

Modern Healthcare

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‘We still have very serious quality problems

‘The Joint Commission, which certifies quality and safety at the nation’s hospitals and other providers, currently has accredited about 22,000 organizations in the U.S. and abroad. It recently stirred controversy when it suspended its Top Performer award program for 2016, citing a need to review its quality measures. Dr. Mark Chassin, the CEO of the Joint Commission, recently spoke with Modern Healthcare quality and safety reporter Sabriya Rice about the move. This is an edited transcript.

Modern Healthcare: The Top Performer program has been around for only five years. Why did you suspend it?

Dr. Mark Chassin: The Joint Commission is continuously evolving and improving how we do our work, hopefully anticipating the changes that are going on in healthcare delivery systems. In this particular instance, we are keeping pace with the move to electronic quality measures and wanting to make sure that it’s done well. We are not getting out of that work. For example, we are increasing our requirements for hospitals to report perinatal measures, going from hospitals that had at least 1,100 deliveries for the past two years to hospitals that have 300 or more deliveries. That will encompass about 80% of all hospitals with delivery services. But we thought that the Top Performer program could not continue in its current form because of the flexibility that hospitals now have in reporting data on quality, which includes reporting electronically. We don’t have enough experience to be able to compare measures reported that way with the traditional chart abstraction measures.

MH: Will it definitely be back in 2017?

Chassin: I can’t answer that right now because we’re in the middle of evaluating this program. I can say, though, that over the course of the entire Core Measure Program, we’ve seen a tremendous improvement on the part of hospitals on these very solid, highly valid measures. Back in 2002, we only had eight measures that meet our current criteria for accountability measures, and only 7% of hospitals were over 95% performance on those eight measures. Fast forward to last year, the data we reported for 2014 covered 49 measures and 80% of hospitals were over 95% performance. That’s enormous improvement over the life of this program. We thought that the Top Performers was a great way to recognize and further encourage improvement on measures that hospitals were collecting in common. When we are confident that we can recognize top performers in a similar way across a wide array of different measures, we’ll bring it back.

MH: The Joint Commission has been criticized for focusing on process measures rather than outcome measures.

Chassin: We have outcome measures in our portfolio. But an outcome measure has to meet some pretty strict criteria. A lot of the outcome measures that are used by the CMS, Healthgrades and U.S. News fail to meet the criteria for accountability. For example, the mortality measures that the CMS and others use fail because they are very poorly risk-adjusted for critical patient characteristics that affect the risk of mortality. I’ll give one example. The stroke mortality measure that the CMS uses does not adjust for differences between patient populations for the severity of the stroke that caused the hospitalization. When you add severity as a critical component, 58% of hospitals classified as worse than expected are reclassified as average mortality. So, the failure to include severity, which affects the acute myocardial

infarction measure, the heart failure measure, the pneumonia measure as well as the stroke measure in the CMS' database, is an absolutely critical failing. Not all outcome measures are in that category. When I was health commissioner in New York 20-plus years ago, we started the first program of statewide data collection of clinical data on both severity and other factors predicting risk for mortality. We published data on risk-adjusted mortality following coronary bypass surgery by hospital and surgeon. There are similar programs in many other states. Those kinds of outcome measures are absolutely fine for accountability. The overarching problem is that in order to improve outcomes, hospitals have to work with their physicians and other caregivers on improving processes. They can't improve outcomes directly. They can't wave a magic wand. So we believe that both process measures and outcome measures are essential to effective quality improvement.

MH: Joint Commission-accredited facilities often get hit with immediate jeopardy warnings from the CMS. Why do those not affect accreditation?

Chassin: We investigate serious safety events ourselves. We have a different definition and approach to those incidents. But in some instances, serious adverse events do jeopardize accreditation status. Our job is to make sure that the hospitals and other organizations where we see serious lapses in safety fix them as rapidly as possible. If they don't fix them, and we go back and see they continue to be not fixed, we deny accreditation to those organizations. It doesn't happen very often because that's an extreme outcome. The vast majority of organizations want to fix their safety problems.

MH: Federal health officials say fewer patients were harmed in hospitals over the past five years. Yet the National Patient Safety Foundation says overall healthcare is not any safer.

Chassin: We really don't have good metrics on a national basis to judge overall safety or quality. It's clear that we've made progress in a number of areas, in reducing healthcare-associated infections, for example. But we still have very serious quality problems, partly because the goal posts keep moving. We keep adding in to the healthcare delivery armamentarium: tests, treatments, procedures and equipment that requires safe adoption and safe integration into how we provide healthcare. What constituted high quality 10 years ago is not the same as what constitutes high quality today. It's a constant state of activity to increase safety and quality. We are learning from other kinds of organizations that manage similar levels of risk, but do it much better than healthcare. They're called high-reliability organizations. Healthcare can get to that state where the operation of the organization is so good that zero harm is a byproduct of the way they do their work. That's the way commercial aviation, nuclear power, even amusement parks maintain high levels of safety. The journey starts with the commitment of leadership to getting to the ultimate goal of zero harm. That means the board of trustees, physician leaders, nurse leaders, executives—all components of leadership need to be committed to achieving that goal.