

The Joint Commission

Journal on Quality and Patient Safety

Improvement from
Front Office to Front Line

October 2007
Volume 33 Number 10



Courtesy of Genesis Medical Center

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American Hospital Association–McKesson Quest for Quality Prize®

Introduction

Gail Lovinger Goldblatt

The American Hospital Association (AHA)–McKesson Quest for Quality Prize® honors hospitals that have made a commitment to achieving the six quality aims in the Institute of Medicine (IOM) report *Crossing the Quality Chasm**—patient-centered care, safety, effectiveness, efficiency, timeliness, and equity—and to redesigning how they deliver patient care to ensure sustainable achievement.

The goals of the prize are as follows:

- Raise awareness of the need for an organizational commitment to highly reliable, exceptional quality, patient-centered care
- Reward successful efforts to develop and promote a systems-based approach toward improvement in quality of care
- Inspire organizations to systematically integrate and align their quality improvement (QI) efforts throughout the organization
- Communicate successful programs and strategies to the field

The AHA–McKesson Quest for Quality Prize offers three possible levels of recognition—a \$75,000 winner, up to two finalists (\$12,500), and Citations of Merit. Approximately 50 hospitals applied for the 2007 award. Of these, 5 were site visited. Columbus Regional Hospital (Columbus, IN) was awarded the \$75,000 prize and Cedars-Sinai Medical Center (Los Angeles) and INTEGRIS Baptist Medical Center (Oklahoma City) were awarded the \$12,500 finalist prizes. Two other hospitals—McLeod Regional Medical Center (Florence, SC) and the Amarillo VA Health System (Amarillo, TX)—were awarded Citations of Merit.

Although the three hospitals winning the top honors this year differ in many respects, their quality journeys have a number of common threads:

- Active engagement of leadership in quality with close collaboration among the governing board, executive management, and medical staff
- Shared vision throughout all parts of the hospital
- Integration of the six IOM quality aims throughout the hospital strategic plan, goals, and priorities
- Use of continually updated dashboards and benchmarks at

* Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.



From left: C. Bruce Lawrence, executive vice president and COO, INTEGRIS Health, representing INTEGRIS Baptist Medical Center, Oklahoma City; Doug Leonard, former CEO of Columbus Regional Hospital, Columbus, IN, and now president and CEO of the Indiana Hospital & Health Association; and Neil E. Romanoff, M.D., vice president for medical affairs and chief patient safety officer, Cedars-Sinai Medical Center, Los Angeles.

the individual-unit level as well as the organizational level

- Empowerment of staff at all levels to innovate, adapt, and lead change
- Use of a variety of different tools and methods for QI

For each of these hospitals, QI is not a project or the job of a particular department; rather, QI permeates the fabric of the organization and is the work of each individual who works there. As you read about these 2007 honorees, we hope that you will reflect on your own organization's commitment to highly reliable, exceptional quality, patient-centered care.

In 2008, the prize will honor hospitals (1) that have committed in a systematic manner to achieving all six IOM quality aims and can document their progress and (2) that provide replicable models and systems for the hospital field.

The application and criteria for the AHA–McKesson Quest for Quality Prize are available on the Quest for Quality Web site (<http://www.aha.org/questforquality>). Applications for the 2008 prize are due October 14, 2007. ■

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American Hospital Association–McKesson Quest for Quality Prize® Winner

Columbus Regional Hospital: Creating a Learning Environment

Katherine J. Wallace, R.H.I.A., C.P.H.Q.
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Columbus Regional Hospital is a 225-bed not-for-profit, county-owned hospital located in Columbus, Indiana, a community of 39,000 people. The hospital serves a 10-county region of southeastern Indiana by delivering acute care through 35 medical specialties.

A Turnaround Story

The path to excellence at Columbus Regional Hospital (CRH) began 20 years ago when its board of trustees started to transform a 70-year-old county-owned hospital into the preferred medical center in the region. Following a major renovation and an expansion of services, CRH had some success in the 1990s in making the transformation—until a revolt in 1997. The medical staff's dissatisfaction and turf-battle issues led to a public dispute with hospital leadership, and the chief executive officer (CEO) resigned after a 10-year tenure. Patient satisfaction and medical staff and employee morale were low, and the community's perception of the hospital was damaged.

The new CEO, along with the board of trustees and the executive team, resolved to get CRH out of crisis and to forge ahead on the path to excellence. Initially, the executive leadership did not start out with a "plan;" the only plan was to get back to "normal." They were able to successfully address patient, physician, and employee satisfaction and restore the community's trust in CRH.

The executive leadership identified six success factors that enabled it to emerge from "crisis mode" and to create an engaged workforce:

1. Rebuilding trust with the medical staff
2. Relentless focus on the patient
3. Benchmarking against the best
4. Creating a balanced scorecard
5. Implementing effective methods of improvement
6. Elevating aspirations: vision

REBUILDING TRUST WITH THE MEDICAL STAFF

To rebuild trust with its physicians, CRH had to learn what physicians wanted. The board of trustees and the executive team made a commitment to openness and transparency to members of the medical staff. Strategy and all outcomes were shared openly. The executive team worked to build relationships on the basis of a common interest to both: the best patient care. CRH also adopted objectives to make a physician's day more efficient and care more reliable. At first, physicians were viewed as CRH's customers but now they are seen as partners in strategy, delivery, and quality. They are deeply involved in strategic decision making and direction of the hospital. Although not employed by the hospital, they are key members of the workforce in delivering care to CRH's patients on a daily basis. Overall physician satisfaction with the hospital was at the 92nd percentile in 2006.

RELENTLESS FOCUS ON THE PATIENT

To satisfy its patients, CRH had to learn what patients wanted and deserved. The organizational chart had CRH functioning in silos, yet it quickly became apparent that patients do not experience CRH functionally but through

the core process of care delivery. In addition, all employees may not instinctually know how to satisfy patients; training and clear expectations need to be provided. It is not good enough to be a technically competent employee alone; everyone is expected to treat patients respectfully. Patient satisfaction moved from the 16th percentile in 1997 to the 97th percentile (second quarter of 2007).

Another key to patient satisfaction is employee satisfaction. We started conducting yearly employee satisfaction surveys (and acted on the results) and created multiple feedback mechanisms for employees, including quarterly CEO updates. We rewarded employees for going above and beyond in serving patients and improved our selection and training. Overall employee satisfaction was at the 95th percentile in 2006.

Finally, we established a focus on patient safety. CRH worked to pull back the curtain on its own safety issues, with discussions that started with the board of trustees and extended to frontline employees.

BENCHMARKING AGAINST THE BEST

In its initial efforts to return to normal mode after the crisis, CRH began to benchmark by identifying and pursuing best practices in all five of its performance “pillars”: people, service, quality and safety, growth and innovation, and finance. CRH completed evidence-based research, sought recommendations from external organizations, measured its performance against external benchmarks, and competed in recognition programs.

CREATING A BALANCED SCORECARD

In 1999, the executive team, in conjunction with the board of trustees, developed a corporate balanced scorecard to provide them with a clear picture of progress toward meeting strategy in all five pillar areas. CRH has since progressed to a balanced scorecard system that cascades throughout the organization (Figure 1, page 594).

Process Management and Improvement Efforts

CONSISTENCY AND RELIABILITY OF PROCESSES

CRH builds consistency and reliability of processes around a team-based culture of high performance. Consistency and reliability are addressed through four major components:

1. A pursuit of excellence, which guides the approach to the design of overall processes
2. The interdisciplinary clinical case management (ICCM) care delivery model, which is designed to deliver effective, evidence-based care in a timely, efficient, and equitable manner
3. Cycle of accountability, which designs accountability for outcomes through our cascading scorecards
4. A culture of high performance enhanced by interdisciplinary teams using complexity science to reach beyond current best practice and innovate

After implementation action plans (including communication and education) are developed, pilots are conducted to test the new processes' viability. Grand Rounds and nurse manager rounding are used to ensure that process performance in day-to-day operations meets requirements. Meetings between unit-based case managers, clinical nurse specialists, and utilization management coordinators are held twice weekly to identify unique patient safety needs requiring intervention at an advanced practitioner level.

ELECTRONIC-BASED INNOVATIONS

Many innovations in patient safety and support have been made by deploying wireless and other electronic capabilities. Patients' call buttons are linked to their caregiver's telephones, allowing for their needs to be met more timely. Nurses carry wireless telephones so that patients, physicians, and other caregivers can immediately reach the patient's primary nurse. An electronic “white board” identifies which caregivers are assigned to care for each patient, along with the telephone number of their wireless devices. Caregivers wear radio frequency identification (RFID) badges, which identify their locations in the hospital.

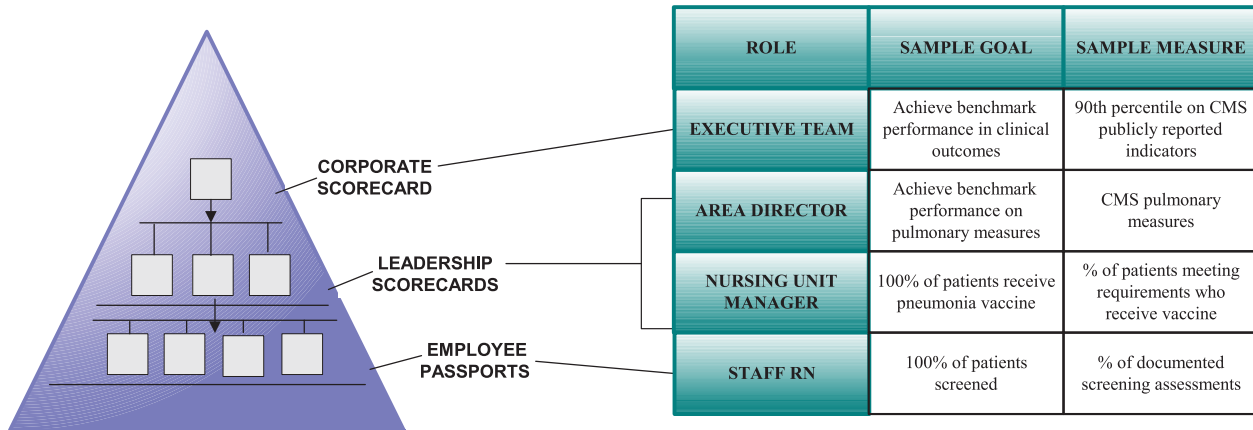
The wireless system is also integrated with the bed alarm system (all beds have bed alarms). If a patient is determined to be at high risk for falling, the bed alarm is turned on so that caregivers are immediately notified via a wireless device if a patient tries to leave the bed.

The emergency department uses color codes on a tracking board to indicate the length of time a patient has been waiting; ancillary departments (such as radiology) are informed if a patient is waiting for their service.

The nursing administrative coordinators use a computerized dashboard that provides notification of bed status to assign beds and to plan, schedule, and monitor room

Sample Cascading Balanced Scorecard Goals and Measures

STRATEGY DEPLOYMENT AT CRH
Cascading Balanced Scorecard Goals & Measures



©Columbus Regional Hospital

Figure 1. In the balanced scorecard system, goals and measures are applied at the executive, area director, nursing unit manager, and staff nurse levels. CMS, Centers for Medicare & Medicaid Services; RN, nurse.

cleaning. Availability of beds translates into availability of other critical resources, such as nursing staff, and allows CRH to increase the efficiency of patient flow.

Error checking is electronically hardwired into clinical systems wherever possible. For example, a computer-aided detection system examines every pixel of film digitally and marks suspicious areas. The radiologists use those markings and go back to the original mammograms to see if anything was missed.

BUILDING PATIENT NEEDS INTO PROCESSES AND SERVICE INTERACTIONS

CRH uses five approaches to ensure that patient needs are built into its processes and service interactions:

1. **Analysis of Patient Satisfaction Results.** Patient satisfaction results are analyzed through a Web-based tool to identify patient expectations and preferences. Action plans are then established to build them into work processes. For example, a patient satisfaction survey revealed that patients identified a need for improvement in “staff concern for privacy.” Benchmarking of best practices suggest-

ed use of “key words at key times” (scripting). Employees who enter a patient’s room for care or services can now be heard saying, “I’m pulling this curtain for your privacy.”

2. **Nurse Managers’ Patient Rounds.** Nurse managers conduct interdisciplinary care rounds each morning to determine if patients’ and families’ needs are being met.

3. **Identification of Patients’ Needs.** Nurses and environmental services use white boards in patient rooms to identify the patient’s top three needs or priorities and to track daily goals.

4. **Resolution of Complaints.** The patient representative emphasizes patient education, comprehension, and empowerment in resolving patient or family complaints.

5. **ICCM Model.** The ICCM Model factors patient decision making and patient preferences into the delivery of health care services. The care model begins at admission when each patient is asked what his or her goals are for the stay. In addition, the patient’s primary care nurse assesses spiritual, cultural, and religious needs, which are incorporated into a patient-specific plan of care used by the interdisciplinary care team. The ICCM model is also used in

the design of new services, such as in the development of the cardiac surgery program, which required complex integration of the CRH care delivery model across multiple departments.

Challenges and Lessons Learned

Challenges remain. For example, a building project to provide all private rooms will begin soon. As the population CRH serves diversifies, the diversity of staff and its ability to effectively serve new immigrant populations must be addressed. The continued growth of the uninsured and underinsured population will cause dramatic changes in the hospital and its financial integration with physicians.

Yet the answer to all challenges is obvious, elegant, and profound: *Do what is best for the patient and everything else will take care of itself.* **J**

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