



Developing the Role of the  
Patient Safety Officer

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PHILADELPHIA  
DAILY NEWS  
PEOPLE PAPER

RETHINKING  
ALPHIA  
A 16-PAGE  
SPECIAL REPORT

Dr. Fedup

BOB LARAMIE and BRAD J. GUIGAR/Daily

THE DOCTOR IS OUT

# Inflection points in history



## – Automobile Manufacturing

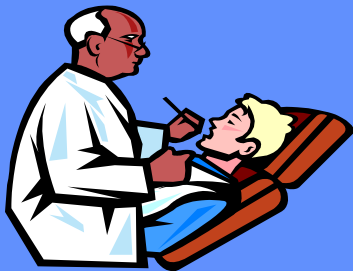
- Implementation of new management theory (Frederick Taylor)
- The vision of Henry Ford

## – Banking

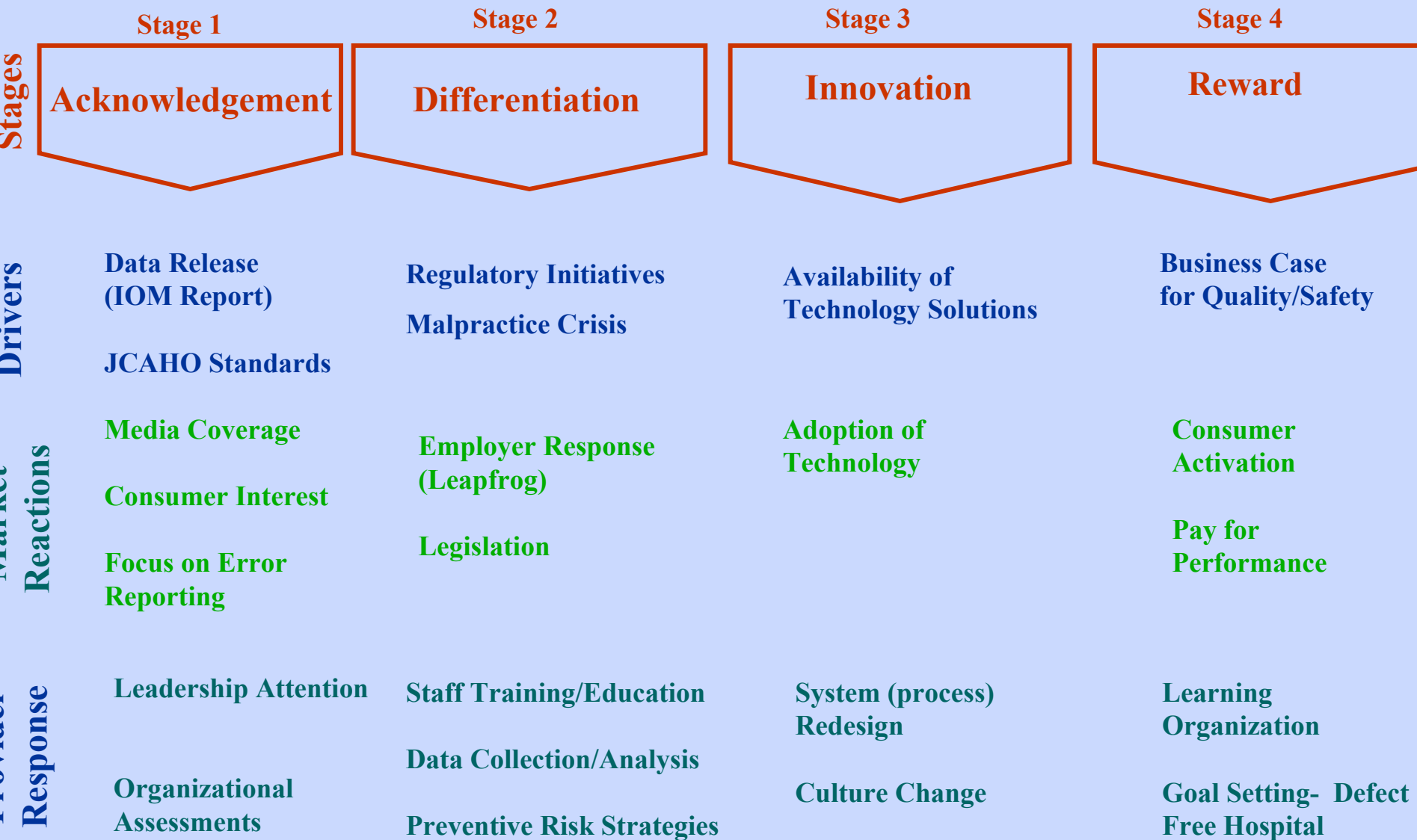
- Deregulation
- Consolidation
- New Technologies
- New Competitors

## – Health Care

- The Flexner Report
- Managed Care Reimbursement
- Quality/Patient Safety ??



# The Market Model for Quality and Patient Safety





# Stage I- Acknowledgment

# Hospital lab error a 'system failure'

Executives of the chain that owns St. Agnes also defended the handling of the crisis, saying staff acted quickly.

By Nancy Phillips,  
Mark Fazlollah  
and Josh Goldstein  
INQUIRER STAFF WRITERS

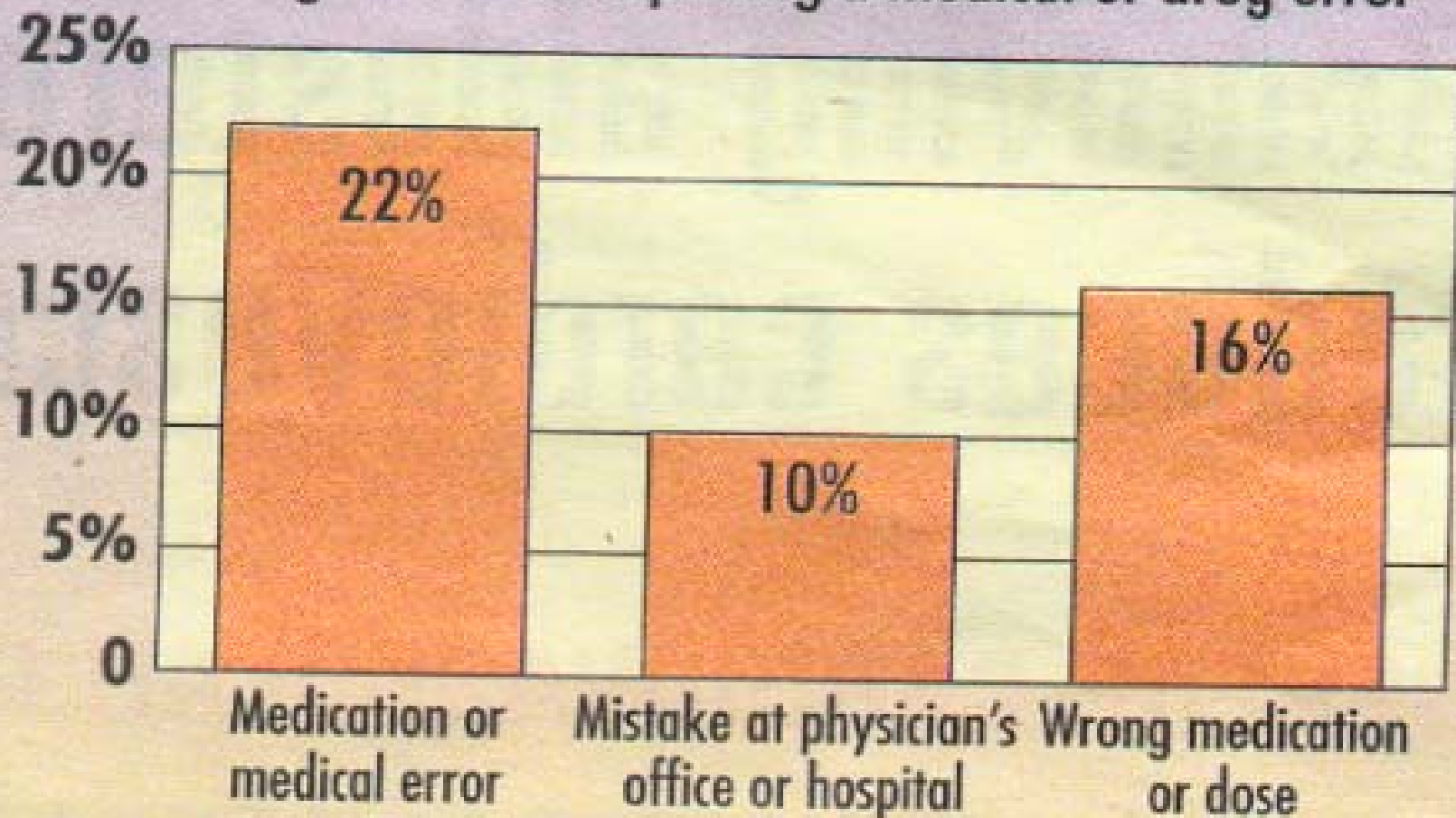
The blood-test mistakes that may have caused the deaths of five patients at St. Agnes Medical Center were the result of a "system failure" in the South Philadelphia hospital's lab.

That was how executives of the chain that owns St. Agnes described the episode yesterday. They also defended St. Agnes' handling of the crisis, saying hospital personnel acted quickly last month to identify patients who were in the greatest danger and begin alerting them by phone calls, letters and visits.

"Our first priority was to do all that was necessary to reach all of the patients in harm's way," Richard F. Afa-ble, chief medical officer of Catholic Health East, said in a telephone interview.

## IT COULD HAPPEN IN YOUR PRACTICE

Percentage of adults reporting a medical or drug error



Source: *The Commonwealth Fund 2001 Health Care Quality Survey*

# Concerns About Safety

According to a recent Survey respondents had the following concerns:

**61 % being given the wrong medicine**

**58% given medicines that interact in a negative way**

**56% complications from a procedure**

# What Patients Say They Want

Keeping Patients and Families Fully Informed Throughout Care

Reliance on Evidence Based Guidelines

Customized and Individualized Treatment Plans

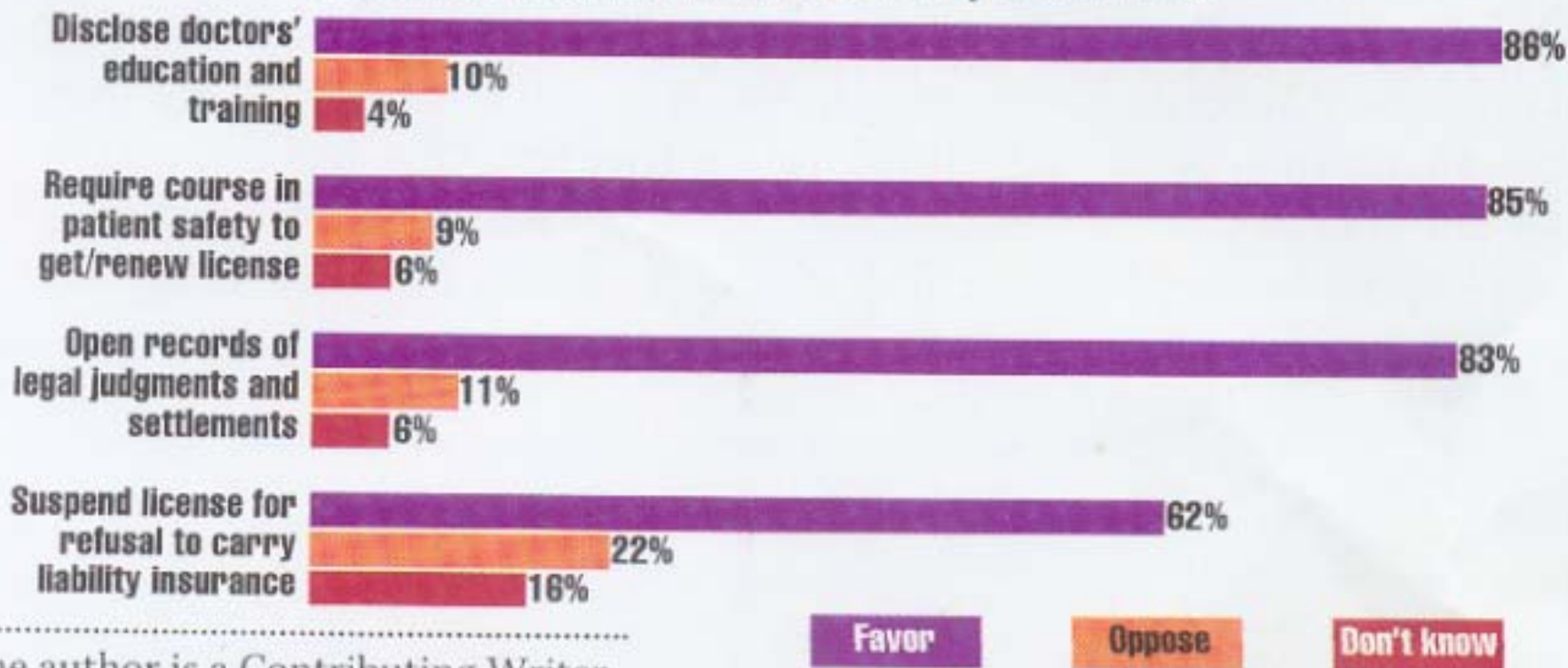
Computerized Information Processes to Capture all Patient Information

Full Chart Review with Patients before Discharge

VHA Study, 2002

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## Steps patients favor to make medical practice safer



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The author is a Contributing Writer.

# Stage II- Differentiation

# The Search for Medical Quality



How do I know if I am getting the right care?

How do I find a high quality doctor?

How can we decrease the risk of a medical error?

# MARKET DRIVEN

## Health Care

Who Wins, Who Loses  
in the Transformation  
of America's Largest  
Service Industry.

**REGINA HERZLINGER**  
HARVARD BUSINESS SCHOOL

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# Choosing Doctors

- 82% of patients would change doctors based upon quality information

# Choosing Hospitals

- 87% of patients would choose a different hospital based upon information on quality

# Surgery Scorecard

Rating New York City area hospitals on abdominal aortic aneurism surgery. To look for your hospital's performance in a variety of areas, see page D2.

HOSPITAL	PROCEDURES IN 2000	MORTALITY RATE
St. Francis Hospital	105	7.86%
Mount Sinai Medical Center	95	8.98%
North Shore Univ. Hospital	76	7.52%
Winthrop University Hospital	66	11.56%
Montefiore Medical Center	54	7.26%
LIJ Medical Center	53	9.35%
Westchester Medical Center	49	5.26%
Maimonides Medical Center	34	9.16%

Source: Empire Blue Cross and Blue Shield



# Study: Choosing right hospital can be lifesaver

## ■ HOSPITALS

from Page 1A

tients would be better served if certain kinds of complicated surgeries were performed at just a few hospitals.

It's a contentious issue: Some hospital officials note that large-scale studies such as this one obscure the actual track records of individual hospitals. A physician cautioned in JAMA that the studies the UCSF researchers relied on for their data may in themselves be skewed.

There are real life and death differences between hospitals, and that shouldn't be ignored.

— Dr. R. Adams Dudley, study author

## AVOIDABLE DEATHS

Researchers found that more than 25 percent of the 2,273 deaths after certain surgeries in California hospitals in 1997 might have been avoided if patients went to hospitals that had a "high volume" practice in the kind of treatment they underwent.

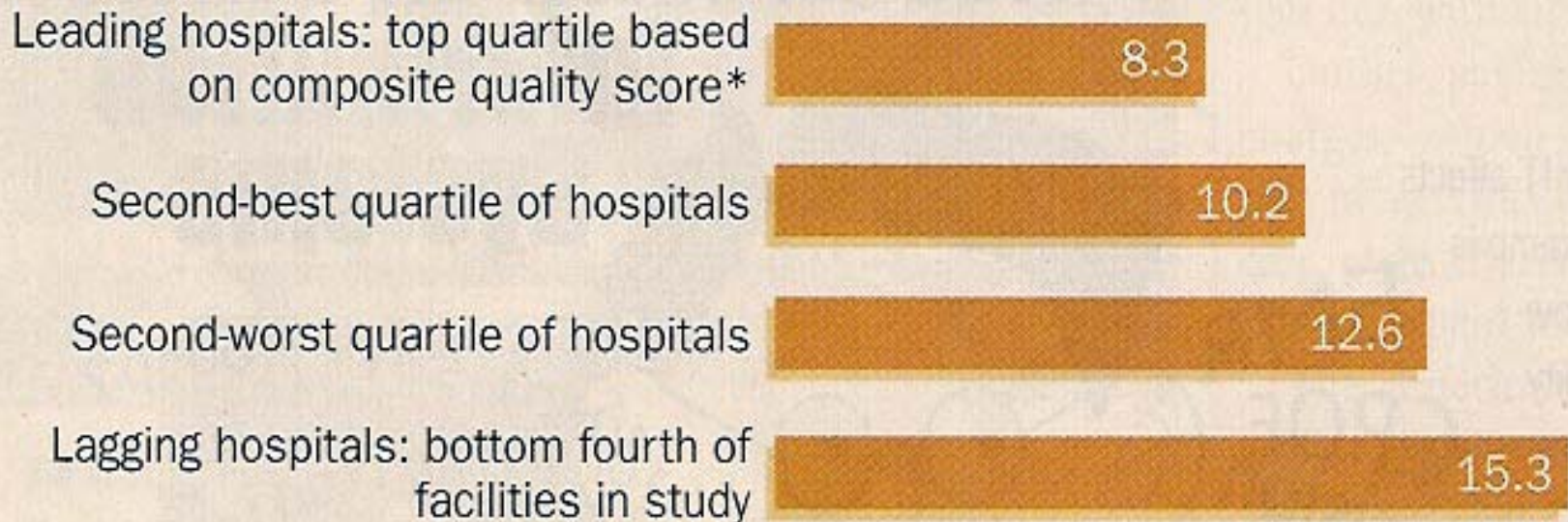
Medical condition	Patients admitted	Total deaths	Avoidable deaths
Heart bypass	21,452	952	258
Lower extremity bypass	4,054	194	37
Heart transplant	21	0	0
Pediatric heart surgery	468	26	7
Coronary angioplasty	16,070	327	80
Abdominal aneurysm	1,837	107	40
Carotid artery	7,476	73	16
Cerebral aneurysm	818	83	36
Esophageal cancer	130	9	7
Pancreatic cancer	271	27	20
HIV/AIDS	5,709	475	101
<b>Total</b>	<b>58,306</b>	<b>2,273</b>	<b>602</b>

Source: Journal of the American Medical Association

MERCURY NEWS

## DEATH RATE RISES AS COMPLIANCE RATE FALLS

Percentage of in-hospital mortality matched against degree of adherence with heart-attack guidelines














\* Ranking of 1,247 hospitals based on adherence to heart-attack guidelines

Source: Presentation at Nov. 17 American Heart Association Scientific Sessions

MH/Adam Doi

# Leapfrog Data on Patient Safety

## Survey Results for New York Hospitals Submitting Responses

Hospital Name	City	Information Submitted	Computerized Drug Orders	ICU Staffing	Number of Procedures
<a href="#">Arden Hill Hospital</a>	Goshen	09/30/2002			<a href="#">Click here</a> for number of procedures.
<a href="#">Bassett Hospital Of Schoharie County</a>	Cobleskill	12/27/2001		N/A	<a href="#">Click here</a> for number of procedures.
<a href="#">Bellevue Hospital Center</a>	New York	12/31/2001			<a href="#">Click here</a> for number of procedures.
Benedictine Hospital	Kingston	01/31/2002			<a href="#">Click here</a> for number of procedures.
<a href="#">Bronx-Lebanon Hospital Center</a>	Bronx	09/30/2002			<a href="#">Click here</a> for number of procedures.
<a href="#">Cabrin Medical Center</a>	New York	03/04/2002			<a href="#">Click here</a> for number of procedures.

# U.S. to Air Ratings Of Health Providers Campaign Aimed At Improving Care

By CECI CONNOLLY  
*Washington Post Staff Writer*

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The federal government is planning for the first time to issue detailed ratings of the quality of care provided by nursing homes, Medicare health plans, dialysis centers and eventually hospitals and doctors, a senior Bush administration official announced yesterday.

The Health Care Financing Administration (HCFA), using newspaper advertisements, the Internet and toll-free telephone numbers, plans to release numerical scores for every Medicare provider four times a year based on a half-dozen criteria, ranging from medical credentials to staffing levels.

Relying on both government inspection reports and customer sur-

# Stage III- Innovation

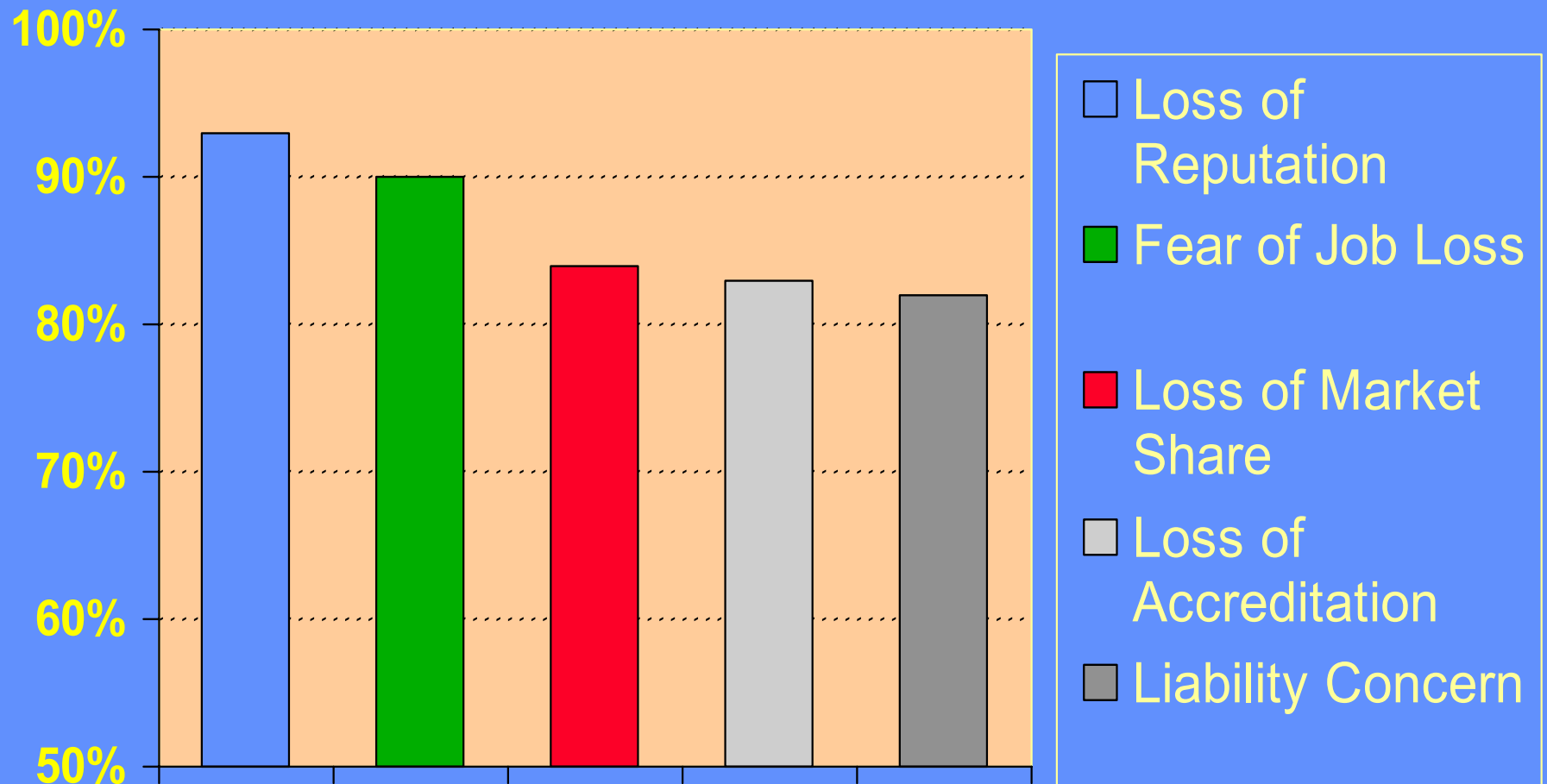
# Time for Innovation?

More Americans die from errors than breast cancer, Traffic accidents, and AIDS- (Institute on Medicine)

Hospital acquired infections kill 90,000 patients annually and have increased 36% since 1980 (CDC)

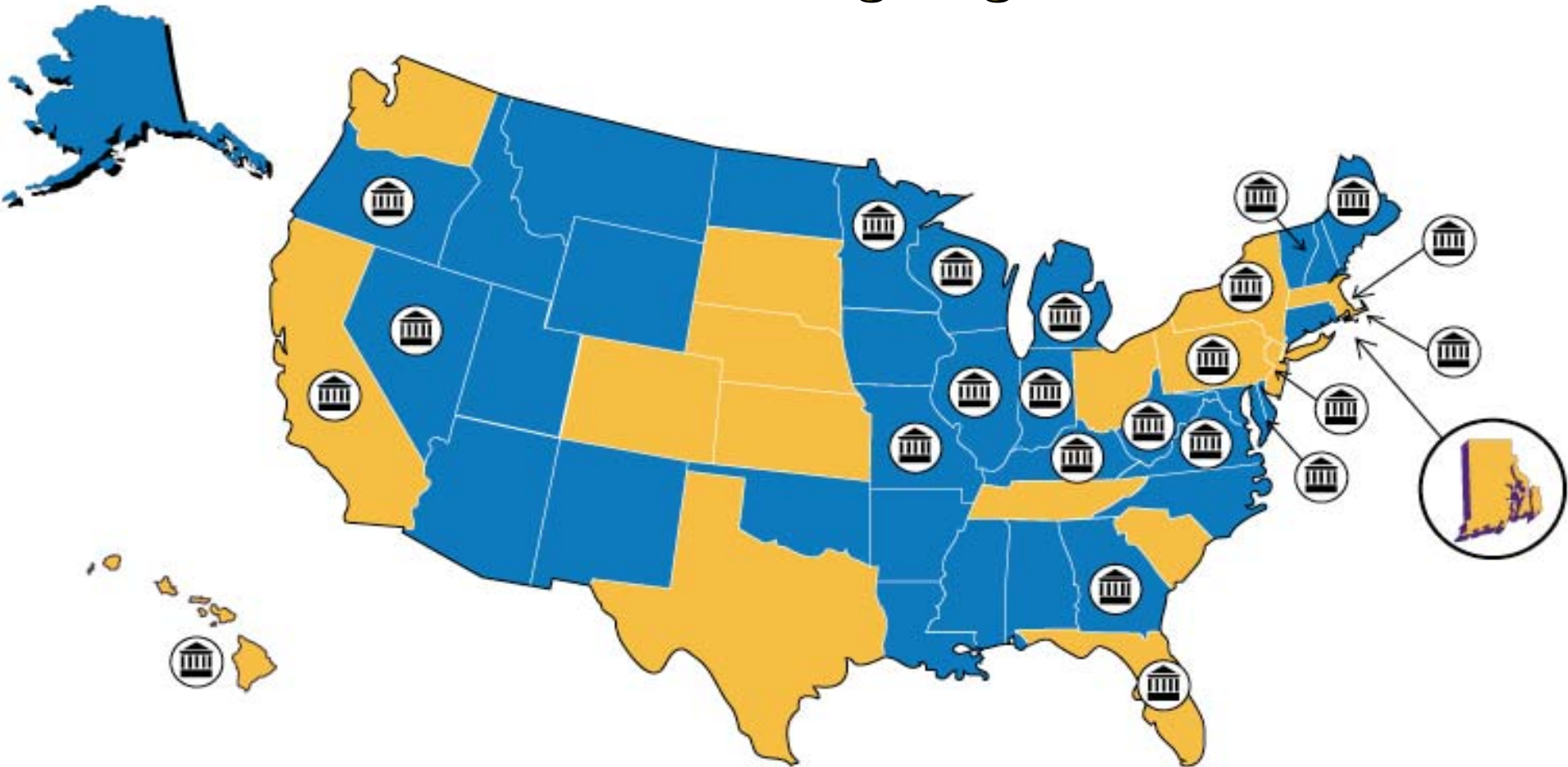
One in five medications dispensed in hospitals and nursing homes are administered with an error (Archives Internal Medicine 2002)



# Why Are Medical Errors Not Reported?



Source: Survey of 644 Healthcare Professionals, October, 2000  
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# Reporting Medical Errors: Current & Pending Legislation



-  15 States Currently Requiring Mandatory Reporting of Medical Errors
-  23 States Introduced Pending Legislation

# Why Errors Occur

Diagnostic Errors (Failure to Act on Results,  
Errors in Dx) 22%

Treatment Errors (Errors in Drug Use,  
Delay in Tx, Technical Errors) 61%

Preventive (Failure to Prevent Injury  
Inadequate Monitoring) 16%

Other 1%

Human Error in Medicine

Marilyn Bogner, 1994

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# Proven Approaches to Quality

53,000 to 175,000 lives saved per year

with Intensivists in ICUs

(Pronovost, P. JAMA, November 2002)

Handwashing can reduce approximately 1 million  
Noscomial infections a year (CDC)

# Improving Patient Safety- Strongest Evidence

VTE Prophylaxis

Use of Perioperative B-Blockers

Sterile Barriers during Catheter Insertion

Antibiotic Prophylaxis

Asking Patients to Recall Patient Consent Information

Aspiration of Subglottic Secretions

Use of Pressure-Relieving Bedding Materials

Ultrasound Guidance with Central line Insertion

Antibiotic Impregnated Catheters

\*JAMA 2002 vol 288(4):501-507

# Other Patient Safety Practice with High Strength of Evidence

Use of Hip Protectors

Use of Supplemental Perioperative Oxygen

Selective Decontamination of GI Tract

Use of Silver Alloy Catheters

Management by Intensivists

Computer monitoring of ADE's

# Patient Safety- Low Strength of Evidence

Changing catheters routinely

Hydration protocols for theophylline

Use of sucralfate to prevent pneumonia

Mechanical rather than manual ventilation during transport

(AHRQ publication # 98-0004)

# Best Practices in Medication Safety

Medication errors are the second most expensive type of malpractice case- averaging \$163,090 per claim

## Use

Daily

Four Times Daily

0.5 mg

5 mg

Thirty

## Don't Use

Q.D.

Q.I.D.

.5 mg

5.0 mg

30

# Organizing Care for Quality

Diabetes – HbA1c < 7.0 from 42% to 70%

Practice guidelines

Academic detailing

Individual and group classes

Medical record flowcharts for patients

Patient registries for risk stratification

Physician and nurse practice teams

Reminder prompts

Premier Health Partners- JAMA 2002

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# Clinical Information Systems

Patient Registries

Reminder systems for complying with guidelines

Feedback to physicians on chronic care measures

Standardized protocols

# Technology- Are We Doing All We Can?

- 92% of Providers believe much more can be done for quality than is being done
- Effectively using technology: 16%
- Federal efforts required: 44%

*VHA Survey, Attendees at International Patient Safety Symposium, 2001*

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# Stage IV- Reward

“It is hard to get someone to understand something when his salary depends on him not understanding it.”



# WHAT HAS BEEN SAID SO FAR

- Patient Safety is a problem and is getting a lot of press anecdotally and statistically
- Patient Safety improvements have been made, but changes have not been widespread
- Best Practices in Patient Safety are known, but not implemented effectively
- Because of counter incentives (legal and cultural) issues, there is a slower implementation of safety strategies