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To assist you in implementing the proven interventions of the Institute for Healthcare Improvement's "100,000 Lives Campaign," the American Medical Association (AMA) is pleased to provide Doctor-to-Doctor resources from physician colleagues already involved in the campaign. Based on personal experience, they offer information, case examples, action plans and advice. You will also find communication models and tools to manage data and assess progress toward campaign goals.

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University of Missouri, Kansas City School of Medicine, Kansas City, Mo.

## Doctor-to-Doctor resources for the Making Strides in Safety® program

# A Staff Leadership Model for Implementing the “100,000 Lives Campaign”

**Carol Bayer, MD, Medical Director, East Jefferson General Hospital in Metairie, La.**

Soon after East Jefferson General Hospital in Metairie, La., enrolled in the Institute for Healthcare Improvement’s (IHI) “100,000 Lives Campaign,” Dr. Carol Bayer, the hospital’s medical director, embraced the IHI message: “signing on to the campaign is not enough; hospitals must plan and execute specific, significant changes in care design and processes.”<sup>11</sup> Dr. Bayer quickly incorporated the principles of the “Seven Leadership Leverage Points for Organization-Level Improvement in Health Care”<sup>12</sup> to execute East Jefferson’s campaign plan, including:

- Establish and oversee system-level aims for improvement at the highest levels of leadership and governance
- Align system measures, strategy, and projects in a leadership learning system
- Channel leadership attention to system-level improvement
- Get the right team on the bus
- Make the CFO a quality champion
- Engage with physicians
- Build improvement capability

### Dr. Bayer’s plan

1. Assign one executive leader and one Medical Executive Committee (MEC) member to each project.
  - Establish that MEC representatives “own” their project.
  - Establish that MEC representatives are expected to report on their respective projects at every MEC meeting. MEC representatives may assign other medical staff members to do the actual hands-on committee work, but they are responsible for presenting the actual report.
2. Put together books for each team that include the IHI information, “getting started” guides, and copies of the cited literature.
3. As the first step in implementation, require MEC representatives and each team to participate in either live or taped IHI teleconferences on each of the initiatives/interventions.
  - Dr. Bayer reports that, in general, each MEC leader assigned to the project took the lead as the intervention’s chair when they reached that point in the implementation plan.
4. Place quality management staff on each team who can rapidly respond to medical staff requests for data.
5. Establish and analyze baseline data for each of the initiatives and each of the components within that initiative.
  - Dr. Bayer reports that these were “some pretty shocking data” and “really poured gas” on the whole project.
6. Set goals for each project.

To measure campaign progress, Dr. Bayer utilized the “Leadership Leverage Points Self-Assessment Tool for the 100,000 Lives Campaign<sup>3</sup>,” a tool specifically designed to assist campaign leaders in designing, planning and attaining campaign goals.

## A Staff Leadership Model for Implementing the “100,000 Lives Campaign,” *continued*

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### Results of Dr. Bayer’s plan

Dr. Bayer reports that, because an elected MEC leader owns each project, the recommended interventions have been met with little to no resistance from the entire medical staff. They see these interventions as coming from the medical staff, not the administration and, therefore, understand that they have been studied and make clinical sense.

Dr. Bayer said that it is not necessary for every medical staff member to know what the “100,000 Lives Campaign” is—it is only necessary that they agree to change something about their methods because doing so makes good medical sense.

“We ran into a tiny bit of trouble when we bypassed an important medical staff committee and brought something to them as a done deal instead of as a proposal for them to contribute to,” she said.

“To this point, we have struggled with our data in regards to congestive heart failure and pneumonia (JCAHO and CMS requirements),” she continued. “We now plan to start two new teams using the same 100,000 Lives format.”

- 1 J. Reinertsen, MD; M. Pugh; M. Bisognano; J. Pearce; C. Beasley. *Leadership Leverage Points for Organization-level Improvement: What Will it Take to Move Big Dots?* Institute for Healthcare Improvement Innovation White Paper; March 5, 2005. Available at [www.ihl.org](http://www.ihl.org)
- 2 J. Reinertsen, MD; M. Pugh; M. Bisognano. *Seven Leadership Leverage Points For Organization-Level Improvement in Health Care*. Institute for Healthcare Improvement Innovation Series; 2005. Available at [www.ihl.org/NR/rdonlyres/C84E1503-C05E-4D1B-B8D5-C74CEFE68F7F/0/LeadershipWhitePaper2005.pdf](http://www.ihl.org/NR/rdonlyres/C84E1503-C05E-4D1B-B8D5-C74CEFE68F7F/0/LeadershipWhitePaper2005.pdf)
- 3 J. Reinertsen, MD; M. Pugh; M. Bisognano. *Seven Leadership Leverage Points For Organization-Level Improvement in Health Care; Appendix A*. Institute for Healthcare Improvement Innovation Series; 2005. Available at [www.ihl.org/NR/rdonlyres/C84E1503-C05E-4D1B-B8D5-C74CEFE68F7F/0/LeadershipWhitePaper2005.pdf](http://www.ihl.org/NR/rdonlyres/C84E1503-C05E-4D1B-B8D5-C74CEFE68F7F/0/LeadershipWhitePaper2005.pdf)

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# Biography



**Carol L. Bayer, MD**

Dr. Bayer is a board-certified psychiatrist and was a partner at Jefferson Psychiatric Associates in Metairie, La. She was elected to serve as vice-speaker of the Louisiana State Medical Society (LSMS) House of Delegates in October 2000, and has held numerous committee appointments in state and local societies and on hospital medical staffs.

In December 2001, Dr. Bayer was elected to serve on the governing council of the American Medical Association (AMA) Organized Medical Staff Section, and served on the council through 2005. She received her medical degree from Cornell University Medical College in New York, completed an internship at Long Island Jewish Hospital and served as chief resident at Louisiana University Medical Center in New Orleans. In addition to the LSMS and the AMA, she is a member of the Jefferson Parish Medical Society, the Louisiana Psychiatric Medical Association and the American Psychiatric Association.

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# “100,000 Lives Campaign” Initiatives Tracking Template

**Joseph L. Murphy, MD, Medical Staff Immediate Past President, St. Joseph’s Hospital, Chicago**

Timing is everything. In December 2004, when Joseph L. Murphy, MD, introduced John C. Nelson, MD, who was serving as the American Medical Association (AMA) president at the time, to physicians and administrators at a meeting for the St. Joseph Hospital medical executive committee, he also introduced the hospital to a breakthrough campaign. Dr. Murphy, a governing council delegate to the AMA Organized Medical Staff Section, along with the rest of the committee listened while Dr. Nelson told them about the Institute for Healthcare Improvement’s “100,000 Lives Campaign,” and the AMA’s role as a strategic partner. Dr. Murphy relates that the medical staff and administrators “bought into” the campaign at the meeting, which distinguished St. Joseph Hospital, a 335 bed hospital in Chicago, as one of the earliest enrollees in this national campaign to improve processes of care.

At the time of its enrollment in the campaign, the hospital was already working on a number of safety initiatives, but was able to incorporate the campaign interventions into their 2005 quality and safety goals. Dr. Murphy credits Carol Schultz, director of quality outcomes, and her team with maintaining a culture of safety and quality improvement that facilitated St. Joseph’s ability to implement all six of the campaign’s interventions.

The next steps were critical to ensuring the campaign’s success. The hospital engaged its physicians, initiated policy changes to facilitate the campaign’s data collection process, and developed a tool that could easily and creatively reflect the hospital’s activities and show the hospital’s data.

St. Joseph’s identified physicians with a history of interest in patient safety and quality to champion the campaign interventions. The hospital overcame barriers to participation by demonstrating the campaign’s benefits. Campaign progress is posted in the hospital cafeteria where all can see the hospital’s progress and goals.

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# Biography



### **Joseph L. Murphy, MD, FACP, AGSF**

Dr. Murphy has been in solo practice as a primary care physician for more than 30 years. He is also an assistant professor of medicine at Northwestern University Medical School, where he received a Feinberg award for more than 25 years of service as an instructor.

Dr. Murphy is board certified in general internal medicine (GIM) and geriatric medicine. He received his medical degree from Stritch Loyola Medical School in Chicago. He remained in the city to complete his residency training at St. Joseph Hospital, where he later became the chief and program director of GIM. He also served as acting chairman of medicine and as an ongoing member of the teaching service.

As a committed member of the medical staff at St. Joseph Hospital, Dr. Murphy was elected president of the medical staff on two occasions; served as chair of the quality improvement, bylaws and medical executive committees; and currently is the immediate past president of the medical staff.

He is deeply involved in the Institute for Healthcare Improvement's "100,000 Lives Campaign" at his hospital through the efforts of the American Medical Association's (AMA) Organized Medical Staff Section (OMSS) Governing Council. Dr. Murphy has been the AMA-OMSS representative for St. Joseph Hospital for more than 20 years. In addition, he has served as a director on the St. Joseph Hospital Board and is a past chairman of medicine at Lincoln Hospital in Chicago.

Dr. Murphy is the AMA-OMSS delegate to the AMA House of Delegates. He is also a lifetime member of the AMA, whose energy and dedication have made him a highly successful membership recruiter.

Dr. Murphy's local involvement and leadership in organized medicine include: president of the Chicago Medical Society (CMS); vice president of the Illinois State Medical Society (ISMS); and president of the Illinois Society of Internal Medicine. He has written numerous articles and resolutions and given many lectures on physicians' rights and bylaws issues. Currently, he serves on physician advocacy committees at both CMS and ISMS.

Dr. Murphy has received numerous leadership awards including two as a "Top Doctor" by Castle Connelly. He is a fellow of the American College of Physicians, American College of Medical Quality, Chicago Institute of Medicine and the American Geriatrics Society.

At the Joint Commission on Accreditation of Healthcare Organizations, Dr. Murphy serves as the AMA representative on the Professional Technical Advisory Committee on Long Term Care and Assisted Living.

Dr. Murphy and his wife, Marilyn, have been blessed with seven children and seven grandchildren.

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# Developing Acute Myocardial Infarction Protocol

Peter M. Kerwin, MD, Medical Director, Cardiac Catheterization Laboratory,  
Advocate Good Samaritan Hospital, Downers Grove, Ill.

### Background

One of the six evidence-based planks of the Institute for Healthcare Improvement's (IHI) "100,000 Lives Campaign" includes delivering reliable care for acute myocardial infarctions (AMI). Following are recommendations to help implement the intervention and frequently asked questions on the AMI protocol.

Based on strong, evidence-based literature, the American College of Cardiology (ACC) recommends that the following seven key care components should be provided to all AMI patients:

1. Early administration of aspirin
2. Aspirin at discharge
3. Early administration of beta-blocker
4. Beta-blocker at discharge
5. ACE-inhibitor or angiotensin receptor blockers (ARB) at discharge for patients with systolic dysfunction
6. Timely initiation of reperfusion (thrombolysis or percutaneous intervention)
7. Smoking cessation counseling

### Implementation and barriers to implementation

#### Question:

We often hear that the improved AMI care interventions are not applied uniformly to patients with AMIs. What are your suggestions and solutions that may assist in overcoming barriers to adopting the AMI interventions?

#### Answer:

##### 1) Improving door to balloon time:

First get the diagnostic ECG. Any adult with chest pain (no matter how atypical) should have an ECG by protocol less than 10 minutes after arrival. Treatment of acute ST-elevation myocardial infarction (STEMI) is a time sensitive event. Timely diagnosis, treatment and reperfusion of our patients requires that hospital resources be immediately diverted to our patient's care.

Then initiate an immediate response. Preliminary diagnosis and ECG in the field by paramedics have allowed us to greatly improve our time to diagnosis and intervention in acute STEMI, leading to significant improvements in door to balloon time. Similar changes have been made to the way our walk-in patients with chest pain are triaged. We initiate our call-in of interventional cardiology and cardiac cath lab based upon the assessments done by the first providers, the paramedics and the triage nurses.

Everyone needs to know their role. Physicians across departments (ED, primary care and cardiology) must quickly coordinate their efforts. We have attempted to model our approach similar to how a trauma center approaches a trauma patient. The team involved in treatment of STEMI includes paramedics, ED greeters, ED triage RNs, ED RNs, ED physicians, ECG staff, cardiac catheterization lab staff, non-invasive and invasive cardiologists, CCU RNs, staff RNs and sometimes CV surgery. In order to effectively treat our patients, each team member needs to understand their responsibility in achieving reperfusion in less than 90 minutes, as recommended per ACC/American Hospital Association (AHA) guidelines. We have developed a hospital protocol defining precise roles and expectations for each of these providers involved in treatment of AMI. Through this protocol, we have decreased our door to balloon times from 99 minutes in 2003 to 66 minutes from January to June 2005.

## Developing Acute Myocardial Infarction Protocol, *continued*

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### 2) Appropriate medications:

After reperfusion, standing orders and follow-up by nursing staff have helped to assure that appropriate treatments with aspirin, beta blockers, ace inhibitors statin therapy and smoking cessation counseling are initiated and continued through discharge, or that appropriate contraindications are documented. We have used elevation of troponin as a trigger to have cardiac rehabilitation staff review compliance with medication guidelines within 24 hours of admission and prior to discharge.

#### **Question:**

Above all, what do you recommend to physicians?

#### **Answer:**

Remember, it's not "all about us."

As cardiologists and ED physicians taking care of a patient having an AMI, we are leading a team roughly the size of a football team dealing with a time-critical event. If a patient with STEMI waits for two hours in the waiting room before getting an ECG because her symptoms were not quite typical enough, our system has failed that patient even if the physicians have performed to perfection. Every member of that team needs to know their job and do their job correctly and in a timely manner for us to take good care of that patient. This will not just happen. Physicians and staff at each hospital need to develop a protocol that works for them. After the protocol is developed, it will likely need to be modified as each team member identifies ways in which it can be improved. We need to educate team members about their roles and practice until we have perfected our system.

#### **Question:**

Please define the leadership role for physicians as health care systems implement the AMI interventions.

#### **Answer:**

As we have tried to initiate a "Cardiac Alert" protocol at several of the hospitals in which my group practices, we have found that each hospital will require a slightly different approach to taking care of our patients with AMI. One thing, however, has become clear. Without strong physician leadership in both cardiology and ED, the system cannot work. While we believe that empowering paramedics and triage personnel to initiate the diagnosis and call-in of cardiology/ cardiac cath lab staff is essential, this is a process that must be overseen and championed by physicians.

#### **Question:**

Can you recommend resources for physicians that would assist in implementing the AMI interventions?

#### **Answer:**

ACC/AHA guidelines for STEMI, JACC 2004, 44:671-719

ACC "Guidelines Applied in Practice Program"

AHA "Get With The Guidelines Program"

IHI "100,000 Lives Campaign" AMI How-to-Guide

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# Biography



**Peter M. Kerwin, MD**

Dr. Kerwin is chairman of the Interventional Cardiology Committee, Midwest Heart Specialists, Lombard, Ill., and medical director of the Cardiac Catheterization Laboratory, Advocate Good Samaritan Hospital, Downers Grove, Ill. He and his colleagues at Advocate Good Samaritan have developed a multidisciplinary protocol for care of patients with ST-elevation myocardial infarction that has decreased their time to reperfusion (door to balloon time) with primary PTCA from 99 minutes in 2003 to 66 minutes (2005).

Dr. Kerwin received his MD from the University of Illinois at Chicago, College of Medicine. He did an internship and residency in internal medicine, and a fellowship in cardiolovascular diseases at Loyola University Medical Center in Maywood, Ill. He and his group at Midwest Heart Specialists have been active in clinical research in cardiology and have a special interest in treatment of acute myocardial infarctions.

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# Medication Reconciliation Q&A

**Eric J. Alper, MD, Associate Professor of Medicine, University of Massachusetts Medical School; and Patient Safety Officer, Office of Quality, University of Massachusetts Medical Center**

The following are frequently asked questions concerning medication reconciliation, answered by Eric J. Alper, MD. Dr. Alper addresses the origin of medication reconciliation, the implementation process and its barriers, and how to encourage staff involvement.

**Question:** Medication reconciliation (Med Rec), as one of the six scientific planks of the Institute for Healthcare Improvement's (IHI) "100,000 Lives Campaign," is receiving national recognition. What is the origin of Med Rec? How did Med Rec become a process of care? Who were the early adopters?

**Answer:** Staff, including Jane Justesen, RN, at Luther Midelfort Hospital, Mayo Health System in Eau Claire, Wis., under the leadership of Roger Resar, MD, developed Med Rec as part of a process to improve medication safety at Midelfort. The protocols initiated at Midelfort include: sitting down at admission with patients and families to detail and verify all medications taken by patients; determining drug dosage, frequency, and when last taken; comparing that information to physicians' orders; and reconciling discrepancies as the hallmarks of Med Rec. Patient hand-offs, transfers and discharges from the hospital trigger the Med Rec process. Justesen and her team at Midelfort developed Med Rec and pioneered its tools as part of an IHI initiative.

Dr. Resar and John D. Rozich, MD, PhD, MBA, conducted early research on medication safety that revealed that more than half of all hospital medication errors occur at the interfaces of care (Rozich and Resar, 2001). Dr. Rozich and Dr. Resar (2004) additionally found that Med Rec interventions successfully decreased the rate of medication errors by 70 percent, reduced adverse drug events by more than 15 percent, and that a successful reconciliation process reduces the work and re-work associated with management of medication orders.

The Massachusetts Coalition for the Prevention of Medical Errors identified a set of safe practices for Med Rec that had been shown to promote patient safety (Fenn, Federico, et al., 2003). The coalition has been working on Med Rec for three years or so, promoting its adoption and showing outcomes of the Med Rec process. Practices identified by the coalition include:

- Adopting a standardized form for reconciling and then placing that form in a consistent, highly visible location within the patient chart (Midelfort moved the admission Med Rec notes to the front of the chart)
- Assigning responsibility for resolving variances in medication orders to someone with sufficient expertise
- Identifying time frames for completing the reconciliation process
- Improving access to complete medication lists at admission
- Addressing supporting policies and infrastructure

**Question:** On the IHI campaign calls, we hear that Med Rec is difficult to implement. What makes Med Rec so difficult? What have you identified as barriers to implementing Med Rec?

**Answer:** Redefining the process of care around Med Rec is difficult. Med Rec is a transformational, systemic change that requires substantial time and effort. The benefit to patient care may not be immediately seen and the information gained from the Med Rec process may not be perceived as valuable to clinicians in every instance. There is not a clear answer to the question, "Who does Med Rec?" Most hospitals design the system for reconciling medications using primarily nurses. Some use pharmacists; in some institutions, physicians perform this task. Ultimately, the physician is responsible for determining which medications patients receive.

## Medication Reconciliation Q&A, *continued*

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### Barriers to Med Rec include:

- Conveying the value of Med Rec across the system and across specialties
- The time needed to complete the process
- The difficulty of executing the process across the system
- System support—processes in the existing system may not support the Med Rec process
- Determining who is going to do it; for instance, should the organization hire in or assign the duties of Med Rec to existing staff
- Patients do not know their medications

**Question:** What are your suggestions or solutions that may assist in overcoming those barriers?

### Answer:

- Design a process of Med Rec on the strength of your hospital. Physician-driven models eliminate the need for more than one person to collect and verify Med Rec information. Some hospitals design this process using primarily nurses or pharmacists to gather medication histories and resolve discrepancies with the physician.
- Identify team members. Hospitalists, who have systems knowledge, are excellent Med Rec team members.
- Form a team with clinical experience. Work with staff on the front lines of care.
- Create a form that captures the admission medication list for the basis of all other comparisons and develop a way to carry that list forward across the system through discharge.
- Standard forms (like admission order forms) should refer to the Med Rec form or process. It should be integrated throughout the system.
- Gather a good history; have a clear process for identifying and correcting discrepancies between medications on the list and what is ordered.
- Encourage documentation of medication decisions.
- Begin in the pre-admission testing areas. Med Rec during transfers and on discharge is more challenging.

**Question:** Above all, what do you recommend to physicians?

**Answer:** Emphasize and make your staff appreciate the importance of Med Rec. Make every effort to carefully manage patients' medications around transitions in care. Enlist the assistance of nursing and pharmacy, as this is truly a team effort.

### Recommended resources

*Reconciling Medications: Safe Practice Recommendations and Implementation Tools*; Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Hospital Association; [www.macoalition.org/Initiatives/RecMeds/ProjectOverview.pdf](http://www.macoalition.org/Initiatives/RecMeds/ProjectOverview.pdf)

Rozich JD, Resar RK. *Medication Safety: One Organization's Approach to the Challenge*. JCOM. 2001;8(10):27-34. The authors describe reconciliation as a powerful strategy, along with broad cultural changes and other interventions, to reduce adverse drug events. Results reported include a 70 percent reduction in medication errors and a 15 percent reduction in adverse drug events.

Rozich JD, Resar RK, et. al. *Standardization as a Mechanism to Improve Safety in Health Care: Impact of Sliding Scale Insulin Protocol and Reconciliation of Medications Initiatives*. Joint Commission Journal on Quality and Safety. 2004;30(1):5-14. This paper describes two interventions: first, standardization of insulin administration, with the outcome of significantly reducing hypoglycemic events; second, the introduction of medicine reconciliation ("clarifying, correcting and specifying medications") with a subsequent seven-month chart audit, showing errors falling from 213 per 100 admissions to fewer than 50.

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# Biography



**Eric J. Alper, MD**

Associate Professor of Medicine, University of Massachusetts Medical School  
Patient Safety Officer, Office of Quality, University of Massachusetts Medical Center

### **Educational experience:**

Brown University, Sc.B., 1989

UMass Medical School, MD, 1993

UMass Medical Center, Residency in Internal Medicine, 1996

Hospitalist, 1996-present

### **Professional experience:**

Dr. Eric Alper has been on staff at UMass Memorial Health Care (UMMHC) for nine years, during which time he became the first hospitalist at UMMHC. He helped to create the hospitalist programs at the university and memorial campuses and continues to care for patients on the adult medical service at both campuses.

Dr. Alper was appointed physician patient safety officer for UMass Memorial Medical Center in 2003. Major efforts have included instituting leadership patient safety rounds, medication reconciliation, improving the reporting of critical test results, improving communication of patient allergy information, treatment of patients with alcohol withdrawal, safety of intravenous heparin, and creation of clinical practice guidelines and standard order sets. He has worked to improve the safety and functionality of the hospital information system, and he is assisting to lead a system-wide effort to install a computerized order entry system and electronic medical records. He is a member of the Clinical Performance Improvement Committee, pharmacy and therapeutics, critical care operations, and he chairs the Patient Safety/Risk Management Committee.

For the past eight years, he has also directed the internal medicine clerkship, a required three-month experience for all medical students in their third year.

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### RRT/ MET Q&A

**Michael DeVita, MD, Associate Professor Critical Care Medicine and Medicine; Associate Medical Director, University of Pittsburgh Medical Center Presbyterian Hospital**

The following are frequently asked questions concerning rapid response teams (RRT) and medical emergency teams (MET), answered by Michael DeVita, MD, associate medical director of the University of Pittsburgh Medical Center (UPMC) Presbyterian Hospital since 1997. Dr. DeVita addresses the origin of RRT/MET, how to overcome the barriers of implementation, and provides further resources to help your hospital successfully establish RRT/MET.

**Question:** The concept of RRT/MET is one of the six scientific planks of the Institute for Healthcare Improvement's (IHI) "100,000 Lives Campaign." When was this process first formalized?

**Answer:** RRTs were formalized in 1995, in print. At the University of Pittsburgh Medical Center, we initiated teams in 1989 and first published results around 2002. Ken Hillman and Rinaldo Bellomo, both in Australia, have led the charge in the medical literature. Starting in 1995, they described the concept, and provided data that improves outcomes in a wide variety of settings. "RRT" has yet to receive recognition in the medical literature, as MET is the preferred terminology. RRT is the IHI's name for the same thing. We recently convened an international consensus conference on MET, and one of the findings (to be reported soon) is that some sort of planned response for medical crises is needed in hospitals, and both MET and RRT seem to be reasonable alternatives.

**Question:** Sometimes events give rise to change. Can you connect an event or events to the formalizing of RRT/MET in hospitals? Or, did they "creep" into the culture?

**Answer:** RRT/MET definitely did not "creep" in. At all hospitals of which I am aware, people saw a gap in providing critical care resources to patients who suddenly needed those resources. We saw a need, designed a response, and then implemented the response. All three steps are tough to do. We have spent 10 years trying to improve it. This has been a full time job.

**Question:** Who were the early adopters?

**Answer:** The early adopters were Ken Hillman and Rinaldo Bellomo in Australia and Michael Buist, MD, in New Zealand. For approximately the past three years, the United Kingdom has used a critical care nurse outreach (a variant) as a national model. UPMC Presbyterian Hospital, as I previously noted, was an early adopter. In fact, the UPMC McKeesport Hospital won the Eisenberg Award from the Joint Commission on Accreditation of Healthcare Organizations last year. Their model is based, in part, on UPMC Presbyterian Hospital's experience, expertly reworked for a community hospital setting.

**Question:** During the IHI "100,000 Lives Campaign" calls, we hear that RRT/MET are difficult to implement. There seem to be cultural barriers. What makes RRT/MET so difficult to implement?

**Answer:** They require a restructure in responsibility for care, making some physicians and nurses fear that they will be "tattled on," seen as "bad" caregivers, or that they will be "left out" of the care of their patients. Our reply is: "It's not about YOU. It's about your patients' well-being. This is an institutional methodology to bring the Intensive Care Unit to the patient in minutes, keep them safe, and return them to you as soon as possible." No blame, just focus on safety.



## RRT/ MET Q&A, *continued*

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**Question:** When a hospital first introduces RRT/MET, how should that system establish baseline data?

**Answer:** Count codes. Count deaths. Review events leading up to both. Look for process errors that preceded and created a crisis, or death. Keep Count. Show data. Be willing to implement partial solutions. Successes and failures will both foster growth in quality.

**Question:** Please identify the barriers to RRT/MET implementation.

**Answer:** This is a huge question. At our consensus conference in Pittsburgh in June 2005, we made a table listing this. It will be available soon. It is also in our textbook, but the answer is too detailed for this short reply. Also, we made a DVD of our conference in June. The DVD has a huge amount of material in it and is available through the Agency for Healthcare Research and Quality (AHRQ) funding at no cost. The short answer is culture, history, cost, time, training and experience are all barriers. However, once begun, the obvious benefit (and shortcomings of partially implemented systems) promote revision and growth.

**Question:** Please suggest solutions to overcoming those barriers.

**Answer:** The solutions can be complex, but the basic answer is, keep count of codes and causes. Be willing to compromise.

**Question:** If an institution could only accomplish one aspect of RRT/MET, what is the essential component of this intervention that you recommend?

**Answer:** I would institute counting process errors leading to crises/deaths. Count how many could have been prevented with such a team. That will lead to all else. Regarding the response team itself, you should identify willing, capable, trusted people to be on the team. The team should be kind and encouraging.

### **Recommended resources**

“Medical Emergency Teams: A guide to implementation and outcome measurement.” DeVita MA, Hillman K, Bellomo, R, Eds. Springer Verlag, New York. 2005.

“First International Conference on Medical Emergency Teams Program” DVD. Produced by University of Pittsburgh, with support from the Agency for Healthcare Research and Quality. Thirteen continuing medical education credits possible.

## Doctor-to-Doctor resources for the Making Strides in Safety® program

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# Biography



**Michael A. DeVita, MD**

Since 1997, Dr. DeVita has been associate medical director of the University of Pittsburgh Medical Center (UPMC) Presbyterian, the flagship hospital of UPMC. In this role, he is charged with evaluating the effectiveness and efficiency of clinical care. An experienced consultant in ethics, Dr. DeVita is well published in the fields of ethics and critical care medicine. He is a widely recognized speaker on ethical issues confronting physicians, especially regarding end-of-life care and organ donation.

Dr. DeVita was appointed chairman of the UPMC Medical Ethics Committee in 1992. During his tenure, the committee has developed the nation's first policy on non-heartbeating organ donation. This policy has served as a template for hospitals and organ procurement organizations nationally. The committee achieved another national first by creating the Committee for the Oversight of Research Involving the Dead (CORID), which oversees cadaver research at UPMC. This endeavor has been the focus of a national consensus conference and reports in *Science* and *U.S. News & World Report*. In addition, he served as chairman of the Ethics Committee of the Society for Critical Care Medicine from 1996 to 1997.

In 1998, Dr. DeVita received the Christer Grenvik Award for contribution to ethics in critical care from the Society of Critical Care Medicine. He is a member of the faculty of the Center for Bioethics and Health Law at the University of Pittsburgh and a fellow of the American College of Physicians.

Dr. DeVita provided expert testimony to the second Institute of Medicine committee on non-heartbeating organ donation, and to the Commission de l'Éthique de la Science et de la Technologie, which prepared the report, "Organ donation and transplantation: Ethical dilemmas due to shortage." In 2005, he testified before Health Canada's Donation after Cardiocirculatory Determination of Death Forum, and has advised the United Network for Organ Sharing (UNOS) and the U.S. Health Resources and Services Administration on donation after cardiac death.

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# Biography



**Richard Hellman, MD, FACE, FACP**

Dr. Richard Hellman is the vice president of the Board of Directors of the American Association of Clinical Endocrinologists, chairs their Patient Safety Committee, and is a member of the AACE Executive Committee. He chaired the American College of Endocrinology Consensus Conference on Patient Safety in Diabetes and Endocrinology, which was held in Washington, D.C. in January 2005. He has published and presented numerous papers on the topics of medical errors and patient safety.

Dr. Hellman is in private practice in North Kansas City, Mo., and is a clinical professor of medicine at the University of Missouri/Kansas City School of Medicine. He graduated from the Chicago Medical School and completed all of his post-graduate training at the University of Kansas Medical Center. Dr. Hellman is a member of Alpha Omega Alpha, the national medical honor society. He is also the medical director of the Heart of America Diabetes Research Foundation.

A methodology and data expert for the Physician Consortium for Performance Improvement (Consortium), Dr. Hellman is also a member of their executive committee and co-chairs their implementation work group. The Consortium is convened by the American Medical Association and includes representatives from more than 70 national medical specialty and state medical societies. The Consortium seeks to provide physician performance measures for both Centers for Medicare & Medicaid Services and the specialty boards. He was the first to show how an electronic health record can be used to improve adherence to the Consortium's physician performance measures. He is the AMA representative for the Joint Commission on Accreditation of Healthcare Organizations Advisory Group for Disease-Specific Care Certification and serves on the National Diabetes Quality Improvement Alliance's Technical Expert Panel. He is currently on the AMA expert panel on medication reconciliation.

Dr. Hellman is also active in his own community. He is past president of the Metropolitan Medical Society of Greater Kansas City, a member of the Mayor's Health Commission and chair of the Patient Safety Task Force of the health commission.

He lives at home in Leawood, Kan., with his wife, Julie, and their dog, Zoe. He enjoys hiking and jogging.

