Pittsburgh Regional Healthcare Initiative

PRHI Executive Summary

August 2001

Why Top-Down Fixes Won't Work in Health Care

. . . and Why Leadership Will

Ken Segel, PRHI Director

The theme for this issue of *Executive Summary* shows we have a few biases when it comes to issues of hierarchy in health care.

"Top down" management in healthcare delivery organizations doesn't jibe with their fundamental nature. Healthcare delivery systems are by necessity complex, dealing with an endless variety of patient needs. Clinicians need dynamic ways to meet those individual needs "at ground level."

Yet, much of healthcare management (and regulation) depends on rigid rules and procedures. Some standardization at the corporate level is important, but reliance on control-based strategies can lead to tremendous waste. One experienced local administrator and former clinician said, "The higher you go, the less you actually know about what's going on on the floors, but the more you decide. Is it any wonder that what we decide is often different from what really happens in patient care?"

> "Top down" management in healthcare delivery organizations doesn't jibe with their fundamental nature.

Traditional silos of the responsibility don't help, either. Is it really the best use of time for a hospital's chief operating officer to "resolve" an operational problem between pharmacy and nursing?

What kind of management approach makes more sense? Complex organizations perform at much higher levels when they gear their management systems to promote problem solving and improvement at the lowest possible level of the organization. Researchers at Dartmouth call these the "smallest replicable units" in health care. This approach affords people closest to the problem the opportunity to identify and solve it, working in teams. Executives become a vital part of the "help chain," helping to solve problems that can't be solved at lower levels.

When problems are solved closest to where they occur, leadership changes fundamentally. No longer do managers "fix" day-to-day operational problems. Instead, they become educators and partners in problem solving. They focus on disseminating information about what the teams have learned, how they solved a certain problem, and what improvements came about. This information is not issued as mandatory best practices, but as potential solutions others might try. The focus is on solving problems, not working around them.

But even the most basic steps toward this "bottoms up" focus cannot occur without strong leadership. PRHI is experimenting with such a system, using the problem solving principles of the Toyota Production System. We have made the most progress where: (1) patient outcomes are the focus; (2) we help the delivery system support clinicians and patients "at the bedside;" and (3) organizational leaders have stepped forward to champion change.

Inside . . .

Clinical Initiatives

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Beginning with the outcome

THIS APPROACH LOOKS AT PATIENT OUTCOMES AND WORKS BACK THROUGH THE PROCESSES OF CARE, ELIMINATING THE VARIABLES AND IMPROVING THOSE OUTCOMES.

> A doctor treats four diabetic patients. Each patient has a different health plan and a different payer setting laudable—but different—standards of care. The doctor must deal with four sets of care guidelines and quality incentives relating to four sets of outcomes.

> A hospital must meet different reporting requirements for three governmental or accreditation associations. While the data prove useful, they may not translate to face-to-face dealings with actual patients.

> A physician awaits the results of a new clinical trial before amending a process of care—a tried and true method. However, this physician misses the chance to improve care by examining outcomes and adjusting processes to improve outcomes more rapidly. While valuable, clinical trials are carefully controlled within narrow constraints. Real patients may react differently, and do not benefit by waiting years for trial results.

The result of such conflicting top-down mandates is a clinical process in chaos.

The Northern New England cardiovascular project has taken a different approach. When their own data collection system flags a problem—for example, a slight rise in deep sternal wound infections—the group looks carefully at the variables in the processes of care that may have led to the variation in outcome. They form a hypothesis about what processes may yield better results and apply it, continually measuring their outcomes. Instead of waiting years for clinical trial results, these physicians use short cycles to find ways to improve care.

PRHI is extending NNE's model, relying on the collective intelligence of healthcare providers in our six-county region. These people, who deliver services at the point of care, select areas for improvement and create the measurement tools to define progress. For instance, the cardiovascular working group has gathered dozens of cardiac surgeons, cardiologists, nurses, and data analysts to define 89 outcome and process points that these **professionals at the point of care** believe they need for experimenting with improved ways of doing business. We hope to replicate this "bottom up" success story with each clinical work group, starting with orthopaedics and working sequentially through depression, diabetes, and obstetrical care.

We believe this approach can eventually solve a host of other problems relating to confusing top-down requirements. The result should improve patient outcomes while driving out waste and inefficiency from the system. And *those* outcomes will benefit everyone.

Clinical initiatives progress

In other of clinical initiatives:

- The **Depression Subcommittee** meets August 14 to draft conclusions covering the depression report, to be distributed in September. If you are a hospital CEO or a purchaser, watch for this revealing report.
- The **Cardiac Work Group** is developing a registry to be launched in the fall.

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PRHI's partnership among clinicians, businesses, hospitals and insurers aims to achieve those goals in five pilot areas by constructing outcome data that caregivers trust; and supporting collaborative efforts to improve care.

Center for Shared Learning

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Bottoms-up problem solving

Healthcare professionals share a common motivation: to deliver what patients needs, when they need it, in the quantity they need it without waste and error, in a safe and respectful environment. The challenge is in creating an environment where problems can be identified and solved at the point of care.

Traditionally, managers who want to make changes at the point of care face a daunting task. They most often are not physically on the floor where the problems exist. They do not have the advantages of first-hand observation, data gathering, or experience about how the work is really done. Usually managers are forced to make decisions based on general aggregated data, coupled with their own previous knowledge and perceptions. Decisions and mandates made this way are usually either:

- Very general, not helpful in solving specific problems at the point of care, and don't represent the reality facing workers on the floor; or
- Very specific, but often unworkable because the real problem is not well understood.

Solving problems at the point of care, the TPS approach, is a radically different enterprise. Changes to the system are initiated by the people closest to the work, at the point of care, using a disciplined, scientific problem-solving method. Problems solved immediately in this "bottoms-up" way are more likely to create sustainable improvements.

In this system, leadership is essential. Leaders move from managers to problem solvers. How quickly the system changes and improves depends on how many people are solving problems in the course of their work, and how quickly. Leaders help those front-line problem-solvers when they need it. Leaders must:

- Create a safe, non-punitive work environment where it is okay to expose problems.
- Assist working teams in solving problems down to their root cause, by removing barriers and ensuring a blame-free environment
- Teach problem solving method to caregivers, rather than jump in and solve the problem for them.

While the motivation is the same–giving patients the best care possible–this systemic TPS approach is very different from traditional "top-down" methods. With TPS, people who do the work begin solving problems scientifically at the point of care, experimenting with possible solutions. For problems that require additional help, a defined, functional pathway extends from the floor all the way up the leadership chain to the CEO. In this way, *everyone* in the organization has an active role in improving patient care.

PROBLEMS SOLVED FROM THE "BOTTOMS-UP" BY THE PEOPLE DOING THE WORK ARE MORE LIKELY TO CREATE SUSTAINABLE IMPROVEMENTS.

PRHI Partner Spotlight

Clinical Advisory Committee

We are always updating our lists. If you note errors or omissions, please call Tony Kelly at 412-594-2567

Alan Axelson, President & Medical Director, InterCare Psychiatric Svcs

Daniel Brooks, MD, V-P & CMO Heritage Valley Health System

John R. Combes MD, Sr. Med. Advisor, Hospital & Health System Association of PA

Michael Culig, MD Shadyside Medical Center

William DiCuccio, MD, Medical Director Butler Area Hospital

Anthony DiGioia, MD, Renaissance Orthopaedics, P. C.

Paul Dishart, MD Director, Medical Education UPMC-St. Margaret Hospital

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Patient Safety Programs

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Complex system requires teamwork

IT'S A DECEPTIVELY SIMPLE OBJECTIVE: *PROVIDE APPROPRIATE, EFFICIENT HEALTH-CARE SERVICES TO EVERY PATIENT .*

The objective of the healthcare system is deceptively simple—to provide appropriate, efficient services to every patient. Yet the healthcare system is extremely complex, and the needs of patients infinitely variable. Meeting this "simple" objective requires teamwork throughout the organization.

PRHI's Patient Safety programs use multidisciplinary teams to evaluate and implement the tools required to identify and remedy policy, process, and cultural challenges. With support from an engaged leadership, the people who do the work—those positioned to best assess the needs of each patient— can begin to design the processes that streamline the provision of care.

PRHI's Patient Safety programs, in medication error and nosocomial infection, represent the complexities of typical healthcare processes. As such they present excellent opportunities to explore and test this multidisciplinary approach to system redesign.

Data collection under way

Initial data collection cycles are under way for both medication errors and catheter-associated bloodstream infections. PRHI plans to release quarterly reports to PRHI hospitals and targeted working groups.

- The first bloodstream infection data cycle was completed in June, with the report scheduled for an August release.
- The first medication error data cycle is July through September. Report release is planned for October or November.

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PRHI's Patient Safety governance and operations

Patient Safety Executive Committee (PSEC)

√ Day-to-day management of ADEAC & NIAC
√ Represented: business leaders, clinical, operations, and healthcare executives

Chair: **Mark Laskow**, CEO, Greycourt and Company, Inc.

Adverse Drug Event Advisory Committee (ADEAC)

√ Deploy MedMARx reporting system
√ Define areas of inquiry & processes
√ Represented: pharmacy, quality improvement, risk management, info systems

Co-chairs: **JoAnn Narduzzi**, **MD**, Exec. V-P, Medical Affairs, Pittsburgh Mercy Health System
Robert Weber, Director Pharmacy, UPMC Presbyterian & Shadyside

Nosocomial Infections Advisory Committee (NIAC)

√ Establish region-wide NI reporting system based on NNIS
√ Develop, convey, facilitate practice interventions
√ Represented: infectious disease physicians, infection control practitioners, risk managers, quality improvement managers, and Centers for Disease Control

Chair: **Carlene Muto, MD**., Hospital Epidemiologist/ Director, Asst. Prof. Of Medicine, UP School of Medicine, Division of Infectious Diseases

PRHI partners are working collaboratively to eliminate two major patient safety concerns: healthcare-acquired infections and medication errors.

Action required

Data release forms have been forwarded to administrators at participating organizations for review and execution. These are similar to the data release forms recently submitted for reporting bloodstream infections.

If you haven't returned your signed release documents, please do so by mail or fax:

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Patient safety

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PRHI partners recognize that, while important, consistent reporting systems do not in isolation create change. It is with whom and in what context the data is shared and what is done with the data that provide information, knowledge, learning, and ultimately sustainable processes for improving healthcare delivery.

PRHI's Nosocomial Infections and Adverse Drug Event Advisory Committees are charged with defining reporting formats, data standards and interpretation, and devising and supporting recommended interventions.

- *Committee members will review nosocomial infection and medication error rate information that is identifiable by institution. The only acceptable use of this data is for community-based shared learning. As such, this information will be reviewed and analyzed only in official PRHI committee meetings. Every effort will be made to control distribution of this material.*
- *De-identified regional reports will be provided quarterly to each participating facility. Distribution includes the administration, medical director, nursing director, and the infection control, pharmacy, quality, and risk management departments as appropriate. These de-identified reports will also be made available to PRHI operating and governance committees. Again, this information is intended to inform patient safety improvement efforts and may be used only in this context.*

Partner Spotlight—Clinical Advisory Committee

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Donald Fetterolf, MD, Medical Director, Health Care Informatics/Research, Highmark BlueCross BlueShield

Michael Fine, MD,MSc
Assoc. Professor of Medicine
UPMC-Montefiore

Michael Flaherty, PhD
Jewish Healthcare Foundation

Jean Fleming, Infection Control Pracitioner, Mercy Hospital

Renée Frazier, MHA,CHE
Exec. Ofcr.,VHA Pennsylvania

Samuel Friede FACHE, Sr. Consultant, Public Affairs & Community Liaison, VHA PA

Marlene Garone, MD, V-P Operat'ns, Western PA Hospital

Thomas Gessner, MD, Medical Director, Latrobe Area Hosp.

Dolores Gonthier, MD, Medical Director, Aetna US Healthcare

John Harper, MD, Associate Medical Director, UPMC-MUH

Dennis Hurwitz, MD, President Allegheny Cty Medical Society

Sharon Kiely, MD
Department of Medicine
Allegheny General Hospital

Mark Kissinger, Practice Mgr, Genesis Med Assoc

Jack Krah, Allegheny County Medical Society

Diane Lares, Consulting Manager, PMSCO

Judith Lave, PhD, Prof of Health Econ, U of Pittsburgh

George MacGovern Jr., MD
Allegheny General Hospital

Jerome Martin, PhD, Dean, Rangos School of Health Sciences

Michael Miller, MD, Greater Pittsburgh Orthopaedic Assoc's

Robert Muscalus, MD,Physician General, Commonwealth of PA

JoAnn Narduzzi, MD
Executive V-P,Medical Affairs
Pgh. Mercy Health System

David Nash, MD, Asst. Professor of Pediatrics, Children's Hospital of Pgh.

Walter O'Donnell, Vice Chair of Clinical Affairs, Dept. of Medicine, AGH

Harold Pincus, MD
Senior Scientist, RAND

Charles Prezzia, MD, MPH
Gen Mgr, Health Svc & Medical Director, USX/USSteel Group

Ian Rawson PhD, President
Hospital Council of W. PA

John Reefer, MD
Butler Medical Associates

Mark Roberts, MD, Center for Research on Healthcare, U of Pittsburgh School of Medicine

C. Daniel Sacco, V-P, Planning & Managed Care, West Penn Allegheny Health System

Mark Schmidhofer, MD,Director Inst. for Performance Improvement, UPMC Health Plan

John Schulhoff, MD
Director of Surgery
St. Francis Medical Center

Joni Schwager, Program Officer
Staunton Farm Foundation

Cliff Shannon, President
SMC Business Councils

Richard Shannon, MD
Professor & Chairman, West Penn Allegheny Health System

Fred Sherman, MD, Director, Department of Perinatal Cardiology
Magee Womens Hospital

Carl Sirio, MD, Assoc.Professor
U. of Pgh. School of Medicine

Thomas Smitherman, MD
Prof. of Medicine, Med. Director, Cardiac Intensive Care, UPMC

Francis Solano Jr., MD
UPMC Health System

Alexander Vasilakis, MD
Cardiothoracic Surgical Assoc's

Paul Vaughn, MD, MPH,
V-P Medical Affairs
Western Region HealthAmerica

Carey Vinson
Highmark BlueCrossBlueShield
Steven Raab, MD, Director
Cytology & Outcomes Research
Allegheny General Hospital

Marc Volavka , Exec Director
Pennsylvania Health Care Cost Containment Council

Cliff Waldman, MD, Medical Director, Western Pennsylvania HealthAmerica

Flossie Wolf , Director, Policy & Legislative Affairs, PHC4

Alan Yeasted, MD, V-P, Medical Affairs, St. Clair Hospital

Nikola Zivaljevic, MBA, NHMS, Western PA Hand & Trauma Center

Note: Members of Clinical Work Groups will be featured in future Partner Spotlights.

Third Annual Spotlight on Healthcare

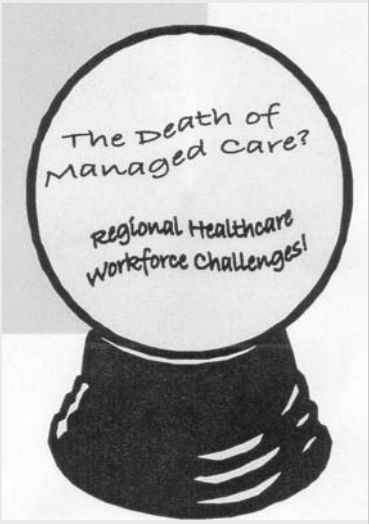
Radisson Hotel, Greentree
Thursday, November 1
1:30 –4:30 p.m.
"Looking Into the Crystal Ball of Healthcare"

The Death of Managed Care?
Panelists: Jim Klingensmith, Highmark;
Charles O'Hanlon, National City;
Tom White, Jameson Memorial Hospital

Regional Healthcare Workforce Challenges
Panelists: Karen Feinstein, PRHI/Jewish Healthcare Foundation;
Marc Cammarata, HCWP

Cost $95 per person
Register by phone, 412-922-9124 (Sherry)
Or by e-mail, slageman@vha.com

Presented by Accenture; Cohen & Gribsby; Highmark; SMC Small Business Councils; and VHA Pennsylvania



Clinical initiatives *cont'd from page 2*

An RFP will help select the best options for this resource to serve every cardiac program in the region.

- The **Orthopaedic Work Group** is further examining the HC4 data to better understand the causes of three areas of complication that lead to readmission– infections, dislocations, and DVT. The Pennsylvania Medical Society Consulting Organization (PMSCO) will deliver this report to the group to help define the next steps and possible focus for a registry.
- The **Diabetes Work Group** is discussing a range of interventions that may lead to better outcomes, even before the expected release of the HC4 outcomes report in October. A fall retreat will help the group sort through the many ideas for improvement.

Oklahoma bars MedMARx-type data from use as evidence

—From American Society for Healthcare Risk Management

Oklahoma has become the first state in the nation to specifically bar information reported to MedMARx, a national medical errors database, from being introduced as evidence in a legal proceeding. US Pharmacopeia (USP) in Rockville, MD, launched MedMARx in 1998 to enable hospitals to report and track medical errors anonymously. MedMARx has more than 400 users across the country. USP has asked Oklahoma to recognize reports to USP's medication error reporting programs as privileged communications after learning that the state's privacy statute extends protection to national organizations approved by the Board of Health.

For a copy of the Oklahoma statute, please e-mail your request to Naida Grunden at *grunden@jhf.org*.

Calendar at a glance, September 2001*

Tony Kelly, Administrative Coordinator
412.594.2567, *kelly@jhf.org*

Sept 4	Nosocomial Infections Working Group	8 am-12 pm
Sept 10	CoChairs Lunch	12-1:30 pm
	Patient Safety Executive Committee	2-3:30 pm
Sept 11	Adverse Drug Event Advisory Committee	3-4:30 pm
	Center for Shared Learning Information Session	6-9 pm
Sept 20	Buying Heathcare Value Committee	2:30-4 pm
	Clinical Advisory Committee	6-8 pm
	Location TBA*	
Sept 25	Center for Shared Learning Information Session	6-9 pm

**all meetings at JHF offices unless otherwise noted*

CONTACT INFORMATION

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Progress Report

This month has marked increased participation in the MedMARx medication error and National Nosocomial Infection Surveillance (NNIS) reporting systems.

PRHI Partner	NNIS Blood Stream Infect'n Report to CDC: 4-01	5-01	6-01	MedMARx med. error report sys.: Con-tract?	System in use?
Butler Memorial Hospital*					
Children's Hospital of Pittsburgh	✓	✓	✓	✓	
HealthSouth Rehab. Hospitals	n/a	n/a	n/a		
Heritage Valley Health System, Inc.*					
Sewickley Valley Hospital	✓	✓	✓	✓	✓
Medical Center—Beaver	✓	✓	✓	✓	✓
Latrobe Area Hospital*	✓	✓		✓	✓
Lifecare Hospitals of Pittsburgh, Inc.	n/a	n/a	n/a		
Monongahela Valley Hospital, Inc.	✓	✓	✓	✓	✓
Ohio Valley General Hospital					
Pittsburgh Mercy Health System					
Mercy Hospital of Pittsburgh	✓	✓	✓	✓	✓
Mercy Providence Hospital					
South Hills Health System					
Jefferson Hospital	✓	✓	✓	✓	✓
St. Clair Memorial Hospital*	✓	✓	✓		
St. Francis Health System	✓	✓	✓	✓	
Uniontown Hospital	✓	✓	✓	✓	✓
UPMC Health System					
Bedford Memorial	✓	✓	✓	✓	
Braddock			✓	✓	
Horizon	✓	✓	✓	✓	

PRHI Partner	NNIS Blood Stream Infect'n Report to: 4-01	5-01	6-01	MedMARx med. error report sys.: Con-tract?	System in use?
UPMC, continued					
Lee Regional				✓	
Magee Womens Hospital	✓	✓	✓	✓	
McKeesport	✓	✓	✓	✓	
Passavant	✓	✓	✓	✓	
Presbyterian	✓	✓	✓	✓	
Rehabilitation Hospital	n/a	n/a	n/a	✓	
Shadyside	✓	✓	✓	✓	
South Side	✓	✓	✓	✓	
St. Margaret	✓	✓	✓	✓	
Western Psychiatric Institute	n/a	n/a	n/a		
West Penn Allegheny Health System					
Allegheny General Hospital	✓	✓	✓	◔	
Allegheny Valley Hospital		✓	✓	◔	
Canonsburg General Hospital	✓	✓	✓	✓	✓
Forbes Regional	✓	✓	✓	◔	
Suburban General				◔	
West Penn Hospital	✓	✓	✓	◔	
Westmoreland Health System					
Frick Hospital	✓	✓	✓	✓	✓
Westmoreland Regional Hospital	✓	✓	✓	✓	✓

* *Collaborating w/ national VHA Patient Safety Initiatives*

✓ *Fulfilled* ◔ *In progress*