

MANAGEMENT FOCUS

— For Providers of Emergency Medical Services —

Vol. 22, No. 1

Fitch & Associates, LLC

Summer 2007

BREAKTHROUGH PRODUCTIVITY ENHANCEMENT

Every December, Harvard Pediatrician and Institute for Healthcare Improvement (IHI) founder, Donald Berwick, MD ignites thousands of high level healthcare executives with passionate speeches that layout ambitious charges to save lives. In December 2006, he proposed that hospitals across the nation strive to protect five million patients over the next two years from incidents of medical harm. Berwick estimates that nearly 15 million instances of medical harm occur in the US each year or 40,000 per day. Through 12 changes in care, he believes the goal of saving lives and reducing patient injury for five million patients is attainable.

Berwick's charge seems larger than life. For EMSers who have heard great calls-to-arms before that never materialized, it's easy to be a skeptic; but as these healthcare heavy weights exited the keynote, they were already making plans and calling colleagues to jump start the initiative. They believed. Six months later, many are well under way or at least know where they are. Using a practical approach, IHI member hospitals will enhance their organizational performance and reach 5 million lives. Let's look at how they'll do it.

System of Profound

Knowledge. At the heart of the IHI effort is a foundational theory or system of profound knowledge introduced by management and improvement guru, W. Edwards Deming. This is the framework taught in IHI's Improvement Advisor program. Deming is most known for his work in enabling the Japanese auto industry to be the leader it is today. He argues that there are four inter-related parts to understanding a system and enhancing its organizational performance: appreciation for the

system, knowledge about variation, a theory of knowledge, and psychology. Let's look at each:

► **Appreciation for the System** – Each emergency caregiver and leader has to recognize that we are part of a system (e.g., health care system). Focus should always be on maximizing the success of the system and not its individual parts. This means appreciating our interdependence and working to cooperate and communicate. It requires that each position, division, or organization work

to the optimization of the whole system first and not their individual productivity. And, it entails stakeholders negotiate solutions that work for all and not just one constituent.

► **Knowledge About Variation** – Nothing we do personally or in our organizations are perfect. Success 100% of the time is not attainable. The goal is to reach a certain comfortable performance benchmark and then reduce variability. Everything we do has variation. Identify-

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GROUP LOOKS TO DOUBLE SURVIVAL

While sudden cardiac arrest (SCA) represents only a fraction of most service's call volume, it has been a key driver of EMS system design and practice for more than 40 years. Physicians inspired by the potential of saving more lives by taking advanced cardiac life support (ACLS) care to the patient's side were a major catalyst behind many of the early paramedic programs in the United States.

In spite of enhancements in bystander training, easier and more accessible automated external defibrillators, and advances in ACLS care, survival rates still average 6-7% nationwide and the varia-

tion is extreme with cities like Boston and Seattle achieving upwards of 40% to 45% survival annually. Why is it one system has four times more success than another? Likely it's the result of a broken system of processes.

Enter Take Heart America - a non-profit group that blends the efforts of emergency medical personnel, researchers, doctors, community leaders, and the manufacturers of medical-products together. The organization is on a mission to integrate efforts and reach dramatic improvement in out-of-hospital SCA survival. Currently, it has launched a pilot pro-

gram in three communities: Austin-Travis County, Texas (pop. 1.2 million), Columbus, Ohio (pop. 730,000), and St. Cloud, Minnesota (pop. 125,000).

One of the key challenges with making substantive improvements in a process like resuscitation is the complexity of integrating all of the links of the Chain of Survival. Take Heart America is attempting to do just that. Some of the many interventions employed include:

► **Distributing self-instruction CPR training** to increase bystander CPR.

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EMS & HOSPITAL TRENDS & NOTES



Is EMS Obese? The National Registry of EMTs surveys registrants as part of a longitudinal study. With the prevalence of obesity in the industry and the risks associated, recent re-registrants were asked to supply their height and weight to calculate their Body Mass Index (BMI). Results are expected in a future paper.

Fire-Based EMS Ideal? Fire-based EMS advocates released a “white paper” at the

Fire-Rescue Med conference that makes an argument that the fire service is the ideal provider of EMS. The paper is absent of peer-reviewed research or expert sources to support the case. The National Association of EMTs followed with a position paper advocating for the acceptance of diverse delivery models and *Best Practices* published an open letter requesting fire service action to follow their words.

GAO - Cost vs. Reimbursement. The General Accountability Office (GAO) released a report: *Ambulance Providers: Costs & Expected Medicare Margins Vary Greatly*. The study concluded Medicare pays EMS an average

6% below the cost of providing the services and 17% below the cost for “super rural” areas. The fire service was excluded from the study due to difficulty isolating the cost of EMS operations. The GAO recommended the administrator of the Centers for Medicare & Medicaid Services (CMS) monitor the disparity.

On-Duty Firefighter Deaths. A study in the *New England Journal of Medicine* (2007, March) identified that 45% of on-the-job firefighter deaths were attributed to heart disease. Risk of death increased with emergency versus non-emergency work. It did not conclude that firefighters were at increased risk for heart dis-

ease or that the heart disease could be attributed to factors associated with the job.

Happy Caregivers = Happy Patients. Doctoral research at Saybrook Graduate School by Owen Owens, Ph.D. discovered a correlation between the satisfaction of caregivers and the overall satisfaction of patients. Considering a caregiver may encounter multiple patients in the course of a workday, their level of satisfaction can influence the service experience felt by a large number of patients and other stakeholders. This may carry over into overall perception of the care delivered or whether to refer or return to the care provider in the future.

BREAKTHROUGH...

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ing when variation is from a common cause (i.e., normal or expected variation, stable) or a special cause (e.g., isolated or out of the norm variation, unstable) helps leaders to know when it is appropriate to act. Measuring processes, recognizing variation will occur, and only reacting when and where it is special cause variation, empowers leaders for change.

Measuring data and understanding variation is not enough though. Leaders must also take action to reduce the variability of common cause variation and try to eliminate the frequency of special cause variation. Doing so involves asking yourself, What do I want to accomplish, How will we know the change was an actual improvement, and What

changes can we make to create improvement? Only then, you can plan an improvement, implement it, check to see if it worked, and then act on what you discover to improve forward.

► Theory of Knowledge – Leaders need to use data and experience to predict future outcomes. You enter improvement efforts knowing you could be wrong, but by observing outcomes and new data, you modify or adjust to achieve the goal. Information is not knowledge, it’s in how we use that information and apply it forward that we gain knowledge on how to enhance something.

► Psychology – The final piece, involves understanding the organizational behavior within the workplace. Are people intrinsically mo-

tivated? Is there a culture of asking “why”? How do teams communicate and manage conflict? Many change practitioners admit that data and control charts show the meat of process issues, but the human interaction, decision-making, and motivation require a bulk of attention to be successful.

Deming’s system of profound knowledge is not complicated. It recognizes that when organizational or process improvement is essential, that leaders must take a holistic and systemic approach. It assumes we have to do more than let our environment impact our service and effectiveness. We need to acutely understand how it is working, how it can improve, and what we can do to improve it. Finally, it puts

the responsibility on you to make sure it worked. Aspiring to achieve a system of profound knowledge in emergency services would be a major leap for most organizations, but the results would be well worth the effort. How many lives could you save?

MANAGEMENT FOCUS

*published quarterly by
Fitch & Associates, LLC*

*Subscriptions are complimentary and
are available for download at
www.fitchassoc.com or from:*

*Fitch & Associates, LLC
303 Marshall Road, Box 170
Platte City, MO 64079-0170
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CLINICAL DECISION MAKING TRAPS?

EMS caregivers have great confidence in their ability to help their patients and provide an increasingly higher level of care. Elevating the scope of care requires EMTs and paramedics to be skilled at assessment and history-taking, enabling them to determine what is the patient's true medical issue and know what to do for it. While many may think EMS is capable, several studies have shown that in certain circumstances caregivers struggle to make good decisions or are influenced by their biases.

A new book by Harvard Medical School physician and *The New Yorker* magazine article author Jerome Groopman, M.D. explores clinical decision making at the physician level. *How Doctor's Think* has received positive reviews in the lay press. Groopman reports 15% of physician diagnosis are wrong and many suffer from unfortunate biases and mind traps. He makes the case that doctors and patients must act differently to avoid mistakes.

While much of Groop-

man's narrative praises the sound work of skilled physicians, he discusses several issues that caregivers should be conscious of, such as:

- ▶ Doctors are trained that 80% of diagnosis can be accomplished through careful study of the patient chart and their past medical history. Believing this, can lead a caregiver to focus on past data rather than communicating with and assessing the patient.

...caregivers struggle to make good decisions or are influenced by their biases.

- ▶ A past "diagnosis" can lead a caregiver to explore only how the new symptoms are associated with the known condition. Groopman shares a story of a young woman diagnosed with an eating disorder who continued to lose weight in spite of trying to eat and suffering from severe nausea. In and out of hospitals and passed from specialist to specialist, everyone continued to point to the diagnosis. It wasn't until one physician opted to re-

interview the patient and diagnosed an allergy to a protein that inhibited absorption of certain nutrients. It had no relation to eating disorders.

- ▶ Lack of training and experience with quality patient interviews. This included not learning how to ask open-ended questions, listening deeply for cues, and then probing the details. Often, picking up on some of the smallest clues can result in discovering the key to the

patient's problem.

mental illness, etc. A caregiver must be careful that pre-conceived bias towards a homeless person or a regular doesn't cloud their judgment in properly assessing the patient.

- ▶ Being trapped by familiarity. You personally know the patient or have treated them many times. This can create an expectation that past issues are valid. It can also influence ordering treatment options that hurt or are expensive that other patient's might get.

Groopman's book is a fascinating exploration into the many complex factors that influence the clinical assessment and diagnosis of clinicians. While he is specifically talking in the context of physicians, the issues described and resulting adverse effects are all possible at any level of caregiver engaged in assessment and treatment. EMS organizations should consider the implications of the factors described and whether your training and quality control processes adequately address avoiding the negative outcomes.

...DOUBLE SURVIVAL

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- ▶ Increasing the installation and 9-1-1 system tracking of public access defibrillators.

- ▶ Ensuring 9-1-1 callers receive scripted CPR instructions to encourage effective bystander CPR.

- ▶ Training on and continually refreshing first responders and ambulance personnel on the American Heart As-

sociation 2005 Guidelines for CPR and reinforcing key considerations like compression quality and rates.

- ▶ Using technologies like the ResQPOD.

- ▶ Implementing treatments like induced hypothermia and improving in-hospital interventions.

Take Heart America reports implementation of

these steps alone could result in survival rates of 19-33%.

Take Heart America is not inventing something new. What is fresh is their approach of working to bring communities and stakeholders who can have an impact at each link in the chain of survival together and integrating them so the whole process can reach maximum effec-

tiveness. Medical Director, Edward M. Racht, MD of the Austin/Travis County EMS System (Texas) was quoted as saying if they can double their community's survival rate, "that equals 100 more people walking around every year." It's a vision that's worth the effort and very much inline with the mission of EMS systems.

UNDERSTANDING INTERPERSONAL RELATIONSHIPS

Managers in general tend to under appreciate the productivity drag associated with poor interpersonal interactions in the workplace. We write it off as, 'Oh, that's just Jane' or build work arounds instead of trying to learn what causes people to have effective interpersonal relationships. Appreciating how we impact others and how they impact us, helps us lead more effectively.

Psychologist William Shultz introduced a theory of interpersonal relations he called Fundamental Interpersonal Relations Orientation (FIRO). He believed people have unique interpersonal

needs that motivate and affect our behavior in personal and professional relationships. This manifests in how a person typically behaves towards others and how they would like others to behave towards them.

FIRO is based on three dimensions that can explain most human interactions: Inclusion, Control, and Affection. Each of us has varying degrees of how much we need or express them.

► *Inclusion.* How you participate in forming relations with others. When a person wants inclusion, they want to be noticed and have others invite them to belong.

When it's expressed, they try to include others in what they do.

► *Control.* How you prefer to be involved in decision-making, control, and influence. Those that have a want for control prefer well-defined situations where instructions and expectations are clear. When it's expressed, individuals prefer to organize and direct others and exert control and influence over things.

► *Affection.* How you build rapport and openness between colleagues. When wanted, people look for others to share feelings and encourage their efforts. They

hope for people to be warm to them. When expressed, the individual takes it upon himself or herself to get close to others. They are okay sharing their feelings and like to support people.

FIRO has many applications in organizations. It is commonly used with individuals and groups to assist with career development and coaching, improving team performance, and in leadership development. A simple questionnaire is used to identify individual behavior and needs. Do you know what you want from others or what they may want from you?



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