

# Healthcare Benchmarks and Quality Improvement

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**MAY 2008**

**VOL. 15, NO. 5 • (pages 37-48)**

## ‘Stunning’ CPOE study spurs immediate action in Massachusetts

*Hospitals could recoup investments in 26 months, researchers estimate*

The implementation of computerized physician order entry (CPOE) by hospitals in Massachusetts could save each facility an estimated \$2.7 million a year by reducing error rates, shortening length of hospital stays, and curtailing unnecessary drug tests and laboratory use, according to a study co-sponsored by the Massachusetts Technology Collaborative (MTC) and the New England Healthcare Institute (NEHI). That means, say the authors, that an investment in a CPOE system could be recouped in as little as 26 months.

The findings of the report, which were called “stunning” by MTC’s executive director, **Mitchell Adams**, have spurred major organizations to immediate action. For example, on the day the report was released, Blue Cross and Blue Shield of Massachusetts said it would require all of the state’s hospitals to fully install a CPOE system within four years or face the loss of income from an incentive program that promotes high quality of care. In addition, Massachusetts State Senate President **Therese Murray** (D) has introduced a bill that sets a deadline of 2012 for statewide adoption of CPOE. After this date, the use of CPOE would be required for hospital licensure.

The study, which examined 4,200 medical charts from patients

## Key Points

- Financial penalties threatened for hospitals that do not meet Blue Cross and Blue Shield’s deadline.
- More than 10% of patients in Massachusetts hospitals suffer preventable adverse drug events.
- Proponents say hospitals should no longer let cost be a disincentive to implement CPOE.

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admitted to six Massachusetts community hospitals, was conducted by **David Bates**, MD, chief of the division of general medicine at Boston's Brigham and Women's Hospital and author of a landmark study on his own facility's experiences with CPOE. Pricewaterhouse Coopers provided the financial analysis.

Here are some of the report's main findings:

- The average baseline rate of preventable adverse drug events in the participating hospitals was 10.4%, meaning one in every 10 patients admitted to these community hospitals suffered a preventable adverse drug event;
- The one-time average total cost of a CPOE system is \$2.1 million, with yearly operating costs of \$435,000, compared with projected annual savings of \$2.7 million;

- The annual savings for the hospitals and payers could be about \$170 million, and 55,000 adverse drug events could be prevented every year.

## Perceptions changed

The report's findings run counter to some commonly held perceptions about CPOE, asserts **Karen Nelson**, RN, senior vice president for clinical affairs with the Massachusetts Hospital Association (MHA).

"These findings dispel rumors that it is nearly impossible to have a CPOE system because it is so costly you'll never get your money back," she says. "It put the facts on the table, and ROI [return on investment] is better than we thought; this has created a changed thinking in Massachusetts about the next steps we should take."

Once a hospital knows the ROI is on a shorter time frame and there is a range of examples of implementation and operating costs, it can begin planning and budgeting for such a system, she adds. Nelson also finds it significant that the six hospitals volunteered to participate in the study, "and to tell us what happened," she adds.

**Wendy Everett**, ScD, president of NEHI, agrees. "There has been a mythology among hospitals that they have to pay for technology, but payers reap all the benefits," she notes. "We were able to demonstrate the payback period for CPOE."

While the co-sponsors understandably hailed the study as "groundbreaking," it clearly had a strong impact on other organizations as well. Everett has her own thoughts on why it had such an impact.

"This kind of study has never been done before, outside a major academic medical center," she says. "Some very few community hospitals have done CPOE, but no one has been able to go in and say how many patients were in the hospital that had suffered from preventable medication errors."

There are three factors behind the strong reaction, she continues. "One, it had a very strong methodology — rigorous, in fact. Dr. David Bates is extremely well regarded — a nationally recognized figure for this area of patient safety. Second, Mitch Adams and I had put together a very significant collaborative across the state; we had involved payers; government and insurance organizations, the MHA, CEOs, and CFOs of

**Healthcare Benchmarks and Quality Improvement** (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid in Atlanta, GA 30304. USPS# 0012-967. POSTMASTER: Send address changes to **Healthcare Benchmarks and Quality Improvement**, P.O. Box 740059, Atlanta, GA 30374.

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### Editorial Questions

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some community hospitals, and the business community were involved before we even started the study. So, when people went to make policy decisions as a result, there were absolutely no naysayers. Third, there is not one of those hard issues you can't do something about if you have the data. Doctors in the audience [during the presentation] stood up and said this was the first time they had hard data they could believe in, and now there was no reason not to implement CPOE."

The bottom line, she says, is that "you change policy as the result of good evidence."

### ***A long journey to the evidence***

Getting to that evidence was a lengthy process, says **Bethany Guilboard**, MPQ, MTC's director of health technologies and the report's project manager. "We had partnered with NEHI to look at a series of technologies that would help improve quality of care, save lives, and reduce costs simultaneously," she recalls. "We had published a report called *Advanced Technologies*, in which we looked at seven different technologies. One area that had significant potential for improvement and savings was inpatient CPOE, and nobody had seemed to take that one on."

They worked with First Consulting Group (now CSC) and came up with a case statement in October 2003 for the implementation of CPOE in all Massachusetts hospitals. "If implemented, we could recognize significant savings," Guilboard notes. "We moved ahead with First Consulting with the endorsement of MHA and other key health care stakeholders."

They issued an on-line survey to all Massachusetts hospitals they believed had not yet implemented CPOE and had a good response rate. "It gave us a fairly strong indication of where hospitals were in moving forward," Guilboard notes. "It looked like 13 or 14 were closer in readiness with implementation and had more planning in place; they looked more ready to launch, so we started talking to them."

In 2006, Bates' study appeared in *JAMA*, taking a look at Brigham and Women's 10-year experience with its "home-grown" system. "They showed the opportunity for improvement in quality and cost savings, and that was the springboard for our study," Guilboard says. "We considered whether it would be reasonable to

engage Dr. Bates and his team to conduct a similar study in six community hospitals to see if their findings could be extrapolated."

The six hospitals were chosen out of the ones with which the collaborative had been speaking, and were "absolutely promised" anonymity, Guilboard says, noting that some may have been in the midst of CPOE implementation.

"In addition to hiring Dr. Bates, we also hired Pricewaterhouse Coopers, because we did not want this to just be an academic exercise; we wanted to make a business case for financial payback," Guilboard explains. "We asked them to develop a financial model, took clinical findings from Bates' chart reviews, and came up with a calculation to extrapolate what the error rate reduction would be and how much would accrue to hospitals and payers."

Bates' study, adds Everett, indicated that a preventable medication error led to 4.6 additional patient days of hospitalization. "Knowing that and knowing how many errors there were, we could calculate how much money we could save," she explains.

### ***Looking to the future***

In addition to promoting universal adoption of CPOE, the report also recommended that payers adopt "robust" incentives to help hospitals achieve the stated goals. "Our intent is to work with payers to create a significant pay-for-performance incentive — in the 7%-10% range," says Everett. "The risk the payers take is that as with any technology, it can be installed and never used to the maximum."

Thus, there will be metrics attached to the awarding of incentives. "So, for example, if you have a pre-implementation error rate of 10%, after implementation you should bring it down to 2%-3%," says Everett. "In other words, it's not good enough to sign a contract and purchase the system; you have to show you are able to reach these milestones."

Nelson, however, adds a note of caution in light of the rapid actions by Murray and Blue Cross Blue Shield. "There is enthusiasm about the initial report, but that should create a pause to consider what it tells us, and what the next step should be," she says. "Hospitals will think about how to make choices, and how to prioritize, while others are telling us quickly what to prioritize. Full agreement is terrific, and CPOE does create a safer environment and

save money, too, yet different hospitals are on different timelines with this or any other approach.”

All stakeholders have to start thinking together on the right things to do, such as how to revise incentives, says Nelson. “In terms of meeting a deadline, everyone needs to be on the same track,” she asserts. “It’s not just a financial issue — there are other competing priorities for a particular hospital’s community. And in terms of operationalizing, it can be somewhat disruptive, and it takes a huge commitment and a very strong relationship with the medical staff — and requires additional expertise not all hospitals have.”

Nelson imagines “there will be a stampede of consultants coming to Massachusetts to help meet these deadlines. All stakeholders need to be aware of those factors to help implement CPOE in a reasonable fashion.”

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*For a free copy of the study, “The Imperative for Computerized Physician Order Entry in Massachusetts Hospitals,” go to: [www.nehi.net](http://www.nehi.net).] ■*

## Hospital/physician alliance creating new care model

*Collaborative approach improves care processes*

A unique partnership between SSM St. Joseph Hospital of Kirkwood, MO, and six physician groups has created a separate new company to manage a pilot nursing unit designed to develop and test new patient care processes for the future SSM St. Clare Health Center.

St. Clare, which will open in March 2009 in southwest St. Louis County, will replace St. Joseph. The health care professionals are using Lean Six Sigma techniques to identify opportuni-

## Key Points

- Giving physicians an ownership stake gives them an additional incentive to improve processes.
- Pilot nursing unit includes decentralized nursing stations so nurses are closer to their patients.
- Staffing has been altered so that nurse-to-patient ratios are the same on all shifts.

ties to improve care processes and to find solutions.

“We have designed a new building that will support exceptional patient care; now we need the right processes,” says **Sherry Hausmann**, RN, president of St. Joseph. “We felt we needed a microcosm to pilot; we knew other industries had done this and it just made sense.”

What led to the creation of this new group? “We needed some engaged staff, and hoped to have a smaller staff to enable rapid cycle testing,” says Hausmann. “We looked for staff with a rapid-cycle mind frame and physicians to do it with.” The positions were posted in-house and many of the new staff came from within the hospital (they were given the first opportunity to sign up), but staff were also supplemented from the outside, says Hausmann

### Co-management model

Hausmann had heard of co-management models being used in a specialty setting and thought “it seemed to make sense” for what she had in mind. “I started to talk to our physicians about partnering, and they felt as frustrated [about wanting to change processes] as we were; I asked six of them to join, and they all opted in.”

The six practices participating in the partnership include more than 80 physicians. According to local press reports, the physician groups own 75% of the new company and the hospital owns 25%. The hospital then pays the company to provide management services.

“We wanted to create a vehicle to give the physicians ownership; that’s why a company made sense,” Hausmann continues. “In a more traditional structure you may have committees, and the doctors will come in for a quarterly meet-

ing, provide some input, but then go back to their busy practices. They don't really own the process. We wanted to create that sense of ownership and their response has been phenomenal. They have started meeting on their own and driving processes so quickly; they are extremely vested in the staff, and are working with them differently."

## **Seeing the difference**

**Mary Brobst**, RN, MSN, clinical director of the new St. Clare pilot unit, has seen that difference first-hand. "They are actively engaged and come to the table in a whole different mindset; they just want to be involved," she says. "They are not only seeking to help their own flow, but flow for nurses as well. We are collaborating together, in what was clearly a needed partnership."

"What we've seen on the floor has been phenomenal," adds Hausmann. "We were 'short' a couple of evenings recently. The nurses stepped up and helped, and the docs later went up and thanked them."

The news of this collaborative approach "spread through this place like wildfire," says Hausmann. "It sparked discussions of patient care processes not seen in committee settings," she asserts. "To see collaboration like this between nurses and physicians is just amazing."

## **Making real change**

Of course, good will and team spirit do not by themselves improve processes, but this new "med/surg" unit represents a real change from similar St. Joseph units in many ways. "Typically, on a med/surg unit the [nurse-patient] ratio changes from shift to shift, with the night shift having a larger ratio," notes Brobst. "When the night shift gives a report, it is typically inefficient; if you try to do a face-to-face [handoff] you might have to wait for two or three different people."

So in the new unit there is a six-to-one ratio around the clock. "We have 'podded' the patients into three groups of six," Brobst explains. "They are in the same vicinity, and we balance acuity as we make bed assignments. We don't want staff congregating in the central [nursing station] area; we want them out there with our patients."

In the new facilities, she notes, nurses and care partners will be able to work in decentralized

nursing stations, complete with a countertop work area. In addition, many items for the caregiver — such as the computer and medications — will be in the patient rooms, which will allow for more one-on-one time between the nurse and patient.

"There is great efficiency gained with only one nurse talking to one nurse when you turn over the whole assignment," she explains. "It also allows you to do walking rounds, where you can introduce the next caregiver to the patient."

Speaking of rounding, the goal for this pilot unit is that no physicians will round on the floor by themselves. "They either will be with the primary nurse, the patient care manager, or the clinical director," says Brobst. As they round, she says, "They will always talk about what the goal is for that patient for the day and what questions we have, so we make the most efficient use of our time." If questions come up about orders, for example, they can be corrected prior to the physician leaving the floor. "In the old world, you did not round with the doc, so if he made a note and you couldn't read it, you had a problem," she notes.

Every week one of the heads of the six physician groups is on call, or serves as the "go-to" person, Brobst explains. "We typically round early, and then they meet with myself, the patient care manager, and case management," she says. "We look at who out of our patients meet any criteria for CMS core measures and do concurrent reviews to see if we are meeting the guidelines. We serve as a kind of oversight committee, and we try to be proactive."

The patient care manager (there is one available 24/7) frees other staff members of certain care responsibilities. "They are a buffer; if I am overloaded with patients, the manager steps in and helps, or if a physician on the floor needs help, they can hang blood," says Brobst. "It is the old 'head nurse' mentality — one person who knows pretty much all that's going on with every patient."

## **Improving processes**

In just a few short months, says Brobst, processes have already been improved. "The docs had asked for all morning labs to be drawn, resulted, and on the charts by 6 a.m.," she recalls. "In any typical lab you try to do draws at a reasonable hour so the patient is not awakened at

3:30 or 4 in the morning and you get a rush of requests for phlebotomists.”

The staff wanted to see if they could meet this goal while being more patient friendly. “Our theme is to put the patient at the front of every process change,” Brobst explains. “Staff nurses know that in the old world if a patient was awake at 3:45, to take care of their needs they would help them get settled in and back to bed and the phlebotomist might show up 45 minutes later for a draw, which would be a huge dissatisfier. We approached the staff nurses and for two weeks trialed having the nurses draw the a.m. labs when the patient was awake. This seems to be working very well.”

### **Care enhanced**

Hausmann says the new initiative already has enhanced patient care. “We’ve seen the improvement in continuity already,” she asserts. “Just the fact that someone is always rounding with the physician creates more continuity and patient education. The important messages are reinforced if the family has questions and the nurse has heard what’s been communicated by the doctor.”

The focus on core measures is also critical, Hausmann continues. “The doctors and nurses work together to get 100% performance,” she says. “The alignment of the goals and incentives will create outcomes that were not possible before.”

“We went 32 days before the first fall,” notes Brobst. “And in February we were in the 98th percentile [Press Ganey] and in March we were in the 99th.”

As part of the new management agreement, Brobst continues, the metrics they use are tied to how they perform on core measures. They are also benchmarking their performance against other facilities.

The Lean initiative, Hausmann adds, is being carried out across the entire SSM system. She is convinced other facilities could replicate what St. Joseph has done. “I don’t think the size of the hospital or community [would make a difference], but I would suggest you start out small,” says Hausmann. “And your staff must be dedicated. We’d like to replicate this across the house, but until we work out the kinks and have piloted processes and standards across the house, starting small serves us best.”

One key to success, Hausmann emphasizes, is

letting the frontline staff drive the improvements. “We did not come up with a prescription for this unit; we’re not controlling in what is expected of them,” she explains. “We hired people with the right mindset, we framed a vision, and we made sure we shared that vision with the doctors and set it out before they were hired. We created an environment, and then got out of their way.”

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## **Patient navigators improve care of cancer patients**

*Proponents say health enhanced as stress is reduced*

Exempla Saint Joseph Hospital in Denver has launched a Patient Navigator Program, becoming the fifth site in the state to participate in a nationwide effort to extend the reach of the American Cancer Society’s (ACS) initiative, designed to assist individual cancer patients in negotiating the health care system. There are currently 87 American Cancer Society Patient Navigator Program sites across the U.S.

The Patient Navigator Program, formally launched in 2005 in collaboration with community-based hospitals and cancer centers, links those affected by cancer to the patient navigators — who serve as personal guides for patients to help them deal with the psychological, emotional, and financial aspects of their cancer experience.

### **Training provided, staff prepared**

Patient navigators receive national-level training through the ACS, in collaboration with the National Cancer Institute Patient Navigation Research Program, as well as localized training and opportunities for ongoing education. “We cover case studies, talk about how we would proceed in the face of certain behaviors and questions, and so forth,” explains **Mandy Hodach, MS**, patient navigator at Exempla Saint Joseph. “They also provide us

## Key Points

- Newly diagnosed cancer patients are often confused and unaware of the options available to them.
- ‘Navigators’ receive both national and local training as part of the American Cancer Society program.
- Needs assessment measures level of patient ‘distress’ to determine most appropriate referrals.

with information on diagnosis and treatment in pamphlet form that we can share with patients.”

Before she formally began her role on Feb. 28, there was an inservice for the staff to “tell folks who I am and what I do,” she says, adding that this has been an ongoing process as she ran into different staff members.

“I introduce myself so they can put a name with a face,” she explains. “I have also attended some meetings and gotten involved in aspects of oncology to let them know I’m here now.”

There was also a formal launch for the program. “AstraZeneca [which funded her position] wanted to get the word out so they invited the oncology department, physicians, and folks in the community,” she recalls. Representatives of AstraZeneca and the ACS spoke about the incidence of cancer and social issues people face when they are diagnosed.

AstraZeneca has pledged \$10 million to the American Cancer Society to accelerate development of at least 50 new Patient Navigator Program sites over a five-year period in communities throughout the United States.

“People become overwhelmed; they get a lot of information but do not know what direction to take, or what services are available to them,” Hodach explains.

For several weeks before the formal launch she met with patients and explained her role — and got the opportunity to provide some early help. “A woman and her daughter were sitting in the waiting room and the daughter needed rides to her treatment; well, that’s one of the things we can provide,” says Hodach, explaining that ACS volunteers drive patients who need rides.

“We can also help people set up appointments with community resources — financial

aid, support groups, and so on,” she continues. “For example, there is an ACS program ‘Look good, feel better,’ that helps women do their hair and makeup.” Some navigator programs, she adds, have community resource centers with large collections of wigs, turbans, and head covers.

“Primarily I am there for support and information — to give patients the sense that there’s somebody out here who can help them,” Hodach says. “The biggest benefit, I find, is that people feel overwhelmed and do not know what’s available to them; they may feel they can’t pay for chemo or radiation, and do not know money is available. Or, they do not have access to a computer and can’t get the information they need. I kind of offer a hand to hold.”

If the patient is unable to work, she adds, the navigator will assist them in finding monies that are available in the community to help them pay their rent or their mortgage.

### **Assessing needs**

Upon first meeting a patient, the navigator performs a formal needs assessment, notes **Alison Jones**, RN, ND, cancer survivorship program manager at the University of Colorado Cancer Center in Aurora, which has had a patient navigator for about a year.

“Our navigator meets with all patients who are newly diagnosed and lets them know about the services we have here, and she also conducts a ‘distress thermometer’ assessment,” she explains. “Based on the assessment, which shows how distressed the patient is on a scale from 0-10, she can figure out if the stressors are things she can help with or if she needs to refer the patient on to social work, nutrition, psychology, rehabilitation, or community resources.”

Jones is convinced the program has contributed to improved quality of care. “It absolutely helps with the patient’s ability to deal with disease; it helps them focus on their treatment and on getting better,” she says. “If we can reduce their stress in any way, it definitely helps.”

Jones says the program has been “a wonderful addition” to her own. “We have just been able to touch so many more people’s cancer journey through our navigator,” she says, adding that it is “absolutely invaluable for hospitals with cancer patients.”

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## Radiology lab speeds throughput with Six Sigma

*Changes include shift in personnel positioning*

The radiology lab at Newton-Wellesley Hospital in the Boston area has nearly cut the wait time for patients in half through the implementation of a Six Sigma process improvement initiative. What's more, the program has also saved the department more than \$700,000 with increased efficiency.

"When I started here in February 2004, the department had a number of challenges," recalls **Brian McIntosh**, RTR, operations manager for diagnostic and interventional radiology. "There was not enough staff, nor were there effective processes in place to get patients through in a timely manner. There were long delays; a number of times during the course of each day, there could be between 15-20 patients waiting for X-rays."

Much of the department traffic is walk-in and unpredictable, he explains. "It was a nightmare every day," he continues, noting that even after patients were registered, they would sometimes wait 30 to 60 minutes. "There was a full waiting room, disgruntled patients, and then volume got even bigger when a nearby hospital closed," he observes.

After the initiative was completed, the median "cycle" was down to about 23 minutes.

### **Hospital brings in G.E.**

It was the decision of the hospital leadership team to bring in Six Sigma consultants from General Electric, says McIntosh, adding that they were used by several of the departments in the facility.

"They performed internal leader training for individuals who became Green Belts, and some eventually became Black Belts," he says.

## Key Points

- Inefficiency leads to \$700,000 in savings for radiology lab.
- Six Sigma helps cut waiting time for patients in half.
- G.E. consultants train Green Belts to serve as leaders in process improvement.

"The training took about five or six months," adds **Laurie Davis** of operations management, who was a Black Belt and project manager for the radiology initiative. She adds that the program was implemented simultaneous to the training.

"We were on the throughput project as a team and we were able to consult with our G.E. mentors on what to do and how," she explains.

There were three Green Belts on the team in all, says Davis. McIntosh was the "approver of decisions," and there was also an executive sponsor. "The Green Belt team met with the staff on a regular basis — every week or so at first for two to three hours, taking the time to explain each step we were going through," he says. "We all learned at the same time, and as the Green Belts learned, they pulled data, analyzed it, explained it to the staff, and we made our decisions off of that data. While the Green Belts facilitated the discussions, we had collective agreement as to the best solutions."

It was this heavy involvement of staff that engendered buy-in, says Davis, who notes they were brought into the project "from the get-go. They were fully part of the project team; they identified what the barriers were, as well as potential solutions to help us improve wait times," she notes.

In general, she says, the staff became "heavily invested" in the process. "We had early adopters and some who were resistant, but as we went through the process we tried to move those who were resistant to be more supportive," she notes.

### **Key changes made**

A number of changes were made through the Six Sigma initiative, including some "simple" layout changes made at the outset. "We added computer work stations and fax machines — just little things to help with the efficiency of the actual

work flow," says Davis. "Then, we turned our attention to day-to-day operations."

That's where processes were changed, says McIntosh. "The way patients used to flow, they would be registered, then a registration person would get them changed, and we also had a 'radiology coordinator' who was kind of running the show," he recalls. "She did a good job, but she was about 20 and did not have a professional license; the staff did not feel comfortable reporting to her."

The flow pattern was changed, he continues, to remove parts of the process that took extra time. "For example, when patients checked in and the order was put in, the tech might meet with them only to discover there was something wrong with the order," says McIntosh. "It could take 10-15 minutes just to reconcile the orders, so we eliminated that possibility by having the coordinator be the facilitator of throughput. Now, this person gets the patient changed, so the registration person never leaves their desk anymore. There is a printed requisition, as well as a written order; they are compared, and if there are any contradictions we take the time while the patient is changing to fix the order."

The goal, he explains, was to have a technologist pick up a correct order to begin with, and then bring the changed patient into the X-ray room.

"Theoretically, we now have techs only do exams," adds Davis. "We reduced the amount of time they spent doing things that were not tech-related."

"They were doing a lot of ancillary things before helping with throughput, which really didn't help," McIntosh explains.

The other process change involved the lead person in the department. "She was on the floor before, but she was not located in an area that allowed her to oversee operations — she was in the back and out of sight," McIntosh explains. "She would have the authority to direct work flow and hold people accountable, but that led to issues. We put her up front to oversee the flow, and be more proactive rather than reactive."

In measuring their results (the time it took from registration to getting into a room, and the time from registration to a completed exam), McIntosh learned another valuable lesson. "At first we looked at averages, but we learned median figures were more accurate," he says. "Some exams, for example, take five

hours; we can't help that, but they skew the averages."

## **Satisfaction up, dollars down**

McIntosh says both patient and employee satisfaction have risen. "Patient satisfaction numbers [they use Press Ganey] have gone up dramatically," he says. "The surveys include comments, and a number of people say they love the improved processes, that things are more efficient now."

When he shares these comments with the staff, he notes, "they have a great effect," adding that employee satisfaction numbers are improved as well.

On the financial side, "we have been able to realize and exceed our volume targets by reducing wait times," says Davis. "We had also had planned on building another diagnostic imaging room in another building, but when we went through the data, we determined we were not even at 50% capacity, so we halted those plans. This came to a cost avoidance of upwards of \$500,000."

*[For more information, contact:*

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## **AHRQ reports a slowdown in overall quality gains**

*'Health care quality is improving only modestly'*

The latest edition of the Agency for Healthcare Research and Quality's (AHRQ) *National Healthcare Quality Report* contained some disappointing news for quality professionals: The quality

### **Key Points**

- Expenditures rise 6.7% per year during same time period that quality improves only 2.3%.
- The good news: More than 93% of heart attack patients received the recommended hospital care, up from 77%.
- AHRQ suggests quality managers use its numbers for benchmarking.

of health care improved by an average 2.3% a year between 1994 and 2005, compared with the 3.1% average annual improvement rate published in the 2006 reports. While some important advances were noted, the overall report showed that “health care quality is improving only modestly, at best,” according to AHRQ Director **Carolyn M. Clancy**, MD, commenting in a prepared statement released to coincide with the report.

The AHRQ report noted that during the same time period the Centers for Medicare & Medicaid Services estimated health care expenditures rose by a 6.7% average annual rate. “Given that health care spending is rising much faster, these findings about quality underscore the urgency to improve the value Americans are getting for their health care dollars,” said Clancy in her statement.

“People might want to be careful to not over-emphasize that linkage,” adds **Jeff Brady**, MD, MPH, acting director, U.S. National Healthcare Reports, and lead manager of the AHRQ report. “But what we’re talking about there is really value. While quality and costs may not be directly related, you start raising questions about what value we are getting for these increased costs. At a very high, superficial level, it should be concerning to everyone that those two figures are not moving at the same rate.”

There were, however, some improvements noted in the report. For example, more than 93% of heart attack patients received the recommended hospital care in 2005, up from about 77% in 2000/2001. The percent of heart attack patients who were counseled to quit smoking increased from about 43% in 2000/2001 to about 91% in 2005.

However, measures of patient safety showed an average annual improvement of just 1%. This reflected such measures as what portion of elderly patients had been given potentially harmful prescription drugs and how many patients

developed post-surgery complications.

The report measures quality and disparities in four areas: effectiveness of care, patient safety, timeliness of care, and patient centeredness.

### ***Bucking the trend?***

The overall tenor of the report seems to run counter to the more upbeat reviews of nationwide collaborative QI efforts issued by several leading organizations. “Very simply, you can make data look however you want,” says Brady. “What we try to do is not only report individual measures [but provide an overall picture]. We use federal statistics plus private data; for example, we use [the Centers for Disease Control and Prevention] and others, and AHRQ data for individual measures, but we also try to put it together in a meaningful way. Our scope of review is the entire country — to give one simple indication of how we are doing.”

This report, he continues, is AHRQ’s charge from Congress. “In its simplest form, this is our report to Congress,” he says. “Hopefully, not only folks like your readers but also people at the state level and the health plan level will all have interest in what we report.”

For quality managers, he continues, this represents a benchmarking opportunity. “We are reporting national numbers, and we’d like to see folks take those numbers and, to the extent they can, report the same kinds of things with the same sorts of specifications,” says Brady. “There is a whole field of study considering what is appropriate [for benchmarking] and what is not, but one simple fact is your study is more valid if you compare apples and apples.”

AHRQ, he adds, has tried to make its report as transparent as possible. “The subset of measures that relates to care in hospitals is clearly of most interest [to quality managers],” he notes. “If they are interested in more specific levels of analysis, they can possibly determine which measures contribute [to quality issues].”

### ***Ongoing commitment needed***

As to why improvement has been so modest, Brady notes that his group “generally stops short of providing a lot of interpretation of what drives these numbers, but among the suppositions we have is that it takes a continual, renewed commitment to make significant progress — it does not

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happen automatically.

“Those things that are attended to are the things we change the way we like to see them change. For example, look at inpatient care for heart attack and heart failure; over this period we have seen some pretty dramatic improvements.”

In addition, he says, it’s important to focus on identifying recommended (evidence-based) care, delivering the care recommended, and measuring results. “It sounds simple and straightforward, but your commitment needs to be constant, because when you get to the individual hospital level there is a whole set of complex factors,” he says.

At the bottom line, he adds, the report has a fairly simple message — there is clearly still opportunity for improvement. “Quality managers are really the champions on the front lines for these issues as they try to make their case across whole systems of care,” says Brady. “They are the leverage point where a lot of the improvement will happen.”

*[The AHRQ report is available at [www.ahrq.gov/qual/qdr07.htm](http://www.ahrq.gov/qual/qdr07.htm), by calling 1-800-358-9295, or by sending an e-mail to [ahrqpubs@ahrq.hhs.gov](mailto:ahrqpubs@ahrq.hhs.gov).] ■*



## HealthGrades partners with Google for consumers

Health Grades Inc., the Golden, CO-based health care ratings company, is partnering with Google to “help individuals find the best health care providers.” HealthGrades will make independent information on doctors and hospitals, based on quality and cost, accessible via Google Health — a new product that is being tested in a pilot with the

Cleveland Clinic. (Look for an article on the Cleveland Clinic initiative in the May issue of *Healthcare Benchmarks and Quality Improvements*.)

“HealthGrades’ goal is to guide Americans to better health care,” said Kerry Hicks, HealthGrades’ CEO, in a prepared statement. “For researching health care, more Americans turn to Google to start their search than any other source, so we are proud to be providing Google users with independent, objective quality ratings and cost information so that they can choose the best possible doctor and hospital.”

HealthGrades’ content on the quality of most of the nation’s hospitals and practicing physicians is already appearing in Google Maps, including expanded profiles of health care providers, with more content to be added in the months to come.

HealthGrades independently rates the quality of care at each of the nation’s nearly 5,000 non-military hospitals, using star ratings to reflect patient outcomes for procedures and treatments ranging from bypass surgery to total knee replacement. HealthGrades also rates the quality of care at virtually every nursing home and home health agency in the country.

HealthGrades also maintains cost and quality reports for 700,000 physicians, nearly every practicing physician in the country. Reports include patient-satisfaction ratings, detailed education and training information, disciplinary action information, malpractice judgments (in 15 states), board certification, affiliated hospital quality ratings, comparisons to other physicians, specialty and national averages comparisons, and more. ▼

## PHCQA launches new quality web site

A new web site has been launched that for the first time compiles outcome and quality data for Pennsylvania’s acute care hospitals for the

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general public.

The site — [www.phcqa.org](http://www.phcqa.org) — is the work of the Pennsylvania Health Care Quality Alliance (PHCQA), an association of the Commonwealth's hospitals, Blue Cross insurers, the Pennsylvania Medical Society, government policy makers, and other organizations concerned with promoting quality and transparency in health care.

"While hospital quality data have become more available on the Internet, consumers are at a disadvantage when they must search out multiple sites, each with its own measurement standards," said Gerald Miller, chairman of the alliance, in a prepared statement. "PHCQA has developed, and is continuing to refine, a consistent and uniform approach that makes it easier for consumers to access, understand, and use the data."

The site was launched with information gathered from the federal Medicare program (Centers for Medicare & Medicaid Services), the Pennsylvania Health Care Cost Containment Council (PHC4), and The Joint Commission. Visitors to the site are able to search hospital quality measures in four major clinical areas:

- heart attack;
- heart failure;
- pneumonia;

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- prevention of health care-associated infections.

These clinical areas represent some of the most common conditions treated in hospitals — and some of the most costly.

"These areas are just the beginning," Miller emphasized. "We will add more clinical topics and quality measures as they are developed, and will continue to modify the site to make it as useful to consumers as possible. By sharing these data, we can provide objective quality information, while at the same time encouraging best practices that improve the performance of hospitals statewide." ▼

## On-line bonus book for *HBQI* subscribers

Readers of *Healthcare Benchmarks and Quality Improvement* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

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