme; and instead of having a clear, amber color, it was a darker liquid with a greasy texture.”

The techs replaced it with the correct product and reported to their supervisor to see what to do next. “It was decided to run the correct product through an empty cycle three times to clear out the lines,” she reports. “Then they rewashed those instruments three more times to make sure all the residue was off.”

At the time, it was thought the hospital had just gotten a bad batch, so the supplier was contacted for a refund. Later in the month, however, the supplier informed the hospital that it may have gotten some hydraulic fluid by mistake. As it turns out, the other three or four barrels already had been disposed of when the techs thought they had gotten a bad batch of cleanser.

### Overcoming reluctance

Overcoming an employee’s natural reluctance to report something amiss is an ongoing process, says **Ron Small**, MBA, vice president for quality outcomes.

“When you start talking about a culture of

excellence, obviously a lot of variables go into that,” he explains. “I define culture as peoples’ behaviors — it’s not what they write about or think about, but what they *do*.”

The current QI campaign theme is “Quality is Our Difference,” Small notes. “That means it’s everybody’s responsibility every day.”

Getting over reluctance to report problems requires behavior change over time, he continues. “Trust comes when they see it’s OK for them to say they have concerns,” Small continues. “For example, we want our nurses, pharmacists, and so on,

to say to the physicians and their colleagues, ‘Excuse me, I have a problem,’ and to stop any such process.”

At Wake Forest, it’s OK to stop a process, he adds. “We even give them phrases, like ‘I need clarification,’ that automatically stops the process. When that occurs, there’s no question — it just stops. This fits in nicely with [Joint Commission on Accreditation of Healthcare Organizations] JCAHO requirements.”

The program’s standards of behavior also address the manner in which concerns can be raised and responded to. “When you make a commitment to excellence, it’s OK to make sure you get your concerns addressed, but we will not tolerate rudeness,” Small asserts. “We have outstanding clinical leadership, and they will follow up with anyone who is rude in the process.”

### The four C’s

If a facility is really going to improve, he says, it must begin with what he calls the Four C’s. One is “commitment of leadership.” The others are:

- **Candor:** You have to admit you can improve processes.
- **Courage:** Have the courage to admit that, and start looking for ways to improve.
- **Comparison:** Know how you stand compared to similar facilities. “We try to be in the top 10% for all measures,” Small says.

### Need More Information?

For more information, contact:

- **Ron Small**, MBA, Vice President for Quality Outcomes, Wake Forest University Baptist Medical Center, Winston-Salem, NC. Phone: (336) 713-3410. E-mail: rsmall@wfubmc.edu.

He might have added "Communication," because the facility does a lot of it. "Our marketing folks put posters everywhere [for the new campaign]," Small notes.

"A lot of the clinical administration executives met people at the door and gave out buttons, which had all the [JCAHO] National Patient Safety Goals on the back," he says.

The internal newsletter *Infinity* contains three or four articles each month. "So far, there have been about 21 articles this year, and I and others have also made presentations about quality," Small adds.

The hospital's core values are excellence, compassion, innovation, integrity, and collegiality, each of which has its own standards of behavior. "Culture is how you behave, not what you say," he concludes. ■

## Study: Poor performers have best improvement

*Significant improvement for 15 of 18 measures*

A new study by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on hospital performance between 2002 and 2004 showed that hospitals with a low level of performance at baseline had greater improvements over the two-year period than hospitals with a high level of performance at baseline in 16 of 17 process-of-care measures.<sup>1</sup>

In addition, the study, which examined hospitals' performance on 18 standardized indicators of the quality of care for acute myocardial infarction, heart failure, and pneumonia, found significant improvement in performance on 15 of the 18 measures. (See box, p. 106.)

Among those measures, the greatest improvement was seen in the three measures of counseling for smoking cessation. In addition, a 19%, 32%, and

### Key Points

- Greatest improvement seen in three measures for smoking cessation counseling.
- Increased documentation may have contributed to reports of greater compliance.
- Room for improvement seen in heart failure discharge instructions, beta-blocker usage.

### Need More Information?

For more information, contact:

- **Scott C. Williams**, PsyD, Director, Center for Public Policy Research, Joint Commission on Accreditation of Healthcare Organizations, Division of Research, 1 Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5166. E-mail: swilliams@jcaho.org.

33% absolute difference from the first quarter to the last quarter was seen for acute myocardial infarction, heart failure, and pneumonia, respectively.

"We were very encouraged by the results," says **Scott C. Williams**, PsyD, Director of JCAHO's Center for Public Policy Research.

"I'm not sure what we expected, but this is what we hoped for; 15 of 18 measures really did show significant improvement, and the others did not show a downturn," he adds.

One of the things Williams says he found most interesting was that hospitals with a lower level of performance at baseline had greater improvements. "I'm not sure we've seen similar findings to this previously, but our initial reaction was that this was kind of intuitive," he asserts.

"But the more we thought about it, it *shouldn't* be intuitive. Here these folks had been performing at a lower level, and for whatever reason, they were improving. There's no reason to expect that they would look at their data and just improve. That's an impressive thing and a good thing," Williams explains.

That's not to say that high performers stood still, however. "High performers, where there was room to improve, still continued to improve," he notes.

The researchers recognized that increased documentation, in response to JCAHO requirements, may have helped boost the performance numbers, as more improvements might now be recorded than in the past.

"One of the things we expected was as we shined the light on these processes, documentation would improve — which we did see," says Williams. "All you can really say about what happened before is you *didn't* know, because it was not documented."

The other key finding in the JCAHO paper was that despite the improvement, things certainly could get better. For example: 91% of heart attack victims got beta-blockers, and only 55% of heart failure patients received the necessary discharge

## Joint Commission's 18 Quality-of-Care Indicators

### ACUTE MYOCARDIAL INFARCTION

- ✓ Aspirin within 24 hours after admission
- ✓ Aspirin prescribed at discharge
- ✓ ACE inhibitors prescribed at discharge for patients with left ventricular systolic dysfunction
- ✓ Smoking-cessation counseling or advice
- ✓ Beta-blocker within 24 hours after admission
- ✓ Beta-blocker prescribed at discharge
- ✓ Mean time from arrival to thrombolysis
- ✓ Mean time from arrival to PCI
- ✓ Inpatient death

### HEART FAILURE

- ✓ Discharge instructions regarding medications, diet, weight, worsening of symptoms, follow-up, and activity
- ✓ Assessment of left ventricular function
- ✓ ACE inhibitor prescribed at discharge for patients with left ventricular systolic dysfunction
- ✓ Smoking-cessation counseling or advice

### PNEUMONIA

- ✓ Oxygenation assessment within 24 hours after admission
- ✓ Pneumococcal screening, vaccination, or both by discharge
- ✓ Blood cultures collected before initiation of antibiotic therapy
- ✓ Smoking-cessation counseling or advice
- ✓ Mean time from arrival to initial antibiotic administration

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

instructions. "Those discharge instructions, smoking cessation, pneumococcal vaccination measures all saw good improvement but were still nowhere near where they need to be," he states.

As for the number of patients receiving beta-blockers, "I'd be happy if I saw 98% to 99% compliance on all the measures," Williams explains.

As for the future, he has this message for quality managers: "We will look to continue expanding measures and measure sets, so they have

greater choices in what to focus on.

"We'd also like to see, whether from the federal government or from some other source, a real push towards electronic medical records. This will absolutely contribute to better outcomes," adds Williams.

### Reference

1. Williams SC, Schmaltz SP, Morton DJ, et al. Quality of care in U.S. hospitals as reflected by standardized measures, 2002-2004. *N Engl J Med* 2005; 353(3):255-264. ■

## AHRQ begins first phase of intervention reviews

*Evidence to be made available to decision makers*

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, has begun the first phase of research reviews that will be performed under its new Effective Health Care Program. The program largely will include work funded under Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The essential goals of the Section 1013 mandate are to develop evidence on the comparative effectiveness of different treatments and appropriate clinical approaches to difficult health problems.

The program also will identify important issues for which existing scientific evidence is insufficient to inform decisions about health care. The reviews, which will be available beginning in October 2005, cover the following set of initial topics:

- Management strategies for gastroesophageal reflux disease.
- Benefits and safety of analgesics for osteoarthritis.
- New diagnostic technologies for evaluation of

### Key Points

- Key goal is to compare effectiveness of treatments appropriateness of clinical approaches.
- Reviews also will identify issues where scientific evidence is insufficient to inform decisions.
- Review and analysis will be undertaken by the Agency for Healthcare Research and Quality's Evidence-based Practice Centers.

## Need More Information?

For more information, contact:

- **Jean Slutsky, PA, MSPH**, Director, Center for Outcomes and Evidence, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850. Phone: (301) 427-1601. Fax: (301) 427-1639. E-mail: [jslutsky@ahrq.gov](mailto:jslutsky@ahrq.gov).

abnormal breast cancer screening.

- Epoetin and darbepoetin for managing anemia in patients undergoing cancer treatment.
- Off-label use of atypical antipsychotic medication.
- Renal artery stenting compared to aggressive antihypertensive medical therapy for mild renal artery stenosis.
- Therapies for localized prostate cancer.
- Oral medications for diabetes management.
- Medications for depression management.
- Drug therapies and behavioral interventions (i.e., exercise, diet).

AHRQ's Evidence-based Practice Centers (EPCs) will review and analyze all the scientific literature relating to key questions under each topic, and will produce a set of high-quality reviews that concisely synthesize the evidence, clearly state conclusions about the evidence, and identify research gaps.

The Oregon Evidence-based Practice Center at Oregon Health & Science University and the Kaiser Permanente Center for Health Research, both in Portland, will serve as the Methodology Resource Center for the program and will translate identified gaps into suggestions for priority studies to fill critical information gaps.

"There are 13 EPCs based in North America," explains **Jean Slutsky, PA, MSPH**, director of AHRQ's centers for outcomes and evidence. "The centers will examine the scientific evidence, primarily in the form of studies, and look at the quality of the evidence."

That often is quite dense reading, she continues. "So to make it useful to different audiences,

a secondary translation will have to occur, where language is used so that everyday people can make more immediate use of the findings."

AHRQ also will work with different sectors, such as the IT vendor community, to make sure the results are translated into products more easily used in health care IT systems, Slutsky adds.

The Methodology Resource Center will, in effect, be creating a resource for all the EPCs, in terms of using a highly rigorous methodology for all reviews and a centralized resource of information, she says. "Oregon will also provide access to the public by the addition of web sites within our own site."

Slutsky contends having this type of information available will improve health care outcomes. "I think one of the most important things to remember about having information on what works and what doesn't is that it informs how we deliver and provide and seek care," she asserts. "Clearly, information on effective interventions has a huge capacity to improve the quality of health outcomes."

How will quality managers know when new results are available? "We'll be pretty loud and clear about that," Slutsky promises. "One of the key components of the program is having people use the information." ■

## NEWS BRIEFS

### President signs patient safety bill

On July 29, President Bush signed into law The Patient Safety and Quality Improvement Act of 2005, which will create legal and confidentiality protections for patient safety information that providers share for educational purposes, and create patient safety organizations to promote

### COMING IN FUTURE MONTHS

■ AHA spearheads effort to reduce complications following surgery

■ HCA uses eMAR system to boost patient safety

■ Videotaped health information more helpful to patients than physicians realize

■ Study: Hospitals found to fall short on cardiovascular care, pneumonia

information sharing. The House Energy and Commerce Committee had unanimously passed the legislation, designed to enhance patient safety by encouraging voluntary reporting of health care errors.

Similar to bills that passed the House and Senate last session but failed to make it to conference committee, the latest bill contained language agreed to in a bicameral, bipartisan manner, avoiding the need for a conference. ▼

## CMS gives Congress a quality roadmap

The Centers for Medicare & Medicaid Services (CMS) has presented congressional committees with jurisdiction over Medicare and Medicaid with a roadmap for improving the nation's health care quality. The agency's five-point plan calls for close partnerships with federal agencies and private-sector groups; widespread use of quality measures such as those of the Hospital Quality Alliance; payment reforms to tie Medicare and Medicaid payment to quality; steps to promote adoption of health information technology; and efforts to speed access to new and better treatments and evidence.

CMS said the goal of its roadmap is "to ensure the right care for every person every time and to do this by making care safe, efficient, patient-centered, timely, and equitable." ▼

## Hospital charges reported

Charges for U.S. hospital stays totaled nearly \$754 billion in 2003, according to just-released national data from the U.S. Agency for Healthcare Research and Quality (AHRQ).

The charges, which do not include physician fees, were for approximately 38 million patient stays and cover the amounts that hospitals billed to insurers and consumers.

The five most expensive conditions to treat were:

- blocked arteries and other heart conditions that can lead to a heart attack — \$44 billion (1.2 million patients);
- heart attack — \$31 billion (750,000 patients);
- congestive heart failure — \$26 billion (1.1 million patients);
- pneumonia — \$26 billion (1.3 million patients);
- newborns — \$25 billion (4 million patients).

The information was produced using HCUPnet,

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an on-line query system that provides access to health statistics and information on hospital stays from AHRQ's Healthcare Cost and Utilization Project (HCUP). This project comprises a family of health care databases and related software tools developed through a federal-state-industry partnership and sponsored by AHRQ.

HCUP includes the largest set of publicly available databases on all patients in the United States, regardless of type of insurance or whether the patients had insurance. To access HCUPnet, go to <http://hcup.ahrq.gov/HCUPnet.asp>. ■