American Hospital Association’s Physician Leadership Forum

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The Joint Commission
We are three 501 3(c) Companies

One Vision

All people always experience the safest, highest quality, best-value health care across all settings.
Current JCIA

52 Countries as 1 Jan 2013
529 Accredited Organizations
Knowledge gaps

- Disparity in knowledge and commitment among members of the C-suite on quality and safety
- Technical performance improvement expertise
- Accreditation and regulatory
- Accountability principles
- Change management skills
- Safety culture
Case Study No. One

Hospital has second similar sentinel event resulting in a poor surgical outcome

First root cause analysis (RCA), did not have any physician participation

CMO lacked knowledge around event analysis and the RCA process

Upon retrospective review, first RCA did not identify the common cause that could have prevented the second event
Case Study No. Two

- Chief Quality Officer presents lengthy detailed report with copious data to the board
- No response or questions are raised from the board members
- For the next meeting, in lieu of presentation the chief quality officer is asked to submit an executive summary for the binder
Case No. Three

- VPMA presents proposal to the medical executive committee for a new patient safety initiative
- Members protest because of the potential impediments to practice the initiative may impose
- The proposal is unanimously rejected
Aspiring Higher: Organizations will need to achieve optimal physician engagement
Beyond Accreditation

- Performance Measurement
- Sentinel Event Review and Analytics
- Complaint Analysis
- National Patient Safety Goals
- Intra-Cycle Monitoring
- Sentinel Event Alerts
- Performance Improvement
- Standards Development
- Advocacy
Our Mission: Transform health care into a high reliability industry and to ensure patients receive the safest, highest quality care they expect and deserve.
RPI, Safety Culture & Leadership

Essential and foundational components of High Reliability-consistent excellence over long periods
The Joint Commission’s Center for Transforming Healthcare aims to solve health care’s most critical safety and quality problems. The Center’s participants – the nation’s leading hospitals and health systems – use a proven, systematic approach to analyze specific breakdowns in patient care and discover their underlying causes to develop targeted solutions that solve these complex problems. In keeping with its objective to transform health care into a high reliability industry, The Joint Commission will share these proven effective solutions with the more than 19,000 health care organizations it accredits.
Robust Process Improvement™ (RPI) – A New Way in Delivering Results

**Usual Approaches:**
“One-size-fits-all” works well only in very limited circumstances:
- Process varies little from place to place
- Causes of failure are few and common

**New Generation of Best Practices:**
Complex processes require RPI to produce solutions – customized to an organization’s most important causes

- Many causes of the same problem
- Key causes different from place to place
- Each cause requires a different strategy
Reducing Colorectal Surgical Site Infections

135 SSIs avoided → Patients with SSIs went home 2 days earlier after solutions were put into action.

$3.7+ million savings across 7 hospitals

Source: Joint Commission Center for Transforming Healthcare www.centerfortransforminghealthcare.org
Germ Farm

Hand hygiene affects all HAIs

- C diff, MRSA, other MDRO
- Urinary tract (CAUTI)
- Central line (CLABSI)
- Ventilator pneumonia (VAP)

Average TST improvement

- 35% drop in HAIs
- Impact is substantial
Transforming to Become a High Reliability Organization

Essential and foundational components of High Reliability-consistent excellence over long periods
Preparing to Transform

What keeps the C suite up at night?

Physician leadership capabilities

Gap analysis
- Structural
- Cultural
- Resources
Strategies for Physician Leaders

1. Board Engagement
   - Safety Culture Measurement & Improvements
2. Safety Culture Measurement & Improvements
   - Daily Safety Briefings
3. Daily Safety Briefings
   - Executive Adopt a Unit Program
4. Executive Adopt a Unit Program
   - Safety Leadership Rounds
5. Safety Leadership Rounds
   - Decentralization of CEQI
6. Decentralization of CEQI
Board Engagement

- Setting aims “zero defects”
- Data to enlighten, share stories
- Clinical teams make presentations
- Learning starts with the board
- Drives the cultures of safety
- Establishes measurement and monitoring
- Establishes executive accountability
Safety Culture Measurement and Improvements

- C-Suite should be directly involved in the application of the knowledge that has been generated through the measurement of culture
- Analysis of the data drilled down to the unit level
- Data drives actionable ideas for improvement
- Leadership provides structure
Daily Safety Briefings

15 minute meetings of senior leaders with all departments with the following agenda:

- **Look back**: Significant safety or quality issues in past 24 hours
- **Look ahead**: Anticipated safety or quality issues in next 24 hours
- **Follow-up**: Status reports on issues identified today

Executive Adopts a Unit Program

- Drives the culture of safety
- Learn from defects
- Shared learning and awareness
- Provides resources and removes barriers
- Creates partnerships
- Provides tools to investigate and learn from defects
Safety Leadership Rounds

- Opportunity for leaders to learn about safety
- Drives the culture of safety
- Opportunity to review unit based outcomes data and performance improvement efforts
- Leadership provides resources and removes barriers
Decentralization of CEQI

Clinical Based Unit Leadership led by nurse and physician
- Supported by IC, data analyst, QA specialist
- Includes participation from all ancillary clinical and non clinical services, patient and family representative
- Unit community receives dashboards and data is visibly posted within the unit
- All unit can review comparative data
- Clinical chief are accountable for performance of relevant units
Leadership Skills and Attributes

- Credibility
- Change management
- Communication skills
- Operations management skills
- Organization structure and culture
- Performance measurement and data analytics
More……

- Event management and analysis
- Regulatory and accreditation
- Expertise in risk reduction
- Innovation
Aspiring Higher:
Organizations will need to achieve optimal physician engagement

- Overall Physician Indifference
- Some Physicians Participate Some of the Time
- Optimal Physician Engagement

Quality and Safety Continuum

- Searching for Stability
- Building for Success
- Achieving Superior Performance
Questions?