South Carolina models high reliability standards through pilot program

The South Carolina Hospital Association (SCHA) and the Joint Commission Center for Transforming Healthcare have teamed up to make the state’s healthcare highly reliable.

In a joint project titled “South Carolina Safe Care Commitment,” 21 hospitals in South Carolina are learning about high reliability practices (chart, p 12).

High reliability is defined as consistent performance at high levels of safety over long periods of time. Highly reliable healthcare is care that is dependable excellent, every time, for every patient.

The multiyear project, launched in February 2013, was built on a combination of the work South Carolina was doing with a collaborative model to improve the quality and safety of patient care and the platform of work the Joint Commission had done around the 3 key components of highly reliable organizations, says Rick Foster, MD, senior vice president for quality and patient safety at SCHA.

The 3 components are:
- full leadership commitment and participation in driving a system to high reliability
- an organization-wide culture of safety
- system-wide application of robust process improvement (Lean, Six Sigma, Change Management) (figure).

“We have been very encouraged by the number of hospitals that responded initially,” Dr Foster says. “The 8 systems represent about 40% of patient discharges in the state, so it represents a pretty good percentage of our inpatient work.”

Leadership commitment

“Striving for high reliability is not just another project—it is a long-term commitment to fundamental and social change in our hospitals and health systems,” says Dr Foster. “We were very intentional about including the term ‘commitment’ in the name.”

Hospital CEOs cannot commit to the program and then turn it over to someone else in the organization to lead the effort. “We told them they need to turn it over to themselves and stay actively involved,” he says.

Participating hospitals sign a 3-year commitment promising that their CEOs and leadership teams will be actively involved. Those leaders are expected to:
- complete the Joint Commission’s High Reliability Self-assessment Tool
- perform a safety culture survey assessment
- use a common process to identify events of harm and close calls that will help facilitate the development of a standardized high reliability measure.

Ultimately, participating facilities will receive comparative information from peer organizations on these key high reliability metrics.

Self-assessment tool

Each hospital has a leadership team led by its CEO that participates in up to 3 in-person meetings each year with SCHA and the Center for Transforming Healthcare, along with a series of webinars and coaching calls.

During the first meeting, the teams were provided information on high reliability in general, and then they heard from hospitals that were already successfully appli-
ing practices to achieve consistent excellence in patient care.

Each hospital completed the High Reliability Self-assessment Tool developed by the Joint Commission and received a report back from the Joint Commission team. Hospitals used the report to move forward with their individual high reliability plans.

The South Carolina Safe Care Commitment is part of a beta testing group for the tool, says Dr Foster.

**Standardized safety reports**

At the meetings, the SCHA and Joint Commission teams also looked at each hospital’s existing culture of safety surveys. All but 2 organizations in the state were using surveys from the Agency for Healthcare Research and Quality (AHRQ).

Dr Foster says they are looking at a standard system for safety culture reporting and will begin using Healthcare Performance Improvement’s Safety Event Classification system as a uniform reporting system to allow hospitals to track near misses. This system is already being used by many hospitals that are moving toward high reliability, he says.

Healthcare systems differ from high reliability industries like commercial aviation, amusement parks, and nuclear power in that they tend to focus on reviewing and taking action only when harm actually occurs, whereas the other organizations also look at their near misses, says Dr Foster.

“We hope to have a system that helps hospitals better track events that might lead to harm, which has been an area that has been difficult to measure,” he says.

By the second year, Dr Foster says, hospitals should have better baseline statistics on their rates of harm and near misses.
Safe Surgery program
One of the preexisting initiatives SCHA is involved in that Dr Foster says provided the foundation for their move toward high reliability is the Safe Surgery program. As part of this program, carried out in partnership with Atul Gawande, MD, and his team at Harvard’s department of health policy and management, Boston, all South Carolina hospitals committed to putting the World Health Organization’s Surgical Safety Checklist into routine use in their ORs by the end of 2013.

“When you look at the level of leadership engagement, the culture, the environment where staff work, and the opportunity to reduce invasive harm and near misses in the OR, there is no other area from a hospital standpoint where I think the principles of high reliability apply more,” says Dr Foster.

SCHA has been working with every acute care hospital in the state as well as a number of ambulatory surgery centers to implement the checklist and change the way surgical teams communicate. They have been tracking process and outcomes measures, and they hope to complete a formal report by the first quarter of 2014, he says.

Dr Foster noted that 1 hospital is using the debriefing part of the checklist to track near misses. “It was the first time a surgical team reported that they hadn’t had a wrong-site or wrong-patient surgery in 2 years, but they had 4 situations in the past week that could have led to an error. The checklist totally changed the way they look at errors,” says Dr Foster.

Thanks to the Safe Surgery program, SCHA has built a strong network of physician champions across the state that includes anesthesiologists and surgeons who are some of the individuals responsible for looking at how to spread high reliability across the organization.

Lessons learned
Beyond the 21 hospitals initially participating in the initiative, the South Carolina Safe Care Commitment is designed to improve safety and quality in healthcare organizations across the state.

The initial cohort of hospitals has been willing to share and learn from one another, and they will help spread this model to the newer cohorts.

The idea of having multiple overlapping cohorts is that the first group of hospitals becomes mentors and coaches for the next group, says Dr Foster.

Hospital participation and progress in moving toward high reliability will be recognized annually at the first meeting each year.

—Judith M. Mathias, MA, RN

References
http://www.safesurgery2015.org/about-us.html
http://www.scha.org/south-carolina-safe-care-commitment
http://www.scsafecare.org