

Clinical Excellence Series

The Ascension Health Journey to Zero: Lessons Learned and Leadership Perspectives

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The article is the tenth and final article of a series, which charts the journey of one health care system, Ascension Health, toward the clinical transformation of inpatient care and no preventable injuries or deaths.

In 2002, Ascension Health articulated a Call to Action to provide Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind. The vision for Healthcare That Is Safe was defined as excellent clinical care with no preventable injuries or deaths by July 2008, which was operationally defined as zero occurrences for each of eight priorities for action (PFAs; Table 1 [page 741]). As described elsewhere,¹ Destination Statement II specified the vision, seven aims of care (the six Institute of Medicine [IOM] quality aims² and care that is spiritual to attend to the whole patient—mind, body, and spirit), 10 rules (also adopted from *Crossing the Quality Chasm*²), five challenges, and three sets of metrics (long-term outcome, short-term outcome, and short-term process metrics). In addition, the PFAs were identified with the support of the Institute for Healthcare Improvement (IHI) and have been validated as a presumptive method to eliminate preventable injuries and deaths.¹

Just months before the July 2008 deadline, the PFAs have been widely implemented throughout Ascension Health, and we have documented substantial reductions in events related to the PFAs.³⁻⁸ Since our work began, at the current rate, we have documented more than 2,000 lives saved a year compared to our baseline mortality (Figure 1, page 740).

A cornerstone of Ascension Health culture is the notion of being a “clinical obligated group” for transparency, support for knowledge transfer, and clinical per-

Article-at-a-Glance

Background: In 2002, Ascension Health, a 65-hospital nonprofit health care system, articulated a call to action to provide Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind. The goal is to provide excellent clinical care with no preventable injuries or deaths by July 2008. Just months from this target date, substantial reductions in events related to eight priorities for action have been documented, and at the current rate more than 2,000 lives a year are being saved compared to the baseline mortality rate.

Building the Agenda for Change: Progress toward the goal of zero preventable injuries or deaths required transformational change. Key steps toward this change included establishing a sense of urgency, creating a guiding coalition (the clinical excellence team), and developing the Destination Statement II. Other key factors in our early success included methods of process and outcomes measurement, the formation of appropriate and diverse leadership groups comprised of primary stakeholders, methods of knowledge transfer, and the involvement and leadership of the Ascension Health Quality Committee and individual health ministry Boards.

The Journey Continues: An ongoing discussion of what “zero preventable deaths and injuries” really means has led to the identification of additional interventions to further reduce preventable injuries and deaths.

Ascension Health System Observed Minus Expected Mortality Rate per 100 Discharges

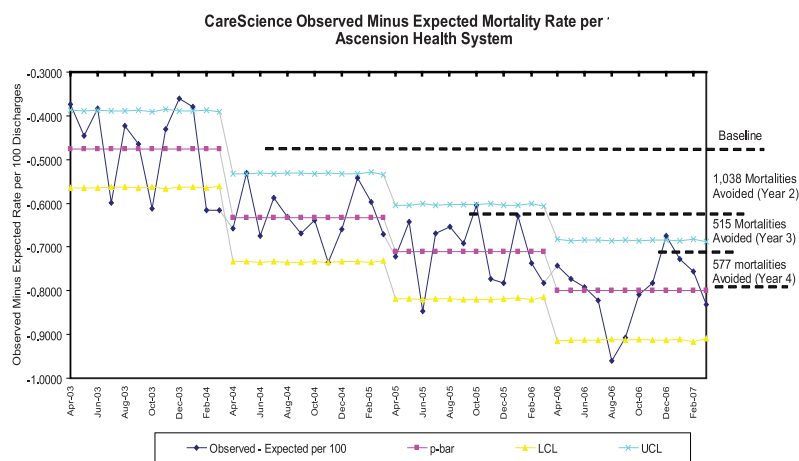


Figure 1. At the current rate, more than 2,000 lives have been saved a year compared to baseline mortality. This figure was developed by Ascension Health using Care Science risk-adjusted data from the Ascension Health Outcomes Measures database.

formance. During the last three years, our employees, clinical leaders, and allied health professionals have partnered with quality, risk, and financial officers and executive leaders at hospitals and the system office to sustain and prioritize the strategic and operational focus to deliver superior PFA performance. This article describes our organizational structures and processes that have facilitated the transformational change of this large, complex health care system.

Building an Agenda for Change at Ascension Health

Ascension Health is the largest Catholic and largest non-profit hospital system in the country. It comprises 65 acute care hospitals in 20 states and the District of Columbia organized into 29 health ministries (each of which represents a group of individual hospitals). The geographical and organizational diversity of Ascension Health was not the only challenge to the goal of transformational change.¹ As others have described, several factors make the health care industry itself refractory to innovation, including competition for patients, conflicting agendas of different stakeholders, complex regulations, the medicolegal environment, inadequate information technology (IT) infra-

structures, and varying reimbursement policies.⁹ With such obstacles, it is no surprise that widespread progress in achieving the delivery of safe health care has been slow and incremental.^{2,10-14}

Successful organizational transformation requires leadership, focus, and execution. It also requires an appreciation and understanding of the long list of reasons why change can be difficult for any organization. Moreover, true transformation, by definition, cannot be implemented only through incremental approaches, but must also address the organizational environment that will permit an accelerated pace. Destination Statement II identified the environmental challenges that needed to be addressed

at Ascension Health (culture, the business case, infrastructure, standardization, and how we work together). In essence, the strategy for Ascension Health focused on large-system change around both our PFAs and challenges.

One relevant perspective on creating major change is described by Kotter (Table 2 [page 741]).¹⁴ In accordance with these principles, clinical performance was elevated in priority at all 29 health ministries. The first steps of this process have been described in detail previously.¹⁵ They included the initial Call to Action in the form of three overarching goals: Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind. These goals were infused by a sense of urgency (step 1) regarding the need to provide completely safe health care. The guiding coalition is represented by the Clinical Excellence Team (CET; step 2). The CET crafted the Destination Statement II, which described the vision and the strategy (step 3) for implementing the Call to Action.¹ This strategy focused on the eight PFAs and the five challenges. Destination Statement II was widely disseminated and adopted throughout the organization, including the board of directors of Ascension Health (step 4). Ascension Health's distributive leadership is modeled by the clinical leadership forum (CLF), where broad-

Table 1. The Ascension Health Priorities for Action

1. The Joint Commission's National Patient Safety Goals and core measures
2. Preventable mortality
3. Adverse drug events
4. Falls
5. Pressure ulcers
6. Surgical complications
7. Nosocomial infections
8. Perinatal safety

Table 2. The Eight-Stage Process of Creating Major Change

1. Establish a sense of urgency.
2. Create the guiding coalition.
3. Develop a vision and strategy.
4. Communicate the change vision.
5. Empower broad-based action.
6. Generate short-term wins.
7. Consolidate gains and produce more change.
8. Anchor new approaches in the culture.

Adapted from: Kotter J.P.: *Leading Change*. Boston: Harvard Business School Press, 1996.

based action ensues (step 5).

Key factors in implementing this agenda included process and outcomes measurement, the formation of appropriate and diverse leadership groups comprising primary stakeholders, methods of knowledge transfer, and the involvement and leadership of the Ascension Health quality committee and the health ministry boards.^{1,15} These factors are now discussed in detail.

MEASURING PROCESS AND OUTCOMES

The PFAs and the methods used to achieve improvements have been discussed previously in this series. To measure and report on process and outcomes for each PFA, as described in the Destination Statement II, each Ascension Health hospital has used manual- and automated-data capture methods. A customized Web-based application was developed for data collection from individual hospitals. Operational definitions for each PFA measure (process and outcome) were adopted from national consensus standards and/or specialty groups for consistency.

This approach reduced redundancy of data collection and allowed for national and internal benchmarking. Definitions were built by group consensus and then standardized to ensure consistency between sites and to generate system-level reports.

In the early months, we relied on administrative coded billing data sets from diagnosis-related group (DRG) screening and the corresponding national Patient Safety Indicators (PSI) defined by the Agency for Healthcare Research and Quality (AHRQ) complication codes.¹⁶ However, hospital leaders quickly realized that coding variability can influence the validity of the outcome data. The objective was to measure true clinical outcomes rather than billing criteria; therefore, our clinical leaders chose to increase the reliability of PFA reporting by selecting the few vital measures needed to detect improved performance related to the specific interventions. Because improvement could be detected through the regular reports, these data became a critical driving force for the reinforcement of practice and behavior changes aligned with PFAs.

For example, nursing chose both to perform a systemwide annual pressure ulcer prevalence audit for all patients and to measure monthly occurrence rates for all admissions. This discrete level of outcome data enabled timely reviews of hospital performance at the monthly system chief nursing officer advisory council (CNOAC) meeting, which gave the key stakeholders (in this case, nursing) an opportunity to intervene and collaborate as needed to improve outcomes for these and other PFAs.

Transparency. The willingness of our hospitals to share individual performance data has promoted sharing of best practices and the various techniques used to implement or resolve hospital-specific barriers to execution of the bundles, protocols, and standards for each of the PFAs. These standardized data sets, including core measure performance, were included in a standard report format produced by the system office. Performance of all organizations across the system was shared with their board members.

Efforts are also being made to bring this internal transparency into the public domain. An evaluation process is currently underway to expand the public reporting of outcomes metrics. At the hospital level, patient and family representatives are being integrated among the key stakeholders on boards and in community groups.

ORGANIZATIONAL STRUCTURE

The importance of leadership and organizational structure in the implementation of this agenda cannot be overemphasized. In the distributive leadership model, the overall system recognizes and draws on the skills and vision of leaders distributed throughout the 29 health ministries. Each of these leaders contributes to the system agenda and helps to establish the sense of urgency and to communicate our vision of transformational change. Key elements of the organizational structure of Ascension Health are summarized in Table 3 (page 743).

Committee Structures and Shared Governance. The CLF had significant influence on the building of systemwide consensus on a variety of issues and has continued to set direction on behalf of the broader CLF. A key evolution of the medical and nursing leadership has been the development of respective committee structures linked to the CET and the CLF. These committees are used to build consensus on specific topics (clinical, informatics, supply chain) and to determine the best course of action. A central theme for these groups has been standardization “where it makes sense,” fully recognizing the diversity of the larger system.

Examples of standardization include care bundles created around the PFAs, such as the pressure ulcer bundle termed SKIN (surfaces, keep the patients turning, incontinence management, nutrition management); these bundles are described in detail elsewhere.^{1,3-8} For many PFAs, a single standard of care was created and adopted at local health ministries.

Ascension Health has been able to spread knowledge and change quickly through a series of short steps by keeping committees to a minimum and ensuring that the key stakeholders are able to make change. These groups are chaired by our health ministry leaders and their membership is composed of their peers for the topic area. Special attention has been given to ensure the committees are “cross-seeded” to maximize integration and continuity of decision making in and among the groups.

For example, the CNOAC has the ability to process systemwide topics in their “pod” structure. Each CNOAC member takes the agenda from the council to a regional chief nursing officer (CNO) monthly telephone meeting, where a smaller group can provide input and build consensus on the same topic. The recommendations from

each pod come back to the CNOAC for a single outcome, where the group can quickly authorize and empower systemwide decisions.

Our efforts to reduce pressure ulcers, for example, led to a systemwide assessment of bed frames and surfaces. The audit identified more than 60 types of bed frames across the system that could be reduced to just a few. To support the pressure ulcer PFA, a business case proposition was generated for an organizationwide bed-replacement plan to align practice, process, and technology. The systemwide business case led to a strategic partnership with a health care equipment corporation and a group purchase of \$60 million in capital replacement that was fully supported by our chief executive officers (CEOs) and chief financial officers (CFOs). As in any hospital setting, competition for capital is extreme. The value proposition and business case jointly led by finance and clinical excellence was based on four cross-cutting deliverables inherent in the advanced bed technology:

1. Reduction of caregiver work-related injuries
2. Surfaces designed to prevent skin breakdown for all patients
3. Rotational therapy aimed to reduce ventilator-acquired pneumonia (part of the nosocomial infection PFA)
4. Reduction in rental expenditures

This case was one of Ascension Health’s first examples of a PFA being used to drive quality and cost reduction to support the practice change.

Another example of a key committee linked to the CET was the implementation support group for the electronic medical record implementation. With broad representation and empowered decision making, this group was able to balance the advantages of standardization with the inherent difficulty in broad-scale implementation, while creating a reasonable cycle time for decision making.

Steering Committees and Affinity Groups. The original work for each of the PFAs was first implemented at our nine alpha sites.¹ Alpha sites were selected on the basis of several factors, including a strong desire to test and implement process improvements for the PFA and to relay this information to others. Although it was initially estimated that it would take 18 to 24 months for other health ministries to join the alpha site in implementing the PFA, the process occurred much more quickly. In a type of rapid

Table 3. Key Elements in the Organizational Structure of Ascension Health*

| Committee and Membership | Charter | Links and Purpose |
|--|---|--|
| <p><i>Clinical Excellence Team</i></p> <p>CEO, CIO, CMO, CNO, pharmacy, information services</p> | <p>Provides strategic direction and tactical input for the vision and goals for clinical excellence and the related subgroups</p> | <p>Links to CLF, all chief medical and nursing officers, quality and risk professionals, presidents of the medical staff</p> <p>Provides broad oversight and consensus-driven validation for systemwide initiatives recommended by CET</p> |
| <p><i>Patient Safety Advisory Council</i></p> <p>CMO, CNO, pharmacy, risk professionals</p> | <p>Provides recommendations to the CET in specific areas of adverse events and/or patient safety-related topics</p> | <p>Links to CET for integration of approaches and process(es) related to the vision and goal; assists local health ministry patient safety councils</p> |
| <p><i>Affinity Groups</i></p> <p>Membership and chairs vary according to topic area. Key stakeholders populate these focused groups from the ministries. IHI and external experts for the specialty area provide additional expertise.</p> | <p>Provides ministry-based leadership to the specific PFA to maximize topic/clinical expert input; provides definitions and metrics for outcome measurement</p> | <p>Reports to the CET for action and approval of tactics. Most have spread bundles/practice and measures systemwide through the CLF.</p> |
| <p><i>Informatics Subgroups</i></p> | <p>Provides clinical expertise in the design and development of order sets, protocols, measurement, and prompts/alerts within the electronic record</p> | <p>Reports to the CET and various Information Services groups for integration of practice guidelines, assessments, tools, and forms to ensure that standards are integrated into the electronic record</p> |
| <p><i>Business Case Development</i></p> <p>An analysis of each PFA is jointly led by finance and clinical excellence.</p> | <p>Development of a business case for each PFA to determine impact (human and fiscal)</p> | <p>Reports to the CET, CLF, and administrative and CFO groups</p> |
| <p><i>Physician Specialty Groups</i></p> <p>Chiefs of staff/president of medical staff, specialty and subspecialty physicians</p> | <p>Provides strategic and thought leadership on a variety of topics (practice, IT, education, alignment)</p> | <p>Reports to the CET and CLF for clinical recommendations; advises other specialty groups based on topics</p> |
| <p><i>Chief Nursing Officers</i></p> <p>Representative CNOs. Each chair regional pods (small clusters of CNOs) for a shared governance model of decision making.</p> | <p>Provides strategic and thought leadership for system-led initiatives (practice, IT, workforce, innovation, measurement, research)</p> | <p>Reports to CET and CLF</p> |

* CET, clinical excellence team; CEO, chief executive officer; CIO, chief information officer; CMO, chief medical officer; CNO, chief nursing officer; IHI, Institute for Healthcare Improvement; PFA., priority for action; CLF, clinical leadership forum; IT, information technology.

assimilation termed *viral spread*, within months nearly all the health ministries had already joined each of the PFA efforts.

As the number of health ministries participating in each PFA increased, it became necessary to establish a system-level course of action to support and promote large

group communication, peer-to-peer interaction, and the sharing of documents, literature reviews, external experts, and best practices from Ascension Health and other health care systems. Within a few months, an affinity group or a steering committee corresponding to each PFA was created to set agendas and time frames and to plan for short-

term wins. The affinity groups and steering committees helped to consolidate gains and produce more change.

Systemwide Summits. Implementation of each of the PFAs has benefited from our system summits. Each summit is a large PFA-focused meeting planned by the system office director liaison and the corresponding affinity group. External and internal experts are sought to deliver state-of-the-art content in a rapid design format. Although these meetings often take weeks to plan, they deliver superior results in a short period. Significant strategic resources were approved for system summits and affinity group activities at both the system and local ministries. The key attributes of these meetings are listed in Table 4 (right).

System summits generally host 120 to 300 attendees, including practicing physicians, nurses, educators, quality professionals, pharmacists, and allied health professionals. The impact of having these key stakeholders meet face-to-face early in the process has been a critical success factor in the rapid spread and dissemination of organizational knowledge and in building personal and organizational will. For example, at a 2005 summit on pressure ulcers, participants voiced unanimous support for a standardized pressure ulcer assessment, prevention, and treatment program using the SKIN bundle—and committed to implementing the SKIN bundle by January 1, 2006.^{8,17}

Knowledge Transfer

A key enabling infrastructure to support the summits and the affinity groups has been the development of the Ascension Health Clinical Excellence Exchange home page. The intranet provides space to post, communicate, and share key documents across 20 states. Several iterations have occurred during the last three years as groups changed and evolved, and the volume of material has grown. Conference calls and Web-hosted meetings allowed for dynamic sharing of slides and real-time on-screen dialogue. In addition, the system office has generated CNO and chief medical officer newsletters to enhance communication within their respective peer groups. Listserves for each group have been established to provide easy access for quick posts or questions regarding quality, regulatory, or specialty topics with all health ministries. Listserves provide a push-pull capability that permits a quick way to transfer questions, knowledge, and even alerts.

Table 4. Key Attributes of Systemwide Summits

- The agenda is driven by the Ascension Health mission and values designed to fulfill our Call to Action and our 2008 goal.
- Key stakeholders must be carefully identified by the individual health ministry based on the priority focus area topic.
- Those closest to the care or problem should be the representative majority and a critical core of the group process.
- Objectives are clearly identified by the affinity group, and this drives the entire agenda, speakers, and group process.
- The best-in-class knowledge sources are sought to provide the content for the audience.
- Real-time voting technology (table-top electronic voting) is often used during a meeting to process small-group work with the larger attendee group throughout the meeting.
- Health ministry groups are provided adequate time to network, collaborate, and socialize with all attendees during the meeting.
- Listserves and technical support are set up prior to the meeting so when the summit ends all participants are already connected.
- Debate, dialogue, and active discussion is the group norm, reflective of our Ascension Health model work life community values.
- Summits often produce “toolkits” that are comprehensive packages of tools, education, and measurement tools so everyone is ready to implement within days of the meeting.

The Role of Boards

In March 2006, midway through our journey, the quality committee of the Ascension Health board of trustees chose to explore more fully the relationship between the local health ministries and their respective boards' focus on quality. The quality committee, with full support of our CEOs, chartered a CEO/board survey to measure the perceived role of the quality board chair and the CEO in organizational quality. Ascension Health CEOs identified the appropriate committee chair (quality, safety, board) for survey distribution. A total of 29 CEOs and 33 board chairs (two sites had two chairs respond) completed the 36-item questionnaire, representing all our health ministries. A tool was adopted from the 2004 American Hospital Association and the Centers for Medicare & Medicaid Services project for the purpose of comparison.

Table 5. CEO/Board Survey Results: The Most Significant Changes Required to Improve Patient Care Quality and Safety*

| Area | Recommended changes |
|--------------------------|---|
| 1. Technology/Data | <ul style="list-style-type: none"> ■ Standardized measurement ■ Computerized physician order entry ■ Enhanced clinical technology to support care process ■ Access to performance data quickly ■ Turn data into timely information |
| 2. Reimbursement | <ul style="list-style-type: none"> ■ Focus of payment based on quality and outcomes |
| 3. Learning Organization | <ul style="list-style-type: none"> ■ Culture (organization/safety) and collaboration ■ Knowledge transfer ■ Standardized measurement for comparative purposes ■ High-reliability characteristics and measurement |
| 4. Physician | <ul style="list-style-type: none"> ■ Alignment and engagement ■ A full-time CMO leading quality/safety ■ At-risk compensation aligned with clinical outcomes ■ Standardization |
| 5. Regulatory | <ul style="list-style-type: none"> ■ Aligning The Joint Commission accreditation procedures with strategy |

* CMO, chief medical officer.

More than 400 boards in nine states were included in this study, and the results were compared with the Ascension Health data set.

Key findings of this survey were as follows:

- Many similarities were present between our CEO/board responses and the comparative database responses.
- 100% of Ascension health ministries have an active patient safety committee, and most meet quarterly or monthly.
- Time spent on quality at governance meetings is perceived to be greater at Ascension Health than the comparative profile.
- Formal metrics and measures are more prevalent at Ascension Health (for example, scorecards).
- 93% are willing to share their formal board report with other boards.

The various domains from the survey have been linked to tactics used in the implementation of the PFAs. The most significant changes required to improve patient care quality are listed in Table 5 (above). Overall, there was close correlation between board and CEO perceptions regarding the need to measure performance against stan-

dardized measures, to devote significant time to improving the measures, and to give the necessary attention to it as a governance priority. Key themes included enabling infrastructure and physician alignment. There was also a stated desire to use standardized measures and to collaborate.

Board Scorecard. A single Ascension Health scorecard was developed by building consensus regarding how to report PFA and core measures in a standardized format for all Ascension health ministry boards and CEOs. The scorecard also illustrates the intentional effort to align all executive goals and performance-based compensation plans with the Call to Action.

The scorecard clinical goal has been aligned with the overall clinical goals of the organization to ensure focus on and execution of the clinical priorities.

CEO Perspectives

The perspectives of three CEOs of individual health ministries within Ascension Health, summarized in Table 6 (page 746), provide an in-the-trenches perspective on the implementation of this systemwide initiative, including insight into potential barriers, the importance of leadership, and strengths of the Ascension approach.

There were several important commonalities. First, all the CEOs noted that they and their boards were inspired by the Call to Action and, in particular, by the goal of zero preventable injuries or deaths. All cited patient safety as among their main priorities as CEO. Second, overcoming organizational culture was a common theme. Cultural barriers included blame-based analysis of errors and clinical inertia regarding the attempt to improve safety. Third, all PFAs had been implemented at all sites in these health ministries, and the patient safety goals were integrated into health ministry agendas.

Table 6. Summary of Health Ministry CEO Perspectives on the Process of Implementing PFAs*

| Theme | Summary | Quotation |
|-------------------|---|---|
| Motivation | The Call to Action is a powerful and inspiring motivator. The passion inspired by these goals was central to the CEOs' own priorities and a key element in leading their organizations to change. | "There is one thing we ought to be explicit about: the notion that people go into health care for a reason. That reason is deeply a part of who they are. One of the really terrific things about this particular initiative is that it allows people to get back in touch with that reason." [L.B.] |
| Priority | Patient safety must be a main priority for the CEO, the board, and all employees within the system. Prioritizing patient safety means integrating this objective into overall system goals, as well as spending significant time and resources on implementing PFAs and analyzing progress. | "One of the things that worked well for us was integrating patient safety into the overall operational objectives of the organization. There aren't just patient safety objectives, and then financial objectives; all of that and everything else we do here gets integrated into a single operational plan." [L.B.] |
| Leadership | Leadership was critically important to implementing the PFAs. Elements of leadership included spending adequate time on safety issues, demonstrating the need for improved patient safety, dedicating appropriate resources, and motivating for organizational change. | "The leadership involves two elements. First, the CEO has to be passionate about it. Second, the people at the next level on both the physician and the nursing side must also be passionate. They have got to be zealots for patient safety." [L.B.] |
| Culture | Specific cultural issues were cited as barriers to overcome as part of implementing the PFAs. These issues included the "blame-based" culture, and the inertia of believing that the current level of care is adequate. | "The biggest achievement for me is the change in mind-set of doctors and nurses that bad things are going to happen to a subset of patients. What is happening now with the initiatives is 'Nobody deserves to have this happen to them.' It is a huge defeat when one of these things happens. And that for me—changing the mind-set—does more to create a culture of safety than anything else." [L.B.] |
| Transparency | Transparency allows for close inspection of problems, provides for input from multiple viewpoints, allows for the celebration of successes, and assists in the rapid dissemination of information within and between health ministries. | "I don't know of any better way than to show your warts, because we all hate it when we look bad. Shine a bright light on your organization so you understand where you need to improve, what you need to do to be world class." [L.B.] |
| Metrics | Having quantifiable metrics helps to define the problem and to monitor progress. The regularity of measuring is also important (e.g., weekly vs. quarterly). | "Setting a clear target, as high as that might be, that was quantifiable was part of what made the difference [in joining Ascension Health]. We had quality objectives before, but I think what made the difference was targeting them very clearly in terms of metrics." [S.J.] |
| Sequencing | Implementing the PFAs often required prioritizing and sequencing of events. This involved prioritizing organizational needs such as finances and infrastructure, as well as understanding which PFAs to implement first at which sites. | "We developed an approach which we've called 'Sequencing,' thinking about what order we do things so that we don't create problems. We began to identify the ones that would have the greatest impact." [C.B.] |
| Value Proposition | CEOs all noted that certain aspects of implementing the PFAs required specific financial investments. They provided differing responses with regard to case mix index and overall reimbursement rates. The relationship between implementation of the PFAs and financial outcomes has not been completed. | "We have seen some great results, and if you look at operating efficiencies—cost per discharge, length of stay reduction, increasing case mix index—we can see real results here. Can we tie them directly to the safety work? I know that the system is challenged by coming up with these metrics." [S.J.] |

* CEO, chief executive officer; PFA, priority for action.

The Role of Process Improvement and Journey to “Zero”

Even as Ascension Health has made tremendous progress toward the 2008 goal for each of the PFA categories, there has been a philosophical discussion regarding what “zero preventable deaths and injuries” really means. Initially, the decision was made not to spend valuable time debating what was and was not preventable, knowing that over time this would likely change. Rather, we agreed to track every event associated with each PFA, with a zero rate as the goal. Key points abstracted from this discussion included several important reflections. There has been a general recognition that the closer an organization gets to zero, the more difficult it becomes to eliminate these final events. This does not mean drawing back from our system goal of zero events but rather identifying variation that occurs as the rate of events approaches zero. Eliminating this variation is what differentiates performance.

We believe that several factors account for this difficulty. First, the bundles, standards, and processes put in place to eliminate PFA-related events and harm will not address all possible clinical situations. For example, the system pressure ulcer occurrence rate is slightly above 1/1,000 patient-days. In the few cases remaining, our alpha site has identified a small population of patients who receive the SKIN bundle⁸ in place with full compliance but still have skin breakdown. Careful process tracking has revealed a subset of clinical symptoms in these patients that includes compromised cardiovascular and vascular status, suggesting a skin failure condition that may not be preventable due to underlying patient pathophysiology. We suspect that this population will be very resistant to the conventional protocol and that additional interventions may be required.

Second, building the organizational capacity for sustainability must include the ability to track event occurrences not just for our PFA categories but for all other events. Doing so brings us much closer to measuring reliability and performance because all events can be classified for severity and causal analysis. Each PFA is now being tracked for all events to identify trends and latent failures within our hospitals that might otherwise go undetected. The individual hospital summary of root causes helps Ascension Health amass and analyze these events for rapid trend analysis. In effect, this process serves as an early

detection system by which similar patient populations and events can be shared across multiple environments. The process also enables a seamless transition to methods appropriate to high-reliability organizations, in which each event, near event, and antecedent must be investigated to further reduce “defects.”

Third, as medical and nursing interventions advance and disruptive technologies become common practice, what was once viewed as nonpreventable becomes a moving target. For example, mortality rates associated with coronary heart disease decreased by over 40% between 1980 and 2000 because of reductions in risk factors and the use of evidence-based medical therapies.¹⁸ We believe this will be the case for many of the PFAs as well. We have built the 2008 Ascension Health scorecard on this rationale. The scorecard goal is intended to transfer responsibility for operational performance for each PFA to the health ministry leaders. The role of the system office will be to support the efforts by disseminating organizational knowledge from groups and from the causal analysis of the summarized event data. The PFA and event outcome data will be generated from our self-reported standardized PFA data sets and from the standardized event reporting system, known as SafERSystem. The goals set by organizational scorecards from 2005 to 2008 correlate with advances in performance.

Barriers to Implementation

Potential barriers to implementation have been described previously.¹⁵ Confounders faced by health care organizations include the malpractice environment and reimbursement issues. Transparency, for example, can be problematic because some clinicians may resist efforts toward full disclosure. Shifting reimbursement policies complicate matters further. However, Ascension’s success may ameliorate some policy changes, such as reduced reimbursement for preventable conditions by the Centers for Medicare & Medicaid Services beginning in October 2008.¹⁹

Other barriers include the alignment and commitment of key players and the allocation of resources. Surveys at Ascension revealed a schism between clinical and administrative staff with regard to perceptions of safety; administrative staff ratings of the safety climate were three times higher than those of the clinical staff. The task of bringing these disparate perspectives together fell to the individual

Table 7. Progress on the Journey to Zero*

| Questions at the Outset | Current Status |
|---|---|
| How will we respond to hospitals that may be slower to adapt? | All Ascension Health ministries have fully embraced the PFA work. For those who are not yet at zero, an intensive look into variation and root cause analysis is underway. |
| What will be the capital implications? | PFA categories have required new capital investments as described (bed frames and surfaces, monitoring devices, and simulators). Results have shown benefit with each investment. |
| What will make the investments feasible? | Business case reviews are in place to monitor impact (human and fiscal). Not all investments will generate a positive financial return. Patient safety and care quality are the determining factor. |
| Will we be able to engage frontline caregivers in rapid adoption? | Caregivers have been involved in the development of all protocols and bundles. Adoption has not been trouble free but much easier than anticipated. We attribute this to local leaders who have been steadfast as the primary sponsors at each ministry. |
| Will we be able to sustain early gains? | Our results demonstrate sustainability up to this point. The process(es) and practices have been engrained into educational programming, inclusion in the electronic health record forms and tools, and continued transparency in systemwide scorecard reports. |

* PFA, priority for action. Questions adapted from Pryor D.B., et al.: The clinical transformation of Ascension Health: Eliminating all preventable injuries and deaths. *Jt Comm J Qual Patient Saf.* 32:299–308, Jun. 2006.

health ministry leadership.

Allocating sufficient funds required system and local commitments. Initially, local resources were dedicated to funding managers for each of the nine alpha sites. System funds were used for strategic investments in meetings and resources, and health ministries shifted capital to the systemwide bed-frame initiative. Thus, leadership alignment and allotment of strategic capital were required both from the top down and the bottom up.

Discussion

In large complex systems, the balance between “systemness” and local leadership requires continuous reflection and discernment. The value of working as Ascension Health is apparent in our system PFA results, yet the success has been driven from the health ministry leadership working at the local hospital/system level. The improvements have been the result of the work of thousands, including medical and nursing leaders, allied health professionals, all our employees, executive leaders, and CEOs and their boards. We have learned a great deal about how to balance the expected tension between these components while demonstrating significant improvement in saved lives and improved clinical performance. Some of

these lessons are illustrated in Table 7 (above), which outlines current status with regard to questions we posed at the outset of our journey.

The transformational process has moved from a period of strategy and development, through the testing and validation of the PFAs, and now into operations (Figure 2, page 749). As such, our commitment to health care that is 100% safe is only just beginning. A business case for each of our PFAs will be completed by June 2008 to describe the operational impact of eliminating or nearly eliminating these events from our hospitals.

The journey to zero is by no means finished. Just as continuous improvement models suggest, and as true learning organizations know, the pursuit of excellence is never really complete. Ascension Health’s 2020 Strategic Direction acknowledges our aim and desire to develop transformational care models in unique and expanded care environments while targeting chronic disease, meeting the needs of the underserved and underinsured, and improving community health, all while providing an exceptional patient experience. Our 2015 goal is to expand the PFAs beyond the level of acute care into all aspect of health care. The relentless pursuit of clinical excellence, therefore, continues beyond the hospital setting into the community.

A Framework for Clinical Transformation

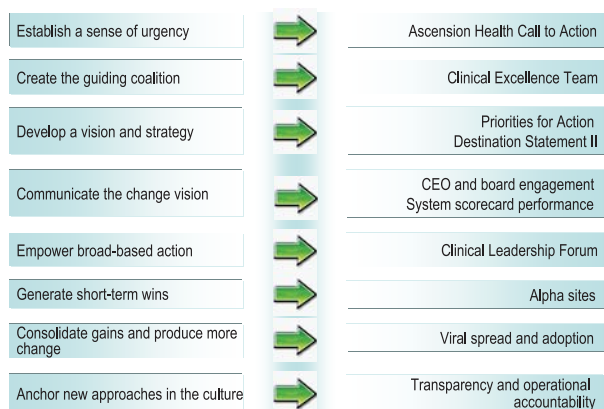


Figure 2. The transformational process has moved from a period of strategy and development, through the testing and validation of the priority focus areas, and now into operations. CEO, chief executive officer.

This migration and diversification will present additional challenges to improve safety, quality, and efficiency with patient-centric care that addresses the entire patient's need and is spiritual in nature. Our journey and learning will continue for the foreseeable future. Hence, our desire to learn from others who share our goal has been our primary objective in publishing this series of articles. We strongly encourage others to share their improvement journey as well so we might all advance quicker by being more informed in pursuit of clinical excellence with “zero preventable injuries and deaths.” ¹

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