Pittsburgh Regional Healthcare Initiative

Reprinted from *PRHI Executive Summary*, July 2004

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Guest editorial

Hospital quality: What's the next step?

By Paul O'Neill, Ken Segel, Jan Jennings, John Snyder, Jon Lloyd, MD, and Karen Wolk Feinstein, Ph.D. on behalf of the Pittsburgh Regional Healthcare Initiative. Adapted from invited comments for the Commonwealth Fund Funded Study by the Economic and Social Research Institute, *"Hospital Quality: Ingredients for Success."*

At one local hospital recently identified as providing among the highest quality and lowest cost care in the country, we were struck by this comment from the CEO: "We may be good by comparison, but we could be a lot better."

One finds this attitude ingrained in organizations performing at high levels. And indeed, in any American hospital today, it is true. We can do much, much better. But how?

At the Pittsburgh Regional Healthcare Initiative, we have had the privilege of working closely with dozens of fine institutions from Southwest Pennsylvania, and learning from many others across the country. We also draw on our own experience outside health care. One of us led the safest business in the world, an 120,000 employee corporation operating in 41 countries that, as of May 7, 2004, was 33 times safer to work in than the average American hospital (Alcoa lost workday rate = .070 per 200,000 work hours, US hospitals = 2.3).

Here are a set of linked observations, meant to challenge leaders of institutions and the medical profession:

1. It is common wisdom in the quality and safety movement that leaders must establish quality and safety as priorities. We don't think that goes far enough. They must be preconditions – non-arguable ingredients of how we care for patients. Priority implies that safety is one of a number of institutional objectives and might change, perhaps in the next fiscal crunch. We have seen elements of that no compromise thinking, such as our local Jefferson Health System's commitment to absorb the costs of any care day denied reimbursement if their clinicians believed a patient needed to remain in the hospital. But how much further could we take this principle, and to how much greater yield from our workforce?
2. We have seen great power in setting goals at the theoretical limit – perfection or as close to it as scientifically possible. It defuses defensiveness and excuses, keeps the pressure on for breakthroughs, and lays the groundwork for a cycle of escalating quality. "It isn't an issue of 'good' or 'bad,' just what's the next thing we have to do to get closer to the ideal."
3. To have a chance at closing the gap between here and the ideal, leaders must embrace the notion that they are responsible for everything that occurs in their institutions, especially things gone wrong. Everything. Today, it is difficult to find hospital leaders – clinical or administrative – that truly accept this notion. Lucian Leape, MD, notes that first observation of a safety sciences expert viewing a typical hospital would be "No one's in charge."
4. Once a leader accepts that responsibility, the next question is whether we are telling ourselves the truth, every day, about each thing gone wrong?

   Here's a test for executives. Work on a nursing unit for a morning, as one of us did regularly as CEO. Note how many times a nurse needs to seek clarification of a medication order from a physician. Then go down to the pharmacy and see how many times the order entry pharmacist needs to clarify an order, or fill an incomplete order. Then ask yourself how many days, months, and years these "small" problems have gone on, and on. Why haven't they been addressed? And how many other kinds of problems like these occur every day in other parts of the organization?

   How to evoke the truth in a way that supports the

most rapid possible improvement? Ask yourself, do our employees and colleagues capture everything that has gone wrong, investigate a cause, take action to address the root cause, and share all of that essential information across the enterprise within twenty four hours? Leaders can use such "real time" tools not as a means to find fault, but to assess on a daily basis how well their institutions support problem solving and improvement on the front lines, and to allow people on the front lines to learn from each other.

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At one partner hospital, they are acting on a commitment to eliminate every unsafe condition. Over a year, they have gone from reporting 3.2 incidents or problems a day to an average of 37, and assessing whether they are solving each problem to root cause. After lots of practice, they are solving 6% of their problems to root cause each day, compared to near zero percent previously. The gap between the number of problems and the number they are solving is driving them crazy, fueling their determination to close the gap.

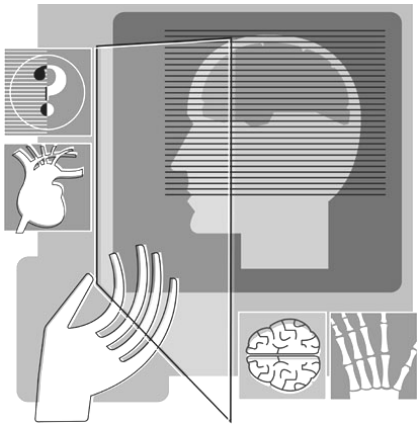
5. Use of such a problem-solving system soon calls the question of what structure best supports excellence, especially in an organization as complex as a hospital. The study recognizes that the featured hospitals have avoided the fatal flaw of most organizations: to assign "quality" to a "quality department" or safety to a "safety officer" but instead to have those experts serve as "technical assistance," with everyone expected to "own" the work of improvement. Risk management is no longer assigned to isolated specialists. The experts focus on letting the facts empower folks who do the work to make change. We applaud this focus, and have seen the power of this approach play out on a community scale, through the kind of collaborative registry pioneered by the Northern New England Cardiovascular Disease Study Group.

Here are some thoughts about how to push that thinking even further.

There is still a prevailing assumption that much of improvement has to occur through committees, whether established or "ad hoc." Great organizations recognize that committees are mechanisms for codification and communication, but that improvement must occur in "real time" and in the course of regular work. In medicine, one of the giants of surgery, Frank Spencer, MD, has driven this point home in his capacity as patient safety officer at NYU Medical Center. When a problem occurs at NYU, a small team is immediately assigned and has a week to implement a "root cause" solution as close to the ground as possible. The relevant committees are informed of what changes were made; they aren't asked for permission. Two hospitals we work with are on the edge of disbanding their quality committees, in order to concentrate on getting to the floor and solving real problems.

Act on the specific, and act today.

We see evidence in our partners' work that these ideas can generate levels of performance that most people consider to be utopian. Leaders establish "quality and safety" as preconditions of serving people and protecting the workforce. They accept responsibility for everything. They ask themselves whether they are getting information on everything gone wrong, every day, and ensuring that the front line troops have the permission and tools they need to solve each problem. And leaders ask ceaselessly: how far are we from the ideal and what's the next improvement that will move us closer?



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