IHI partners with Kaiser
$10 million collaboration aims to improve safety, satisfaction

BY ANDIS ROBEZNIEKS

Kaiser Permanente patients might now be more satisfied with the better and safer care they’re reportedly receiving through a partnership with the Institute for Healthcare Improvement, but Kaiser’s roughly 13,000 physicians and other caregivers could get a little nervous with patient-safety pioneer Donald Berwick analyzing their every move.

A $10 million collaboration between Oakland, Calif.-based Kaiser—which operates more than 400 medical facilities in nine states and the District of Columbia—and Cambridge, Mass.-based IHI, which Berwick heads, seeks to leverage the resources and 8.5 million-member base of the nation’s largest not-for-profit integrated health system to improve patient safety and satisfaction across the U.S. Participating providers will be put under a microscope, which may raise their performance anxiety while leading others to question if true healthcare transformation can only occur if big dollars are attached.

“We’re absolutely focused on improving frontline care,” says Lisa Schilling, a registered nurse and a Kaiser patient-safety practice leader, explaining that the general idea behind the initiative is process improvement. “Let’s identify what’s not working. Let’s measure. Let’s test,” she says.

Doug Bonacum, Kaiser’s vice president of safety management, adds that the intent is to share any innovations that are developed as a result of the collaboration. “We, at Kaiser, basically refuse to compete on safety,” he says.

One of the leaders of the collaboration, IHI Senior Vice President M. Rashad Massoud, M.D., says he is aware that his organization is a facilitator but not the driver of quality-improvement efforts at Kaiser.

“Kaiser Permanente has 145,000 employees. We’re an 85-person organization,” he says. “We’re realistic about the proportion.”

Launched in December 2004, Kaiser’s collaboration includes scholarships funded through an $8 million endowment to the IHI—for Kaiser employees and workers at other organizations that partner with Kaiser to attend IHI education and training programs over the next 15 years. Topics include clinical outcomes; patient safety and satisfaction; office and hospital redesign; and healthcare access and disparities.

There’s also a $2 million contract for the IHI to provide “strategic guidance” on patient safety, organizational metrics and management; assistance with innovation pilot tests that use IHI methodology; guidance in leveraging results to positively affect more patients; and help with organizational structure improvements such as staff training and skills development.

“Kaiser Permanente is excellent at everything somewhere,” Bonacum says. “We want to be excellent everywhere, and we think we can do that with IHI’s help.”

Berwick, an M.D. who is IHI’s president and chief executive officer, echoed a similar sentiment during a Kaiser Family Foundation symposium on healthcare improvement this fall. Berwick mentioned how several hospitals working with the IHI have gone months without a central-line infection and asked “If there, why not everywhere?”

Berwick, who was not available for comment on this story, was involved in hammering out the collaboration with Kaiser and is active in managing its progress, an IHI spokeswoman says.

Looking for leverage

Bonacum adds that the collaborative effort was “brokered” in a large part by the longtime working relationship between Berwick and Louise Liang, a past chairwoman of the IHI board and Kaiser’s senior vice president of quality and clinical systems support. In the early ’80s, Berwick was vice president for quality-of-care measurement at the Harvard Community Health Plan while Liang served as associate medical director.

In addition to Kaiser, Massoud says the IHI has similar but smaller-scale relationships with HHS, Allina Hospitals & Clinics, the national alliance Premier and Ascension Health, as well as partnerships in Sweden and the U.K.

“We partner with organizations that can leverage IHI’s work to thousands of patients,” Massoud says. “One of the things (Kaiser) brought to the table is that they have made the single-largest investment in electronic medical records outside of the military.”

Considering that Kaiser is spending some $3.2 billion on its HealthConnect EMR system, Massoud says the goal is to squeeze every last

Continued on p. 12
Continued from p. 11

benefit out of that massive expenditure and to answer the question: How can we make this the best investment they’ve ever made in the area of improving quality of care?

Bonacum agrees.

“We have an expensive IT system,” he says. “You can show up in any part of the Kaiser Permanente system—from Hawaii to Washington, D.C.—and we will know you.”

The key, however, is to make use of this resource beyond the random emergency department visit by a tourist visiting another state. Bonacum says Kaiser is working to automate the IHI’s “trigger tool” strategy that calls for some 20 random chart reviews a month to check if any unnoticed adverse events or patient harm may have occurred. The practice is now done manually at Kaiser, and Bonacum says the goal is to have it done electronically, which would be more efficient in terms of staff time.

Schilling adds that this is also important because programs can flag incidents that are considered adverse events from the eyes of a patient. For example, a patient may be nauseated for several days, and this might not have been officially registered as an adverse event or patient harm but that patient would hold a different opinion.

Massoud says he was particularly excited about a Kaiser project now being tested in which physicians have telephone consultations with patients whose chronic care they are managing. Both doctor and patient view the patient’s medical record on a computer during the discussion.

“Imagine the difference in having a 15-minute phone conversation at home without the driving, waiting and driving back of a typical office visit,” Massoud says. “We realize the future of medicine is in that type of interaction.”

Early indications are that such a method for managing chronic conditions “increases patient satisfaction dramatically,” Massoud says.

Observers agree and say they are glad Kaiser is pushing programs like this forward.

“We think it’s the future as well, but the reason we haven’t seen a lot of uptake is twofold,” says Steven Waldren, a physician who is director of Kaiser’s prominence as a national quality leader. This is consistent with one of the values Kaiser lists for HealthConnect: “KP brand image is enhanced with more patient-centered care and new service modalities.”

Kaiser, however, isn’t the only company conducting high-profile quality-improvement projects. Chicago-based Aon Healthcare has launched its Return on Risk strategy, which Debra McBride, vice president with Aon Risk Services of Minnesota, says “perfectly mirrors” what Kaiser is doing.

The strategy involves establishing hundreds of small regional pilot projects exploring topics such as improving patient flow and removing emergency department bottlenecks and then fast-forwarding the innovations that work into the community, says McBride, an R.N. and an attorney. She says that there are advantages to having big healthcare systems driving the improvement process.

“Data is the key to change,” McBride says. “And having meaningful data requires pooling. That’s why outside assistance has really spurred this movement.”

While large organizations spending millions of dollars grab the lion’s share of the industry’s attention, smaller facilities implementing homegrown quality-improvement efforts are also doing their part to transform healthcare.

“We’re certainly not a Kaiser by any means,” says Cassy Horack, an R.N. who is director of quality and safety at OSF St. Francis Medical Center in Peoria, Ill., a 593-bed facility and the largest in the six-hospital OSF system. “But change can be done, no matter how big or small you are. But you have to have the commitment from the top down. You have to have the culture.”

Continued on p. 13
Tuesday/Thursday evening schedule for busy professionals

646-312-3105

www.HealthCareMBA.org

MARKET PLACE

OSF St. Francis has worked with the IHI and has staff that has done work for the organization. For instance, John Whittington, an M.D. who is the patient-safety officer for the entire OSF Healthcare System, is an IHI faculty member. But the system’s initiatives—such as work on preventing ventilator-associated pneumonia and pressure ulcers—often predate those launched by the IHI or mandated by the Joint Commission on Accreditation of Healthcare Organizations.

Its current ahead-of-the-curve activities along those lines include initiatives on blood-sugar management, anti-coagulation management and deep-vein thrombosis prevention. “We’re always dabbling in something,” Horack says. “You can keep plugging away to do things that are not in the national spotlight.”

Data measurement is a big part of the initiatives, and Horack says one of the keys is to select someone in each hospital department to be a “process owner” who is accountable for the indicators presented in the data. If the indicators on a department’s scorecard fall below an acceptable rate, the process owner is required to develop an action plan to reverse the trend.

This constant measurement is referred to as “practicing in a fishbowl” in one Kaiser document, but Horack says such an approach is welcomed more often than not.

“From a managerial perspective, it’s a huge relief because there’s something you’ve been trying to improve, but haven’t been able to,” she says. “And now you know you’ll get the resources to do it.”

Schilling says Kaiser’s collaboration with the IHI isn’t creating a sense of Big Brother watching them. “It’s not about Don Berwick looking over your shoulder and creating a sense of anxiety,” she says. “They’re helping us rise to the challenge.”

Massoud says that, rather than creating anxiety, staff observation for quality-improvement purposes often relieves worry for many providers who felt hindered by a lack of progress in quality, safety and patient-satisfaction improvement.

“They find a liberation and a means to accomplish why they got into healthcare in the first place,” he says. “I see energy. I see people’s eyes light up.”

Catrina Sniffen, an R.N. at Kaiser’s 218-bed Woodland Hills (Calif.) Medical Center, says staff generally find value in such observations as long as it has a purpose and they’re not just collecting data and tucking it away someplace.

“For me, personally, I don’t feel pressure because it’s part of giving good nursing care,” she says. “Some people need that extra push. ... But I think it’s great that they do track and do studies. That way everyone is informed and, if you need extra help or training, it’s there.”

Continued from p. 12

Using the Six Sigma quality-improvement methodology developed by Motorola to produce nearly defect-free products and services, St. Francis launched its quality efforts in February 2001 with the simultaneous launch of 11 separate projects. “You have to have a methodology; we just happen to have Six Sigma,” Horack says.

Though she credits the Six Sigma system for much of her hospital’s success, Horack says the system doesn’t follow it to the letter.

“They want you to quantify financial gains,” she says. “We’ve taken a stand that—for patient safety—dollars don’t matter when you can save a human life.”