Modern Healthcare
The only healthcare business news weekly

Opinions-Commentary >> *Written by Paul O'Neill and Jan Jennings*

Pushing performance

When quality and safety aren't goals but preconditions for doing business

Story originally published August 2, 2004

The chief executive of a Pittsburgh-area hospital that was recently identified as providing among the highest-quality and lowest-cost care in the country wasn't impressed: "We may be good by comparison, but we could be a lot better."

We at the Pittsburgh Regional Healthcare Initiative have found this attitude across southwest Pennsylvania and around the country at high-performing institutions. They're good, but they know they could be much better. But how?

A forthcoming study of high-performing hospitals commissioned by the Commonwealth Fund and conducted by the Economic & Social Research Institute reveals a number of conclusions meant to challenge leaders of institutions and the medical profession.

It is common wisdom that hospital leaders must establish quality and safety as priorities. We don't think that goes far enough. These must be preconditions, essential 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. The authors of this article have seen elements of that no-compromise thinking, such as our local Jefferson Health System's commitment to absorb the costs of any day of care denied reimbursement if their clinicians believed a patient needed to remain in the hospital. But how much further could we take this principle, and is the available workforce adaptable enough?

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.

To have a chance at closing the gap between the current reality and the ideal, leaders must embrace the notion that they are responsible for everything that occurs in their institutions, especially things gone wrong. Today, it is difficult to find hospital executives who truly accept this notion.

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 the authors did regularly as a 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?

Ask whether you or your colleagues capture everything that has gone wrong, investigate root causes, take action on them and share all of that essential information across the enterprise within 24 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.

At one hospital in the study, officials are acting on a commitment to eliminate every unsafe condition. Over a year, they have gone from reporting 3.2 incidents or problems per day to an average of 37, and assessing whether they are solving each problem at its root. After lots of practice, they are achieving a 6% rate of solutions per day, compared with almost zero previously. The gap between the number of problems and the number they are solving is driving them crazy, fueling their determination to close it.

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. But we need to push that thinking further.

There is still a prevailing assumption that much of the improvement has to occur through committees. Great organizations recognize that committees are mechanisms for codification and communication, but that improvement must occur in the course of regular work. In medicine, one of the giants of surgery, Frank Spencer, 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. The relevant committees are informed of what changes were made; they aren't asked for permission. Two hospitals we work with in Pittsburgh are on the edge of disbanding their quality committees, in order to concentrate on getting to the floor and solving real problems.

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 to move us closer?

Ken Segel, John Snyder, Jon Lloyd and Karen Wolk Feinstein contributed to this article.