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New IHI campaign will target medical harm in U.S. hospitals

'5 Million Lives' campaign seeks to reach its goal in two years

Looking to build upon the momentum of its successful 100,000 Lives Campaign, the Boston-based Institute for Healthcare Improvement (IHI) has launched the 5 Million Lives Campaign, whose goal is to "protect patients from five million incidents of medical harm over a 24-month period, ending December 9, 2008." The IHI defines medical harm as "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment, or hospitalization, or results in death." (IHI provides a more extensive definition of medical harm on its web site, www.ihi.org.)

Hospitals will not have to pay a fee to join the 5 Million Lives Campaign. However, they will be obligated to adopt at least one intervention and to regularly report hospital profile and mortality data throughout the campaign.

IHI claims that in the 100,000 Lives Campaign, 3,100 participating hospitals reduced inpatient deaths by an estimated 122,000 in 18 months. It estimates that 15 million incidents of patient harm occur in U.S. hospitals each year.

The 5 Million Lives Campaign will include 12 interventions. Six of these were the foundation of the 100,000 Lives Campaign

Key Points

- Volunteer "nodes" and mentor facilities will offer guidance to participating hospitals.
- "Getting boards on board" may be most challenging of six new initiatives.
- Measurement of complications may be more difficult than measurement of mortality.

— deploying rapid response teams; delivering "reliable, evidence-based care" for AMI; preventing adverse drug events; preventing central line infections; preventing surgical site infections; and preventing ventilator-associated pneumonia.

According to a FAQ on the IHI web site, the six new interventions include the following:

• "Prevent pressure ulcers… by reliably using science-based guidelines for prevention of this serious and common complication;

• "Reduce Methicillin-resistant *Staphylococcus aureus* (MRSA) infection… through basic changes in infection control processes throughout the hospital;

• "Prevent harm from high-alert medications… starting with a focus on anticoagulants, sedatives, narcotics, and insulin;

• "Reduce surgical complications… by reliably implementing the changes in care recommended by the Surgical Care Improvement Project (SCIP);

• "Deliver reliable, evidence-based care for congestive heart failure… to reduce readmissions;

• "Get Boards on board… by defining and spreading new and leveraged processes for hospital Boards of Directors, so that they can become far more effective in accelerating the improvement of care."

'A very large challenge'

"This is a very large challenge, but it would be the biggest improvement in patient safety in the modern health care era," asserted IHI president and CEO **Donald Berwick**, MD, MPP, speaking before a press gathering at the organization's 18th National Forum in Orlando, FL, in December 2006, during which the campaign was announced. "We are asking all hospitals to do what few have done, but what we know can be done."

The outpouring of support for the campaign, he continued, "has been stunning," noting flagship sponsorship of $5 million by Blue Cross and Blue Shield, and "a very large award" from Cardinal Health.

"We are in wonderful shape," he added. "Already many systems say they will do this; VHA, Inc., and Premier are completely invested in carrying forward."

Berwick was quick to add that IHI is "not alone" in the effort, noting the participation of the National Patient Safety Foundation, the Centers for Medicare & Medicaid (CMS), and quality improvement organizations, among others. "We are able to list 130 organizations that are working on the campaign," he asserted. (Also present at the announcement were officials from the American Hospital Association, the American Nurses Association, the Centers for Disease Control and Prevention, and the Joint Commission.)

But on the ground, the campaign will be led by hospitals, said campaign manager and IHI vice president **Joe McCannon**. Noting that this new campaign will build upon a structure established in the 100,000 Lives Campaign, he asserted that in that initiative "about 3,100 hospitals participating, representing 80% of the discharges in the

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country, built a national infrastructure for change."

That infrastructure includes 50 "nodes," and approximately 150 mentor facilities. The nodes, McCannon says, are networking groups of volunteers that "bring together hospitals in the state, or a system, or a rural region, to discuss overarching aims, explain the 12 initiatives, and basically act as coaches and resources. The thing hospitals value most is advice from other hospitals."

McCannon told the press conference that IHI believes there are 40 to 50 patient harm events for every 100 admissions. "So, in the next two years, where we would normally expect to see 30 million harm events, we hope to reduce that by one-sixth."

Just as bad as mortality

Harm, asserts **Jeffrey M. Dunn**, MD, MBA, FACS, FACPE, senior medical director, clinical performance, for VHA, Inc., in Philadelphia, "Is just as bad as mortality," adding that "It is very appropriate to look at safety not only in terms of lives saved, but also in terms of the number of complications [prevented]."

Quality professionals, he continues, "Have to get away from the idea that if we salvage a patient and they leave the hospital, it's automatically a great success. There is also quality of life; avoiding complications is probably just as important as addressing the mortality issue."

While adding that IHI "is not really talking about brand new things; these are things hospitals should be looking at anyway," Dunn notes that the organization is conducting "a masterful campaign of getting the attention of people to go forward."

Dunn says he is particularly impressed with an oft-repeated statement he attributes to Berwick: "'Some' is not a number; 'soon' is not a time." Says Dunn: "Let's do this now and be accountable."

If the new campaign, like the prior one, "gets hospitals on board to really seriously look at this as partnering with CMS, the Joint Commission, and others, they will have done a very good job," Dunn asserts.

Nevertheless, Dunn admits to some "mixed feelings" about the campaign. "There is nothing really earth-shattering about the indicators or the things they are trying to fix, but why haven't we done it without the help of programs like this?" He queries. "It's almost shame on us that we need things like this."

He adds, "I see our hospitals and quality managers being overwhelmed with programs and indicators by a million organizations trying to get the public's attention. They have to start prioritizing what they do. One thing I hope is that they will not lose focus on their own problems as they start addressing these issues."

Choosing the initiatives

The six new interventions "come out of a number of sources," according to Berwick. "Like our first campaign, there are medical considerations to be recognized. Then, there's epidemiology. We know the profile of harm, and we have picked out the most frequent causes.

For example, we know that of all the injuries in the campaign, almost half are due to medication in some way or another, and almost half of those are from the high-alert meds."

VHA is already involved in many of the six areas, according to Dunn. "We have had and continue to have major programs on MRSA," Dunn says. "We ran a major national symposium last year, and we have a collaborative that continues."

VHA also is looking at medication errors in terms of reconciliation and safety. "And SCIP is a major part of our 'Transformation of the Operating Room' program, which is a collaboration of hospitals," he notes. That program, he explains, includes three major domains: culture, operations, and quality. "Even before SCIP became mandatory, we had adopted and are comparing key measures," he says. In addition, VHA has major programs addressing evidence-based care for CHF and has an ongoing cardiology task force.

Six recommendations

Berwick told the press gathering that IHI is attempting to offer boards the best available list of suggestions on how to do things. "For many boards, safety is not regarded as a governance issue," he conceded, "But we say it's time to change." IHI, he added, is offering these six recommendations:

- Set safety goals.
- Gather the data on their own organization.
- Set up ongoing monitoring systems on safety at the organizational level.
- Work on the environment — policies and

culture that create transparency and trust and reduce blame.

• Study — i.e., become students of health care safety.

• Hold the executives accountable.

"We have added two 'must do's,'" Berwick continued. "First, do a chart audit — 20-40 random charts from the last month, studied through our tools. Have a very specific report to the board on all injuries found; I think it will open their eyes. Then, conduct a 'deep dive' patient safety study. It should be conducted and detailed by the chief executive and a board member; it may not be delegated."

The six original initiatives also have been updated — "Some minimally, some fairly significantly," McCannon tells *HBQI*. "For instance, we have added 'Tips and Tricks' sections to all of our how-to guides," he says. In terms of rapid response teams, he adds, substantive changes have been made.

"We now talk about early warning scoring systems that help detect problems earlier," says McCannon. "Now, the team alone is not the only way of responding; the scoring systems are another tool."

Major changes also have been made in the medication reconciliation guidelines. "Where we focused a lot on admission and transition points in the first 18 months, we are now focused on discharge as well," he says.

Measuring success

While the 100,000 Lives Campaign has received nearly universal praise, some in health care circles have questioned the methodology used to determine how many lives were "saved." Measurement could be even more of a challenge in the 5 Million Lives Campaign, says Dunn.

"It's clearly going to be more difficult to measure," he asserts. "If you look at the reporting to CMS by hospitals, it is clearly understood that documentation and measurement of complications is much more difficult and error-prone than mortality."

Mortality, Dunn notes, is easy to define, but complications are not. "Talk to an orthopod, and ask them if bleeding is a complication or a matter of fact," he poses. "We tend not to document complications, and it will be a challenge in this program to measure what is and is not a complication."

He adds that it "certainly will not be easy to risk-adjust the data and have an absolute number comparing one hospital to another." He adds, "This does not mean we can't keep looking at the data and trying to fix things."

At the press conference, Berwick recommended measuring on two levels. "The first is process — do you know your rates?" he challenged. "Hospital-specific data are not required, but many have to be reported anyway, and compared to national standards. Then, there is the question, 'Are we getting safer?' We do not have a standard way to answer that question. The best we can do now is a random chart review."

Nevertheless, he said that by choosing those random 20-40 charts every month and using IHI's global trigger tool, "It should give you relatively good measures over time. And we should see that number change."

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Rural facility receives Baldrige for 2006

Culture of 'Servant Leadership' at core of success

Quality leaders at North Mississippi Medical Center in Tupelo say the creation of a culture of "Servant Leadership" is one of the main reasons it has become the first rural health care facility to win the prestigious Malcolm Baldrige National Quality Award, earning the 2006 distinction for organizational performance excellence in the health care category.

Servant Leadership encourages individuals to serve first and then lead as a way of expanding service to others. It is what the facility calls "a no-secrets, no-excuses, open communication

Key Points

- Facility adopts a "no-secrets, no-excuses, open communication environment."
- Care-based management another key strategy that sets facility apart.
- New PI ideas that prove effective in one department are quickly disseminated to rest of facility.

environment."

"Jim Hunter is the current leader of this thought process and has been here leading our effort, so that all our leaders adopt attitudes of humility, of being good listeners, and of trying to meet peoples' needs rather than their wants," explains **Karen Koch**, PharmD, MHA, director of research. (Hunter is the head of J.D. Hunter Associates, LLC, a leadership training and development firm.)

"It takes the employees who thought they were at the bottom of the barrel and puts them in a position of influence," adds **Jan Englert**, RN, director of clinical outcomes.

A servant leader listens and shares authority and empowers their staff, Koch adds.

This approach, in turn, has led to the sharing and dissemination of ideas.

A computer-based program called "Idea for Excellence" allows individuals to make suggestions for improvement. "Every idea is read by the president and disseminated," explains Englert. "So, for example, if you look at our complication rates in any given area, these things pop out at you and you ask yourself what can be done to improve them. Then, you realize it may not apply just to one specific population but to *all* populations."

Care-based management

The facility's mission, vision, and values are translated into measurable actions through five critical success factors: people, service, quality, financial, and growth.

These success factors are then organized into service lines. The quality leaders also have coined a phrase to describe their process improvement approach: Care-based management.

"For years, people have looked at managing costs by looking at the cost of personnel, capital equipment, and supplies, and doing all they can to manage those costs — i.e., reducing capital expenditures, supply costs, and so forth," notes Koch. "What we've done is control or manage costs not by those changes, but by improving processes, reducing variation and complications. By doing that, we are able to actually provide better care — with reduced costs."

In terms of quality, she says, that means examining processes and making sure that whatever they do is state of the art and evidence-based.

Showing real results

The team at North Mississippi has undertaken a number of initiatives that have demonstrated the use of Servant Leadership and care-based management to both improve processes and reap financial rewards. One such initiative involved deep vein thrombosis, or DVT.

"A patient can be at risk for developing DVT just because they are in a hospital; and there are other risk factors as well," notes Englert. "Our front line people, including one of our pharmacists and nurse outcomes managers, developed a process to hardwire both screening patients for their risk of DVT and then putting into action a process whereby the patient's physician would have to respond to a finding that their patient had high risk factors."

In other words, she explains, the physician had to either say what their treatment would be or put in writing why a given treatment was contraindicated.

Engaging physicians

"In the first eight months, there was a 65% decrease in the incidence of DVT," says Englert. "The team associated about $760,000 worth of cost savings with that decrease; this is making the business case for quality."

The initiative also demonstrated the value of Servant Leadership, she continues. "In a traditional organization, a person at the caregiver level can have a great idea for how to do something different, but it may never get above their team of co-workers," says Englert. "In this organization, that particular idea was tremendous and came from a front-line pharmacist; these were small teams that got together. It actually started with stroke patients, but it was such a good idea it became the standard for all patients."

Despite all the process changes that have

been implemented at North Mississippi, Koch feels this level of success would not have been possible without physician engagement. "Without the docs on board and wanting that comparative information on how they are doing, we might not have a quality program, but just a lot of nurses and pharmacists running around with notes to remind them what to do," she says.

Koch and Englert agree that Ken Davis, MD, the chief medical officer, is behind this success. "Engaging physicians was his forte," says Englert. "For successful engagement, you need a physician champion; then, you need reliable data, and someone with some clinical expertise and respect presenting it to the physicians. Dr. Davis says that throwing in a meal and playing on their competitive spirit doesn't hurt, either."

Englert says the physicians are shown their own performance data, how they compare with other physicians, and what the standard of care is for a given population. "We talk about it, and it's amazing how much they want to do better," she says.

They also are sometimes surprised by the data, Englert continues. "One of our physicians was blown away by his data; he had no idea he was only prescribing ACE inhibitors 39% of the time. He would have told you he was doing it 100% of the time, because he thought he was," she observes.

Koch agrees that data are the key to physician engagement. "The data makes it personal and a little competitive," she notes. "They do not want to be left behind."

Koch says that any facility can replicate these accomplishments, and that the Baldrige award will help underscore that point. "We really feel a humility and a blessing in the fact that we are a rural health care facility, and that [the award] gives other folks the message that you don't have to be in a big city or have a lot of resources at your fingertips, to have a quality health care system," she says. "One of the greatest things about the Baldrige honor is that folks can say, 'If people in Mississippi can do it, we can, too!'" she concludes.

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Hospitals collaborate on IV meds standards

Goal is to reduce variation in IV therapy

Collaborations among hospitals to improve the delivery of care is a growing trend in U.S. health care, but a group of facilities in San Diego County, CA, has joined forces to address an area they claim has not previously been targeted in this manner: The delivery of IV medications.

The "San Diego Campaign for Safe Administration of High-Risk IV Medications" involves local hospitals, the San Diego Patient Safety Consortium, and the Cardinal Health Center for Safety and Clinical Excellence. The task force has created countywide standards for safe administration of IV medicines by using a common drug identifier and standardizing the concentration and dosage units for each drug.

When the task force first began its work in June 2005, the 15 participating hospitals used a combined total of more than 85 different concentrations and 57 different dosage units for 34 IV medications. Today, those totals have been pared down to 34 standard, single-strength concentrations and 34 standard dosage units.

Inspired by IHI

The task force got its impetus from the IHI's 100,000 Lives campaign, says **Tim Vanderveen**, MS, PharmD, vice president of Cardinal Health's Center for Safety and Clinical Excellence.

"It came out of a conversation with Dr. Joe Sherger of the University of California at San Diego, who is the director of the San Diego Patient Safety Consortium," he recalls. "He talked of a tragic error that had occurred recently with intravenous medication and suggested we

Key Points

- Task force pares down 85 different concentrations, 57 different dosage units for 34 IV medications.
- Different dosages, concentrations create huge opportunities for errors.
- Program taking hold, garnering attention of national organizations.

should develop a similar bundle to those used by IHI."

In June 2005, they hosted a conference of 60 local representatives, who agreed to set up a smaller task force to meet periodically on target areas. "At about the same time, I and others had published an article on [meds] variation," says Vanderveen. "Because we had 'smart' infusion pumps that helped hospitals control the way they administered a particular drug, we could measure the dosages, and we saw tremendous variation.[1] It was real music to our ears that the task force said they wanted to measure variability, and if they found it, to develop standards."

Cardinal played a key role in helping the task force get started, notes **Nancy Pratt**, RN, MSN, senior vice president of clinical effectiveness for Sharp HealthCare (the largest system in San Diego) and chairperson of the task force.

"We had had the San Diego Patient Safety Consortium together for a few years and done a few things together, exchanging best practices in a variety of areas," she notes. "However, we had run out of our funding from AHRQ and were not sure of the future of the organization, when Cardinal Health stepped forward and offered to support the initiative to give us the space to meet."

Representatives from the 15 hospitals met together to look at current practices and found the variations noted above — which did not surprise Vanderveen.

"It's an area we've never really focused on in the past," he observes, noting that this variation is exacerbated by the fact that nurses may move from one hospital to another, as do traveling and agency nurses, and of course, doctors may work at more than one facility.

"These multipliers are huge," he continues. "If one hospital administers doses per minute, and another administers doses per hour, that's a multiplier of 60. Or, one might use micrograms per minute and another in milligrams per hour; these are really potentially very large errors."

Leading the way

Task force participants had a solid model to follow in Sharp HealthCare, which already had instituted its own standards for its four acute care and three specialty hospitals.

Sharp had installed a new computerized pharmacy system in 2004, and because it used one pharmacy product for the whole system, it wanted to standardize the way meds were prepared. "We have a couple of thousand people in our floating pool staff, so it was important to standardize the concentrations," Pratt says.

Pharmacy heads, the therapeutics committees and nurse executives from all of the facilities met together, identified where the variations were, and reviewed the evidence to determine which approach was better.

Pratt concedes that at first it was a "knock-down, drag-out fight" to get facilities to change. "It took some tough conversations, but at the end of the day it had to be done. We had to change all the electronic order sets that mention those drugs, all of the mixing procedures in the pharmacy, and any standard order sets that are printed on paper. Then, we had to flip the switch — and change all the configurations in the IV pumps."

There were a few "holdout" pieces of really high-risk drugs that needed to change at one facility, which was designed to coincide with the installation of upgraded IV pumps, notes Pratt. That process has just begun.

How did Sharp's standards mesh with the rest of the group? "All the hospitals came together, compared notes on where all the variations were, and what emerged was a de facto community standard," says Pratt. "For every single drug, there was a majority doing it one way. That was the risk that we had — to perhaps need to make some changes — but we put our hat in the ring like everybody else."

Aside from the changes Sharp was already making, "there were only a couple of changes we had to make," Pratt notes.

Initiative spreading

The program is taking hold throughout the community, with Scripps Health having nearly totally adopted the new standards, according to Vanderveen. "They have the smart pumps in their five hospitals," he notes. According to Pratt, Cardinal Health is providing the pumps for those facilities making the change. "The majority of systems are now using them," she says.

It is far too soon to measure the success of the program, she continues."Once the changes are all implemented, we will track medication events, participate in the national database for MEDMARX, and we will see whether or not it is having any impact," she says.

Nevertheless, the San Diego initiative already is garnering attention. "The IHI has asked if they could put our toolkit on their web site," notes Vanderveen, adding that he also has had discussions with representatives from the Joint Commission, as standardized concentrations are part of its National Patient Safety Goals. "We would ultimately love to see some kind of national standard," he concludes.

Having met their goal of standardizing IV concentrations and dosage units, the task force is now working to standardize dosage ranges and drug libraries involved in the use of computerized "smart" pumps, says Vanderveen. "In addition, we are going to start a new initiative; we will probably focus on pain management," he says.

[Editor's note: The toolkit is available at http://meded.ucsd.edu/SDCPS/ and at www.cardinalhealth.com/clinicalcenter.]

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Private sector P4P taking hold, expert says

Hospitals making progress, but public sector lags

Pay-for-performance structures have strongly taken root in the private sector, but progress in the public sector is "quite mixed," according to **Richard Sorian**, vice president of public policy, marketing, and external relations for the National Committee for Quality Assurance (NCQA). Sorian was the coordinator for an NCQA-sponsored meeting on December 1, 2006, in Washington, DC, entitled, "Pay for Performance: A Critical Examination." Speakers included representatives from NCQA, health plans, major corporations, health systems, insurance companies, health care organizations, federal agencies, and Congress.

Responding to a question posed by one of the sessions — "Is P4P ready for prime time?" — Sorian says, "I think the answer is yes when it comes to the private sector and commercial insurance. It has absolutely taken root and is more prevalent than anyone realizes." P4P, he notes, is "embedded in almost every health plan in the country."

He sees more of a mixed bag on the public side, mainly because Medicare has not yet been collecting performance information on physicians. A bill just signed by President Bush includes incentives for doctors to report on a small set of quality measures, but P4P is "nowhere near close" to prime time in this area, he maintains.

"On the hospital side we are much closer," says Sorian. "There has been pay for reporting for the last two-three years; information on virtually all 5,500 [Medicare] participating facilities have been reported out in aggregate form, but not in individual form."

He also notes the progress made in the Premier demonstration project, although it is not yet clear which model Medicare will ultimately adopt.

One area where the public sector appears to be ready and "has been for some time," according to Sorian, is the Medicare Advantage Program, which allows Medicare to go into private plans. "They've been reporting through HMOs and PPOs for 10 years," Sorian notes. "But as a country we do nothing to direct patients to the best plans — or the best hospitals within plans."

It is time, he says, for the program to move to P4P. "We have the data, and the knowledge from the private sector," he explains. "This is a real opportunity."

As for definitive proof that P4P really works,

Key Points

- Data have yet to prove that change has occurred as a result of P4P programs.
- Unanswered questions include, How much reward is necessary to produce results?
- More data, more experience needed for P4P to achieve its full potential.

based on panelists' comments Sorian observes, "I would say the jury is still out. [Despite recent surveys,] we do not have longitudinal information that says real change has occurred as a result of these programs."

Many questions remain unanswered, he continues. "For example, do we just recognize and reward best performers — who likely would be the best performers no matter what?" Some programs in place today do just that, he notes.

"But there was a real interesting discussion at the conference about whether you should not only recognize top performers, but also establish a second set of awards for improvers," Sorian continues. This way, he notes, virtually all facilities have the potential to be rewarded.

"Another big question people are struggling with is, how much reward will it take?" he says. "If you're a small hospital in a rural community, a relatively small reward can produce big results. If you have very high costs, a small reward may not change your behavior much. There's a real question about what kind of awards it will take to create the kind of change we want."

What else is needed?

The NCQA program also examined what additional changes were needed to help P4P achieve its full potential. "For one thing, we need more data," Sorian observes. "Even in health plans, the most data collected is by HMOs; PPOs rarely are required to produce HEDIS data — and they represent 64% of all insured lives. It will take a lot of pushing to get PPOs involved."

There is definitely a need for more research on what kinds of rewards work, he continues. "And, there is a need for more experience, but we will get that naturally."

The biggest issue, says Sorian, and one that "everyone agreed on," is the need for more sweeping payment reform. "Our payment system — particularly in the public sector — continues to reward poor performance," he asserts. "In some ways, we actually penalize high quality care. Take overuse of services. In many cases, antibiotics have proved unnecessary, but if you are a hospital that practices in a certain way, you make income off that. The new P4P approach says we should provide less of those services and more of the less expensive stuff, like physical therapy — but are you really going to abandon that income to pick up a little reward? We really need to figure out how to deal with the over-utilization issue in our health care system."

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CMS to publicly report hospital mortality rates

Hospital Compare will report outcomes data

The Centers for Medicare & Medicaid Services (CMS) has begun a process that will result in the public reporting of new hospital performance data, including the comparisons of heart attack and heart failure mortality adopted last year by the Hospital Quality Alliance. The data, to be published this summer as part of CMS's Hospital Compare program, will use risk-adjusted mortality rate measures.

"The main significance of the acute myocardial infarction and heart failure mortality measures is that they are patient outcome measures rather than process of care measures," notes **Mike Rapp**, of CMS' office of clinical standards and quality. "This is the first time that Hospital Compare will include patient outcomes measures."

The Hospital Compare web site was launched April 1, 2005. The CMS risk-adjusted 30-day mortality measures were developed "using rigorous methodology over the past two years by a team of experts from Yale, Harvard, the Colorado Foundation for Medical Care, and CMS," says Rapp, who notes that they are

Key Points

- Data will be risk-adjusted, using mortality rates 30 days after discharge.
- CMS has begun "previewing" data with hospitals to help familiarize them with new format.
- Additional data may help hospitals put previous "negative" performance reports in perspective.

endorsed by the National Quality Forum and are approved and supported by the Hospital Quality Alliance.

Hospitals get 'preview'

Beginning in December 2006, CMS has been "previewing" the new phase with hospitals to help them familiarize themselves with how the data will be presented. The agency is sending each hospital a private, individualized report of its specific performance through a secure quality exchange web site.

"This is a trial — a test run," Rapp explains. "June will be the first time this sort of information will be provided on our public web site, but prior to doing that we felt it was important to do a trial run."

The data currently being shared are not the data that will be posted in June, but rather from a previous time period. Still, notes Rapp, "The hospitals will be able to see what the confidential report they are going to get looks like, ask questions, and give us feedback."

The American Hospital Association has said it will organize conference calls with the CMS team assembling the data in order for the hospitals to ask direct questions. **(For more on how the AHA is helping with this process, see sidebar, page 23.)**

Additional data beneficial

The addition of this new area of data may help hospitals paint a fuller picture of their performance, notes **Patrice L. Spath**, RHIT, of Brown-Spath & Associates in Forest Grove, OR — especially in light of a recent article in JAMA[1].

"The study looked at the relationship between mortality rates and the compliance with different process measures," she notes. "They found no relationship between the two; high compliance with process measures did not result in a statistically significant improvement in mortality rates."

In other words, she explains, it is possible for a facility to have lower compliance with Hospital Compare measures but have mortality rates that are within what is considered the norm compared to other facilities.

"This [new phase] could be a good thing for hospitals," she continues. "Say you have only 60% compliance with smoking cessation counseling, which makes you potentially look like low-quality providers. But, if your mortality rate is lower, at least this will give people another dimension to look at."

Using the data

In order to make the most out of the data, Spath advises, quality managers need to become familiar with the risk-adjustment methodology "and determine whether or not that adequately explains variations between their patient populations."

Beyond that, she says, "You'd use it like any other comparative data — look at variations and dig into the 'why's' of them." She also warns against falling into the "standard deviations" trap. "Just because you fall within two standard deviations of the mean doesn't mean you don't need to do anything," she advises. "The ideal approach would be to set improvement goals — regardless of where you fall within the range."

Spath notes another disturbing trend she has observed recently: an all-consuming focus on process measures, to the exclusion of other proven QI approaches.

"I visited one facility where they used to do case management rounds but have now cut back on that and just do core measure rounds. In other words, they only focus on those patients for whom data need to be reported publicly."

Quality managers constantly need to remind themselves that what CMS and the Joint Commission are measuring "is really a small percentage of the total inpatient population," says Spath. "You shouldn't just rely on those measures to evaluate your own performance; you've got to be more patient-focused," she concludes.

Reference

1. Werner RM, Bradlow ET. Relationship Between Medicare's Hospital Compare Performance Measures and Mortality Rates. *JAMA* 2006;296:2694-2702.

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AHA helps hospitals view their performance

All hospitals that report the 21 quality measures developed by the Hospital Quality Alliance have received a link from the American Hospital Association to an online report formatted for viewing the quality data their hospital provides to the Hospital Compare Web site.

In a letter to hospital CEOs, AHA President Dick Davidson and President-elect Rich Umbdenstock said the reports provide an easy-to-use way for hospitals to review their performance and share it with their board, medical staff, management team, employees, and the public. "You'll be getting a similar report from us quarterly as a tool to help you set quality improvement goals with your board, focus on specific activities and talk about quality and safety with your community," they said. Hospitals with questions about these reports should contact AHA Member Relations at (800) 424-4301 or hqadata@aha.org. ■

Multivariable testing cuts door-to-doc times by 24%

Approach tests process solutions in short time

Members of the ED staff at Blount Memorial Hospital in Maryville, TN, have cut the door-to-doc time from one hour to 45 minutes, and they hope to get it below 30 minutes, following a new initiative using a process called multivariable testing (MVT).

MVT was developed by QualPro, a process improvement company based in Knoxville, TN. "What MVT does is allow you to rapidly test a number of ideas all at the same time in real world conditions," explains **Joe Smith**, health care director for QualPro.

The premise is to try something for a short while and see if it works or not, to achieve rapid-cycle improvement, adds **Richard Hall**, RN, MBA, Blount Memorial's chief nursing officer. "What they do is take 10 to 20 changes, test those through their MVT, turn those changes on and off, measure the impact, put in their own statistical refinement, and tell you which of the ideas will improve the process, which will not improve — or even hurt — the process, and which will work in combination," Hall says.

The initial step in the process is to establish goals; in Blount's case, they were increased efficiency and patient satisfaction.

Once the goals were established, "We started brainstorming at the end of March 2005," recalls Smith. In the ED, this involved nurses, physicians, management, and clerks. In the first round, 121 ideas were suggested.

"Once we had that big list, we determined that some ideas — like adding more rooms or more staff — were not immediately feasible," notes Smith. By assessing each idea for practicality, speed of implementation, and being cost-free, the 121 were narrowed down to 16. "We implemented all of them in different combinations," Smith says. "Each round was a month, and we did a total of two months' testing."

Why was it necessary to test the ideas in combination? "Frequently the biggest impact will come from the synergy between ideas, and the only way you can discover that is to test more than one idea at the same time," Smith explains.

QualPro determined that three ideas would be most effective. The first was a 'bed ahead' process. "Any time one of the units filled a bed, the staffing office had to re-look at their unit every hour and see if they had a bed for the ED," explains Hall. "If they didn't, they had to identify where the next bed would come from, and if there wasn't one, they had to document what they were going to do about it." This idea proved effective, he says, because of the mindset it created.

COMING IN FUTURE MONTHS

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- Citywide adoption of rapid response teams results in fewer codes outside the ICU
- Study: Patients have broader definition of "medical errors" than clinicians
- What are the keys to a successful palliative care program?

The second idea involved doing the IV and blood draws together. "This saves the patient a 'stick' and actually helps on overall time because you get specimens to the lab more quickly," says Hall.

The third idea involved having the ED doctors write admission orders. "Like a lot of hospitals, in the past when patients looked like they needed to be admitted, ED docs would call and have a specialist or a hospitalist come and see the patient," says Hall.

"Sometimes that would happen quickly, but sometimes the other physicians were tied up." Now, he says, the ED physicians write the basic orders, send the patient to the floor, call the physician, all while the process of finding a bed is under way. "We get the admission written, and the specialist or hospitalist will finish the rest of the orders when they arrive," Hall explains.

The charge nurse for each shift was made responsible for seeing that the new ideas were carried out correctly, says Smith. "Management felt the charge nurses would hate it, but they actually said they loved it, because some of these things were what they were hoping to try," he says. "That's one of the advantages of brainstorming."

Hall agrees. "One of the strengths of this system is that you take process improvement ideas from the physicians and staff. It is yours," he says. "MVT is only a tool for implementation, but it validates the things you think will need to do to improve the process."

To better gauge patient satisfaction and to benchmark their performance using a premiere survey firm, the Blount ED decided to change to Press Ganey Associates of South Bend, IN, for its patient satisfaction surveys. "It was a tougher survey process to go through," says Hall, "but over the past 18 weeks more often than not we have been in the top 2% or 3% for EDs nationwide." ■