Process-Improvement Center to Share Lessons

BY SUSAN BIRK

ROSEMONT, ILL. — In an effort to help health care providers make lasting improvements in quality and safety, the Joint Commission has established the Center for Transforming Healthcare to disseminate data and lessons from leading health care organizations that have successfully implemented robust process-improvement methods developed by other industries.

The Joint Commission's center, which will function separately from the accreditation process, is developing a Web-based tool and other resources to help guide organizations through process improvement.

"The aim is to deliver this to accredited organizations at no extra cost," Dr. Mark R. Chassin said at the Joint Commission national conference on quality and patient safety.

Health care providers have expressed a desire for information from the Joint Commission on effective solutions to safety and quality problems. "What I hear from our customers is: 'Don't keep telling us only about the problems—tell us how we can get better,' " he said.

Health care providers can make major and durable improvements in patient safety and quality by adopting "robust process-improvement" tools that are widely used by high-reliability industries such as commercial aviation and nuclear energy, where adverse events are far less common than in health care, Dr. Chassin said.

The Joint Commission does not plan to require the use of these tools as a condition for accreditation. However, emerging evidence indicates that these methodologies—including the Lean, Six Sigma, Toyota Production System, and GE Change Acceleration Process models—"work just as well when applied to our very nasty safety and quality problems as they do in all of the other very successful business and administrative processes where they've been tried," Dr. Chassin said. "I am firmly convinced that the tools of robust process improvement are an incredibly important vehicle for getting us much farther down the road."

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DR. CHASSIN

With that in mind, "we are collaborating with physicians, nurse leaders, and managers of hospitals and health systems where Lean and Six Sigma are already working—organizations that have already made the investment and have mastered those tools. And we are deploying teams from those institutions to solve the most difficult quality and safety problems facing all of American health care," Dr. Chassin explained. "Our job at the Joint Commission is to build the knowledge database, compiling all of that learning across all of those organizations, and to spread it to other organizations."

The center's first project, devoted to hand hygiene, is a collaborative effort with several institutions nationwide. Using high-reliability strategies, these organizations documented average hand-washing rates below 50% at their institutions, rates much lower than previously believed. A range of solutions tailored to specific causes of noncompliance are now being tested.

See Adviser's Viewpoint on p. 5.

The second project, which will focus on breakdowns in handoff communications, has several different participant organizations across the country.

The third project, which will target wrong-site surgery, will be a collaboration with Rhode Island Hospital (Providence) and Newport (R.I.) Hospital on the development and testing of a universal protocol for avoiding such errors.

High-reliability industries manage risks far more effectively than do health care providers because these industries have "a set of tools and principles that allows them to look very hard at their processes and perfect them, and then a culture that wraps around those improvement tools [and] that allows those nearly perfect processes to continue at high levels of safety for long periods of time," Dr. Chassin said.

This type of firmly embedded culture, currently absent in health care, begins with the rigorous identification of problem root causes. Health care providers generally do a good job of defining problems and measuring outcomes, but they often gloss over the critical step of identifying exactly why a process is not working, he said. In order to develop effective, durable interventions, "you have to understand the specific causes of the problem where you're trying to fix it."

"You can have the best technical solution … but if nobody uses it and everybody hates it, it will have no impact," Dr. Chassin said. To deal with that problem, robust process improvement incorporates explicit change-management principles and tools into the process at the very beginning.

High-reliability organizations often automate processes after they have perfected them, but automation is not always possible in health care, he noted. "What we are charged with if we're going to get improvement that is sustained is changing the behavior of the individuals that work in the health care delivery system and maintaining that changed behavior over long periods of time."

The Joint Commission Center for Transforming Healthcare has received support from the American Hospital Association, BD, Ecolab, GE Healthcare, Johnson & Johnson, the Federation of American Hospitals, and Hospira. ■

For more information, go to www.centerfortransforminghealthcare.org.

More Accountability Needed to Improve Patient Safety

BY SUSAN BIRK

ROSEMONT, ILL. — Despite major patient safety strides during the past decade, health care providers need to create more accountability for medical errors and patient safety lapses in order to continue improving, according to Dr. Robert M. Wachter, professor and associate chairman of medicine at the University of California, San Francisco.

At the Joint Commission national conference on quality and patient safety, Dr. Wachter offered his perspectives on the status of patient safety in health care 10 years after the publication of the first Institute of Medicine report on the subject (To Err Is Human: Building a Safer Health System). He and Dr. Peter J. Pronovost of Johns Hopkins University, Baltimore, published an editorial on the topic shortly after the conference (N. Engl. J. Med. 2009;361:1401-6).

Balancing a culture of "no blame" with a culture of accountability remains a key challenge for providers. While it's true that "most errors are committed by caring, competent people trying hard to get it right … the system produces low-quality, unsafe, unreliable care partly because there's been no business case to do otherwise," said Dr. Wachter, who edits two online publications for the Agency for Healthcare Research and Quality: WebM&M (www.webmm.ahrq.gov) and Patient Safety Network (www.psnet.ahrq.gov).

Dr. Wachter cited the fact that average hand-washing compliance rates continue to hover at only about 50% as an example of the need for more accountability. "I don't believe that is fully a systems problem," he said. Part of the problem is that "there have been no penalties for transgressions."

Dr. Wachter also commented on other aspects of patient safety:

► **Regulation.** Health care organizations need regulators to set standards, but the challenge is ensuring that these standards truly help organizations improve safety. Until the Joint Commission developed standards for reading back instructions, "virtually none of us thought of doing that on our own," he said.

At the same time, "it is extraordinarily difficult to have a set of rules and standards that apply equally in nuanced areas to organizations that are incredibly different in the way they do business, their financial resources, and their capacity," he said.

Part of the problem in improving patient safety is that 'there have been no penalties for transgressions.'

DR. WACHTER

For that reason, "regulation is extraordinarily useful to get people moving, but it tends to run out of gas over time," Dr. Wachter said. To illustrate, he cited the Joint Commission's recent decision to remove adherence to medication reconciliation standards as a requirement for accreditation because organizations struggled to develop appropriate processes.

However, having an "outside organization creating rules and standards we must abide by was extraordinarily important in the first 5 years" after the IOM report, he said. Despite some glitches, "the Joint Commission has improved its processes tremendously" and made an important step in the right direction with the creation of the Center for Transforming Healthcare. (See story on this page.)

► **Reporting.** "The admonition to report everything is silly," Dr. Wachter said. "Our mistake here was to not be thoughtful about what we are going to do with all of these reports" before requiring them.

However, providers have begun to think more critically about what should be reported and how the data should be used, he said.

State reporting requirements on the 27 "never events" put forth by the National Quality Forum have led to more focused patient safety efforts. "Until the state reporting system, our process [at UCSF] for doing root cause analysis was pretty haphazard and ad lib," he noted. Now the institution holds a weekly 2-hour root cause analysis meeting.

► **Information technology.** Health care providers have developed a more robust understanding of the role of information technology in patient safety and now realize that it is not a panacea. Improvement efforts are not nearly as effective "if we just do the computer piece but don't educate people," he said.

Still, "even though we've got plenty of room to go, I think we should all be proud" of what has been accomplished in the past 10 years, he said. ■