Patient Safety Ten Years After the IOM Report on Medical Errors: Unmistakable Progress and Troubling Gaps

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One Thing I Wouldn’t Have Guessed Ten Years Ago...
Here’s One I *Would* Have Guessed*:
The End of Healthcare Exceptionalism

Value = Quality/Cost

* But I would have underestimated the pace of change
The projected exhaustion of the HI Trust Fund within the next eight years is an urgent concern.

...the HI Trust Fund could be brought into actuarial balance over the next 75 years by changes equivalent to an immediate 134 percent increase in the payroll tax (from a rate of 2.9 percent to 6.78 percent), or an immediate 53 percent reduction in program outlays, or some combination of the two.
The New Landscape: CMS Quality Payment Initiatives

- Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)
- Value-based Purchasing (VBP)
- Hospital-acquired Conditions (HACs)
- Readmission initiative
- Meaningful use for IT implementation
- (On top of new payment models such as bundling)

Dollars at stake by 2015: 7-10% of Medicare
Prototype Calculator Summary Page

How much are you leaving on the table?

The answer to this question depends on your hospital’s VBP score and the dollar amount that corresponds to 2% of your baseline DRG payment… For example, a facility with a VBP score of 60 points will earn back 60% of its 2% withhold.

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PN-6: Initial antibiotic choice for pneumonia

HCAHPS 1/2: Communication w/ Doctors and Nurses
“The IOM Report”
December, 1999
What Were the Problems?

- Wrong mental model: all about individual fault
- No expertise: how to analyze errors and fix systems, how other industries do safety
- No infrastructure: IT, national standards, transparency, robust local org chart
- Little research: evidence-based practices that work, implementation science
- Absolutely no business case to invest in/focus on patient safety
Have We Made Any Progress?

New England Journal of Medicine, Nov 25, 2010

Temporal Trends in Rates of Patient Harm Resulting from Medical Care

Christopher P. Landrigan, M.D., M.P.H., Gareth J. Parry, Ph.D., Catherine B. Bones, M.S.W., Andrew D. Hackbart, M.P.H., Donald A. Goldmann, M.D., and Paul J. Sharek, M.D., M.P.H.

Little Change in Patient Safety

The rate of patients suffering harm during hospital stays — from errors or inadvertent problems — showed no improvement over six years, according to a study of 10 North Carolina hospitals.

PROBLEMS PER 100 ADMISSIONS

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Data from internal hospital reviews
What Has Worked?

- Regulations
- Reporting Systems
- Clinical IT
- Balancing “No Blame” and Accountability
Why regulation/accreditation?
- Sign your site: “X” marks the spot
The Joint Commission gets real
But beginning to run out of gas
  - One size fits all
  - Hard to regulate culture (leadership standards, disruptive behavior)
  - Limited knowledge base (med rec)

* Wachter RM, Health Affairs, 2010.*
Reporting Systems: B+

- Flawed notion that reporting has any intrinsic value *by itself*
- Huge opportunity to waste time, money, and squander caregiver good will
  - Admonition to “report everything” was silly and naïve (and a mis-analogy from aviation)
Public Reporting

- Biggest surprise of *quality* revolution
  - Simple reporting leads to major improvements
  - Mechanism is shame/pride, not public scrutiny

- Problem viz medical errors: measuring safety
  - Medicare public measures all quality, not safety
    - Processes (beta blockers, aspirin, flu shots), outcome (risk-adjusted mortality)
  - At this point, measuring safety mostly depends on self reports
    - Except for certain healthcare-associated infections
How Would You Interpret These Hospital Incident Report Data?
And How About These?
Why Reporting Systems Are Gaining Momentum

- Key was to develop a manageable list of topics (NQF “never events”)
- Most states now require reports of NQF list
- Key is internal change, not outside analysis
  - CA’s required reporting of “never events” has transformed UCSF’s RCA process
- New: efforts by CMS to use “never events” to create “non-pay for non-performance” pressure
Healthcare IT: C+

- Not *worse* than it was, but juxtaposition with IT in the rest of our lives is even more jarring
- Early glowing studies were not generalizable to vendor-built systems
- Expect unforeseen consequences
  - Emerging literature re: problems

*But $19B says we’ve now passed the tipping point*
Balancing “No Blame” and Accountability: C+

- The “No Blame,” “It’s the System Stupid” approach has been crucial
  - Most errors are “slips” – expected behavior by humans, particularly when engaged in “automatic behaviors”
  - Can only be fixed by improving systems (checklists, double-checks, standardization, IT, other new technology…)
Why We Needed a Systems Approach
Two Disconnected Conversations

No Blame

Accountability
At the Junction, the Message Gets a Little Garbled...

No Blame

Accountability
In Summary, We Struggle With Two Competing Epiphanies

- Most errors are committed by caring, competent people who are trying hard to get it right.
- Therefore, finger-pointing, shaming and suing them doesn’t help, it stifles open discussions and learning.

- The system produces low quality, unsafe, unreliable care partly because there’s been no incentive to do otherwise.
- Therefore, the last 10 years have seen a variety of initiatives to create accountability, which generates action, focus, and resource flow.
What Does Accountability Look Like?

- Reasonable performance expectations
  - Applied fairly, expectations similar for all
  - Mixture of carrots and sticks
- "No blame" *is* the dominant front-line culture
  - For innocent slips and mistakes
- Clear demarcation of blameworthy acts
  - E.g., Gross incompetence, disruptive behavior, and now, failure to heed reasonable safety/quality rules
Individual Accountability: The Hand Washing Story

- Typical hand hygiene rates circa 1999: 10-30%
- Over last decade, tremendous push to improve (via transparency, social pressures, and more)
- Many organizations now at 40-70%, and stuck
- “It’s a Systems Problem”: Education, dispensers every 3 feet
- A systems problem? I don’t think so.

Wachter, Pronovost. NEJM 10/1/09
Who Decided that a 60% Hand Washing Rate is a “Systems Problem”?
When Is the Accountability Approach Correct?

- The practice is important and works
- The systems have been fixed
- Unintended consequences have been addressed
- Providers understand the practice, its value, the auditing strategy, and the penalties
- A single transgression has led to a warning

**At that point...**
Weakness is provocative
The Bottom Line: Leaders and organizations will be held accountable

“‘No blame’ is not a moral imperative (even if it seems so to providers, it most definitely does not to patients). Rather, it’s a tactic to achieve ends for which providers and healthcare organizations will be held accountable.”

Overall Grade: Patient Safety
10 Years After the IOM Report

B−
When my time has come, I want to go peacefully in my sleep, just like grandpa...

Not screaming, like the passengers in his car.
Some Thoughts About What’s Next

- Value will trump volume
- Pressure from stakeholders will drive change from many directions
  - Limited bandwidth for elective activities when so many mandates and measures
- Single nasty errors trump statistical measures (med mal, accreditation, reputational risk)
- The dysfunctional organizational dichotomy of the US healthcare system will erode
Some Thoughts About What’s Next, II

- MD as king (even proceduralists!) era ending
  - Pressure for standardization; employed MDs; institution can’t allow value-sapping decisions

- Everyone will have IT backbone
  - Data increasingly important and accessible
  - Ability to measure/influence MD practice higher
  - Non-integrated systems increasingly challenged

- New competencies/new vocabulary: systems thinking, checklists, leadership, teamwork
Peace of Mind?