WHAT HAVE WE MISSED IN ACHIEVING SAFER HEALTHCARE??

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Disclaimer

- No conflict(s) of interest to declare

- Used information from published / known data
Flow of presentation

1. Facts & Scenario – Magnitude and Cost of Unsafe Care
2. Myths & Controversies
3. Examples – Successes & Failures
4. Interaction
5. Solutions and Way Forward - Resetting Priorities
Beyond Healing – “O” GOSH

- Awe inspiring gene therapy and life saving transplants go on in a framework that must also ensure that outpatient appointments happen on time – floors are cleaned – broken light bulbs changed........

- It rapidly became apparent that well trained staff, good facilities and modern equipment do not automatically converge to create high standards of healthcare.

- A frequently cited concern of health professionals throughout the world is the extent to which financial issues dominate the healthcare agenda. If most of the time of senior management of HCOs is directed towards finance. . . . How can a commitment towards quality be anything other than rhetoric?

- Sir Liam Donaldson

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Magnitude of Unsafe Care

• Despite increased focus and some indications of improvement, about 1 in 10 patients develops an adverse event, such as a health care–acquired infection, pressure ulcer, preventable adverse drug event, or a fall, during hospitalization (AHRQ Efforts 2014).

• At any time, hundreds of millions of people are suffering from infections associated with health-care facilities.

• In intensive care units, Hospital infection affects about 30% of patients and the mortality may reach 44% (USA)
Magnitude of Unsafe Care

- Roughly **1 in 2 surgeries had a** medication error and/or an adverse drug event (Nanji et al. 2015).

- More than **700,000 outpatients are treated in the emergency** department every year for an adverse event caused by a medication—adverse events severe enough in **120,000 of these** patients to require hospitalization (Budnitz et al. 2006).
Magnitude of Unsafe Care

- More than **12 million patients each year** experience a **diagnostic error** in outpatient care, half of which are estimated to have the potential to cause harm (Singh et al. 2014).
- Globally, there are **421 million hospitalizations** and approximately **42.7 million adverse events** each year (Jha et al. 2013).
- About **one-third of Medicare beneficiaries in skilled nursing facilities** experienced an **adverse event**; half of these events were deemed preventable (OIG 2014).
Costs of Unsafe Care

- Hospitalization is bankrupting worldwide and so is a PUBLIC HEALTH ISSUE.
- 30 – 40% of the money spent on health care – more than half a trillion dollars a year – is spent on costs associated with “overuse, under-use, misuse, duplication, system failures, unnecessary repetition, poor communication and inefficiency.”
- As much as $300 billion is spent each year on health care that does not improve patient outcomes – treatment that is unnecessary, inappropriate, inefficient, or ineffective.
- Countries are estimated to lose from US$ 6 Billion to 29 Billion Annually on a/c of unsafe care!

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Challenges in providing safer healthcare
Health care is increasingly complex
.....Technology advances
The healthcare team - 133 People to take care of the patient

Lack Of Communication
Lack Of Collaboration
Team work
Lack of Coordination
Trust Deficit

Lack of Communication

Not Taking Action on reports

Not “Walking the Talk”

Lack of Transparency

OMG... HOW DID THAT HAPPEN

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If “Quality” is…

Conformance to standards

Then Excellence is…

Conformance to standards

Wanting to conform

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Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after... *To Err Is Human*

- While the release of “To Err Is Human” significantly heightened the focus on patient safety, expectation was that expanded data sharing and implementing interventions to solve specific concerns would result in substantial, permanent improvement.

- In the intervening decade and a half, it has become increasingly clear that safety issues are far more complex—and pervasive—than initially appreciated.
The “Know – Do” G...A...P

- Despite the Knowledge and Recognition of magnitude and costs of unsafe healthcare;

It does not happen –

WHY???
Patient safety

- The Safety Risks
  - Physical
  - Mental
  - Financial
Myths

1. Data Collection Vs Data sanctity- Data sanctity more Important e.g. Failed RCAs

2. Complaining Vs Reporting

“ In God we trust all others must bring Data”
Missed Focus

- Inappropriate Care – IOM
- Engaging Clinicians
- The First Challenge – building trust to create culture.
<table>
<thead>
<tr>
<th>Category</th>
<th>Sources</th>
<th>Estimate of Excess Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>• Overuse—beyond evidence-established levels</td>
<td>$210 billion</td>
</tr>
<tr>
<td></td>
<td>• Discretionary use beyond benchmarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unnecessary choice of higher-cost services</td>
<td></td>
</tr>
<tr>
<td>Inefficiently Delivered</td>
<td>• Mistakes—errors, preventable complications</td>
<td>$130 billion</td>
</tr>
<tr>
<td>Services</td>
<td>• Care fragmentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unnecessary use of higher-cost providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Operational inefficiencies at care delivery sites</td>
<td></td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>• Insurance paperwork costs beyond benchmarks</td>
<td>$190 billion</td>
</tr>
<tr>
<td></td>
<td>• Insurers’ administrative inefficiencies</td>
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<tr>
<td></td>
<td>• Inefficiencies due to care documentation requirements</td>
<td></td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>• Service prices beyond competitive benchmarks</td>
<td>$105 billion</td>
</tr>
<tr>
<td></td>
<td>• Product prices beyond competitive benchmarks</td>
<td></td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>• Primary prevention</td>
<td>$55 billion</td>
</tr>
<tr>
<td></td>
<td>• Secondary prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tertiary prevention</td>
<td></td>
</tr>
<tr>
<td>Fraud</td>
<td>• All sources—payers, clinicians, patients</td>
<td>$75 billion</td>
</tr>
</tbody>
</table>

SOURCE: Adapted with permission from IOM, 2010.
Statistics (Data sanctity)

• **Finagle’s Law:**
  • The information you **have** is not what you **want**
  • The information you **want** is not what you **need**
  • The information you **need** is not AVAILABLE

• **Churchill:**
  • The only statistics that you can trust are those you falsified yourself

• **Mark Twain:**
  • Statistics are like a lamp post for a drunkard, used more for support than illumination
Aims of WHO medical curriculum

- Build a Safety Culture
  - Blame & Shame to Systemic Approach
  - Ability to speak up
    - Attitudinal change to accept information from all sources/levels
- Communication
- Collaborative Teamwork
Myths ...contd:-

- Reinforced behaviour can change attitude (WHO challenges contrast with the guide)

- Measurement Must –incorrectly quoting Deming
  
  - What cannot be measured, can’t be improved.
Examples
Examples

- Mid-Staffordshire Crisis
- Numerous Recommendations Vs Don Berwick’s simple recommendation
- Surgical Checklist in India
- Don Berwick- Era 3 Healthcare
Mid-Staffordshire Crisis

(Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC-290
Recommendations

- Negative culture
- Professional disengagement
- Patients not heard
- Poor governance
- Lack of focus on standards of service
- Inadequate risk assessment of staff reduction
- Nursing standards and performance
- Wrong priorities
EXAMPLES

- Infection Control in SGH – Dr. Ling Moi Lin

- Aravind Eye Care System also Shankar Nethrayalaya and LV Prasad Eye Institute – South India

- Knee Implant from Sancheti Hospital

- CUSP

- CLABSI

- Sustained Safety projects – Analyze for reasons of success

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Retail Management perspective – UK in 80s,

“Quality of healthcare can be assured if good quantitative measures e.g. performance indicators could be developed, would help identify problems – make changes and improve healthcare services.”

This vision has been tempered with realisation that the issue of “quality” in complex healthcare scenario is more complicated and nebulous.
Q. I. Research – Learning?

- Process indicators describe actual medical care.

*Improving process has been described as the primary object of quality assessment / improvement.*

- “We believe that using consensus techniques – which systematically combine evidence and opinion, and guideline driven approaches facilitates quality improvement.”

- Quality measurement cannot be achieved without accurate and consistent information systems.
Q. I. Research – Learning?

• “In a complex field like healthcare, the predictive power of even the best risk adjustment models will only ever be partial.”

• “Disease specific mortality is an insensitive tool to compare quality of care among hospitals” – Mant & Hicks

• Errors resulting in fatality get highlighted while near misses get overlooked – a harbinger of disaster.

• “Environment in which an organization operates affects the care provided.”
Key Learning

- To understand the success or failure of interventions to change practice – *look into the “black box”*

- Process evaluation contributes significantly to the development of potentially successful interventions.

- Process evaluation helps to describe the QI intervention itself, the actual exposure to and the experience with the intervention.

- Paying attention to the target group, implementers, frequency of activities, features of information imparted. It is an intensive task that requires great attention to detail.
Interaction
Solutions and Way Forward- Resetting Priorities
Solutions

- Back to Basics – Building trust & creating culture
- Trust, Transparency, Transactions
- Actions to improve
  - Rewards & Recognitions
  - Solutions based approach
Current Consensus

- Various agencies like NPSF, IHI, AHRQ in US as also in Europe and globally, as well as thought leaders, are coming round to the realization that creating a safety culture built on trust and transparency is a pre requisite for sustained safer healthcare.
Creating Culture

• Effective organizational culture essential to the success of new patient safety initiatives.

• Embedding the goal of providing safe care in the culture of the organization is a prerequisite to lasting impact.
Creating Culture

- Advancement in patient safety requires an overarching shift from reactive, piecemeal interventions to a total systems approach to safety.
- Leadership consistently prioritizing safety culture and the wellbeing and safety of the health care workforce.
- More complete development of the science, and tools of patient safety.
- Also include partnering with patients and families at all points along the journey.
Globally, patient safety needs to be integrated into the foundation of quality care — safety is not a special program.
• **By embracing safety as a core value, other industries have moved beyond competition to a stage of cooperation.**

• **Health care organizations should also make this shift.**
Trust

- Fragmentation and poor communication whether between primary, secondary and tertiary healthcare services or between health, social services and education can cause more than a breakdown in trust.

- Two important aspects of developing trust:
  A more open dialogue with patients and more equality in the balance of power between patients and doctors.
Issues in Healthcare

Point

- TRUST
  - TRANSPARENCY
  - TRANSACTIONS

Counterpoint

- SYSTEM COMPLEXITY
  - RESOURCE PRESSURE
  - UNCERTAINTY

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Perspectives of Stakeholders

- **Health professionals** tend to focus on professional standards, health outcomes and efficiency.

- **Patients and carers** often relate quality to an understanding attitude, communication skills and clinical performance.

- **Managers’ views** are influenced by data on efficiency, patients’ satisfaction, accessibility to care and increasingly, outcomes.
Common to All Stakeholders

- Trust – Transparency – Transactions
- Effective Outcomes
- Value for Money

THE HOW

- Contribute what we have
- Mutual Respect and Appreciation
- Build Interlinkages
- ROI vs. EROI
TRANSITION

- STRUCTURE
- STRATEGY
- SYSTEMS

- PURPOSE
- PEOPLE
- PROCESS

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Solutions based approach

1. Fault Finding Results in Defensive reaction
2. In solution based approach we ask to present the best practice that they have.
3. Analyze the reason for best practice
4. Gently redirect to do the same in other areas needing improvement.
Carry Home

- Build TRUST
- Through TRANSPARENCY and
- TRANSACTIONS (Communication)
- Build INTERLINKAGES
- Stress BALANCE
- Focus on Processes

“TINA Factor”
Concepts fundamental to making sustainable improvements to the safety of our health system

1. Transparency
2. Care integration
3. Patient/consumer engagement
4. Restoration of joy and meaning in work
5. Medical education reform

FAIRNESS ALGORITHM?

1. Did the individuals intend to cause harm?
2. Did they come to work drunk or impaired?
3. Did they do something they knew was unsafe?
4. Could two or three peers have made the same mistake in similar circumstances?
5. Do these individuals have a history of involvement in similar events?

(Adapted from IHI open school)
Case of Cystic Fibrosis

- **1960s**: Average Life expectancy – 3 yrs. Annual Mortality – 20%
- **1964**: Mathews Center: ALE=21yrs. No deaths below 6 yrs. In last 5 years – “Mathews Protocol” – Followed at all centers
- **1966**: National ALE – 10 yrs. **1972**: 18 years **2003**: 33 yrs
  - Best Center >40 yrs.
- **Quality of Life**: Pulmonary Capacity 90 to 109% of Normal
- **Fairview Center**: Minnesota – Oldest Pt. 67 YEARS!
The 7 Steps to Patient Safety

- Step 1: Build a safety culture
- Step 2: Lead and support staff
- Step 3: Integrate risk management activity
- Step 4: Involve and communicate with patients and the public
- Step 5: Promote reporting
- Step 6: Learn and share safety lessons
- Step 7: Implement solutions to prevent harm
Healthcare Excellence
Knowing is not enough; we must apply.
Willing is not enough; we must do.

Goethe

A small body of determined spirits fired by an unquenchable faith in their mission can alter the course of history.

Mahatma Gandhi
THANK YOU !!