

INDEX

Page references followed by *fig* indicate illustrated figure.

A

Accountability, 178–180
Acute myocardial infarction (AMI), 28
Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs (AMA), 58
Admission risk points, 45*fig*
Adverse events: communication failure examples of, 49; definition of, 6; internal responses to, 14–15; medication error, 120, 156; poor communication as primary cause of, 47; quality management's role in controlling, 126–128*fig*. *See also* Malpractice; Patient safety; Sentinel events
Agency for Healthcare Research and Quality (AHRQ), 5, 6, 9, 58
AHRQ National Healthcare Disparities Report, 58
Alcoholism-suicide comorbidity, 19
Ambulatory care: for children, 104–105; prevention role in, 101–105; promoting prevention in setting of, 104; tables of measures on, 102*fig*
American Board of Medical Specialties Maintenance of Certification, 166
American Heart Association, 58
American Medical Association (AMA), 53, 58
APACHE (Acute Physiology and Chronic Health Evaluation), 84–85
Aspiration pneumonia, 99

B

Bar graph, 35*fig*
Behavior health: monitoring, 121–123; table of measures on, 124*fig*
Benchmarks, 27
Blue Cross Blue Shield, 6, 77
Brain aneurysm database, 160–161

C

“C suite”: enlisting in quality movement, 13–15; quality role by, 187–188; role in good outcomes, 72–74; understanding quality and finance link, 70–72, 80–81, 188
CABG (coronary artery bypass graft) data, 75
Cardiac surgery, 81
Centers for Disease Control and Prevention, 6
Central line infections, 138–139
Chief executive officers (CEOs), 153, 165, 188

Chief financial officers (CFOs): never events role by, 125; patient care unit design role by, 173; role in good outcomes, 72–74; understanding quality and finance link, 70–72, 80–81, 138–139, 188
Chief medical officers (CMOs): role in good outcomes, 72–74; understanding quality and finance link, 70–72, 80–81, 138–139, 188
Child ambulatory care, 104–105
Chronic disease management: improved communication for improving, 62; patient-focused care role of, 61, 63; prevention role in, 99–101. *See also* Patients
Clinical alarms: effectiveness assessment tool for, 182*fig*; infant abduction, 176
Clinical pathways: description of, 51–52; patient safety improved through, 52
CMS (Centers for Medicare and Medicaid Services): chronic diseases focus by, 190; communication and patient education requirements by, 58; as driver of quality, 6–7, 186; end-of-life care standards by, 138; error reporting standards by, 125–126; evidence-based measure compliance required by, 29; falls treated as never events by, 106; National Patient Safety Goals as defined by, 107–108; never events focus of, 70–72; never events list developed by, 124; on patients discharged with inadequate information, 43; pay-for-performance initiative by, 4, 7, 43, 73; physician care defined by variables of, 75; quality indicators collected by, 23; standardized treatment plan recommended by, 82–83; transparency supported by, 157; on use of restraints, 66; value as defined by, 187
Code Blue approach, 51
Codman, Ernest A., 16–17
Communication: across disciplines, 172–174; guidelines for care and, 51–52; handoff information transfer, 47, 56, 103; improving chronic disease management by improving, 62; lines of effective, 38*fig*; patient safety improved through effective, 37–38; patient-focused care role of, 43–46; risk points in, 45*fig*; about safety, 181; SBAR technique for standardizing, 47–48. *See also* Patient education

Communication barriers: overview of, 48–50; strategies to reduce, 50–51

Communication failures: incorrect drug dosage example of, 49; mishandled pathology sample example of, 49

Communication improvement: brain aneurysm database example of, 160–161; establishing common language for, 157–159; good processes and monitoring for, 160–163; sustaining common language changes for, 159

Compassionate caring, 65–67

Competency: assessing, 163–164; medical staff credentialing for, 165; objectifying, 165–168; promoting, 169; regulatory requirements for ensuring, 164–165; staffing effectiveness and, 168–169

Confidentiality issues, 65

Continuing medical education (CME), 15

Control charts, 35, 36*fig*

Credentialing: algorithm for physician, 167*fig*; Joint Commission requirements for, 163–164; medical staff, 165

Critical Infrastructure Protection Committee, 181

Crossing the Quality Chasm (IOM), 115

Culture. *See* Health care culture

D

The Dartmouth Atlas of Health Care 2008 study, 85–86

Data analysis, *The Dartmouth Atlas of Health Care 2008* study, 85–86

Diabetic patients: Hemoglobin A1c (HBA1c) test given to, 101; prevention measures taken with, 100–101

Discharge: CMS on inadequate information provide during, 43; CMS requirement for documentation of, 55–56; risk points in communication during, 45*fig*; as vulnerable area for patients, 78

DNI (do not incubate) orders, 84

DNR (do not resuscitate) orders, 67, 84

DOHs (state departments of health): as driver of quality, 7–8; near miss data collected by, 59

DRGs (diagnosis-related groups): cost of transplant, 80–81; description of, 81; maximizing effectiveness of, 82–83

Drivers of quality: external, 5–11; illustrated diagram of key, 4*fig*; insurers, 6; internal, 11–19

DVTs (deep vein thromboses), 98

E

ED (emergency department): acute myocardial infarction care in, 28; inadequate handoff information transfer from, 47, 56, 103; managing quality issues of the, 143–144; measuring

quality of care in, 27; myocardial infarction treatment in, 161–162*r*; prevention measures related to the, 100; used as proxy for primary care physicians, 103, 143–144; quality management of, 127; quality measures of, 128*fig*; queuing theory applied to, 28; tracer methodology on care continuum from, 35, 37; as vulnerable area for patients, 78.

See also Hospitals

Elderly patients: end-of-life issues and, 65, 67, 84–85, 137–138; managing the, 83–84

EMR (electronic medical record): entering patient data into, 110; prevention role of, 108–109.

See also Patients

End-of-life care: APACHE data on quality of, 84–85; costs of, 137–138; DNI (do not incubate) orders, 84; DNR (do not resuscitate) orders, 67, 84; patient decisions related to, 65

Errors. *See* Sentinel events

Evidence-based medicine: care recommendations based on, 8; CMS initiative on hospital compliance with, 29; definition of, 7

External drivers of quality: additional, 9; CMS (Centers for Medicare and Medicaid Services), 67; DOHs (state departments of health), 7–8; IHI (Institute for Healthcare Improvement), 9; insurers, 6; Joint Commission, 8–9; Leapfrog Group, 5; the public as, 10–11

F

Falls: prevention of, 28–29, 67; treated as never events by CMS, 106

Financial issues: critical proportions of, 187; end-of-life care costs, 137–138; improving ICU costs, 134–135; malpractice economics, 129–130; matching ICU resources to the patient, 136–137; sustaining quality and change, 138–140; understanding how quality is linked to, 70–72, 80–81, 138–139, 188

5 Million Lives Campaign, 9

FMEA (failure mode and effects analysis): comparing RCA and, 51*r*; description of, 50; as prevention methodology, 106–107; quality management role in conducting, 126, 185

Food and Drug Administration, 6

G

General Electric (GE), 72

Gestational diabetes, 100–101

Good outcomes: cardiac surgery example of improving, 81; CMO and CFO roles in, 72–74; establishing method to improve, 78–79; financial value of, 76*fig*–77; physicians' role in, 74–76

H

- Handoff information transfer, 47, 56, 103
- Handwashing hygiene, 10–11
- Health care culture: adopting guidelines to improve outcomes, 80; establishing method to improve outcomes as changing, 78–79; factors involved in changing, 77–81
- Health care value: CMS definition of, 187; good outcomes as financial, 76*fig*–77; measuring patient safety and health care, 27; RCA (root cause analysis) as increasing, 117–121, 185; relationship between improved care and, 189–190
- Health Insurance Plan of New York (HIP), 6
- Health literacy, 43, 58
- Healthy People 2010, 102
- Hemoglobin A1c (HBA1c) test, 101
- HIPAA (Health Insurance Portability and Accountability Act), 65
- Hospital Quality Alliance, 58
- Hospitals: clinical and safety indicators data collection by, 186–187; CMS initiative on evidence-based medicine compliance by, 29; how traditional hierarchy leads to errors in, 128–129; managing throughput approach by, 143–146; proactive prevention promotion in, 106–107; specialty beds purchased by, 71; tracer methodology required by, 35, 37. *See also* ED (emergency department)
- Human resource (HR) departments, 163

I

- ICU (intensive care unit): APACHE quality data on, 84–85; central line infections problem in, 138–139; *The Dartmouth Atlas of Health Care 2008* study on, 85–86; improving costs of, 134–135; matching resources to the patient, 136–137; patient care unit design of, 174; preventing nosocomial pneumonia in the, 100; quality management of, 127; ventilator-associated pneumonia danger in, 79
- Incident analysis: benefits of, 115–116; changing framework for, 115–117. *See also* RCA (root cause analysis); Sentinel events
- Infant abduction alarms, 176
- Infection rates: reporting, 25–26; SCIP (surgical care infection prevention), 26*t*
- Infections: central line, 138–139; MRSA (methicillin resistant *Staphylococcus aureus*), 10, 144; SSIs (surgical site infections), 152–155
- Informed consent, 65
- Institute for Healthcare Improvement (IHI), 9, 23, 51

- Institute of Medicine (IOM): *Crossing the Quality Chasm* by, 115; patient safety focus of, 107, 115; *To Err Is Human* by, 115
- Insurers: discounts for quality by, 76*fig*–77; as driver of quality, 6
- Internal drivers of quality: enlisting the C suite, 13–15; governing boards, 11–13; quality data, 15–16; quality management, 16–19

J

- Joint Commission: CME recommended by, 15; competency and credentialing requirements of, 163–164; data collection and analysis supported by, 18; as driver of quality, 8–9; National Patient Safety Goals (NPSGs) of, 9, 76, 83, 107–108, 182; near miss data collected by, 59; patient education requirements by, 58; RCA matrix by, 115; sentinel event alerts issued by, 118; sentinel events database kept by, 47, 122; tracer methodology requirement of, 35, 37; on use of restraints, 66
- Joint Conference Professional Affairs Committee, 142–143

L

- Leapfrog Group, 5
- LOS (length of stay): of patients without primary care physician, 103; prevention approach to shorten, 100; as quality measure, 27, 72, 76; surgical site infections (SSIs) extending, 152–153; ventilator-associated pneumonia increasing, 79

M

- M&M (mortality and morbidity): inadequacy of, 189; physician education focus of, 115; review process of, 79
- Malpractice: economics of, 129–130; past evaluation function of, 163. *See also* Adverse events; Sentinel events
- Malpractice insurance, 130
- Maternal death, 121
- Medical errors. *See* Sentinel events
- Medication errors: example of, 120; reducing, 156
- Monitoring: behavior health, 121–123; communication improvement through, 160–163; North Shore-LIJ Health System experience with patient, 163; patient safety, 176–177. *See also* Oversight
- Mortality rates: quality data to reduce, 140; stroke, 99
- MRSA (methicillin resistant *Staphylococcus aureus*), 10, 144

200 Index

Myocardial infarction: AMI (acute myocardial infarction), 28; ED treatment of, 161–162; table of measures, 162*t*

N

National Adult Literacy Survey (1992), 58

National Healthcare Disparities Report (AHRQ), 58

National Patient Safety Foundation (NPSF), 9, 116

National Patient Safety Goals (NPSGs), 9, 76, 83, 107–108, 182

National Quality Forum, 124

National Quality Forum (NQF), 5, 6, 9

Near miss: definition of, 59; distribution collected from OR, 60*fig*; reporting, 59–61

Never events: CMS treatment of falls as, 106; definition of, 6, 7, 70; list of, 124; measuring for eliminating, 124–125; patient safety context of, 70–72; wrong-site surgery, 118–119

New York State Committee to Reduce Infection Deaths, 10

New York State Health Department, 56

Nightingale, Florence, 16

North Shore-LIJ Health System: APACHE database used by, 84–85; behavioral health table of measures of, 123–124*fig*; on compassionate care by reducing restraints, 66; on physician roles in improving quality, 75; prevention measures taken by, 97, 100, 104; on value of monitoring patients, 63

Nurses: coordinating care role of, 164–165; credentialing of, 165; errors and traditional hierarchy of, 128–129; establishing common language used by, 157–159

O

Organ transplants, 80–81

ORs (operating rooms): communicating across disciplines to design, 173; how errors are related to traditional hierarchy in, 128–129; improving efficiency in, 141–142; managing quality issues of the, 144. *See also* Surgeries

Orthopedic surgery: algorithm for quality of, 142; DVTs (deep vein thromboses) complication of, 98; patient education on, 54; Total Hip Replacement Guideline, Patient Version form, 55*fig*; VTEs (venous thromboembolism) following, 142

Oversight: establishing safe environment of care, 180–181; patient safety improvement by improving, 142–143. *See also* Monitoring

P

Patient education: CMS on inadequate discharge, 43; orthopedic surgery, 54; patient-focused care

role of, 52–53, 55–59; Pneumonia Guideline, Clinical Version form, 53*fig*; Pneumonia Guideline, Patient Version form, 57*fig*. *See also* Communication

Patient safety: communicating about, 181; drivers of quality and, 4*fig*–19; executive summary of indicators of, 13*fig*; fall prevention, 28–29; improving, 22–38; measuring health care value and, 27; monitoring, 176–177; understanding financial link to quality and, 70–72, 80–81, 138–139. *See also* Adverse events; Safe environment of care

Patient safety improvement: effective communication for, 37–38*fig*; enlisting physicians and administrators for, 22–23; improving oversight for, 142–143; managing throughout for, 143–146; measuring value in health care for, 27–29; presenting results for, 34*fig*–37; questions via quality data, 30–33; understanding quality measures for, 23–24; working with quality data for, 24–27. *See also* Quality management

Patient Self-Determination Act (1990), 65

Patient suicide, 19

Patient-focused care: benefits of, 42–43; chronic disease management for, 61–63; compassionate caring role in, 65–67; handoff information transfer and, 47, 56, 103; near-miss reporting, 59–61; patient education role in, 52–59; patient rights and responsibilities role in, 65; role of communication in, 43–46, 48–52; SBAR technique and, 47–48; task forces for, 63*t*–64*t*

Patients: aspiration pneumonia and stroke, 99; compassionate care of, 65–67; diabetic, 100–101; elderly, 65, 67, 83–85, 137–138; health literacy of, 43, 58; informed consent of, 65; matching ICU resources to, 136–137; prevention role of, 92–93; restraints used on, 66; rights and responsibilities of, 65. *See also* Chronic disease management; EMR (electronic medical record)

Pay-for-performance measures: CMS initiative for, 43, 73; patient quality driven by, 4, 7

PDCA (Plan-Do-Check-Act) cycle: cardiac mortality outcomes improved using, 81; as performance improvement methodology of, 15, 56, 78, 82, 116–117, 185

Performance improvement: credentialing for, 163–164, 165, 167*fig*; increasing competency for, 163–169

Performance Improvement Coordinating Group (PICG), 180–181

Physicians: algorithm for credentialing of, 167*fig*; CMS variables defining care of, 75; credentialing of, 165; ED used as proxy for primary care, 103; enlisting into patient safety movement,

- 22–23; establishing common language used by, 157–159; failures of communication by, 48–51; good outcomes role of, 74–76; how errors are related to traditional hierarchy of, 128–129; M&M (mortality and morbidity) focus on educating, 115; outpatient prevention programs developed by, 102–103; standardized treatment plan recommended for, 82–83
- Pie charts, 35, 36*fig*
- Pneumonia: aspiration, 99; clinical guidelines on, 53*fig*; ICU nosocomial, 100; Pneumonia Guideline, Clinical Version (form), 53*fig*; Pneumonia Guideline, Patient Version (form), 57*fig*
- Power outages, 178–179
- Prevention: ambulatory care and, 101–105; FMEA (failure mode and effects analysis) for, 50, 51*r*, 106–107; management of chronic conditions for, 99–101; measures taken for, 93–94; National Patient Safety Goals (NPSGs) role in, 9, 76, 83, 107–108; patient role in, 92–93; proactive promotion in hospitals, 106–107; problems related to, 91–92; promotion of, 90–91; quality data's role in promoting, 95–99; regulatory groups' role in, 94–95; suicide, 122–123; technology role in, 108–110
- Primary care physicians: ED used as proxy for, 103, 143–144; LOS of patients without, 103
- Privacy issues, 65
- The public, 10–11
- Public report cards, 14
- Q**
- Qualitative quality measures, 109
- Quality data: APACHE (Acute Physiology and Chronic Health Evaluation), 84–85; CABG (coronary artery bypass graft), 75; driving change with, 15–16; increasing patient safety by using, 17–19, 186–187; link between quality and finance, 70–72, 80–81, 188; prevention promoted by use of, 95–99; RCA (root cause analysis), 30–31*fig*; on specialty beds, 71; validity of, 33; ways to report, 34*fig*–37; working with, 24, 27
- Quality data analysis: benchmarks established by, 27; improvement made through, 31–32; presenting results of, 34*fig*–37; traditional and quality management modes of, 80*fig*
- Quality data collection: amount of data gathered by, 32–33; sample size for, 33
- Quality indicators: definition of, 23; executive summary of patient safety, 13*fig*; hospital data on, 186–187. *See also* Quality measures
- Quality management: C suite role in, 13–15, 70–74, 80–81, 187–188; chronic disease, 61–63; compassionate caring role in, 65–67; controlling adverse events role by, 126–128*fig*; driving safety with, 16–17; near-miss reporting role in, 59–61; patient education role in, 52–59; patient rights and responsibilities role in, 65; role in increasing trust by, 151; role of communication in, 43–47, 51–52, 56, 62; SSIs (surgical site infections) reduced by, 154–155; sustaining change in, 138–140; task forces role in, 63–64*r*; throughput approach to, 143–146. *See also* Patient safety improvement
- Quality management department (QMD), 11
- Quality measures: ambulatory care, 102*fig*; behavior health, 124*fig*; definition of, 24; ED (emergency department), 128*fig*; fall prevention, 28–29; health care value established by, 27; link between finance and quality, 70–72, 80–81, 138–139, 188; quantitative and qualitative, 109; reporting infection rates, 25–26; safe environment of care, 176*fig*; SCIP (surgical care infection prevention), 26*r*; short length of stay (LOS) as, 27, 72, 76; understanding, 23–24*fig*. *See also* Quality indicators
- Quantitative quality measures, 109
- Queuing theory, 28
- R**
- RCA (root cause analysis): comparing FMEA and, 50–51*r*; description of, 30–31*fig*; Joint Commission matrix for, 115; maternal death, 121; medication error, 120; value of, 117–121, 185. *See also* Incident analysis; Sentinel events
- Restraints, 66
- Risk-adjusted data, 7
- RRTs (rapid response teams), 51
- Run chart, 34*fig*
- S**
- Safe environment of care: assessing and improving the, 182–183; clinical alarm effectiveness assessment tool for, 182*fig*; communicating about safety for, 181; communication across disciplines for, 172–174; ensuring accountability for, 178–180; establishing oversight for, 180–181; improving processes for, 175–176; maintaining a, 180; monitoring safety for, 176–178; power outages and, 178–179; Sharps injuries by activities measure of, 177*fig*; table of measures for, 176*fig*; working together to identify and solve problems, 174–175. *See also* Patient safety
- Sample size, 33
- SBAR technique, 47–48
- SCIP (surgical care infection prevention), 26*r*
- Sentinel event alerts, 118
- Sentinel events: definition of, 8; how traditional hierarchy leads to, 128–129; identification

- of, 115; improving reports of, 125–126; Joint Commission database on, 47; maternal death, 121; medication error, 120, 156; patient suicide, 19; suicide prevention, 122–123; wrong-site surgery, 118–119. *See also* Adverse events; Incident analysis; Malpractice; RCA (root cause analysis)
- Sharps injuries by activity, 177*fig*
- Specialty beds, 71
- Staffing effectiveness concept, 168–169
- Stroke mortality rates, 99
- Suicide prevention, 122–123
- Suicide-alcoholism comorbidity, 19
- Surgeries: cardiac, 81; organ transplants, 80–81; orthopedic, 54, 55*fig*, 98; wrong-site, 118–119. *See also* ORs (operating rooms)
- Surgical site infections (SSIs): performance improvement to reduce, 154–155; reporting, 152–153
- ## T
- Task forces: heart failure clinical pathway interventions by, 64*t*; improving processes role of, 175–176; patient-focused care role of, 63–64; quality management and evidence-based, 63*t*
- Technology: EMR (electronic medical record), 108–109, 110; prevention measures and role of, 108–110
- Throughput approach, 143–146
- Time-out precaution, 118–119
- To Err Is Human* (IOM), 115
- Total Hip Replacement Guideline, Patient Version (form), 55*fig*
- Tracer methodology: competency promoted through, 164–165; definition of, 37; Joint Commission requirements for, 35
- Transparency movement: as changing the traditional culture, 77; Ernest Codman's early push for, 16–17; organizations participating in, 10; patient rights and informed consent role in, 65; quality driven by, 5, 7, 9, 15; rationale behind the, 8; trust increased through, 151–157
- Transplants, 80–81
- Treatment cycle: risk points in communication during, 45*fig*; throughput approach to, 143–146
- Trust: developing, 150–151; quality management role in increasing, 151; transparency role in increasing, 151–157
- Type 2 diabetes, 100–101
- ## V
- Validity of data, 33
- Value. *See* Health care value
- Ventilator-associated pneumonia, 79
- VTEs (venous thromboembolism), 142
- ## W
- Waste reduction: APACHE data on, 84–85; *The Dartmouth Atlas of Health Care 2008* study on, 85–86
- Welch, Jack, 72
- World Trade Center attacks (2001), 181
- Wrong-site surgery, 118–119