VIEWS FROM THE FIELD

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GRANT MAKERS IN HEALTH

What Patient Safety Is Teaching Us

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At what level will America's health care system be improved? The answer may lie in figuring out why Mrs. Stevens didn't get her critical medication during a recent hospitalization.

Admitted to a Pittsburgh hospital for an irregular heartbeat, the 60-year-old was supposed to receive Rhythmol each day at 9 A.M. One morning the pharmacy did not send it. Ordinarily, Mrs. Stevens' nurse would work around the problem, by calling the pharmacy and maybe even running down to retrieve the medication herself. While this would address the immediate problem, it would also create new ones by forcing the nurse to interrupt her regular duties and sacrifice time caring for other patients.

As this true scenario demonstrates, working around a problem has never *solved* a problem. And when the problem involves patient safety, the consequences can be deadly. In Mrs. Stevens' case, a late or missed dose of medication could have sent her into atrial fibrillation, a potentially fatal heart arrhythmia.

Our current system of delivering health services is faltering, and the prospect of tackling any of its complex problems is daunting. Nonetheless, foundations of different sizes and strategies are beginning to focus on the issue. The question for all of us as grantmakers is how do we change the system? For the Jewish Healthcare Foundation, our engagement with the issue of patient safety has been a powerful teacher.

We came to the issue almost by accident.

By 1997, our region's health care delivery system – its largest economic sector – had serious difficulties. Financial and quality-of-care problems were escalating, and dissatisfaction was acute among all stakeholders, from nurses and physicians to union leaders and corporate purchasers. The Jewish Healthcare Foundation convened the leaders of the region's health care institutions to see if we could agree that (1) the system was in trouble and (2) collectively, we could do something about it. That shared effort became the Pittsburgh Regional Healthcare Initiative (PRHI), which receives significant additional support from other local foundations and corporations, as well as The Robert Wood Johnson Foundation.

The more than 30 regional hospitals, four health plans, and other major purchasers that comprise PRHI agreed to collaborate on several clinical priorities with ambitious targets. Among them, PRHI chose to focus on the elimination of two major patient safety problems: medication errors and health care-acquired infections which occur, respectively, in roughly 2 percent and 7 percent of all patients admitted to the hospital.

The real question, then, became how best to take on the system. In framing PRHI's patient safety projects, we owe our education to the initiative's founding chair, Paul O'Neill, the former CEO of Alcoa now serving as Secretary of the United States Treasury. Some of the following points are drawn from works we collaborated on with Secretary O'Neill, which also formed the basis for his recent testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions.

Collaboration is the only way to fix complex systems. Coercion won't work. The performance of a complex organization will only improve when all of its units and the people in those units know how to raise their performance.

Pick unimpeachable goals. Persuading people and institutions with divergent interests to collaborate requires a powerful, unassailable target. For PRHI, the only focus is meeting the needs of the patient. Patient safety is a particularly powerful goal: No one in our care should be hurt from our care.

Recognize the tip of the iceberg. The patient safety problems rising to the surface of American medicine are a

symptom of the imprecision, inefficiencies, and errors that lie below. Does the reason for a medication error such as Mrs. Stevens' have anything in common with the cause of growing frustration among nurses, or rising costs, or patient dissatisfaction? At root, it probably does. Working on patient safety offers a logical place to begin to confront the fundamental forces stressing and bedeviling the system.

Stretch goals to the theoretical limits of performance. It was a challenge to get the region's hospitals and clinicians to agree to the goal of perfect patient care. Yet striving for zero patient safety incidents adds power to our efforts. As Secretary O'Neill testified, "progress comes in increments, but to set incremental goals – even seemingly ambitious goals such as reducing errors by 50 percent – risks complacency" and loses moral ground. Who volunteers to be hurt by the remaining medical mistakes that don't get fixed?

The people who do the work create change. Raising the performance of complex systems means recognizing that it is the people on the ground who have to make and sustain change. Superior results every time cannot be ordered from Washington or the hospital's CEO. Rather, the focus must be on building the capacity of each person in the organization – like Mrs. Stevens' care team – to identify problems and improve the system. And that requires an alignment of values, goals, and skills among everyone in that system, from the dietary aide to the trustee.

Working harder isn't the answer. Errors like Mrs. Stevens' don't occur because health care workers aren't trying hard to provide good care. They occur because the design of the system creates an environment where errors are much easier to make. Patient safety problems force us to focus on flaws in the health care system, and not on the faults of individuals.

Use problems as a learning tool. A key to high performance in complex organizations lies in identifying and solving problems. In many health care organizations and American workplaces, it is not safe, professionally or emotionally, to identify problems or errors, or to engage others in solving them. A commitment to patient safety forces organizations and collaboratives to begin to treat problems like Mrs. Stevens' as opportunities for improvement, not punishment.

Learn from the success of other industries in improving work plans and solving problems. The world's leading example of highest quality/lowest cost manufacturing, Toyota, has followed these methods for years; they were also adapted successfully by Alcoa. Such applications have powerful potential in health care. For example, two PRHI hospitals have launched "learning lines" to test various approaches to prevent medication errors.

Start small. Just as you can't fix the whole health care system all at once, you can't fix a whole hospital all at once. Toyota recommends beginning with a very small slice of the organization, even smaller than a clinical unit.

Here's what happened when PRHI experimented with Toyota's methods. When Mrs. Stevens' medication didn't arrive on time, her nurse called her team leader for immediate assistance, knowing that no one would be punished. The health care team worked with a coach to identify the source of the error – a simple scheduling problem – and suggested a solution that was implemented the same day. When the problem recurred, another administrative issue was quickly identified, and the responsible staffers soon redesigned how medications are stored and ordered. The result? All 9:00 A.M. medications are now delivered on time throughout the hospital, and the incidence of the pharmacy running out of medication has gone from 9 percent of all orders to none.

In the process of solving one specific problem, a system-wide problem was also resolved, averting the cascade of errors that easily could have followed.

Today, this community's humble pharmacy – a pharmacy operating precisely and safely because of our learning-based approach to making change – has become the model and learning lab for some of the region's largest and most sophisticated health systems. Who knows what dramatic improvements lie ahead with this type of experimentation?

It's clear to us now that the smallest grantmaker-funded direct service project can lead to systems improvements. The key is to involve people in the system from the ground up, with everyone working together to "see with their own eyes" and to meet the needs of people in our communities.

The Jewish Healthcare Foundation invests in leadership ideas, programs, and people, and looks for innovative ways to strengthen and protect the health of the Pittsburgh community and Western Pennsylvania residents.

For grantmakers interested in learning more about PRHI or working with other grantmakers on patient safety issues, GIH is planning a site visit to Pittsburgh to review the PRHI model.

Please contact the writers at 412.594.2550, or Kate Treanor at GIH, for more information.

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