Patient Safety Workforce Training

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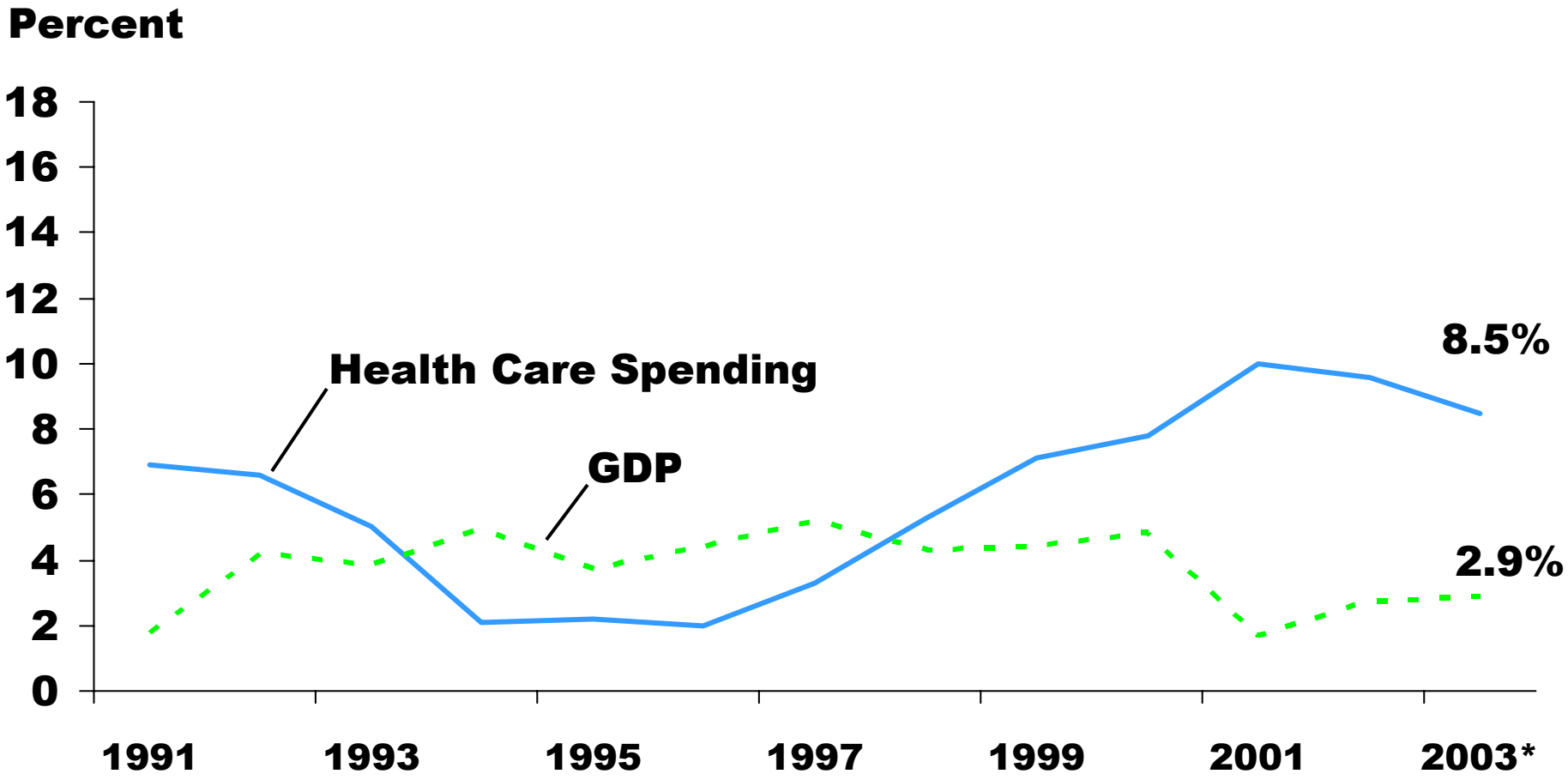
Overview

- **Perceptions on Patient Safety**
- **Workforce Training**

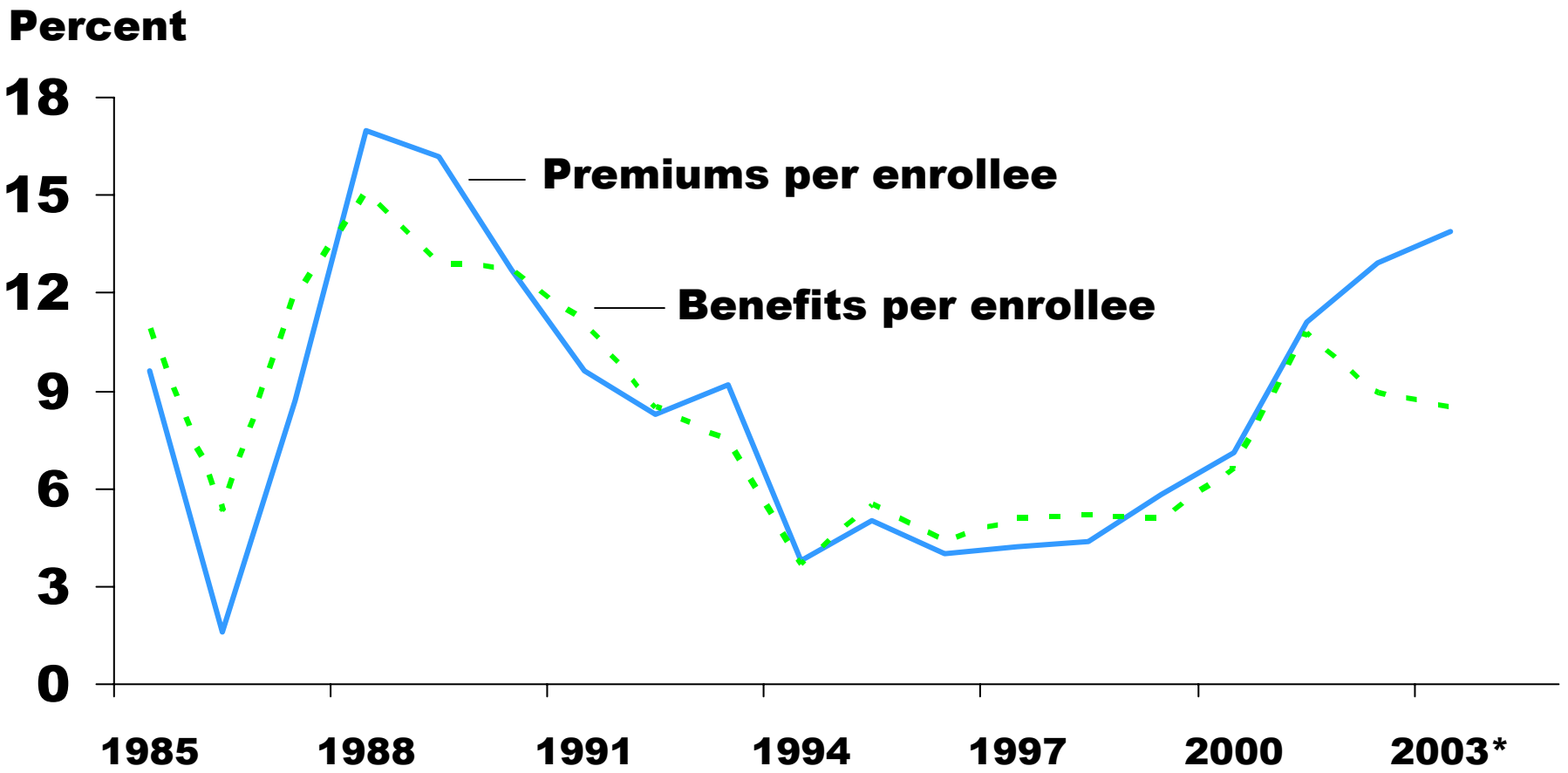
Change Per Capita In Health Care Spending and GDP



* Data for January through June 2003, compared with corresponding months in 2002

Source: B. Strunk and P. Ginsburg, "Tracking Health Care Costs: Trends Stabilize But Remain High in 2002," *Health Affairs* (Web Exclusive June 11, 2003); B. Strunk and P. Ginsburg, *Tracking Health Care Costs: Trends Slow in First Half of 2003*, Center for Studying Health System Change, December 2003.

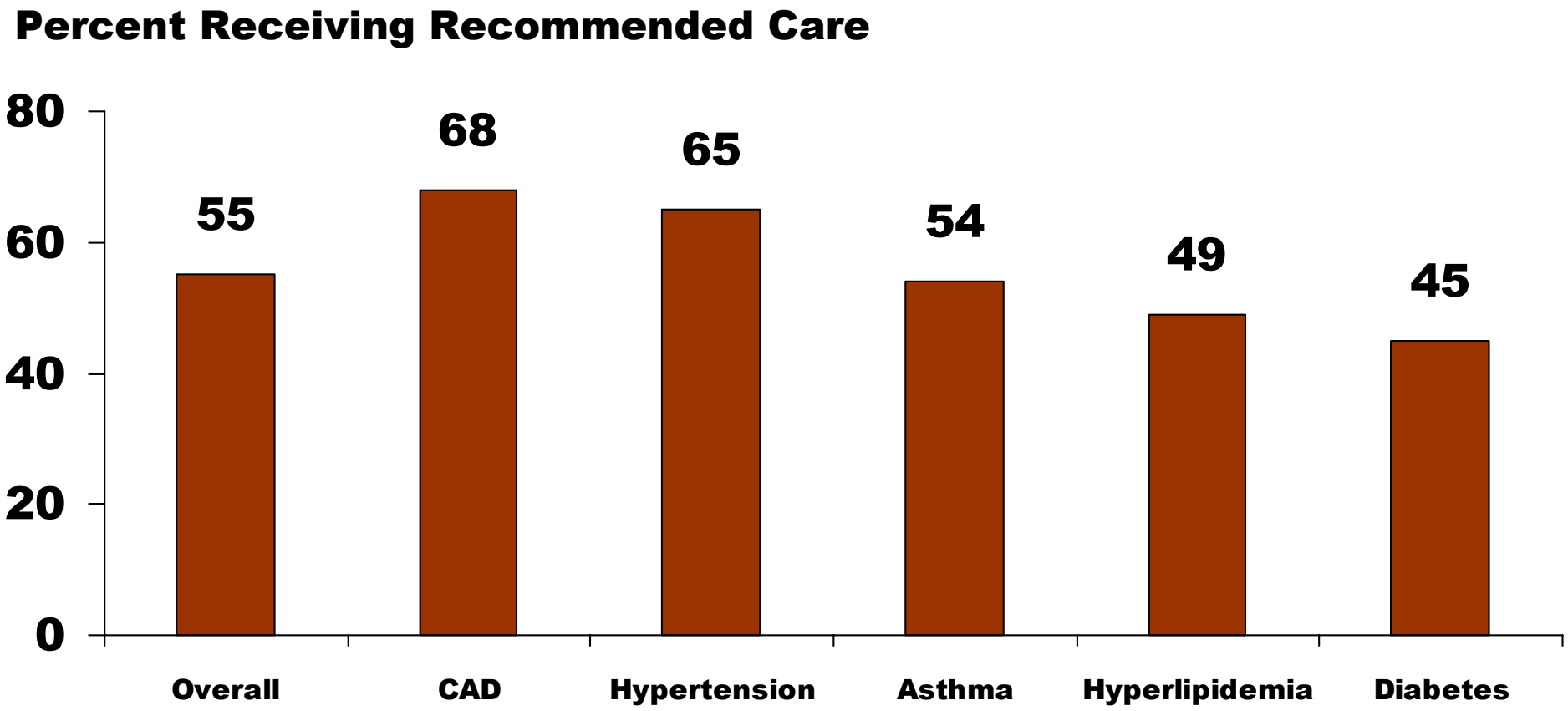
Growth in Per Enrollee Premiums and Benefits



** Data for growth between Spring 2002 and Spring 2003*

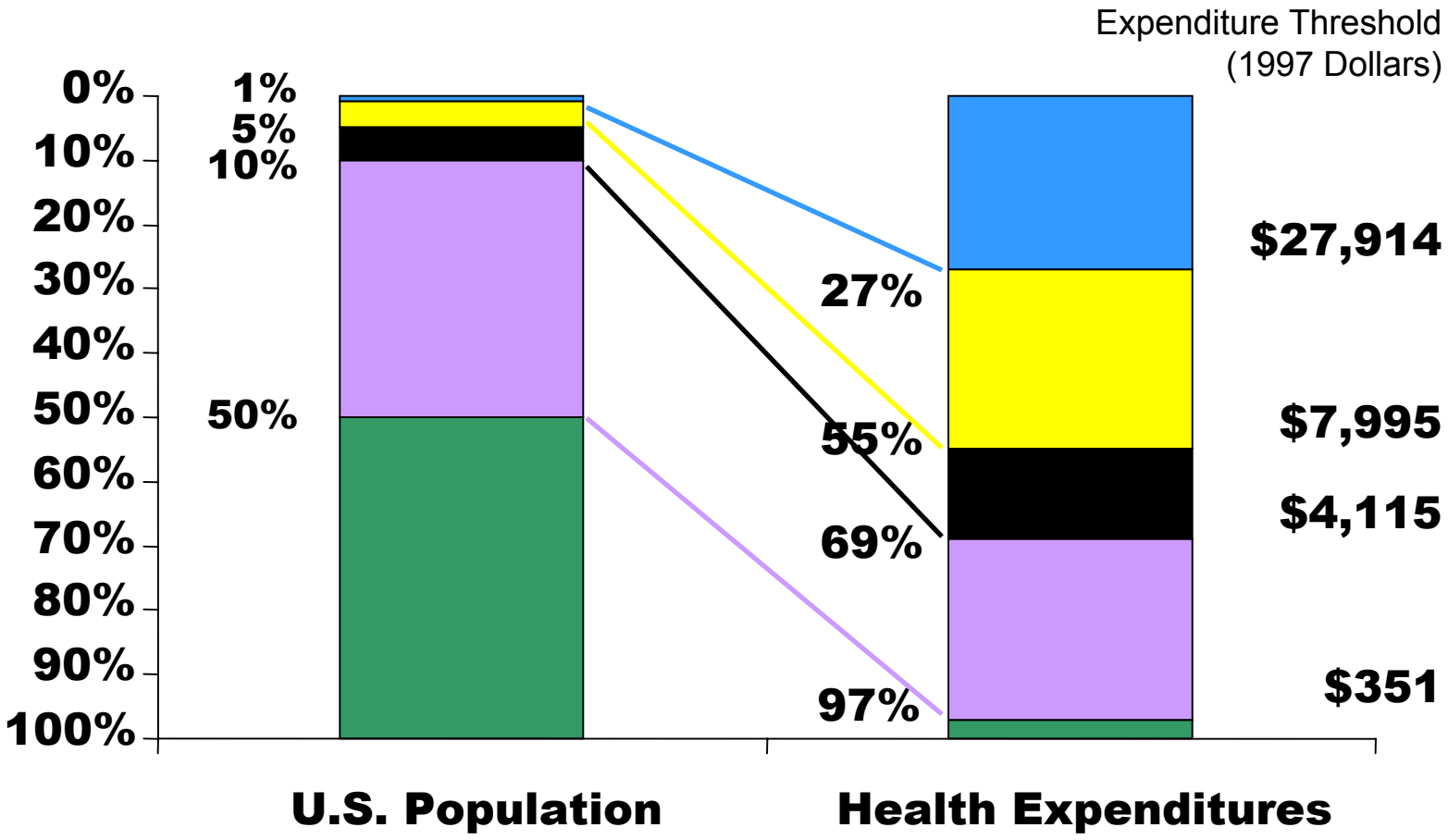
Source: Heffler et al., "Health Spending Projections for 2002-2012," Health Affairs (Web Exclusive February 7, 2003) for 1985–2001; Employer Health Benefits 2003 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust, September 2003 for 2002–2003.

Recommended Care and Quality Varies



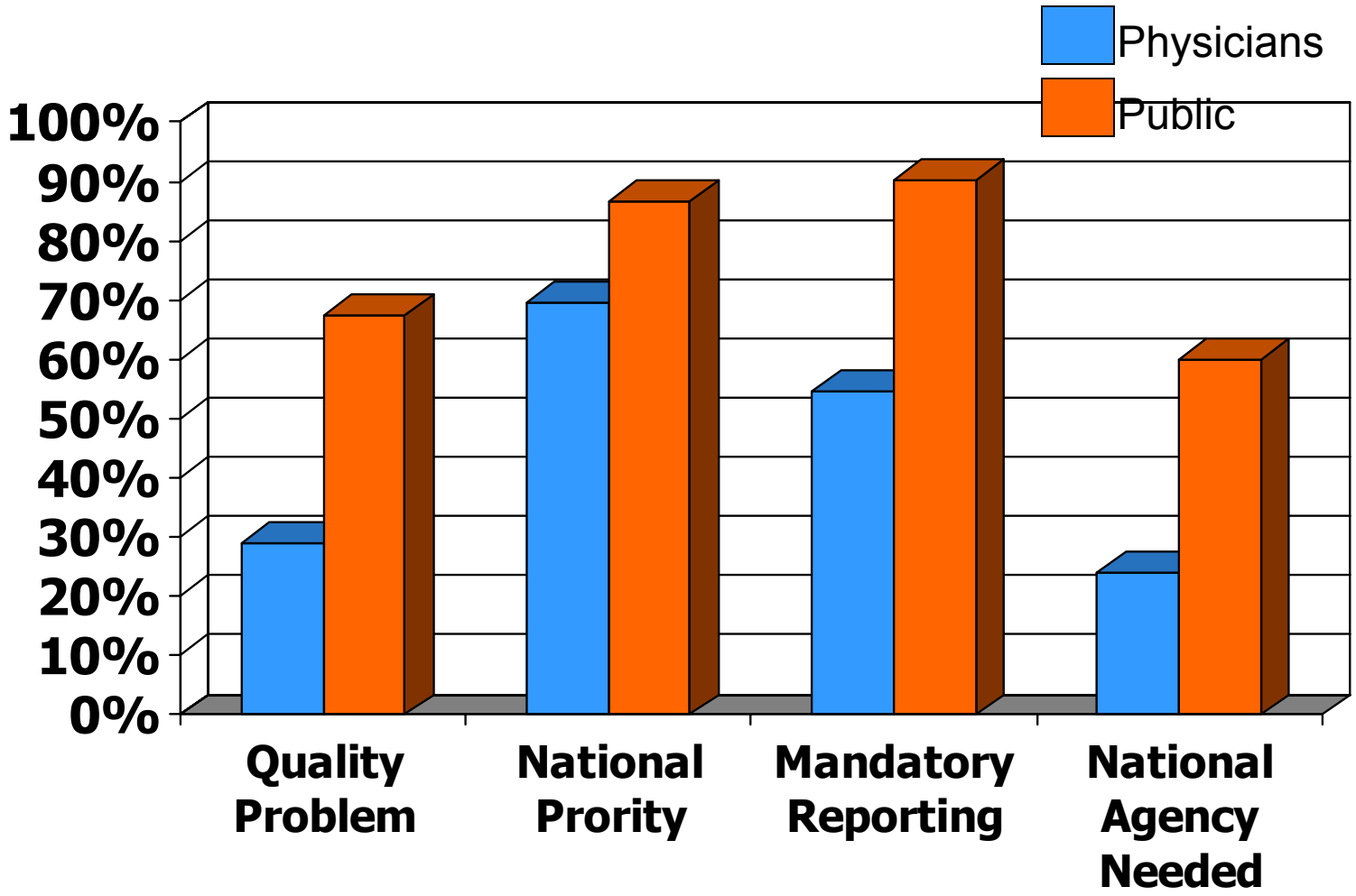
Source: McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," The New England Journal of Medicine (June 26, 2003): 2635–2645.

Health Care Costs Concentrated in Sick Few



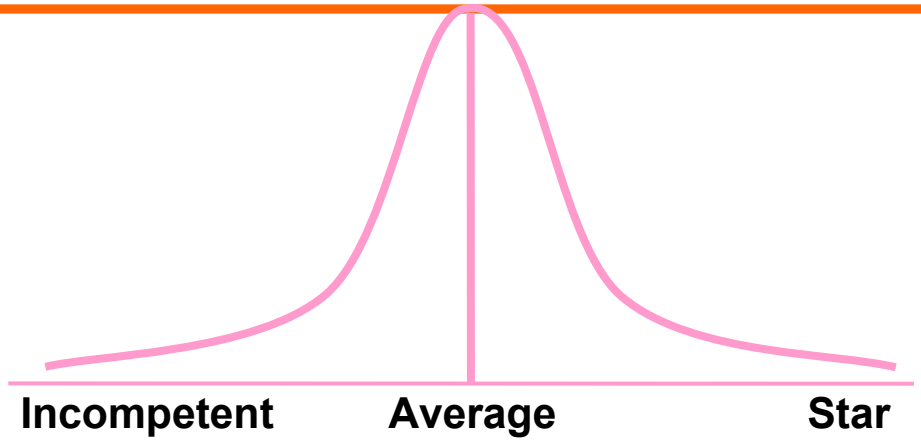
Source: AC Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," Medical Care 41, supplement 7 (2003): III53–III64.

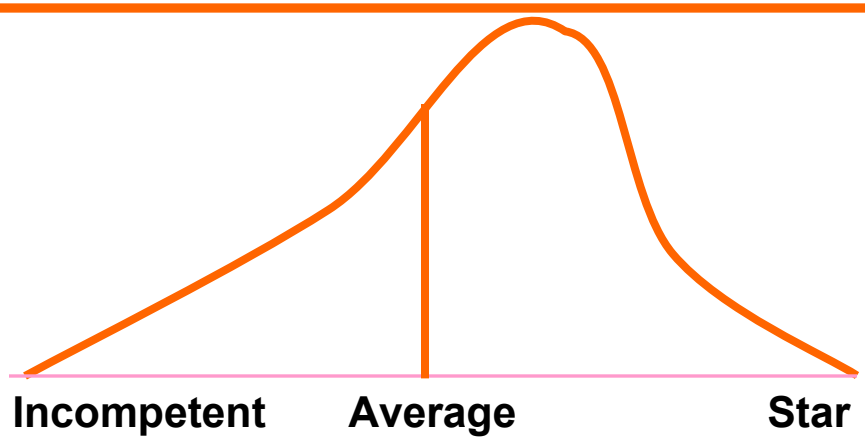
Physician/Public Opinions on Safety



Source: Robinson AR, et. al. Physician and public opinions on quality of health care and the problem of medical errors. Arch Intern Med 2002;162:2186-90.

Public Perceptions on Errors





- Carelessness
- Incompetence
- Substandard providers
  - Physicians
  - Nurses
  - Laboratory technicians

Eye-Opening Results

	Physicians	Public
Medical error self or family	35%	42%
Serious Error	7%	10%
Death	7%	10%
Long term disability	6%	11%
Severe pain	11%	16%

Source: Blendon RJ, et. al. Views of Practicing Physicians and the Public on Medical Errors. NEJM 2002;347:1933-40.

Differences in Problem List

- **Physicians**
  - Malpractice (29%)
  - Cost of health care (27%)
  - Insurance comp. (22%)
  - Medical errors (5%)
- **Public**
  - Cost of care (35%)
  - Drug costs (31%)
  - Medical errors (6%)

68% of public did not know what a medical error is

After defined, 50% of public attributed errors to people (20% for physicians)

Source: Blendon RJ, et. al. Views of Practicing Physicians and the Public on Medical Errors. NEJM 2002;347:1933-40.

Causes of Errors

- **Physicians**
  - Nurse shortage (53%)
  - Overwork, stress (50%)
- **Public**
  - Physician/Pt. time (72%)
  - Overwork, stress (70%)
  - No teamwork (67%)
  - Nurse shortage (65%)

Deaths due to errors (53% physicians/60% public)

5,000

Source: Blendon RJ, et. al. Views of Practicing Physicians and the Public on Medical Errors. NEJM 2002;347:1933-40.

Solutions

- **Physicians**
  - **Develop systems (55%)**
  - **Increase nurses (51%)**
- **Public**
  - **Increase physician time (78%)**
  - **Develop systems (74%)**
  - **Better training (73%)**
  - **Intensivists (73%)**

Source: Blendon RJ, et. al. Views of Practicing Physicians and the Public on Medical Errors. NEJM 2002;347:1933-40.

More Dissonance

	Physicians	Public
Suspend medical licenses	3%	50%
Require error reporting	23%	71%
Keep reports confidential	86%	
Publish reports		62%

Source: Blendon RJ, et. al. Views of Practicing Physicians and the Public on Medical Errors. NEJM 2002;347:1933-40.

Overview

- Perceptions on Patient Safety
- Workforce Training

Workforce Training Program

- Introduction to Patient Safety I
- Introduction to Patient Safety II
- Role of Clinical Staff in Patient Safety
- Role of Non-Clinical Staff in Patient Safety
- Patient Safety in the Ambulatory Care Environment
- Medication Safety
- JCAHO and Patient Safety
- Patient Responsibility and Patient Safety

Introduction to Patient Safety I, II

- Origins of the safety movement
- Terminology
- Causes of errors
- Leadership
- Safety organizations
- Management practices for safety
- Epidemiology

Role of Clinical Staff in Patient Safety

- Error reporting
- Surveillance
- Clinical IT systems
- Teamwork
- Communication
- Roles

Role of Non-Clinical Staff in Patient Safety

- Error reporting
- Surveillance
- Teamwork
- Communication
- Roles
- Customer service

Patient Safety in the Ambulatory Care Environment

- Error reporting
- Surveillance
- Teamwork
- Communication
- Roles
- Customer service

Medication Safety

- Medication managment
- Five rights
- Bar-coding
- Clinical IT systems
  - Pharmacy
  - CPOE
- Clinical decision support
- POC administration
- ISMP

JCAHO and Patient Safety

- Regulations
  - National Patient Safety Goals and Requirements
- Risk management
- Sentinel Event Advisory Group
  - Database

Patient Responsibility and Patient Safety

- Culture of patient safety
- Communication
- Event reporting
- Web-based information sources
- Risk management

Board Certification

- ABQAURP (www.abqaurp.org)
- Healthcare professionals
  - Credentialed
- Continuing education
- Work experience
- NBME exam
  - Computerized
  - Updated regularly

Reality of Systems

"every system is perfectly designed to achieve exactly the results it gets"

- Don Berwick, MD
Institute of Healthcare Improvement