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

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Harvard School of Public Health

The National Congress on Health Reform
Washington, DC
September 23, 2008
02138

Perhaps the most opinionated zip code in America

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
- **J CAHO requirements** – getting serious about it
- **World Alliance for Patient Safety**
% of INR out of Therapeutic Range

Luther Midelfort Mayo Health System

90% ↓
Missouri Baptist: Adverse Drug Events per 1000 doses

95% ↓
# Baystate SCIP Results

<table>
<thead>
<tr>
<th>Complication</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical site infections</td>
<td>68%</td>
</tr>
<tr>
<td>Postoperative MI</td>
<td>65%</td>
</tr>
<tr>
<td>Postoperative DVT</td>
<td>55%</td>
</tr>
</tbody>
</table>

*
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

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 “heparin,” 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

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

- Copay, deductibles, etc
- Contribution to insurance premium

Hewitt Assoc
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

Infant Mortality Rate, 2002

Infant deaths per 1,000 live births

International variation


Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006
Mortality Amenable to Health Care, 2002–03

Deaths per 100,000 population*

France 65
Japan 71
Australia 71
Spain 74
Italy 74
Canada 77
Norway 80
Netherlands 82
Sweden 84
Greece 84
Austria 90
Germany 93
Finland 96
New Zealand 101
Denmark 103
United Kingdom 103
Ireland 104
Portugal 104
United States 110
Why are costs so high?

WASTE

INAPPROPRIATE CARE

PROFITS
Waste

Inefficiency: 20%
Administrative:
  Internal: 10%
  External: 10%
Total waste: 40%
<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overuse</td>
<td>20%</td>
</tr>
<tr>
<td>Underuse</td>
<td>45%</td>
</tr>
<tr>
<td>Misuse</td>
<td>10%</td>
</tr>
</tbody>
</table>
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
70% of health care costs are incurred by 10% of the population.

Who? Patients with chronic disease.
Costly Chronic Diseases

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

Halvorson
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
<table>
<thead>
<tr>
<th>Name</th>
<th>Company</th>
<th>Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ronald Williams</td>
<td>Aetna</td>
<td>$42,991,700</td>
</tr>
<tr>
<td>H. Edward Hanway</td>
<td>Cigna</td>
<td>30,962,470</td>
</tr>
<tr>
<td>Michael McCallister</td>
<td>Humana</td>
<td>24,500,191</td>
</tr>
<tr>
<td>Dale Wolf</td>
<td>Coventry</td>
<td>20,171,239</td>
</tr>
<tr>
<td>Jay Gellert</td>
<td>Health Net</td>
<td>14,543,679</td>
</tr>
</tbody>
</table>
## Compensation of CEOs – Hospitals (2006)

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<tr>
<th>Name</th>
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<th>Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack Bovender</td>
<td>HCA</td>
<td>$35,856,377</td>
</tr>
<tr>
<td>Alan Miller</td>
<td>Universal HS</td>
<td>13,913,419</td>
</tr>
<tr>
<td>Wayne Smith</td>
<td>Community</td>
<td>13,155,952</td>
</tr>
<tr>
<td>Trevor Fetter</td>
<td>Tenet</td>
<td>6,453,523</td>
</tr>
</tbody>
</table>

Modern Healthcare
Why are costs so high?

WASTE

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
<table>
<thead>
<tr>
<th>Excess Costs → No Health Benefit</th>
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<tbody>
<tr>
<td>Inefficiency</td>
</tr>
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<td>Misuse</td>
</tr>
<tr>
<td>Chronic care</td>
</tr>
<tr>
<td>Profits</td>
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UNIVERSAL HEALTH CARE

COST CONTROL

QUALITY CONTROL
INAPPROPRIATE CARE

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

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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COST CONTROL

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PAY FOR COORDINATED CARE