Safe Passage – Crossing the Quality Chasm

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To Err Is Human: Building A Safer Health System

<u>First Report</u>

Committee on

Quality of Health Care

in America

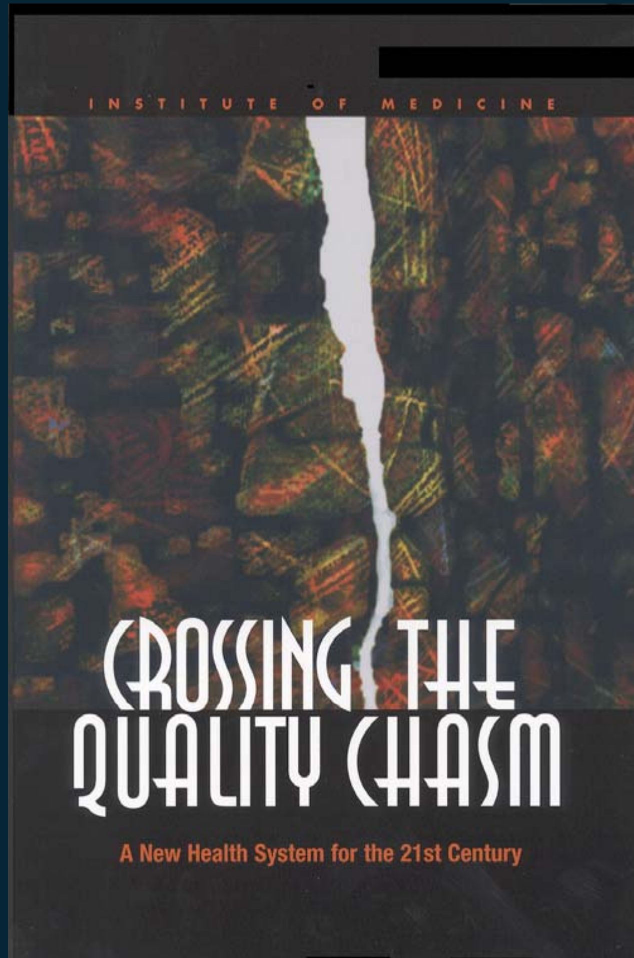
Key Findings

- Errors occur because of system failures
- Preventing errors means designing safer systems of care

Medical Errors

- Early recognition
- Early acknowledgement
- Prompt apology
- Early settlement

Crossing the Quality Chasm



Second Report

Committee on

Quality of Health Care

in America

Studies Documenting the “Quality Gap”

Literature review conducted by RAND

- Over 70 studies documenting quality shortcomings

Large gaps between the care people should receive and the care they do receive

- true for preventive, acute and chronic
- across all health care settings
- all age groups and geographic areas

Major Forces Influencing Health Care

- Expanding Knowledge Base
- Information Technology
- Chronic Care Needs
- Payment Policies

IT Can Improve Quality

- ***Safety --*** **computerized physician order-entry reduced adverse drug events by 84% (Bates, 2001)**
- ***Effectiveness --*** **reminder systems and computer assisted diagnosis and management improves compliance with practice guidelines (Durieux, 2000; Evans, 1998)**
- ***Patient-Centered --*** **Internet can provide access to clinical knowledge, online support groups, customized health education and disease management messages**

IT Can Improve Quality

- *Timeliness --* mothers receiving computer-generated reminders had 25% higher on-time immunization rate for their infants (Alemi, 1996)

- *Efficiency --* 9% of redundant lab tests at a hospital could be eliminated using a computerized system (Bates, 1998)

- *Equity --* Internet-based health communication can improve access and provide a broader array of options for interacting with clinicians

Increased Chronic Care Needs

- About 100 million people (40% of population) have one or more chronic conditions
- Chronic conditions account for more than two-thirds of health care expenditures (Robert Wood Johnson Foundation, 1996)
- 80/20 Rule: Limited number of conditions account for most of these health care expenditures (Ray et al., 2000)

Delivery System Inadequate

- Dearth of clinical programs with infrastructure to provide full complement of services to chronically ill (Wagner, 1996)

- Physician groups and hospitals operate as silos without benefit of complete information

Chronic Care Delivery Models

- Planned, systematic approach
- Attention to information and self-management needs of patients
- Multi-disciplinary teams
- Extensive coordination required across settings and clinicians, and over time
- Unfettered and timely access to clinical information is critical

Aims For Improvement

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

Ten Rules To Redesign Care

1. Care based on continuous healing relationships
2. Customization based on patient needs and values
3. Patient as source of control
4. Shared knowledge and free flow of information
5. Evidence-based decision making

Ten Rules To Redesign Care

6. Safety as a systems property
7. Transparency
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians

Information Technology

- There must be a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.

- This commitment should lead to the elimination of most handwritten clinical data by 2010

Payment

- Purchasers should examine their current payment methods to remove barriers that impede quality improvement, and to build in stronger incentives for quality enhancement
- HCFA and AHRQ should identify and evaluate various options for better aligning current payment methods with quality improvement goals

Summary

American health care is beset by serious problems, but they are not intractable. The committee envisions a system that uses the best knowledge, that is focused intensely on patients, and that works across health care providers and settings. Achieving this ideal will require crossing a large chasm between today's system and the possibilities of tomorrow.

Success Stories

- Iowa Health System
  - 75% decrease ADE in one year
- St. Joseph Medical Center, Illinois
  - 50% reduction ADE - <1year
- Safety leadership Walk Rounds
- Safety Briefings

Important Tools

- Computerized Physician Order Entry (CPOE)
- Electronic Medical Record
- Patient Safety Indicators (AHRQ)
- Voluntary National Reporting Systems
- Proprietary Error Reporting Systems

FDA Responses

- Bar Codes (VA)
- 15 day reporting
- Safety Center

Disease Management Programs

- Improved Outcomes
- Decreased Costs
- Increasing Commercialization
- Role of Physician
- Motivation for Cost Reduction

Source: Weingarden et al., BMJ, 2002.

Obstacles

- Physicians disbelief
- Resistance to change
- Technology skepticism
- Cost

Keys to Success

- Leadership
- Opinion leaders
- One-on-one instruction
- Carefully orchestrated rollout
- Local data

Administration Efforts

- Presidential Statements
- Support of Health Information Infrastructure
- Health information leadership
- CMS funding

Next Steps

- Maintain momentum
- Standard language
- Connectivity of systems
- Increased incentives
- Stronger accreditation
- Increasing role of CMS
- 100,000 Lives Program

Education Implications

- Multidisciplinary Learning
- Effective use of IT
- Continuous Quality Improvement
- Joint Problem Solving
- Team Management
- Understand the “10 Rules”

20th	21st
Autonomy	Teamwork
Solo Practice	Systems
Continuous Learning	Continuous Improvement
Blame / Shame	Problem Solving
Knowledge	Change

Well Informed Joint Patient-Doctor Decision Making