



RAPID RESPONSE TEAMS

Ten Essentials Leaders Need to Know

- by Gretchen M. Dahlen, FACHE, and Betsy A. Benz

Rapid response teams bring **critical care expertise** directly to the patient's bedside. These mobile **units save lives** and are revolutionizing culture in participating hospitals. Executive leadership plays a crucial role in the success of this initiative.

Henry Ford Hospital initiated a pilot for rapid response teams on December 15, 2004. The mobile teams supported nurses in two units of the Detroit-based hospital. In the first two weeks, nurses called the team 10 times. By January that number grew to 80, and by the end of that month, the program began to spread throughout the hospital.

“The benefit for the overall continuum of care was very clear to us as soon as we implemented the pilot rapid response team,” says Tony Armada, CHE, president and chief executive officer of Henry Ford Hospital and Health Network. “It’s a complementary model that speaks highly of patient care, of commitment to quality and professionalism, and of our desire to support our nursing staff, especially in times of need.”

Once the teams were implemented, the hospital’s mortality rate dropped almost 17 percent. Although the hospital introduced other interventions that also may have impacted those numbers, experiences at other hospitals confirm that rapid response teams are saving lives.

The impact on patient care is sizeable. Executives armed only with 10 essentials can lead the charge.

1. Patients Live

When the Institute for Healthcare Improvement (IHI) began its 100,000 Lives Campaign (page 30), it flagged rapid response teams as the most promising of its six life-saving initiatives. The organization predicted that the teams had the potential to save 60,000 lives over an 18-month period—more than the other five initiatives combined. Rapid response teams target mortality among patients who are not in an intensive care unit. Nurses and other staff members are charged with calling the team when a patient’s condition worsens or if something goes awry, helping to avoid unnecessary deaths.

According to studies cited in the IHI’s *Getting Started Kit: Rapid Response Teams How-to Guide*, more than two-thirds of patients who suffer a cardiac arrest will exhibit signs of deterioration approximately six to eight hours before the arrest. The rapid response team is designed to intervene before the arrest, to assess and stabilize the condition, and if necessary, move the patient to the ICU where the chance of surviving arrest is greater. At Henry Ford Hospital, those efforts have helped decrease the blue alert rate by 30 percent.

2. Executive Leadership Is Critical

Despite its impact, rapid response teams are one of the least known of the 100,000 Lives initiatives. These teams are most

successful when executives and clinicians work collaboratively from the start. A successful planning phase should include senior executives, physician leaders and chief nursing officers.

“My involvement mainly is supporting the effort,” Armada says, “and making sure it has the proper attention and resources to make it successful. This is a true commitment on the hospital’s end to be sure that we’re providing very timely and responsible patient care.”

Such leadership is essential to a cross-departmental effort like rapid response teams. Jack Jordan, Henry Ford Health System administrator of quality initiatives, says, “We’re trying to stay ahead of the curve in every way we can in terms of quality control. If you have the will of your leaders to say, ‘We’re going to try this in a diligent way,’ that’s a huge help.”

3. Implementation Is Fast and Straightforward

Executives can expect to move from discussion to full implementation in approximately two months. During the planning phase, hospitals need to adopt the criteria for calling the rapid response team and what type of documentation to use. Standing protocols should be clarified and the alert mechanism—usually a beeper, overhead page or cell phone—should be chosen. The rapid response team members must be selected and the required training organized for nurses and other staff.

Update: The 100,000 Lives Campaign

The Institute for Healthcare Improvement's initial 18-month campaign to save 100,000 lives ended on June 14, but the organization will continue to support the six life-saving initiatives, says Joe McCannon, director of the campaign. "Given the great infrastructure for change that's been developed and the momentum that's in place, we have a responsibility to continue to support hospitals," he says.

The 100,000 Lives Campaign began in December 2004, asking hospitals across the nation to take on at least one of the six initiatives. More than 3,000 hospitals joined the effort. The program called for the deployment of rapid response teams; improvement of care for acute myocardial infarction; and the prevention of adverse drug events, central line infections, surgical site infections and ventilator-associated pneumonia.

As this article went to press, the IHI had not yet announced the results of its full campaign, but participants were celebrating improvements. Henry Ford Hospital, for example, implemented all six initiatives. The average length of stay in the ICU fell by more than half a day. St. Peter Community Hospital implemented five of the initiatives and experienced four consecutive months without a single death. As of June 1, 2006, the IHI estimated that almost 85,000 lives had been saved.

Visit www.ihl.org/campaign to obtain an updated progress report or to access materials related to the campaign. Free starter guides, mentor lists, templates, discussion groups and a bibliography will continue to be available on the Web site. New hospitals can join the existing network. "While our primary aim is to save those 100,000 lives, embedded in that aim is the desire to change the standard of care," McCannon says.

In a large hospital, a three-day pilot test may be sufficient to identify any oversights in planning. However, hospitals with fewer than 15,000 annual admissions will likely require a one- to two-week test. Once the pilot is complete, a review of each call and any in-hospital deaths should help determine possible operational improvements. Statistics and related information can be charted and formally presented to the team. Help for unanticipated problems can be obtained through IHI's mentor hospital network or the online discussion boards.

4. Free, Step-by-Step Support Already Exists

The IHI created free support materials that can be accessed and downloaded at www.ihl.org. The site simplifies virtually all of the front-end work, providing model criteria for calls, templates for record keeping and step-by-step guides.

IHI-suggested criteria include a general "staff member is worried" criterion as well as six objective clinical parameters, any one of which can trigger a call. Templates enable the tracking of the situation, background, assessment and recommendation (SBAR) of each call. SBAR creates a simple, familiar format for organizing information, not only for the teams, doctors and nurses, but also for the person compiling data about the program.

5. Most Hospitals Do Not Add Staff

The make-up of the rapid response team varies depending on the hospital's size and resources. Hospitals can expect the volume of calls to reach 25 per 1,000 admissions. A typical hospital with 10,000 admissions per year will only average about five calls a week and can use existing staff. Hospitals with large annual admissions may experience more calls than hospitals with low patient volume. For example, Henry Ford Hospital employs 10 full-time, dedicated rapid responders.

The typical team is a two-person unit, made up of a critical care or ICU nurse and a respiratory therapist. Some hospitals also include a hospitalist, resident, intensivist or physician assistant. When choosing team members, hospitals must select employees who will be able to respond to a call within five minutes.

Ten Essentials Leaders Need to Know

All staff in the hospital—even those who work in non-nursing areas such as radiology, therapy and housekeeping—should be trained to initiate a call to the team.

6. Responders Need Dual Skills

For the intervention to function well, floor nurses and other staff must know that the call will never be treated as a nuisance. As a result, a team member's communication and interpersonal skills become just as important as advanced cardiac life support and critical care training. The team should treat every call as a teaching opportunity, avoiding the appearance of taking over a floor nurse's charge.

7. Physicians Support the Initiative

The support of physicians should be enlisted at the onset of the planning phase, especially in review of the criteria for a call. Concerns should be openly discussed, with emphasis placed on the team's role as a short-term consult rather than an outside entity assuming care for the patient.

Leaders will want to discuss the logistics of the calls. Will the attending physician be contacted right after the initial alert or after the team's visit is completed? How will the team, the nurse and the physician follow up with one another after each call? Physicians may be skeptical, but the story of one successful intervention can dispel those doubts.

Residents at Henry Ford Hospital overcame initial qualms and have embraced the teams. "Teaching hospitals have had a resistance to rapid response teams because they fear it is going to interfere with the autonomy of residents," Jordan says. "But it just simply was not the case. It's been perceived as helpful by everyone involved."

8. The Model Fits All Hospitals

The IHI provides a flexible plan for implementing rapid response teams, and the model can be customized to meet any hospital's individual needs and resources. If a policy or procedural dispute occurs in a group of

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hospitals, agreement does not have to be forced. Each hospital can be successful by choosing the model to meet its needs. The basic concept has been successfully molded to fit large hospitals like Henry Ford, as well as small, critical access facilities like the 22-bed St. Peter Community Hospital based in Minnesota. Benjamin W. Chaska, M.D., medical director and patient safety officer, says, "We saw that these interventions had value, but they didn't match our situation, so we modified them. Every small hospital can do this."

At St. Peter, patient volume does not necessitate new full-time rapid responders. The hospital has no ICU and no respiratory therapists. Instead teams are made up of the attending nurse and on-call physician. The results have been strong: The hospital has seen about a 50 percent drop in mortality since implementation, as well as a 28

percent reduction of transfers, saving the hospital \$6,200 per avoided transfer.

9. Measures Are Simple

The IHI suggests three key measures of success, most of which hospitals already track. The number of codes per 1,000 discharges should drop. Codes outside the ICU should decline, ideally achieving zero. Calls to the rapid response team should increase over time, from a starting rate of 10 or 12 calls per 1,000 admissions to an average of about 25 per 1,000. That number can be higher, however. Henry Ford Hospital averages 76 calls per 1,000 discharges.

Hospitals also may want to track information such as the response time for the team, the time of day calls come in, the type of patient involved, the number of unplanned transfers to the ICU and mortality.

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10. Everyone Considers the Teams a Success

Nurses, physicians and patients overwhelmingly embrace this intervention. It is changing the hospital culture, providing nurses with the support they need and favorably impacting retention. Physicians who feared miscommunication and an overwhelming number of calls say those problems have not materialized. Patients appreciate the idea that the nurse called for assistance when needed. Some hospitals have implemented programs that support family activation of the team.

Hospitals say there is no downside to rapid response teams. At Henry Ford Hospital, Jordan says implementation was over-

whelmingly accepted and supported by staff. "I was shocked at how little resistance we had," he says. "I never had a project that just took off like this. A lot of people are saying, 'Why weren't we doing this 20 years ago? This makes so much sense.'"

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Update: Keystone ICU

The Michigan Health and Hospital Association's Keystone Center for Patient Safety and Quality partnered with the Quality and Safety Research Group at Johns Hopkins University to create Keystone ICU in October 2003. The project provides support and research for evidence-based practices that eliminate bloodstream infections and ventilator-associated pneumonias, while at the same time implementing strategies to improve safety culture in the ICU.

More than 120 ICUs and 70 hospitals participated in the study. From March 2004 to December 2005, researchers estimate that the interventions saved up to 1,600 patient lives; 84,000 hospital days; and \$175 million. This success reflects dramatic improvements in clinical outcomes, which at the beginning of the project were near national averages. Ventilator-associated pneumonia rates fell 40 percent, and participating ICUs achieved a median catheter-related bloodstream infection rate of zero.

"We believe this level of dramatic and sustained improvement is the result of project engagement at all levels of the organization," says Chris Goeschel, Keystone's executive director. She attributes project success not only to clinical practices like the use of chlorhexidine, but also to improved communication between ICU staff and executives. "We use the Safety Attitudes Questionnaire to provide psychometrically sound measurement of safety culture and are beginning to recognize links between cultural issues and clinical outcomes," she says. "A pivotal component of our work is fostering a one-on-one relationship between the executive and the unit that involves not just the unit manager and medical staff, but also bedside caregivers." She and Peter Pronovost, M.D., Ph.D., director of the Quality and Safety Research Group and principle investigator for the project, stay in close communication with executives, discussing the progress of ICU teams and suggesting specific leadership tasks to address barriers.

Systematic data collection allows researchers to analyze results and identify best practices. Initially funded for only two years, the study continues today, self-funded by participants. The project's success has achieved nationwide attention, and Johns Hopkins researchers have begun similar work with other organizations, including a statewide Rhode Island ICU collaborative.

This article is a follow up to the one that appeared in the March/April 2005 issue of Healthcare Executive, "Improving ICU Care: It Takes a Team."

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“AmerisourceBergen and its Pharmacy Healthcare Solutions division offered a broad range of services to help enhance our supply chain operation, one of which was helping us set up the qualification and managing process for 340B.”

David McCombs
Vice President
Enterprise Resource Planning and Supply Chain Operations at Bon Secours

Bon Secours Health System, headquartered in Marriottsville, Md., which comprises 20 acute care hospitals in nine states, has been on a four-year journey to develop a new supply chain model. A key component of that model was the development of an effective partnership with Bon Secours’ pharmacy distributor to assist in creating a systemwide approach to pharmacy cost and operations that would improve performance beyond what could be achieved through individual facility efforts.

At the same time, Bon Secours was pursuing eligibility for the federal 340B Drug Pricing Program. Developed by the Health Resources and Services Administration, 340B helps qualifying facilities serve the disadvantaged by limiting the

cost of outpatient drugs covered by the program. Because Bon Secours’ mission is to “bring compassion to healthcare and to be *good help* to those in need, especially the poor and dying,” its leaders saw an opportunity to further help its disproportionately disadvantaged patient population.

According to David McCombs, vice president of Enterprise Resource Planning and Supply Chain Operations at Bon Secours, “AmerisourceBergen and its Pharmacy Healthcare Solutions division offered a broad range of services to help enhance our supply chain operation, one of which was helping us set up the qualification and managing process for 340B.”

AmerisourceBergen was equally pleased to work with

Bon Secours to help provide more charity care to disadvantaged populations. “In healthcare today, organizations are looking for partners to help them facilitate economic expansion while increasing their care services to all patients in need,” says Allen E. Zimmerman, senior vice president of AmerisourceBergen Solutions Group. “We help organizations determine whether they are eligible for the program and whether it would be feasible for them to participate. Once they are operating under its guidelines, we help ensure their compliance,” says Zimmerman.

The initial difficulty Bon Secours faced was that its hospitals had neither the knowledge nor the administrative capacity to start up and effectively manage the

program. The administrative hurdles included gathering the documentation to initiate the 340B program and maintaining adherence to eligibility requirements.

After attempting to facilitate the 340B qualification process itself, Bon Secours recognized the need to outsource. “We did not have a good mechanism by which to analyze the opportunity and assess whether it would be worth pursuing, so we believe it is an excellent area for us—and many other organizations—to consider outsourcing,” says McCombs.

AmerisourceBergen evaluated Bon Secours’ eligibility by looking at the expanse of the health system to determine its scope of operations. It then determined which entities within the system were eligible to participate in the program. To do this, AmerisourceBergen identified specific patient populations via financial data streams to make sure all individuals served by the health system were documented. Finally, AmerisourceBergen continually monitors all facilities within the health system to pick up any that have since become eligible to participate.

AmerisourceBergen also is working to expand the 340B program to include inpatient drugs. “The 340B program was intended to cover outpatient services only. However, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 opened the door for organizations to be able to negotiate coverage agreements for some inpatient services as well,” says Zimmerman. AmerisourceBergen has successfully supported the implementation of inpatient disproportionate share agreements for Bon Secours and other systems to cover some drugs that might not otherwise be recognized under the program.

AmerisourceBergen’s resources and support helped make a positive difference in the lives of Bon Secours’ needy patient population, and Bon Secours also achieved dramatic savings in pharmaceutical costs in the process. According to James DeFazio, system director of Pharmacy at Bon Secours, the organization thus far has realized an estimated savings of \$5.3 million from the 340B program. “We have documented savings in the first

year of \$1.4 million, about half of which is applied to cost recovery allowed by federal law for the previous 12 months. In the second year, which reflected the first year at a ‘steady state,’ Bon Secours achieved \$1.1 million in savings. And in the first six months of 2006, we have saved \$1.6 million, and we project a \$3.3 million savings for the entire year, our third year of participating in the 340B Drug Pricing Program.”

“Three million dollars in savings in a year is significant, especially for the four hospitals that are eligible for 340B. This savings enables Bon Secours not just to survive under challenging circumstances but to expand its services to the neediest areas,” McCombs says.

“A well-planned and well-executed approach to the 340B program can result in freeing up money that can be used to fund other charitable initiatives or community care efforts,” adds Zimmerman.

“AmerisourceBergen’s philosophy is that our customers are our business partners. Working with organizations, our goal is to ensure the health of our customers so that they can create healthy patients and communities.”

Both Bon Secours and AmerisourceBergen caution that the 340B Drug Pricing Program is not fully understood by healthcare organizations. It is a complex process. The high degree of difficulty involved may lead healthcare executives to abandon the effort as too much of a burden on their already taxed facilities. But McCombs urges healthcare leaders to take the time to fully explore the program’s potential. “Considering the mission of the Bon Secours system and the growing disadvantaged populations being served, it is very important to be able to maximize the opportunities that this program offers,” says McCombs. He adds, “Every eligible hospital should be doing this. Becoming qualified under the 340B program creates a more healthy organization that will better serve its needy populations.” The AmerisourceBergen–Bon Secours partnership is a testament to how corporations and healthcare organizations can come together to do great things for the community.

For additional information, visit www.amerisourcebergen.com/hs or contact Sheri Newell at snewell@amerisourcebergen.com or (610) 727-7217.