

The Joint Commission

Journal on Quality and Patient Safety®

Improvement from
Front Office to Front Line

May 2011
Volume 37 Number 5



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—James L. Reinertsen, M.D. (p. 199)



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John M. Eisenberg Patient Safety and Quality Awards

An Interview with James L. Reinertsen



2010 John M. Eisenberg Award Recipient for Individual Achievement

Interviewed by Penny Carver, M.Ed., Senior Vice President, Institute for Healthcare Improvement, Cambridge, Massachusetts, and Marcia L. Delk, M.D., M.B.A., Senior Vice President for Medical Affairs and Chief Quality Officer, WellStar Health System, Marietta, Georgia

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Penny Carver: It has now been a decade since you contributed to the Institute of Medicine's reports To Err Is Human¹ and Crossing the Quality Chasm.² Since those landmark publications, you have been working tirelessly with senior leaders across the world to improve safety and quality in health care. Can you reflect on what you feel has changed during the past decade?

In the past 10 years, governing boards and senior executive teams have become much more aware of clinical quality and safety issues. A decade ago, they thought that their role was all about finances and facilities; they presumed that doctors and nurses—and perhaps the quality staff—could take care of clinical matters. But today, they're more likely to understand that trustees and administrators are not just the stewards of physical assets, *they are the leaders of a clinical care system*. They are responsible for *everything* in the organization—especially what goes wrong clinically. Many factors have brought about this awakening, such as publicly reported quality and safety data, pay-for-performance plans, and regulatory pressure to meet safety standards. Yet no factor has been more powerful than front-page media coverage of major safety mishaps, particularly if it's your hospital's name on the front page. The good news in all of this is that many boards and clinical executives now realize that safety is their job, not just the doctors', and that they need to learn how to do that job.

Another very positive development in the past decade is that board and executive leaders now have numerous examples of care systems that are getting the job done—where real improvements in hard measures of clinical quality and safety have been achieved and sustained at scale. They can learn from a variety of organizations, such as Cincinnati Children's in Ohio, the George Eliot Acute Trust in the English NHS (National Health Service), WellStar in Atlanta, Immanuel St. Joseph's Mayo in

Minnesota, the 70-plus hospitals in the Ascension system, McLeod Regional in South Carolina, the Delnor Community Hospital in Illinois—and collaboratives, such as the Keystone Project in Michigan—how to reduce preventable harm and deaths. This collective experience has shown that it is possible to reduce mortality rates by 20% to 30%, as measured by actual "harse counts," not just coding-dependent risk-adjusted rates; to decrease the number of serious safety events by up to 80%; and to reduce the overall risk of health care-associated infections by 50% or more. Although these pioneers might not have achieved the theoretically ideal level of performance in every instance, for many safety risks they have shown us that "zero" is in sight.

Of course, the third trend in the past 10 years is actually the *absence* of a trend—the disappointing realization that despite awareness of the safety problem, and despite a growing number of breakthrough safety achievements in leading-edge organizations, not enough hospitals and care systems are making progress, so that the overall level of safety across the health care system in the United States has not improved.^{3,4}

Marcia Delk: So it seems that some hospitals and systems are getting significantly safer, but many are not. In your view, what distinguishes those that are making real progress from those that are just trying hard?

According to the Institute for Healthcare Improvement (IHI) Leadership Model, leaders of improvement must develop the *will* to make changes, generate good *ideas* about what changes to make, and then *execute* the changes.⁵ In my view, the difference between organizations that achieve results and those that don't is not that the successful organizations have better ideas. For example, evidence-based bundles that reduce the risk of central line infections and implement preprocedural check-

lists to reduce surgical harm and death are not some sort of proprietary secret. They're widely known to everyone. What separates organizations that get results from those that don't is that the boards and senior leaders of successful systems have developed and sustained the will to make necessary changes in structures, processes, and, most importantly, patterns of behavior, and they have then executed those changes with skill and persistence. Marcia, your own organization, WellStar Health System, provides a very good example of this. In the course of the last four years or so, your board and medical staff leaders developed the will necessary to push through major changes in the culture, such as a serious increase in accountability for safety behaviors. The leaders of your five hospitals had the backbone to stand behind these expectations, even if it meant that some staff members lost their privileges to practice at WellStar. And your administrative team executed needed improvements in measurement, process reliability, and many other changes, with skill and persistence. The result has been a 78% reduction in safety events; near elimination of health care-associated infections such as central line bloodstream infections, ventilator-associated pneumonia, and those caused by *Clostridium difficile*, and a 23% reduction in overall mortality.

All the ideas and knowledge that you used—human factors and safety science, high-reliability organizations, culture of safety, and so on—are widely available. What sets WellStar, as well as other organizations that have achieved and sustained similar results, apart from those organizations that just spin their wheels and don't get any results is the combination of fierce will and competent execution. And that has to start at the top.

Penny Carver: Speaking of the top—you, as a consultant, often have only a few hours with a health care organization's board or corporate (C-) suite team, in which to activate them to take a leadership role in safety. You seem to have a remarkable rate of success. What do you actually do when you get behind closed doors with senior leaders?

When I have only a few hours with a hospital's leadership team, I usually start with Paul Batalden's first law of improvement, "Every system is perfectly designed to produce the results it gets." Drawing on the hospital's own data and reports, in terms of the annual number of deaths, serious harm events, nosocomial infections, and defects in evidence-based care delivery, I show them what their hospital is perfectly designed to produce in terms of simple counts of these events—without any complicated risk-adjusted rates, rankings, or other coding-dependent measures that are principally designed for compar-

isons with other hospitals. I call it "eliminating the denominator." A common response of board members is, "We've been looking at our quality numbers for years, and we had no idea that we were harming that many people."

The next step is to ensure that the stories behind their data are brought out so that the board and executives can see the impact of surgical complications, diagnostic delays, *C. difficile* infections, and so forth, on their own patients. It is unfortunately not difficult to find recent examples of these stories—the chief medical officer (CMO)'s office, the quality department, and risk management staff are generally my best sources.

Then, to make it clear that a large proportion of the harm that the hospital is "perfectly designed to produce" is preventable, I share specific examples of proven methods, such as infection control bundles and surgical checklists, as well as examples of organizations whose leaders have implemented those methods with stunning success.

And just in case they aren't moved by the data, the stories, and the examples of others, I also make sure they know the regulatory and legal risks that they face if they fail to improve serious safety problems. For example, I tell them that if leaders know (or should have known) about problems such as physicians who are not meeting safety standards or following key safety policies, and if the leaders then do nothing about those problems and merely continue to send out bills as if their services were meeting standards, those leaders—the board, CEO, and others—are at risk of prosecution for "false claims" fraud by the U.S. Department of Justice. I then provide a few specific, recent examples of such prosecutions. If all else fails, that gets their attention.

In essence, I get the board and CEO to see the problem and to own the problem. And that usually leads them to ask the key question, "OK, how do we solve the problem?"

Marcia Delk: In helping leaders to learn how to improve quality and safety, you've often used the Seven Leadership Leverage Points model, which has been used to develop the capability of senior executives not only in the United States but in Canada and Europe. What has been so powerful about the Leverage Points framework?

The history of quality and safety improvement has largely been a history of projects, in which a team is formed around a specific improvement opportunity for a unit, clinic, disease, or condition and then uses quality improvement methods to test and implement changes that might make things better. Projects, as the atomic units of organizational improvement, are very important. However, for all too many projects, the

Sidebar 1. Sample “Handholds” for Use When Starting to Improve Quality Performance

- Adopt a specific, “how good, by when, as measured by” aim for improvement at the whole organization level, and monitor it at the highest level of governance.
- Develop a plan (including scale, pace, resources, key drivers, measures) for achieving the aim in the time allotted, and steer the execution of that plan at the corporate-suite, not the quality department, level.
- Channel leadership attention to the aim.
- Engage patients and families in achievement of the aim.
- Connect the aim to the organizational business model (engage the chief financial officer).
- Connect the aim to the hearts and minds of the medical staff.
- Develop the technical capability needed to achieve the aim.

improvements seldom spread to other relevant areas, are rarely sustained for more than a few months, and are almost never knit together with other related projects to achieve significant improvement in an organizationwide (“system-level”) measure of something important, such as overall mortality rate. In other words, “everybody do some projects” is not a plan for organizationwide improvement.

We wrestled with this problem 10 years ago or so in the IHI/Robert Wood Johnson Pursuing Perfection initiative⁶ and developed a theory of what leaders might need to do in order to achieve measurable improvement at the level of whole systems. The theory—the Seven Leverage Points framework⁷—has proved to be remarkably useful, in terms of both building training programs for executive leaders and supporting those executives’ ability to create concrete, specific plans for getting organizationwide, not just project-level, results in clinical quality and safety.

Why have these Leverage Points been useful? I think it’s because busy executives and board members are faced with an enormously complex challenge in guiding health care organizations and need some good “initial handholds”—places to get a grip and begin—if they are to start improving their quality performance. The seven individual “handholds” are not rocket science. Executives have done something similar for years for strategic business aims. The Leverage Points merely make quality and safety strategic business aims, like financial performance and growth, in handholds such as those shown in Sidebar 1 (above).

I should point out that the Leverage Points framework is hardly a “normative management theory,” in that I cannot tell a CEO, “If you do these seven things you will achieve system-level results.” It is rather closer to a “descriptive management theory,” that is, “these seven things are associated with achievement of system-level results.” I’m quite sure that we have a lot more to learn about this and that the framework will be revised,

expanded, or even discarded as we learn more.

That said, I am quite proud that hundreds of executive teams in the United States, Canada, and Europe, led in each instance by the CEO—a requirement on which I have insisted for the “executive quality academies”—have learned and attempted to apply the Seven Leadership Leverage Points to their quality and safety challenges. Many of those organizations, using the Leverage Points as a guiding framework, have shown us that safety can be improved and sustained, not just in one unit or disease, but for the entire organization.

Marcia Delk: At the start of this interview, you cited boards’ increased awareness of clinical safety and quality issues as a key development. Can you expand on why it is so important for the board, along with the organization’s senior leaders, to become a driver of quality and safety, given that the majority of board members are usually not even health care professionals?

The board is the highest authority within any organization and therefore is the primary source of what I’ve referred to as the will or “backbone” to make the changes necessary to improve safety. Such changes, especially deep cultural changes, are very difficult indeed. For example, the Seton Health (Austin, Texas) system leadership adopted a firm rule—no elective inductions prior to 39 weeks—as part of its strategy to eliminate preventable harm to newborns.⁸ Staff faced inevitable pressure from doctors and families to bend this rule but stood firm, knowing that the board had their back. This is a massive cultural change—from putting physician autonomy and patient convenience first to putting patient safety first. Seton hasn’t had a pre-39-week elective induction in years, and its birth trauma rate is approaching zero. Many other boards have taken similar stances on mandatory use of time-outs and checklists, handwashing and infection control practices, and abusive behavior.

Everyone in the organization watches the signals sent by the

board. Is it really serious about safety? Will it provide the necessary resources? If an important doctor, for example, a surgeon who is a major source of revenue to the hospital, fights the board on an issue such as infection control policies, will the board back down? Once we start measuring things, if we don't look good, will the board bury the data? If management and medical staff spend most of their time giving excuses to the board about why results aren't happening, does the board ask any hard questions? Making the organization safer, and changing its culture, starts at the top, and the board is the very top.

The board is also one of the primary organizational reservoirs of what Deming called "constancy of purpose." The quality transformation of any organization takes 10 to 20 years. Given the turnover rate of CEOs, that means that transformation is a "2- to 4-CEO project" in the United States, for example, and a "5- to 10-CEO project" in the English NHS. If transformation is really to take place, it cannot be the pet project of one of these CEOs. It must be a long-term commitment of the board.

Penny Carver: You have developed some very successful approaches to engaging physicians in safety and quality work. Can you tell us what you feel has been most successful?

There is a complicated answer to this question, but let me make it very simple. In any sort of health care organization, whether it's a group practice, a hospital with an independent medical staff, or a major academic medical center, there are three absolute requirements for physicians' engagement in quality and safety:

1. *Ask doctors to engage and to lead the improvement of clinical care.* I find that far too many organizations have given up before they even start, and don't really ask, in a respectful way, "What do the doctors want to improve? How would they measure it?" Ask them, and listen to the answer.

2. *Expect doctors to be responsible leaders and to deliver results.* I find this to be a particular challenge in hospitals with independent medical staffs. One excellent way to deal with it is for the board to ask the medical staff leaders to outline their plan for results and to report to the board on a regular basis on whether the medical staff is on track to achieving the results. In other words, treat the medical staff leaders like responsible adults.

3. *Make it easy for doctors to do this work.* Most doctors are very busy with clinical care. Make it easy to try out improvements, to lead improvement teams, to get data, and to communicate results. If it costs doctors enormous amounts of time and effort to do improvement work, it won't happen.

Marcia Delk: Health care reform, as represented in the Affordable Care Act,¹⁰ is presenting a very large "to do" list to hospitals, physician practices, and care systems. What are the greatest safety and quality challenges facing health care senior leaders for the next decade?

Let's talk about safety first. I think that the U.S. Congress, government regulators, accreditation agencies, and the public are growing impatient with our lack of overall progress on safety. I fully expect that leaders are going to face a powerful surge in expectations—and incentives and regulations—to reduce preventable infections, injuries, complications, and deaths. It's an urgent problem. We haven't done enough, fast enough, in our industry, and we can expect that the payers and regulators are going to turn up the heat.

The second challenge is to deal with a fundamental change in how health care works as a business—as it moves from a volume-driven to a value-driven model. Or, as I often phrase it, from "relative value units" to "potentially avoidable complications." In the current business model, hospital chief financial officers (CFOs) are happy when the hospital has lots of admissions, the operating rooms are busy, and imaging centers stay open late to accommodate demand. In the new business model, the CFO will be unhappy about that portion of the admissions that are readmissions, as well as the surgical procedures that are not clinically indicated; overuse in computerized tomography and magnetic resonance imaging; and complications, such as pressure ulcers, that lead to increased lengths of stay without increased reimbursement.¹¹ During the transition from the old to the new business model, there is going to be an enormous amount of organizational schizophrenia about what is good for business and what is bad for business. My suggestion is to commit to the new model—and once you've decided to go there, to move as quickly as possible.

And the third challenge, the deepest one of all, is a cultural challenge—to *make value a value*. For too long, doctors and other health care professionals have regarded the need to reduce the cost of health care while maintaining or improving quality as someone else's problem at best and a professionally illegitimate notion at worst. They're fine with improving quality, mind, just as long as you don't talk about reducing costs.

The problem with that view is that *the fundamental driver of health reform in the United States was not political, it was economic*. Even the insured can no longer afford our product. Even if legislated health reform is repealed in its entirety, health care leaders in this country, as throughout the world, will still have to address this problem. And one root of the problem is that "delivering value" is not a traditional professional value.

Despite these three very serious challenges in front of us, I would note at least one ray of hope. I have had the enormous pleasure of helping to develop the leadership curriculum for the IHI Open School.¹² The experience of dealing with these young leaders-in-training in nursing, medicine, health care administration, pharmacy, and other health professions from all over the world has convinced me that our health systems are about to change—to become safer, more reliable, more patient centered, and more efficient. If the current leaders don't get the job done, there's an extraordinarily capable set of leaders waiting to take their place. **1**

References

1. Institute of Medicine: *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000.
2. Institute of Medicine: *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.
3. Department of Health & Human Services Office of Inspector General: *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*. Report OEI-06-09-0090, Nov. 2010. <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf> (last accessed Mar. 14, 2011).
4. Landrigan C.P, et al.: Temporal trends in rates of patient harm resulting from medical care. *N Engl J Med* 363:2124–2134, Nov. 25, 2010. Erratum in: *N Engl J Med* 363:2573, Dec. 23, 2010.
5. Institute for Healthcare Improvement (IHI): *A Framework for Leadership of Improvement*. Feb. 2006. <http://www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFrameworkforLeadershipofImprovement.htm> (last accessed Mar. 11, 2011).
6. Institute for Healthcare Improvement (IHI): *Pursuing Perfection*. <http://www.ihl.org/IHI/Programs/StrategicInitiatives/PursuingPerfection.htm> (last accessed Mar. 11, 2011).
7. Institute for Healthcare Improvement (IHI): *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*, 2nd ed., 2008. <http://www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/Literature/SevenLeadershipLeveragePointsIHIwhitepaper.htm> (last accessed Mar. 11, 2011).
8. Mazza F, et al.: Eliminating birth trauma at Ascension Health. *Jt Comm J Qual Patient Saf* 33:15–24, Jan. 2007.
9. W. Edwards Deming Institute: *The Deming System of Profound Knowledge*. <http://deming.org/index.cfm?content=66> (last accessed Mar. 11, 2011).
10. The Patient Protection and Affordable Care Act (PPACA) of 2010, P.L. 111–148, 111th Congress, 2010.
11. Centers for Medicare & Medicaid Services (CMS): *Hospital-Acquired Conditions (Present on Admission Indicator)*. <https://www.cms.gov/HospitalAcqCond/> (last accessed Mar. 11, 2011).
12. Institute for Healthcare Improvement (IHI): *IHI Open School for Health Professions*. <http://www.ihl.org/IHI/Programs/IHIOpenSchool/> (last accessed Mar. 14, 2011).