



CEEQNET Health Care Quality Newsletter 2006

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Quality improvement implementation and hospital performance on patient safety indicators

<http://psnet.ahrq.gov/resource.aspx?resourceID=3253>

This AHRQ-funded study describes the association between dimensions of effective quality improvement (QI) and their impact on hospital-based patient safety indicators (PSI)*. Investigators combined data from a national survey of hospital QI practices with four PSIs in demonstrating that physician involvement in QI was the only significant association with improved indicator scores. Involvement of senior management and multiple hospital units in a QI effort failed to demonstrate a significant association with PSI values. This study expands on previous efforts at understanding the organizational factors involved in achieving patient safety improvement.

*The Patient Safety Indicators reflect the quality of inpatient care but also focus on preventable complications and iatrogenic events.

Standardizing a Patient Safety Taxonomy

<http://psnet.ahrq.gov/resource.aspx?resourceID=3358>

In this report, the National Quality Forum presents four consensus standards that support the application of the Joint Commission on Accreditation of Healthcare Organizations' Patient Safety Event Taxonomy—a standardized framework for classifying patient safety data.

Fairview Healthcare Services improves patient and physician satisfaction using Six Sigma

<http://www.premierinc.com/all/safety/publications/01-06-full-txt.jsp#story-02>

The Six Sigma methodology is associated more often with manufacturing companies than healthcare systems and has been used in industry to improve operational efficiency and customer satisfaction. However, Fairview Health Services, a large Minneapolis, Minn.-based integrated health care system has demonstrated dramatic improvements in financial viability, patient and physician satisfaction and stronger employee engagement since successfully deploying the Six Sigma methodology. Six Sigma is a performance improvement method that is a disciplined, data-driven, measurement-based approach to reduce process variation and eliminate errors in organizational processes that require significant improvements.

Fairview began by targeting four clinical projects - Medicare profitability, emergency department cycle time reduction, clinic patient preparation, and medication safety.

The *Medicare profitability* project goal was to look at a specific diagnostic related group (DRG) - joint replacement - where the hospital was losing money and develop a prototype for applying Six Sigma to other DRGs to lower overall length of stay. Fairview reorganized this project into two projects and set up one team focusing on reducing the length of stay for orthopedic patients discharged to home care and another team focused on preoperative patient education, setting physician expectations and developing best practice protocols.

The *emergency department cycle time reduction* project selected four strategies to focus on: decreasing imaging turnaround time, lab turnaround time, time to get patients to rooms, and improving distribution methodology of patients, staff and physicians.

Clinic patient preparation focused on improving the efficiency of assigning rooms for clinic patients. Six Sigma objectives and measures were incorporated into this already-existing project.

The *medication safety initiative project* retrofitted Six Sigma methodology onto an already existing pilot pain management project.

The application of Six Sigma to these projects often led teams in new directions. Some lessons learned included:

- It is difficult to successfully graft Six Sigma techniques onto the project if a process improvement project team has begun work on analyses or solutions.
- Six Sigma training provided a menu of improvement methods available for various situations.
- The selection and sequence for implementing strategic improvement projects and the decision to use Six Sigma methods should be guided by an overall system of project portfolio management.
- The Six Sigma language can cause resistance to adopting Six Sigma methods.

Overall team members were supportive of the methodology. They described administrative ownership of each project, noting that the Six Sigma method forced project clarity from the outset. The team also felt the methodology was more reliable because of its rigorous data collection and saw the analyses methods as positive benefits.

Misdiagnosis: The Overlooked Patient Safety Issue

http://www.hhnmostwired.com/hhnmostwired_app/jsp/articledisplay.jsp?dcrpath=HHNMOSTWIRED/PubsNewsArticleMostWired/data/060118MW_Online_Britto&domain=HHNMOSTWIRED

While patient safety issues are receiving unprecedented attention, most of the discussion has focused on prescription and care delivery errors. Misdiagnosis, however, is a common and underemphasized component of medical errors and warrants attention from health care executives.

The magnitude of failed, missed or delayed diagnosis is significant. A recent multi-institutional collaborative project by Schiff et al, funded by the Agency for Healthcare Research and Quality, reported that diagnosis errors far outnumber medication errors as a cause of malpractice claims (32 percent versus 8 percent). Further, a Harris poll commissioned by the National Patient Safety Foundation found that one in six people have experienced a medical error related to misdiagnosis.

Measures of Pediatric Health Care Quality Based on Hospital Administrative Data: The Pediatric Quality Indicators

http://www.qualityindicators.ahrq.gov/downloads/pdi/word/pdi_measures_v31.doc

This report documents the work undertaken in Phase I of a two-phase process to develop the Pediatric Quality Indicators as part of the Agency for Healthcare Research and Quality (AHRQ) contract, "Support for Quality Indicators II" under subcontract with Battelle Memorial Institute by Stanford University and the University of California at Davis. This work was initiated in response to a charge to develop indicators of children's health care utilizing inpatient administrative data. These indicators examine both the quality of inpatient care, as well as the quality of outpatient care that can be inferred from inpatient data, such as potentially preventable hospitalizations.

The report contains three main sections:

1. The introduction section launches the actual technical report and provides background regarding pediatric indicator development and the current effort to develop an indicator set based on administrative data.
2. The methods section outlines the approach used to gather evidence to identify and evaluate potential patient safety indicators, including the literature review, empirical analyses, and clinician panel review, as well as the operationalization of indicators and evaluation of risk adjustment approaches.
3. The results section is divided into two parts. The first part highlights general themes and summarizes the overall results. The second part provides detailed results for each AHRQ QI examined.