Interview with J. Michael Henderson, MD, Chief Quality Officer, The Cleveland Clinic Health System

By Art Thomson, MA

Dr Henderson received his medical degree from St. Andrews University in Scotland and completed his surgical training in Scotland, developing an interest in liver disease. At Emory University in Atlanta, he rose to professor of surgery, working on portal hypertension and liver transplant, with funding from the National Institutes of Health (NIH). He moved to the Cleveland Clinic in 1992 as chairman of general surgery and director of the transplant center, with interest in hepatobiliary-pancreatic disease. He obtained further NIH funding for a large multicenter randomized clinical trial in the field of portal hypertension.

In 2006, he started the Quality and Patient Safety Institute at the Cleveland Clinic as its first chairman. The goal has been to coordinate all regulatory, quality, and risk-management activities under a single structure to address current demands. As chief quality officer for the Cleveland Clinic Health System, his current focus of activity is on quality outcomes measurement and patient safety.

Q: You are in the position to offer a unique perspective on quality and organ transplantation because you have held the positions of director of the transplant center and chairman of quality and patient safety, both at Cleveland Clinic. Did your perspective on quality change as you made the transition between these positions? And if so, how did it change?

A: While in organ transplantation, quality as I know it now was not on my radar screen. We did, of course, monitor clinical outcomes, graft and patient survival, and other data on our programs that were made available through the Scientific Registry of Transplant Recipients. While this is important, it is but a small segment of the big picture. Now my perspective on quality is much different, and I understand the importance of quality in a much larger context. It is about the basics of all aspects of patient care and must include standardization of processes.

Q: Many programs and centers are grappling with new Condition of Participation requirements from the Centers for Medicare and Medicaid Services (CMS), which include a quality assurance and performance improvement program. What advice would you give to transplant hospitals to ensure that they are meeting this requirement?

A: The most important requirement is that the transplant quality initiatives tie back in to the overall hospital quality and patient safety priorities and initiatives and that they mirror those efforts. Transplant programs do not need "different" quality initiatives, but can lead the broad, basic quality programs for hospitals. For example, infection control and medication management are 2 initiatives that are important for both hospitals and transplant programs.

Q: Are quality issues different in transplant than in other areas of medicine? If so, how?

A: Overall, no. Transplant quality measures should mirror the overall quality program for the hospital. Certainly, transplant patients are some of the sickest patients in hospitals, but using broad and basic hospital quality programs, such as hand hygiene compliance, will contribute to better care and outcomes. Transplant programs should lead hospitals in programs such as this!

Q: The Joint Commission has identified 10 performance measures for stroke certification. From your perspective, what are some of the key performance measures that transplant centers should target for their quality improvement programs?

A: There is an opportunity for transplant centers to define useful quality process measures similar to The Joint Commission's core measures. Transplant has done a great job with patient and graft survival in sorting out the good programs from the bad. The types of quality process measures that I believe transplant can get together and develop are reporting of infection rates, medication management—right drugs at right time, use of standardized order sets, and maintenance of renal function. The goal is to define measures that represent optimal patient management.

Q: Transplant centers have flown under the radar screen with The Joint Commission and CMS for many years. There are so many oversight groups and databases that it can become overwhelming trying to

keep up in 2009. What are your thoughts on how to best collect data, share data, and use data to improve quality?

A: This is the key issue; if you can't measure it, you can't improve it. So how do we do that effectively? I have learned several lessons in my different roles. First, in my role as director of transplant, we developed a "Unified Transplant Database" in the early 1990s with the goal of being able to provide payors with all the transplant-related data they were requesting. We were fairly successful in persuading all of them that a standardized report was good for them all. Data management is now much more sophisticated.

Next, when I moved into my role in quality, I saw the whole data flow as one of the greatest challenges, but also a great opportunity. The principles on which I currently believe that this needs to work are

• Tie quality data capture to daily clinical activity. Having frontline providers embrace the importance of this improves the data collection—and ultimately they are the people who are going to need to see and use the data for improvement.

• Develop and implement clinical documentation systems where data can be captured in a usable format. This requires standardization and good electronic medical records.

• Work with your data management group to develop simple, useful, and actionable reports. The more in "real-time" these are available to the front line, the more effective they will be.

• Share the data in an open and transparent forum so that the whole team knows how you are performing. The transplant program leadership needs to develop and articulate program priorities—keep it simple. Quality improvement initiatives are the responsibility of all team members and depend on good leadership with accountability for everyone's performance.

I do think that if you develop a standardized approach along these lines, then the ability to address all the other multiple demands being put on us for required reporting in one format or another fall into place.

Q: How does a transplant program ensure its quality improvement program reflects the goals of the organization's quality program? How should data at the transplant institute/program level report up to the organization's program? Should there be representation from the transplant center's quality assurance and performance improvement (QAPI) program on the organization's QAPI program?

A: These are very good questions, and speak to the need for integration and cooperation. It does come back to some of the themes we have already touched on. Overall hospital quality plans should be prioritized and set in the hospital's QAPI program. It is hospital leadership's responsibility to ensure that these priorities are communicated and implemented in all areas. Transplant can and should take a lead for some of the programs in such plans, and members of the transplant teams should play important roles in hospital-level committees and teams for quality improvement. Get involved!

Transplant, like all hospital specialty areas, should have its own quality committee, with a charter that addresses hospital priorities and also has additional transplant-specific quality projects and metrics. I believe that the sign of a successful transplant QAPI program is that the rest of the hospital knows about, talks about, and is proud of the quality improvement successes they achieve.

Financial Disclosures

None reported.

Suggested Reading

Byers JF, White SV. *Patient Safety: Principles and Practice.* New York, NY: Springer Publishing; 2004.

Dlugacz YD, Restifo A, Greenwood A. *The Quality Handbook for Health Care Organizations: A Manager's Guide to Tools and Programs.* San Francisco, CA: Jossey-Bass; 2004.

McLaughlin CP, Kaluzny AD. *Continuous Quality Improvement in Health Care.* Sudbury, MA: Jones and Bartlett; 2006.

Nelson EC, Batalden PB, Godfrey MM. *Quality by Design: A Clinical Microsystems Approach.* San Francisco, CA: Jossey-Bass; 2007.

Ogrinc GS, Headrick LA. *Fundamentals of Health Care Improvement: A Guide to Improving Your Patients' Care.* Joint Commission Resources; 2008.