

Healthcare Benchmarks and Quality Improvement

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Hospital associations put nix on billing for 'never events'

Observers say a dozen or more states considering similar policies

Within months of each other, the states of Minnesota and Massachusetts established policies whereby facilities in those states will no longer bill for some or all of a list of 27 adverse events identified by the National Quality Forum as "never events." In the case of Minnesota, the policy, adopted in September, covers all of the events. In the case of Massachusetts, the following nine events are covered:

- surgery on the wrong body part;
- air embolism-associated injury;
- surgery on the wrong patient;
- wrong surgical procedure;
- medication error injury;
- retention of a foreign object;
- artificial insemination/wrong donor;
- infant discharged to the wrong family;
- incompatible blood-associated injury.

"No state has any experience in doing this; although Minnesota was ahead of us a month or two, they are still learning," says **Karen Nelson**, RN, MPA, the Massachusetts Hospital Association's senior vice president for clinical affairs, explaining why Massachusetts limited its policy to nine events. "There is no magic formula, so [we

Key Points

- Hospitals, associations agree that the policy is 'the right thing to do.'
- CMS announcement it would not reimburse for specified errors may have impacted timing of policies.
- Not paying for adverse events likely a trend to spread to other states.

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chose] the most actionable.”

The NQF list was designed “as a dictionary of things to report on. It was never designed as a payment tool,” she says. In choosing its nine items, she explains, the association used four criteria — the event has to be preventable, within the control of the hospital, the result of error, and actually result in patient harm.

As for Minnesota, **Bruce Rueben**, the Minnesota Hospital Association’s president and CEO, says, “we’ve had much more experience with public reporting and tracking and have been able to refine our definitions; so rather than trying to parse [the events] we chose to take the approach that no matter which event occurs, we are not going to bill.”

In the case of Minnesota, he adds, “these

[never] events were specifically chosen [by the NQF] because they can be defined, are preventable, and can be measured. If they are not preventable, they will not be one of these events. You assume all these [preventive strategies] are in place, and if something was preventable, no one believes you should bill the patient for care; the same holds true if additional care is needed. And if you find the error later in the billing cycle, you will pull that bill out.”

In any event, he continues, the knowledge base across the country is sure to grow. “I think this is already spreading; there are probably a dozen states that have similar laws or are about to have them, although they don’t all approach it in the same way. I think as the others get more experience, they will see there’s not all that much to worry about,” he proffers.

A logical step

Officials in both states note that their policies do not represent a sudden break from tradition (see article, p. 15), but rather were the logical next step in an evolutionary process — which involved pressures from both within and outside the state boundaries.

“We immediately started to deal with this issue when we began formally collecting data on adverse events [now required by state law],” Rueben explains. “Obviously, once we identified what they are and report on what can be done to prevent them [Minnesota hospitals are required to perform root cause analyses and publish corrective measures on all adverse events], the whole issue comes to front of mind.”

The state hospital association collaborated with the state’s council of health plans and the governor’s office to come up with the policy, and payers and hospitals were in agreement.

“So, within a few months we stated out loud what was already happening,” Rueben continues. “If hospitals are aware of such an event, they do not let the care get into the billing cycle. It’s only right that you do not bill the patient.”

And what about the recent announcement by the Centers for Medicare & Medicaid Services (CMS) that it would no longer reimburse hospitals for a specified list of preventable errors? “The CMS announcement probably did have something to do with the timing,” Rueben says.

“In our case, this came about over a long course of time,” says Nelson. “We looked at the consideration of non-charges more than a year

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Editorial Questions

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

ago and brought it to some of our internal committees, but the timing was just not right. People understood the principles, but they could not come to agreement.”

In the past year, she continues, things changed dramatically in Massachusetts, with increased calls for transparency as evidenced by the public availability of nurse staffing plans. “That gave our members more confidence that this was the right thing to do and that this was the time to do it,” says Nelson.

As for the CMS announcement, says Nelson, “it is significant because it is consistent with the same philosophy — that is, hospitals should [only] get paid for good care. It will be a challenge, but we will implement both at the same time.”

Tracking errors, boosting quality

Of course, in order to be proactive about the non-billing policy, hospitals must be able to keep an accurate record of adverse events. “We have a patient safety registry, which is web-based, where hospitals report the event,” Rueben

shares. “It then prompts you to share your findings with the other hospitals in the state. The hospitals have their own internal approaches, too, so it is a combination of an overarching collective approach.”

“There is no consistency across the country,” adds Nelson. “Here, we are blessed with two mandatory reporting systems, and you also have The Joint Commission sentinel events. But the agencies to which we report did not use the NQF taxonomy. When they do, we will be able to count more accurately.”

These policies clearly are a boost to quality, says Rueben. “A policy that promotes patient safety and quality is one that requires a hospital to do root cause analysis and develop a corrective action plan — how and why, and what must be done,” he asserts. “We exponentially add to that because the hospitals here share knowledge. If an adverse event happens in hospital A, hospital B has access to its information and can put the fix in at their hospital to keep it from happening. That is the way it becomes a very powerful safety improvement mechanism; the billing process is just an adjunct to that.”

Risk manager: New policy just recognizes reality

For **Cathy Sampson**, CPHRM, manager of risk management for North Memorial Healthcare in Robbinsdale, MN, the new state policy concerning non-billing for never events is no big deal. In fact, her hospital has been practicing such a policy for years.

“We have not been billing for the never events and we have also done as much as possible for other types of events,” she says. “Adverse health care events are pretty much related to some significant harm, but there may be situations where harm has not been that great but it may be a good idea from patients’ perspectives [that they not be billed] for care provided.”

So, for example, a patient may need to go to a higher level of care for more intensive monitoring and doesn’t, but there is no untoward outcome — or even any real effect on the patient’s condition.

As for the state’s new policies, “I think it’s appropriate because we’ve been doing something similar in varying stages for probably 20 years — but it’s

never been structured in a guideline format. It helps with consistency and continuity and also helps because other people in the facility are aware of the process; in other words, you are not leaving it in the hands of one person to remember that this is what you want to do,” she says.

Sampson says her hospital is not unique in its approach. “I can only speak to the facilities I usually have contact with in the Twin Cities metro areas, or some bigger facilities outside the area, but I would say that with those I’ve spoken to, they have primarily done the same as we have with some variation,” she observes.

How is reporting handled within her facility? “When I am made aware of an event I believe meets the criteria, then I advise our business office to put the account on hold,” Sampson says. “We also have a nurse auditor — she reviews the medical records and is pretty much able to identify what care was required as the result of an event.”

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"It shines a light on these events, which heretofore was not done," adds Nelson. "It is a total acknowledgement."

Nelson is convinced this trend will spread. "I can say for certain the [American Hospital Association] is looking at it as well; they've adopted some principles also for partial or non-payment for certain serious events. I would expect to see acceleration of this across the county within a year."

"It's simply the right thing to do," says Rueben. "It restores and establishes patient and public trust, since you have now made it a priority to keep these events from happening."

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Joint Commission still sees room for improvement

Latest survey shows how, where hospitals fall short

While U.S. hospitals continue to demonstrate overall improvement in quality and safety, they still have a long way to go in several key areas, according to *Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2007*.

The report released several other key findings:

- Requiring hospitals to follow a standard process for continual quality measurement, reporting, and improvement has contributed significantly to this improvement.

- There is great variability in performance by state, as well as between the highest- and lowest-performing facilities.

Specifically, the quality of care for heart attack, heart failure, pneumonia, and surgical care patients improved based on 2006 performance data provided by accredited facilities. In addition, they achieved 90% compliance or greater on most of the 2006 Joint Commission National Patient Safety Goals.

Key Points

- Discharge instructions for heart failure patients, pneumococcal screening, ACE inhibitor at discharge still areas of concern.
- Requiring a standard process for continual quality measurement, reporting, and improvement has contributed to improvement.
- Processes are not yet 'ingrained in facilities and systems and process redesign;' the right things don't happen in 'all encounters' all the time.

"In terms of quality data, this is consistent with what we have seen in a variety of quality-related reports," notes **Jerod M. Loeb, PhD**, executive vice president, quality measurement and research for The Joint Commission.

One of the keys behind the continued improvement, he asserts, is that "things that get measured get managed," but he is quick to add that it is "also abundantly clear these processes are not ingrained in facilities and systems and process redesign so that in all encounters all the right things happen."

What The Joint Commission measures, he continues, is basically processes. "We have seen a tremendous increase in the use of ACE inhibitors and smoking cessation programs for acute MI [myocardial infarction], but not everyone is at perfection. The same goes for heart failure and pneumonia," he observes.

Where hospitals fall short

Even when it comes to the National Patient Safety Goals, Loeb notes, there is room for improvement, despite the 90% compliance rate. "If you look at these goals, we have requirements, and the data suggest a fair number of things where we continue to see non-compliance — such as time-outs between surgery, use of abbreviations that are known to cause problems, reporting critical tests results, and medication reconciliation. It's very difficult for hospitals to do these and to remain compliant," he notes.

There are a variety of reasons for this difficulty, Loeb adds. "When you've seen one hospital, it doesn't mean you've seen them all," he explains. "Not all hospitals have the same electronic infrastructure and databases, or ways to accomplish things."

Even something that at face value seems sim-

ple, such as giving aspirin within 24 hours of admission for acute MI, can have its difficulties, he continues. "Between the point the medicine is thought about and ordered and the point at which it is actually placed into the patient's mouth, 100 different steps need to be followed. They can break down — and often do," says Loeb. "Health care is a uniquely human endeavor."

One of the keys to sustaining improvement, says Loeb, is to constantly think about the process in question. "Even when you change from 20% to 95% compliance, if you do not continue to measure and to emphasize the process, it will drop," he warns.

Compliance still lags on four measures introduced five years ago, according to the report:

- discharge instructions for heart failure patients: 17.7% of respondents are not performing it consistently;
- pneumococcal screening for pneumonia patients: 22.7% of respondents are not performing it consistently;
- ACE inhibitor prescribed at discharge for heart failure patients: 36.1% of respondents are not performing it consistently;
- ACE inhibitor prescribed at discharge for heart attack patients: 43.6% of respondents are not performing it consistently.

"The discharge instruction measure has different pieces," notes Loeb. "I'm not sure providing any med is more difficult than providing any other, but many times it's a matter of disparity between what the evidence suggests and what people think in their minds."

Unfortunately, he notes, not everyone practices evidence-based medicine. "ACE inhibitors are newer meds, and it's entirely within the realm of reason that they are not on the daily radar screen of all doctors in terms of prescribing them," he says. "We have knowledge base deficits as well."

Standardization is key

The authors of the report attribute improvements in part to requiring that hospitals follow a process to measure and report quality advances. "What we've done," Loeb says, "is to identify a series of standard processes of care we know have good linkage to outcomes, and have developed standardized measurement tools so all hospitals can look at the same clinical cases the same way.

"So, for example, if a patient is allergic to

aspirin or had a recent GI bleed, even though the literature says to get aspirin on board, it may not be a good thing to do," says Loeb. "We look at a clinical condition with all its complexity."

"We state explicitly what to look for, and where it should be found in the medical records," adds **Stephen Schmaltz**, associate director of The Joint Commission's Center for Data Management and Analysis.

The Joint Commission also hopes to make its performance measurement and reporting requirements "increasingly relevant," states the report. "These are clinical conditions that represent the bedrock of American medicine — the most common DRGs," Loeb explains. "We try to focus on very specific practices that are associated with better outcomes."

The Joint Commission also plans to continue collaboration with groups such as the Centers for Medicare & Medicaid Services, the National Quality Forum, and the Hospital Quality Alliance.

"In today's world of performance measurement, we hope to coalesce with others," Loeb explains, but is quick to add that the development of one single measurement standard is "the Nirvana state — it will not exist today or tomorrow."

The closest we can come, he says, "is to be sure all data are collected once at the point of care and streamed then at that point. Then, let those who ultimately have need of it utilize it in whatever way they need to in order to meet their specific demands."

"That's why our focus has been on the standardization of the reporting," adds Schmaltz.

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AAN: Technology may to be blame for nursing shortage

Study leaders seek more efficient use of nurses' time

Nobody questions the seriousness of the nursing shortage, but so far no one has come up with a satisfactory solution. The

American Academy of Nursing believes it is on the right track with a project called “Technology Targets,” funded by the Robert Wood Johnson Foundation.

“In 2002, the American Academy of Nursing [AAN], in response to the sustained shortage of nurses, began to look at what initiatives it could bring to the table to help improve the work environment — which is often cited as one of the main factors in nurses spending decreased time in the hospital,” recalls **Linda Burnes Bolton**, DrPH, RN, FAAN, vice president of nursing at Cedars-Sinai Medical Center in Los Angeles and principal investigator for Technology Targets.

“At the same time, providing care has become so much more complex and that care was adversely impacted by the amount of waste in a nurse’s time — they could not provide as much care as they had in the past because they were too busy with other things like trying to find supplies and equipment or waiting for information and documentation,” says Burnes Bolton.

Looking for feedback

In 2002 the organization began to look at demand and how other industries had been able to address work and work flow, to see if technology might apply to helping nurses. It held a three-day invitational conference including futurists and invited staff nurses from around the country.

“Since health care is a ‘team sport,’ we included architects, engineers, human factor experts, experts in technology, doctors, CEOs, pharmacists, and respiratory therapists,” says Burnes Bolton. “We asked them to think about the future work environment — what it would look like — and what we needed to get in order to be able to create it.” In other words, she explains, they were looking for an environment

in which nurses would stay in spite of the shortage.

“The consensus we arrived at was that we needed to delve deeper into understanding the work environment and what was needed by nurses and the other team members — including manufacturers,” says Burnes Bolton. (All major manufacturers also had been invited, and all had attended.) “The nurses said the technology that was being produced took more of their time, not less, and they had developed work-arounds because of it,” Burnes Bolton reports.

On to TD2

The next step was to get a grant from the foundation for pilot testing that ultimately led to the development of a process the group called “Technology Drill Down,” or TD2. “The drill down was a way to get to see what in the work environment needed to change and what type of technology products were needed,” Burnes Bolton explains.

The first step was to conduct non-participant observation, having others watch what people do. “We had doctors, engineers, and hospital executives watch nurses work, and then we talked to the nurses,” she says. This process was piloted in three hospitals, and led to the creation of TD2, says Burnes Bolton.

TD2, according to the AAN, “precisely defines and measures the technological gaps between practice and need and, in generic terms, describes technological products that could close the gaps.”

“We went out to 25 different hospitals and systems involving over 10,000 individuals from a variety of settings — rural, urban, academic,” says Burnes Bolton. “We conducted drill downs and identified over 1,000 different things that needed to be produced.”

At Cedars-Sinai, for example, a random sample of 20 staff nurses was selected, and then volunteers were requested to fill the other team slots. “In the three months before we did the actual drill down, we conducted observation of work and work patterns, which were then analyzed by the [nursing] academy staff,” recalls Burnes Bolton. “Then we held an invitational session where we posed the following question: What would make a perfect workday for you?”

From prior literature, she adds, it was known that anywhere from 20% to 40% of a nurse’s time was spent moving back and forth looking for

Key Points

- Nurses spending much less of their time actually caring for patients.
- Technology must improve so that devices in different areas of treatment can ‘talk’ to each other.
- American Academy of Nursing making available a tool to measure work practices, technology being used.

supplies, waiting for someone to assist them, or waiting on the phone. “We also knew from 20% to 33% of their time was spent in documenting, which means less time in direct patient care,” says Burnes Bolton.

The remainder of day one was spent asking for suggestions about redesigning the work flow. On day two, the participants were asked to envision ideal products in the morning session. “Then in the afternoon we showed them the technology products on the market — even if they did not have them in their hospital,” says Burnes Bolton. The participants were then asked to prioritize the 1,000 solutions they had proposed.

The feedback indicated the most complex parts of nursing work involved medication systems and communication (no matter with whom). “The third issue was that the existing technology products don’t talk to each other,” says Burnes Bolton. “So, for example, if you need data from an infusion pump, you read it, and instead of that data going directly to the electronic medical record, you have to put the results on paper and then enter them into the system. That’s a lot of the documentation time we’re talking about.”

Another example would be a patient who needs to be ambulated and requires two helpers. “It may take three phone calls to get someone to assist you, although there are technology products out there that allow you to schedule therapy events,” says Burnes Bolton.

More direct care

The take-home message of the project, says Burnes Bolton, “is that workers are not spending as much time as they should in direct patient care — and we know from the literature that the more time nurses can spend in direct care, the fewer incidents they will have. What’s more, other studies have found that the more time is spent in direct patient care, the more satisfied nurses are and the more likely it is that they will stay.”

What AAN wants, she continues, “is for hospital CEOs and chief information officers and vendors to step up to the plate and demand that they address this lack of interoperability that can affect our ability to provide safe patient care. That’s the policy piece we want — to have one set of standards.”

As for hospitals themselves, Burnes Bolton

adds, “I hope, in terms of their product selection, they will not purchase something if it does not meet the right standards.” The bottom line here, she emphasizes, is that “money talks.”

“We believe strongly that if we can get a critical mass of institutions to say to vendors that if their product won’t talk to another product they are not going to buy it, we will get results,” Burnes Bolton asserts.

Vendors, she emphasizes, “need to listen to the voices of the people who need to use their products.” And for hospital executives, “we will be saying that we will give our process away to every hospital in the U.S. Here’s how to conduct a technology drill down. You should do this first so you don’t buy something your staff won’t use.”

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For a free copy of TD2, go to: www.aanet.org/committees/td_orderform.asp.] ■

UPMC to develop organ donation program for ED

Program to complement rapid response system

The University of Pittsburgh Medical Center (UPMC) Presbyterian is laying the foundation for a program designed to facilitate organ donations in its emergency department. Not only does this represent an innovative approach to the organ donation process, which has traditionally been restricted to the ICU, but it also underscores UPMC’s unique approach to rapid response.

While many facilities now have a rapid response team in place, UPMC has several; in fact, it views those teams as part of a rapid response system — of which the organ donation program, or Condition T (for “transplant”), will be a logical extension.

“The rapid response system includes equipment, administrative supervision, and QI to make sure you have the right people, that they show up on time, and that you are adequately funded,” explains **Michael Devita**, MD, professor of critical care medicine and internal

medicine at UPMC School of Medicine, the driving force behind Condition T and developer of several protocols for rapid response teams. UPMC Presbyterian, he adds, has a total of 12 rapid response teams.

“This is simply a new application,” echoes **Charissa Pacella**, MD, director of emergency medical services for UPMC Presbyterian. “The basic tenet underlying rapid response teams is to mobilize all the right equipment, personnel, and actions to get things done.”

“You have to think of this as a system,” Devita emphasizes. “The whole goal [of rapid response] is that when a situation requires a lot of things to happen in a certain order in a certain way in a very short time, you need to plan it ahead and rehearse it ahead.” So, for example, when a patient is about to “code” and you need to send the rapid response team, “you have to make sure the critical care doctor and nurse, the medicine, and equipment all show up in a couple of minutes,” says Devita. “We want the same type of response in the ED.”

System creates an advantage

Because the ED already is part of the existing system, Devita continues, this extension will be much smoother. “They do not use all the teams, but they have a sepsis team for patients admitted in shock, and an ACS [acute cardiac system] team to get patients into the cath lab as quickly as possible,” he notes.

When a patient passes away in the hospital, it is routine for CORE (the local Center for Organ Recovery and Education) to be contacted to determine if the deceased is an organ donor, he continues. The challenge is that while ICUs are equipped to respond rapidly enough for a transplant to be possible, EDs are not. UPMC says many organs from patients who die in the ED are never used.

“If we have the same rapid assembly deployment of personnel, equipment, and services in the ED [as they have in the ICU] we could do what would not be possible otherwise,” Devita asserts.

One of the obvious concerns, he says, is that the public may be wary of staff being too aggressive about procuring organ donations. “We want people to feel safe coming here and knowing they will get the best care possible,” Devita emphasizes. “We are building the protocol so that ‘Condition T’ does not get triggered until after

Key Points

- Rapid response system includes equipment, administrative supervision, and QI.
- System approach includes planning ahead and rehearsing responses.
- It can take several years to develop protocols and pilot a new rapid response program.

the patient dies, after CORE notification and learning that the patient was a donor — that’s when we activate the system. This way it also frees the ED of any burden of worrying if a patient is a donor.”

Earlier attempts at other institutions to develop such a program have failed, says Devita, “either because of inadequate community education and support, or because the hospital did not continue to provide the administrative support they needed. It’s a fairly sizable package you need to put together from an educational and administrative standpoint.”

A three-year program

The UPMC initiative — which is being funded by a grant from the Healthcare Resources Services Administration as part of its collaborative aimed at increasing the number of organs transplanted in the United States by more than 40% — will take three years to complete, says Devita. “That’s our timeline; we already have a lot of the pieces, but it’s just not all together yet.”

Devita and his team will use the first six months to create a web site, make slide shows, and get the educational and equipment infrastructure in place. Next, staff will be trained at UPMC Presbyterian — hopefully, early this summer. “Then, probably in late fall, there will be additional training at the University of Michigan,” Devita adds.

The project, he continues, will be characterized by a process approach and by transparency. “We will try to create all the process steps and allow everyone in the world to use it,” he says. “We will make available the policies, the content of the equipment cart, educational pieces, slide sets for the community, hospital staff, ED staff, and members of the team.”

The web site, he adds, will be an “open source,” and will include surveys to evaluate

community attitude and knowledge exams for health care professionals.

As for the team members, says Devita, “we have identified the skills that need to be available; individual hospitals may choose to staff theirs differently, but at ours we have a group of emergency medicine physicians who are not on duty in the ED but who participate in several research projects, and who are available when emergencies happen.”

The key, he adds, is staff availability and staff with the knowledge and skills to set up the equipment and perform the initial procedures. As for the equipment itself, “we need to have a mechanism to get everything together at the same time.”

The project, he re-emphasizes, “is all about process. The biggest thing is the notion of a pre-planned team. You need pagers, a mechanism for triggering a bunch of pagers at the same time, and equipment that is in a [convenient] locale and ready to use at all times. And your hospital has to have policies to permit this to occur — such as death determination.”

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Two health care systems bring home Baldrige award

QI programs at Sharp initiated by ‘sponsors’

Not too many years ago, the health care industry was applauding the first hospital recipient of the prestigious Malcolm Baldrige National Quality Award. This year not one, but two, health care organizations were recently announced as Baldrige winners.

They are Sharp HealthCare, of San Diego, and Mercy Health System, of Janesville, WI. Mercy reports that in the last five years it has averaged a 7.1% return on net revenues and has steadily decreased its rates for community-acquired pneumonia, reaching 1.2% this year — significantly below its benchmark of 4%. (*Look for an in-depth article on Mercy’s QI efforts in our next issue.*)

As for Sharp, Nancy Pratt, RN, MSN, senior

Key Points

- Baldrige evaluators look for organizations where consistent, systematic processes are fully deployed.
- Standard order sets, education, and training are keys to system’s quality improvement.
- New processes are driven down to the unit and department levels to ensure adaptation.

vice president, clinical effectiveness, notes that “Baldrige looks for organizations where systematic processes are fully deployed, rather than you just getting lucky and obtaining good results you can’t duplicate. In other words, they want to see consistent, reliable processes.”

Managing blood sugar

For example, notes Pratt, “we spent a lot of time and energy on trying to manage patients’ blood sugar — which not all hospitals do successfully.”

Sharp put processes in place across the entire system — which includes seven licensed facilities (four acute care and three specialty). “We used standard order sets and advanced practice nurses in our inpatient hospital and did a lot of education and training and standardized approaches to medicines — for instance, we don’t use oral agents,” Pratt notes. “It took awhile to start to see the needle move, but we’ve had sustained improvement year after year and we continue to improve.”

In fact, Sharp has been addressing diabetes for about five years, using Lean Six Sigma to drive performance improvement. “We have also used some other tools we learned from GE — workout and change acceleration process, for example,” says Pratt. “We applied the right tools to the right processes, using Lean for some components, such as getting meals timed along with insulin and delivered within the right time interval.”

‘No sponsor, no project’

Every process improvement initiative at Sharp has a process owner, a leader or manager, and every project has an executive sponsor. “No sponsor, no project,” says Pratt. In fact, she adds, “sometimes it is the sponsor who asks for the project — other times it’s whoever owns the process.”

To launch the diabetes project, a steering group was put together, comprising stakeholders and key leaders to manage the process. “We put on a lot of education programs so people would be up to date on the latest literature,” says Pratt. “We taught them that we were using a basal insulin — a long-reacting drug that stays in the background — and then additional [insulin] to cover what they eat.”

The intravenous and subcutaneous insulin were given on a proactive basis, she adds. “We did not wait until their sugar got higher.”

Patients who come in for other reasons but who are type II diabetics, receive insulin if their blood sugar is more than 150. “We don’t want it over 120, and we may have parameters to hold them a lot tighter,” says Pratt.

Blood sugar is usually measured four times a day — before meals and at bedtime. “We’re pulling 10,000 blood sugars for analysis, with 1,700 beds in our health system,” Pratt notes.

In order to sustain the improvement, Pratt

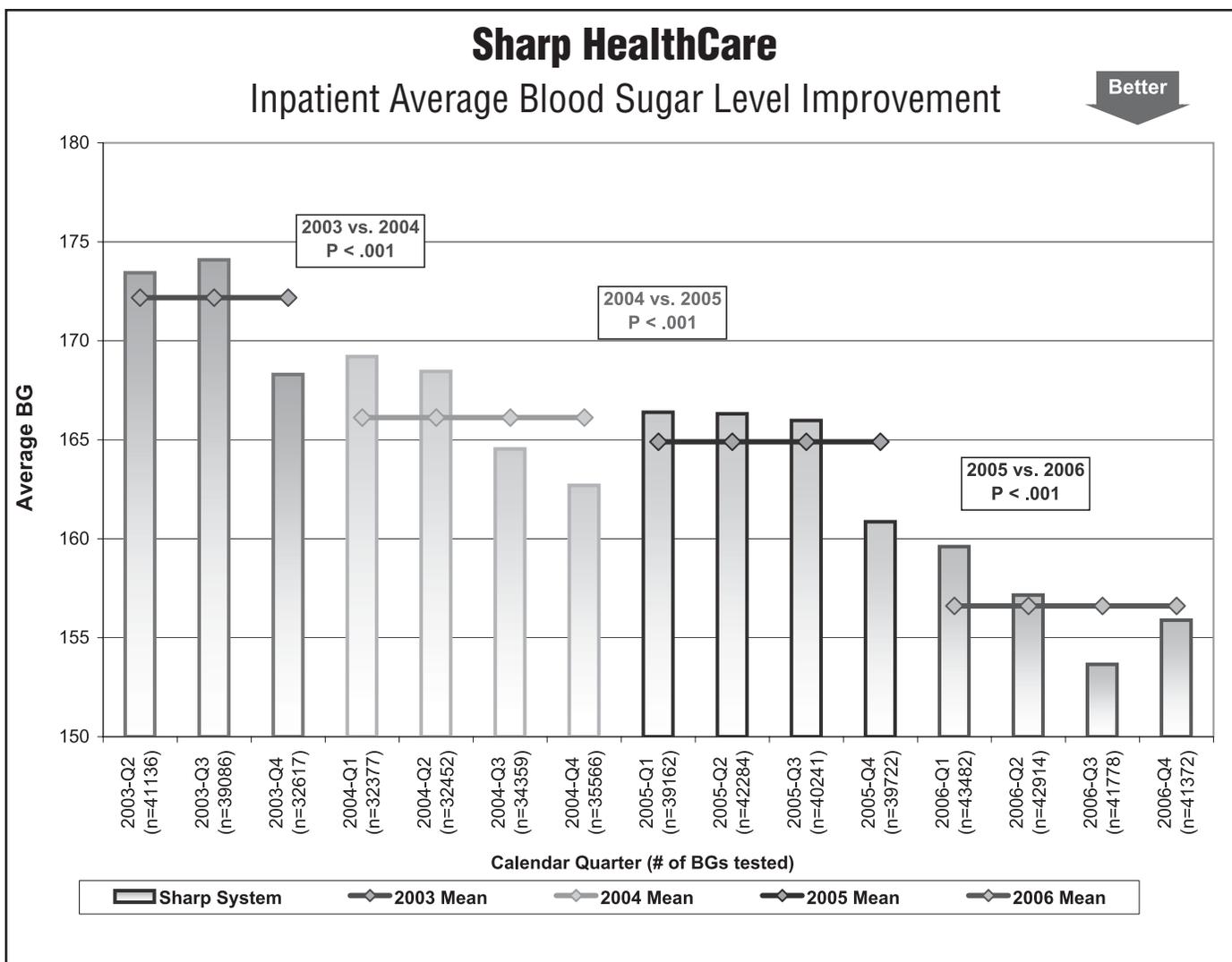
explains, “we refine the measurement every year and raise the bar.” For example, she notes, at the beginning of the process the steering committee decided it would not measure blood sugars the day the patient was admitted and the day he or she was discharged. “Now, we’re a lot more rigorous; if you come in with bad blood sugar that’s fine, but from then on we should be able to control it.”

The six pillars

Pratt says that all Sharp activities are grounded in six pillars:

- quality;
- people;
- service;
- finance;
- growth;
- community.

In terms of people, for example, (which includes employees) and service (which encom-



passes patient relations), “we hard-wire our must-haves,” says Pratt. These include greeting people with a smile and saying hello, displaying an “attitude of gratitude,” and “using key words at key times.”

“We have taught these to all our employees — like taking people where they are going; if someone looks like they need to go somewhere, you ask where they are going and you take them there,” Pratt explains.

This was rolled out to about 14,000 employees. How does Sharp do it? “Sometimes we take a situation and divide it up and deploy it out to individual hospitals — and then to each department and each unit,” Pratt explains. “We also have an annual meeting at the San Diego Convention Center, and three separate staff meetings for inspiring and celebrating.”

The overriding issue Sharp had to address before it could bolster improvement in any of these areas was the fact that “as a system, we were process-ignorant,” says Pratt. “Sometimes that was because we did not have one, and sometimes we could not tell a process if it hit us in the face — we just could not articulate what a process was.”

Now, she says, “when something doesn’t work, people will say it’s not working because we do not have a process. We now have a lot of process flow diagrams, and this has helped us make the systematic, standardized changes needed to make our processes better.”

This, she continues was “the biggest learning we have made.” Some of the changes were enabled through using tools such as Lean Six Sigma, and others came by getting feedback from Baldrige examiners and having everyone read the comments. “They ask what your process is and how you do it, and you have to be able to answer,” Pratt explains. “So, we got people together and said, ‘Let’s map [the process] out.’”

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NEWS BRIEFS

New device developed to prevent wrong-site surgery

Richard Chole, MD, PhD, has developed a new system called CheckSite, designed to prevent wrong-site surgeries by reminding surgeons to take a time-out before the procedure.

The system includes wristbands with microchips embedded in them, which are placed on the surgical patient. Sensors that correspond with the microchips are placed by the operating room doors. Following an appropriate time-out, a staff member puts in place a sticker that deactivates the microchip. If that step is not taken, an alarm will sound, reminding physicians to do the time-out. The system is in place in six hospitals throughout the United States, according to the *St. Louis Post-Dispatch*.

For more information, visit www.check-sitemedical.com. ▼

CA Assembly passes health reform bill

The California Assembly passed a newly amended ABX1 1, which Gov. Schwarzenegger was expected to sign as of press time. The latest version of the bill, ABX1 1, as passed by the

COMING IN FUTURE MONTHS

■ Can a hospital’s need to survive come into conflict with quality?

■ Anatomy of a Baldrige winner: How one system did it

■ Washington governor pitches tough new patient safety plan

■ Michigan hospital association posting hospital cost, quality information on-line

Assembly on Dec. 17, requires employers to either “pay or play” for care or coverage and creates a mandate for individuals to have a minimum level of insurance for themselves and their dependents.

Comprehensive health reform could have a significant impact on the health care system, according to a new report by the Commonwealth Fund. A combination of universal coverage and several policy options could result in \$1.5 trillion in U.S. health care system savings over 10 years, according to the report.

The report cautions that in order to see real savings and higher value, policies must address overall health system costs and not shift cost from one part of the health care system to another. ▼

Telemedicine diabetes project expanded

A project designed to prevent diabetes-related blindness has proved so successful in California’s Central Valley that it is being expanded across the state, with a goal of serving 100 clinics and 100,000 patients, according to the California HealthCare Foundation (CHCF), the project’s sponsor. Diabetic retinopathy is the leading cause of blindness among working-age adults and 24,000 diabetics become legally blind each year in the United States. With regular screening, blindness can often be prevented, but half of all patients with diabetes don’t get recommended

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yearly eye exams. The problem is even greater in the Central Valley, with a high incidence of diabetes, shortage of health care providers, rural settings, and high numbers of poor and uninsured patients.

CHCF’s Better Chronic Disease Care program funded a pilot project that uses telemedicine software developed by the University of California Berkeley School of Optometry, expert consultation, digital retinal cameras, and screenings during regular office visits at 13 Central Valley safety net and rural clinics. The pilot led to a \$1.8 million expansion of the project to selected clinics across California. For more information, visit www.chcf.org. ■

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