Pittsburgh Regional Healthcare Initiative

PRHI Executive Summary

Special Edition

Fundamental Change: Can we get there from here?

PRHI continues to learn from and challenge healthcare leaders involved in transforming health care delivery This special edition of PRHI Executive Summary describes (1) one leader's perspective of his hospital's fundamental change; (2) two imaginary scenarios of how healthcare transformation could proceed in Pittsburgh; and (3) a proposed action plan for successful change.

We begin below with the perspective of Jim Conway, Senior Vice President and Chief Operating Officer of the Dana-Farber Cancer Institute, who addressed the Leadership Obligation Group on September 3.

SEPTEMBER 2002

Inside this issue:

1. One Leader's Perspective

In 1994, beloved *Boston Globe* health columnist, Betsy Lehman, checked in to the revered Dana-Farber Cancer Institute for chemotherapy treatment of her breast cancer. The mother of two was no ordinary patient. Not only was she a locally renowned reporter who had written movingly about her bout with cancer, but her husband was a senior research scientist on the Dana-Farber staff.

Days later, Lehman died from a massive chemotherapy overdose, given due to a misinterpretation of the doctor's order.

"After we killed Betsy Lehman, we had to rethink our notion of stewardship," says Jim Conway, Dana-Farber's Senior Vice President and Chief Operations Officer. "Her death created enormous tension for change—not incremental change, but fundamental change."

Conway said that, in the reflection that followed, Dana-Farber executives began the painful process of uncovering the cracks, flaws and foibles of the organization. The "arrogance of excellence" gave way to a new slogan, borrowed from Swissair following its crash of Nova Scotia: "We're an excellent organization. We're not perfect."

Dana-Farber dealt with the Lehman death by using it to move the whole organization to a different place. "Our goal is to lead the way in patient safety, to hold it as a core value as important as our goal to cure cancer."

Boston Globe
December 5, 1994

BETSY LEHMAN FUNERAL TODAY. A funeral service will be held at 1 p.m. today for Globe health columnist Betsy A. Lehman at Temple Shalom, 175 Temple St., West Newton. Ms. Lehman died Saturday, December 3, at the Dana-Farber Cancer Institute while undergoing treatment for breast cancer. Following the service, burial will take place at Sharon Memorial Park, Dedham Street, Sharon.

The family requests contributions to the Betsy Amanda Lehman Scholarship Fund at Brown University.

What happened vs. Who-dunnit

Management supported the staff during the ensuing rounds of publicity, investigation and soul-searching by asking, "What happened?" The hospital president was there to offer comfort, making it clear that they were out to fix a bad system, not punish "bad people." They offered EAP and private counseling to the staff involved. Of the 18 nurses pursued, 13 remain with the institution.

"We didn't send out the hanging party," said Conway. "Staff can and need to talk about error, about what's not going right, about what keeps them up at night. And management needs to hear it."

WHAT'S SCARY TO ME AS A HEALTHCARE EXECUTIVE IS NOT WHAT *I KNOW*: IT'S WHAT *I DON'T KNOW*

—JAMES CONWAY, SENIOR VP, COO DANA-FARBER CANCER INSTITUTE

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1. One Leader's Perspective

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Disclosing errors: ignoring the lawyers

Arrogance compounds the damage from error. As one patient put it, "I wanted to talk and all they gave me was a lawyer."

Today at Dana-Farber, patients and their families are immediately told of any errors. At Dana-Farber now, every hospital committee includes patients and family members.

Significantly, as the rate of disclosed errors has increased, the rate of harm to patients has decreased. Initially reluctant, staff counsel have come to see wisdom in this approach: after 7 years, there have been *zero legal claims* by families on disclosed errors.

WE'VE CONFRONTED OUR WORST FEARS WITH OPENNESS AND HONESTY, AND NOTHING TERRIBLE HAS HAPPENED

—James Conway

It's naïve to think patients are unaware of error," says Conway. "Patients tell us, 'We know there's error. We were afraid YOU didn't know.'"

Pockets of data

"At Dana-Farber we thought we were great because 'stuff' wasn't rising to management," said Conway. "Pockets of data were sitting around the institution that we'd never turned into learning."

Now woven into everything they do is the acquisition and sharing of information about errors.

"There is far more risk in not sharing the data than in sharing it," says Conway. "What's scary to me as a healthcare executive is not what I know: it's what I *don't* know."

Eyes to see

A corollary problem was what Conway calls the "normalization of deviance." Too often, so many systemic problems exist that employees become inured to them and learn to work around them.

"People close to the work see much more than anyone," says Conway. Executives routinely do "walkarounds," talking with workers and patients and getting a feel for problems in the system.

Execs consistently ask staffers, "What's getting in the way of safe practice?"

Within 30 minutes of a report of a sentinel event, management knows about it. An incident review occurs within eight hours. "It's a schedule-breaker," says Conway.

Conway says that it takes courage for hospital executives to create tension in their organizations by allowing more information to flow to them. Execs can create a safe environment for staff to report problems by realizing that the staff is watching their every move and every gesture, and by asking "what," not "whom."

Allowing better information flow at Dana-Farber now means that the CEO sits in on every root cause analysis. It is "very sobering." Many of the problems are "very, very fixable."

Money

Don't ask how much these changes cost. Dana-Farber doesn't. Initially, following Betsy Lehman's death, the hospital allocated $1.3 million to go toward fixing problems in the system.

"That was the last time it was discussed," says Conway. "We quit using money as an excuse. It has ceased being a barrier. And in fact, I don't even think we've used it all."

Instead, says Conway, the motivation has moved toward "getting it right the first time. Our notion is, 'It's the right thing to do.'"

Dana-Farber's incessant pursuit of safe practice has unexpectedly become its strongest recruitment and retention tool. Where area hospitals suffer double-digit RN vacancies, Dana-Farber has no RN jobs open.

"Nothing terrible has happened"

Conway described the institutional fears that had to be addressed in the aftermath of Betsy Lehman's death. Although there have been sentinel events since then, the culture of the organization now allows them to learn and improve from them.

"We routinely discuss risk, harm and error among management, staff and patients," says Conway. "We immediately disclose errors. We have patients and family members on every committee. Lawsuits have not inundated us. Unfavorable media coverage has not ensued. We've confronted our worst fears with openness and honesty, and nothing terrible has happened."

And what of Betsy Lehman's story?

"Betsy Lehman is part of the Dana-Farber story now. We met the truth. An nothing terrible has happened." ☙

Two Imaginary Scenarios*

What will our region's hospitals look like in a couple of years? It all depends.

As a leadership exercise, PRHI staff put their heads together to imagine what might happen if the initiative stalls. Runs out of gas. Doesn't live up to its promising beginning. What would happen, for example, if hospitals don't fully implement the reporting tools at their disposal, like MedMARx for medication errors and NNIS for hospital-acquired infection?

Now, imagine what our region's hospitals could look like if PRHI actually picks up steam. Hospital leaders become excited. Want to go further, ignore barriers, set new standards. Suppose they insist that MedMARx and NNIS be used in the fullest possible way. What then?

PRHI staff set out both imaginary scenarios in a set of articles, written in the style of the *Wall Street Journal*. The introduction to the articles, below, is the same. The results are markedly different.

Please understand, in reading these articles, that everything about them is imaginary—the quotes, the target numbers and so on. They are meant to provoke discussion and inspire PRHI members to move beyond the daunting barriers that face the initiative.

(… could be the) *Wall Street Journal*

Introduction

Four years ago, the Pittsburgh region's health and civic leadership banded together to achieve a lofty goal: perfect patient care. All the players were there. The collaborative has grown to include 42 hospitals, four major insurers, the State's Attorney General, over 30 of the region's largest health purchasers and over 500 health professionals.

Under the banner of the Pittsburgh Regional Healthcare Initiative (PRHI), the region was determined to lead the nation in patient outcomes, promising high quality, lower costs and best value. Secretary Paul O'Neill, one of the founding fathers of the Initiative said, "We had the wild idea that what ailed health care was the failure to design systems from a customer point of view."

High aspirations were paired with a precise formula for healing a wounded system of care. Over 30 major purchasers and 40 hospitals signed on to a set of goals making Pittsburgh the region achieving the world's best patient outcomes.

Efforts focused on three patient-centered strategies:

Reduce medication errors and hospital acquired infections to zero by using common reporting systems and rapid response cycles that quickly turned learning into practice. The intent was to analyze errors as they were identified, test solutions within minutes, and spread improvements within and among the member institutions speedily.

Identify best practices in five clinical conditions through data registries that carefully measure the outcomes of different interventions. Again, the pattern is repeated: collect data and analyze quickly, share learnings, apply best practices, and repeat the cycle.

Rely on a new system for organizing and improving work, a framework the Initiative labeled "Perfecting Patient Care." Modeled after the Toyota Production System, it deployed skilled resources at the point of patient care to help unit teams learn world-class system design principles by solving problems in the course of work.

The region applied itself to the task. Partnerships with the Centers for Disease Control and the Agency for Healthcare Research and Quality, led to grants. Local corporations and foundations pledged funds. Participating hospitals installed state-of-the-art medication error and infection control databases. Traveling Field Managers helped hospital personnel in the use of these systems. The nation's largest Cardiac Data Registry began tracing patient outcomes from heart surgery in 13 different cardiac surgery units.

Early results were impressive. Southwest Pennsylvania led the State in outcomes from cardiac surgery. One "learning line" at a local hospital virtually eliminated particularly deadly antibiotic-resistant infections. Southwest Pennsylvania led all regions participating in the MedMarx system in identifying medication errors.

But progress slowed. "We were able to leap the high hurdles", said Mark Laskow, the Chair of the Patient Safety Committee, "but we stumbled over the low ones—the subtle, more deeply rooted problems. We breezed through the challenge of getting competitors to collaborate, distinguished docs to take leadership, and common databases universally installed. We stumbled over tradition, distraction, and fear of litigation."

Jim Rohr (CEO of PNC Bank) and Chair of the PRHI Leadership Obligation Group saw the flaw. "We're trying to plant a new framework for improvement into hospital cultures without a good soil to grow it."

CONTINUED

***Articles on pages 3-5 are fictional; meant to provoke discussion and thought about the future of the Pittsburgh Regional Healthcare Initiative**

CONTINUED FROM PAGE 3

(… could be the)

Imaginary Scenario 1: Initiative Falters

Missing the Healthcare Bull's-eye*

One Hospital's Challenge

The challenges faced by one local hospital typified those of the collaborative. Besieged by personnel shortages and competing priorities, this hospital failed to feed necessary data into its information systems. Rapid response languished.

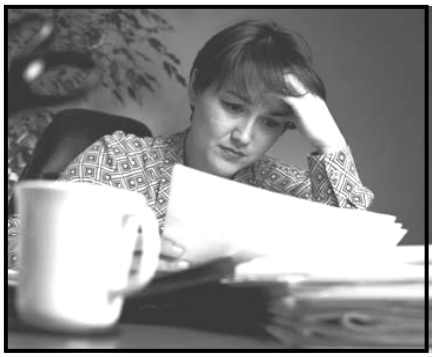
> **WE TOOK SHELTER IN THE OLD ADAGES: *'TO ERR IS HUMAN,' 'MISTAKES HAPPEN,'* OR *'IF THE NURSE HAD BEEN MORE CAREFUL, THIS WOULDN'T HAVE HAPPENED.'***
>
> ***—IMAGINARY NURSE ADMINISTRATOR****

"We fell back on comfortable old practices" said a hospital administrator. "We returned to sentinel event analysis that took six months to complete and by that time was of so little interest that the final report inspired little system response."

A nurse administrator added, "We failed in our commitment to keep learning and applying the best practices to every patient, without error, waste or inefficiency. Instead, we took shelter in the old adages, 'To err is human,' 'Mistakes happen,' or 'If the nurse had been more careful, this wouldn't have happened.'"

Perhaps the biggest impediments were the legal challenges to openly reporting information and sharing data. Existing vulnerabilities in Pennsylvania's peer review protection statutes were exacerbated by the passage of Act 13, a new patient safety law. Its ambiguous components inflamed an existing fear of litigation.

"We couldn't take advantage of the resources supplied to us, like the field managers, because of concerns about 'discoverability,'" conceded the hospital's AHRQ Team Site Captain.



Leadership Considers Next Steps

The Leadership Obligation Group of the PRHI convened last week to consider the failure to maintain momentum.

"Without question we tried to plant a new framework for improvement into hospital cultures that lacked the soil to grow," said Mellon Bank CEO Marty McGuinn, a PRHI leadership chair. "Old attitudes prevailed: it's not ok to report errors; just fire the person who errs; if no one got hurt, and then let's forget it; someone down the line will notice this glitch and fix it later."

For example, one local hospital recognized that a major source of medication error lay in transcription. However, instead of making necessary changes in the pharmacy, they decided to let the error proceed to the patient care unit where, they hoped, a harried nurse would pick it up at the bedside.

Looking for the "big fix," this hospital system invested heavily in brand new information systems, forgetting, in the words of David Sharbaugh, an Informaticist now working with PRHI, "Computers can introduce a new set of errors. The only way to be error free is to deal with the issue of human fallibility up front, to focus on the handoffs between people, to design systems that make it almost impossible to err and easy to do the best thing. Most important, you want to make sure that every health professional in your organization starts the morning confident that 'I can make a purposeful change today that will make someone healthier.'"

This hospital, like all PRHI participating institutions, hopes to gain back the momentum they lost. They realize that any framework for change is only as powerful as the fundamental values within which it's embedded. ☙

***Articles on pages 3-5 are fictional; meant to provoke discussion and thought about the future of the Pittsburgh Regional Healthcare Initiative**

Wall Street Journal

Imaginary Scenario 2: Initiative Succeeds

Is Health Care's Elixir in Pittsburgh?*

One Hospital's Experience

One active hospital CEO had a defining moment. A presentation by Jim Conway, Senior VP of the Dana Farber Cancer Institute, talked about the experience of his Institute in building a new culture for safety following a tragic episode that involved a *Boston Globe* reporter who died of a drug overdose. His admonition: don't wait for the public disaster: revisit your notion of stewardship.

Conway's presentation, along with his years of experience at the helm of a large regional hospital, inspired this local CEO to declare, "At my hospital, things are going to be different."

The CEO led the charge as the hospital leaders became 'barrier busters.' Instead of waiting for quarterly, aggregated data, he started gathering information himself, appearing on units, observing behaviors and asking questions. He rejected the notion of 'whistle-blowing,' instead rewarding any employee who suggested purposeful changes—on the spot—that improved care or prevented adverse events.

[NOTE: THESE NUMBERS ARE IMAGINARY]

PITTSBURGH'S DRAMATIC RESULTS FOLLOWING CARDIAC SURGERY:

DEATH RATE .4%
READMISSION .5%

BLOODSTREAM INFECTIONS: 9 PER QUARTER (V 116 IN 2000)

STAFF TURNOVER –80%
OPERATING PROFITS +30%

Most important, this CEO made it clear that any glitch was to be reported immediately, by anyone; solutions were to be devised and tried by care teams, measured within minutes or hours, and shared when successful.

"We said we were patient-focused, but I'm not sure we were living it," said the CEO. "I made explicit to all employees the connection between incidents and the human beings they affect. I made it personal."

Now patients and their families are engaged in the improvement process. They were encouraged to report their concerns and observations; they were notified immediately when an error was made or a practice turned out to be harmful.

"Some of our most enthusiastic change agents turned out to be our housekeeping, dietary, and record keeping staff," reported the CEO.

This hospital began hitting bull's eyes. As medication errors and infections were systematically and speedily analyzed to root cause and long term solutions put in place, the hospital began to realize substantial cost savings. It turned out that it was not only more humane but cheaper to prevent a problem than to deal with the complications.

Information from the cardiac and orthopedic surgery registries yielded useful clues to best practice; surgeons adopted new techniques quickly. Employee morale also improved and more experienced workers became available to help with problem solving. As patients and families were brought into the problem solving process, litigation diminished. This hospital was among the first to overcome fears about sharing data throughout the region and everyone benefited.

AT MY HOSPITAL, THINGS ARE GOING TO BE DIFFERENT.

—HOSPITAL CEO

Other hospitals began following this one hospital's lead, and the entire region began to post dramatic results. Within the past three years:

- *Death rates after cardiac surgery have fallen to .4%, readmissions to .5%*
- *Bloodstream infections average 9 per quarter, down from 116 three years ago*
- *Staffing turnover down 80% in hospitals with the most dramatic safety improvements*
- *Costs stable; operating profits* up 30%

The Pittsburgh initiative isn't prepared to say that it has found the answer to what ails health care, the perfect solution to the safety and quality failures, rising costs and employee departures that plague providers. But it is willing to declare that their framework for improvement is a powerful tool when planted in the right context—a safe and respectful environment—and they continue to refine their interventions.

Committed to the principle that sharing information about quality and safety is a key to their success, they do say, "Come visit. See for yourself." ☙

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3. An action map for hospital leaders: and PRHI's role

PRHI seeks to support the efforts of healthcare leaders championing the intensive use of patient safety reporting systems. The following call to action was given to hospital CEOs at the conclusion of the Leadership Obligation Group meeting on September 3.

Examination and Reflection – Declaring Patient and Worker Safety the Highest Priority

Hospital CEO/physician leadership galvanize institution to rethink partnerships with:

- Patients and families
- Staff who are trying to meet patient needs

Define how *"It will be different."*

Establish the Preconditions of a Safety Culture

1. Executives personally lead and are accountable for safety commitment, without delegating that function.
2. Executives personally encourage blame free reporting through:
   - Regularly visiting points where care is delivered;
   - Following up on individual incidents;
   - Encouraging problem identification by inquiring about unsafe conditions.

Create expectation for immediate analysis and problem solving and timely support for staff solutions … for each error.

1. Hospital CEO/physician leadership tells staff they expect reporting of all medication errors and nosocomial infections to them with 24 hours of discovery, complete with an analysis of each error's causes and intended "local solutions" (with recommendations for any system-wide changes).

2. By personally reviewing problem reports, analysis and solutions each day, CEO and medical leaders have mechanism and information necessary to fully and visibly support needs of patients, and of the workers trying to meet those needs.

Champion Shared Learning Externally as Well as Internally

Executives provide access to meetings and other situations in which lessons learned may be captured and encourage protected dissemination across the region.

PRHI CAN SUPPORT CEO/PHYSICIAN LEADERSHIP BY:

- ***HELPING HOSPITALS INCREASE CAPABILITY OF MEDMARX TO DELIVER REAL-TIME REPORTS; AND NNIS TO SUPPORT INDIVIDUAL INFECTION ANALYSIS.***

- ***HELPING LEADERS IDENTIFY CURRENT STATE AND INTERNAL AND EXTERNAL BARRIERS THROUGH JOINT FIRST-HAND OBSERVATION.***

- ***PARTNERING WITH YOU TO BREAK THROUGH BARRIERS TO EFFECTIVE PROBLEM SOLVING THAT YOU IDENTIFY, INTERNALLY AND EXTERNALLY.***

PRHI STANDS COMMITTED TO HELPING OUR HOSPITAL PARTNERS REACH THEIR GOALS. PLEASE LET US KNOW HOW WE CAN HELP.

Clinical Initiatives

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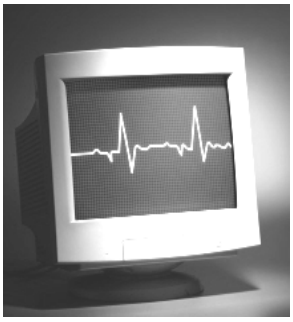
PRHI Cardiac Registry Progress Report



The PRHI Cardiac Registry is a regional effort by 12 cardiac surgery units in Southwestern Pennsylvania to collect and share data to promote the best patient outcomes in the country for coronary artery bypass graft (CABG) surgery.

PRHI's Cardiac Registry is modeled after the highly successful registry of the Northern New England Cardiac Study Group, which succeeded in lowering mortality following CABG by over 20%.

The table below shows the progress of Pittsburgh's regional units in preparing for the launch of PRHI's Cardiac Registry.

Cardiac Facility	Cardiac Forum Participant	IRB* approval	Agreement signed	Data submitted
Allegheny General Hospital	✓		✓	
Butler Area Hospital				
Dubois Regional Medical Center	✓		✓	
Jefferson Hospital	✓			
Mercy Hospital of Pittsburgh	✓			
St. Clair Hospital	✓		✓	
The Medical Center of Beaver	✓		✓	
UPMC Passavant	✓			
UPMC Presbyterian	✓		✓	
UPMC Shadyside	✓		✓	
Washington Hospital	✓	✓	✓	
Western Pennsylvania Hospital	✓	✓		
Westmoreland Regional Hospital				

Calendar, September 2002

Wednesday, October 2 – Chronic Care Physicians	6-8pm
Monday, October 7 – PRHI Co-chairs Depression subcommittee (location TBA)	noon-1:30 pm 4-6 pm
Tuesday, October 15 – Perfecting Patient Care (TPS) Information Session JHF Offices, Centre City Tower	6-9 pm
Wednesday, October 16 – Hospital Learning Line visit Location TBA	8am – noon
Thursday, October 17 – Clinical Advisory Committee Location TBA	6-8 pm

All meetings at JHF Offices, Centre City Tower, 650 Smithfield unless otherwise noted. For further information contact Helen Adamasko at 412-594-2581

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PRHI Executive Summary is also posted monthly at **www.prhi.org**
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ON THE WEB AT
WWW.PRHI.ORG

***Uniting hospitals, practitioners, business and community leaders in Southwestern Pennsylvania to lead the world in perfecting patient care.**

Founded by the Jewish Healthcare Foundation of Pittsburgh