



## CONFERENCE CALL

September 10, 2009

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### Attendees:

Mark R. Chassin, M.D., M.P.P., M.P.H., President, The Joint Commission  
Victoria Nahum, Co-Founder, Safe Care Campaign  
Ronald Peterson, President, The Johns Hopkins Hospital and Health System  
Thomas M. Priselac, President and CEO, Cedars-Sinai Health System  
Mary Reich Cooper, M.D., J.D., Senior Vice President/Chief Quality Officer, Lifespan  
Donny Lambeth, President, North Carolina Baptist Hospital (Wake Forest)  
Robert Malte, President and CEO, Exempla Lutheran Medical Center

**MARK CHASSIN:** Good morning. I'm Dr. Mark Chassin, President of The Joint Commission, and I'm pleased to welcome all of you here at the National Press Club in Washington, D.C., and those joining us by phone, to the launch of The Joint Commission's new Center for Transforming Healthcare. After my comments, you'll hear from three other speakers — Victoria Nahum, the co-founder of Safe Care Campaign; Tom Priselac, President and CEO of the Cedars-Sinai Health System and President of the Board of Trustees of the American Hospital Association; and Ron Peterson, President of The Johns Hopkins Hospital and Health System.

I'd also like to recognize the three other executives that are here from organizations participating in the Center's first set of projects: Mary Cooper, Senior Vice President/Chief Quality Officer of Lifespan; Donny Lambeth, President of the North Carolina Baptist Hospital, which is a part of Wake Forest University Baptist Medical Center; and Bob Malte, President and CEO of Exempla Lutheran Medical Center. The seven of us will be available for your questions in person and on the phone after the formal remarks. I'd also like to acknowledge Tom Russell, Executive Director of the

American College of Surgeons. Tom's been a big supporter of the Center from the very beginning when it was a tiny idea. And we're delighted to have with us this morning representatives from the many financial supporters of the Center for Transforming Healthcare. We are very grateful for the commitments that we've received from these organizations — American Hospital Organization, Ecolab, GE Healthcare and Johnson & Johnson. These organizations share our goal to improve patient safety, eliminate preventable complications and their associated cost and, ultimately, to transform health care. In these incredibly difficult economic times, it was not easy for these organizations to commit to support the Center financially, but they did, and we're very grateful.

The representatives with us today — from Ecolab, Paul Chaffin, North American Vice President and General Manager of Healthcare; from GE Healthcare, Mark Vachon, President and CEO for the Americas, and Mike Swinford, Vice President and General Manager for American Services; from Johnson & Johnson, Don Casey, Worldwide Chairman of Comprehensive Care, Jane Adams, Senior Director of Federal Affairs, and Greg White, Senior Director Health of Policy and Reimbursement; and from BD, Tony Lakavage, Vice President for Corporate Public Policy and Government Relations, Jennifer Farrington, Director of Social Investing, and Elizabeth Woody, Director of Public Policy and Government Relations; and I've already mentioned Tom Priselac, Chairman of the Board of the American Hospital Association. Additionally, I'd like to acknowledge the support of the Federation of American Hospitals and Hospira, organizations that have also shared with us the goals of the Center. Joining us today from the Federation, Jayne Hart Chambers, Senior Vice President for Strategic Policy and Corporate Secretary. Complete press kits, bios of the sponsors, the participants and the speakers, and much more is available on the Center's website at [centerfortransforminghealthcare.org](http://centerfortransforminghealthcare.org).

Now let's get to the reason that we're here. Nuclear reactions do not routinely endanger people by leaking radioactive material, commercial jets don't fall out of the sky every

day, but every day patients in America's hospitals suffer serious harm or even die as a result of preventable adverse events. The facts are sobering. More than 400,000 injuries from medication errors occur in hospitals every year in the United States, adding an extra \$3.5 billion to the cost of hospital care. Health care-associated infections are one of the top 10 causes of death in the United States. In fact, estimates are that about 247 people die in the United States every day because of health care-associated infections. That's the same as one 767 aircraft crashing every day, 365 days a year. Surgical procedures are performed on the wrong part of the body, the wrong side of the body or even the wrong patient. More than 40 of these occur every week in the United States. And that's the reason that we're here today to announce the launch of the Center for Transforming Healthcare.

Our aim is to transform health care into a high-reliability industry with rates of preventable adverse events that are equal to or better than the best high reliability industries in the world, just as low as commercial jet travel and nuclear power. We can make health care safer — not just a little safer; a lot safer. The Center for Transforming Healthcare aims to solve some of the most difficult and pressing quality and safety problems that plague American health care, and, indeed, plague global health care, because all of the problems that we struggle with are global problems. Health care-associated infections, avoidable injuries from medications and surgical complications threaten lives and increase costs.

The Center is clearly not the first effort to tackle these problems, but it does bring a unique approach. The Center is using new methods to systematically measure the magnitude of these problems, pinpoint exactly what their causes are, and develop and test targeted durable solutions. As the solutions are proven, The Joint Commission will spread the use of these tools and interventions to improve the safety and quality of the care provided at the more than 16,000 health care organizations that we accredit in the United States. That's what's different about this Center — the systematic approach to solving a problem is coupled with the reach of The Joint Commission.

The Joint Commission has long led the way in the effort to identify and prioritize the most serious safety and quality problems for health care organizations to work on. Our National Patient Safety Goals, our state-of-the-art accreditation standards and performance measures have helped hospitals and other organizations prioritize and achieve great improvement in safety and quality. Health care organizations today devote sizable resources to improvement and have made important progress, but despite our best efforts, serious quality and safety problems still exist across a wide array of different health services in the United States. This is clearly an issue that is very much in the news the last few months, especially this morning, with the President's speech last night, as lawmakers are struggling to try to figure out how to save enough money within the health care system to spread insurance to the uninsured while preventing government and individual costs from skyrocketing. President Obama again last night emphasized how critical cost control is to the whole effort to reform our health care system. Eliminating preventable complications and their associated costs could easily save many of the billions of dollars that lawmakers are struggling so hard to find in the effort to try to get our health system overhauled, and that's where the hard part begins.

Health care organizations want highly effective, durable solutions that are relevant to their circumstances and ready to implement. We need a new approach to achieve the magnitude, the breadth, the depth of improvement that everyone wants — health care organizations, patients, families, physicians and other clinicians, as well as public stakeholders. The work of the Center for Transforming Healthcare will show health care organizations exactly how they can improve and sustain high levels of quality and safety that are customized for their circumstances. The methods the Center is using to create these solutions have long been proven in industry for many years to improve safety quality and efficiency — I'm talking about Lean Six Sigma and change management processes. The Joint Commission itself adopted these tools starting early last year to direct all this internal process improvement activity, and we recruited to the Center 16 of

the leading hospitals and health systems throughout the country that have already made the investment and mastered the use of these tools and methods.

The Center's first group of participating hospitals, four of which are represented here today, are Cedars-Sinai Health System, Exempla Healthcare, Froedtert Hospital, Memorial Hermann Healthcare System, Johns Hopkins Hospital and Health Systems, Trinity Health, Virtua and Wake Forest University Baptist Medical Center, in alphabetical order. They volunteered to collaborate with The Joint Commission's new Center to address the problem that they identified as a high priority for them but one that plagues all of America's health care — and, indeed, again, as I said earlier, all of global health care — and that is failure of hand hygiene.

They committed in this first Center project to dig deep into those processes, understand exactly why they fail and create solutions that actually work. This is a vitally important safety process, especially at a time when we face the threat of a major outbreak of H1N1 influenza. Proper hand hygiene is a low-tech but incredibly effective way to reduce the spread of infection if we do it right all the time. These hospitals used Lean and Six Sigma methods systematically. They measured the magnitude of the problem, they identified precisely why the process was failing in the places they were trying to fix it, and they created targeted solutions that they are testing and proving now. Let's face it, nobody likes to be measured and nobody likes to find out that their performance is not where they want it to be. But these eight hospitals and health systems had the courage to step up and do exactly that, both of those things, has they tackled hand hygiene.

It seems like, what could be simpler? Just wash your hands. Everybody expects it to happen and can't understand why it doesn't. But even a seemingly simple problem turns out to be complicated. These hospitals know that sound measurement is the only way to identify exactly how a process is working, where it's failing and why it's failing. It's the only way you can develop a package of interventions that are directed at the

causes of the failures in each of these different situations that solve these complex problems — and more importantly, not just fix the problem today but produce long-lasting, durable solutions that keep working over and over again over time. A simple slogan campaign is not the answer. Demanding that health care workers try harder is not the solution. Those approaches have been tried, and they have failed. They have failed to produce long-lasting, consistent excellence, which is what our aim is. A comprehensive approach is the only way that we can solve these complicated problems.

These highly respected hospitals have each struggled with this problem on their own. They came together. They first decided on exactly how they would measure the problem so they could be confident that they were getting data on how their own performance was stacking up. And although they thought their level of compliance was high, when they used these methods, they found that, in fact, their staff was washing their hands a little less than 50 percent of the time. Why? What were the causes that they found? Well, you'll see the information on the storyboards and in the press kits around the room here. Some of the causes included faulty data that suggested that performance was high was lulling the organizations into complacency about how well hand hygiene was working. In some places, soap and alcohol gel dispensers were not placed in convenient locations for caregivers, some caregivers were approaching patients' rooms with their hands full, didn't have anyplace to put down what they were carrying so that they could wash their hands before entering the room, some places found a lack of individual accountability, and there are a long list of other causes.

This enumeration of those specific causes allowed a set of targeted solutions, each hospital using a different set, to attack the problems that were most impactful in their locations — and some of those include programs to hold everyone accountable — physicians, nurses, food service workers, housekeepers, chaplains, technicians, therapists. Anybody going into a patient's room needs to wash their hands, using a reliable reproducible method to measure performance, giving frequent and real-time

feedback on performance, and tailoring education on proper hand hygiene to specific types of caregivers. And as I said, a lot more information about the initial findings of this work are in the press kit, on the website or in the storyboards around the room here.

You'll also see when you look at that material another critical finding of this Center's first project that has vast implications for its future work. The causes that were prevalent in one hospital were not the same as the causes prevalent in another hospital. They differed from place to place. We expected to find those differences. The fact that they exist, and are likely to exist for all of the complicated problems that we are testing, have vast implications for the next and critically important part of the Center's work — that is, spreading the learning from this small group of Center hospitals to the rest of the health care delivery system. To accomplish that goal, the Center will create very simple, easy-to-use assessment tools that will guide hospitals and other organizations in how to measure the magnitude of their problem, assess the specific causes that are prevalent in their locations. They will not need any Six Sigma or Lean expertise in order to do that. And then after they assess what their causes are, the Center will be able to match a package of interventions customized to those causes that were proven effective by Center hospitals that those new hospitals can use to get much further down the road in improvement than they could if they were starting from scratch.

There is no silver bullet, quick fix, poster, video that will achieve this level of excellence, but we believe strongly that the strategies in play here — Lean, Six Sigma, change management — that many other industries have used for years can help transform American health care into that high reliability industry that ensures patients receive the safest, highest quality care they expect and deserve.

Before I turn the podium over to Victoria Nahum, who will share with us a very personal experience with how hand washing can make a life-and-death difference, I want to again applaud the courage and the diligence of the hospitals and health systems who participated in our first project. I would encourage you to ask questions of the hospital

CEOs who are here today — Ron Peterson of Johns Hopkins; Tom Priselac of Cedars-Sinai; Donny Lambeth of Wake Forest; Bob Malte of Exempla, four of the eight hospitals participating in the first project for hand hygiene — to find out how the hand-hygiene effort is working on the ground in their locations.

I also want to note that two Rhode Island hospitals who are part of Lifespan, Rhode Island Hospital and Newport Hospital, who are collaborating with the Center for Transforming Healthcare on a project to improve the safeguards that protect patients from wrong-side, wrong-patient surgical procedures. Like many hospitals in the United States, these hospitals recognize that while wrong-site surgery is an uncommon event, when it does happen, its impact can be devastating. And very simply put, wrong-site surgery should never happen. Despite our best efforts, it still does happen. And, in fact, I suggested earlier the best estimates are that it happens about 40 times every week in the United States. Through this collaboration with the Rhode Island hospitals, the Center will produce new improvement — new ways to dramatically reduce the risk of wrong-site surgery. Dr. Mary Cooper of Lifespan, who is with me today, will be happy to answer questions about that project.

And, finally, the Center for Transforming Healthcare's next project will target another critical problem in health care quality safety, the failure of hand-off communications, failure of communication in transitions of care. The other eight hospitals in the Center — Fairview Health Services, Intermountain Healthcare, Kaiser-Permanente, Mayo Clinic, North Shore-LIJ, Partners HealthCare System, New York Presbyterian Hospital and Stanford Hospital and Clinic — again, in alphabetical order — will be the hospitals participating in that project.

Thank you very much. And now, please welcome Victoria Nahum.

**VICTORIA NAHUM:** Good morning, everyone. On October 22, 2006, my husband, Armando, and I lost our son Joshua to a health care-acquired infection. This infection in

his spinal fluid caused so much pressure around his brain that it actually pushed parts of his brain into his spinal column before it killed him, making him a permanent ventilator-dependent quadriplegic.

And while the battle we waged against his infection was lost, the war was not. To this very day, that war continues on within American hospitals, within your walls, within your wards and inside every patient room. There are some who say we are incapable of fighting an invisible enemy against impossible odds. There are some who say we cannot discover straightforward solutions, for the problem is far too complex. There are some who say we are fools to even try.

From time immemorial, prudent and committed American men and women with imagination and vision have taken on outrageous odds and impossible challenges, facing desperate situations and the possibility of failure and disappointment, and yet have responded with tenacity, devotion, persistence and hope only to prevail in the end. I am convinced that this fight for safest patient care cannot be won by passive bystanders who think it good to wait for sometime in the future when someone smarter than we are will finally figure it out. Ladies and gentlemen, make no mistake, we are the ones we've been waiting for.

Today, I stand here before you humbled and privileged on the occasion of the formal announcement of The Joint Commission's Center for Transforming Healthcare as it seeks to tread further on the prudent path of progress of best care, safe care every time, everywhere. I am just one woman, yes, just one mom, one citizen, just one consumer who gratefully welcomes the now and future promise of better health care and best outcomes achieved by committed leaders and compassionate caregivers within American hospitals who strive daily to deliver best care every time, believing that the status quo is not appropriate in the face of turmoil, in times of failure and with even the most remote possibility of preventable loss of life.

Dr. Chassin, it is my sincere pleasure to join with you today as you offer up the fruit of your good efforts to all who would receive it in the hope that tomorrow's health care environment will indeed be a better place than was yesterday's and that patients who trust, need and depend on you for best outcomes may fully realize the manifestation of your good work that officially begins here today. Thank you.

**TOM PRISELAC:** Good morning. It's a pleasure to be here with you this morning. I'm Tom Priselac. As Dr. Chassin said, I have the pleasure of being here today in two roles. One, it is an honor to be serving this year as the Chairman of the American Hospital Association. I'm also here as President and CEO of the Cedars-Sinai Health System in Los Angeles, one of the organizations that have been participating in the first initiative of the Center.

There is nothing, nothing more important to America's hospitals than providing the highest quality and safest care we can. The men and women who work in our hospitals, as Vicky, I think, alluded to a moment ago — I think wake up every day just dedicated to making sure that just that happens. But, unfortunately, as Dr. Chassin has identified, that doesn't occur in our hospitals, but America's hospitals are committed to seeing that day happen.

Over the past 10 years in particular, America's hospitals have put great effort into this — into that issue, and significant strides have been made; however, great work remains before us. There remains much for us to do in order to achieve the goals that need to take place in our highly complex hospital environment today, and we need to find strategies that work across the broad spectrum of America's hospitals, ranging from small — literally five- and 10-bed rural sole community providers to the typical community hospitals in our country to major research and teaching centers in our urban areas like my own. And that's why the AHA applauds and was pleased to be a significant contributor towards the establishment of the Center. We believe that the work of the Center can help the nation's hospitals achieve just that goal.

Designed to spur quality improvements through targeted projects, we believe that by creating these laboratories, we will be able to test strategies, and the Center can ultimately help us identify methods and techniques that will help hospitals achieve breakthrough results that are truly sustainable, as Dr. Chassin mentioned. The Center, we believe, will be an important complement to the work that our member institutions and the AHA itself is undertaking in that regard.

At Cedars-Sinai, we've embarked on an effort to completely eliminate hospital-acquired infections. Even though our performance is among the nation's best already prior to this effort, we determined that it wasn't enough and that we owed it to the patients who we treated to make sure that we strive and someday achieve the complete elimination of hospital-acquired infections. Hand washing, as Dr. Chassin mentioned, although low tech, is a significantly important part of that effort and can be an effective tool to reduce hospital-acquired infections. We've been pleased to be part of that initial project. Participation has helped our effort to identify strategies that, in fact, increase hand-washing compliance. Achieving optimal hand-washing compliance requires, really, a multi-faceted approach, but among the most important are methods and techniques that allow us to monitor and measure accurately and to be able to put in place the accountability systems that are an important part of achieving hand-washing compliance.

In the end, again, to meet that broad spectrum of institutions that I mentioned across the country, we will need to have techniques that are reliable, scalable and affordable, and we believe that the work to date has been very helpful both in our own efforts and in contributing to the kind of solutions for our nation's hospitals that I just described. Thank you very much.

**RONALD PETERSON:** Good morning. I'm Ron Peterson, president of Johns Hopkins Hospital and Health System. We're located right up the road in Baltimore. I didn't have quite the commute that Tom did to get here.

I'd like to first start by thanking The Joint Commission for inviting me to be here today at this important event. I'd also like to thank them for their sponsorship, for the transforming health care initiative. The seeds of innovation being planted today with this initiative will grow, blossom and bear fruit, of a transformative kind. We are especially pleased that the mission of The Joint Commission's newly formed Center for Transforming Healthcare aligns so wonderfully with our own mission to improve health of the community and the world by setting the standards of excellence in patient care.

We at The Johns Hopkins Hospital are honored to be among the first participants in this program and are excited to have the opportunity to collaborate with like-minded organizations that have also embraced robust process improvement tools, such as Lean and Six Sigma. We believe our great success with the program is a harbinger of what can be expected in the future from the Center, which will act, really, as a powerful catalyst, we believe, for sharing tools and approaches, solving common problems among participating hospitals.

The Center's focus on hand hygiene as its initial project fits well with our own ongoing efforts to prevent transmission of health care-acquired infections, and it's especially timely, given the looming threat of H1N1, as has already been mentioned. We know the best way to minimize and even eliminate many hospital-acquired infections is through good hand-washing techniques. Our involvement with the project has led to a better understanding of the factors leading to lapses in hand hygiene, and in turn, to interventions that have brought lasting improvements across all eight participating hospitals. The identification of common causal factors among the participants is an encouraging sign that the interventions have the potential to improve hand hygiene at hospitals everywhere across this country.

Our engagement in this initiative has also promoted networking beyond the hand hygiene project and is a promising conduit for continued learning and sharing of best

practices that will ultimately transform the delivery of health care in this country. Thank you so very much.

## **Q&A SESSION**

**QUESTION:** Last night President Obama mentioned in his speech two systems — again, Geisinger and Intermountain Health. My question is, what about hospitals that are not organized with a system where the physicians and others are employed in the system? Is that going to create an impediment to some of these efforts you want to do? Because in my day of practice, doctors often were on the staffs of five or six different hospitals and often had patients in all of those hospitals, so their allegiance to do some of these things were sort of split. So I'd like to have your thoughts on that. And secondly, will somebody point out that — we think that this term "hospital-acquired infections" is very simple to identify. Remember that a lot of patients come in hospitals with infections, and so we have to make certain that we have good metrics that sort out those patients that truly acquired their infection in the hospital, or do they come in with an already-existing infection. Thank you very much.

**MARK CHASSIN:** So I'll take a stab at it, and perhaps Ron or Donny will be able to tackle it from their perspectives as well. I think the answer to the question about the way in which we can work with organizations that have different kinds of medical staffs is twofold. One is that we'll be working with organizations like yours, Tom — the American College of Surgeons, the American College of Physicians, the AMA, to highlight the need for all of us to pull together to solve these problems. And by providing fact-based solutions that directly address the specific circumstances that individual physicians find in their own organizations, we really think that we can get them on board. We work with virtually every physician organization, as you know, and haven't found one yet who is not devoted to improving safety and quality using fact-based methods.

**RON PETERSON:** Let me take a stab at the question by coming at it in a slightly different way and start by saying that we have experience with not only the flagship hospital, Johns Hopkins Hospital — where, as you say, sir, the model is that the faculty are paid, salaried by the institution — we also have experience with a couple of community hospitals that are part of our system. And interestingly, what we have found is that the interventions to address hand-hygiene compliance actually work equally as well in the complex environment of the Hopkins Hospital as well as in the less complex environment of the community hospital. In fact, one of the challenges in the more complex environment is that we have so many different personnel coming in and out of the patient room. Actually, in the community hospital, it's a little bit less fraught with that traffic going in and out of the rooms. But interventions such as role modeling, training that we do, the monitoring and so forth are equally applicable in the community hospital setting. So we have some hope that we can, in fact, get voluntary members of the medical staff at the community hospitals to comply.

**TOM PRISELAC:** I would just add that, like Ron's organization, ours is also a hybrid, actually, and a substantial amount of our admissions to the hospital come from private community physicians. We've found that among the keys to success, I think, is the question of leadership and establishing approaches with your medical staff leadership in which they establish for themselves goals that are in sync with what the institution is trying to achieve. And we've found that goal-setting process working with our medical staff to be effective in that regard. Your second point about linkages to the community, I think, is also an important one, and I think that whether it's issues like hospital-acquired infections or readmissions, I think this has given us all an opportunity to think more systematically in our community and work — and reach out to skilled nursing facilities and other organizations to identify the root causes of these and to build the linkages to both allow us to know the status of the patient better when they come in, but also perhaps to use the resources of the hospital to help those facilities avoid the same problem in their organization.

**QUESTION:** Yes, hi. There was recently a meeting of the infection control group, the Association for Professionals in Infection Control, and they report that — a lot of job shortfalls in staffing. And I'm just wondering, Dr. Chassin, what is The Joint Commission doing to ensure that these programs are adequately resourced? These people have been fighting this fight with hand washing for years.

**MARK CHASSIN:** Thanks for the question. I'll take a stab at it from The Joint Commission's perspective and then invite any of the hospital folks to chime in. The Joint Commission standards and National Patient Safety Goals — in other words, requirements for health care organizations that underpin safety and quality — don't change with economic fluctuations. So if we find that there's a problem with infection prevention and control, we will work with the organization to solve it, whether it's a staffing problem, a training problem, an implementation problem. So we're not seeing, actually, in our own survey results yet any substantial increase in problems due to reduced staffing in these critical programs. But our surveyors look for that, as well as for the lack of compliance of requirements for other reasons.

**ROBERT MALTE:** I'll try to respond to the question in just a little different way. I think this is also where the beauty of Lean and Six Sigma can come into play here. Not only can it produce in the case of hand washing or other clinical processes wonderful results, but it also helps to make sure that the staff we do have are supported that they don't have to work in broken processes and broken systems, that there isn't waste and that they can actually focus on those things that add value. So while there is a challenge and a burdening challenge, a growing challenge, of health care — sufficient health care workers, particularly in nursing, in this country that we have to deal with, those that we do have are very well-intentioned people, and it's our obligation using things like Lean and Six Sigma and other processes for improvement to support them and to make their jobs easier so they can focus on the right thing.

**QUESTION:** I work with the National Journalism Center. And as I'm probably one of the younger ones in the room, the whole health care debate and reform has been quite a big deal and something that's going to become very important for my generation especially. But I feel like a lot of the discussion has been over insurance or uninsured or over-treating patients or the kind of things along those lines, and I'm just wondering how kind of improving the overall quality of care and working at it from kind of the hospital's perspective and as physician and treatment will factor in with all the things that Congress is doing and the overall kind of reform that Americans just want to see in health care.

**MARK CHASSIN:** That's a really good question, and I agree with you, the debate has been all over the map, but here in Washington principally focused on insurance and on coverage issues and pretty esoteric descriptions of how we can tweak programs here and there. But the fundamental issue, we believe, is that while we absolutely need to find ways to cover the tens of millions of Americans that don't have insurance, if we just bring 50 million more people into a system that has broken processes and that doesn't care for patients as safely or with as high quality as we would all like, that's adding to the problem. And what we focus on with the creation of this new Center is a way to systematically get rid of preventable complications which cost a lot of money — tens of billions, if not hundreds of billions over time. We can get rid of those and improve quality, because patients don't suffer from those complications, and save the money that we now use to treat those patients, free up those resources to provide effective care to people who aren't getting it today. So we're using this bottom-up approach within the health care system to try to fix the problem so that when we welcome the tens of millions of Americans into the system that don't have insurance today, they find a much safer, higher quality system.

**QUESTION:** Good morning, this is a question first for Dr. Chassin, and then if some of the hospital executives would like to chime in, that would be great. I'd be curious if you see any of the work that you're doing in the Center eventually making its way over to the

accreditation process and if there's any kind of links between applying for the best practices, whether it will become mandatory or linked to the accreditation.

**MARK CHASSIN:** That's a very good question, and I think it's part of what is unique about this effort, the coupling of these highly effective methods with the reach of The Joint Commission. This is a new activity for The Joint Commission, new in the sense that we have been setting standards and inspecting against and surveying against those standards for decades. But The Joint Commission has not been directly engaged in producing interventions to solve the problems that the requirements put in place for hospitals and other organizations to need. So we are starting this effort in order to do that work, to create the intervention, and that's why it's separate from accreditation today, because we're creating new solutions. Over time, as these solutions prove themselves and as The Joint Commission is able to spread them, as Tom Priselac said, to the broad sweep of America's hospitals, and outside hospitals to other organizations, we will certainly look at the elements of those interventions that work, that are uniformly effective to build into our accreditation requirements to further cement their use throughout the American health care system. That is certainly part of the future — not what we're doing today, because we're creating them, but it is part of the framework for why we believe this initiative will be very effective over time.

**DONNY LAMBETH:** Yes. One of the aspects that we really like about this program is the fact that while this is a very controlled and pilot group, you're going to share this information across a broad array of hospitals throughout the country. And I think we all can learn from each other the techniques that we're going through, and the fact that we can share these with other hospitals is what's really exciting to me.

**QUESTION:** Hello. My question concerns the incidence of wrong-site surgery that you cited. Could you please repeat that and explain how you determined that statistic?

**MARK CHASSIN:** Sure. There are a couple of states— Minnesota and Pennsylvania — that for the last several years have had a requirement for all of the hospitals in the state to submit to the State Health Department the frequency of different kinds of adverse events, including wrong-site surgery. And if you take the Minnesota data and extrapolate it and assume that everybody is as good or as not so good as Minnesota in this regard, you get to the number that I cited, which is about six every day, seven days a week, or 42 or 44 of these occurrences every week in the United States. That's the source of the information.