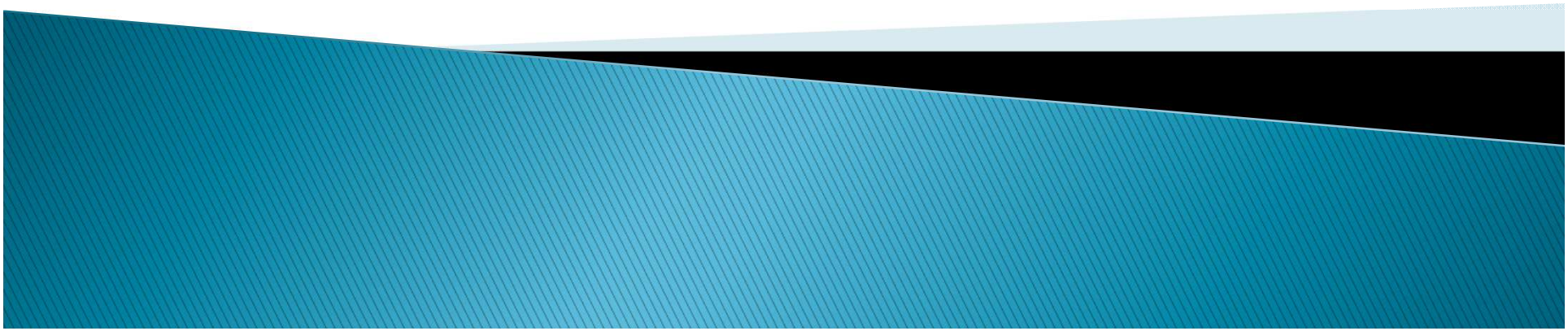
Quality and Safety In U.S. Health Care: A Brief History

Joe McCannon
Brasilia
8.13.2013



A Brief History of Quality in American Health Care

- Food and Drug Administration (1906)
- Flexner report (1910)
- National Board of Medical Examiners (1915)
- American College of Surgeons Hospital Standardization Program (1917)
- Hill Burton Act (1946)
- Centers for Disease Control and Prevention (1946)
- Joint Commission on Accreditation of Hospitals (1952)

from Luce, et al, 1994

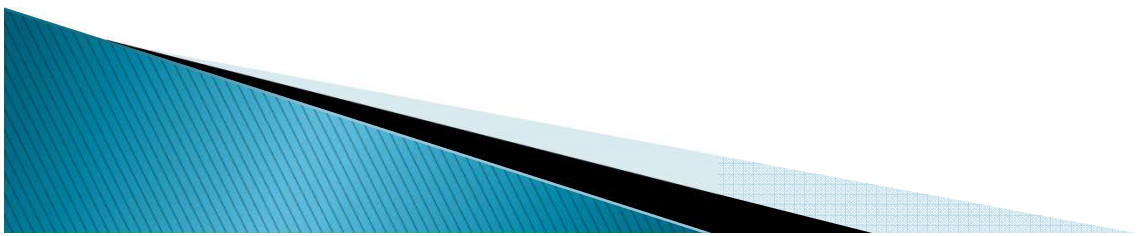
A Brief History of Quality in American Health Care (cont.)

- Medicare and shift to "optimal achievable standards" (1965-1966)
- Professional Standards Review Organizations (1972)
- Agency for Healthcare Research and Quality (1989)
- Harvard Medical Practice Study (1991)
- Institute for Healthcare Improvement (1991)

from Luce, et al, 1994

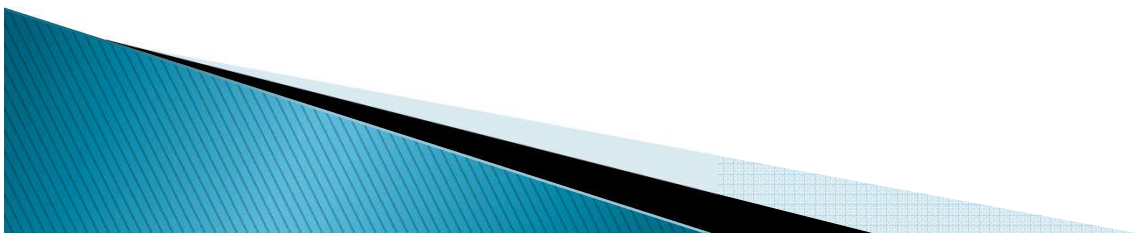
A Brief History of Quality in American Health Care (cont.)

- *To Err is Human* (1999)
- *Crossing the Quality Chasm* (2001)

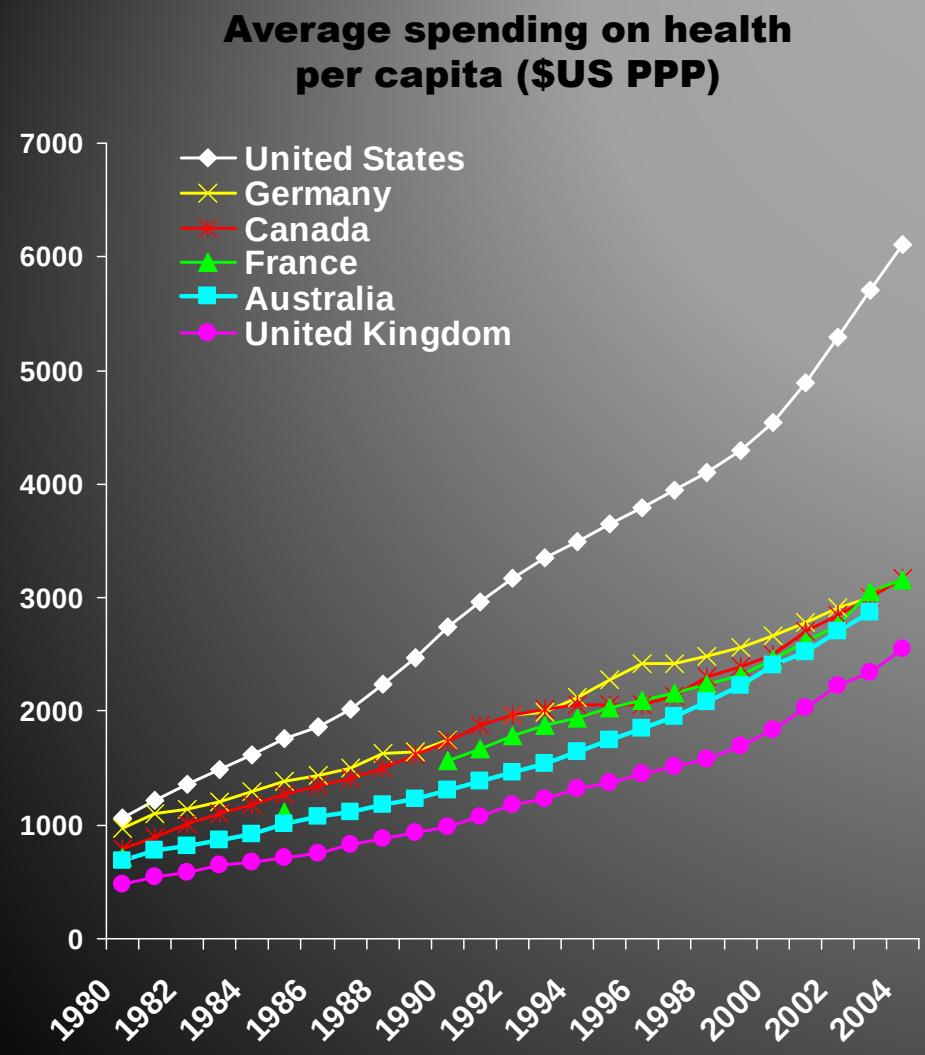


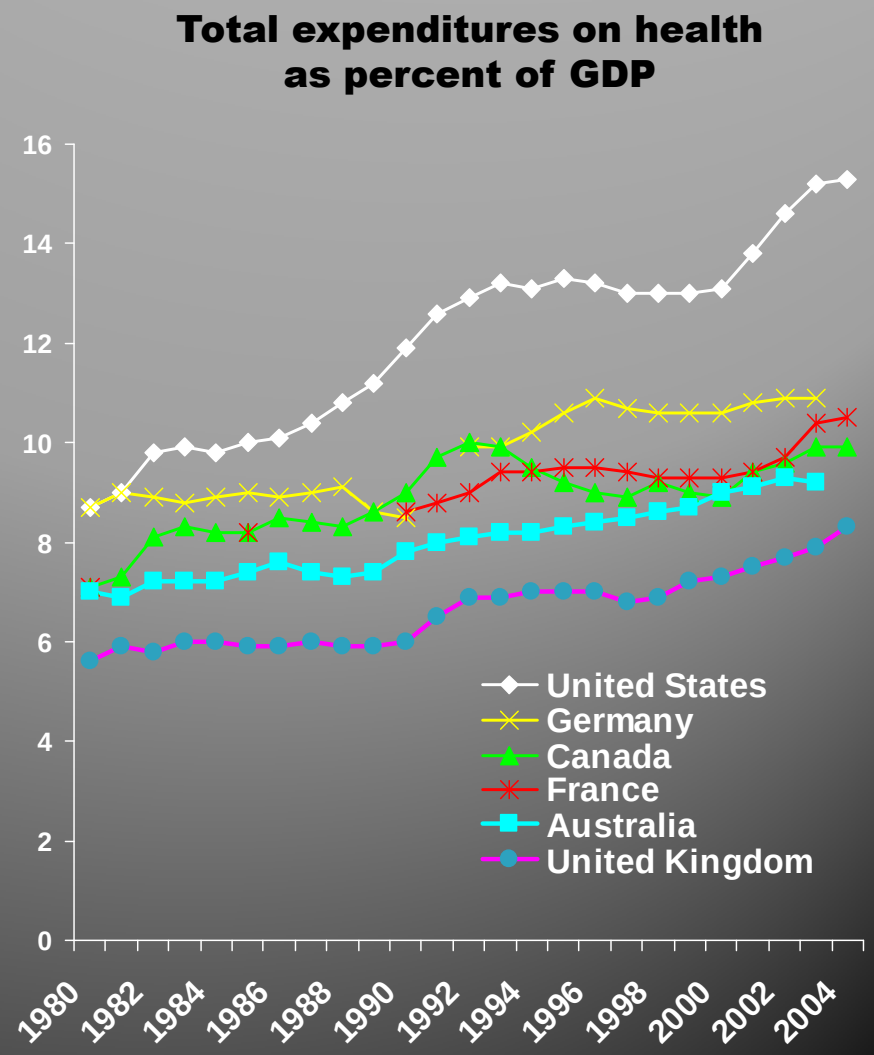
Defects and Harm: Examples

- 44,000 to 98,000 people die each year as a result of preventable medical errors
- 45% defect rate in care for adults
- 22% of chronically ill adults report “serious error” in care
- 74% of chronically ill adults say the system needs “fundamental change” or “complete rebuilding
- Case-mix adjusted hospital death rates vary by 400%
- Resource use in the last six months of life varies >500% among 77 top-rated US hospitals
- Estimated 15 million incidents of harm per year in US hospitals



International Comparison of Spending on Health,[6] 1980–2004





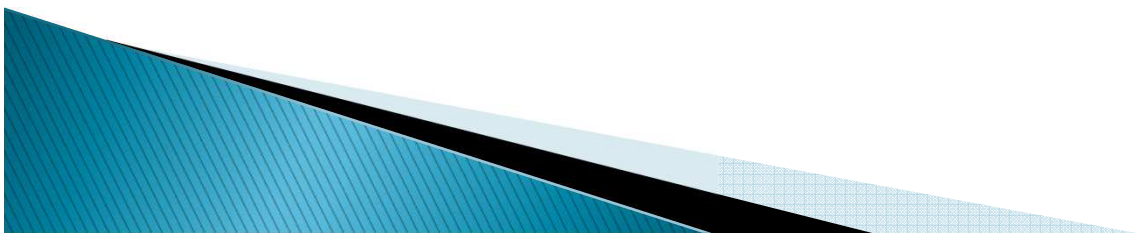
Data: OECD Health Data 2005 and 2006; **Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006**

American College of Healthcare Executives Annual Survey:

Issue	2003	2004	2005	2006
Financial challenges	73%	71%	67%	72%
Physician/hospital relations	26%	32%	33%	40%
Care for the uninsured	26%	36%	35%	37%
Quality	17%	18%	23%	29%
Patient safety	9%	16%	20%	27%
Governmental mandates	18%	19%	16%	23%
Patient satisfaction	7%	13%	18%	16%
Capacity	28%	16%	17%	11%
Malpractice insurance	24%	25%	11%	3%

Institute of Medicine Dimensions of Quality (STEEP)

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



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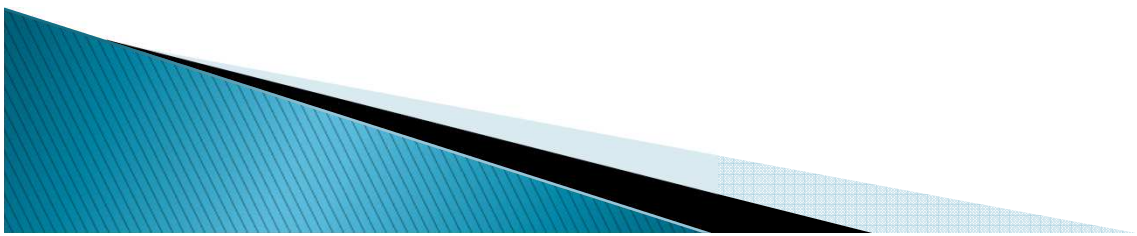
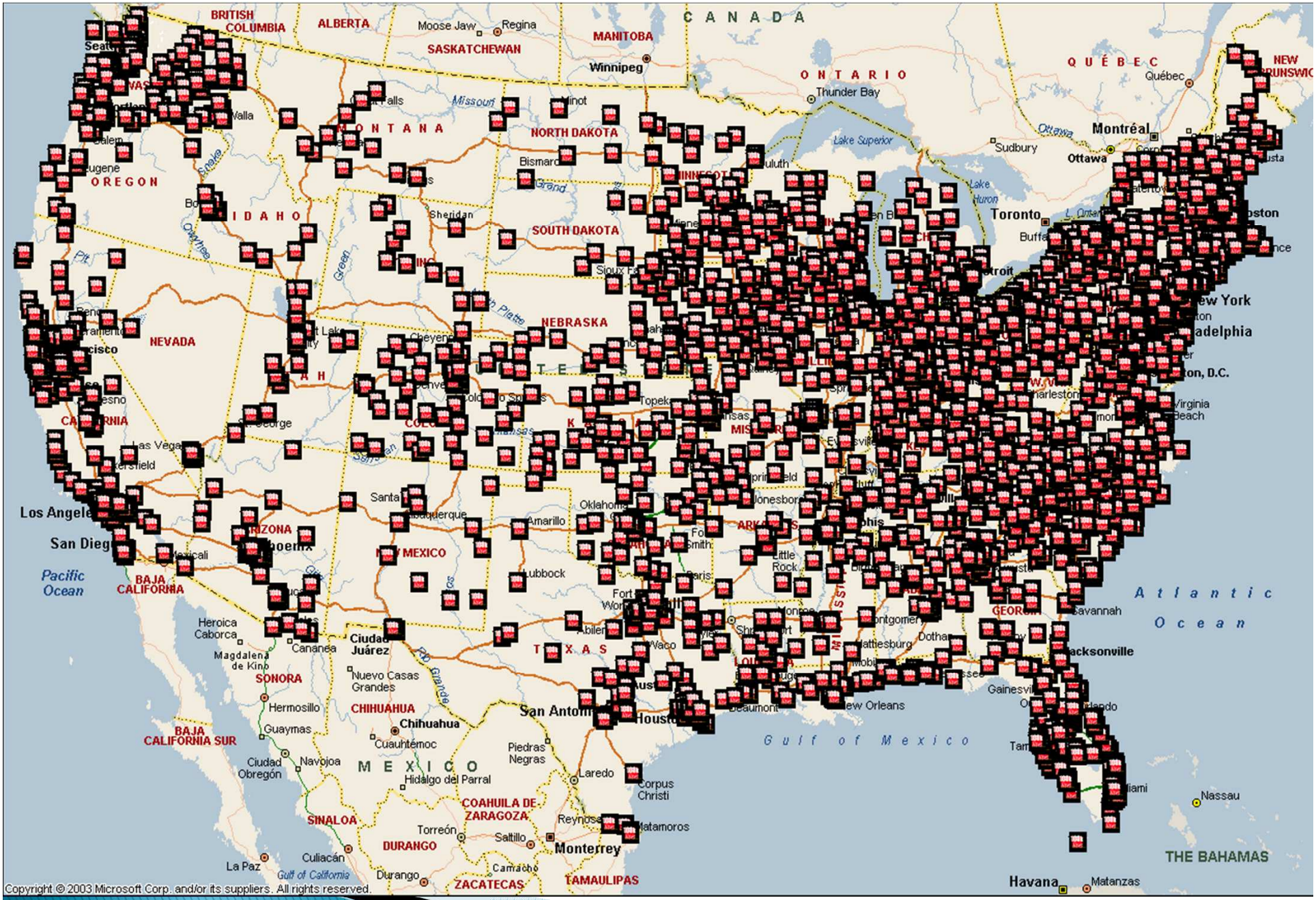


A Ten-Year Journey toward Safety (2001-2011)

- Small-scale demonstrations
- Regulation "with teeth" (Joint Commission)
- Voluntary Campaigns (100,000 Lives Campaign and others)
- Transparency (Medicare/Medicaid and private insurers)
- Introduction of "no pay" conditions
- State regulations
- Introduction in graduate medical education and professional certification



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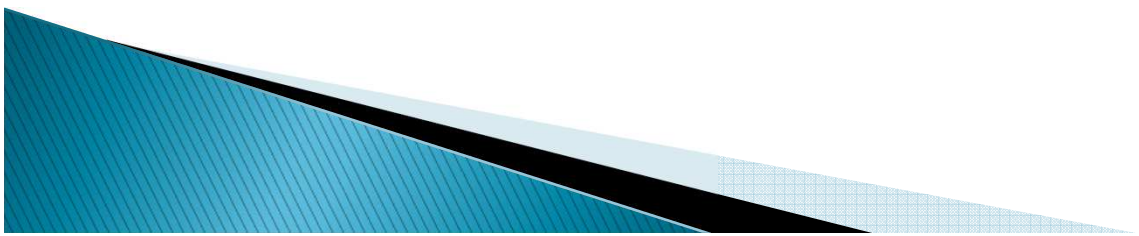
Is There A “Silver Bullet?”

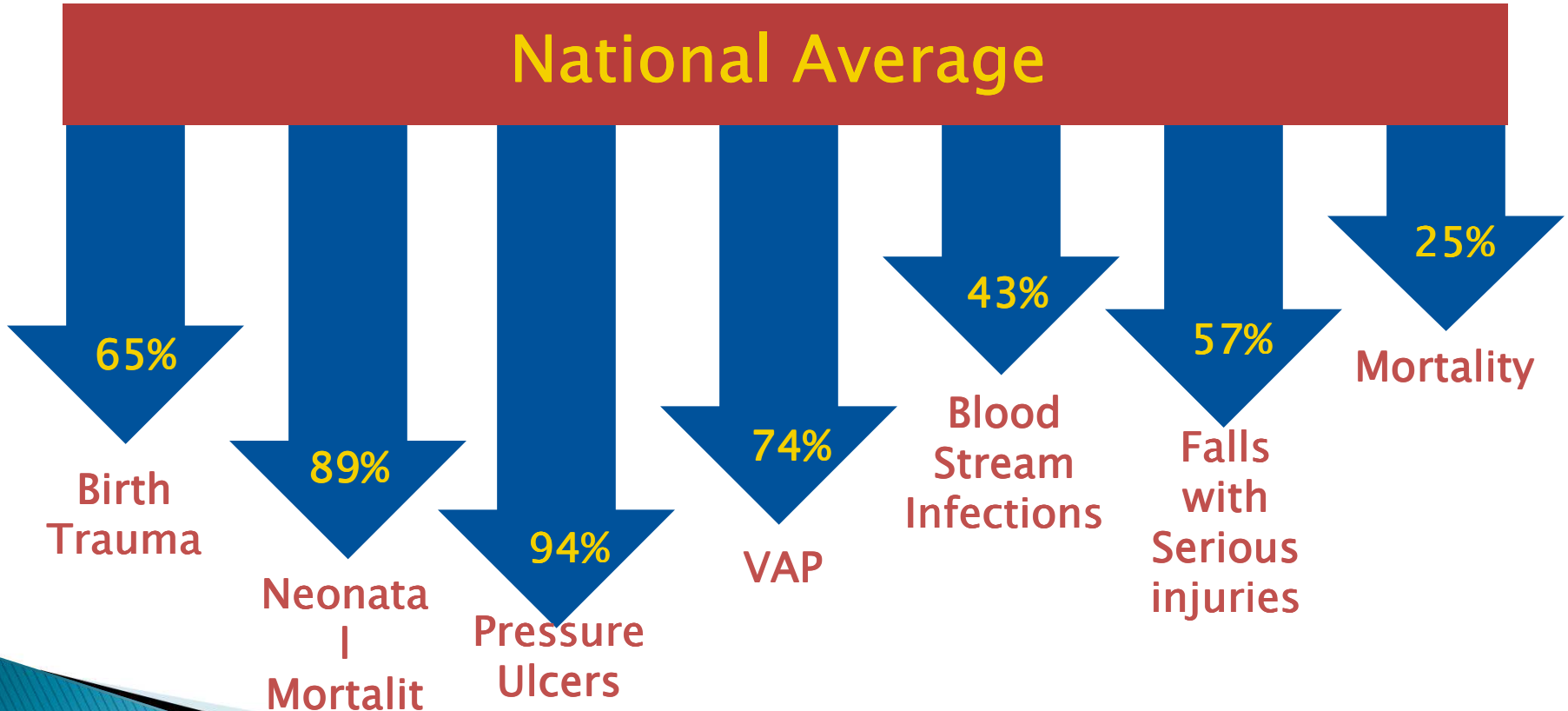
NO.



Some Progress

- 58% national reduction in central-line infections between 2001-2009
- 150 New Jersey health care facilities reduced pressure ulcers by 70%
- More than 65 Institute for Healthcare Improvement Campaign hospitals reported going more than a year without a ventilator-associated pneumonia in at least one unit.
- Ascension Health sites participating in a 2007 peri-natal safety initiative achieved birth trauma rates that were at or near zero.

Ascension Health
Our Journey to Zero –FY10 Results



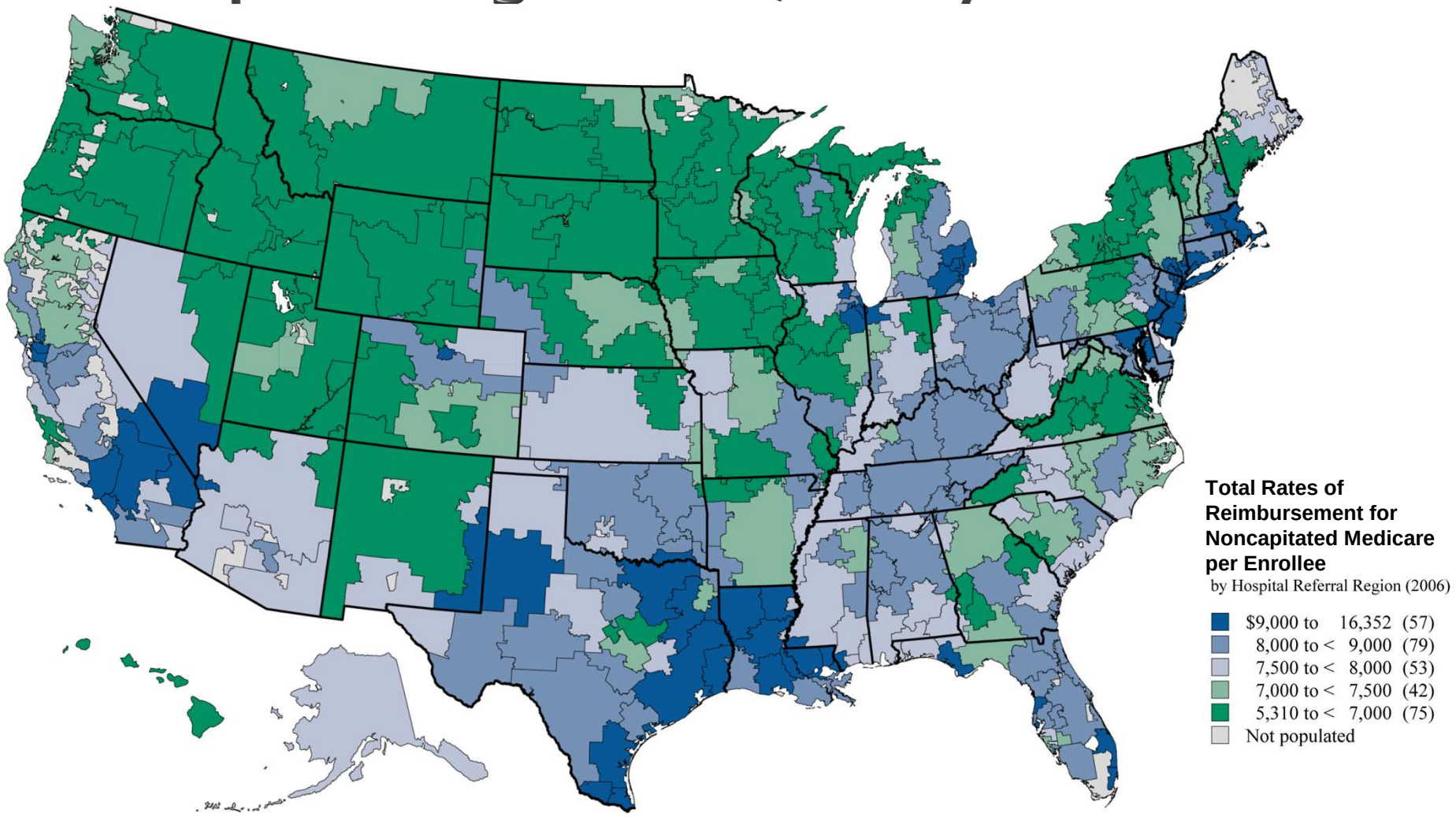
Measurement of Ascension Health Performance 07/01/09 - 6/30/10. National estimates are the latest available in the literature and other sources of data (data collection methodologies may not be identical). Birth Trauma & Neonatal Mortality -2005, Facility-Acquired Pressure Ulcers – 2004 data; Falls with Serious Injury 1985 – 1999 data; Central Line Blood Stream Infection & Ventilator-Associated Pneumonia – 2006 -2008 data, Mortality – 2008 data.

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,558	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

Unwarranted Variation in Medicare Spending and Quality of Care



Source: E. Fisher, D. Goodman, J. Skinner, and K. Bronner, *Health Care Spending, Quality, and Outcomes*, (Hanover: The Dartmouth Institute for Health Policy and Clinical Practice, Feb. 2009).

The Affordable Care Act ("Obamacare")

- Increasing Coverage (46 million Americans without insurance)

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- Increasing Coverage (46 million Americans without insurance)
- Managing cost *by improving quality* (approximately 1/3 of expenditures are "waste")

Major Quality and Cost Strategies

- National Quality Strategy
  - Affordable Care
  - Better Care
  - Healthy People/Healthy Communities
- Center for Medicare and Medicaid Innovation ($10 Billion)

Partnership for Patients: Better Care, Lower Costs

Nationwide public-private partnership to tackle all forms of harm to patients. Goals:

- **40% Reduction in Preventable Hospital Acquired Conditions over three years**
  - 1.8 Million Fewer Injuries
  - 60,000 Lives Saves
- **20% Reduction in 30-Day Readmissions in Three Years**
  - 1.6 Million Patients Recover Without Readmission

If successful, potential to save $35 Billion Dollars in three years

- Up to $1 billion in government funds committed; over 3,500 hospitals on board.

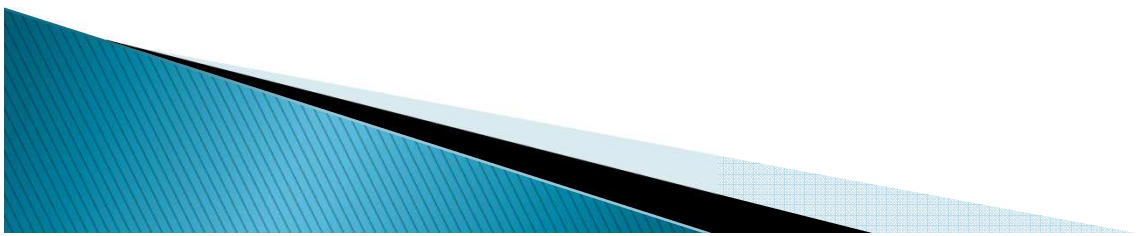
Key Preventable Harms

- Central Line-Associated Bloodstream Infection
- Venous Thromboembolism (post-surgery)
- Pressure Ulcer
- Surgical Site Infection
- Ventilator-Associated Pneumonia
- Catheter-Associated Urinary Tract Infection
- Adverse Drug Event
- Obstetrical Adverse Event
- Injury from Fall

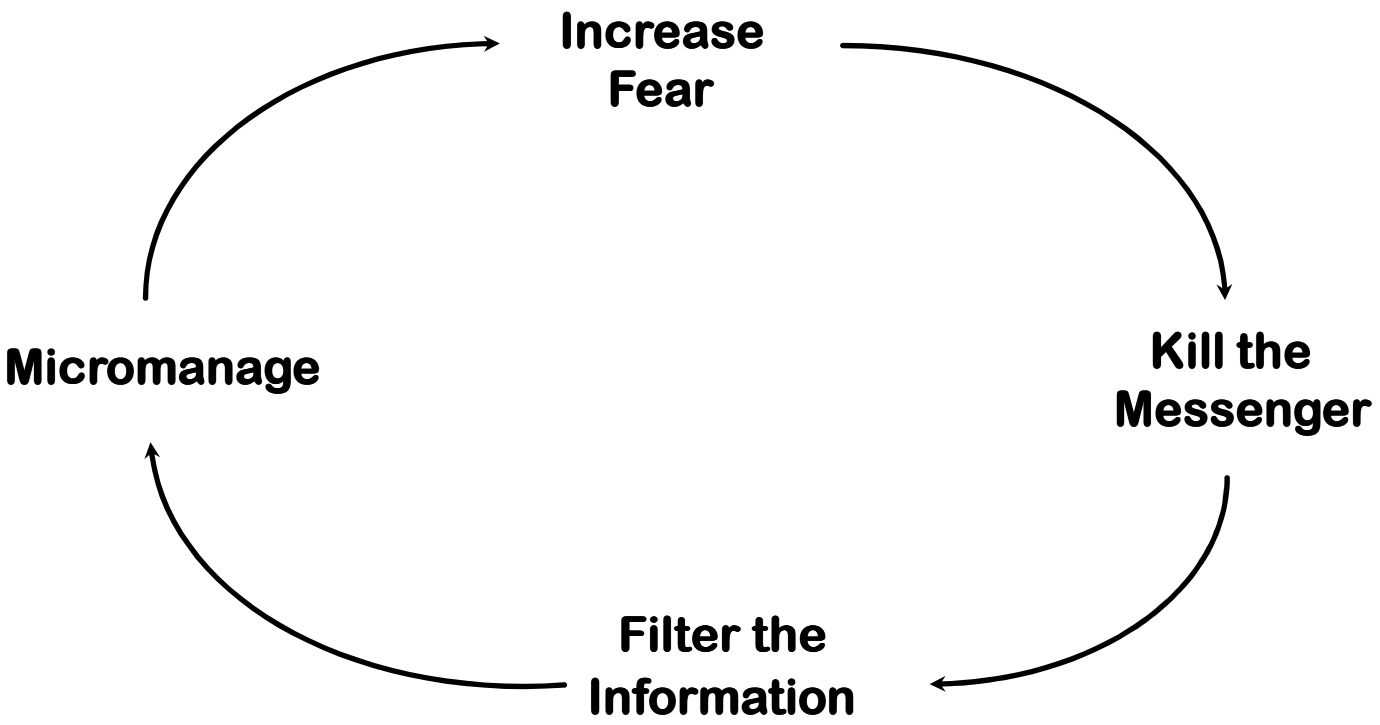
AND ALL-CAUSE HARM

The Path More Taken

- General mission statement
- Consensus building
- Heavy measurement and regulation
- High reliance on web sites, publishing
- High reliance on education, experts



The Cycle of Fear



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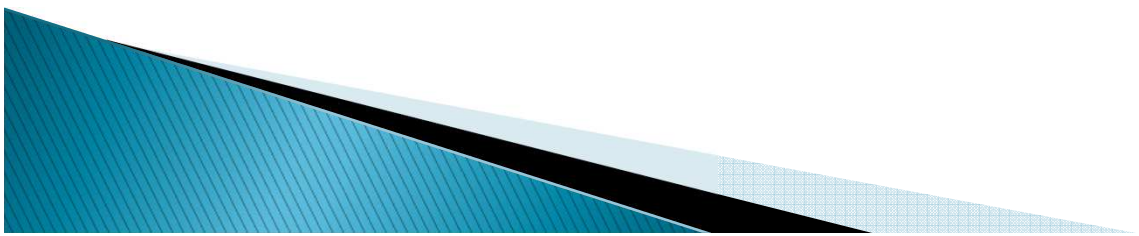
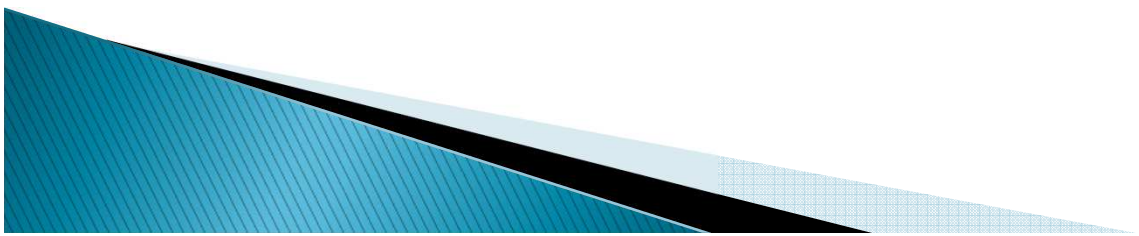


The Path Less Taken

- Clear, public aims
- Relentless leadership attention (pace)
- Active barrier removal (versus regulation)
- Incident command approach (versus "business as usual")
- Heavy bias toward rapid testing, field application
- Useful, real-time data
- Patient and families informed and involved

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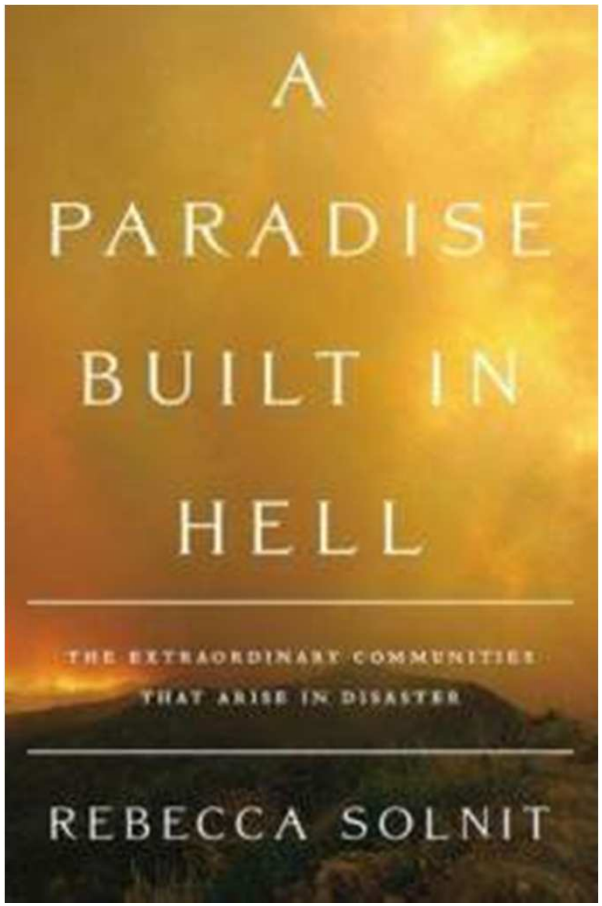
A
PARADISE
BUILT IN
HELL
THE EXTRAORDINARY COMMUNITIES
THAT ARISE IN DISASTER
REBECCA SOLNIT

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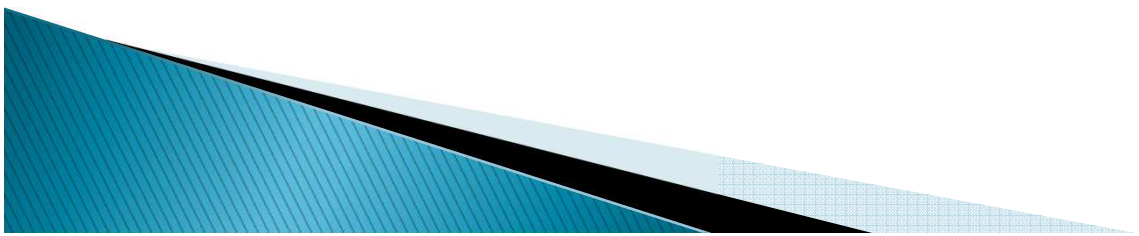
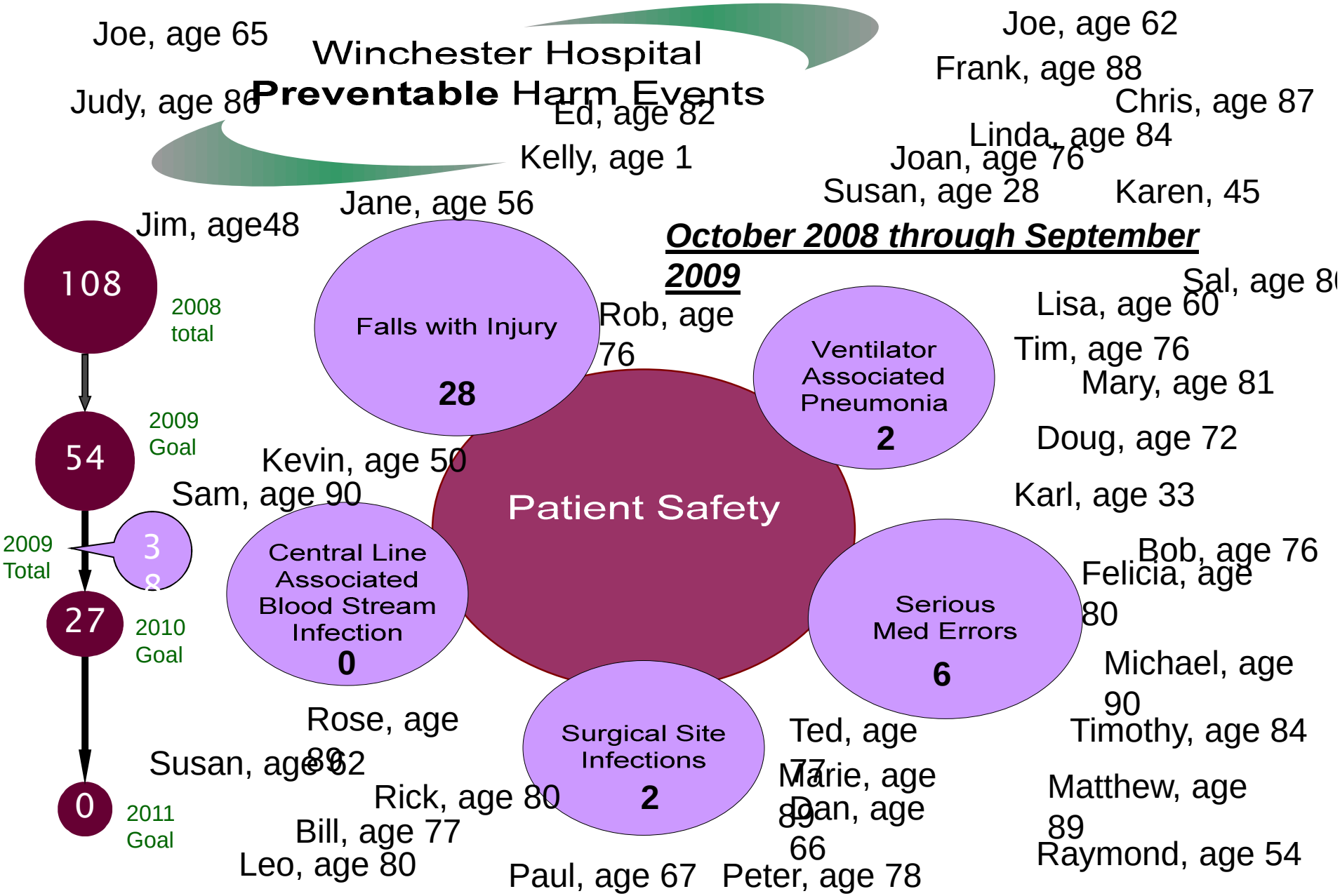



Abril - Mayo
Atenciones Niño < de 5 años
Atenciones del Adulto
Atenciones Generales
CR SR CA SJ Otros
Año 2012 40 200 32 9 15
Año 2013 54 228 28 6 14
Año 2012 172 444 127 13 54
Año 2013 156 481 172 31 45
Año 2012 212 844 159 22 99
Año 2013 200 709 140 37 62
Referencias Maternas al HRO
Total de Referencias al HRO
C.A.R.A.A.
G # 16: % de niños <5 años de edad con diagnostico de Diarrea que fueron manejados de acuerdo a
G # 17: Numero de muertes maternas



Fiscal Year 2009 Goal: Reduce preventable harm by 50%

The Path Less Taken

- Clear, public aims
- Relentless, tenacious leadership attention (pace)
- Active barrier removal (versus regulation)
- Incident command approach (versus "business as usual")
- Heavy bias toward rapid testing, field application
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THANK YOU!
CONGRATULATIONS!