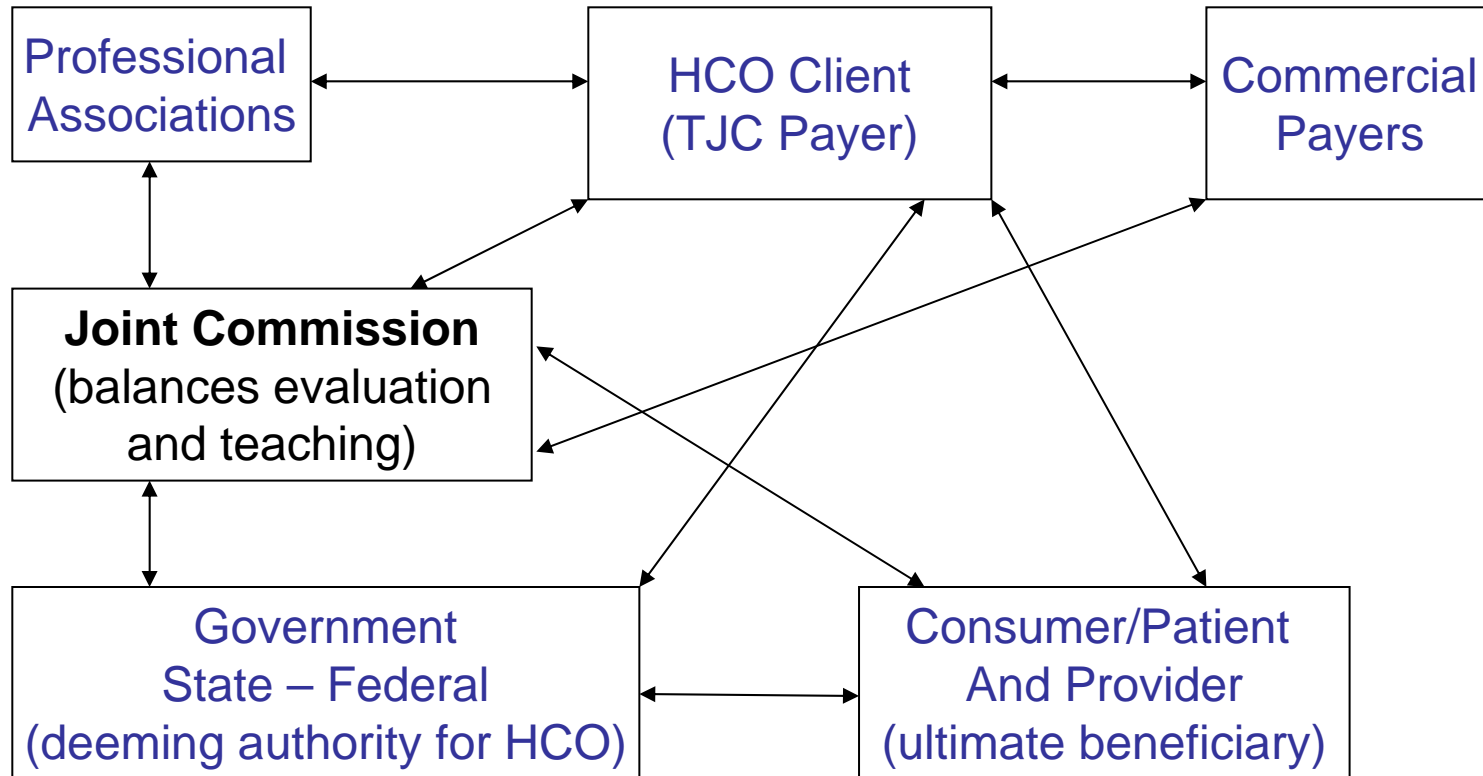




# **The Massachusetts General Hospital and The Joint Commission: Working Together to Improve Quality and Patient Safety**

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## Quality and Patient Safety: Balancing Constituents



# Today and Tomorrow's "Vision" for The Joint Commission

- ▶ Together with our health care organizations, to lead the transformation of health care into a high-reliability industry, with rates of adverse events and safety process breakdowns comparable to air travel



# The Sigma Gap

Sigma Level

Defects per Million

1	690,000
2	308,000
3	66,800
4	6,210
5	230
6	3.4

Airlines – 0.43  
deaths/million  
passengers

Hospitalizations – approx  
2,300 deaths due to  
error/million admits

Merry, M.D. & Brown, J.P.  
J. Innovative Management  
7(2), 2001

# What is High Reliability?

- ▶ Characteristics of organizations that manage serious hazards extremely well
- ▶ Focus on a particular culture and a set of operating and management principles
- ▶ Weick: “Safety is a dynamic non-event”
- ▶ Getting to high reliability will be a long road

# Characteristics of High Reliability Organizations

- ▶ Continually operate under difficult, unpredictable situations yet have fewer than typically expected problems
- ▶ “Do the right things right” more consistently than expected
- ▶ Avoid harm to human beings
- ▶ Use a series of defense mechanisms and “checks and balances” to constantly anticipate what might happen, evaluate when something hasn’t happened that should have, or imagine the “unthinkable”

# Examples of HROs Outside Healthcare

- ▶ Air travel maintenance operations
- ▶ Air traffic control
- ▶ Aircraft carriers flight deck operations
- ▶ Nuclear energy
- ▶ Aerospace industry
- ▶ Firefighting



Sources: [Managing the Unexpected](#), 2<sup>nd</sup> edition (2007) by Weick and Sutcliffe & [Managing Maintenance Error](#) (2003) by Reason & Hobbs

# Analogy to Hospital Care



- ▶ Aviation safety and hospital safety are not perfectly analogous- lots of hospital emergencies, much less planned, many small hospitals, vagaries of biology, etc...but,
- ▶ Both are highly technical endeavors, with highly trained, smart and well paid people in charge
- ▶ Public expects a high degree of professionalism and safety
- ▶ Both industries run on thin margins and need to balance safety with the bottom line and customer satisfaction

# Common Reasons Healthcare Organizations Do Not Behave Like HROs

- ▶ **Current improvement methods in health care are excessively dependent on vigilance and hard work**
- ▶ **The current practice of benchmarking to limited outcomes in health care give clinicians and leaders a false sense of process reliability**
- ▶ **A permissive attitude toward clinical autonomy creates and allows for wide, and unjustifiable, performance variation**
- ▶ **Processes are rarely designed to meet specific, articulated reliability goals**

Source: IHI experience with 40 organizations working to achieve higher levels of reliability for Core Measures

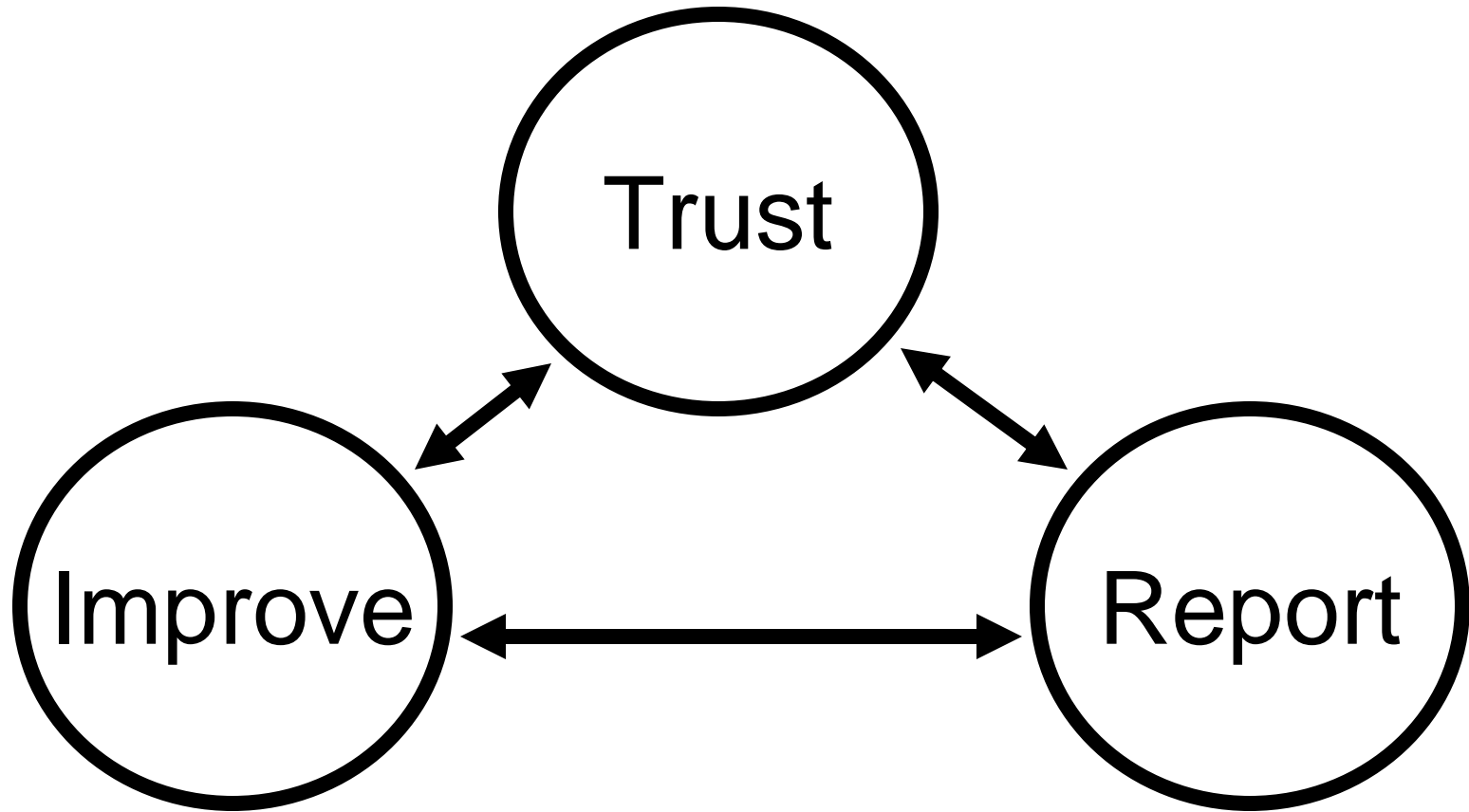
# Challenges with High Reliability

- ▶ “Patient Safety and Quality” – the second most pressing issue identified by hospital CEOs (ACHE 2008)
- ▶ Healthcare Acquired Infections – 5% to 10% of hospitalized patients (~ 2 million each year – 99,000 deaths and \$4.5 billion in additional health care costs)
- ▶ Medication errors – 1.5 million Americans injured annually (IOM 2007)
- ▶ Wrong site (patient or procedure) surgery – 116 new cases reported to The Joint Commission in 2008 (741 cases since 1996)

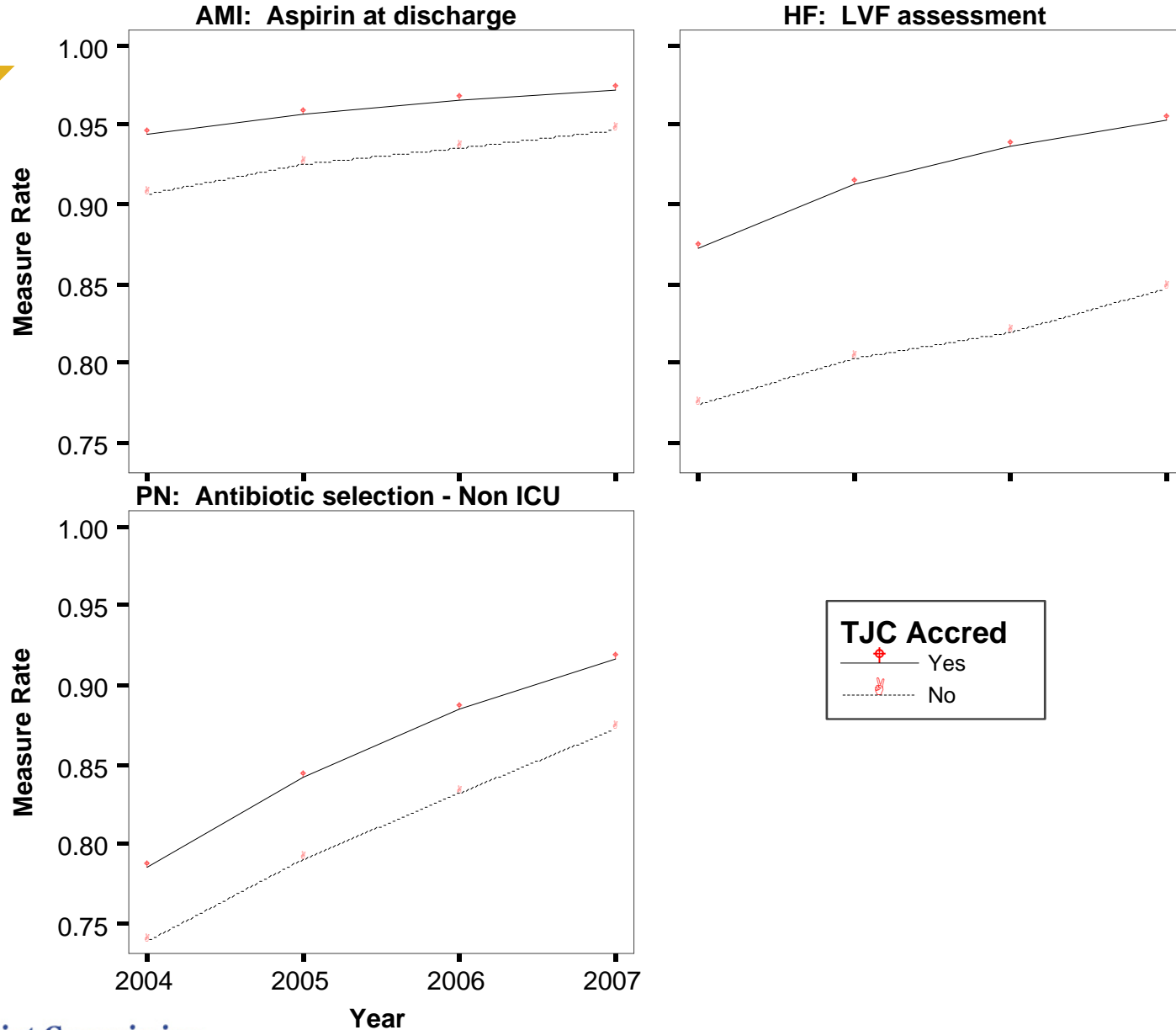
# How Can We Do Much Better?

- ▶ Our goal must be to drive the delivery system to achieve major, sustainable improvements
- ▶ A “little better” is not good enough
- ▶ We must document improvements for replicability
- ▶ Major barriers are:
  - 1) Lack of capacity to execute and disseminate findings
  - 2) Poor understanding of how to greatly reduce rates of serious adverse events

# The 3 Imperatives of a Safety Culture

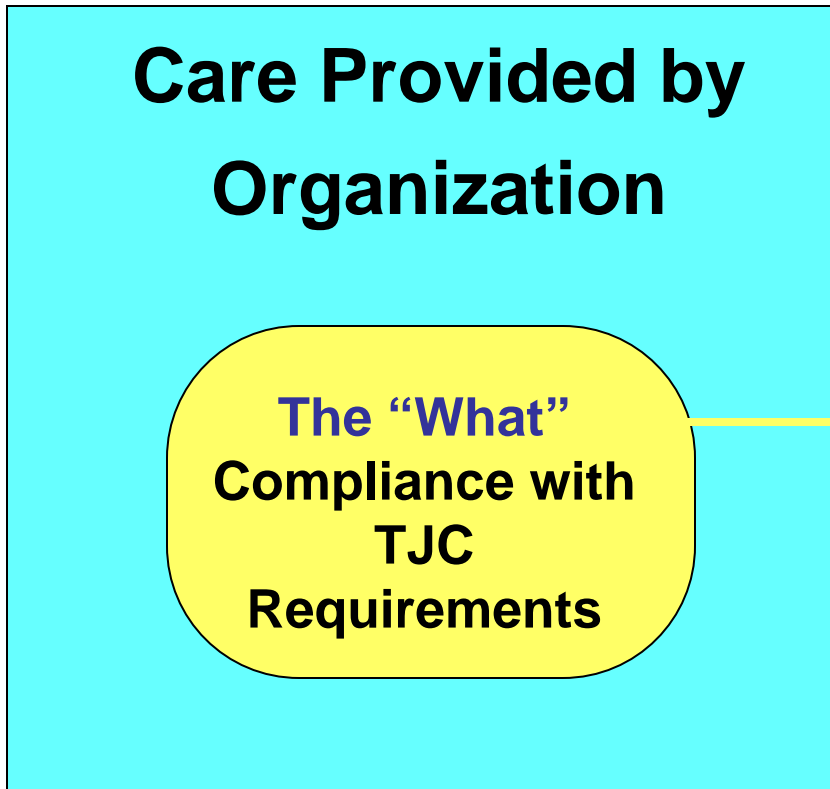
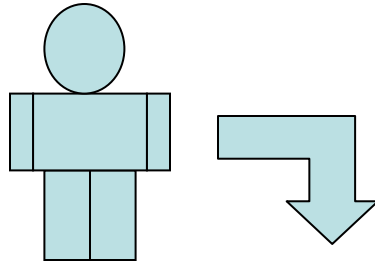


# Joint Commission Accreditation Does Make A Difference

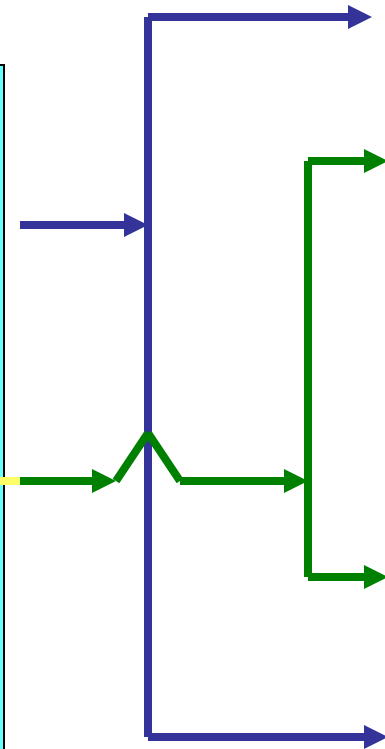
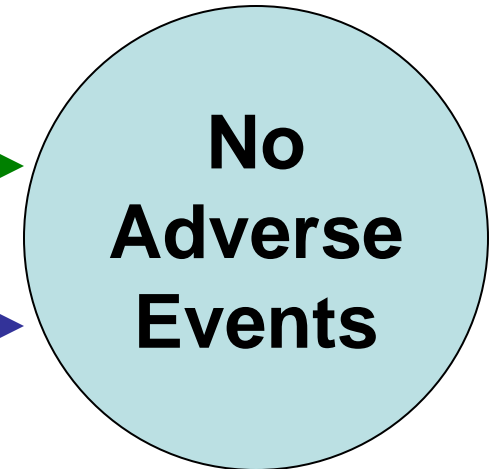


# Key Link: Evaluate Process Measures & Patient Outcomes

Patients



The "How"



# Moving Forward: Today's Joint Commission

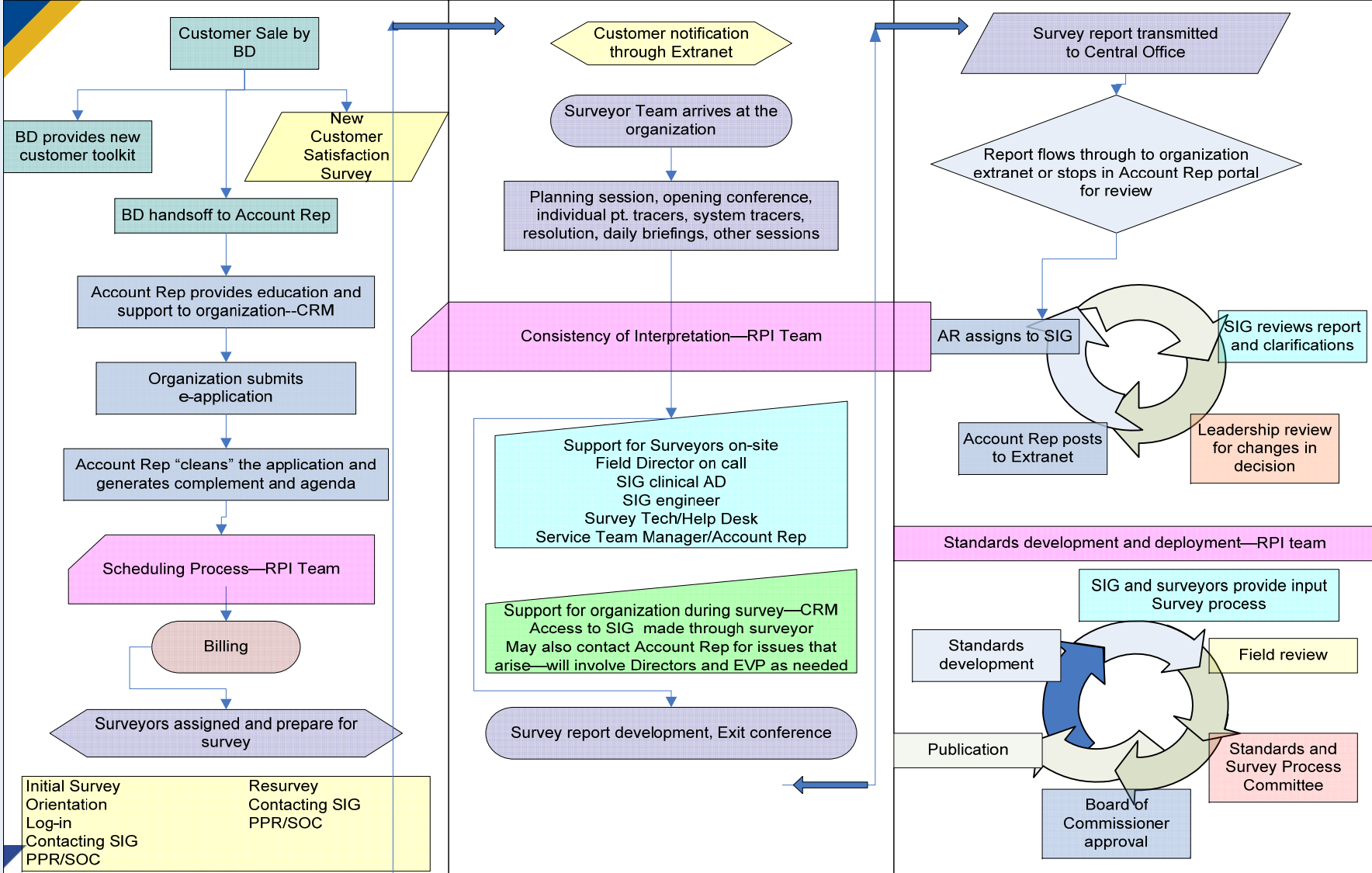
- ▶ Continue to aggressively improve standards and survey process (for example, the Standards Improvement Initiative)
- ▶ Lead effort to “harmonize” measures and focus improvement on highest priorities
- ▶ Increase confidence that improving on measures and complying with standards will improve health outcomes
- ▶ New programs to use robust process improvement to increase safety and quality

# Accreditation Mega Process Redesign

## Pre Survey Processes

## Survey Process

## Post Survey Processes



# Moving Forward: Tomorrow's Joint Commission

- ▶ Remarkable world-wide convergence on health care quality and safety issues
- ▶ Balance evaluative/regulatory function with coach/teacher/mentor functions
- ▶ Harness global investment to produce generalizable, durable solutions
- ▶ Spread these highly effective interventions throughout delivery system
- ▶ Next generation of accreditation standards will assess institutions for their robust process improvement

# Progressing Up “The Stairway to Excellence”



High Reliability,  
Quality and Safety

*The Joint Commission’s value is built on helping each organization on its own journey up these “Steps” to High Reliability, Quality and Safety*



# Questions for Consideration

1. What is the most critical action health care organizations must pursue to become highly reliable for patients?
2. How do we engage physicians in this journey?
3. What can The Joint Commission do to help in the journey?