LEADERS: DR. STEVE NARANG

Giving Pediatric Patients the VIP Treatment

Dr. Steve Narang, a pediatric hospitalist in Baton Rouge, La., has a deceptively simple philosophy about delivering care to his patients: He wants them to get the best care available, even if that isn't the latest and supposedly greatest therapy.

Over the last decade, he has worked with his colleagues to apply that philosophy in hospitals in the Baton Rouge area, and he has watched quality of care improve while costs decline. Now he is working with other pediatric hospitalists to spread his quality-improvement approach to hospitals around the country.

"There's a lot of emphasis in our health care system on what is the newest drug, the newest technology," but very little comparative effectiveness data can be tapped to help physicians judge "what makes something better to use than something else," said Dr. Narang, who serves as the medical director for quality and safety at Our Lady of the Lake Regional Medical Center in Baton Rouge.

About 2 years ago, Dr. Narang joined forces with four other pediatric hospitalists to launch the Value in Inpatient Pediatrics (VIP) Network. The small, informal steering committee included Dr. Narang, Dr. Matthew D. Garber of the University of South Carolina in Columbia, Dr. Brian M. Pate of the University of Missouri–Kansas City, Dr. Shawn Ralston of the University of Texas Health Science Center in San Antonio, and Dr. Mark Shen of Dell Children's Medical Center of Central Texas in Austin.

'Not only do you need outcome measures, you need performance drivers. How and why did these things occur?'

DR. NARANG

The grassroots project had no funding source, but it did have a straightforward goal: "Let's ask people to share their secrets" was how Dr. Narang and the other VIP Network members expressed their intent.

They began by asking hospitals around the country that care for children to report benchmark data on one of the most common diagnoses in hospitalized children—bronchiolitis. They invited the hospitals to provide a mix of process and outcome data about such patients. They sought information on length of stay, utilization of therapies, readmission rates within 72 hours, and variable direct costs for the treatment of children with bronchiolitis. They also asked hospitals to report on the percentage of such patients receiving bronchodilators, steroids, chest x-rays, respiratory syncytial virus antigen testing, and chest physiotherapy.

The project, which is now in its second year, so far has collected data on about 7,000 patients who were treated for bronchiolitis at about 30 hospitals. The hospitals participating in the VIP Network can compare their performance with that of other institutions on a quarterly and annual basis. But the more exciting part, Dr. Narang said, is that hospitals are beginning to form collaboratives within the network, and the best-performing hospitals are sharing how they achieved success.

Dr. Narang said that he hopes that the VIP Network will be able to obtain funding and thereby continue to grow. The network founders are applying for a grant from the Agency for Healthcare Research and Quality, which they would use to hire a paid staff member who could automate and validate the data coming from the hospitals in the network.

Although other organizations are also performing this type of benchmarking work, Dr. Narang said that the VIP Network offers something unique because it does not focus only on freestanding children's hospitals. Approximately 75% of children are cared for outside of freestanding children's hospitals, he noted, so quality data from general hospitals are needed to find the quality gaps.

The other characteristic that makes the VIP Network stand out is that it links process and outcome data, while most databases contain information only on outcomes. "I think the key thing that we're learning in health care is not only do you need outcome measures, you need performance drivers," Dr. Narang said. "How and why did these things occur?" ■

By Mary Ellen Schneider

Clinical Benefits Still Unproven

Rapid Response *from page 1*

nition and response to a patient's changing condition a national patient safety goal. The requirement, which went into effect in 2009, does not call on hospitals to have a rapid response team in place. However, institutions must have some type of system to respond quickly to calls for assistance at the bedside.

As rapid response teams have become more commonplace, some of the initial barriers to adoption have fallen away, Ms. Duncan said. For example, the high cost of having dedicated staff for the teams was initially a roadblock for many institutions; but Ms. Duncan said she has not been asked about cost in almost 3 years.

'Nursing satisfaction is something that is really driving not just the sustainability of rapid response teams, but is something that ... will continue to play a big role in how these teams work.'

And many hospitals are getting away from the idea of having "teams" with dedicated staff, especially in rural and small hospitals with a low volume of rapid response calls. Instead, some small hospitals are setting up systems that let the bedside nurse call on emergency physicians or paramedics, or just reach out to the only other nurse in the building.

But just as the rapid response teams themselves are changing, so are the expectations surrounding the results the intervention is likely to achieve. Early uncontrolled trials, mainly from outside the United States, showed that rapid response teams could lower inpatient mortality, unanticipated transfer to the ICU, and cardiac arrest rates. Some more recent studies, however, have cast doubt on those early findings. One much-cited randomized, controlled study could not reproduce the clinical benefits found in earlier studies (Lancet 2005;365:2091-7).

Despite the lack of evidence on hard clinical outcomes, other "salient benefits" of rapid response teams have emerged that encourage their use and have increased their popularity, said Dr. Sumant Ranji, assistant professor of medicine in the division of hospital medicine at the University of California, San Francisco.

The most significant benefit of the use of rapid response systems appears to be their appeal among bedside nurses, he said, who report that being able to call a rapid response team when a patient is deteriorating improves their ability to do their job well and their overall satisfaction at work.

At his own institution, Dr. Ranji said that the nurses value the presence of the rapid response team so much that when the administration considered cutting back the hours of the team for financial reasons, some of the nurse managers gave up part of their budgets to keep the team operating on a 24/7 basis.

The benefits of the rapid response teams from a nursing standpoint extend beyond just helping out in emergency situations, he said. The rapid response team at UCSF, which consists of a critical care trained nurse and a respiratory therapist, also provides education to the nurses on how to care for specific clinical situations. For example, their team has spent time educating the nurses in the step-down unit about the proper care for patients who have tracheostomies. That additional education has helped to minimize adverse events among those patients, Dr. Ranji said.

"Nursing satisfaction is something that is really driving not just the sustainability of rapid response teams, but is something that … will continue to play a big role in how these teams work," he said.

But researchers and clinicians are still figuring out the rapid response team model that works best, Dr. Ranji said. For example, is a physician-led model preferable to the typical model of a team with a nurse and a respiratory therapist? The nurse-led team has some pluses, Dr. Ranji said. At UCSF, they switched to a nurse-led team after their bedside nurses failed to call on the physician-led team. It was too big a leap to expect bedside nurses to ask for help from a physician who was not otherwise involved in the care of the patient, he said.

But physician-led teams have their own advantages, according to Dr. Winthrop F. Whitcomb, chief quality officer at Mercy Medical Center in Springfield, Mass., and cofounder of the Society of Hospital Medicine.

Having a hospitalist serve on the rapid response team, for example, brings physician-level diagnostic and therapeutic acumen to the bedside. Hospitalists can deliver "definitive" care, he said, diagnosing the cause of the patient's decline and starting treatment without delay. ■

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