What is High Reliability, and Why Does Health Care Need It?

Mark R. Chassin, MD, FACP, MPP, MPH
President and CEO, The Joint Commission

Oklahoma Hospital Association
Annual Convention
Oklahoma City, OK
November 2, 2016

The Joint Commission

The Joint Commission Today

1. Strong focus on enhancing customer value: improving accreditation, engaging physicians
2. Effective advocate with CMS: modernizing the most outdated COPs (2012 LSC, finally)
3. High reliability is gaining momentum
4. We are an improvement company, creating and delivering effective quality solutions: Center for Transforming Healthcare (CTH)

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Reframing the Mission of The Joint Commission

- Board refocused our mission in 2009
- Key part of effort to improve customer value
- Mission:

  "To improve health care for the public by evaluating health care organizations and inspiring them to excel…"
- Reoriented surveyors to the central need to conduct educational, collaborative surveys

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Representative Customer Comment

"I'm just getting caught up after last week; 30 surveyor days is exhausting. The survey team was highly collaborative while not yielding an inch on standards. I know---just the balance you're looking for. There were over a dozen systemic opportunities for improvement that we had not recognized on our own. I've never seen as experienced and effective a team as this group."

Bill Conway, MD, Henry Ford Health System

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Exceed Customer Expectations

- We track Net Promoter Score (NPS)
  - High bar for customer satisfacti
  - 0 to 10 scale on likelihood to rec d
  - NPS = (%9-10) minus (%0-6)
  - Assess drivers and work to i
- Likelihood to recommend (NPS)

2012	2013	2014	2015
59	61	62	64

Apple 66

Amazon 66

Comcast (Cable TV) -19

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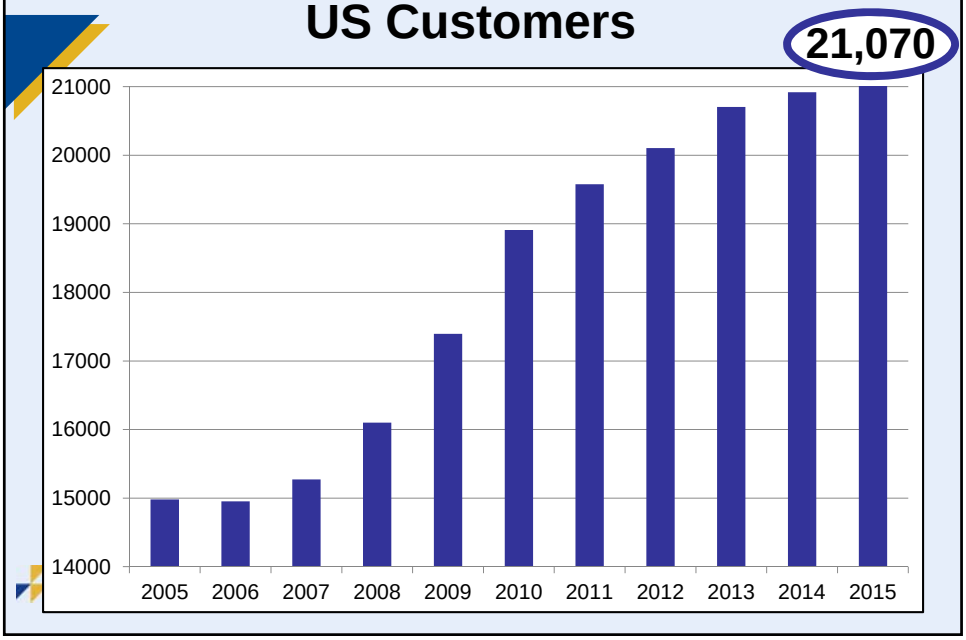
Growth in Joint Commission US Customers



Joint Commission US Customers

Program	2015
Ambulatory Care	2106
Behavioral Health	2288
Certification	3982
Home Care	5791
Hospitals	4393
Laboratory	1502
Long Term Care	1008
Total	21,070

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Payer Initiatives: Swiss Re

- One of world's largest reinsurers
- Preferential underwriting terms to liability insurance clients for using CTH tools:
  - Oro™ 2.0 (high reliability self-assessment)
  - Targeted Solutions Tools (TSTs) to improve hand hygiene, reduce falls, etc.
- 1st direct financial incentive for CTH adoption
- Exploring other incentives: ↓ premiums

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Payer Initiatives: Anthem Blue Cross

- Nation's 2nd largest private insurer
- Quality incentive program for 800 hospitals
  - Will include bonus payments for our integrated care certification and for antimicrobial stewardship standard
  - Incentive should offset certification fee
  - Joint promotional activities underway
- Exploring similar incentives for hospital-based palliative care, among others

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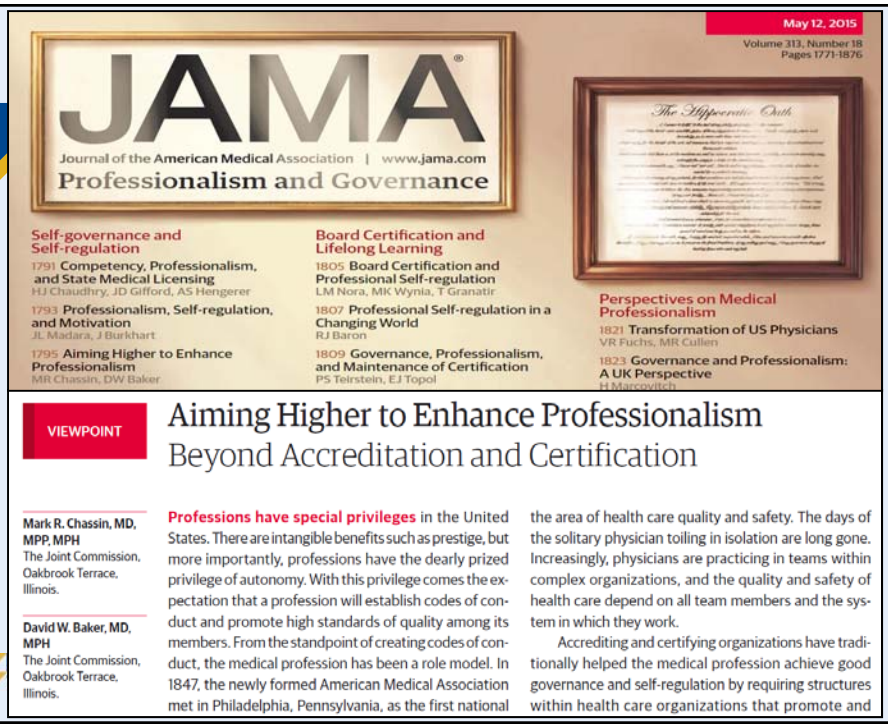

May 12, 2015
Volume 313, Number 18
Pages 1771-1876

JAMA
Journal of the American Medical Association | www.jama.com
Professionalism and Governance

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VIEWPOINT

Aiming Higher to Enhance Professionalism
Beyond Accreditation and Certification

Mark R. Chassin, MD, MPP, MPH
The Joint Commission, Oakbrook Terrace, Illinois.

David W. Baker, MD, MPH
The Joint Commission, Oakbrook Terrace, Illinois.

Professions have special privileges in the United States. There are intangible benefits such as prestige, but more importantly, professions have the dearly prized privilege of autonomy. With this privilege comes the expectation that a profession will establish codes of conduct and promote high standards of quality among its members. From the standpoint of creating codes of conduct, the medical profession has been a role model. In 1847, the newly formed American Medical Association met in Philadelphia, Pennsylvania, as the first national

the area of health care quality and safety. The days of the solitary physician toiling in isolation are long gone. Increasingly, physicians are practicing in teams within complex organizations, and the quality and safety of health care depend on all team members and the system in which they work.

Accrediting and certifying organizations have traditionally helped the medical profession achieve good governance and self-regulation by requiring structures within health care organizations that promote and

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Griffin Hospital: Insulin pen misuse could have infected patients with diseases

3000 patients over 6 years

Griffin Hospital President and CEO Patrick Charmel, left, demonstrates how the insulin pen was misused. Dr. Harold Schwartz, center, chief of gastroenterology, and Dr. Howard Quentzel, chief of infectious diseases, also spoke at a Friday press conference. Mercy A. Quaye — New Haven Register

Comments

Print

By Mercy A. Quaye, *New Haven Register*

POSTED: 05/16/14, 11:34 AM EDT | UPDATED: ON 05/17/2014 6 COMMENTS

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Illinois Woman Dies After Catching Fire in Surgery

Published September 18, 2009 · Associated Press 0 0

ST. LOUIS – A southern Illinois woman died after being severely burned in a flash fire while undergoing surgery, a rare but vexing problem in operating rooms.

Janice McCall, 65, of Energy, Illinois, died at Vanderbilt University Medical Center in Nashville, Tennessee, on Sept. 8, six days after being burned on the operating table at Heartland Regional Medical Center in Marion, Illinois, her family's attorney said.

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'You're taking out wrong kidney, surgeon was told'

by CLARE KITCHEN, Daily Mail

Comments (0) | Share

A surgeon accused of killing a patient by taking out the wrong kidney was warned he was making a mistake by a medical student watching the operation, a court heard yesterday.

Dr Mahesh Goel dismissed the concerns of student Victoria Fern and pressed on with the surgery, it was said.

Goel and consultant urologist John Roberts are accused of manslaughter over the 'appalling error' which left 70-year-old Graham Reeves with one diseased kidney.

The Korean War veteran died five weeks after the botched operation.

Roberts, 59, and Goel, 39, had shown a level of care far below that which is expected of competent surgeons, prosecutor Leighton Davies QC said.

'It was a drastic surgical error described by Mr Roberts himself in the aftermath as the worst thing he had done in his life,' said Mr Davies. 'He says it was an appalling error.'

Mr Reeves, who was single, was due to have his damaged right kidney removed. But the surgeons removed his left kidney and before the mistake was realised it was put in a jar of acidic sterilising agent.

'The right kidney was diseased for years and non-functioning,' Mr Davies told Cardiff Crown Court.

'The operation played a significant part in causing his death. It deserves to be condemned as gross negligence and therefore a crime.'

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Current State of Quality

- 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 ORs, retained foreign objects
  - Infant abductions, inpatient suicides

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Current State of Improvement

- We have made some progress
  - Project by project: leads to “project fatigue”
  - Satisfied with modest improvement
- Current approach is not good enough
  - Improvement difficult to sustain/spread
  - Getting to zero, staying there is very rare
- High reliability offers a different approach
  - The goal is much more ambitious
  - High reliability is not a project

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High Reliability Healthcare

- Our team has worked for 7 years with academics and experts from HROs (nuclear, aviation, military, amusement parks)
- We have created a model for healthcare:
  - Leadership committed to goal of zero harm
  - Safety culture embedded throughout
  - RPI (lean, six sigma, change management)
- Many resources, tools, and programs

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Milbank Q 2013;91(3):459-90

Joint Commission High Reliability Initiatives

- High Reliability Resource Center
- Self Assessment Tool for hospitals (Oro™ 2.0) extensively tested, available now
- Partnering in South Carolina, Michigan, and Illinois with state hospital associations
- Using high reliability framework on survey
- Tools for getting to zero: Center for Transforming Healthcare and TST

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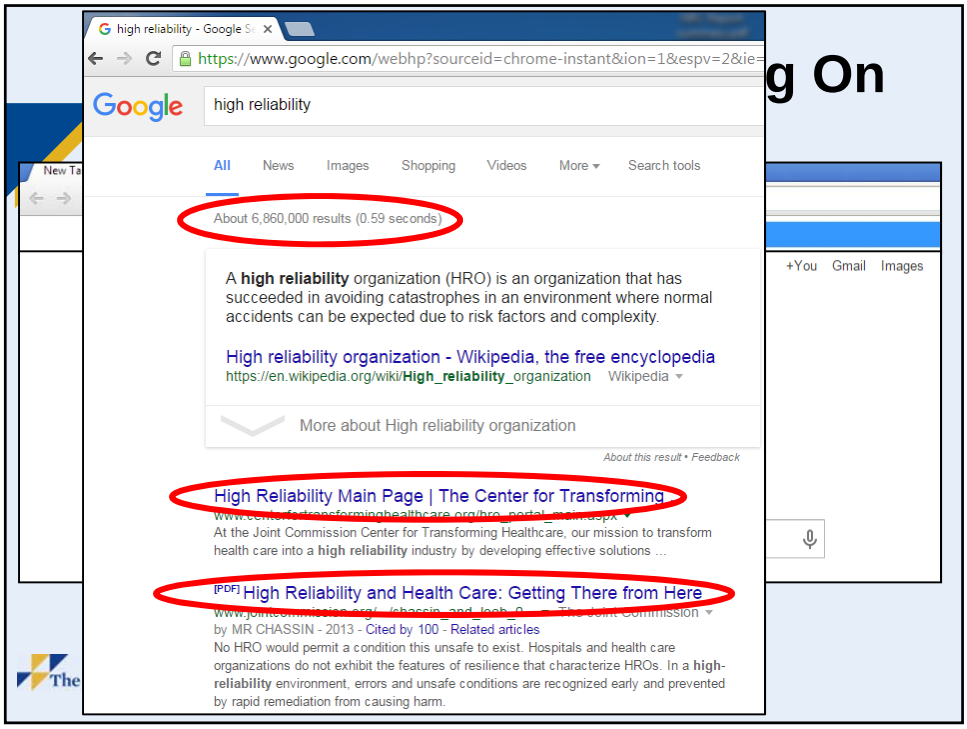
tst
TARGETED SOLUTIONS TOOL™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A high reliability organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.
High reliability organization - Wikipedia, the free encyclopedia
https://en.wikipedia.org/wiki/High_reliability_organization Wikipedia
More about High reliability organization
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High Reliability Main Page | The Center for Transforming
At the Joint Commission Center for Transforming Healthcare, our mission to transform health care into a high reliability industry by developing effective solutions ...
[PDF] High Reliability and Health Care: Getting There from Here
by MR CHASSIN - 2013 - Cited by 100 - Related articles
No HRO would permit a condition this unsafe to exist. Hospitals and health care organizations do not exhibit the features of resilience that characterize HROs. In a high-reliability environment, errors and unsafe conditions are recognized early and prevented by rapid remediation from causing harm.


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by MR CHASSIN - 2013 - Cited by 100 - Related articles
No HRO would permit a condition this unsafe to exist. Hospitals and health care organizations do not exhibit the features of resilience that characterize HROs. In a high-reliability environment, errors and unsafe conditions are recognized early and prevented by rapid remediation from causing harm.

Leadership

- All components of leadership must commit to the ultimate goal of high reliability (zero harm): Board, management, MD and RN leaders
- Quality is the number one strategic priority
- Physicians lead and participate in QI
- Quality program goes beyond requirements
- Improvement efforts directed at most important causes of harm in your patients
- Quality measures widely published

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Safety Culture

- Aim is not a “blame-free” culture
- HROs separate blameless errors (for learning) from blameworthy ones (for discipline, equitably applied to all groups)
- Prerequisites for safety culture in health care
  - Eliminate intimidating behaviors
  - Hold everyone accountable for consistent adherence to safe practices
- HROs balance learning and accountability

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What Behaviors are Intimidating?

- Wide range: impatience to physical abuse
- Most common?
- Refusal to answer questions or to return phone calls or pages; condescending tone or language; impatience with questions
- 2013 ISMP survey:
  - 11-15% personally experienced these from MDs and non-MDs >10 times in past year
  - 63%: constant nit-picking, fault-finding

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Sentinel Event Alert on Intimidating Behaviors

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Results from ISMP

2095 4884

"At least once" in past year (%)	2003	2013
1. Assumed order correct to avoid contact	39	33
2. Asked colleague to talk to prescriber	39	38
3. Pressured to act, despite safety concern	49	39
4. Assumed order safe due to reputation	34	30

	2003	2013
Past disrespectful behavior altered handling of order clarification or questions **(% YES)**	49	44
My organization deals effectively with disrespectful behavior **(% NO)**	61	56

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Robust Process Improvement

- Systematic approach to problem solving (lean, six sigma, and change management)
- The Joint Commission has fully adopted 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

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Quality Progress
Cover Story
June 2016

The Joint Commission

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Lean and Six Sigma

- Lean empowers employees to identify and act on opportunities to improve processes
- Lean tools increase value by eliminating steps in processes that represent pure waste
- Six sigma improves outcomes of processes by identifying and targeting causes of failure
- Together they are a systematic, highly effective toolkit for process improvement

→ Lean and six sigma routinely produce 50%+ improvement

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Technical Solution is Not Enough

- Lean, six sigma provide technical solutions that can markedly improved processes
- Why does improvement fail so often?
  - Not for lack of a good technical solution
  - Failures occur when organization fails to accept and implement a good solution it had
- RPI addresses this challenge directly
- Change management = a systematic way to implement and sustain good solutions

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Technical Solution is Not Enough

- Lean, six sigma provide technical solutions th
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- R
- Change management = a systematic way to implement and sustain good solutions

Change management is the rocket science of improvement

had

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Facilitating Change™

Key components of managing change

1. Plan: engage all stakeholders, identify sponsor, champion and process owner
2. Inspire: paint a convincing picture of how beneficial the change will be
3. Launch: initiate the change, intensify communication to stakeholders
4. Support: sustain the improvement; empower process owner

- Change management is not linear

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Resistance to Change

- Managing resistance is critical to success
  - "Resistance Analysis" is a vital tool
  - Who is likely to resist and why?
- Sources of resistance
  - Technical
  - Political
  - Cultural
- Each requires a different strategy to overcome

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RPI in Health Care Today

- Only a small percentage of hospitals or systems use RPI in any form or fashion
- RPI is used differently by different hospitals
  - Most use only some of the parts; change management is most often left out
  - Most limit training to small group
  - Most do not use it to transform
- Compelling business case for RPI

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The Business Case

- Administrative processes in health care are often just as broken as clinical processes
  - Billing, supply chain, throughput
  - RPI can improve margins directly
- Learning RPI allows organizations to solve their own problems, eliminate consultants
- Quality improvements often don't save $$
- Generate positive ROI now while learning how to redesign care processes for future
- Mayo program ROI = 5:1

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J Patient Safety 2013;9(1):44-52

Training and Deployment

- We have a large group of experts in lean, six sigma, and change management (RPI)
  - Studied experience of major corporations (for example, GE, Lilly, BD, Cardinal)
  - Extensive experience with 27 hospitals and systems applying RPI tools
- We are training hospitals and systems to:
  - Get the most out of RPI tools and methods
  - Embed RPI throughout their organizations

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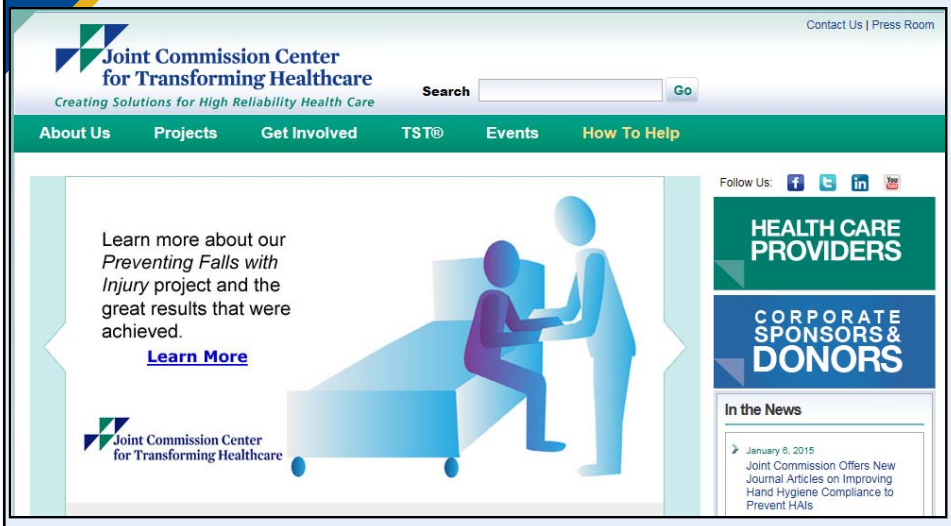
Center for Transforming Healthcare



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Center for Transforming Healthcare

- Using RPI together with leading US hospitals and health systems to solve most difficult quality and safety problems
- Project topics:
- 2009-10: hand hygiene, wrong site surgery, hand-off communications, SSIs
- 2011: safety culture, preventable HF hospitalizations, and falls with injury
- 2012: sepsis mortality, insulin safety
- 2013-4: C. difficile prevention, VTE

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Participating Hospitals

- Atlantic Health
- Barnes-Jewish
- Baylor
- Cedars-Sinai
- Cleveland Clinic
- Exempla
- Fairview
- Floyd Medical Center
- Froedtert
- Intermountain
- Johns Hopkins
- Kaiser-Permanente
- Mayo Clinic
- Memorial Hermann
- New York-Presbyterian
- North Shore-LIJ
- Northwestern
- OSF
- Partners HealthCare
- Sharp Healthcare
- Stanford Hospital
- Texas Health Resources
- Trinity Health
- VA Healthcare System-CT
- Virtua
- Wake Forest Baptist
- Wentworth-Douglass

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Health Facilities Management Magazine

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RPI Improves Housekeeping

- New wing added in 2012: 130,000 SF
- Challenge to ES staff:
  - Add this building to existing 364,000 SF
  - No new staff, same high quality cleaning
- Used RPI to redesign workflow
- Met the challenge
- Saved the hospital about $440,000

Wentworth-Douglass RPI program = 3:1 ROI
(only 60% of projects aim at financial goals)

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Current State of Quality

- Routine safety processes fail routinely
  - Hand hygiene
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  - Infant abductions, inpatient suicides

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RPI Delivers Results

- "One-size-fits-all" best practice is inadequate
- Complex processes require more sophisticated problem-solving methods (RPI)
- Three crucial and consistent findings:
  - Many causes of the same problem
  - Each cause requires a different strategy
  - Key causes differ from place to place
- **RPI**: producing next generation best practices; solutions customized to your causes

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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

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Causes Differ by Hospital

Main Causes of Failure to Clean Hands (across all participating hospitals)	Each letter = one hospital							
	A	B	C	D	E	F	G	H
Ineffective placement of dispensers or sinks		x		x	x		x	x
Hand hygiene compliance data are not collected or reported accurately or frequently	x	x		x	x			x
Lack of accountability and just-in-time coaching		x	x	x	x		x	x
Safety culture does not stress hand hygiene at all levels			x	x	x	x		x
Ineffective or insufficient education		x	x	x	x		x	
Hands full	x	x	x	x	x		x	
Wearing gloves interferes with process	x	x	x	x			x	
Perception that hand hygiene is not needed if wearing gloves	x		x	x	x		x	x
Health care workers forget	x	x		x			x	
Distractions	x	x				x	x	

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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.

RPI Drives Major Improvements

Center Projects	Results(%)
Hand hygiene	71↑
Hand-off communication failures	56↓
Wrong site surgery risks	
• Scheduling	46↓
• Pre-op	63↓
• Operating Room	51↓
Colorectal SSIs	32↓
Falls with injury	62↓

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Milbank Q 2013;91:459-90; J Nurs Care Qual 2014;29:99-102

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Targeted Solutions Tool (TST)

- Web-based tools: secure extranet channel
  - Available to all accredited customers now
  - No added cost, voluntary, confidential
- Educational, no jargon, no special training
- Coaches available to guide users to solutions
- Targeting only your causes means you don't use resources where they aren't needed
- 2010: hand hygiene; 2012: safe surgery and hand-off communication; 2015: falls

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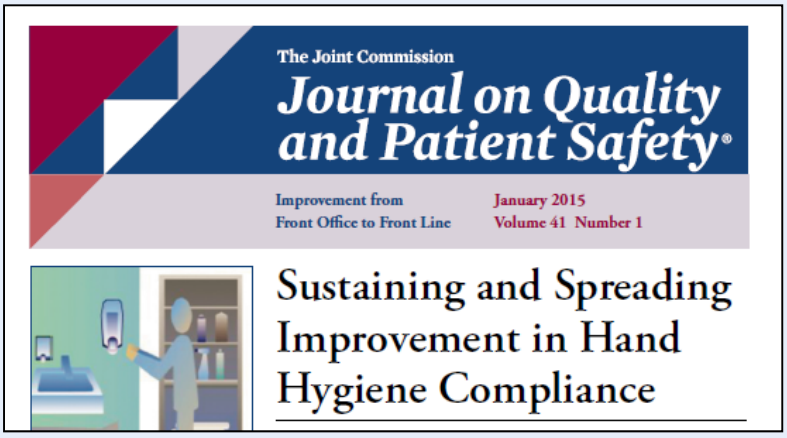
January 2015



Jt Comm Journal on Qual Pat Safety 2015;41(1):4-12 and 13-25

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Impact of Hand Hygiene TST

TST improves HH: 55% to 85%, Reduces HAIs by 35%

200 Beds

- Expect 370 HAIs/yr
- Annual impact:
  - 129 fewer HAIs
  - 8 lives saved
  - $2.5M cost avoided

400 Beds

- Expect 730 HAIs/yr
- Annual impact:
  - 260 fewer HAIs
  - 16 lives saved
  - $5M cost avoided

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CLEVELAND.COM

Cleveland MetroHealth Medical Center increases hand washing, reduces infections

Published: Saturday, September 03, 2011, 5:50 AM Updated: Saturday, September 03, 2011, 7:44 AM

By Sarah Jane Tribble, The Plain Dealer

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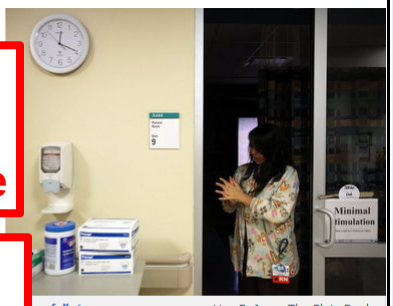
CLEVELAND, Ohio — Who would have thought that Mom could be so right?



ew full size Lisa DeJong, The Plain Dealer

veland MetroHealth Hospital nurse Midalia Gonzalez uses
d sanitizer Friday after seeing a patient in the pediatric ICU.

Used TST to achieve >95% hand hygiene compliance

Bloodstream infections fell by 2/3

they are called, began making their rounds in January, bloodstream infections at the hospital have dropped to one-third what they were for all of last year.

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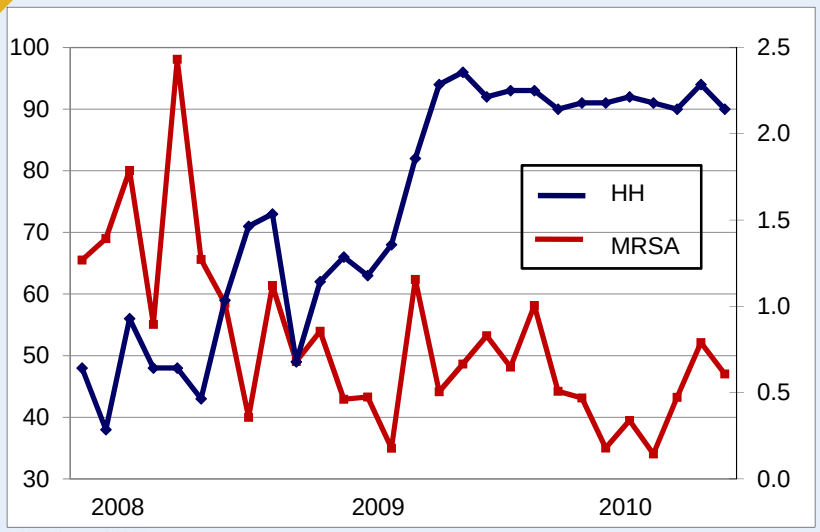
MRSA Rate Decreases as Hand Hygiene Improves



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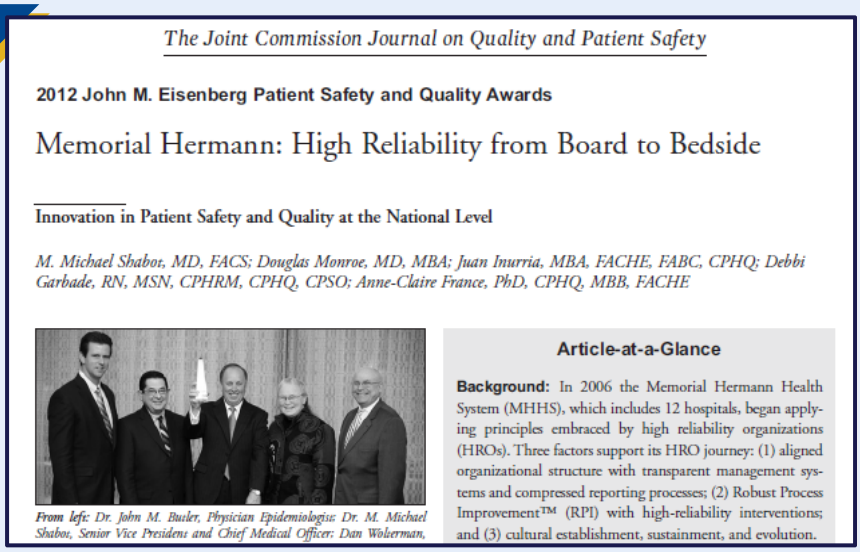
Memorial Hermann: Getting to Zero



The Joint Commission Journal on Quality and Patient Safety

2012 John M. Eisenberg Patient Safety and Quality Awards

Memorial Hermann: High Reliability from Board to Bedside

Innovation in Patient Safety and Quality at the National Level

M. Michael Shabot, MD, FACS; Douglas Monroe, MD, MBA; Juan Inurria, MBA, FACHE, FABC, CPHQ; Debbi Garbade, RN, MSN, CPHRM, CPHQ, CPSO; Anne-Claire France, PhD, CPHQ, MBB, FACHE

From left: Dr. John M. Bueler, Physician Epidemiologist; Dr. M. Michael Shabot, Senior Vice President and Chief Medical Officer; Dan Wolverman,

Article-at-a-Glance

Background: In 2006 the Memorial Hermann Health System (MHHS), which includes 12 hospitals, began applying principles embraced by high reliability organizations (HROs). Three factors support its HRO journey: (1) aligned organizational structure with transparent management systems and compressed reporting processes; (2) Robust Process Improvement™ (RPI) with high-reliability interventions; and (3) cultural establishment, sustainment, and evolution.

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Jt Comm J 2013;39(6):253-57

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Journal on Quality and Patient Safety®

Improvement from Front Office to Front Line

January 2016
Volume 42 Number 1

Sustaining Improvement in Hand Hygiene and Health Care–Associated Infections

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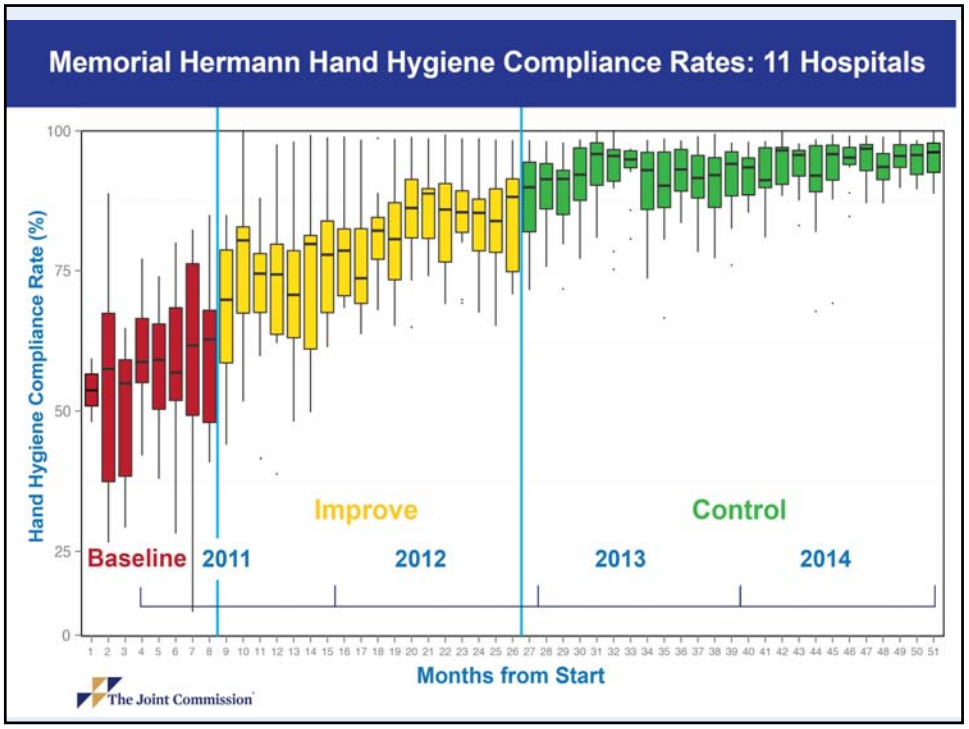
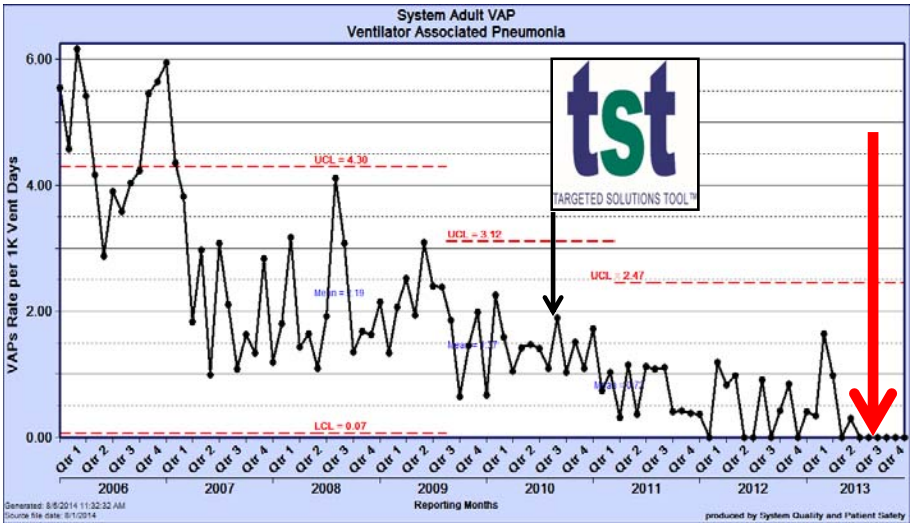
Jt Comm Journal on Qual Pat Safety 2016;42(1):6-17



System - Ventilator Associated Pneumonias: All Adult ICUs

MEMORIAL HERMANN



HAI Hospital Scorecard

MEMORIAL HERMANN

Sugar Land Hospital HAI Scorecard

ICU CLABSI	Floor CLABSI	ICU CAUTI	Floor CAUTI	Total SSI	Perf Std SSI	NHSN SSI
0	0	0	0	0	0	0

Hip	Knee	ORIF	MRSA	Clostridium *difficile*
0	0	0	0	0

Number of HAIs in one month

Michael Shabot, MD
Memorial Hermann System EVP

"We fully attribute to the Center for Transforming Healthcare's hand hygiene TST the final drop in HAI rates to zero or near-zero system-wide. After implementing the hand hygiene TST, our hospitals began to report zeros as their most common monthly CLABSI and VAP result. Our mothers were right after all! Feel free to quote me. This actually saves lives."

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Joint Commission and High Reliability

- We must have much more ambitious goals for healthcare improvement: zero harm
- Current methods are inadequate
- Culture change is difficult, takes time
- Lean, six sigma, and change management (RPI) are delivering impressive results
- ROI of at least 4:1 is readily achievable
- Some hospitals/systems approaching zero
- Joint Commission has tools to help

The Joint Commission