Quality and Safety: Overview

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INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING

The Economist

JUNE 27TH–JULY 3RD 2009 Economist.com

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The mystery of Mrs Merkel

Asia's consumers to the rescue?

The Greeks and those marbles

Evolution and depression

Reforming health care

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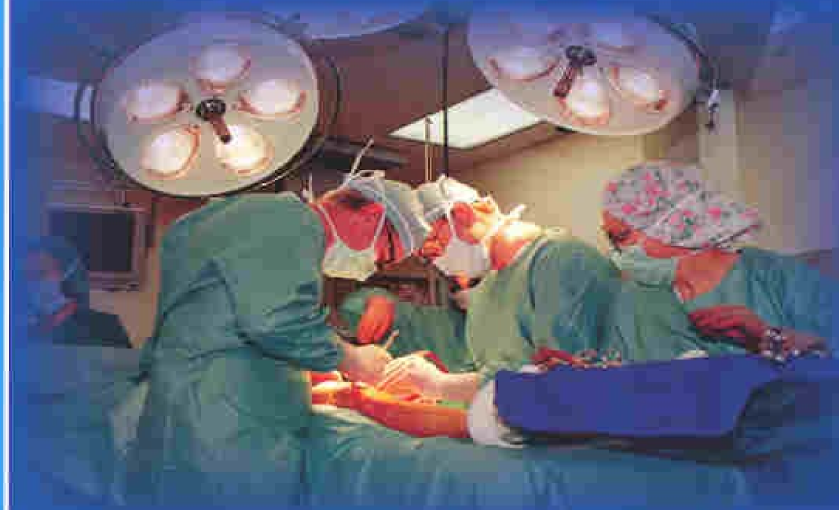
Total Hip and Knee Replacements

FISCAL YEAR 2002: JULY 1, 2001 TO JUNE 30, 2002



PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL
JUNE 2005

Center for the Evaluative Clinical Sciences

Regional Variation in Rates of Spine Surgery

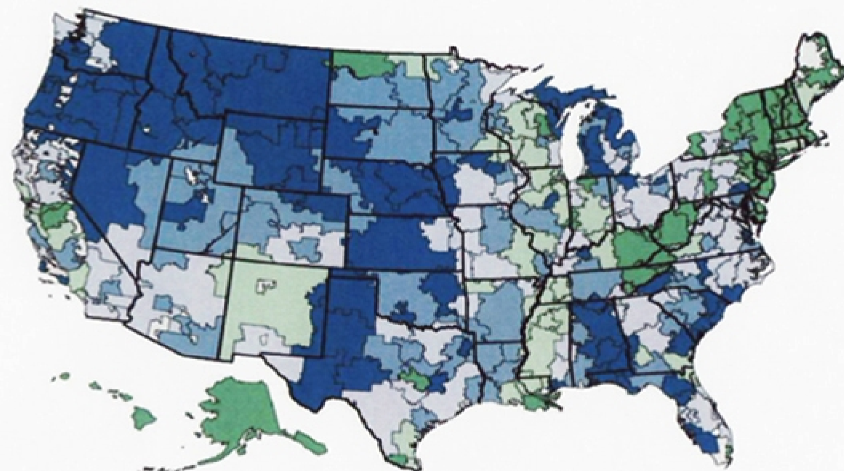
Total Spine Surgery

There was substantial regional variation in overall spine surgery rates among Medicare enrollees in 2002-03 (Figure 3). Rates varied by a factor of almost six, from 1.6 per 1,000 enrollees to 9.4. Among the hospital referral regions where rates of spine surgery were highest were Casper, Wyoming (9.4); Mason City, Iowa (9.0); Bend, Oregon (8.7); Boise, Idaho (8.2); and Billings, Montana (8.0). Regions with rates lower than the national average of 4.0 spine surgery procedures per 1,000 enrollees included Honolulu (1.6); Newark, New Jersey (1.7); Paterson, New Jersey (1.8); Manhattan (1.8); and East Long Island, New York (1.8).

Spine surgery per 1,000 Medicare enrollees (2002-03)

Each point represents the rate in one of the 306 HRRs in the United States.

Figure 3. Rates of Spine Surgery Among Hospital Referral Regions, 2002-03

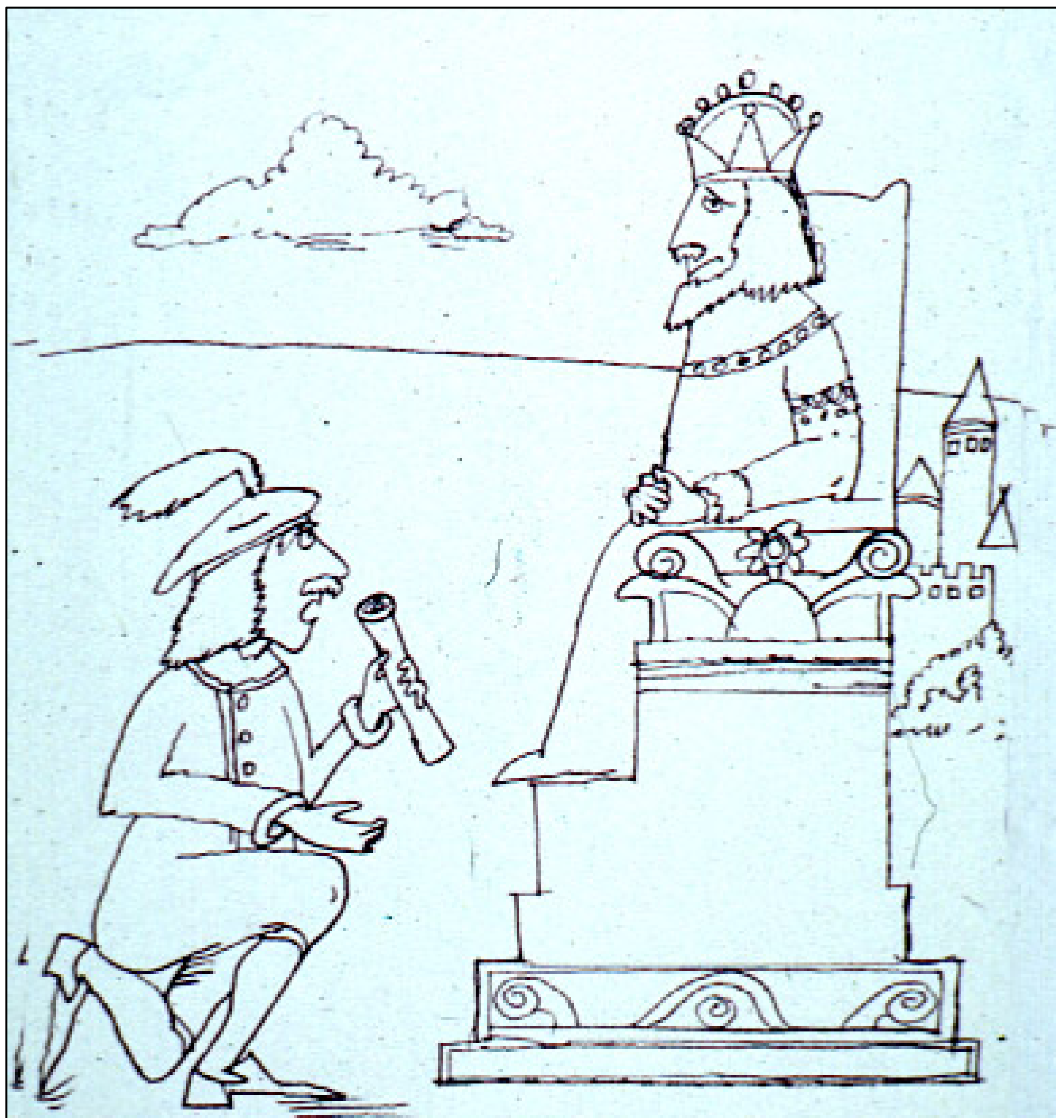


Ratio of Total Rates of Spine Surgery to the U.S. Average
by Hospital Referral Region (2002-03)

- 1.30 to 2.36 (71)
- 1.10 to < 1.30 (56)
- 0.90 to < 1.10 (80)
- 0.75 to < 0.90 (47)
- 0.40 to < 0.75 (52)
- Not Populated

Map 1. Spine Surgery

In 71 hospital referral regions, rates of spine surgery were at least 30% higher than the United States average of 4.0 per 1,000 Medicare enrollees. In 52 hospital referral regions, rates were more than 25% lower than the national average.



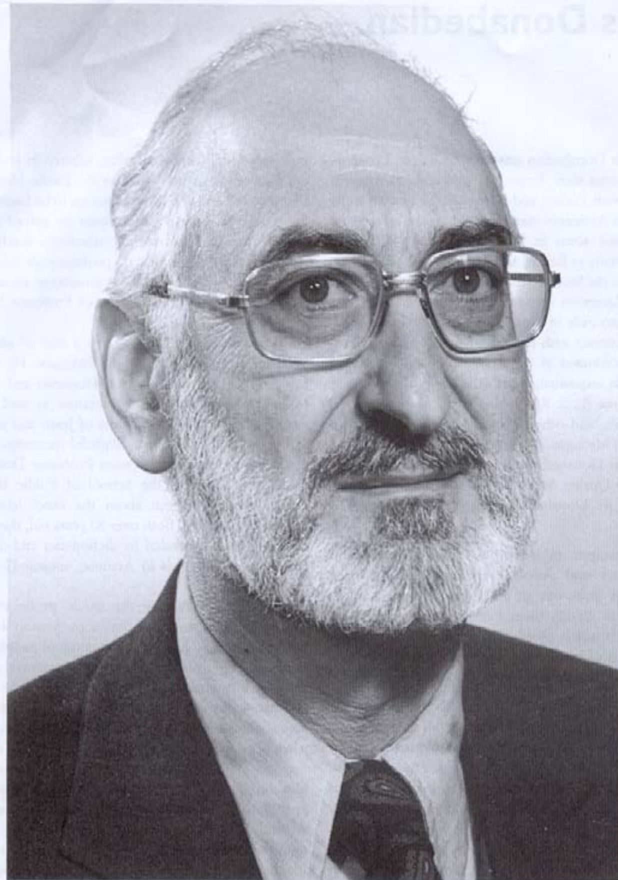
"Your Honor, please remember — my mission is to deliver the news. I had nothing to do with making it!"

... all hospitals are accountable to the public
for their degree of success...

If the initiative is not taken by the medical profession, it will be taken by the lay public.

Ernest A. Codman, M.D.
Boston, Massachusetts
1869-1940

International Journal for Quality in Health Care 2000; Volume 12, Number 6: pp. 451–454



Avedis Donabedian
7 January 1919–9 November 2000

The President, Executive Board, Members and Friends of The International Society for Quality in Health Care and the Editors of the Society's Journal, honour the distinguished life and acclaimed contributions of **Avedis Donabedian**, primary architect of the field of quality in health care and a life Member of ISQua, who died peacefully at his home in Ann Arbor, Michigan, USA on 9 November 2000.

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IMMIGRATION (P. 35) | MILLER TIME (P. 64) | P&G's BUZZ MOMS (P. 32)

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BusinessWeek

MAY 29, 2006

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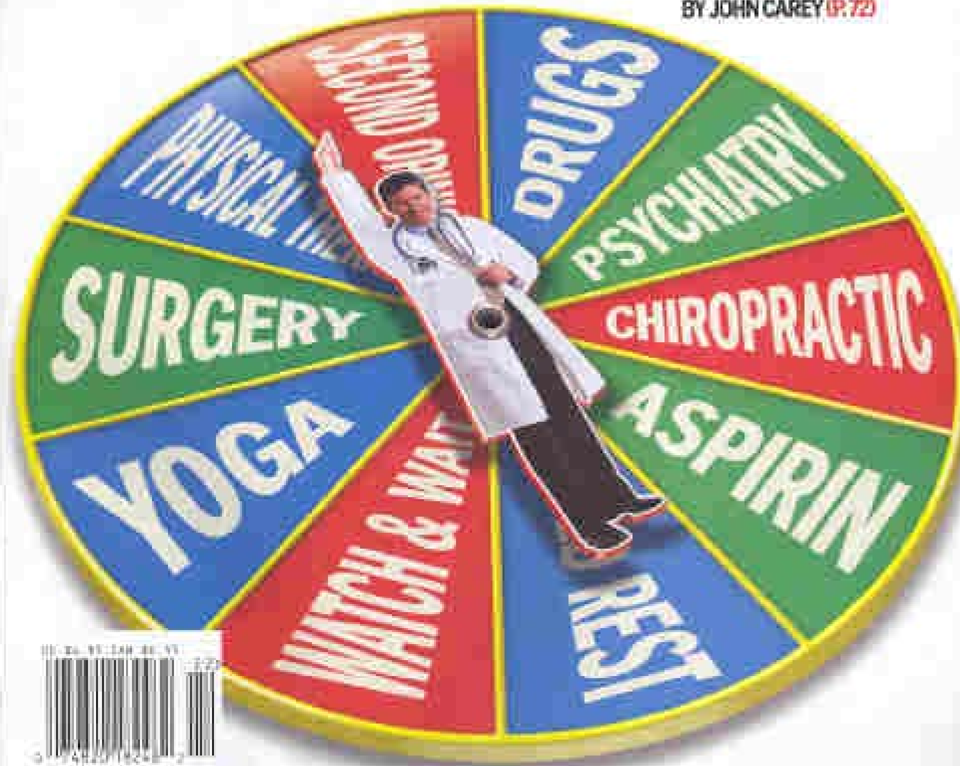
Medical Guesswork

From heart surgery to prostate care, the medical industry knows little about which treatments really work

BY JOHN CAREY (P. 72)



ARE DOCTORS JUST PLAYING HUNCHES?

We expect them to use hard data. But that's not always the best kind of medicine

By CHRISTINE GORMAN

NOBODY PRETENDS MEDICINE IS EASY, BUT IF THERE'S ONE thing we ought to be able to rely on, it's that the doctors looking out for us are doing more than playing hunches. We take certain medicines because they work, right? We go into the operating room for certain procedures because they'll make us well, don't we?

Well, maybe. More and more, however, doctors are making the unnerving case that no matter how reliable a drug or other treatment appears to be, too often there's simply little hard evidence that it would make a long-term difference in a person's quality of life or prolonged survival. Obviously, drugs are tested rigorously to show that they are safe and effective before they are approved by the U.S. and other developed countries. But a clinical study is not the real world, and just because a drug leads to a statistically significant improvement in, say, cholesterol levels doesn't guarantee that the desired effect—a healthier heart and a longer life—will follow. Often your doctor is left to make prescription decisions based at least in part on faith, bias or even an educated guess. That ought to be enough to spook even the least jumpy patient, but the fact is, recognizing just what a roll of the dice medicine can be may be a good thing.

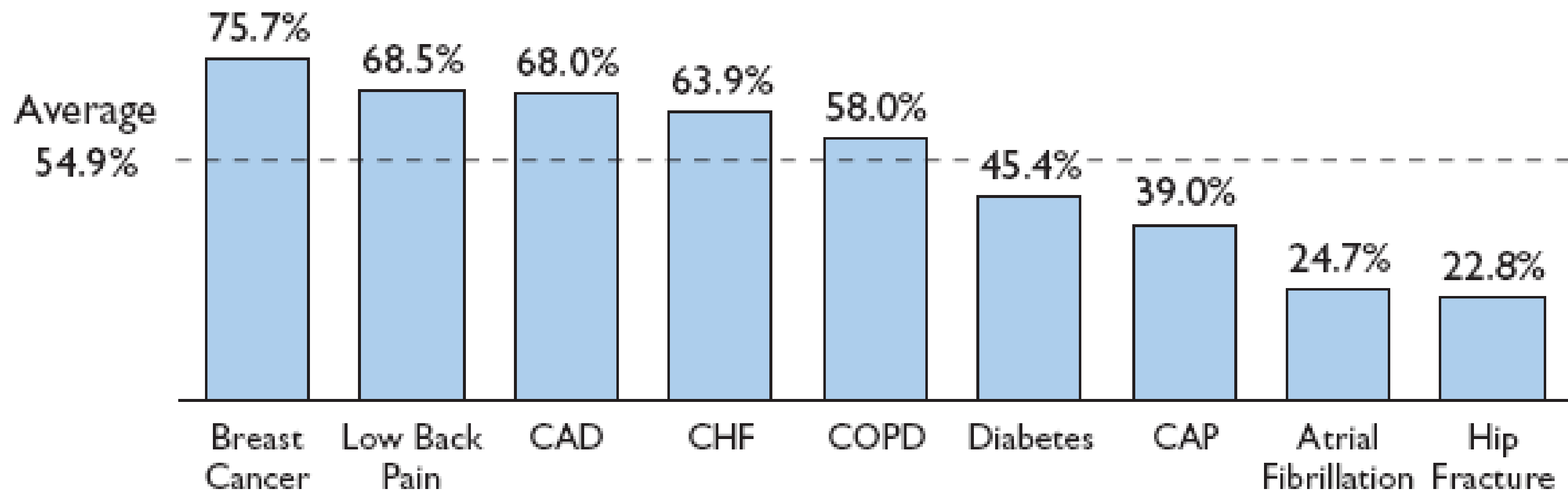
Increasingly, doctors seeking to provide their patients with the best possible care are exploring what is known as evidence-based medicine—a hard, cold, empirical look at what works, what doesn't and how to distinguish between the two. It's not enough to prove that a particular blood test or CT scan really spots cancer, for example. You also need to know whether early detection of that cancer would make a difference in your ability to respond to treatment or it merely means that you would die at the same point but learn about your illness earlier than you would have without the test.

> "Some things can't be tested; some things are so obvious, they don't need it."
>
> —DR. PAUL GLASZIOU, director, Center for Evidence-Based Medicine in Oxford, England

Evidence-based medicine, which uses volumes of studies and show-me skepticism to answer such questions, is now being

Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition[1]



Number of Indicators	9	6	37	36

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*. June 26, 2003: 2635–2645.

Overall Ranking

Country Rankings	
Green	1.00–2.33
Yellow	2.34–4.66
Red	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	$3,588	$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).

VALUE-DRIVEN HEALTH CARE

A PURCHASER GUIDE

VERSION 1.0 - FEBRUARY 2007

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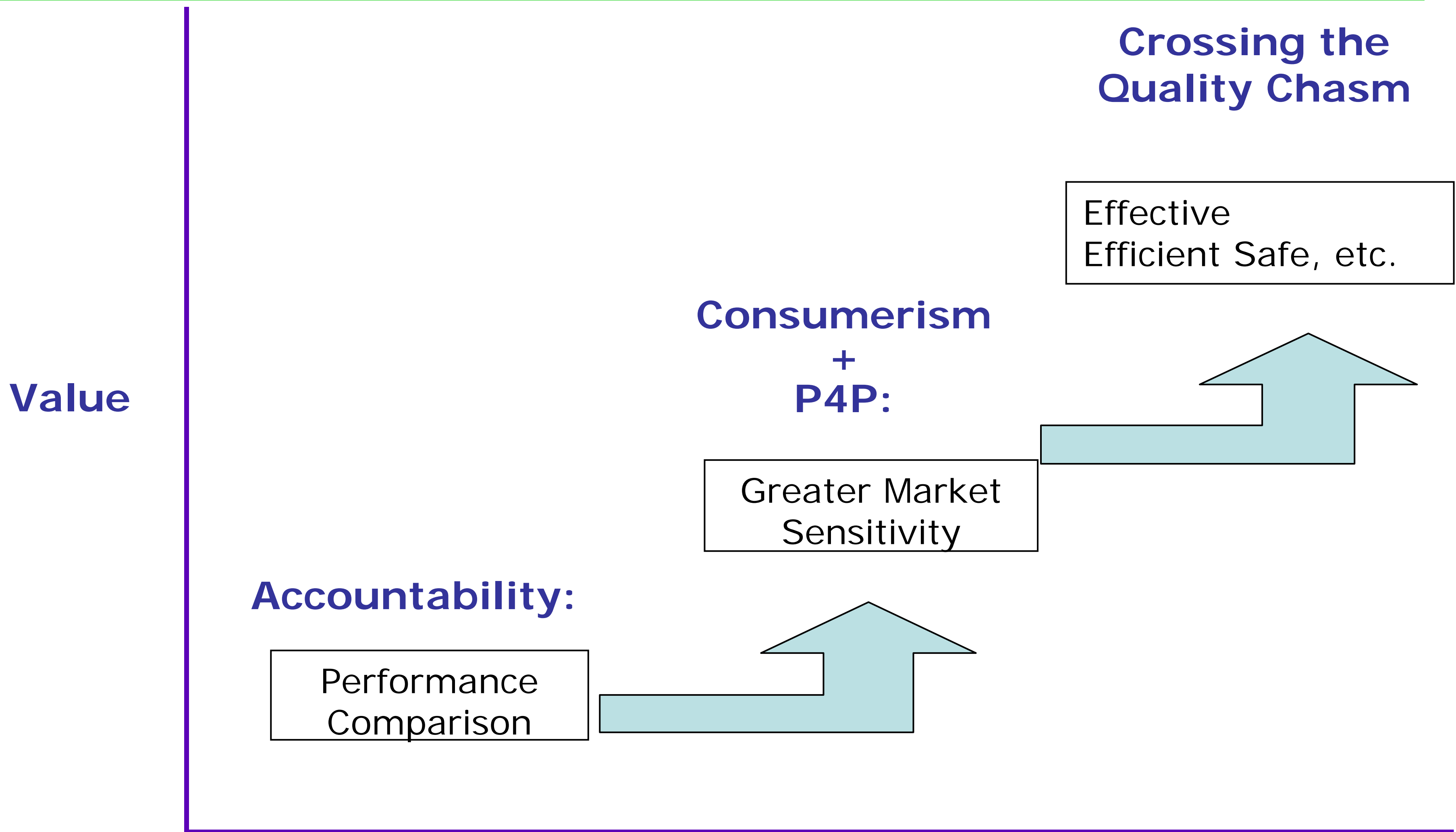
It is possible to improve care

and dramatically lower costs.

Berwick* _*Annals*_ *2/98

The Vision



Imperatives of the New Century

- Accountable for the health status of defined populations
- Global Budgets/Targets
- Incentives to actively manage clinical care
- Incentives to provide a coordinated continuum of care
- Incentives for continuous quality improvement
- The demand for value

The Seamless Continuum of Care

COMMUNITY

Patients

Prevention and Wellness	Primary Care	Acute Care	Rehabilitative Care	Chronic Care	Supportive Care
• Occupational Health • Wellness Centers • Physician Offices	• Physician Groups	• Physician Groups • Hospitals • Ambulatory Surgery Centers	• Hospitals • Nursing Homes • Home Health Agencies	• Rehab Units • Physical/ Occupational Therapy Centers • Recovery Centers • Home Health Centers	• Hospices • Home Health Agencies

Shortell Stages of Integration

- Functional
  - bring partners together
- Physician - System Integration
  - bring together doctor groups
- Clinical integration

What will clinical integration require?

- Centralization of process
- Evidence based medical practice
- Commitment to self evaluation

Cultural Barriers to Integration *(and Industrialization)*

- Autonomous decision making
- Socialization
- Uneven evidence about outcomes
- Fear of performance assessment

Definition of Quality
Institute of Medicine

" The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The Institute of Medicine (IOM)

- What the public thinks (and assumes that we give them) is important about healthcare
  - Safety
  - Best practice
  - Service

What do we measure?

What do we deliver?

SPORTS C1

RVL playoffs

Pirates Inn, Merchants win

COUNTY A3

Mansfield's open space idea

Committee eyes asking residents for tax

WEATHER

Burlington County Times

40TH YEAR

Tuesday, August 4, 1998

1 2 3 4

35 CENTS

Fast service at these ERs, or you don't pay for visit

4 more Robert Wood Johnson hospitals guarantee evaluations

By Linda A. Johnson
Associated Press

TRENTON — Two more hospitals in the Robert Wood Johnson Health Network are guaranteeing emergency room patients get service even quicker than LensCrafters' hour wait for eyeglasses.

Starting today, Bayshore Community Hospital in Holmdel and Raritan Bay Medical Center, which has facilities in Perth Amboy and Old Bridge, pledge they won't bill for any emergency room services unless patients are evaluated within 15 minutes by a nurse and 30 minutes by a physician.

"Quality care in 30 minutes ... and not just saying 'Hello,' " promised Andrew Greene, chief executive officer of the New Brunswick-based network. "I think all hospitals should do this."

Robert Wood Johnson University Hospital in New Brunswick, the flagship of the eight-hospital network, began the program in March 1996, apparently the first U.S. hospital to make such a generous pledge.

Four more network hospitals plan to offer the guarantee in the next several months. Robert Wood Johnson University Hospital at Hamilton and CentraState Healthcare System in Freehold plan to start Sept. 1, while Rahway Hospital and Warren Hospital in Phillipsburg should do so early in 1999.

Greene said the hospitals have made changes from redesigning the layout of their emergency departments to adding staff and new computer systems to enable

See ER D2

The Hazards of Hospitalization

ELIHU M. SCHIMMEL, M.D., *West Haven, Connecticut*

RECENT MEDICAL PROGRESS has brought dramatic advances in methods of diagnosis and treatment. With each new advance, however, reports of adverse reactions have soon followed. The occurrence of occasional reactions is now considered to be an accustomed and almost predictable hazard rather than evidence of improper medical care.

These hazards have been called "the price we pay" for modern diagnosis and therapy (1). This new type of clinical pathology, documented in numerous reports of drug reactions and of the untoward effects of diagnostic or therapeutic procedures, has been catalogued under the title, "Diseases of Medical Progress" (2). These reports and reviews usually cite only unusual reactions or those of major magnitude. The incidence of such "major toxic reactions and accidents" has been estimated as 5 per cent in a series of hospital patients whose minor complications were unreported (1). An assessment of all untoward reactions, regardless of severity, is important to determine their total incidence and to indicate the cumulative risk assumed by the patient exposed to the many drugs and procedures used in his care. An evaluation of these hazards was the purpose of the work reported here.

Received July 19, 1963; accepted for publication August 23, 1963.

From the Department of Internal Medicine, Yale University School of Medicine, and the Grace-New Have. Community Hospital, New Haven, Connectic.

Req· ts for reprints should be addressed to Elihu ! Schimmel, M.D., Veterans Administration Hospita West Spring Street, West Haven 16, Connecticut.

PLAN OF STUDY

This investigation was planned as a prospective study of the type and frequency of hospital complications occurring in the patients of a university medical service. The project was designed for performance during the author's tenure as chief resident on that service and was a joint effort of all the medical house officers. To allow new staff members to become accustomed to the service, the project was begun on August 1, 1960, rather than during July. It was concluded on March 31, 1961, after more than a thousand patients had been studied. The investigation included all patients admitted to the Yale University Medical Service of the Grace-New Haven Community Hospital. This service, comprising three wards with a capacity of 80 beds, cares for private patients of the full-time university staff and for service patients attended by the ward interns, residents, and staff physicians.

The participating house officers sought and reported every noxious response to medical care occurring among their patients. These untoward events, complications, and mishaps are hereafter referred to as "episodes." An episode was included in this analysis if it resulted from acceptable diagnostic or therapeutic measures deliberately instituted in the hospital. Reactions were excluded if they arose from inadvertent errors by physicians or nurses, or if they occurred as postoperative complications or as nonspecific psychiatric disturbances. The adverse effects of previous treatment, occasionally the reason for hospitalizing a patient, were also omitted from this survey.

The symptoms, signs, and laboratory abnormalities of each episode were reported together with the suspected cause. Also noted were the duration of manifestations, their need for treatment, and their effect on the patient's subsequent hospital course. An episode was considered to be *persistent* if it had prolonged the patient's hospital stay or was unresolved at the time of his discharge. An episode was classified as *minor* if it was short and subsided without specific treatment, as *moderate* if it required

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FIRST, DO NO HARM

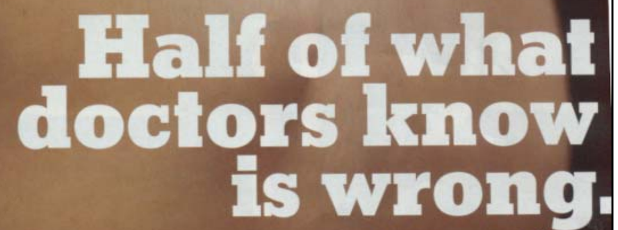
TO ERR IS HUMAN

BUILDING A SAFER HEALTH SYSTEM

INSTITUTE OF MEDICINE

The New York Times Magazine
MARCH 16, 2003 / SECTION 6

This War's Medic



Half of what doctors know is wrong.

Can prevention kill you?
Is it ever O.K. for a doctor to refuse to treat a patient?
Are nurses expendable?
Should the results of an insidious experiment be ignored?
Are men the stronger sex?
What's really responsible for the malpractice morass?
Can old-fashioned treatments still work?

"USA TODAY hopes to serve as a forum for better understanding and unity to help make the USA truly one nation."
—Allen H. Neuharth, Founder, Sept. 15, 1982

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Today's debate: Medical errors

Why do so many still die needlessly in hospitals?

Our view:

Part-voluntary, part-mandatory reporting system can reduce deaths.

When a report came out last week from a private group claiming that nearly 200,000 hospital patients die each year from preventable medical errors, it promptly sparked a fierce controversy.

The estimate was double the number found in a landmark study in 1999 by the Institute of Medicine (IOM), a federal advisory group, and the lead author of that earlier study went on the offensive. He charged that the new report used flawed research methods that inflated the fatalities.

But why argue? The difference alone makes a more telling point: Five years after the IOM report drew front-page headlines and widespread outrage, there still is not even a sure way to measure the problem. And that appalling fact should concern any prospective hospital patient — which is to say, everyone.

This year, Congress is finally doing something, though hardly enough.

Before the end of the year, it is expected to install new incentives for medical personnel to report errors. The new system, already approved by both houses, would allow doctors, nurses and other hospital workers to report mistakes anonymously. Independent analysts would then look for patterns and recommend changes. Lawyers and employers would be kept in the dark.

That's an important step.

Suppose, for instance, that a nurse gives a patient the wrong pill because its name and packaging resemble a drug next to it on the hospital's pharmacy shelf. Neither she nor the pharmacist will want to reveal the error, for fear of being punished or sued. The error likely will recur.

But if they can confidentially report the problem, experts can devise ways to improve the packaging and placement of medicines to reduce the risk of simple human error. Lives will be saved.

Six states that have set up similar procedures have seen a significant increase in reported mistakes.

That's clearly the right way to handle relatively minor mistakes, even when they result in some harm.

Even so, the picture will still be woefully incomplete — and patients will remain at risk — unless the reporting of errors that kill or cause the most serious injuries is made mandatory.

Only 22 states currently have mandatory error-reporting systems. The others rely on hospital-industry watchdogs or malpractice lawyers to be on the lookout for mistakes.

The argument over numbers is proof that leaving the solution to the courts is not a prescription for eliminating deadly errors.

Five years ago, the IOM recommended a two-tiered approach, part voluntary, part mandatory. It is still the most sensible compromise.

The question is why five years have elapsed with so little being done. With tens of thousands dying needlessly every year, the next life at risk may be your own.

Mistakes cost lives

Highlights from a new study of medical errors involving Medicare patients hospitalized from 2000 through 2002:

- Out of 37 million hospitalizations, 1.14 million "safety incidents" occurred.
- 263,864 deaths were directly attributed to the incidents.
- The safety incidents accounted for $8.54 billion in additional Medicare costs.
- Nearly 60% of safety incidents involved the failure to diagnose and treat conditions that developed in the hospital, bedsores and post-operative infections.

Source: HealthGrades' "Patient Safety in American Hospitals" study released July 27

The Forum

Medical mistakes plague Medicare patients

Today's inspector general's report: About 1 in 7 patients experienced serious harm during hospital stay

By Daniel R. Levinson

Today's hospitals are modern-day marvels of healing, and we expect them to be models of patient safety as well. But a just-released report from my office shows that medical care is falling short for too many hospitalized Medicare patients. A decade after an Institute of Medicine study placed preventable medical errors among the leading causes of death in the United States, our latest study found that a disturbing number of hospitalized patients still endure harmful consequences from medical care, 44% of them preventable. These instances, which the report calls "adverse events," include infections, surgical complications and medication errors.

Such occurrences are not always preventable, particularly since many Medicare patients are elderly and have complicated health problems. But enough patient harm is avoidable to make a strong case for action. Hospitals must improve, but they need the help of lawmakers, medical professionals and patients to do so.

2008 USA TODAY photo

Hefty price: Additional care caused by errors costs more than $4 billion each year.

Errors prolonged hospital stays

This study began in response to a congressional mandate to determine the number of harmful medical events Medicare patients experienced, and the cost to taxpayers. My office arranged for physician reviewers to examine a random sample of 780 Medicare patients discharged from hospitals around the country during the month of October 2008.

Physicians determined that about one in seven patients (13.5%) experienced at least one serious instance of harm from medical care that prolonged their hospital stay, caused permanent harm, required life-sustaining intervention, or contributed to their deaths. Projected to the entire Medicare population, this rate means an estimated 134,000 hospitalized Medicare beneficiaries experienced harm from medical care in one month, with the event contributing to death for 1.5%, or approximately 15,000 patients.

Strikingly, medication errors factored in more than half the patient fatalities in our sample, including use of the wrong drug, giving the wrong dosage, or inadequately treating known side effects. Such events were commonly caused by hospital staff diagnosing patients incorrectly or failing to closely monitor their conditions.

Less serious harm also occurred. An additional one in seven hospitalized Medicare patients experienced temporary problems, such as allergic reactions or injuries from falls. And many experienced multiple events, including an elderly heart patient who had six separate events during a single hospital stay. Obviously, this situation is unacceptable — and expensive, costing taxpayers more than $4 billion a year due to the need for additional treatment or longer hospitalizations (and even more if you add costs for follow-up care).

Hospitals clearly want to excel in patient care — and often do. Still, improvements can and must take place. Fully addressing the far-reaching implications of our study requires both an official response and a personal one.

The report made recommendations for improvement to agencies within the Department of Health and Human Services that monitor medical care. Those agencies are committed to increasing medical effectiveness and have embraced the recommendations. Among them are the following:

- ▸ Too many patient safety efforts concentrate on a narrow list of egregious medical problems that thankfully occur rarely, such as surgery performed on the wrong body part. This focus overlooks the need to also concentrate on far more common harmful incidents, such as blood clots and poor diabetes control.
- ▸ Government, which pays for a large portion of the nation's medical care, must hold hospitals accountable for better care. New authorities granted by Congress further enable the Medicare program to use hospital performance as a basis for payment. Private insurers can join Medicare in finding effective ways to tie payment to quality.

Government commitment is important, yet hospitals bear much of the responsibility. Although hospitals have broadly embraced safety initiatives, the still-high rate of adverse events indicates that far more needs to be done. Hospitals must work faster to adopt evidence-based practices that reduce medical errors. Hospitals can also learn together by volunteering to join patient safety organizations, which collect confidential information about instances of harm that occur from medical care to assess what went wrong and improve patient safety. Further, hospitals can continue to improve patient care systems, including effective use of electronic health records, to help staff avoid mistakes and to alert them to problems.

What you can do

Vigilance saves lives. Family members with hospitalized loved ones should educate themselves regarding medical treatment and expected outcomes and speak up when things go awry. Hospital staff should treat patients and their families as partners, welcoming family monitoring of patients as an additional safeguard against poor medical outcomes.

Sooner or later, most of us will need the help of hospitals. They have earned their current, central place in saving lives and curing disease. We owe it to these critical institutions to help them increase quality of care for the continued health of us all.

Daniel R. Levinson is the inspector general of the Department of Health and Human Services.

Section I. Surgical or invasive procedure is scheduled (with right or left specified when laterality is involved), and Pre-Admission Testing sheet is consistent with documentation on current medical record and patient's verbal verification.

Site verified as (circle one): Right Left Bilateral No Laterality

PAT RN Signature

Section II. Surgical or invasive procedure is verified and site has been marked by the physician and is consistent with the patient's current medical record, which must include the H&P and consent.

Site verified as (circle one): Right Left Bilateral No Laterality

Site verified and marked by Surgeon

Staff Nurse Signature

Patient Identification and Site Verification Immediately Prior to the Procedure

(Procedure Physician Signature below indicates that the surgeon identified the patient immediately prior to surgery with the patient on the OR/Procedure table.)

	Provider(s) Present	Procedure	Side
Circulating/ Assisting Nurse/Personnel		Right heel ulcer debridement with Oasis graft & wound VAC	Left Right Bilateral N/A
Procedure Physician			
Anesthesia Provider			

(Circulating/Assisting Nurse to list name of anesthesia provider, if present. If no anesthesia provider is involved in the procedure, document N/A for Not Applicable. Anesthesia Provider signature, procedure and site will be documented by the Anesthesia Provider on the Anesthesia Record.)

The surgical/procedure team (Surgeon/Procedure Physician, Anesthesiologist, and Circulating/Assisting Nurse/personnel) as listed above has paused to verify the correct patient, procedure and site, and availability of correct implants/special equipment as indicated, by active communication immediately prior to the procedure with the patient on the procedure table. If x-ray films are present, the procedure physician has verified the proper orientation of the films.

Signature – Circulating/Assisting Nurse/Personnel	Date	Time
	2/23/09	1526

The Joint Commission
Journal on Quality and Patient Safety

Improvement from Front Office to Front Line

August 2007
Volume 33 Number 8

How Medical Errors Affect Physicians

Features

Reporting Systems

- The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

5 Million Lives Campaign

- Miles to Go: An Introduction to the 5 Million Lives Campaign

Teamwork and Communication

- The Continuing Problem of Missed Test Results in an Integrated Health System with an Advanced Electronic Medical Record

Health Professions Education

- Housestaff and Medical Student Attitudes Toward Medical Errors and Adverse Events

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Rapid Response Systems: The Stories

- Improving Rapid Response Systems: Progress, Issues, and Future Directions

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Only 77% wash hands after using the toilet

Advocates are pushing for more frequent scrubbings in health care and non-health care settings.

VICTORIA STAGG ELLIOTT
AMNEWS STAFF

How clean are your hands? How about the person who just shook yours?

Several presentations at last month's Interscience Conference on Antimicrobial Agents and Chemotherapy in Chicago suggested that people not only wash their hands less often than they say they do, but the number who really do appears to be decreasing. Also, improving hand hygiene in the health care setting saves money.

"Hands are great distributors of disease, but hand washing is a great intervention," said Judy Daly, PhD, spokeswoman for the American Society for Microbiology, which organizes this meeting. She is also director of the microbiology laboratory at Primary Children's Medical Center in Salt Lake City.

According to data from observational and telephone surveys by Harris Interactive, which were commissioned by the society as well as the Soap and Detergent Assn. and released at the meeting, 92% of adults say they always wash their hands after using a public restroom. When observed in places such as train stations and sports stadiums, only 77% actually do. This represented a decline from the 83% observed in the 2005 version of this survey.

Significant gender differences also were seen, with only 66% of men soaping up compared with 88% of women. Similar gaps between men and women also were found by other studies that examined the behavior of doctors and health care professionals.

"Very clearly, guys need to step up to the sink," said Brian Sansoni, vice president of communication for the soap association.

This issue has long concerned medical societies, patient safety organizations and public health agencies. The American Medical Association urges everyone to view hand washing as important. Experts suggest, however, that while this activity is important across the board, more payoff may be gained from programs that focus on health care settings.

"The message about improving hand hygiene is a good message to support, but we will naturally see the greatest result in the places where the sickest people are," said Dr. M. Lindsay Grayson, vice chair of Austin Hospital/Austin Health in Melbourne, Australia.

In these venues, the benefit of hand hygiene is increasingly being quantified. For instance, a paper presented by Dr. Grayson found that hand hygiene education for health care professionals along with ensuring that alcohol hand rubs were available significantly reduced the number of methicillin-resistant *Staphylococcus aureus* infections. In turn, this result saved his state's health system more than a million dollars.

"We need a culture change," Dr. Grayson said. "Those who provide care should feel funny walking up to a patient having not used an alcohol-based hand rub. And the patient should feel pretty funny, too."

An Argentinean study also found that upping compliance with hand hygiene recommendations in the intensive care unit reduced the device-associated infection rate from nearly 20% to just shy of 5%. But although researchers say these efforts can pay for themselves, improving hand hygiene comes with significant challenges. In Dr. Grayson's study, the urban institutions did not do as well as the rural ones because of high staff turnover.

The factors that motivate health care professionals to wash more often also might not be the most obvious ones. A study out of the University of Geneva Hospitals in Switzerland found that the opportunity to reduce nosocomial infections did not increase hand washing, but peer pressure and easy access to hand-washing facilities did. ◆

PHOTO BY TED GRUDZINSKI
Judy Daly, PhD, presented the hygiene findings at the Chicago conference.

MAY 1, 2006
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WHAT DOCTORS HATE ABOUT HOSPITALS
An insider's view of what can go wrong—and how you can improve your odds of getting the right treatment
BY NANCY GIBBS & AMANDA BOWER
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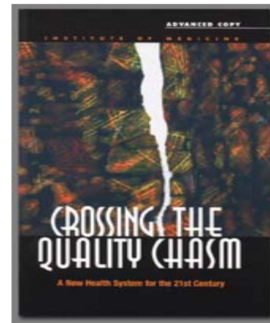
INSTITUTE OF MEDICINE

A New Health System for the 21st Century

Institute of Medicine Report 2001



Outlines Key Dimensions of the Healthcare Delivery System:

Safe: avoiding injuries to patients from the care that is intended to help them.

Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

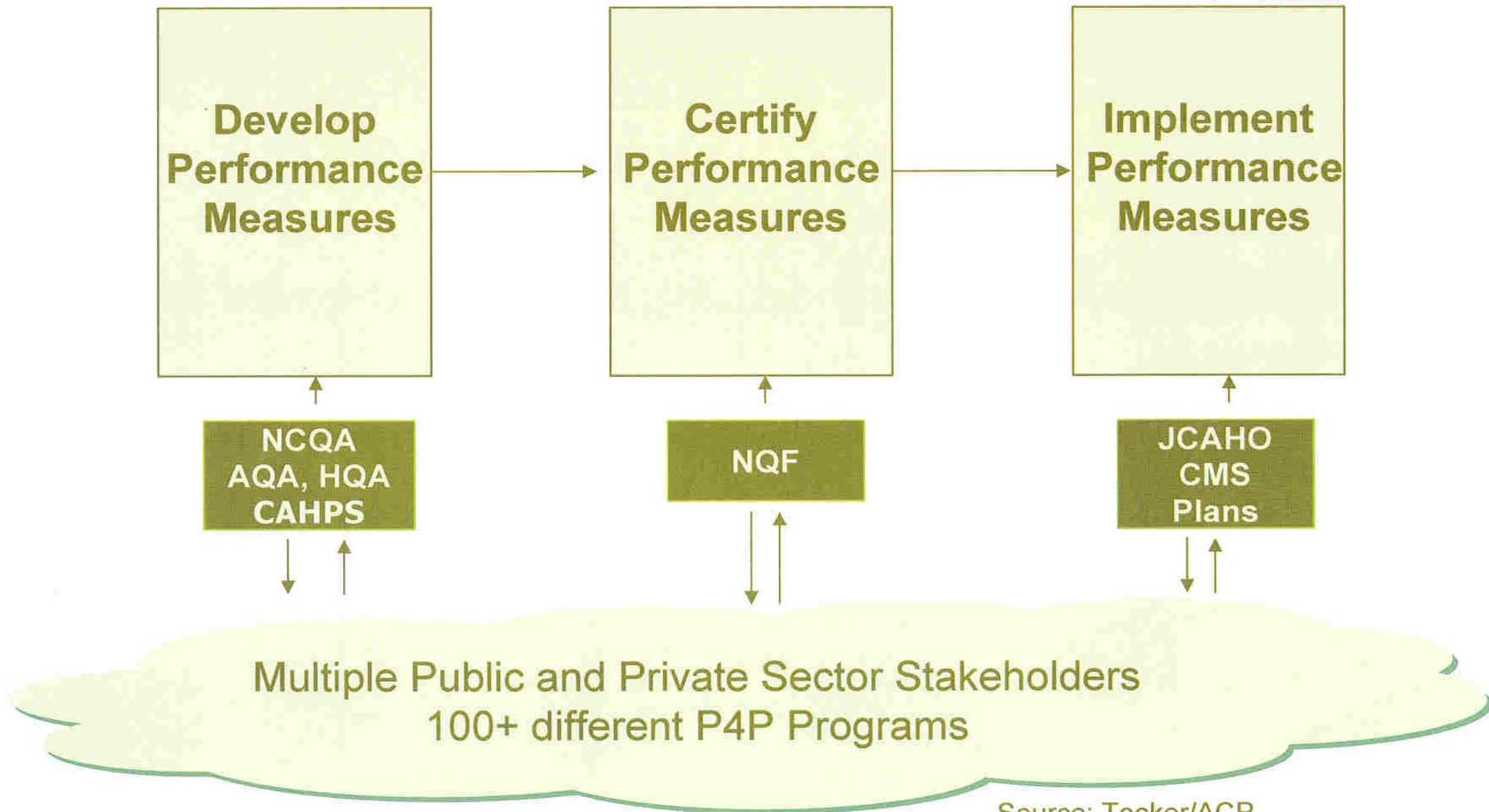
Timely: reducing waits and sometimes harmful delays for both those who receive and those who give care.

Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.

Source: Institute of Medicine 2001; 5-6

A need for unified governance



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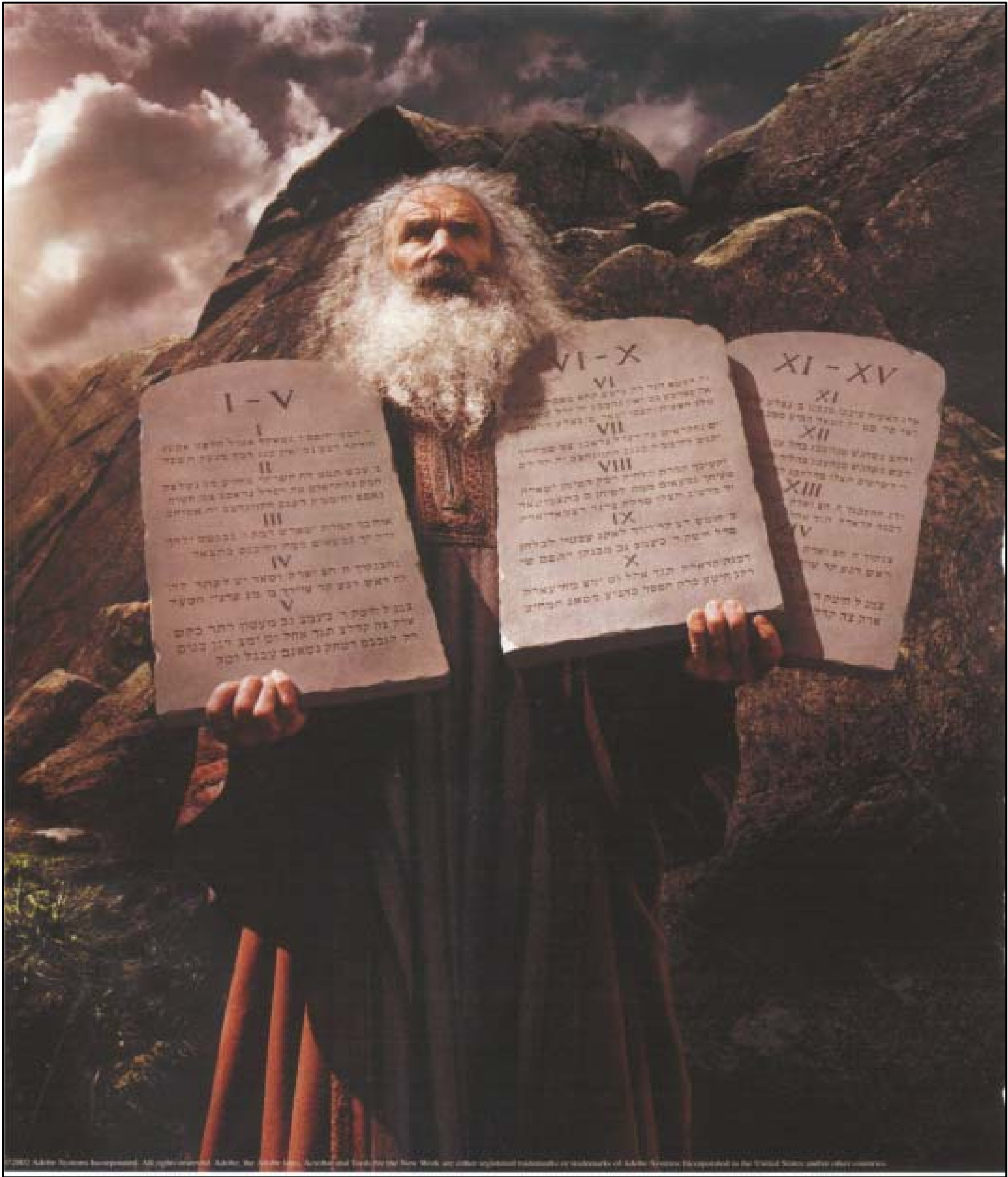
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XIII

Ten Commandments
Crossing the Quality Chasm

Current Rules

1. Care is based primarily on visits
2. Professional autonomy drives variability
3. Professionals control care
4. Information is a record
5. Decision making is based on training and experience

New Rules

1. Care is based on continuous healing relationships
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge is shared freely
5. Decision making is evidence-based

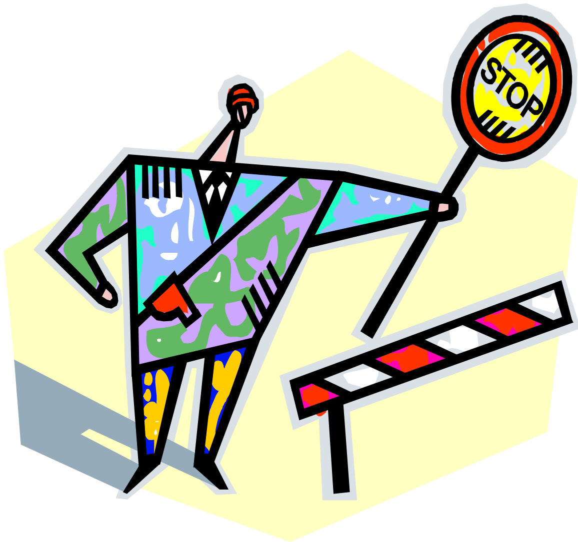
Don Berwick 2002

Ten Commandments (*cont.d*)

Current Rules	New Rules
6. "Do no harm" is an individual responsibility	6. Safety is a system property
7. Secrecy is necessary	7. Transparency is necessary
8. The system reacts to needs	8. Needs are anticipated
9. Cost reduction is sought	9. Waste is continuously decreased
10. Preference is given to professional roles over the system	10. Cooperation among clinicians is a priority

Don Berwick 2002

“Unexplained Clinical Variation”

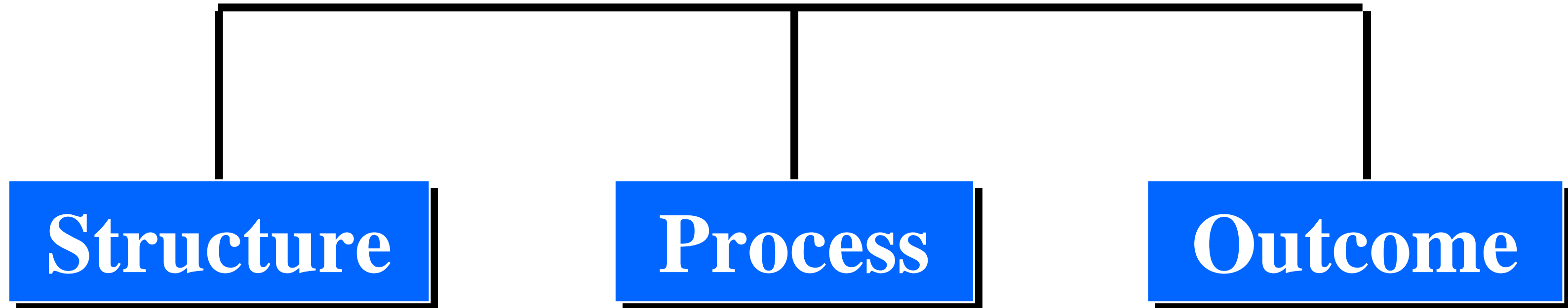


- Major roadblock to:
  - Lowering costs
  - Improving quality
  - Establishing accountability

The Assumption of Financial Risk

- Creates need for accountability.
- Makes me care what my partners order!
- Most importantly, it obviates need for external control.
  - *Yes, but now we have to do it ourselves!*

Old Quality Tripod



Sculpting the Three Faces of Quality

- CQI, TQM
- Re-engineering
- Process Improvement

- Outcomes Management
- Disease Management
- Profiling

- Clinical Guidelines
- Case Management
- Standardization
- Evidence Based Medicine

What is Outcomes Management?

- Three tiered definition

Tier One
Outcomes (Traditional)

- Morbidity
- Mortality
- Return to the O.R.
- Nosocomial Infections

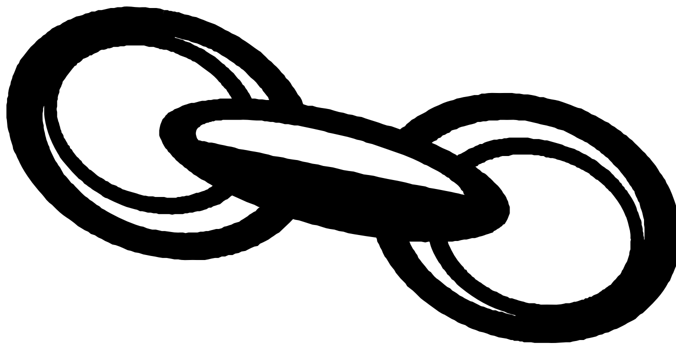
Tier Two
Outcomes (Modern)

- Patient satisfaction
- Functional status
- Return to work

Tier Three
Outcomes (Ellwood)

- Linking tiers one and two to payment

Tier 1



Tier 2

=

Tier 3

Autonomy and Accountability

A Zero Sum
Game?

Nash's Immutable Rule

High Quality Care
Costs Less!

A Real Integrated System

- Performs no scientifically groundless treatments
- Formally searches for effective, proven care practices
- Is the safest health care organization
- Involves patients and families fully in their own care
- Is an open health care organization

ACT