

EXECUTIVE SUMMARY

March 2012

2011 FINE AWARDS WINNERS — PUTTING PERFECTING PATIENT CARESM TO WORK

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PRHI'S Center for Perfecting Patient CareSM has been approved by the Pennsylvania State Nurses Association as a provider of continuing education.

Teamwork plays a critical role in health care. The Fine Awards, sponsored by The Fine Foundation and the Jewish Healthcare Foundation, were established to recognize and reward outstanding examples of healthcare staff working together toward a common goal. On November 17, five local teams were recipients of the 2011 Fine Awards for Teamwork Excellence in Health Care during a reception at the August Wilson Center for African American Culture. For the first time, the awards included teams from federally qualified health centers and teams who have been able to sustain improvement for at least three years.

In addition to continuously striving to provide the best patient care, the 2011 Fine Awards winners have something else in common — they all employed problem-solving approaches consistent with Perfecting Patient CareSM (PPC), PRHI's flagship quality improvement methodology. Founded upon the principles of the Toyota Production System and the Alcoa Business System, PPC is a powerful, proven approach designed to address the challenges healthcare organizations are facing today — patient safety, process improvement, cost savings and quality health outcomes. PPC brings problem solving out of the conference room and onto the front lines by empowering people at every level of an organization to improve and redesign their work to fulfill a common mission. PPC aims to eliminate errors, inefficiency and waste in complex systems through continuous improvement and standardization of work practices.



Pittsburgh Regional Health Initiative President and CEO Karen Wolk Feinstein stands with Milton and Sheila Fine of The Fine Foundation.

The 2011 Fine Awards winners demonstrate that a dedicated team of people working at the front line of care and supported by engaged leaders can generate impressive and sustainable improvements — and they can do so across healthcare organizations and diseases. Winners this year came from both large health systems and smaller federally qualified health centers. Teams worked on complex challenges like reducing avoidable readmissions for patients with congestive heart failure and chronic obstructive pulmonary disease, to emergency department flow, to transitions of care and the implementation of the patient-centered medical home model.

Fine Awards Winners' Circle



Platinum Fine Award:
VA Pittsburgh
Healthcare
System

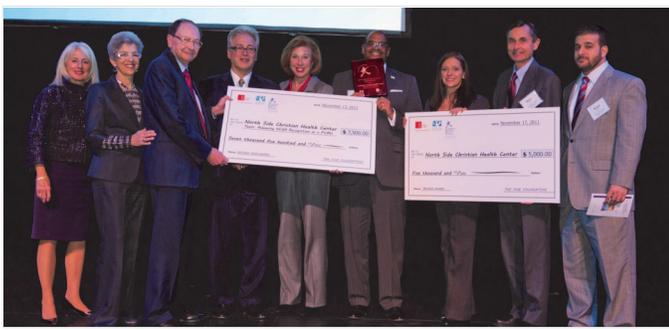


Gold Fine Award for Sustaining Improvement: St. Clair Hospital



Gold Fine Award for Sustaining Improvement: UPMC St. Margaret

Silver Fine Award:
UPMC Shadyside Family Health
Center and Shadyside Hospital
3 East



Bronze Fine Award:
North Side Christian Health Center

PRHI relied heavily on our distinguished selection committee to complete the difficult task of judging the 2011 Fine Awards submissions. We thank them for contributing their time and expertise:

- Michael Blackwood; *Gateway Health Plan*
- Basil M. Cox; *West Penn Allegheny Health System Board of Directors*
- Joel H. Ettinger; *Category One, Inc.*
- Renee S. Frazier; *Healthy Memphis*
- John P. Friel; *MEDRAD, Inc. (retired)*
- Jerome E. Granato, MD, FACC; *Excelsa Health System*
- Russell Johnson; *North Penn Community Health Foundation*
- Jason Kunzman; *U.S. Department of Health & Human Services*
- Shankar Lakhavani; *Precision Therapeutics, Inc.*
- Steven M. Lieberman; *National Governors Association*
- JoAnn V. Narduzzi, MD, FACP
- Meredith B. Rosenthal, PhD; *Harvard School of Public Health*
- Ralph Schmeltz, MD, FACP, FACE; *Pennsylvania Medical Society*
- Thomas P. Timcho; *Jefferson Regional Medical Center (retired)*
- Ann Torregrossa, Esq.; *PA Health Funders Collaborative*

Platinum Award

VA Pittsburgh Healthcare System – Zeroing in on Congestive Heart Failure Readmissions

To win the first ever Platinum Fine Award, the team from VA Pittsburgh Healthcare System took a structured approach to caring for a complex patient population. Perfecting Patient Care methodology isn't new to the VA – improvement teams across its system have long used the methodology to achieve and sustain impressive results like nearly eliminating hospital-acquired MRSA infections and redesigning diabetes care delivery. This time, with their focus on patients with congestive heart failure, VA Pittsburgh staff set out to apply the same approach to improving standards of care and reducing avoidable readmissions.

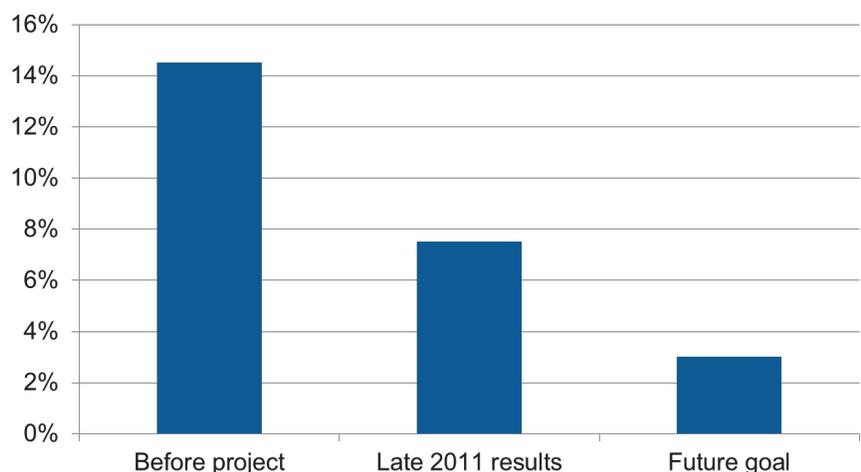
Congestive heart failure (CHF) is a chronic and progressive disease managed by patient education and medication management. The VA Pittsburgh, following its mission “to honor America’s veterans with world-class health care,” knew it needed to reduce the high rate of CHF readmissions among its patient population. A dedicated CHF team was formed in 2007 to put best practices associated with caring for heart failure patients in place across the facilities. The team worked with the different disciplines to unite elements of caring that had previously been managed separately. This included creating patient education materials and a tracking system for providing focused and standardized discharge and follow-up instructions.

Before they started the project, the readmission rate for CHF patients at the VA Pittsburgh was 14.5%. By late 2011, the team’s work had nearly halved the readmission rate to 7.5%, and the goal for the next fiscal year is to get the rate down to 3.0%.

The CHF team used a data-driven approach to hit these numbers. First, they set their goal to achieve a nearly error-free environment. The bold target empowered employees to reshape processes and outcomes. Next, they began implementing strategies to improve performance like the TeleHealth service. TeleHealth installs a scale and electronic blood pressure cuff in the home of CHF patients. The equipment transmits data directly back to the care providers at the VA Pittsburgh, allowing them to proactively monitor and assess patients. Such measures demonstrate the VA Pittsburgh’s emphasis on patient safety to achieve the best possible outcomes.

With these improved numbers, the VA Pittsburgh has brought its CHF readmissions percentage well below the average range of 14-24%, as reported by the Agency for Healthcare Research and Quality in 2010 for state-level CHF hospitalizations. The quality improvement efforts also had a major impact on CHF patients’ life expectancy, increasing it by 8-10 years.

Readmission rates for CHF patients at the VA Pittsburgh



Watch the 2011 Fine Awards video on the VA Pittsburgh [here](#).

Gold Award – Sustained Improvement

St. Clair Hospital – Sustaining Excellence in Patient Flow in the Emergency Department

Gold Fine Award winner St. Clair hospital shows that aiming for “perfect” in Perfecting Patient Care is a plausible goal; its Emergency Department had already set and achieved excellent levels of quality care and service in 2008-2009.

That dedicated effort, dubbed “Toyota at St. Clair” set a high target in 2008 – achieve 95th percentile nationwide in overall patient satisfaction. Tania Lyon, PhD, former PRHI coach and current director of organizational performance improvement at St. Clair, used Perfecting Patient Care principles in developing and deploying the hospital’s quality improvement process. By the first quarter of 2009, the emergency department staff had already hit the goal. Wait time from walking in the door to seeing a provider had dropped from an average of 81 minutes to 40 minutes. Suddenly, the department knew what it was capable of and in the next two quarters the scores were even better, first the 98th, then the 99th percentile respectively.

By 2010, staying in the 99th percentile was the expectation and Emergency Department staff couldn’t imagine going back to the way things were before. But maintaining a goal was different from achieving it a single time. St. Clair needed to learn how to sustain their high scores, especially as room volume continued to climb, new hires joined the team and new technology, like computerized physician order entry (CPOE), became integrated into the work environment.

As St. Clair staff rightly pointed out in their Fine Awards application, “In Toyota thinking, no problem is too small, and anything short of the ideal is worth improving.” The staff knew that the same data-driven Toyota principles that helped them improve the emergency department in the first place could help them to “sustain the gain.”

The countermeasures to keep their success going has included monitoring, real-time problem solving, education, and consistent communication – all hallmarks of the Perfecting Patient Care methodology. To monitor and solve problems, emergency department staff use an electronic status board to track each patient’s status in real time. Trigger points are built in so that if a patient does not progress, the charge nurse can initiate a staff huddle to determine the cause of the delay and enlist resources from leadership if needed. Emergency department leadership reviews volume and patient satisfaction scores daily. The full dashboard is reviewed monthly with members of the senior management team so quarterly reporting never comes as a surprise.

The entire department staff also receives information around wait times and patient satisfaction at least twice a month via bulletin boards, meetings and through a popular departmental newsletter called “The InformER”. To maintain the momentum and culture of the department, all new hires must complete a required annual training course.

Overall, the St. Clair emergency department staff, by refining and reinforcing its efforts, has managed to turn an initial impressive result into a lasting improvement.

Overheard by a St. Clair employee at the intake desk of a crowded emergency room at another hospital: “Can you tell me if we’re going to have to wait longer than 45 minutes? Because I can drive to St. Clair Hospital in 45 minutes and I know they will see me immediately.”

Patient flow in the Emergency Department at St. Clair

	2008	Now
Patients per day	145-148	176
Door to room	54 minutes	4 minutes
Door to provider	81 minutes	22 minutes

Highest raw score > 50,000 ED visits

Watch the 2011 Fine Awards video on St. Clair Hospital [here](#).

Gold Award – Sustained Improvement

UPMC St. Margaret – Sustaining the Gain on COPD Readmission Reduction

In a tie for the Gold Fine Award, UPMC St. Margaret also demonstrated what it takes for a healthcare team to keep quality improvement going. Back in 2006, data from the Pennsylvania Health Care Cost Containment Council (PHC4) indicated that, at slightly over 25%, UPMC St. Margaret had one of the region's highest readmission rates for patients with chronic obstructive pulmonary disease (COPD).

In the fall of 2007, after the publication of the PHC4 report, PRHI approached UPMC St. Margaret administration with a plan to collaborate on an innovative approach to decrease avoidable COPD readmissions. A COPD Readmission Reduction Team was formed and included key players and experts in the field of COPD patient care with the desire to provide overall improved outcomes for this patient population. Participants included pulmonary and family care physicians, nursing, respiratory, physical and occupational therapies, pharmacy, quality, care management, and information systems.

By 2008 the team was applying Perfecting Patient Care strategies including observing current work processes, developing the ideal process, value-stream mapping, and Kaizen events to remedy defects and eliminate waste. Early in the process, the team utilized the PPC tool of observation to clearly understand its current COPD pathway by following several patients as they moved from admission through discharge and then to post-acute care. With the detailed observation data, the team identified numerous opportunities for improvement, traced problems to their root cause, and implemented a series of countermeasures.

Improvement opportunities identified via observation and value stream mapping included:

1. Challenges with identifying patients with COPD and mobilizing the appropriate care team
2. Undefined and inconsistent roles and responsibilities related to educating patients about inhaler use and smoking cessation
3. Ineffective patient education materials
4. Lack of standardized COPD protocols and physician order sets

The team systematically addressed each of these items, viewing them as opportunities and involving frontline staff and providers in the redesign of the COPD care pathway. Changes in care delivery included having respiratory and physical therapy use a consistent process with patients to educate and teach inhaler use. There is also a care manager in place to coordinate follow up outpatient care – including a home visit program. On a home visit, a nurse sees the patient at home within 24-72 hours following discharge. The nurse answers medication questions, instructs on breathing techniques, and explains symptoms of exacerbation and possible actions to take. The team also established a COPD "breathe better kit" which conveniently gathers patient COPD information into a handy travel bag. Patients take the information with them to doctor appointments to aid in the continuity of care.

The changes worked. The team achieved a 37% reduction in COPD readmissions and has sustained these inspiring results for three years. UPMC has started to adopt these practices system wide, and the St. Margaret team members are moving forward as well – they are applying the same Perfecting Patient Care principles to other complex conditions, and are already beginning to see results.

UPMC St. Margaret held several beneficial Kaizen events. A Kaizen is a two-to-four day continuous improvement event that brings together a team of people from all levels of an organization to focus on a specific process enabling small, rapid improvements over a short period of time.

Watch the 2011 Fine Awards video on UPMC St. Margaret [here](#).

Silver Award

UPMC Shadyside Family Health Center and Shadyside Hospital 3 East – Creating a Bridge between Inpatient and Outpatient Care

The UPMC Shadyside Family Health Center (SFHC) is a hospital-based outpatient facility focusing primarily on community health care. It is located right across the street from UPMC Shadyside Hospital. History showed that SFHC shared many of the same patients with the hospital – especially its 3 East family medicine unit – but until recently, the two groups had no formal way to transition care.

A 2009 report issued by the Joint Commission identified transitions of care as a key component in an effective continuum of patient care; inadequate communication and poor transition of care are critical safety and quality issues in health care. In looking at its data, SFHC saw that transitions of care with 3 East had ample room for improvement. Only 46% of patients discharged from the hospital followed-up with their primary care physician in the outpatient setting, there was no consistent medication reconciliation within 48 hours of discharge, and 3 East patient scores on overall satisfaction with the discharge process ranked a low 11th percentile.

That data, combined with the report's clear imperative – that early post-discharge follow-up care is effective in reducing readmissions, educating patients and improving medication reconciliation – compelled SFHC and 3 East into action. One of their first steps was to establish a multidisciplinary team of caregivers to generate ideas and prioritize them based on impact to the patient. Former SHFC Medical Faculty Bruce Block, MD, and Administrative Director Mark Valenti, now both with PRHI, empowered employees to become individual agents of change across the departments.

Cycles of Plan-Do-Study-Act, a foundation of the Perfecting Patient Care problem-solving approach, was the method the team implemented to establish and achieve the following goals:

1. Increase the number of people who schedule – and show up – for follow-up appointments with primary care physicians
2. Complete medication reconciliation within 48 hours
3. Improve patient satisfaction with the overall discharge process

Through multiple work redesigns, a new process was developed ... and it got results. Before discharge from the hospital, several steps take place: the physician goes into the patient room and hands out a business card, a pharmacist consults in room with the patient about old and new medications, and the patient sets up his next appointment with SFHC. After discharge, there are two important follow-up measures: a pharmacist places a call to the patient within 2-3 days and the patient sees the same physician at the health center as he did in the hospital.

Scheduled appointments jumped from the initial 46% to 80% with a show rate of 73%. Overall discharge satisfaction improved from the 11th percentile to the 48th percentile, and scores demonstrating that patients understood how to take their medications after discharge improved from the 19th percentile to the 90th percentile.

More than just the raw data improved – overall interactions between SFHC and 3 East are better too. Physicians realized their impact on the patient experience during both the inpatient stay and the follow-up clinic visit, clinical staff gained insight into other disciplines, and patients built stronger relationships with their caregivers so that they were more willing to return for follow-up care.

Improving discharge and follow-up care between SFHC and 3 East

	Before	After
Scheduled appointments	46%	80%
Overall discharge satisfaction	11th percentile	48th percentile
Patient satisfaction with medication instructions	19th percentile	90th percentile

Watch the 2011 Fine Awards video on UPMC Shadyside Family Health Center and Shadyside Hospital 3 East [here](#).

Bronze Award

North Side Christian Health Center – Achieving NCQA Recognition as a Patient-Centered Medical Home

North Side Christian Health Center's journey to become a recognized patient-centered medical home (PCMH) has its roots in solid quality improvement methodology.

The health center, with its commitment to ensuring the highest quality of care for its complex, medically underserved patient population, has worked with PRHI on a structured approach to quality improvement to address issues like access, chronic disease management, care coordination and patient-centered interactions. It is also a part of PRHI's Safety Net Medical Home Initiative which supports safety net family care sites in their transformation to patient-centered medical homes.

In 2010, the health center staff decided to apply for recognition as a PCMH through the National Committee for

Quality Assurance (NCQA). The NCQA recognition process is time consuming and rigorous. It requires that all aspects of practice operations are clearly defined by policies and procedures that demonstrate a commitment to patient centeredness consistent with NCQA's high standards. The health center staff members, because they used quality improvement methodology to operationalize elements of the practice before, knew a similar strategy could guide the application process as well.

The health center began by assembling a team of care givers and administrators guided by a PRHI coach. Using Perfecting Patient Care methods, the team developed a thorough current condition assessment of all practice operations, policies, and procedures. The team then used observation and process-mapping techniques to better understand the patient experience, and let data drive the improvements. They examined all aspects of their practice operations, and set about to improve any part of their care delivery system that was not up to NCQA standards.

In addition to the application process – which would tax a practice's time and personnel resources in even the best-case scenario – the health center was in the midst of a major electronic health record (EHR) implementation. The double challenge might have deterred others from pursuing recognition, but not the staff at the North Side Christian Health Center. They thoughtfully aligned the goals of the NCQA recognition process and the EHR implementation with clearly defined roles and responsibilities for affected staff. Reflecting the fundamental Perfecting Patient Care principle that those who do the work are the ones best equipped to redesign it, team members most closely connected with the processes created the new work flows, tested the improvements, and updated policies and procedures to reflect the changes in care delivery.

The overall results are impressive; the team achieved level 3 recognition, which is the highest level awarded by NCQA. This far surpassed the original goal of achieving level 1+ recognition. In addition to the quantitative scores, the health center staff had great qualitative outcomes too: improved teamwork, a sense of pride and accomplishment, and the satisfaction of knowing the years of adopting a disciplined approach to quality improvement have paid off by making care better, safer and more efficient for their patients.

As Diana Williams, MS, patient advocate at North Side Christian Health Center concludes, "We could have never gotten NCQA recognition without PRHI. They came in, they provide workshops, they provide one-on-one coaching, and they support you, but they don't take over."

Watch the 2011 Fine Awards video on North Side Christian Health Center [here](#).



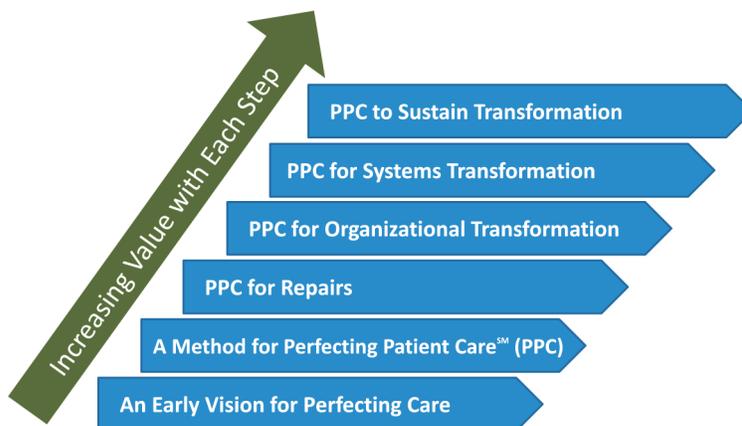
Perfecting Patient Care: What Are the Next Steps?

The 2011 Fine Awards winners join the 2010, 2009, and 2008 winners to show how Perfecting Patient Care can be used to drastically improve care delivery. The winning teams made quality improvement a priority, and they have the positive results for patients, improved employee satisfaction scores, and reductions in costs to prove that the method works.

Two of our winners, St. Clair Hospital and UPMC St. Margaret, tied for gold in a newly created Sustained Improvement category. They won for the same quality improvement initiatives in 2011 as they did in 2009 because they demonstrated that improvement is continuous, and goals achieved once won't stay that way without steady, corrective effort. The VA Pittsburgh and UPMC Shadyside have won Fine Awards in the past as well, but for different departments targeting and improving different disease management processes.

What does this all mean for PRHI? Once again, we've proven to a wide audience that Perfecting Patient Care methods work ... and work well. What we seek now is to move beyond "spot repair" into greater organizational and systems transformation, and to sustain these improvements over time. The chart below outlines the steps necessary to accomplish this bold change. PRHI uses it as a guide to push ahead, spread Perfecting Patient Care methodology, and help engaged organizations move further up the steps toward true transformation.

Steps to move from repair to transformation



Local media outlets report on the 2011 Fine Awards

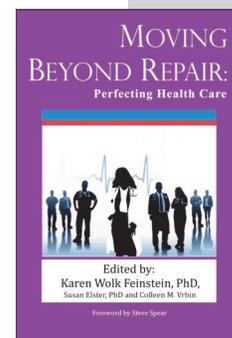
The Pittsburgh Post-Gazette, Tribune-Review, and neighborhood-specific sites like Patch.com all posted positive coverage of the Fine Awards winners. Click on the links below to read more:

[Pittsburgh Post Gazette](#)

[Pittsburgh Tribune-Review](#)

[Pittsburgh Business Times](#)

[Patch.com](#)



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