High Reliability Healthcare: Realistic Goal or Wishful Thinking?

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President, The Joint Commission

4th International High Reliability Organizing Workshop
Making HRO Operational
Washington, D.C.
April 21, 2011
Joint Commission Overview

- American College of Surgeons: 1917
- Now----The Joint Commission
- We accredit or certify nearly 19,000 organizations or programs in the US and nearly 450 in 45 countries
- Programs include hospitals, home care, ambulatory, behavioral health, long term care and laboratories
- Private, not for profit, and voluntary
<table>
<thead>
<tr>
<th>Program</th>
<th>2010</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care</td>
<td>1900</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1900</td>
<td></td>
</tr>
<tr>
<td>Certification</td>
<td>2100</td>
<td></td>
</tr>
<tr>
<td>Home care</td>
<td>5800</td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>4500</td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>1700</td>
<td></td>
</tr>
<tr>
<td>Long Term Care</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18,900</td>
<td></td>
</tr>
</tbody>
</table>
Traditional Core Strengths

1. Create “optimally achievable” safety and quality standards for health care organizations

2. Continuously update standards to reflect changing science and practice

3. Develop and deploy most effective methods for onsite evaluation
Current State

Routine safety processes fail routinely

- Hand hygiene
- Medication administration
- Patient identification
- Communication in transitions of care

Uncommon, preventable adverse events

- Surgery on wrong patient or body part
- Fires in operating rooms
- Infant abductions
Future State

Joint Commission Vision

All people always experience the safest, highest-quality, best-value health care across all settings.
A Model That Works

TJC hospitals have improved markedly on core measures in use since 2002; several are at high levels of consistent excellence.

Acute MI: 2009 Hospital Performance

<table>
<thead>
<tr>
<th></th>
<th>US avg(%)</th>
<th>% &gt; 90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin on arrival</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>BB on discharge</td>
<td>98</td>
<td>97</td>
</tr>
</tbody>
</table>
High Reliability Science

- Research has defined how HROs produce sustained excellence over time.
- No health care organizations function at this high level of sustained safety.
- No guidance on how to transform organizations from low to high reliability.
- How do we create blueprints for health care to build high reliability?
Leadership

Trust

Improve

Report

Health Care

Safety Culture

High Reliability
From Health Affairs

**THE QUALITY JOURNEY**

By Mark R. Chassin and Jerod M. Loeb

**The Ongoing Quality Improvement Journey: Next Stop, High Reliability**

**ABSTRACT** Quality improvement in health care has a long history that includes such epic figures as Ignaz Semmelweis, the nineteenth-century obstetrician who introduced hand washing to medical care, and Florence Nightingale, the English nurse who determined that poor living conditions were a leading cause of the deaths of soldiers at army hospitals. Systematic and sustained improvement in clinical quality in particular has a more brief and less heroic trajectory. Over the past fifty years, a variety of approaches have been tried, with only limited success.
Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
## ISMP Workplace Intimidation Survey

### Results from ISMP Survey on Workplace Intimidation

Click here to view article "Intimidation: Practitioners speak up about this unresolved problem (Part I)"
Click here to view article "Intimidation: Mapping a plan for cultural change in healthcare (Part II)"

Total: 2095

<table>
<thead>
<tr>
<th>Potentially Intimidating Behaviors</th>
<th>By Physicians/Prescribers</th>
<th>By Others (e.g., pharmacist, nurse, supervisor)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>a. Reluctance or refusal to answer your questions, return phone calls or pages</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>b. Condescending language or voice intonation</td>
<td>28%</td>
<td>39%</td>
</tr>
<tr>
<td>c. Impatience with questions</td>
<td>25%</td>
<td>41%</td>
</tr>
<tr>
<td>d. Strong verbal abuse</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>e. Negative or threatening body language</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>f. Reporting you to your manager (actual or threat)</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>g. &quot;Just give what I/the attending ordered.&quot;</td>
<td>12%</td>
<td>25%</td>
</tr>
<tr>
<td>h. Physical abuse</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

ISMP, 2003---Respondents: Nurses 74%, pharmacists 17%
What Behaviors are Intimidating?

Wide range: impatience to physical abuse

Most common?

- Refusal to answer questions, return calls; condescending language or voice; impatience with questions
- About ¼ of nurses and pharmacists personally experienced these from MDs more than 10 times in past year

Media misrepresented as “disruptive MDs”
Not Only “Disruptive Physicians”

- High frequency intimidating behaviors
  - Ignoring pages or phone calls
  - Condescension, impatience with questions
- Physicians and others engage in them
- These behaviors destroy trust and stifle reporting of unsafe situations and behaviors
- Joint Commission requirement for Code of behavior aims to eliminate these behaviors
Robust Process Improvement

Systematic approach to problem solving: (RPI = lean, six sigma, change management)

The Joint Commission is adopting RPI
- Improve processes and transform culture
- Focus on our customers, increase value

The Joint Commission is adopting all components of safety culture

We measure RPI and safety culture and report on strategic metrics to Board
Center for Transforming Healthcare

Customers asking us for solutions

Delivering products at no added cost

- TJC: $10M; 9 other major donors
- AHA, BCBSA, BD, Cardinal Health, Ecolab, GE, GSK, J&J, Medline

2009: hand hygiene, wrong site surgery, and hand-off communications

2010: colorectal surgery SSIs (ACS)

2011: prevent CHF hospitalizations (ACP)
Participating Hospitals

- Cedars-Sinai
- Cleveland Clinic
- Exempla
- Fairview
- Froedtert
- Intermountain
- Johns Hopkins
- Kaiser-Permanente
- Mayo Clinic

- Memorial Hermann
- NY-Presbyterian
- North Shore-LIJ
- Northwestern
- OSF
- Partners HealthCare
- Stanford Hospital
- Trinity Health
- Virtua
- Wake Forest Baptist
Semmelweis’ Original Data

Monthly Death Rates

Handwashing Program

1841 1842 1843 1844 1845 1846 1847 1848
Some Important Causes of Hand Hygiene Failures

1. Faulty data on performance
2. Inconvenient location of sinks or hand gel dispensers
3. Hands full
4. Ineffective education of caregivers
5. Lack of accountability

Each requires a very different strategy to eliminate
## Causes Differ by Hospital

<table>
<thead>
<tr>
<th>Main Causes of Failure to Clean Hands</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective placement of dispensers or sinks</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Hand hygiene compliance data are not collected or reported accurately or frequently</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>Lack of accountability and just-in-time coaching</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
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<tr>
<td>Safety culture does not stress hand hygiene at all levels</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Ineffective or insufficient education</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands full</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Wearing gloves interferes with process</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception that hand hygiene is not needed if wearing gloves</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Health care workers forget</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Distractions</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
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Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.
Center Hand Hygiene Project

Aug 2010 = 81%
Sustained 10 mo.

April 2009 = 48%
Current Center Projects

- Hand hygiene: results disseminated
- Wrong site surgery: in pilot testing
- Hand-off communication: initial results released in October: pilots in 2011
- Surgical site infection in colorectal surgery
  - Partner: American College of Surgeons
- Reducing preventable hospitalizations:
  - Partner: American College of Physicians
  - Focus on patients with heart failure
Targeted Solutions Tool (TST)

- Uses secure, established extranet channels
  - No added cost for access to TST
  - Simplified, RPI-driven problem solving
- Educational, no jargon, no special training
- Voluntary, completely confidential
- Guides users to customized solutions
- All solutions proven by testing in hospitals
- Platform for delivering all Center solutions to Joint Commission customers
TST Use: First 7 Months

- 40,561 unique visitors to TST
- Growing rapidly: 1600-1700 per week
- 1667 hand hygiene projects initiated
  - 996 accredited organizations
  - Most but not all are hospitals
  - 40-50 new projects every week
- 135,361 observations entered
- Baseline = 47%
The Joint Commission and High Reliability

Consistent excellence is the vision

Leadership + safety culture + RPI

All Joint Commission programs and activities are aligning around this aim:

- Accreditation, performance measurement
- JCR education, publication, consulting
- Center-developed improvement solutions

Help customers improve no matter where they are on the journey to high reliability