

How Patient Safety and Quality Improvement can be Integrated into Health Reform

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The National Congress on Health Reform

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02138

Perhaps the most opinionated zip code in
America

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The New York Times

UNIVERSAL HEALTH CARE



COST CONTROL

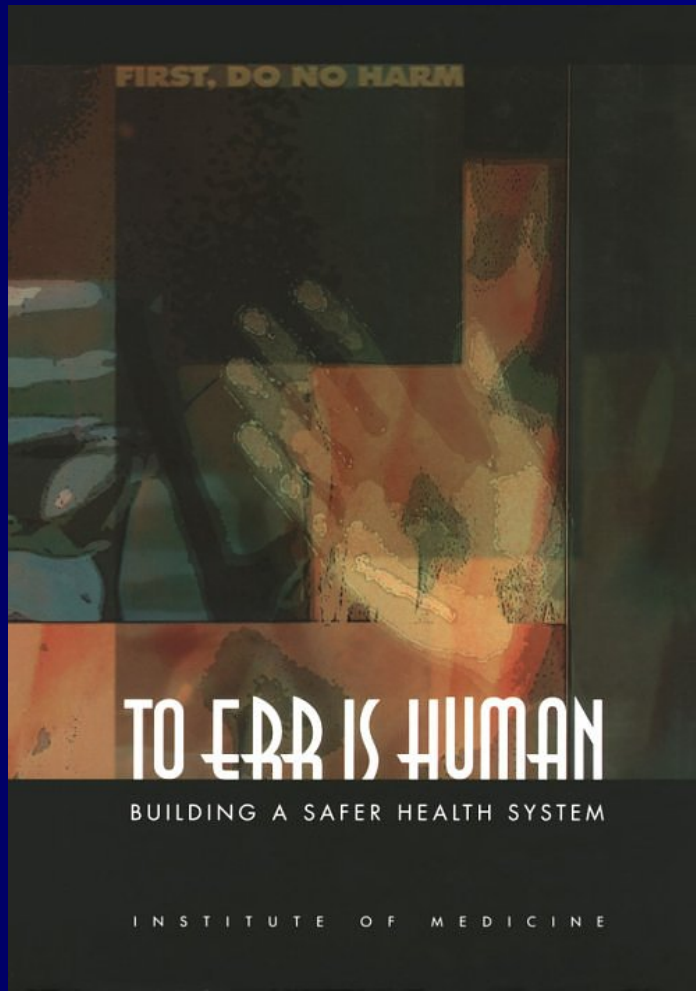


QUALITY CONTROL



CHANGE WHAT WE PAY FOR

TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM



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

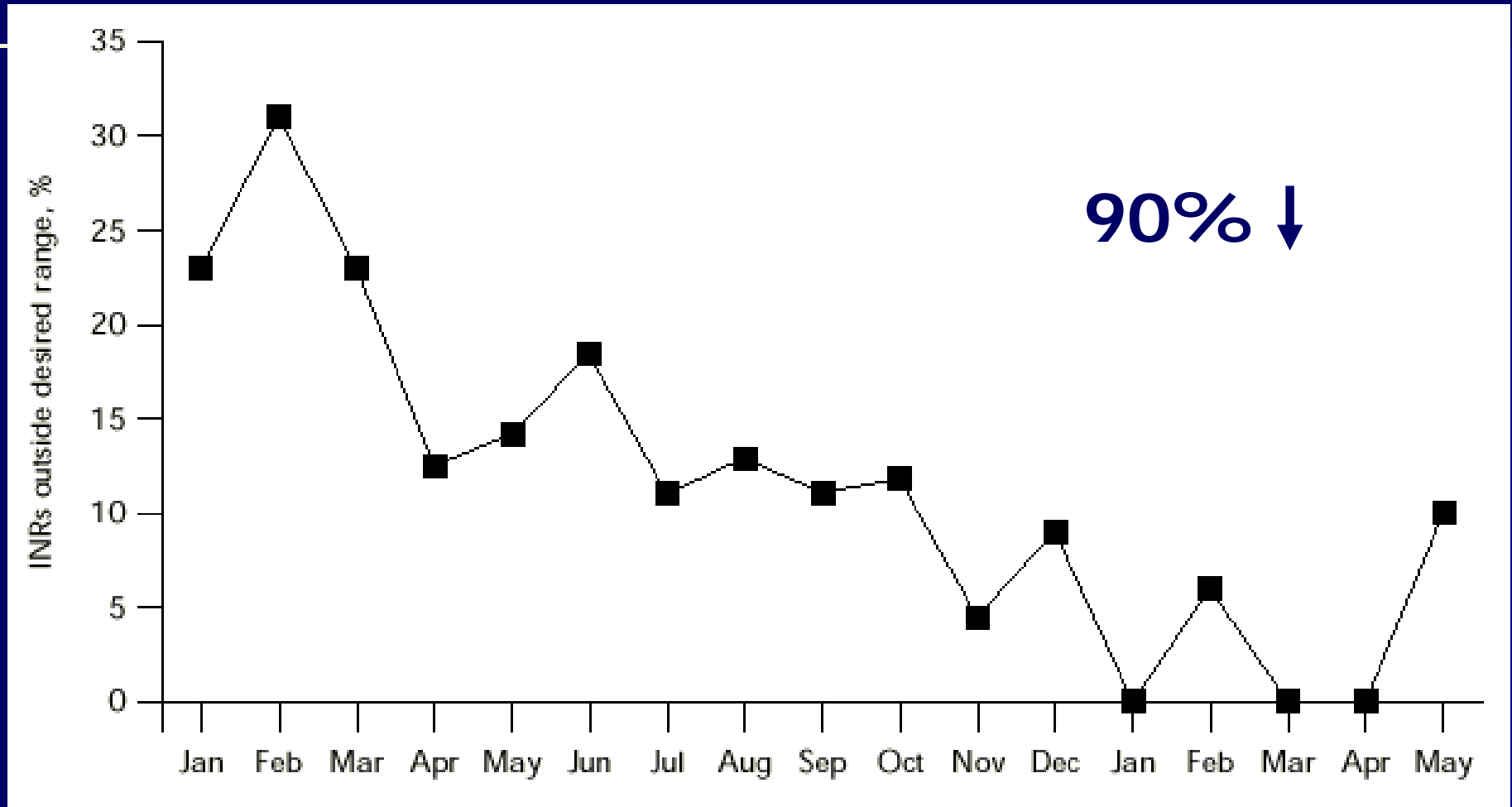
The idea that medical errors are caused by bad systems is a transforming concept

Accomplishments since IOM

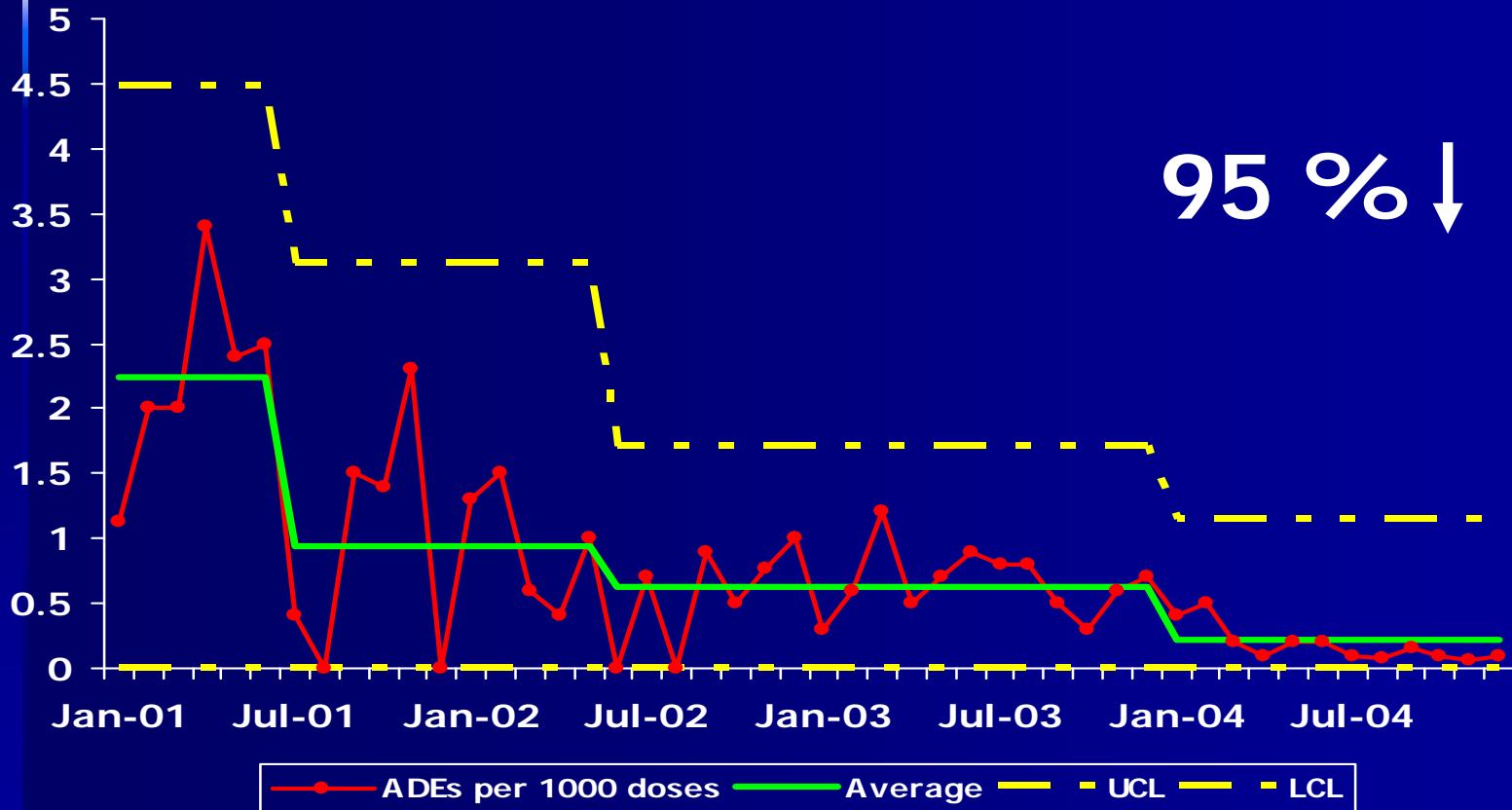
- NQF list of safe practices – we know what to do
- Voluntary implementation
 - Pronovost
 - Shannon
 - Pryor
 - Kaplan
 - IHI 100,000 lives campaign
- JCAHO requirements – getting serious about it
- World Alliance for Patient Safety

% of INR out of Therapeutic Range

Luther Midelfort Mayo Health System



Missouri Baptist: Adverse Drug Events per 1000 doses



Baystate SCIP Results

Complication	Reduction
Surgical site infections	68%
Postoperative MI	65%
Postoperative DVT	55%

*

The Michigan Experience

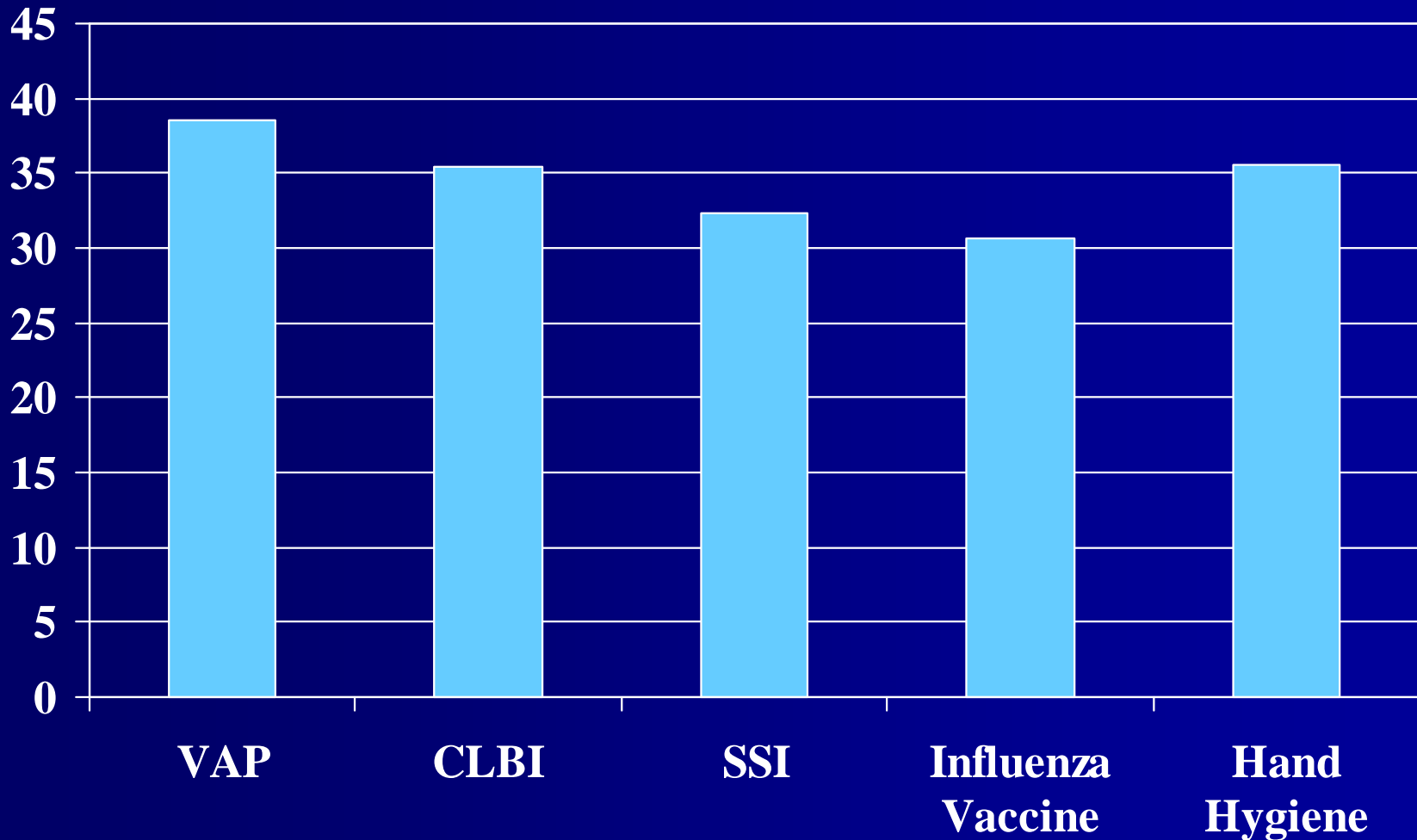
68 Hospitals

March 04-June 05

No CLBI or VAP for more than 6 months

- Lives saved: 1578
- Hospital days saved: 81,000
- Costs saved: \$165 million

Leapfrog Group survey: Full Compliance with standards (1256 Hospitals)



Deaths of 3 babies in Indiana spotlight medication mix-ups

By Tom Davies

ASSOCIATED PRESS

INDIANAPOLIS — Early last Saturday, nurses at an Indianapolis hospital went to the drug cabinet in the newborn intensive care unit to get blood thinner for several premature babies.

The nurses didn't realize that a pharmacy technician had mistakenly stocked the cabinet with vials containing a dose 1,000 times stronger than what the babies were supposed to receive. And they apparently didn't notice that the label said "heparin," not "hep-lock," and that it was dark blue instead of baby blue.

Those mistakes led to the deaths of three infants. Three others also suffered overdoses but survived.

Now, their families, hospital officials, and prosecutors are asking the same question: How could this happen?

Experts say last weekend's overdoses at Methodist Hospital illustrate that, despite national efforts to reduce drug errors, the system is still fragile and too often subject to human error.

"I see what happened here as depressingly normal," said Dr. Albert Wu of Johns Hopkins University, coauthor of an Institute of Medicine report that estimated more than 1.5 million Americans



MICHAEL CONROY/ASSOCIATED PRESS

Heather Jeffers (facing camera) was consoled by her mother Wednesday in Indianapolis. Jeffers's daughter, Thursday Dawn

Clinical
Consequences
Of a Cart Fill
Error

Public Frustration with Our Progress

1. Rapid pace of communication
2. Our inability to learn from our mistakes
3. The slow pace of adopting new safe practices

What's YOUR plan for implementing all of the NQF 30 practices?

Safety is about relationships

- It's not just about reporting, protocols, safe practices
- It's about working together in teams
 - Multidisciplinary
 - Mutual respect
- Teamwork is the secret of every industry that has succeeded in becoming safe

Safety is about relationships

- Nosocomial infections
 - 2,000,000 / year
 - 90,000 deaths / year
 - \$4.5-5.7 billion / year
- How do we change the culture?

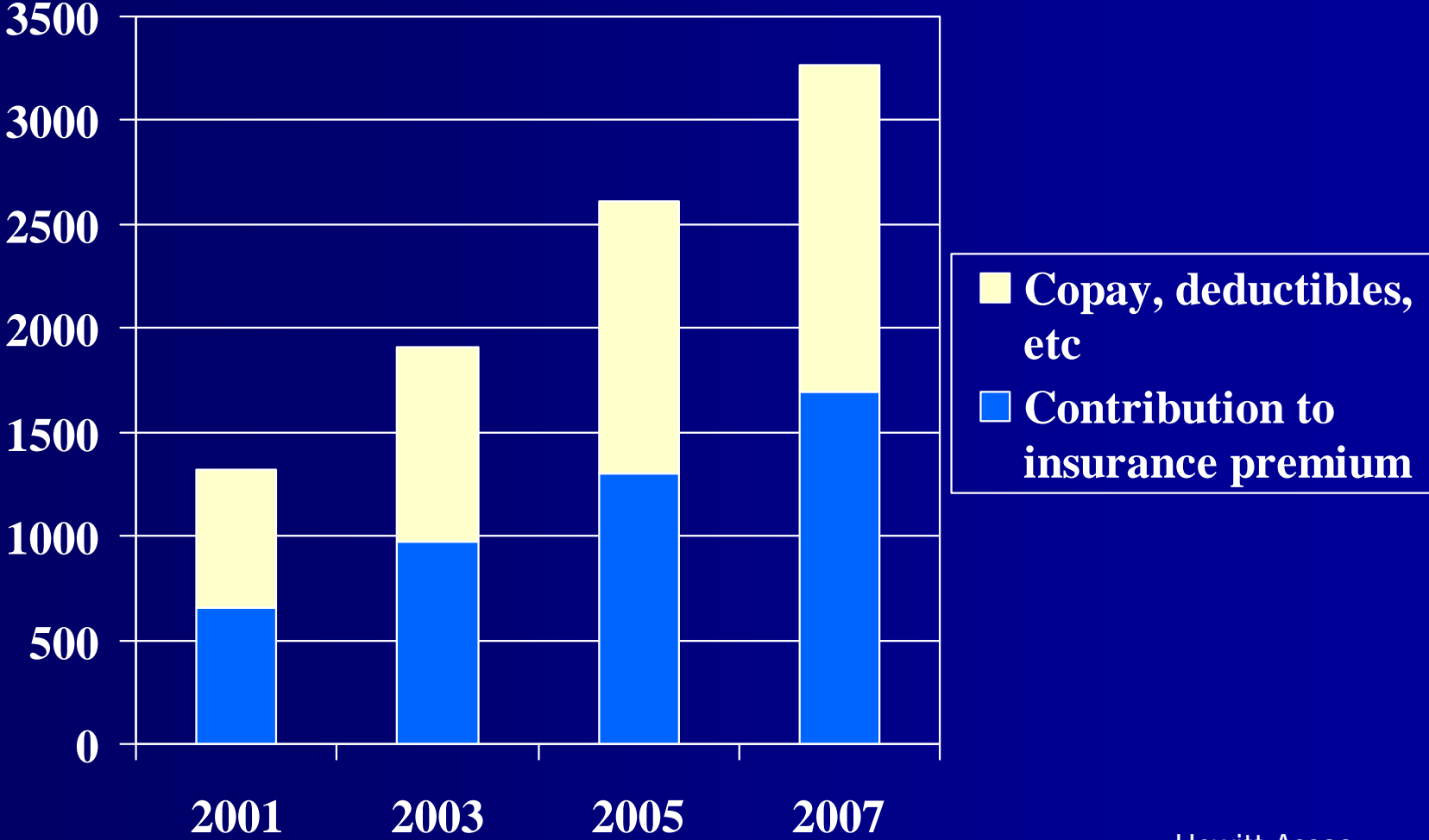


The problems of making health care safe are part of the larger fundamental problems of our health care system

What is the biggest problem with American health care?

It costs too much

Employee contributions to health costs

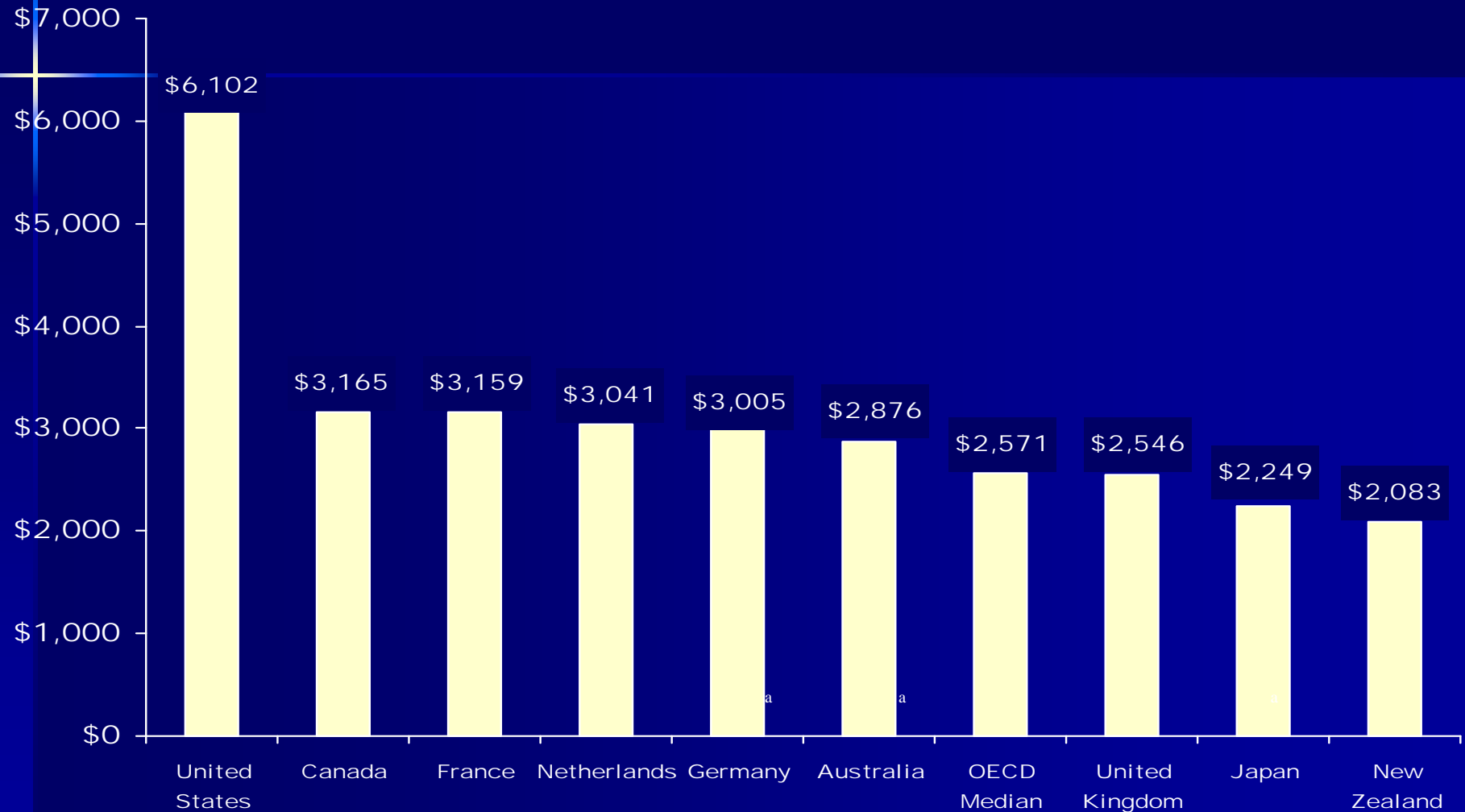


The Costly U.S. Healthcare System

- Uninsured: 47 mil
- Underinsured: 25 mil
- Forego Rx: 37% (59%)
- Bankruptcy: 1,800,000 (NYT 9/1/08)

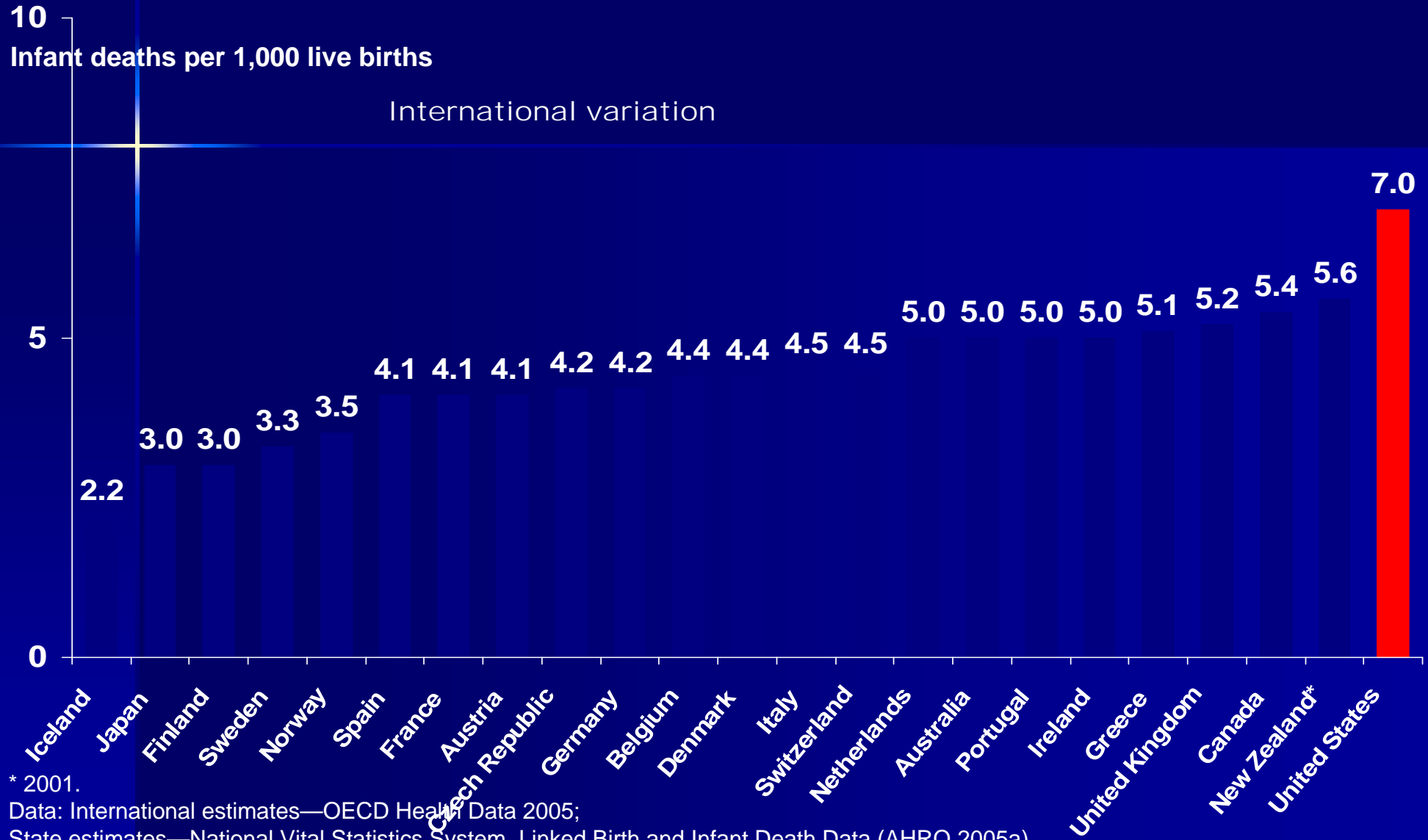
Health Care Spending per Capita in 2004

Adjusted for Differences in Cost of Living



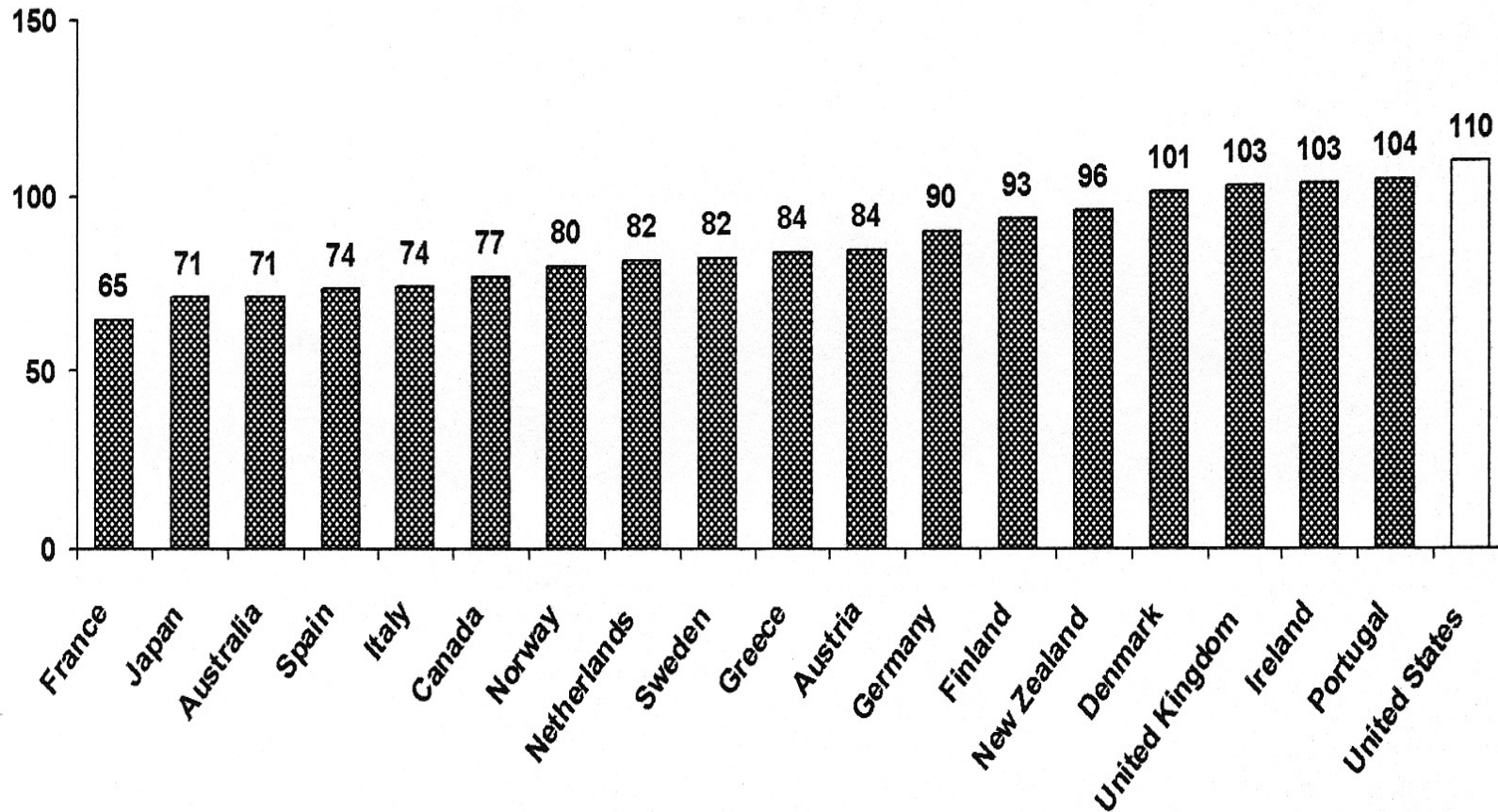
J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2006* (New York: The Commonwealth Fund, Apr. 2007).

Infant Mortality Rate, 2002



Mortality Amenable to Health Care, 2002-03

Deaths per 100,000 population*



Why are costs so high?

WASTE

INAPPROPRIATE CARE

PROFITS

WASTE

Inefficiency 20%

Administrative

Internal 10%

External 10%

Total waste 40%

INAPPROPRIATE CARE

Overuse 20%

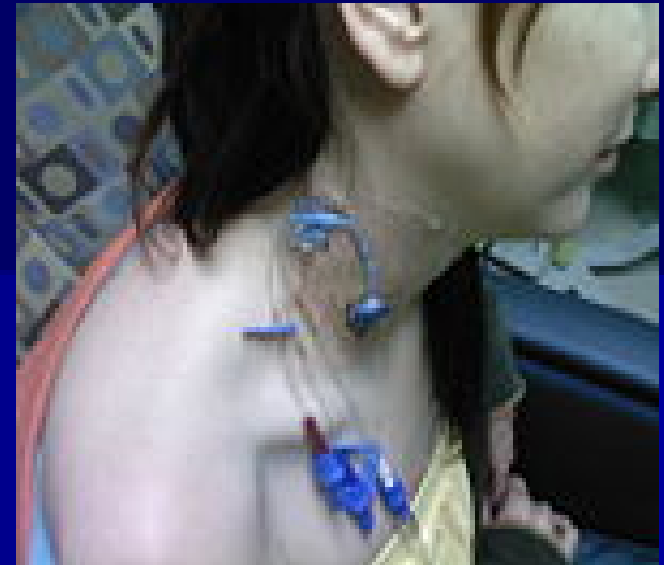
Underuse 45%

Misuse 10%

Central Venous Catheter Bloodstream Infection in ICUs

ICU days: 18 Million

Cath. days: 9.7 M



Infections
48,600

Deaths:
17,000

Cost
\$50 billion

INAPPROPRIATE CARE

70% of health care costs are
incurred by **10%** of the population

Who? Patients with chronic disease

INAPPROPRIATE CARE

Costly Chronic Diseases

- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Asthma
- Depression

Costs of Complications of Diabetes

■ Myocardial Infarction	\$36,256
■ Stroke	48,012
■ Retinopathy	1,004
■ ESRD	44,206
■ Partial foot amputation	36,244

Ann Int Med 2005; 143:256

Why are costs so high?

WASTE

INAPPROPRIATE CARE

PROFITS

Compensation of CEOs – Insurers (2007)

Ronald Williams	Aetna	\$42,991,700
H. Edward Hanway	Cigna	30,962,470
Michael McCallister	Humana	24,500,191
Dale Wolf	Coventry	20,171,239
Jay Gellert	Health Net	14,543,679

Compensation of CEOs – Hospitals (2006)

Jack Bovender	HCA	\$35,856,377
Alan Miller	Universal HS	13,913,419
Wayne Smith	Community	13,155,952
Trevor Fetter	Tenet	6,453,523

Why are costs so high?

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INAPPROPRIATE CARE

BUSINESS MODEL

How to succeed in business?

By growing

- Provide more services
- Expand market share

You succeed by providing **MORE**

How much does it add to costs?

Our for-profit fee-for-service system:

1. Encourages overuse
2. Devalues integrated, coordinated care
3. Encourages waste
4. Penalizes good care
5. Rewards poor care

Fails to provide care for all of our citizens

Excess Costs → No Health Benefit

Inefficiency	20%
Administrative waste	20%
Overuse	20%
Misuse	10%
Chronic care	35%
Profits	20%

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COST CONTROL



QUALITY CONTROL

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Who? Patients with chronic disease

Improving the care of chronic diseases

- Prevent it from becoming ACUTE disease
- Coordinated, integrated, **multidisciplinary** care that emphasizes
 - Prevention
 - Early aggressive treatment of complications

Uncoordinated Care

Bodenheimer, NEJM 358:1064 2008

- Records/tests not available at visit **43%**
- No follow-up arrangements after discharge: **33%**
- Primary care MD informed of discharge plans: **50%**
- PCP never received a discharge summary: **25%**
- No lab reports in discharge summary: **38%**
- No medications listed in discharge summary: **21%**
- Rx by PCP before discharge summ. received: **66%**
- Patients who leave doctor's office and do not understand what they were told by physician: **50%**

How do we make coordinated care happen?

PAY FOR IT!

- Pay for care, not for services

- Pay organizations, not individuals

Multispecialty group, medical home, clinic, HMO

- Stop paying fee-for-service

Providing coordinated multidisciplinary
team care for chronic disease patients
could cut their costs in half

Net impact: **35% reduction in national
medical costs**

(\$700 billion / year)

Providing coordinated multidisciplinary team care for all patients is also the best way to:

- Reduce inefficiency and waste
- Improve quality
- Improve safety

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COST CONTROL



QUALITY CONTROL



PAY FOR COORDINATED CARE

For 30 years, health care policy has been driven by market theory

Current iterations:

- Pay for performance (+ and -)
- Scorecards
- Tiering
- Consumer-driven health care
- Health savings accounts

For 30 years, health care policy has been driven by market theory

- **Costs** have gone steadily up (short reprieve in 90's)
- **Quality** has improved less than in all other Western countries
- **Patient Satisfaction** - and doctor satisfaction continues to drop

Market theory misunderstands doctors

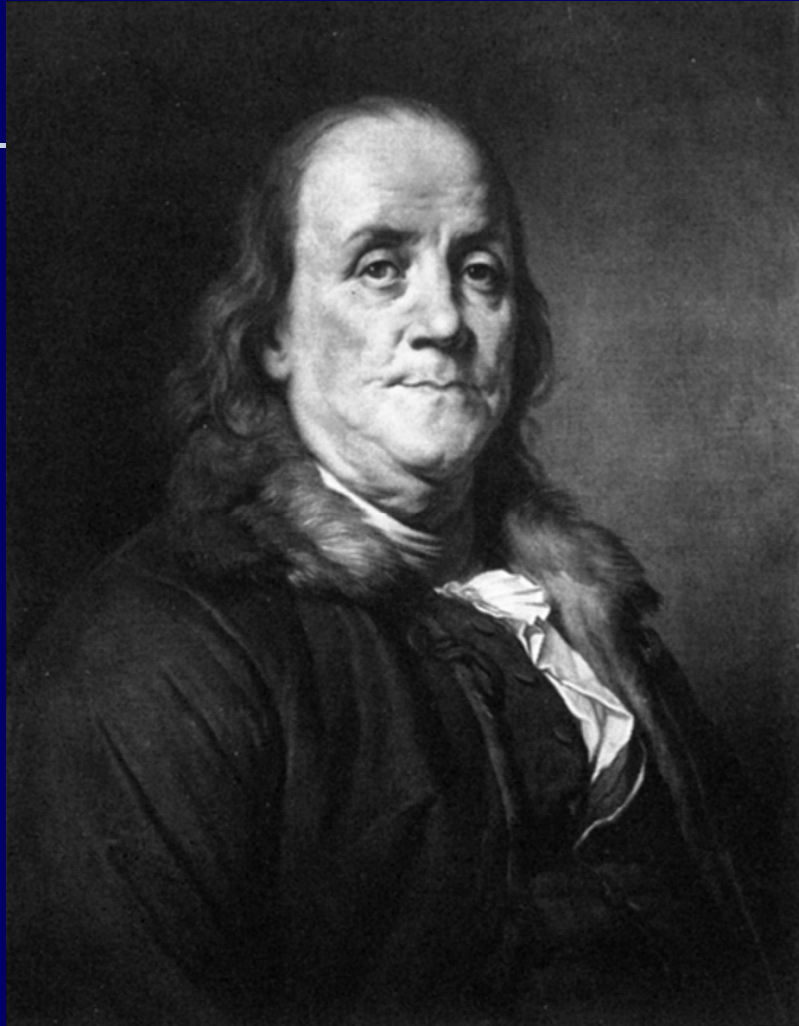
- Money is not their only, nor even most important motivation

Market theory misunderstands people

- Most people don't want to shop when they are well
- No one wants to shop when they are sick

Market theory misunderstands health

- Individuals don't control their need for health care
- Can't predict needs – short or long term
- Disease strikes without regard for ability to pay



The definition of insanity is doing the same thing over and over and expecting different results.

Why not single payer?

WHAT we pay for is much more important than HOW we pay for it

Regulation of Health Insurance

- **Pay only for integrated care**, not for services
- **Pay organizations, not individuals**
(capitation)
- **Defined benefits, no exclusions**
 - Standard minimum package for everyone
 - Primary care, Evidence-based care, Generic drugs
 - No exclusions, terminations, premium increases
 - Community rating – take all comers

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