Learning Organizations

by David Nash, MD, MBA

As previously described, the “third and final stage of integration”—that is, “clinical integration.” Clinical integration describes a setting where physicians, across multiple institutions, have completed a rigorous self-evaluation and have arrived at agreed-upon ways of implementing care processes. In short, clinical integration means a health system has figured out what works and has tossed out what does not work. Clinicians will embrace clinical integration if they believe that the outcome at the patient level will improve, and that their own practice lives will become more efficient (and possibly even fun).

Barnsley and his colleagues went one step further and created a classification scheme that shows how integrated delivery systems can actually become learning organizations. As previously described in this column, Barnsley’s view is one of a shared vision, facilitative leadership, and communication channels all linked together to help integrated delivery systems become accountable for defined populations of patients.

In reflecting on the hard work of our own system, the Jefferson Health System (JHS) in the Philadelphia area, I have been benchmarking our accomplishments against the writings of these national thought leaders. Although I am sure our structure is not unique, the JHS, now comprised of 13 hospitals, has created a loose framework for clinical integration. Many of the constituent hospitals have a chief medical officer or vice president for medical affairs with operational responsibilities for quality. These physicians from each institution serve on an overarching committee at the system level appropriately named The Quality Council. The JHS Quality Council is chaired by the system’s chief medical officer. The Quality Council reports to the JHS Board of Trustees Committee, which is charged with oversight of the quality agenda.

Is there a connection, then, between this organizational structure and improvement in pharmacy practice? I believe there is a direct connection. A parallel committee to the Quality Council is the JHS Pharmacy Taskforce, also ably chaired by our system’s chief medical officer. The JHS Pharmacy Taskforce has representatives not only from the pharmacies in each of the constituent hospitals, but also from the group purchasing organizations with which our system collectively engages.

The JHS Pharmacy Taskforce has tackled very difficult issues, ranging from a top-down review of our policies toward pharmaceutical representatives to an inventory of our multiple group purchasing contracts for everything from cardiac stents to antibiotics. Most recently, the taskforce has begun to look at ways in which we might improve the delivery of pharmaceutical care across the entire system.

With that learning objective in mind, the taskforce smartly reviewed last summer’s Agency for Healthcare Research and Quality (AHRQ) publication entitled “Making Healthcare Safer: A Critical Analysis of Patient Safety Practices.” This important document, with more than 50 chapters from contributors around the country, was released in July of 2001. After a rigorous literature review and national peer-review scrutiny, the AHRQ produced a list of the top 11 safety practices that hospitals ought to rapidly adopt. The top safety practice endorsed by AHRQ is prophylaxis to prevent venous thromboembolism in at-risk patients. This should not come as a surprise to our readership.

As a result of this groundbreaking report and the understanding across our system hospitals that deep vein thrombosis (DVT) prophylaxis was indeed a critical issue, the JHS Pharmacy Taskforce engaged with key physician and pharmacy leaders in a project to improve guidelines for surgical prophylaxis for the prevention of DVT. Of course, it’s difficult for complex, loosely integrated systems to effect clinical integration, especially when it requires changes in the behavior of pharmacists and doctors. By engaging some key physician champions—those with a national reputation in the field of DVT prophylaxis—the taskforce began a systems-wide educational effort geared first toward practicing surgeons, medical consultants, and others affected by the AHRQ recommendations. This is difficult work, because it requires serious self-evaluation and a willingness on the part of experts to admit that they could do a better job.

Through the leadership of our system’s chief medical officer and the JHS Pharmacy Taskforce, the system was able to organize an approach to the literature that made sense to nearly everyone. Using the physician-champion model, based upon good science, the JHS Pharmacy Taskforce endorsed a series of recommendations for DVT prophylaxis in the peri-operative period that closely mirrored the American College of Chest Physicians Consensus Conference on anti-thrombotic therapy.

The ACCP recommendations were analyzed and broken down into specific recommendations for care. The evidence on which these recommendations were based was graded on a scale of A, B, and C, depending on the quality of the evidence underlying each recommendation. Under the auspices of the JHS Pharmacy Taskforce, these evidence-based recom-
recommendations have been widely disseminated. All of the pharmacy directors from the constituent institutions have embraced these recommendations and have urged their own clinicians to follow their lead.

Although I am naturally proud of our system and my small role in the The Quality Council and The Pharmacy Taskforce, I do not believe that our system is automatically deserving of emulation as a national model. I am proud of our system’s chief medical officer, Dr. Stanton N. Smullens, and of our nationally prominent thrombosis expert, Dr. Geno Merli. I also know how hard it is to export one organization’s approach to another. What I advocate, then, is a generic approach to the challenges facing all pharmacy directors and P&T committee members.

What does it take for success in this era of constrained resources and accountability? It certainly takes leadership from the board of trustees level to empower a chief medical officer or related individuals to implement the tools of clinical integration. It takes physician and pharmacy champions at all levels throughout the organization to promote rigorous self-evaluation, which eventually leads to learning and implementation of new tools to improve quality. The ultimate test, for those of us in the JHS, will be “Can the Jefferson Health System improve its surgical prophylaxis for prevention of deep vein thrombosis across all the institutions?” Had we not taken the first step to evaluate our own practice, agree on a standard, and attempt to implement that standard, no one could adequately answer this important question. Now that we have solid support from important organizations like AHRQ, it lends national credibility to our work and makes it difficult for naysayers to excuse themselves from the process of implementing these guidelines.

Is your organization a learning organization? I asked this question previously and will rekindle it. Is your organization committed to linking organizational structure and improved outcomes at the individual patient level? Are the experts in your system willing to admit that they could do a better job? To me, that’s the core question of the 21st century. Of course, I’m always interested in your views; I can be reached at my email address: david.nash@mail.tju.edu.

References