

**TWENTY NEW
JERSEY HOSPITALS
HAVE SIGNED ON
TO THE ICU
COLLABORATIVE,
AN AMBITIOUS
YEARLONG
INITIATIVE TO
INCREASE
QUALITY AND
REDUCE COSTS IN
HOSPITAL
INTENSIVE CARE
UNITS.**

NJHA Rolls Out Innovative Effort to Improve ICU Quality

By KERRY McKEAN KELLY

The image, projected larger than life before a room full of intensive care clinicians, shows a smiling, piggy-tailed toddler playing at a beach. Her wide eyes, all innocence and glee, seem to make direct contact with the audience.

Her name is Josie, and she died in the intensive care unit at The Johns Hopkins Hospital from an undetected blood stream infection. Peter Pronovost, MD, associate professor and medical director for the Center for Innovations in Quality Patient Care at John Hopkins University, keeps Josie's photo in his Power Point presentation as motivation for his important work – improving the quality of care in the nation's ICUs.

"I hope (we) don't need another Josie to be a wake-up call," says Pronovost.

Pronovost shared Josie's story at NJHA this month as he joined the NJHA Quality Institute in the kickoff of the ICU Collaborative, a major new initiative to improve ICU care. Twenty hospitals have signed on to the project in a yearlong commitment of time, money and resources, vowing to work with each other and with an expert faculty to standardize ICU processes and create a new culture of safety.

It's an ambitious undertaking, and the project's one-year goals are equally ambitious: reduce ICU mortality by 20 percent; reduce ventilator-associated pneumonia to the 25th percentile, based on Centers for Disease Control data; reduce catheter-related blood stream infections to the 25th percentile of CDC data; reduce the average ICU

length of stay by one day; reduce direct costs for ICU patients by 20 percent; and increase ICU bed turnover by 20 percent.

"This work that we're about to embark on is truly profound," Pronovost told participants. "But if you adhere to it, you will undoubtedly be able to achieve impressive results. I have no doubt that a year from now you will be seeing outcomes that previously were unimaginable."

And he urged hospitals to pounce on the opportunity without delay.

"Another day that goes by is another potential Josie," he said.

Ambitious Undertaking

The ICU Collaborative is the most ambitious undertaking to date of the two-year-old NJHA Quality Institute. The Institute and its task forces have developed an array of educational programs and have also adopted sample policies for increasing quality and reducing medical errors (see sidebar, Page 3.) The ICU Collaborative takes its work to a new level, an intense, focused approach with clearly defined outcome goals.

Quality Institute Director Aline Holmes, RN, APNC, said the ICU was targeted for a number of reasons: it's a small, contained part of the hospital; its staff is accustomed to change and innovation; and its high-tech care is expensive, making it a

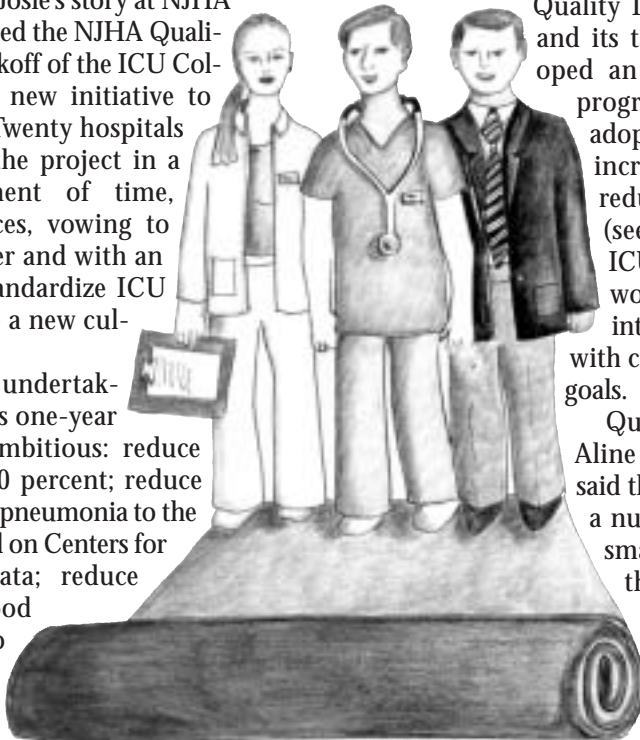


ILLUSTRATION BY PAMELA BROWN-VILLARIZ

continued on page 2

ICU Quality ... continued from page 1

major line item in a hospital's budget. Holmes' own experience as an advanced practice nurse is in the ICU, allowing her expertise to be used to full advantage in steering the project.

"There are always ways to improve care," says Holmes. "The ICU Collaborative aims to look at the ICU with a fresh set of eyes and an open mind. We're saying, 'There may be better ways of doing things.'"

*"This work that we're
about to embark on
is truly profound."*

— Peter Pronovost, MD

To find that "better way," participating hospitals are asked to designate a core team of three to four members from the medical and nursing staffs, the quality improvement team, pharmacy and infection control. These team members lead the change process back in their own institutions, securing buy-in and support from hospital leadership, the medical staff, staff nurses and other members of the hospital team.

Over the course of the year, team members will meet with other participating hospitals in three two-day learning sessions with the ICU Collaborative faculty members, which include Pronovost; Thomas Rainey, MD, of CriticalMed Inc., Frances Griffin from the Institute for Healthcare Improvement and others. In addition, the hospitals will take part in regular conference calls and listservs. And they'll report their efforts back to the Quality Institute every step of the way by sharing staff survey results, action plans, progress reports and data.

"The 'collaborative' aspect of this is key," says Holmes. "No one is working in a vacuum. We will share and discuss our work along the way so we can be accountable and learn from each other."

'We Can Do Better'

ICU care is highly complex, making it a high risk for adverse events. In fact, one national study of hospital ICUs found 1.7 errors per patient per day. Using New Jersey ICU data for 2002, this could conceivably translate into more than 1 million errors per year.

"We recognize that we can do better," says Aryeh Shander, MD, president of the New Jersey chapter of the Society of Critical Care Medicine, which has endorsed the ICU Collaborative. "We want to be better than what the national average is, and that requires a lot of issues — trying to standardize (processes) and transmitting that to everyone."

The ICU Collaborative curriculum was designed by the NJHA Quality Institute, based on earlier models and resources from Johns Hopkins, the Center for Healthcare Improvement and a Pronovost-led effort through the Michi-

gan Hospital Association. Under the program, each organization is expected to develop an aim statement that includes specific goals. Hospitals are instructed to target initial pilot areas for improvement, then spread the improvements to other areas. The curriculum offers specific models and best practices in the areas of cultural change, measuring outcomes, ICU staffing, ventilator bundles and central line blood stream infections. Quality Institute staff and faculty members will offer guidance in implementing and testing the best practices, many of which have been proven at Johns Hopkins and other hospitals.

That evidence of success appeals to Robert Wyman, MD, vice president of patient safety and informatics at Raritan Bay Medical Center and a member of the hospital's ICU Collaborative team.

"What's very encouraging here is that they're presenting a method for us to use

Perspective

GARY S. CARTER, FACHE – President

Several years ago, "quality" became the new trend in health-care, a buzzword everyone was tossing around but nobody really knew what to do with.

Today, our industry has made great progress in the quest for quality. It's not a buzzword anymore — it's an everyday part of our vocabulary. And it's a priority for all our organizations. We've all devoted new staffing and resources to improve our care and make it safer for our patients.

But now it's time to step it up. We're never "finished" with quality improvement. And despite all of our efforts, there remain a number of indicators and outcomes where we continue to fall short. We have stopped questioning the data, blaming individuals or resorting to any other excuses. Instead, we are embracing a new mindset: an absolute commitment to quality

improvement that may very well require us to completely overhaul the way we do things.

This ICU Collaborative is a wonderful example of hospitals rising to a challenge and opening their minds — and their organizations — to an entirely new approach to improving care. I applaud their commitment and I thank them for being the trailblazers for this new approach.

The distinguished professor and author Warren G. Bennis said, "Leadership is the capacity to translate vision into reality." In New Jersey, we are fortunate to have hospital leaders who hold that vision. And I look forward to the day, in the not-too-distant future, when New Jersey hospitals turn that vision into reality.



— almost irrefutable scientific evidence — to achieve that reduction in deaths,” says Dr. Wyman.

Business Case for Quality

Also irrefutable: the business case for improving ICU quality. Dr. Rainey of CriticalMed Inc. says improving ICU care can reduce costs, and also increase revenues.

How? Rainey notes that the best practices and other initiatives under the Quality Institute can reduce complications and lower lengths of stay.

“There are always ways to improve care.”

— NJHA's Aline Holmes

“The result is you have increased capacity,” says Rainey. “You’re able to take in a greater number of cases in the ICU, yet your costs of those cases isn’t really changed.”

So the hospital benefits, Rainey says, from a reduced cost per case and also in the increased capacity to admit more patients to the ICU. Plugging in sample numbers, Rainey shows the results of an increased capacity of 50 ICU patients per year multiplied by a reduced average cost per case of \$20,000. “Your quality work has resulted in \$1 million in increased revenue coming into this institution.”

Rainey notes that the benefits can ripple throughout the hospital by reducing bottlenecks in the Emergency Room, reducing the need for ER diverts and perhaps even saving major capital costs for expanding the ER or ICU.

The bottom line, according to Rainey: “There are two absolutes here. You can reduce costs by improving quality, but reducing costs will never improve quality.”

For more on the NJHA Quality Institute's ICU Collaborative, log on to www.njha.com/qualityinstitute/member.aspx.

Sample Policies: Small Ways to Make a Big Difference

By KERRY McKEAN KELLY

Improving healthcare quality can be as challenging as overhauling an entire department or as simple as eliminating a confusing abbreviation. NJHA's Quality Institute, recognizing that small steps can lead to great strides, has developed industry position statements that offer a common ground for hospitals to make quality improvements without a major investment in resources.

“This is mom and apple pie stuff — the sort of things that virtually everyone can agree is good practice but that may need some re-enforcement,” says Aline Holmes, RN, director of the NJHA Quality Institute.

To date, the Quality Institute has released two position statements developed by the Ad Hoc Task Force on Quality and the NJHA Physician Executive Constituency Group and endorsed by the NJHA Board of Trustees. One aims to reduce wrong-site surgeries through a standard policy for the marking and verification of surgical sites, while the other targets medical errors through the elimination of dangerous abbreviations and dose designations.

Hospitals are encouraged to incorporate these position statements into their own policies and procedures to create standardized processes across the state.

“The NJHA Board has made quality and patient safety one of its top priorities for 2004, and we encourage all hospitals to incorporate the language of these policies into their existing policies,” says NJHA President and CEO Gary Carter.

Specifically, the sample policies include:

■ **SURGICAL SITE MARKING AND VERIFICATION** — This policy outlines a multi-step process for marking surgical sites. Among other steps, it encourages surgical sites to be marked in an indeli-

ble marker with the word “yes” or the physician's initials. It encourages patient involvement, when possible, when marking the surgical site. And it calls for a “time-out” before any procedure is performed for the entire surgical team to verify the patient identity, the correct side and site, the procedure to be performed and the availability of any necessary equipment or implants.

“This is mom and apple pie stuff — the sort of things that virtually everyone can agree is good practice.”

— NJHA's Aline Holmes

The steps are similar to those being promoted in hospitals nationwide during this month's “National Time Out Day.”

■ **DANGEROUS ABBREVIATIONS AND DOSE DESIGNATIONS** — This position statement adopts a standard list of banned abbreviations and dose designations to minimize confusion when physicians and nurses work in different facilities, including hospitals, post-acute facilities and ambulatory surgical centers. For example, it urges clinicians to avoid using a zero after a decimal point (such as 1.0 mg) because the 1.0 could easily be mistaken for 10 mg if the decimal point is not seen.

ADDRESS SERVICE REQUESTED

Frances Griffin: Creating a New Culture

By KERRY McKEAN KELLY

We need a culture change.” That’s the answer we so often hear when an agency or institution is confronted with a major challenge. Whether it’s a hospital aiming to reduce medical errors or NASA trying to overhaul its shuttle operations, attention often turns to the elusive “culture change.”

As a director of the Boston-based Institute for Healthcare Improvement, Frances Griffin offers tangible, practical advice for achieving a change in the knowledge, beliefs, value and behaviors of a group of people — the very things that make up an institution’s culture. She shared her pointers recently with participants of the ICU Collaborative and will continue to serve as a faculty member during the yearlong program.

Leadership and communication are two of the key components of any organization’s culture, says Griffin. Based on those underlying premises, she recommends the following specific strategies for developing a new culture of safety in hospitals:

THE LEADERSHIP WALK ROUNDS — Griffin encourages hospital CEOs and other senior leaders to make weekly unit rounds and interact with frontline staff about patient safety issues. “The message you want to get across is that senior leadership thinks safety is very, very important,” says Griffin. Feedback is a critical part of this process, says Griffin, who encourages hospital leaders to report back to staff with any feedback or follow-up to their walk round conversations.

SAFETY BRIEFING — This briefing brings together unit staff for two 5-minute briefings — one at the start of the shift and another later in the shift. Staff should be encouraged to raise patient safety issues in an open and non-punitive dialogue. One key from Griffin: Keep it brief. You won’t solve major problems in the briefing but you will prime the staff for open and honest discussion about immediate concerns.

PRE-PROCEDURAL BRIEFING — These briefings should relate to a very specific,

immediate situation such as a high-risk invasive procedure or a procedure that occurs infrequently. Similar to the cockpit briefing that occurs in aircraft, it’s simply a time-out to review the plan and make sure the entire team is on the same page.

In all these interactions, Griffin encourages the use of common communication tools to make all members feel encouraged to join in: make eye contact, use first names and explicitly ask for input from all members of the hospital team.

For more tools from the Institute for Healthcare Improvement, log on to www.qualityhealthcare.org.

CHAIRMAN
BOARD OF TRUSTEESJohn P. McGee
PRESIDENT AND CEO Gary S. Carter
VP COMMUNICATIONSRonald Czajkowski
MANAGING EDITOR.....Kerry McKean Kelly

Copyright 2004, New Jersey Hospital Association, 760 Alexander Road, PO Box 1, Princeton, NJ 08543-0001. *Healthcare New Jersey* is a service publication of the New Jersey Hospital Association. Contents may be copied if NJHA is credited.