

Which comparisons of effectiveness of treatment delivery methods are most likely to improve hospital outcomes?

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National Comparative Effectiveness Summit

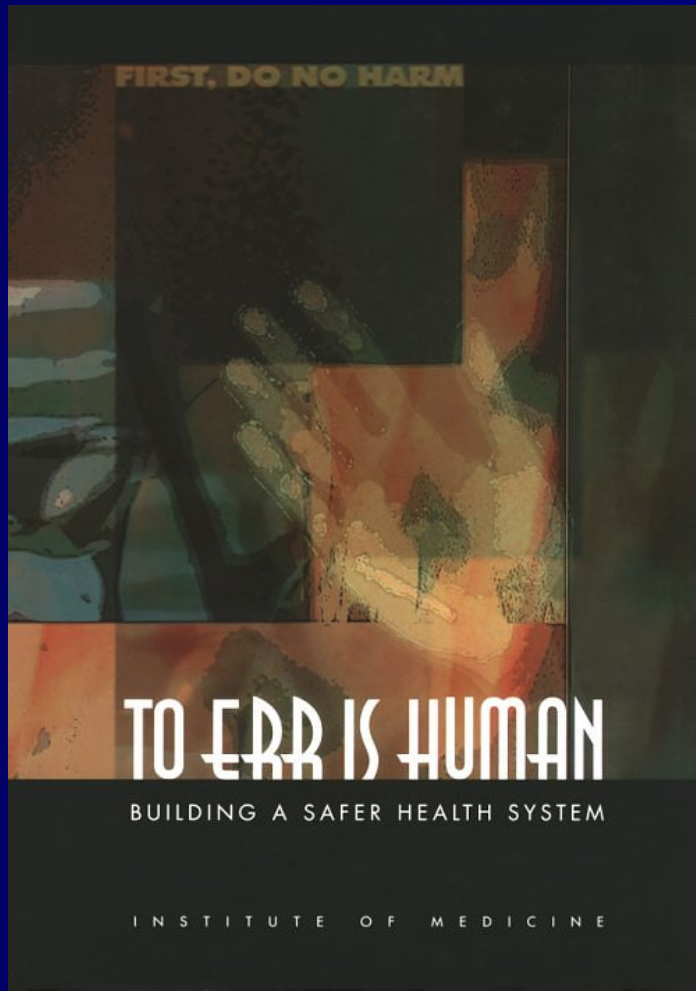
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02138

Perhaps the most opinionated zip code in
America

The New York Times

TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM



**Institute of
Medicine
Committee on
Quality of Health
Care in America**

IOM Message:

It's not bad people, it's bad systems

The Domains of Patient Safety

1. Environment
2. Safe Practices
3. Response to adverse events
4. Teamwork and communication
5. Professional performance
6. Infrastructure

The Domains of Patient Safety

1. Environment

- External – regulat., payment, standards, research

Ex: J.C., CMS, NQF, AHRQ

- Internal

- Policies – explicit, enforced

Ex: Mutual respect, no punish for errors, disclosure

- Conditions

Ex: Hours, work loads, equipment

- Culture

Ex: Supportive, personal account., systems thinking

The Domains of Patient Safety

1. Environment

2. Safe Practices

- Standard practices – NQF 34
- Local - “Ad hoc”

The Domains of Patient Safety

1. Environment
2. Safe Practices
3. Teamwork and communication
 - With colleagues
 - With patients

Teamwork is the secret of every industry that has succeeded in becoming safe

The Domains of Patient Safety

1. Environment
2. Safe Practices
3. Teamwork and communication
4. Professional performance
 - Technical competence
 - Behavior

The Domains of Patient Safety

1. Environment
2. Safe Practices
3. Teamwork and communication
4. Professional performance
5. Response to adverse events
 - Patient – disclosure, apology
 - RCA and systems changes
 - Reporting

The Domains of Patient Safety

1. Environment
2. Safe Practices
3. Teamwork and communication
4. Professional performance
5. Response to adverse events
6. Infrastructure
 - IT – EMR, CPOE, Data
 - Personnel – FTE, expertise

A Culture of Safety (HRO)

- Interpersonal responsibility
- Person centeredness
- Supportive of co-workers
- Friendly, open personal relations
- Creativity
- Credibility
- Interpersonal trust
- Resiliency

The Lucian Leape Institute of the NPSF

- Donald Berwick
- Carolyn Clancy
- James Conway
- James Guest
- David Lawrence
- Julianne Morath
- Dennis O'Leary
- Paul O'Neill
- Diane Pinakiewicz
- Paul Gluck

Five Transforming Concepts

- Transparency
- Consumer Engagement
- Finding Joy and Meaning in Work
- Integrating Health Care
- Reforming Medical Education

LLI Vision of Safe Health Care

We envision a culture that is open, transparent, supportive, and committed to learning; where doctors, nurses, and all health workers treat each other and their patients competently and with respect; where the patient's interest is always paramount, and where patients and families are fully engaged in their care.

LLI Vision of Safe Health Care

We envision a culture centered on teamwork, grounded in mission and purpose, in which organizational managers and Boards hold themselves accountable for safety and learning to improve. In a learning organization, every voice is heard; every worker is empowered to prevent system breakdowns and to correct them when they occur.

The culture we envision aspires to, strives for, and achieves unprecedented levels of safety, effectiveness, and satisfaction in health care.

Comparative Effectiveness (IOM)

Comparative effectiveness research is the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care.

The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels.

Where is assessment of comparative effectiveness needed?

1. Care – What we do

- Drug A v Drug B; Hip prosthesis A v B

2. Delivery processes – How we do it

- Implementing safe practices – e.g., CL insertion
- Practice guidelines

3. The Environment – The support

- External – regulations, financing, reporting
- Internal
 - Institutional policies – transparency, non-punitive reporting
 - Conditions of work – hours, workloads, etc.
 - Professional performance – assessment, improvement
 - Responding to events – RCA, patient support

Which treatment delivery failures most need comparative effectiveness study?

1. Fall prevention
2. Computerized physician order entry
3. Patient flow management
4. Duplicate reading of imaging studies
5. Pharmacist participation in clinical care

Which treatment delivery failures most need comparative effectiveness study?

1. Fall prevention

- 1/3 people > 65 fall each year – OUT of hospital!
- 10% of falls → serious injury
- No. 1 cause of injury in hospitalized patients
- Prevention requires multiple interventions
- No proven superior combination

Which treatment delivery failures most need comparative effectiveness study?

1. Fall prevention

2. Computerized physician order entry

- Highly effective: reduces prescribing errors 66%
- Major value: decision support (allergies, etc.)
- 17% of hospitals have; most without decision support
- Major barriers to adoption: cost, interoperability, physician resistance, major process change

Which treatment delivery failures most need comparative effectiveness study?

1. Fall prevention
2. Computerized physician order entry
3. Patient flow management
 - Emergency rooms are a national shame
 - Average wait to see doctor: 30 minutes
 - Time in ER: S.D. – 3 h 52 m Utah – 6 h 48 m
 - Doctor's offices aren't much better
 - Huge unmeasured cost to patients
 - Flow management works

Which treatment delivery failures most need comparative effectiveness study?

1. Fall prevention
2. Computerized physician order entry
3. Patient flow management
4. Duplicate reading of imaging studies
 - Disagreement of experts on everything: 15%
 - Mammograms – 15-20%
 - Angiograms: 16% no disease; 43% less severe

Which treatment delivery failures most need comparative effectiveness study?

1. Fall prevention
2. Computerized physician order entry
3. Patient flow management
4. Duplicate reading of imaging studies
5. Pharmacist participation in clinical care
 - Participation on rounds in ICU → dec. ADE 66%
 - Office-based – in groups
 - Should review every new prescription

Which treatment delivery failures most need comparative effectiveness study?

AND:

- Methods for collecting, analyzing, and displaying data
- Methods for meaningful engagement of patients in all aspects of care

