Joint Commission
on Accreditation of Healthcare Organizations

Setting the Standard for Quality in Health Care

TESTIMONY
of
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I am Dr. Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to testify on the critically important matter of how to approach the patient safety issues that continue to plague the delivery of health care services.

The Joint Commission is the nation's preeminent health care standard-setting and accrediting body. Founded in 1951, it is a private sector, not-for-profit entity dedicated to improving the safety and quality of health care provided to the public. Our member organizations are the American College of Surgeons; the American Medical Association; the American Hospital Association; the American College of Physicians; and the American Dental Association. In addition to these organizations, the 29-member Board of Commissioners includes representation from the field of nursing as well as public members whose expertise spans such diverse areas as ethics, public policy, and insurance, and academia.

The Joint Commission accredits approximately 17,000 health care organizations, including a preponderance of the hospitals in this country. Our accreditation programs also evaluate the performance of home care agencies; ambulatory care settings whose services range from primary care to outpatient surgery; behavioral health care programs; nursing homes; hospices; assisted living residencies; clinical laboratories; and managed care plans. Further, the Joint Commission is active internationally and has provided consultation and accreditation services in over 60 countries.

Challenges in Changing the System

I have been asked to comment on what is needed to create a true culture of safety in our health care institutions. We like others, are deeply concerned that the number of serious medical errors remains unacceptably high, despite the focus of significant national attention on patient safety in recent years. In 1996, the Joint Commission made patient safety its foremost priority after a spate of high profile errors were vetted in the media. These errors were a clarion call to all of us involved in quality of care oversight, and these events, plus a number of others which occurred subsequently, eventually spurred the landmark 1999 Institute of Medicine report, "*To Err is Human."* That report received unprecedented national media coverage and truly put this issue on the map for the public and for policymakers. While clear steps have been taken towards reducing such errors, we as a nation have not achieved the level of success that the IOM report suggested should have been reached by this time.

As part of the Joint Commission's intensified efforts to improve patient safety over the past seven years, we created a Sentinel Event Database that is the world's most complete record of the full spectrum of serious medical errors and their underlying causes. This database, combined with knowledge learned from working with health care organizations to address their patient safety issues, has permitted us to gain a deep understanding of the interplay and complexity of factors that contribute to health care errors and serious adverse events. The solutions, we believe, are equally complex, representing a range of actions - both low and high cost - that must be taken at all levels of the health care system and by all stakeholder groups.

I would like to briefly identify six strategies for tackling medical errors, discuss some of the relevant actions that have already been taken, and present some remaining challenges to reaching widely held safety goals.

Creating Cultures of Safety

First, health care organization leadership must be encouraged to create cultures of safety for their own setting. The associated values and performance expectations must be demonstrated by example and permeate the entire organization. A culture of safety is characterized by an open atmosphere for reporting and addressing errors, and eventually by anticipating and preventing errors through careful monitoring and timely re-design of internal patient care systems. Adopting such a culture is an overarching strategy necessary to the support of all other solutions, and thus the single most important strategic effort to be undertaken. But this is perhaps the most difficult goal to fully achieve. Cultural changes always require significant leadership energy and commitment. In the case of patient safety this is even a more daunting challenge because what is actually being sought is a counter culture to the deep-seated "blame and shame" orientation of American society. For this reason, the success of this effort depends heavily upon other key actions, the most of important of which is the passage of federal "safe harbor" legislation.

The Joint Commission has been on the forefront in proselytizing cultural change as the foundational basis for achieving real error reduction. To this end, the Joint Commission has established and implemented safety standards that strongly encourage leaders of accredited organizations to make patient safety their top priority; to set a constructive tone for dealing with safety concerns that promotes a safe environment for care; and to invest human and other resource investments in systems improvements and in adopting safe practices. Moreover, the Joint Commission has actively promoted the empowerment of patients and their families as active participants in care planning and treatment. Involving patients as valued partners on the patient care team, and providing them essential information about their care are key elements of an important part of an enlightened organization culture.

The culture of an organization emanates from all of its leaders, but is most notably set by its CEO. However, it is difficult to be sanguine about achieving this goal because of the pragmatic realities facing CEOs today. With operation resources already strained in many organization, potential investments in patient safety compete every day against other basic needs such as staff recruitment, maintenance of the physical plant, clinical technology upgrades simply to meet the standard of care and other investments to respond to community needs. Further, investments in patient safety -- while a moral obligation – usually provide financial benefits to payors and purchasers rather than the organization.

Late last year, the Joint Commission, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Department of Defense and the American Hospital Association sponsored a symposium of hospital CEOs to discuss the business case for safety. Those of us who conceived the idea of the symposium believed that if we could demonstrate a quantifiable return on investments (ROI) in patient safety, then health care executives would be more motivated to elevate safety efforts in their assessments of operational priorities. After two days of intense discussion, the conclusion was reached that the business case had not been made, despite clear consensus that the pursuit of patient safety is the right thing to do. Among the many reasons that the business case could not be made is that public payers pay the same reimbursement for unsafe care as they do for safe care. Further, little capital is available to support major patient safety

improvements, such as computerized physician order entry. And finally, internal and external reward systems place little or no value on investments in patient safety and demonstrated reductions in medical errors.

While I will come back to the issue of paying for safety later in the testimony, I would like to point out that creating a culture of safety involves more then external resource commitment. There are many low-cost dimensions to the needed cultural change. These dimensions involve such factors as an open and non-punitive environment for surfacing the existence of errors and risk points within an organization; creating an atmosphere that encourages broad-based involvement in developing safety solutions; information-seeking behavior that looks externally for safe practices to emulate; and a willingness to re-design care processes as a team function. This leads me to my second strategy, which is introducing engineering tools into the health care industry as a way to improve care processes.

Importing Engineering Concepts and Tools

Concepts and tools are critical ingredients to any type of sea change. If we are to truly achieve improvements in patient safety, we must give health care organization leaders, clinicians and patients the information and tools they need to effect such changes. One of the Joint Commission's important contributions in this regard has been to incorporate into its accreditation requirements a "systems approach" to managing risk that is borrowed from engineering and quality control principles that have been successfully applied in manufacturing. Individuals will always make errors and they should be held accountable for their errors. However, adverse events usually occur when internal systems fail to anticipate errors and keep the effects of mistakes from reaching the patients.

The Joint Commission requires accredited health care organizations to engage in both retrospective and prospective risk analyses that assesses weak points in their systems of care. If a serious medical error occurs in an accredited organization, a "root cause analyses" is required. This analysis must fully assess the circumstances and causes of the event and identify all systemic problems that must be fixed in order to prevent a similar event from happening again. The root cause analysis involves a "no-holds-barred" examination of the contributing factors to the adverse event and should include all staff who were involved in the event. There are invariably many more factors underlying to an event than initially meet the eye, and there are almost always underlying "systems" reasons for the failure. Because the root cause analysis is always rich with causal factors, it becomes the basis for future preventative actions that bear both on the event in question and upon other patient dimensions. Actions commonly taken include the re-design of systems of care, staff training, and the incorporation of checks and balances to mitigate risk.

Of equal value is the prospective analysis of high-risk processes in the delivery of care. In its July, 2001 patient safety standards, the Joint Commission has now brought the application of Failure Mode and Effects Analysis (FMEA) to accredited health care organizations. This systems approach to improving care involves the prospective evaluation of processes identified by the organization as being vulnerable to risk, and the re-design of such processes "to build safety in," e.g., through creating redundancies, before an adverse event occurs.

Improving and Investing in Professional Education

While health care professionals can be provided tools to evaluate risk and re-design care, this country is neglecting to concomitantly improve the professional education system to support this new thinking about prevention of errors and adverse events in this complex delivery system. We need to graduate health care professionals who are proficient in "systems thinking," who are comfortable using decision support tools, and who can actively engage in solving patient safety problems. Instead, we educate physicians for too many years and lead them to believe that they should know how to do it all themselves; that they are more important than any other member of the health care team; and that blame belongs to people, not poorly designed systems and processes. This mindset reinforces the "blame and shame" mentality that retards our progress in solving the medical errors issues by focusing on punishing the person most proximal to the error.

By contrast, nurses -- who are on the front line of the most complex health care we deliver every day -- are educated 2.4 years and receive brief periods of post graduate supervision that average 30 days before they assume responsibility for patient care duties. As a result, many nurses leave patient care because they do not receive the types of clinical skills and training necessary to deal with today's high acuity patients and pervasive safety issues. In deed, many cite fear of making a mistake as a seminal reason for leaving the nursing profession. This becomes a vicious cycle, because the record is clear that inadequate numbers of nurses lead to medical errors and diminishes the overall quality of care. Data from the Joint Commission's Sentinel Event Database demonstrate that in 24% of the unanticipated deaths and serious patient injuries, inadequate numbers of nurses is a contributing factor.

Last year, the Joint Commission published two major white papers on the nursing shortage, its causes and solutions. The papers developed with the assistance of a multidisciplinary expert roundtable contained a number of recommendations, one of which urged federal funding of nursing internships of at least one-year in length. In the view of the Joint Commission, this is a de minimus investment in patient safety. Another dire funding need is additional money to supplement the extremely modest dollars allocated to last year's Nurse Reinvestment Act. Appropriations under this Act are essential to the funding of faculty in nursing schools which today must turn away hundreds of qualified nursing applicants. This is an untenable situation in the face of a major and growing nursing shortage.

I would finally suggest that consideration be given to a government commissioned study of the content of professional education as it relates to patient safety. Such a report could create pressure for sufficient reforms of medical and nursing education to permit appropriate allocations of time to systems learning education about the contribution of human factors to patient safety, and intense professional team training.

Improving Information Infrastructure

Information technology can make important contributions to reducing medical errors. For example, technology can provide significant decision support in the processes of patient assessment, treatment and education. It can further make critical patient information available on a timely basis

to enable appropriate patient management; elicit patient care reminders; raise flags about medication dosages, therapeutic uses and interactions; and enable communication among providers. However, the health care industry lags far behind most other industries in the use of information technology. Investment in information systems at the health care organization level has often been problematic because these expensive systems are usually proprietary and therefore unable to accommodate exchange of information between organizations and between organizations and practitioners. However, there have recently been substantive concerted effort recently to make health care information technology more interoperable through achievement of consensus on standards for data interchange and development of systems that can "talk" to one another. I believe that within the next few years, we will witness accelerated progress in this area and that this progress will favorably impact our collective patient safety improvement efforts.

Notwithstanding the forenoted progress, there remain significant impediments to broader use of information technology. They reside in its cost, the implications for health professions training, and to some degree, government leadership. Few health care organizations can afford major investments in electronic health information systems today, or even in computerized order entry for reducing medication- prescribing errors. We are particularly pleased, therefore, that Secretary Thompson has made the attainment of a national health information infrastructure a priority of his Department. However, we believe that this federal government focus must be expanded to encompass support of timely public health data collection and emergency preparedness. Further, the Congress itself must be prepared to make the capital investments necessary to facilitate rapid adoption of appropriate technologies by health care organizations. The information infrastructure gap between what is possible and where this country is must be closed as quickly as possible. Logic would dictate that any such capital investment be tied to organization incentives to encourage rapid pursuit of this goal.

Performance Incentives for Safety Goals

Behavior change is best achieved when there are incentives that reward desired actions. I would like to mention two powerful incentives that can help move the health care industry toward safer care.

The first incentive lies in targeting the expectations of the oversight framework to health care. All providers, organizations and practitioners want to do the right thing, but even when informed and armed with the tools for change, intervening priorities may take precedence. We have found that organizations respond best to what they know is going to be externally measured. For example, the Joint Commission has issued over two-dozen Sentinel Event *Alerts*, which set forth specific safe practices for avoiding high profile errors. However, compliance with the recommendations in these *Alerts* was not being specifically measured during our on-site accreditation surveys. Therefore, the Joint Commission decided to set a small number of discrete National Patient Safety Goals around significant, documented safety problems and incorporate assessment of compliance with attention to these Goals and their associated recommendations into the survey process.

The Joint Commission implemented its first set of National Patient Safety Goals in January 2003. The Goals selected were drawn from the Joint Commission's Sentinel Event Database and were based on the recommendations of an expert panel. The expert panel also identified one – two

specific recommendations for each Goal, which provides the substrate for the onsite compliance assessment. The 2003 goals are:

- Improve the accuracy of patient identification
- Improve the effectiveness of communication among caregivers
- Improve the safety of using high-alert medications
- Eliminate wrong-site, wrong patient, wrong procedure surgery
- Improve the safety of using profusion pumps
- Improve the effectiveness of clinical alarm systems

Individual organization compliance with the National Patient Safety Goals will be made public beginning in 2004. We believe that the Medicare and Medicaid programs should consider adopting the same safety goals for relevant, non-accredited health care organizations.

The second type of incentive involves rewarding behaviors through payment. This is probably the most powerful incentive in the toolbox and therefore one that must be used wisely. As mentioned earlier in this testimony, pubic purchasers pay the same for safe care as they do for unsafe care. To complicate matters, when medical errors cause longer patient stays or lead to more treatment, the providers often receive higher payments. This is not to suggest that any provider injures a patient for money, but rather to point out that there are no payment **dis**incentives for experiencing preventable adverse outcomes, nor are there payment **in**centives for successfully providing safe care. There is now a growing imperative to determine how payment incentives can be aligned among payors, purchasers, provider organizations and practitioners toward the goal of improving the quality and safety of care. This lofty goal is not without challenges, but the need to achieve this goal is now being elevated in policy discussions in Washington and elsewhere. It should be self-evident that patient safety improvement must be part of the "pay for performance" equation.

Passage of Patient Safety legislation

I have left this strategy for last, but it is the one that Congress can act upon most quickly. Since 1997, the Joint Commission has been advocating for patient safety legislation that would provide certain protections to medical error information as a way to encourage its production and the dissemination of lessons learned. Thousands and thousands of errors remain hidden today, and each of those is a lost opportunity for education and change. Federal confidentiality protections for reported adverse events, near misses, and their underlying causes are inextricably linked to the efforts to create a culture of safety inside health care organizations, because they would provide the essential safe harbor that organizations must have in order to surface, freely analyze, and then share medical-error related information within the health care community. Such protective legislation would establish a solid foundation for leveraging the sharing of information and engaging in neutral problem-solving.

Legislation is currently pending in Congress that would help us bring about this cultural change. The House recently passed H.R.663, the "Patient Safety and Quality Improvement Act. In the Senate, S.720 was introduced by a number of Senators as a marker for this year. We are very hopeful that this is the year in which this critical piece of legislation will actually be enacted. We urge you to support legislation that (1) will protect from subpoena the production of error-related information by health care organizations and practitioners, and (2) contains explicit language to

clearly preserve that protection when the information is shared with an accrediting body for purposes of improving patient safety and health care quality.

In conclusion, there are considerable barriers to be overcome if we are to truly change the culture of our complex health care delivery system to fully embrace patient safety and health care quality. The knowledge of what to do differently and how to do it exists and progress is being made. However, more needs to be done by all of us, including the Congress, if we are to succeed.

Thank you for the opportunity to testify here today.