

## Commentary on “Hospital Quality: Ingredients for Success”

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We were struck by this comment made by the CEO of one of the study hospitals: “We may be good by comparison, but we could be *a lot* better.” This attitude is ingrained in many organizations performing at high levels. And in American hospitals today—even in these showcase hospitals—it is true. We can do much, much better. But how?

At the Pittsburgh Regional Healthcare Initiative, we have had the privilege of working closely with one of the fine institutions analyzed in this report (one of our members was the CEO at the time of the study) and with dozens of others in Southwest Pennsylvania. In addition, we have learned from many other hospitals across the country. We also draw on our own experience outside health care. One of our members led the safest business in the world, Alcoa, Inc., a corporation operating in 41 countries with 120,000 employees. As of April 23, 2004, Alcoa was 46 times safer to work in than the average American healthcare institution (Alcoa’s lost workday rate was .071 per 200,000 work hours compared with 3.3 for U.S. healthcare).

The cases emphasize the need for leaders to establish quality and safety as priorities. We don’t think that goes far enough. To say that safety is a priority implies that it is one of a number of institutional objectives and that it might change, perhaps in the next fiscal crunch. Safety and quality must be preconditions—nonnegotiable ingredients of patient care. The study cites elements of that no compromise thinking, such as Jefferson Regional Medical Center’s commitment to absorb the costs of denied days (i.e., days for which a payer may not provide reimbursement) if the clinicians believed a patient needed to remain in the hospital. But how much further could we take this principle and how much greater yield might we receive from our workforce?

We have seen great power in setting goals at the theoretical limit—that is, at the level of perfection or as close to it as possible. It defuses defensiveness and excuses, keeps the pressure on for breakthroughs, and lays the groundwork for a cycle of escalating quality.

To have a chance at closing the gap between current reality and the ideal, leaders must embrace the notion that they are responsible for everything that occurs in their institutions, especially things that have gone wrong. Today, it is difficult to find hospital leaders—clinical or administrative—that truly accept this notion. Once leaders accept the responsibility, the next step is to examine whether they fully comprehend and take ownership of the current state of affairs in their hospitals.

Executives can test themselves by working on nursing units for a morning, as one of our members did regularly as CEO. They should notice how many times nurses need to seek clarification of medication orders from physicians and how many times the order-entry pharmacists need to clarify orders or fill incomplete orders. How many days,

months, and years have these “small” problems gone on? Why haven’t they been addressed? How many other kinds of problems like these occur every day in other parts of the organization?

To inspire truth-telling in a way that supports the most rapid possible improvement, hospital leaders should examine the way in which they and their employees record what has gone wrong, investigate causes, take actions to address the root causes, and share essential information across the enterprise. This sharing of information should take place within 24 hours and include broad definitions of problems. Then, leaders can use real-time learning tools not to find fault, but to assess how well their institutions support problem-solving and improvement on the front lines, and to allow people on the front lines to learn from each other.

One partner hospital is acting on a commitment to eliminate every unsafe condition. In a year, it has gone from reporting 3.2 incidents or problems per day to an average of 37, and is assessing whether it is solving each problem’s root cause. After lots of practice, it is solving 6 percent of its problems down to the root causes each day, compared with nearly none previously. The gap between the number of problems and the number being solved is frustrating hospital staff and fueling the determination to close the gap.

Using problem-solving systems raises the question of what structure best supports excellence, especially in an organization as complex as a hospital. The study recognizes that the featured hospitals have avoided the fatal flaws of most organizations: assigning quality to a quality department or safety to a safety officer. Instead, they have the experts serve in technical assistance roles, with everyone expected to own the work of improvement. Risk-management is no longer assigned to isolated specialists. The experts use the data to empower the employees to make changes themselves. We applaud this focus and have seen the power of this approach play out on a community scale, through the kind of collaborative registry pioneered by the Northern New England Cardiovascular Disease Study Group.

The study fosters the assumption that improvement has to occur through committees, either established or ad hoc. Great organizations recognize that committees are mechanisms for codification and communication, but that improvement must occur in real time and in the course of regular work. In medicine, one of the giants of surgery, Frank Spencer, M.D., has made this point in his capacity as patient safety officer at NYU Medical Center. When a problem occurs at NYU, a small team is immediately assigned and has a week to implement a root-cause solution as close to the ground as possible. The relevant committees are informed of the changes that were made; they aren’t asked for permission. We work with two hospitals that are on the verge of disbanding their quality committees to concentrate on getting to the floor and solving real problems.

We see evidence in our partners’ work that these ideas can generate levels of performance that most people consider to be utopian. Leaders establish quality and safety as preconditions of serving people and protecting the workforce. They accept

responsibility for everything. They ask themselves whether they are getting all the information they need on what has gone wrong every day, and they ensure that the front-line troops have the permission and tools they need to solve each problem. Finally, leaders ask ceaselessly: How far are we from the ideal and what is the next improvement to move us closer to that ideal?