The age of transparency in health care quality is upon us. Throughout the nation, purchasers, payers, accreditors, regulators and individual patients are expecting providers to share more and more data about their performance (e.g., outcomes, adherence to evidence-based guidelines (processes), compliance with “safe practices” and, in the near future, patient survey responses about experience with the provider). The Quality Institute has been monitoring these national trends and promoting specific measurement and improvement activities to meet existing requirements and prepare for future ones.

Earlier this year, the CCHS executives and Medical Operations Council approved health system performance improvement goals for 2005 and 2006. The goals focus on several clinical areas, safe practices and patient experience survey items. As has been the case since 1998, the Quality Institute supports teams with representatives from each hospital to monitor goal attainment and promote implementation of various best-practices when indicated. In addition, each hospital has identified members of its own staff as accountable for achieving each goal.

Progress has been made on many goals at many CCHS sites. Using national percentile scores as comparative values, the majority of CCHS rates for the core clinical measures have now met or are approaching the 90th percentile level. Particularly noteworthy is the hardwiring of the provision of anti-smoking material to all CCHS patients, which has significantly improved the rates for smoking-cessation measures (many CCHS hospital rates for these measures are now at 100 percent). Streamlined processes have improved timeliness-related measures at all sites, and the use of standard order sets and discharge order forms have improved the rates for medication-prescription measures, including assessment and provision of the pneumococcal vaccine.

All CCHS hospitals completed the Leapfrog Group’s online survey in July. The survey assesses and publicly reports a provider’s adherence to the National Quality Forum’s 30 safe practices. These practices were identified by the Agency for Healthcare Quality and Research as having strong evidence base for association with positive outcomes and fewer medical errors. The CCHS patient safety team monitors each hospital’s compliance with these practices, including implementation of systemwide plans for those warranting closer attention and improvement.

The CCHS patient satisfaction team continues to provide guidance related to the survey instrument and use of response data. And staff from The Quality Institute continues to work with the World Class Service initiative to support interpretation of patients’ responses solicited from both mailed survey and the recently implemented Patient Discharge Call Program. (See page 7.)

This new age of transparency is also starting to target physician-level performance. The QI is presently supporting initiatives to help physicians manage this increased scrutiny. For details, see the article on physician peer review on page 6 in this issue.

Congratulations on the progress made to date with achieving 2005 goals! Maintaining high performance levels and continued work on the remaining goals will keep us busy through the end of the year and into 2006. Furthermore, external requirements will also continue to increase—both in the amount of data requested and the levels of performance expected. The Quality Institute commits to providing the support and guidance to CCHS as we venture into this new age of transparency and the advent of pay for performance.
Force Field Analysis (FFA) was developed by Kurt Lewin in order to help identify those forces that will facilitate, as well as those that will act as barriers to, reaching a desired outcome, such as implementing a process change. Once these “driving” and “restraining” forces have been identified, teams can proactively strengthen support from the driving factors and, more important, develop strategies to eliminate or reduce recognized barriers.

FFA can be used to both study existing issues and to implement process changes more efficiently. As such, it is a handy tool in team building, where resistance to change may be high.

The initial concept of the force field was the recognition that processes at equilibrium (stable) have both positive (driving) and negative (restraining) forces at work. Therefore, to change the process to achieve a new objective or equilibrium, the forces must be shifted. The result of a force field analysis is an action plan or list of strategies to help overcome resistance to the process changes being implemented.

How to Complete a Force Field Analysis

1. Clearly and concisely state the change, objective or solution to be examined; ensure team consensus and understanding of the objective.
2. Divide a flip chart (whiteboard, etc.) in half vertically; label one side “Driving Forces” and the other side “Restraining Forces.”
3. Brainstorm forces in support of (driving) and working against (restraining) the change.
4. Review/clarify each force listed. What is behind each factor? Quickly identifying root causes, as appropriate, can lead to more accurate action planning. Also consider how some forces may work to balance each other and the potential impact of shifting that balance.
5. On a separate sheet, identify ways to expand and strengthen the “Driving Forces.”
   - Reinforce the support through communication and education.
   - Make the support for driving forces more visible in your plans, such as tying process measures to institutional priorities.
6. Based on the ideas that are most feasible to implement and have the greatest potential impact, choose actions to implement that will reinforce the driving forces. This is the beginning of the team’s action plan.
7. Next, go back to the issues listed under “Restraining Forces” and categorize their potential to act as a barrier to the stated objective as high, medium or low.
8. Brainstorm ways to “neutralize” the high-ranking restraining forces.
   - Focus on items in the team’s (or the team’s champion’s) sphere of influence and control.
   - Identify people who can help the team implement items/remove barriers.
9. Based on the ideas that are most feasible to implement and have the greatest potential impact, choose actions to implement that will reduce or eliminate the identified restraining forces. These most likely will be the majority of a team’s action plan.

Definitions

Driving Forces - People, processes, policies, existing situations that support the improvement/objective being studied; forces that tend to initiate change and keep it going, such as incentives, directives, pressure, competition.

Restraining Forces - People, processes, policies, existing situations that pose barriers to the improvement/objective being studied; forces acting to restrain the driving forces, such as apathy and hostility.

Forces - Can be anything that positively or negatively impacts the team’s objective, such as market trends, laws, managers, staff with strong opinions, capital budget, quality and regulatory compliance requirements.

Objective: Increase adverse event and near-miss reporting.

<table>
<thead>
<tr>
<th>Driving Forces</th>
<th>Restraining Forces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>It takes too long</td>
</tr>
<tr>
<td>Management</td>
<td>I’ll get in trouble</td>
</tr>
<tr>
<td>Patients First</td>
<td>The system is hard</td>
</tr>
<tr>
<td>Regulatory compliance</td>
<td>to use</td>
</tr>
<tr>
<td>It’s the right thing to do</td>
<td></td>
</tr>
<tr>
<td>Trend events to prevent others</td>
<td>Don’t want unit to look bad</td>
</tr>
<tr>
<td>Leapfrog/Public reporting</td>
<td>Potential lawsuits</td>
</tr>
<tr>
<td>Don’t know what to report</td>
<td></td>
</tr>
</tbody>
</table>

| Objective: Increase adverse event and near-miss reporting. |
The MUSIC (Medication Use Safety Improvement Champions) Team at South Pointe Hospital recently completed its CCHS Wrong Patient Medication Errors Failure Modes and Effects Analysis (FMEA).

An FMEA is a proactive incident investigation methodology originally developed for use in high-risk industries. FMEAs are designed to evaluate a process to identify its steps/parts that are most likely to fail and, thus, cause errors. The analysis allows teams to correct processes rather than react to adverse events after failures have occurred. Even though the hospital’s analysis was specifically focused on wrong patient medication errors, South Pointe’s team decided to analyze the entire medication administration process to ensure that no steps were omitted.

The topic of wrong patient medication errors was chosen by the CCHS Medication Systems Team after reviewing medication error data. According to the data, wrong patient medication errors continued to be an issue across the health system, and the FMEA was the best performance improvement tool to address the problem.

South Pointe Hospital volunteered to be the first to complete the Wrong Patient FMEA, and the team leaders, Ed Soeder and Sue Sturges, decided to use the existing MUSIC Team as the FMEA Team. The Quality Institute’s Lisa Sturges, Manager of Team Facilitation and Performance Improvement, facilitated the meetings. The team met weekly, over lunch, for 10 weeks, to accommodate the nurses’ schedules. At the end of the 10 weeks, the MUSIC Team went back to their regularly scheduled monthly meetings to work on action plan implementation.

Overall, the team identified 122 failures in the medication administration process, 40 of which were directly related to wrong patient medication errors. The team prioritized lists by wrong patient-related failures only and by all potential failures. Based on this review, the team initially chose 12 failure modes for which to create action plans; all but two are directly related to wrong patient medication errors. Because many of these failures were closely related, the team grouped them for ease of action planning.

The final step in the FMEA process was for the team to create detailed action plans to address their top 12 failures. The action plans developed incorporated an array of easy “just do it” items to those that would involve significant culture changes.

The FMEA process was successful at South Pointe because of strong leadership, a desire to improve their processes, a highly motivated and participative team and their willingness to simply schedule out the meetings and stick to the agenda! In addition, the MUSIC Team leaders re-evaluated the team reporting and meeting structure to incorporate concepts learned in FMEA, as well as to ensure adequate follow-up on action plans.

### Failure Modes and Action Plans

<table>
<thead>
<tr>
<th>FAILURE CATEGORIES</th>
<th>IMPROVEMENT ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart Build</td>
<td>Reviewing and revising the patient identification policy</td>
</tr>
<tr>
<td>Chart Build</td>
<td>Ensuring the patient identification policy and procedures match the medication administration policy</td>
</tr>
<tr>
<td>Chart Build</td>
<td>Reviewing many processes around the MAR, such as print times, who can print a MAR and the frequency of MAR checks</td>
</tr>
<tr>
<td>Verbal Orders</td>
<td>Creating a well-defined and monitored process for daily chart updates</td>
</tr>
<tr>
<td>Verbal Orders</td>
<td>Automating a daily print of pre-labeled medication order and progress notesheets for all patients</td>
</tr>
<tr>
<td>Patient Identification Policy</td>
<td>Obtaining “name alert” chart stickers to use when patients have similar names</td>
</tr>
<tr>
<td>Medication Administration Record Review Process</td>
<td>Developing signs for patient rooms encouraging patient/family participation in several safety issues</td>
</tr>
</tbody>
</table>
March 6-12, 2005, was National Patient Safety Awareness Week. Many CCHS hospitals observed this week with safety fairs, information booths, safety quizzes and prizes. Thursday night, The Quality Institute of the CCHS sponsored the annual “Enhancing Patient Safety across the CCHS IV.” The highlights of this event included a keynote address by Robert Wachter, M.D., nationally known speaker and co-author of Internal Bleeding: The Truth Behind America’s Terrifying Epidemic of Medical Mistakes, a poster session, best practice oral presentations and an update on external safety reporting.

During the poster session, each of the CCHS hospitals had the opportunity to share with other CCHS employees how they accomplished, and what they learned while doing, the safety project/activity at their hospital. Each poster was informative and quite creative. The Ohio Patient Safety Institute (OPSI) also was present during the poster session to provide information about its various safety activities being conducted across the state, as well as resources to assist hospitals with their safety programs.

South Pointe Hospital won this year’s Best Display with the theme of patient safety education initiatives, which showed interventions used for employee education. Dr. Wachter’s presentation enlightened the audience about medical errors occurring in health care. The driving force of a safe health care environment is a culture of safety, whereby everyone feels free to identify safety issues or to stop a process when their gut tells them something is amiss. The culture of safety throughout the organization is an absolute must. Key to a culture of safety is the ability of the health care worker to communicate openly with each other.

Representatives from three CCHS hospitals presented a synopsis of best practices that helped to decrease or resolve patient safety issues at the hospital. Jeff Knop and Shannon Wendland from Huron Hospital presented the interventions put in place to ensure accurate labeling of blood specimen tubes, which have resulted in a significant decrease in the number of events. Jacquie Nowlin, Lakewood Hospital, shared how the surgical areas have 100 percent compliance with surgical site marking and timeouts. Ed Soeder and Sue Sturges, South Pointe Hospital, gave the group a capsule of the results from a Failure Mode & Effects Analysis (FMEA) for wrong patient medication errors. They are currently in the process of implementing interventions with the intended result of eliminating wrong patient medication errors. Deborah Nadzam, Ph.D., R.N., updated the audience on the external reporting movements that are occurring around patient safety. One such organization is The Leapfrog Group, a group of Fortune 500 companies who want to impact the safety of health care through the promotion of 30 safe practices. CCHS hospitals are participating by agreeing to work toward implementing the 30 practices and publicly reporting the progress. The results will be posted on The Leapfrog Group Web site.

Lakewood Hospital Receives National Medal of Honor

Lakewood Hospital received a Medal of Honor from the U.S. Department of Health and Human Services in May 2005, at the first annual Organ Donation National Learning Congress in Pittsburgh, Pa. Lakewood Hospital is one of only three hospitals in Ohio to receive such an honor. The Medal of Honor was presented to Lakewood Hospital because it achieved a life-saving organ donation rate of 75 percent or more and had at least eight eligible organ donors in the 12-month award period between September 2003 and March 2005.

More than 2,000 members of the organ donation community from across the United States participated in the Pittsburgh conference and saw representatives of Lakewood Hospital receive the medal. Lakewood Hospital staff who were critical in achieving the honor include Lynn Larsick, R.N.; Cheryl O’Malley, R.N.; Arthur Dick, M.D.; Terence Kilroy, M.D.; Michael Mervart, M.D.; and the Rev. David Walker.

CCHS hospitals have been participating in a three-year, HRSA-funded study to improve referral and organ donation.

Start planning now to attend the 2006 event, scheduled for March 2, with keynote speaker Dr. Karen Frush, Patient Safety Officer and pediatrician at Duke University.
National Quality Forum’s Safe Practices

In 2004, the National Quality Forum (NQF) released its report on safe practices. Under contract with the Centers for Medicare & Medicaid Services (CMS), NQF convened an expert committee and contracted with the Agency for Healthcare Research and Quality (AHRQ) to identify evidence-based practices associated with decreased mortality (see box).

The IHI reports that more than 2,500 hospitals have joined the campaign and theorizes that 100,000 lives will be saved in the next 12 months as a result.

Participating hospitals commit to implementing at least one of the six practices and to sending monthly discharge totals and monthly mortality totals for the next 12 months (two aggregate numbers for each month, not patient-level information) to IHI.

All CCHS hospitals are participating in the campaign and plan to implement five of the six practices. Although not committing to implementation of Rapid Response Teams (RRT), all CCHS hospitals are reviewing the feasibility of launching RRT’s.

For more information, go to www.ihi.org.

Note of interest: C. Martin Harris, M.D., Chief Information Officer for CCHS, is a member of the IHI board.

IHl’s “Save 100K Lives” Campaign

At the Institute for Healthcare Improvement’s (IHI) annual conference in December 2004, Don Berwick, president, launched the “Save 100K Lives” campaign. He encouraged hospitals across the nation to voluntarily participate in this initiative, aimed at implementing six care practices associated with decreased mortality (see box).

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Note of interest: C. Martin Harris, M.D., Chief Information Officer for CCHS, is a member of the IHI board.

Six practices of the “Save 100K Lives” Campaign

1. Deploy Rapid Response Teams at the first sign of patient decline.
2. Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction to prevent deaths from heart attack.
3. Prevent Adverse Drug Events (ADEs) by implementing medication reconciliation.
4. Prevent Central Line Infections by implementing a series of interdependent, scientifically grounded steps called the “Central Line Bundle.”
5. Prevent Surgical Site Infections by reliably delivering the correct perioperative care.
6. Prevent Ventilator-Associated Pneumonia by implementing a series of interdependent, scientifically grounded steps called the “Ventilator Bundle.”

National Quality Forum’s Safe Practices

In 2004, the National Quality Forum (NQF) released its report on safe practices. Under contract with the Centers for Medicare & Medicaid Services (CMS), NQF convened an expert committee and contracted with the Agency for Healthcare Research and Quality (AHRQ) to identify evidence-based practices associated with better outcomes.

This process resulted in 27 safe practices, presented to the NQF membership for review and vote. One NQF member, The Leapfrog Group, requested the addition of three other safe practices: computerized physician-order entry for inpatient medications, intensivist availability in critical care units, and evidence-based volume for specific procedures. NQF members approved the 30 safe practices.

The Leapfrog Group has added the other 27 practices to its hospital survey since their approval. All CCHS hospitals have assessed their status on all 30 practices and completed the Leapfrog Group’s online survey.

The Leapfrog Group is made up of more than 170 companies and organizations that buy health care. Leapfrog and its members work together to:

• Encourage public reporting of health care quality and outcomes so that consumers and purchasing organizations can make more informed health care choices.
• Reward doctors and hospitals for improving the quality, safety and affordability of health care.
• Help consumers reap the benefits of making smart health care decisions.

Hospital-level results are publicly posted on The Leapfrog Group Web site at www.leapfroggroup.org.

From the Medical Director
Richard Shonk, M.D., Ph.D.

CCHS Physician Peer Review:
The Benefits of Standardization

While individual physician peer review necessarily must remain the purview of the individual hospital and its medical staff, there is much to learn from this important activity. Analogous to patient safety, the sharing of information in the aggregate within the system, without identifying individuals, allows the recognition of trends and causes that, otherwise, would not be appreciated within any one hospital because of the small sample size. However, for this to be possible, standard approaches and definitions need to be implemented. A project to do just that has been under way for the past six months. After a year-long planning and design phase, concluding with Medical Operations Council approval in November 2004, the Medical Executive Committees (MECs) of each hospital have agreed to participate in the standardization of their peer-review processes.

Medical Executive Committees of each hospital have agreed to participate in the standardization of their peer-review processes.

...
A call to a patient 24 to 48 hours after discharge can have a positive impact on the patient's view of their hospital experience. To that end, Jayne McCarthy and Phil Bade of The Cleveland Clinic developed a software program to facilitate this intervention.

Since the implementation at the Clinic, unit and department managers have found the reports very helpful by providing “real-time” feedback about their area of responsibility. The purpose of the phone call is to ensure the patient arrived home safely and to work to resolve any outstanding issues the patient may have, such as additional discharge information or a physical concern referred to the physician office. The caller asks the patient questions about the hospital experience and provides the patient with an opportunity to point out issues and deliver compliments.

The unit/department manager and/or physician will receive an e-mail after the call is completed informing them of issues or compliments. Information from the program is distributed daily to managers and administrators, which helps them to identify new trends, as well as the effectiveness of a recently implemented intervention.

This program now has been implemented at all CCHS hospitals. Between 60 percent and 70 percent of the hospital’s discharged patients are contacted.

Discharge Call Staff

Jayne McCarthy Lynch, Manager/Patient Call Programs
Rosie Manning, Assistant Program Manager

Discharge Call Program Specialists
Michelle Adorno
Amy Basha
Sandy Bohus
Daniel Bokar
Matthew Bolam
Barbara Kelly
Susan Konecek
Jamie Ryan
Cathy Stirling

Hospital-Consumer Assessment of Health Plans Survey

After a long process of development, testing and approval, the implementation of the Hospital-Consumer Assessment of Health Plans survey (H-CAHPS) is close at hand. The Centers for Medicare & Medicaid Services is sponsoring H-CAHPS, which is the standardized inpatient survey established to measure the medical-surgical patients’ and obstetrics patients’ perspective on their hospital experience. The 27-item survey covers several dimensions of care nurses and doctors, hospital environment, communication, discharge and the overall rating of the hospital. A national dry run (data collected, but not publicly reported) began this fall.

The use of the survey is voluntary but strongly encouraged. CCHS hospitals will participate in the survey using the NRC + Picker H-CAHPS survey tool, which will provide more detailed information about the patient’s experience.

The Centers for Medicare & Medicaid Services is developing the survey for use in the ambulatory setting. The survey will help patients assess the quality of care they receive in outpatients clinics, doctor offices and other outpatient settings. The survey will cover several dimensions of care and patients will be asked questions about their experiences at each individual provider and clinic.

Watch for special communiqués about this process.

Notes of interest: Mardi Atkins (Quality Institute) is a member of the National Quality Forum’s Steering Committee on the Hospital-Consumer Assessment of Health Plans Survey.

David Bronson, M.D., (The Cleveland Clinic) is a member of the National Quality Forum’s technical advisory panel, which is considering the measurement of patient experience in the ambulatory setting.
Certified Stroke Centers
The Cleveland Clinic and Lakewood and Marymount hospitals have achieved certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as Primary Stroke Centers. This designation indicates the hospitals have met stringent national stroke care standards based on recommendations from the Brain Attack Coalition and the American Stroke Association. Several East Region hospitals are in the process of applying for certification.

Changes at The Quality Institute
The Quality Institute welcomed Michael Crossen, BSET, ASQ, CQM gr, CQE, QA, to the department in September. He will serve as Team and Process Improvement Facilitator, applying his knowledge of Lean and Six Sigma to hospital and health system projects. Mike comes to The Quality Institute from Rockwell Automation, where he was a process engineer.

CCHS Steering Committee Meeting Dates
The upcoming meeting dates for CCHS Steering Committees are listed below. Remember, the Quality Institute’s intranet Web site may be basic, but it has meeting times, locations, agendas, previous meeting minutes, team rosters, communiqués and all sorts of additional information specific to help you keep in touch and up to date. Check it out at http://intranet.cchs.net/qi.

Diabetes ........................................ 12/13/05
HF/AMI ........................................ 12/15/05
Stroke ............................................ 12/5/05
CCHS Medical Operations Council .... 12/1/05
CCHS Medication Systems Meeting ... 12/16/05
CCHS Patient Safety Meeting ............ 12/1/05
CCHS Patient Satisfaction Meeting ...... 12/21/05
PostAcuteCare ............................... 12/16/05
CCHS Skin Care Team ..................... 12/9/05