

BRANCHES



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PERFECTING PATIENT CARE

REACHES COMMUNITY-BASED ORGANIZATIONS

Five years ago, when the Pittsburgh Regional Health Initiative (PRHI) introduced its Toyota-based Perfecting Patient Care™ System, the idea of using process engineering principles in American hospitals was met with skepticism. Yet the idea, backed by a proven method for implementation, has begun to take root not just in hospitals, but in community organizations too.

“We have found that the principles of process improvement taught by PRHI give us a set of very practical tools for improving quality,” says Eileen Boyle, MD, of the East Liberty Family Health Care Center, and recipient of a Physician Champion grant from the Jewish Healthcare Foundation (JHF).

Perfecting Patient Care™ gains national grantmaking audience

Dr. Boyle's was one of several community health organizations to share their stories during the 57th annual National Convention of the Council on Foundations, an organization of more than 2,000 grantmaking foundations and giving programs worldwide. The conference, held May 7 – 9 in Pittsburgh, drew several

thousand foundation leaders from across the country, and speakers including Teresa Heinz-Kerry, chairman of The Howard Heinz Endowment and the Heinz Family Philanthropies; former House Speaker Newt Gingrich; financier George Soros; astronaut Mae Jemison; Senator Max Baucus; and Donald Powell, Chairman of the New Orleans rebuilding effort.

As part of pre-conference offerings hosted by JHF and Grantmakers in Health, several Pittsburgh-area community organizations described the results they have achieved using process engineering techniques to improve practice. The presentations took on a common theme: the PRHI improvement method known as Perfecting Patient Care™, which began in hospitals, has spread to other community organizations, including those dealing with long-term care, federally qualified health centers, substance abuse and addiction, and HIV/AIDS. The results are transforming some organizations, improving care for patients and the work environment for those who provide that care, and saving money.

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A TIMELINE: QUALITY ENGINEERING SPREADS THROUGH THE HEALTHCARE CONTINUUM

1997

- PRHI challenges the region toward the audacious goals of zero errors and the world's best care.

2000

- A seminal Institute of Medicine report, *To Err is Human: Building a Better Health Care System*, estimates that 98,000 Americans die needlessly in hospital each year.

2001

- PRHI begins community-wide central line infection reduction program.
- PRHI inaugurates Perfecting Patient Care University, a one-week program based on the tenets of the Toyota Production System. Using principles from engineering, the class helps healthcare workers understand how to apply known best practices in every encounter.

2002

- A joint venture between the CDC, PRHI, and the VA Pittsburgh Healthcare System reduces antibiotic-resistant infections in a post-surgical unit by over 85% through the application of Perfecting Patient Care.

2003

- JHF introduces Perfecting Patient Care techniques in diabetes care in a community setting at UPMC St. Margaret Lawrenceville Family Health Center. Improvements in access and care are noted.
- Following training in the Perfecting Patient Care methodology, Dr. Richard Shannon achieves near-zero rate of central line infections in two Intensive Care Units at Allegheny General Hospital within 90 days. His team later shows significant cost savings, providing a conclusive “business case” for infection reduction.

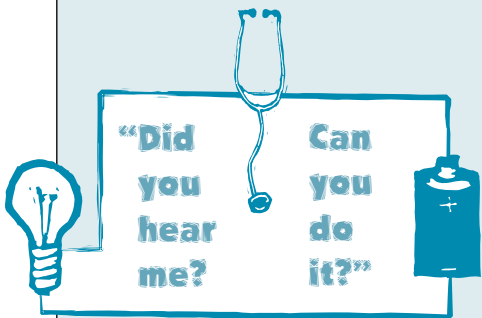
2004

- Pittsburgh region announces 63% reduction in central line infections, capping the 3-year program.
- JHF introduces Perfecting Patient Care at the Jewish Association on Aging, marking its first introduction into long-term care.

2005

- Physician Champion Program and JHF grants spread Perfecting Patient Care into the broader community – Federally Qualified Health Centers, AIDS programming, addiction treatment, and workforce development.
- The Institute of Medicine calls for national adoption of quality engineering disciplines, such as Perfecting Patient Care, in a joint report with the National Academy of Engineering, called *Building a Better Delivery System: A New Engineering/Health Care Partnership*.

BASIS OF THE SYSTEM: THE RULES IN USE



A few basic rules underlie the Toyota-based Perfecting Patient Care™ System. The originators of the phrase, “Rules in Use” were Harvard professors Kent Bowen and Steven Spear. The intent of the phrase is to differentiate “rules” that are often created by managers in a board room far from the frontline of work. Rather than “rules in theory” about how work is done, Bowen and Spear sought to capture what was actually happening on the shop floor in Toyota factories – rules in use. The wording here has been adapted for Perfecting Patient Care.™

Activities:

“What is expected?” Work must be standardized. People doing the work must understand what is to be done, in what order, when, where, and what should happen as a result.

Connections:

“Did you hear me? Can you do it?” Every customer-supplier connection must be specific and direct. Every request must be specific, and met with an unambiguous yes-or-no response.

Pathways:

“Did the request get lost in a handoff from one department to another?” Every product or service travels along a pathway toward the client. The pathway for every product and service must be standardized, simple and direct. A straight, well understood pathway eliminates loops or forks, “Catch-22s.”

Improvements:

“What would perfection look like?” When an improvement is made, it must be designed with the ideal situation in mind. Improvements are experiments, and must be made in accordance with the scientific method, under the guidance of a teacher, where the work is done.

Internal tests:

“Are we making progress?” Because they are done in accordance with the scientific method, the four prior rules have built-in tests that let participants know whether the activities, connections, pathways and improvements are being done as expected.

PRHI TOOLS REACH COMMUNITY-BASED ORGANIZATIONS CONTINUED

A little history

From its inception, PRHI offered a way for hospital CEOs and medical practitioners to exchange ideas with non-healthcare CEOs from small businesses to industrial giants. These conversations led to what, at the time, seemed a radical proposal: perhaps the tenets of an industrial model like the Toyota Production System could be adapted to reduce waste and error in health care as dramatically as it had done in other industries.

A hospital is not an assembly line, and a patient is not a car. Nevertheless, the foundation and techniques of the industrial model seemed a solid underpinning for the healthcare workplace. PRHI created the Toyota-based Perfecting Patient Care™ System for use in health care. This system for making improvement requires a deep knowledge of the way work is actually done on the front line, based on observation and respect, not supposition. The system focuses on solving problems that occur on the front line of care as soon as possible, giving a great deal of discretion to the person closest to the work. (See box at left)

Over time, PRHI partners tested the concept in various hospital units with many successful results. PRHI created Perfecting Patient Care, a practical way to make “best practice” happen – a transformational, on-the-ground method to be used by everyone in an organization.

PRHI also created an extensive curriculum to teach Perfecting Patient Care principles and on-site implementation. The scope and availability of training for this method is unprecedented in any other American community. To date, more than 1500 people from Pittsburgh and beyond have received some form of this training.

National acceptance of an industry-based model arrived in 2005 with a report issued jointly by the Institute of Medicine and the National Academy of Engineering, which called for the application of engineering principles to health care. PRHI and its partners implementing

Perfecting Patient Care were national forerunners in this movement to bring engineering disciplines to clinical practice and are cited repeatedly in the Institutes’ report, *Building a Better Delivery System*.

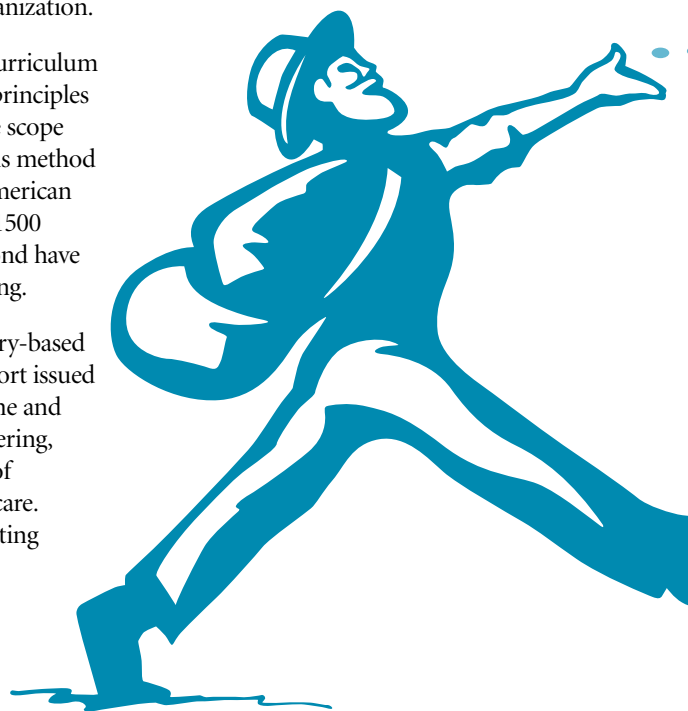
Moving into the community

Two factors have converged to make Perfecting Patient Care attractive in community and social service organizations.

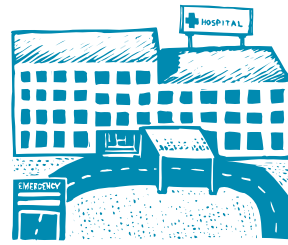
State and federal regulations, combined with funding restrictions, are creating an imperative for community organizations to find a way to deliver the highest quality of care in the most efficient way. (In a seismic shift of understanding, organizations are realizing that delivering high-quality care is not more, but less expensive.)

PRHI has made training in Perfecting Patient Care widely available to community organizations, often with JHF support.

The following pages present stories of improvement that organizations have accomplished using Perfecting Patient Care. The stories begin where PRHI began – with hospitals. However, they quickly fan out to encompass community organizations dealing with long-term care, federally qualified health centers, substance abuse and addiction, and HIV/AIDS.



BEGINNING IN HOSPITALS



The Pittsburgh region has made headlines as a community where industrial principles are being applied to improve hospital care. With the work expanding into outpatient settings and community health organizations, a brief recap of the clinical accomplishments demonstrates why the techniques have gained such broad acceptance.

Infection

In 2001, PRHI began a series of meetings where clinicians shared ideas on best practices for preventing the spread of infections and agreed to begin an assault on central line associated bloodstream infections (CLABs) that would be monitored by the Centers for Disease Control and Prevention (CDC).

Between April of 2001 and March 2005, their collective effort paid off in a 68 percent decline in CLABs, which has been lauded by the CDC and reported in the *Journal of the American Medical Association*.

Case in point #1

Of particular note in the campaign was the work of Dr. Richard Shannon at Allegheny General Hospital. His results will be published later this year in the *Joint Commission Journal on Quality and Patient Safety*.

After taking the week-long Perfecting Patient Care™ University in 2003, Dr. Shannon applied the principles in two intensive care units. By engaging the whole staff to reduce variation in the way central lines were inserted and maintained, he believed, central line infections in the units could be eliminated within 90 days. The work entailed investigating each infection as it became known, in real time, rather than waiting for retrospective data to be reported months later.

Not only did the rate drop to near-zero in 90 days, but from the first year to the next, infected patients declined from 37 to 6 and mortalities from 6 to 1 despite

increased use of central lines and longer periods of use. Sustaining these results requires continuous, real-time learning from each subsequent infection. As the work has continued, evidence of substantial cost savings also has mounted.

Case in point #2

Starting in 2001 the VA Pittsburgh Healthcare System, in cooperation with the CDC, adopted Perfecting Patient Care principles in a single unit to reduce an antibiotic resistant staff infection known as methicillin-resistant *Staphylococcus aureus* (MRSA). Since then, the test unit has accrued dozens of small system improvements, resulting in a greater than 85% reduction in MRSA as well as significant headway against other infections. Along with others, the VA demonstration has shown Perfecting Patient Care methods to be replicable, prompting federal VA administrators to consider a national roll-out.

Across the three-hospital Pittsburgh VA system, other Perfecting Patient Care improvements have been adopted. For example, compliance with hand hygiene increased, medication was delivered on time 99% of the time, information at shift change was more complete and delivered in a fraction of the time, and clean, appropriate wheelchairs were always supplied within minutes.

In concert with the VA, PRHI created a “How To” manual, titled, *Program for Getting to Zero on MRSA for the VA Healthcare System*. The program, under constant review and revision, is posted on the PRHI website for any institution to use.

Cardiac

From modest beginnings in 2001, PRHI’s Cardiac Registry has become one of the premier regional cardiac registries in the country. Through regional collaboration, cardiac surgeons from 10 cardiac centers have now collected uniform data from more than 10,000 coronary artery bypass graft surgeries.

The data are now yielding information about which processes of care lead to the best outcomes for patients. They are also leading to more intriguing questions with national significance: whether tight control of blood sugar following surgery, even in non-diabetics, leads to better outcomes and what accounts for differences in outcomes due to gender. The PRHI Cardiac Registry now has enough information to start piecing together such puzzles, adding to the nation’s knowledge in coming years.

Not only did the infection rate in two ICUs at Allegheny General drop to near zero in 90 days, but from the first year to the next, infected patients declined from 37 to 6 and mortalities from 6 to 1 despite increased use of central lines and longer periods of use.

Pathology

At UPMC Shadyside and affiliated hospitals, the pathology department has improved the quality of Pap smears, increased accuracy of results, and reduced by half the need for retests. This work, funded by JHF and the Agency for Healthcare Research and Quality, bridged the gap between the laboratory, where specimens are analyzed, and physician offices, where they are collected. Creation of checklists and other communication devices has led to an unparalleled degree of collaboration between lab and office, which in turn has led to significant improvements in efficiency and accuracy. The work was published in the December 2005 edition of the *American Journal of Obstetrics and Gynecology*.



PPC: PART OF A LONG-TERM FIX FOR LONG-TERM CARE

Although nursing home reform has been on the national agenda for nearly two decades, its full potential has yet to be realized. In a pre-conference presentation at the COF Convention, Mary Anne Kelly, Executive Director, Southwestern Pennsylvania Partnership for Aging and 2nd Vice President of the Pioneer Network, held out the promising possibility of partnership between the culture change philosophy of the Pioneer Network and Perfecting Patient Care™. A subsequent presentation by David Gritzer, CEO of the Jewish Association on Aging (JAA), and JHF's Fran Sheedy Bost reviewed the theory and practical applications of their exciting work under Perfecting Patient Care, and how it could work in concert with the culture change philosophy to accelerate improvement.

Historic challenges meet today's budget

Currently, long-term care is in a bind, especially in Pennsylvania, with the nation's third highest elderly population and fourth highest per capita spending on long-term care. State and federal funds for long-term care are shrinking every year, and direct-care staff turnover, which is approaching crisis proportions, is drastically reducing morale and quality while increasing cost. Providing better care in a better work environment at lower cost is no longer a wishful slogan: it is an urgent requirement for the very survival of many long-term care facilities. Finding a model or models to help address the issues – now – is crucial. A partnership between Perfecting Patient Care and culture change may be an important part of this answer.

History of the Pioneer Network

Designed to protect seniors from abuse and neglect in the hospital-like nursing home of the 1960s and '70s, the Omnibus Budget Reconciliation Act (OBRA) of 1987 declared that "residents in nursing homes need a home where they can live for the rest of their lives as individuals." Residents' social, spiritual, emotional, recreational and cultural needs were considered to be on par with their physical needs.

Ten years after passage of the bill, as nursing facilities struggled to interpret and put into action the intents of OBRA '87, a small group of nursing home administrators met in New York to discuss how to change the culture of long-term care in a way that respected both residents and employees. The resulting national Pioneer Network has embraced the concept of culture change as the means to transform nursing home care to person-centered care, with resident satisfaction as its chief measures of success.

Complementary models may accelerate culture change

As Kelly pointed out, it might be the opportune time to partner "the best" of Perfecting Patient Care and culture change. Both models rely on a committed leadership to foster a learning organization that touches every employee, resident, and family. Openness, trust, relationship-

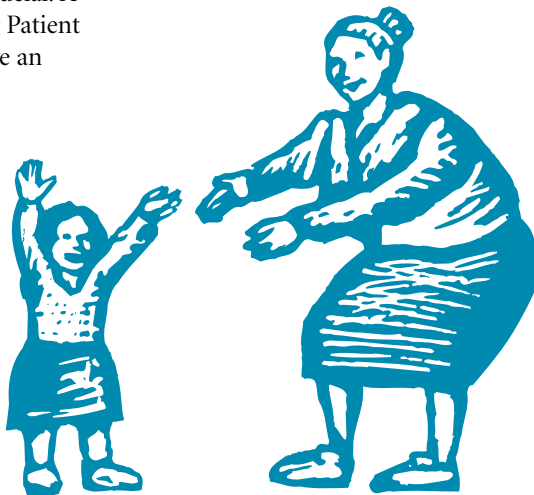
building, experimentation and risk-taking are rewarded, as is real-time problem solving at the point of care. Both models recognize that small changes accrue over time to create major organizational change, and that work is always "in progress."

The challenge, said Kelly, will be how to blend the two approaches. Culture change, embraced by the Pioneer Network, is philosophically driven, while Perfecting Patient Care is a scientific method for implementing improvements. In addition to client satisfaction, Perfecting Patient Care relies on measurements of small experiments in the course of work every day.

JAA approach

In their presentation, Gritzer and Sheedy Bost described how JAA is experimenting with Perfecting Patient Care to improve the quality of resident care, reduce costs, and improve staff retention. The goal, as with the culture change movement, is nothing short of institution-wide transformation.

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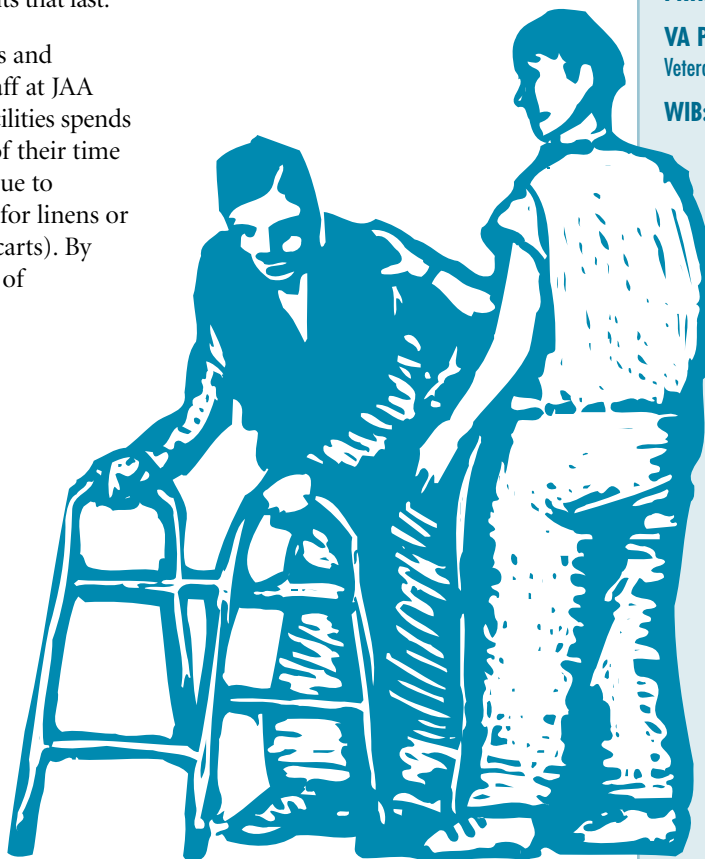
The JAA approach begins at the point of care, focusing on the needs of residents and their families, and systematically eliminating whatever is getting in the way of delivering the highest quality of care at the lowest possible cost. The management team drives and supports these efforts by setting overall direction and high expectations, establishing priorities, removing obstacles, tracking progress, identifying what's working and what's getting in the way, sharing lessons learned, and providing necessary training. Perfecting Patient Care engages frontline staff in real-time problem solving close to the point of care.

“We’ve surveyed the residents, their families and the staff,” said Gritzer. “We have discovered that in their collective wisdom, they know what could be better, and they know how to fix it. Expertise is all around. We are finding new ways to use and honor that expertise, experiment with those ideas, and make improvements that last.”

Based on initial observations and experience elsewhere, the staff at JAA and other long-term care facilities spends from one-third to one-half of their time in activity that adds little value to residents (such as searching for linens or waiting to process cafeteria carts). By involving staff in getting rid of

unnecessary steps that waste their time and effort, they will be free to spend more time with residents in value-added activities, which will increase both resident and staff satisfaction and contribute to higher quality of care outcomes.

To evaluate the impact of these efforts, JAA established baseline measures in resident, family, and staff satisfaction, key quality indicators such as falls and pressure ulcers, and staff turnover. Each individual work experiment also has its own set of measures. JAA plans to calculate the savings achieved from improvements in quality and from reductions in turnover to identify how improvements in quality affect overall financial performance. This experiment should yield new insights into how the philosophy of culture change can actually be implemented. More important, it may help nursing homes find a way out of the double bind of lowering cost while improving quality.



GLOSSARY OF FREQUENTLY USED TERMS

- CAB:** Consumer Advisory Board
- CDC:** Centers for Disease Control and Prevention
- CLABs:** Central Line Associated Bloodstream Infections
- FQHCs:** Federally Qualified Health Centers
- HRSA:** Health Resources and Services Administration
- IHI:** Institute for Healthcare Improvement
- ICU:** Intensive Care Unit
- IOM/NAE:** Institute of Medicine and the National Academy of Engineering
- IRETA:** Institute for Research, Education and Training in Addictions
- JAA:** Jewish Association on Aging
- JHF:** Jewish Healthcare Foundation
- MRSA:** methicillin-resistant *Staphylococcus aureus*
- NOMs:** National Outcomes Measures
- OBRA:** Omnibus Budget Reconciliation Act
- PATF:** Pittsburgh AIDS Task Force
- PECS:** Patient Electronic Care System
- PPC:** Perfecting Patient Care™
- PRHI:** Pittsburgh Regional Health Initiative
- VA Pittsburgh Healthcare System:** Veterans Affairs Pittsburgh Healthcare System
- WIB:** Workforce Investment Board



FEDERALLY QUALIFIED HEALTH CENTERS BENEFIT FROM PPC

Providing excellent diabetes care is a challenge in any healthcare environment. It can be especially so for underserved and uninsured people. For years, these patients, whose disease is just one of many difficulties, have also struggled against an unfair label: non-compliant.

But ask Wilford Payne, longtime Director of Alma Illery Medical Center, about the non-compliant patient, and you will hear one of his most passionately held viewpoints – that there is no such thing.

“Why can’t we have a regional model that meets HRSA requirements?

We had the clinicians, we had the community support and we certainly had the need.”

– Fran Sheedy Bost

“Patients comply based on their priorities,” says Payne. “If the first priority is making rent this month, then maybe medications and appointments slip by the wayside. We, as healthcare givers, are the ones who need to adapt to what is going on in their lives, instead of expecting them to respond to our system.”

Western PA responds

Creating a more responsive system of care for underserved people has made Pittsburgh a national epicenter of innovation in healthcare – a place where health centers decided to join forces with each other in a regional model to eliminate disparities in diabetes care for the underserved. Bringing experience and a track record from one agency – the Health Resources and Services Administration (HRSA), part of the U.S. Department of Health and Human Services – to our region’s community

health centers, known as Federally Qualified Health Centers (FQHCs) requires a combination of skill, commitment and common vision.

The purpose was to establish a regional learning model for diabetes, rather than participate in a national Collaborative model that would require local health center staff to be out of the office attending meetings across the country. Instead, fostering a local partnership strategy would help strengthen the FQHCs, sustain their work, and improve diabetes care in our region.

When, as part of this joint venture, the Pittsburgh Regional Health Initiative offered FQHC providers training in Perfecting Patient Care,[™] improvements quickly took root. The beneficiaries include both patients and their healthcare providers.

HRSA’s Community Health Center Program

HRSA funds programs that expand access to high quality, culturally and linguistically competent primary care for underserved and uninsured people. HRSA serves about 12 million people in 3,500 communities through Community, Migrant, Homeless and Public Housing health centers.

Nationally, there are about 722 FQHCs and 4,000 health centers. In Southwestern Pennsylvania, eight FQHC centers from Erie to West Virginia encompass more than 50 health clinics in underserved rural and urban neighborhoods. Four of the eight community health centers are located in Allegheny County.

IHI and Health Disparities Collaboratives

In conjunction with the Institute for Healthcare Improvement (IHI), HRSA developed a National Health Disparities Collaborative model in 1998 to improve

primary health care practices and eliminate health disparities. IHI is a not-for-profit national healthcare improvement organization based in Cambridge, Massachusetts.

HRSA selected 88 health centers to participate in the Health Disparities Collaborative focusing on diabetes care. The plan implemented the Planned Care Model, a comprehensive care plan based on known best practices, created by Seattle physician Ed Wagner, MD.

Making the Case

The idea to initiate a regional collaborative began with a conversation in early 2004 between Jayne Bertovich, a HRSA official at the time, and Fran Sheedy Bost of the JHF. Wilford Payne and Father Regis Ryan, Director of the Sto-Rox Family Health Center, wanted to participate in HRSA’s national collaborative but were reluctant, because it required too much staff time out of the office. Although HRSA provides funding for travel to required meetings, the simultaneous absence of key staff members from community health centers would affect office productivity and cause a loss of revenue.

The possibility occurred to them that, if HRSA approved, training could be conducted in Pittsburgh. With access to PRHI’s Perfecting Patient Care University and the chance to send coaches to the clinics, training could be brought to the health centers, and travel to national conferences could be limited.

Fran Sheedy Bost, in conversation with HRSA officials, repeatedly asked, “Why can’t we have a regional model that meets the HRSA requirements? Why can’t our eight FQHCs, with over 50 clinics from here to Erie, become its own Health Disparities Collaborative working on diabetes? We had the clinicians, we had the community support and we certainly had the need.”

HRSA responds: JHF helps

HRSA offered a chance to submit a proposal to establish a Regional Health Disparities Collaborative in Western Pennsylvania. The proposal was written by eight health centers, known as the Western Pennsylvania Health Disparities Collaborative, enabling the region to become a demonstration project for HRSA. It was approved in December 2004, and the Western Pennsylvania Health Disparities Collaborative began, with its aim of helping those health centers implement a Regional Planned Care Model among a population of diabetic patients.

The JHF provided financial assistance during the initial learning year for the health centers.

Regional Learning begins

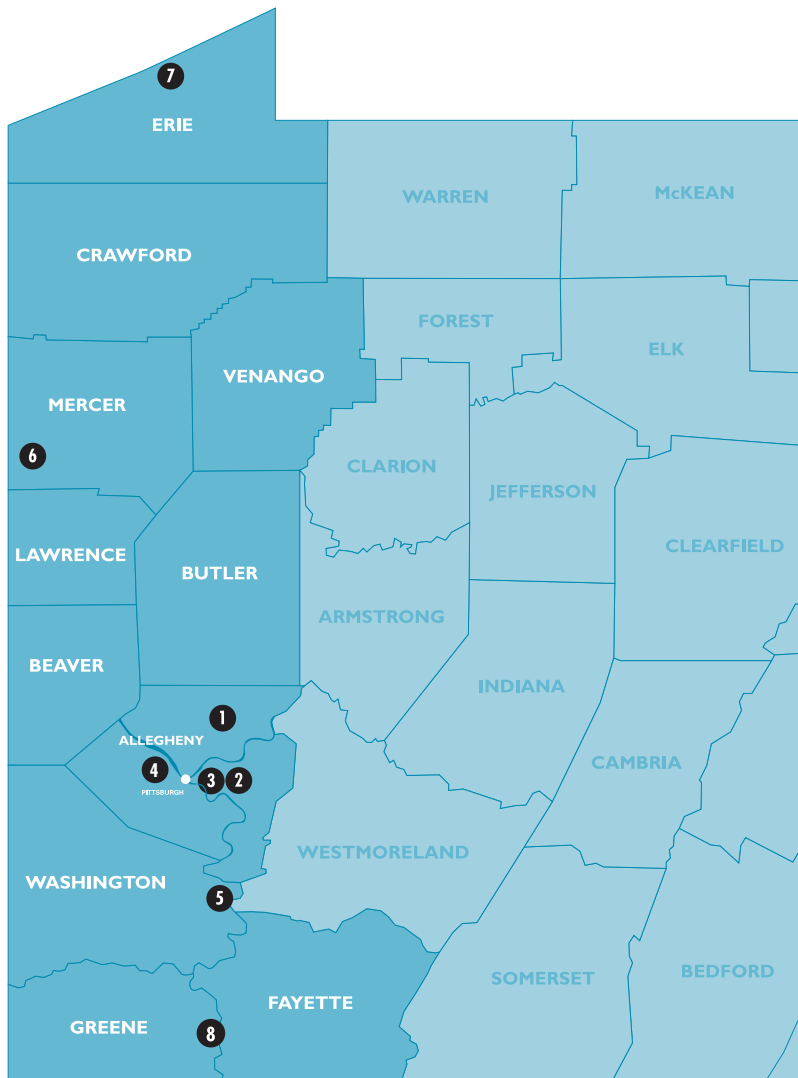
PRHI trainers Sheedy Bost, Mimi Priselac, Barbe Jennion and Debra Thompson worked together to create a streamlined version of the Perfecting Patient Care curriculum specifically for use in this project. Initial training was provided for leaders of the eight health centers.

The most crucial part of training is to enable workers to see the environment in which they are working. Staff members are so accustomed to working around

problems in a chaotic environment that they come to view chaos as the vehicle, with patients and co-workers too often in the back seat.

Breaking through the acceptance of the current condition is the main job of initial training. With permission from a willing diabetic patient at one of the centers, Jennion, Priselac and Sheedy Bost actually filmed her physician encounter, from entry to the waiting room through checkout. Showing this film, from the patient's-eye view, to the leaders of the health centers was a revelation.

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**WPA HEALTH DISPARITIES COLLABORATIVE:
8 CENTERS;
50 CLINICS, 11 COUNTIES**

- 1. Primary Care Health Services, Pittsburgh
- 2. East Liberty Family HCC, Pittsburgh
- 3. UPMC Matilda Theiss, Pittsburgh
- 4. Sto-Rox Family HC, McKees Rocks
- 5. Centreville Clinics, Fredericktown
- 6. Primary Health Network, Sharon/Mercer
- 7. Community Health Net, Erie
- 8. Cornerstone Care, Greensboro, PA

Sheedy Bost adds, “It wasn’t a blaming situation, but a validating one. After the video, when we drew their complex work pathways on a big piece of paper, they applauded. It was liberating for them to gain that level of understanding and acknowledgement of what they’re up against.”

Training also involved exercises to show how the Rules in Use could help them begin to untangle their work, clarify handoffs between co-workers, and involve patients more actively. To create more enthusiasm and credibility among clinicians and staff, Dr. Eileen Boyle of the East Liberty Family Health Care Center, a JHF Physician Champion, taught part of the day-long session.

Adds Payne, “Perfecting Patient Care has opened a lot of minds to change. Now we are trying to figure out a way to get more physicians and staff members trained.”

So is Priselac. Day-long sessions continue regularly, reaching as many staff members as practical each time. But PRHI is now breaking the curriculum into very small learning modules that can be woven into weekly and monthly staff meetings as well.

Key to success: computerized results

A regional and national registry of diabetic patients is perhaps the most powerful tool the clinician will have. As part of the Collaboratives’ work with

Local FQHCs have exceeded national, state and cluster averages, with patients showing big improvements in diabetes test results. HRSA singled out Western PA’s Collaborative as “transformational.”

HRSA, health centers are asked to use the national Patient Electronic Care System (PECS), a national disease registry. Health centers submit monthly Registry Summary Reports for the population of focus – in this case, diabetics.

Clinicians can see whether their diabetic patients are receiving recommended treatment and compare their results. Printouts from the system are put on the front of each diabetic patient’s chart, giving the doctor the most recent information for each patient encounter.

A major drawback to the PECS system is that it does not interface with the offices’ electronic medical record system. This means all data must be entered separately into two systems, which creates double work. Even with the imperfect system, Perfecting Patient Care is making the tedious dual entry process easier. In one morning of team troubleshooting, staff

specified their own work, color-coding the form so that each responsible staff member would know which part of the PECS form to fill out for each patient. They also created a work flow sheet to ensure that all information is entered into the computer system.

Results

Hemoglobin A1c (HbA1c) is a test that shows the average amount of glucose in a patient’s blood over the prior three months. This single test is the best indicator of whether a person’s diabetes is under control: the lower the number, the better.

Among the more than 50 clinics in the Western Pennsylvania Collaborative, the average HbA1c fell from 9 to 7.4 in the first eight months of reporting. One practice achieved an average HbA1c of 6.8 in March 2006. Most of the centers have also met the goals for control of blood pressure and lipids. These results exceeded national, state and cluster averages in March 2006, leading HRSA to single out the Western Pennsylvania Collaborative as “transformational”.

Perhaps most important, measures of patient engagement and self-management continue to show improvement, proving Payne’s point that, when care is properly coordinated, all patients can be “compliant.”



QUALITY CARE IS GOOD FOR WORKERS TOO!



High-quality health care is certainly good for patients. But can it be good for healthcare workers, too? Perfecting Patient Care™ holds that the healthcare system must be equally dedicated to patient care and worker satisfaction. Research affirms that the work environment in health care is directly related to workforce retention, healthcare safety and costs.

The current picture is not encouraging. Poor workforce retention and resulting worker shortages can impair patient outcomes. Each additional patient assigned to a nurse increases rates of mortality and failure-to-rescue. As job dissatisfaction and burnout increase, by some measures up to 23 percent, one out of three hospital nurses under age 30 plans to leave their job in the next year.

Our hypothesis is this: healthcare workforce retention rates, specifically among nurses and among other allied health professionals, can increase if healthcare teams are given tools and skills to improve their work environments. Removing wasted effort and resources that frustrate workers will also improve patient outcomes and reduce healthcare costs.

The Pennsylvania Workforce Investment Board (WIB) gave Health Careers Futures a grant of \$500,000 to test this hypothesis. This grant promotes a two-pronged approach to create healthy work environments in the healthcare industry. The approach, being tested in Allegheny County, features (1) a tiered training program for healthcare workers that will give them skills and tools to improve work processes, and (2) a career renewal center to help workers at risk of leaving the industry due to unhealthy work environments.

By offering a unique on-the-job adult education and career coaching, this project addresses the Commonwealth's and County's goal to retain nursing and other healthcare professionals.



Perfecting Patient Care™ to improve work environment

Using Perfecting Patient Care principles, Health Careers Futures and PRHI worked together to develop learning modules in the following four areas:

- Communication skills
- Conflict management
- Problem solving
- Business case for improvement

In each topic area, two- and four-hour sessions are being developed. The training is being presented in multiple sessions in several nursing homes and hospitals throughout the county.

“The idea is to bring the training to the people,” said PRHI’s Mimi Priselac. “We are breaking up the sessions into small segments so that one or two principles can be taught at a time. It improves retention and doesn’t strain the institution or the people by taking up their whole day.”

The first sessions were held in late June and the evaluations were favorable.

Career Renewal Center

Health Careers Futures will also offer an independent, centralized employee career renewal center. The confidential setting will allow healthcare workers to discuss career difficulties with experienced career counselors. The objective is to help retain those professionals by giving them tools and choices to address their work-related concerns constructively, on the job. Aggregated data from the center are expected to yield excellent research opportunities to support current and future studies of healthcare workforce retention strategies.



ADDICTION: ITS A CHRONIC DISEASE

With the latest Institute of Medicine report lauding the use of engineering principles in redesigning healthcare systems, more kinds of healthcare providers are beginning to explore them. An early adopter of Perfecting Patient Care™ principles was the Institute for Research, Education and Training in Addictions (IRETA), which began to explore model treatments for substance abuse three years ago.

IRETA's efforts intensified as federal, state and commercial health insurers began examining ways to improve the effectiveness, efficiency and accountability of addiction treatment. Most of these efforts took the traditional form of imposing performance measures, process improvement strategies, and specific leadership and training initiatives. Unfortunately, few if any of these efforts resulted in demonstrated, sustained improvements in the quality and efficiency of substance abuse treatment.

A new approach

Three years ago IRETA convened a local group of healthcare stakeholders to find a "model" treatment system that incorporated the known principles for drug abuse care with the latest knowledge of healthcare system improvement. Based on IRETA's deduction that addiction is more a chronic than acute illness, the group began its work to ensure quality, efficiency and accountability and to recommend a model system for implementation across Pennsylvania.

From these discussions, which also involved many national leaders and researchers, IRETA began a pilot program with Pyramid Health System to test a performance measurement system that permitted providers to collect information in real time – as clinicians did their work.

"This program was unique because it addressed improvements in both clinical and process applications," said Jan Pringle, PhD, of IRETA.

Improving access

Research has repeatedly confirmed that patients who get into treatment and stay with it are more likely to return to health and stay better longer. A typical problem is making sure patients can gain quick access to the mental and behavioral health system.

At the pilot site, the team used the industrial techniques associated with Perfecting Patient Care™ to determine where the intake process was bogging down. They discovered that people who were due for court-appointed assessment – though not necessarily in need of treatment – were put in the queue along with those in more urgent need. By scheduling all court-appointed assessments on Fridays and implementing scheduling improvements on the other four days, the team successfully reduced waiting time to first appointments from 14 days to about 48 hours.

By following each patient individually, the group soon learned another crucial fact: it was helpful for more highly trained clinicians to perform initial intakes rather than rely on associates to make appointments. The team discovered that when a person with master's degree-level training engaged each patient over the phone, the patient was far more likely to come in for treatment and stay with it.



Another ongoing challenge was managing the phones during lunch hour or when call volume exceeded expectations. The team specified a process under which clinicians on call helped with the phone work when calls outpaced the usual staff's capacity.

Monitoring changes

Another refinement led intake counselors to pass information along from patients to clinicians within 48 hours of its collection. That way, any problems could be immediately identified, allowing clinicians to focus on clinical changes. Patients like the system and feel that clerical and clinical personnel are listening to them.

During treatment, an update of every patient's clinical condition must be given every two weeks, in accordance with National Outcomes Measures (NOMs). Over two or three years, the IRETA/Pyramid team developed a form with which necessary data can be collected in just two or three minutes. The information is presented in an easily understood way that draws any changes in patients' status to the attention of clinicians. The form documents developments that patients note, but might fail to express in group sessions.



People who get into treatment and stay with it are more likely to return to health and stay better longer. As wait times for appointments declined at Pyramid, length of treatment increased.

“The development of performance measurement has helped our organization take the NOMs and integrate an objective way to measure treatment effectiveness as well as make real time improvements,” said Pyramid CEO Jonathan Wolfe.

Results

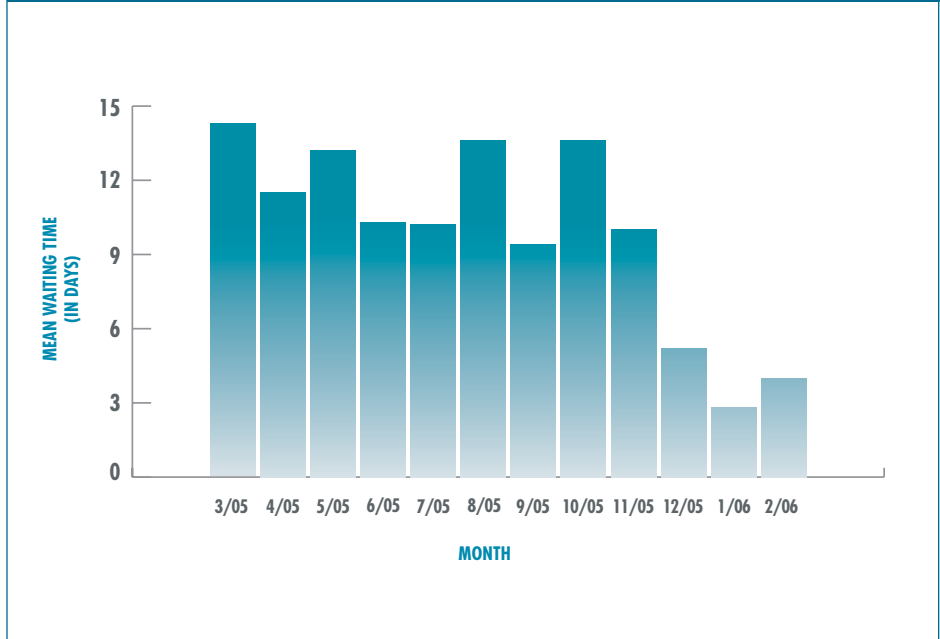
Results from this IRETA/Pyramid demonstration have been promising (see charts). The team improved clinical and process applications by:

- Reducing the amount of time between first contact and first treatment session from an average of 14 days to 48 hours.
- Increasing program census over a one year period by at least 50%.
- Increasing program revenues over a one year period by over 25%.
- Reducing provider-developed redundant and unnecessary paperwork burden by approximately 40%.
- Increasing client retention over a ten month period.
- Significantly increasing referral source satisfaction.
- Achieving impressive clinical outcomes for adjudicated clients – 84% had ceased drug and alcohol use, 60% were employed, 92% had no probation or parole violation and 100% were stably housed six months after discharge.

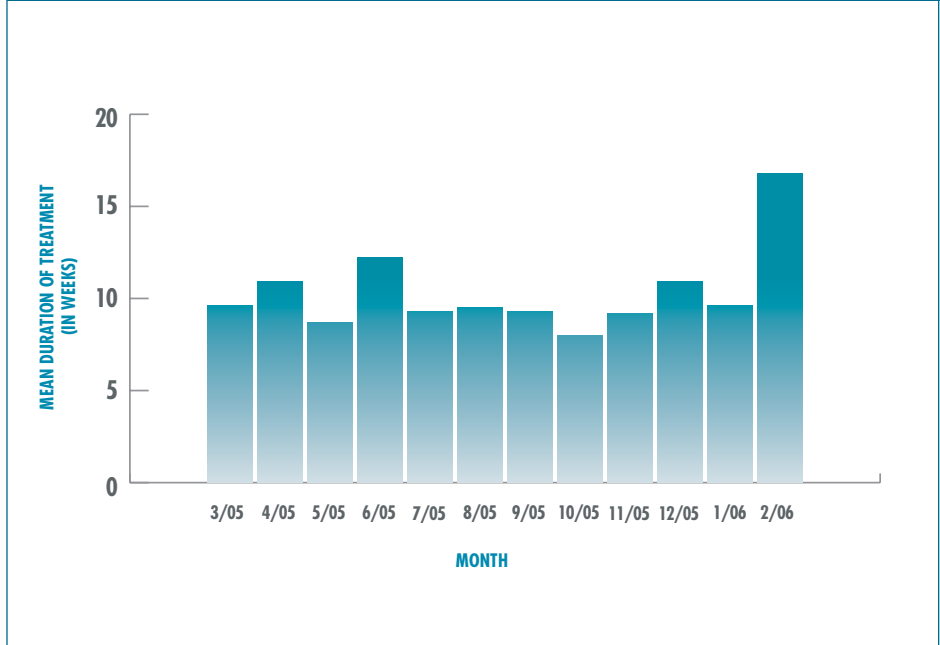
“This is the future” says Michael Flaherty, PhD, Executive Director of IRETA. “With this performance management system, key indicators simultaneously account for and measure both the quality of care provided and the wellness and recovery status of each individual.”

IRETA and Pyramid intend to expand this work to all of Pyramid’s programs, residential and outpatient, and to both adult and adolescent patients. IRETA is currently developing a model for the expansion of this approach to a group of providers within Pennsylvania and New York.

GETTING AN APPOINTMENT



STAYING IN TREATMENT



PITTSBURGH AIDS TASK FORCE IMPLEMENTS PERFECTING PATIENT CARE

Measuring quality is not just for industry any more. AIDS service organizations, for example, are contractually required by the Pennsylvania Department of Health and by the federal Health Resources and Services Administration (HRSA) to maintain their own quality management programs. However, they receive no technical assistance to develop or sustain these programs.

Requirement vs. reality

JHF, the fiscal agent and contract monitor for AIDS service organizations in Southwestern Pennsylvania, recognized the gap between requirement and reality. Through the Pittsburgh Regional Health Initiative, the Foundation developed a training module that consisted of:

- A full-day introduction Perfecting Patient Care™ (PPC) a quality engineering curriculum that PRHI adapted from Toyota's.
- A four-hour visit to the UPMC St. Margaret Lawrenceville Family Health Center, which used PPC in systems changes designed to improve care for diabetics.
- A session on the similarities between PPC and HRSA's Plan-Do-Study-Act model for quality improvement.
- A session to provide tools for planning and implementing a HRSA-compliant quality management program.

PPC works outside the hospital

Each AIDS service organization across the region serves unique populations of vulnerable people living with or at-risk for HIV/AIDS. Although the Perfecting Patient Care™ modules are usually taught in a hospital setting, participants from the community-based AIDS programs found that the principles could be readily applied to community-based AIDS programs as well.

Results

After her Perfecting Patient Care™ training, Kathi Boyle, Executive Director of the Pittsburgh AIDS Task Force (PATF), began to identify and rapidly solve problems to their root causes and to redesign work to better meet clients' needs. Starting with small, measurable improvements, Boyle and her staff were able to:

- Form a small staff committee for a quality management, engaging program leaders. Board member, Tom Mills, MD, a psychiatrist with a vital interest in quality assurance, reminds the group that every change puts them "half way to perfect." Viewing each improvement as a stepping stone keeps the group from feeling overwhelmed.
- Reinvigorate the Consumer Advisory Board (CAB) to gain a deep understanding of consumer attitudes toward services and staff. The CAB will design and implement a consumer survey and present the results directly to the Board of Directors. Organizations across the country report that, when consumers are present on committees and are given a say, healthcare providers learn more and consumers feel valued.

Toward a hopeful future

"Perfecting Patient Care helped to get this whole process started by giving us some first steps that we felt we could accomplish," says Boyle. She said that she looks forward to engaging other local experts in a provider forum for quality management.

Boyle's colleagues also want to sustain a formal peer network. The network will engage local experts in HIV/AIDS quality management to help track quality data through a regional indicator.

The work of the providers, regardless of the services they offer, is directed toward a central aim: a seamless referral system that presents the fewest possible obstacles to consumers.

RESOURCES AND READINGS

American Nurses Credentialing Center
Magnet Recognition Program
www.nursingworld.org/ancc/magnet

Pennsylvania Healthcare Cost Containment Council (PHC4)
www.phc4.org

Health Careers Futures Toolkit
www.hcfutures.org/hctoolkit.asp

Pittsburgh Regional Health Initiative
www.prhi.org

From Silence to Voice: What Nurses Know and Must Communicate to the Public, Bernice Buresh and Suzanne Gordon, Cornell University Press, 2002

Keeping Patients Safe: Transforming the Work Environment of Nurses, Institute of Medicine Committee on the Work Environment for Nurses and Patient Safety, National Academies Press, 2003

Silence Kills: The Seven Crucial Conversations for Healthcare, VitalSmarts Industry Watch, by David Maxfield, Joseph Grenny, Ron McMillan, Kerry Patterson, and Al Switzler, 2005, conducted in partnership with the American Association of Critical Care Nurses

The Bell Curve, The New Yorker, December 6, 2004

Hospital Takes a Page from Toyota, The Washington Post, June 3, 2005

Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics that Inhibit System Change, by Anita L. Tucker and Amy C. Edmondson in California Management Review, (Volume 45, Number 2)

Magnet Hospital Development in the Pittsburgh Region: A Status Update, Health Careers Futures Report, 2004



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