Keystone Center for Patient Safety and Quality

JOHNS HOPKINS MEDICINE

KEYSTONE ICU

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- Aleda E. Lutz VAMC
- Battle Creek Health System
- Bay Regional Medical Center
- Beaumont Hospital-Royal Oak
- Beaumont Hospital-Troy
- Borgess Medical Center
- Botsford General Hospital
- Bronson Healthcare Group
- Chelsea Community Hospital
- Community Health Center of Branch County
- Covenant HealthCare
- Crittenton Hospital Medical Center
- Garden City Hospital
- Genesys Regional Medical Center
- Gerber Memorial Health Services
- Hackley Hospital
- Harper University Hospital
- Henry Ford Health System
- Henry Ford Wyandotte Riverside Hospital
- Holland Community Hospital
- Huron Medical Center
- Huron Valley Sinai Hospital
- Ingham Regional Medical Center
- Lakeland Hospital
- Lapeer Regional Hospital
- Marquette General Health System
- McLaren Regional Medical Center
- Memorial Healthcare Owosso
- Mercy General Health Partners
- Mercy Hospital Cadillac
- Mercy Hospital Grayling
- Mercy Medical Center-Sioux City
- Mercy Medical Center Clinton (IA)
- Mercy Medical Center-Des Moines (IA)
- Mercy Memorial Hospital (Monroe)
- Metropolitan Hospital
- MidMichigan Medical Center
- Mt. Clemens General Hospital
- Munson Medical Center
- Northern Michigan Hospital
- Oakwood Annapolis Hospital
- Oakwood Hospital & Medical Center
- Oakwood Heritage Hospital
- Oakwood South Shore Medical Center
- POH Medical Center
- Port Huron Hospital
- Providence Hospital & Medical Centers
- St. Agnes Medical Center (Fresno, CA)
- St. John Detroit Riverview Hospital
- St. John Hospital & Medical Center
- St. John Macomb Hospital
- St. John Oakland Hospital
- St. John Health-River District Hospital
- St. Joseph Health System-Tawas City
- St. Joseph Mercy Hospital
- St. Joseph Mercy Oakland
- St. Joseph Regional Medical Center-South Bend
- St. Joseph's Mercy of Macomb
- St. Mary Mercy Livonia
- St. Mary's Mercy Medical Center
- St. Mary's Saginaw
- Sinai-Grace Hospital
- Sparrow Health System
- Spectrum Health
- Three Rivers Area Hospital
- United Memorial Health System
- University of Michigan Hospital & Health Centers
- W.A. Foote Health System
- War Memorial Hospital
- West Branch Regional Medical Center
- West Shore Medical Center

Thank you for the opportunity to share our thoughts about Patient Safety.

Healthcare Quality, Patient Safety and Healthcare Reform

As we hear about people who have been harmed by preventable medical mistakes, even in some of the best medical institutions in the world, we have to ask ourselves how this can possibly be happening. And upon reflection the answer shouldn't be all that surprising: We get what we invest in.

In Michigan, through the Keystone ICU project, hospitals are investing in collaborative efforts to improve culture, patient safety, and quality of care in their intensive care units. This effort, to implement evidence-based interventions broadly through a whole state, is achieving significant results but is merely the tip of the iceberg. We have much to learn and much to do.

One of the important patient safety roles of state governments should be to be relentless in advocating for funding changes at the federal level, so that health systems and care providers can learn the most efficient and effective ways to improve quality and safety. These are complicated challenges. Expecting individual providers or individual states to achieve best care through local or regional trial and error is neither efficient nor effective.

There's a concept that comes from quality, and that is "Every system is perfectly designed to achieve the results it gets".

If we want a healthcare system that is safer, the healthcare system must change at four key levels of influence: the level of the patient, the level of the provider, the level of the community and the level of the regulator. States have a crucial role at the regulatory level.

Learning how to prevent harm

We invest in the discovery of biology and disease therapies a hundred-fold more than we invest in how to deliver those therapies to patients. As a result, we have 98,000 people who die each year because we don't know how to deliver care.

By far the most cost-effective opportunity to improve care in this country is not from discovering new therapies but in learning how to deliver those therapies that we know work safely and cost-effectively. We need a more balanced health care research portfolio, to help with those efforts. We know, through research on organizational behaviors, that we need to focus on "systems" to truly impact change.

That's what we have to do in health care, but it gets more complicated because our work is embedded in a social structure, the system, that is "the culture of health care." And to get leverage for changing that, to get stickiness for changing our systems of work and relationships, we're going to need to begin to understand how we can possibly create the culture that we need to ensure, to the maximum extent possible, safety and quality of care.

The first thing we need to do is create desire amongst us. We have to want to do it. Having the courage to tell real-life stories is what is needed to rekindle in us the central fire about why we went into the healing profession to begin with. We do want to heal people, not harm them. Hearing stories of care that missed the mark or errors that have been made can rekindle that desire that is already in us. Cold scientific data, the number of deaths or various satisfaction scores never touches people's hearts with the power that telling our stories and opening up our own fallibility does.

Setting Goals

Since the Institute of Medicine (IOM) released *To Err is Human in late 1999* and *Crossing the Quality Chasm* 18 months later, there has been a huge spike in the number of individuals and organizations talking about patient safety. Most experts would agree, however, that in five years there has been limited actual progress. One of the key reasons for the slow pace of significant and widespread change is that "goal setting" has in large part been left up to providers, purchasers or individual clinicians.

Organizations, providers and indeed the entire industry are struggling with this. Many healthcare leaders are engaged in the issue of safety. Pockets of the healthcare community have become invested in educating themselves and understanding the sciences and the new culture that will be needed to improve safety. However, despite there being great examples of people executing interventions and achieving really dramatic results, for the most part, we haven't evaluated all that much. In some of these pockets the results that we've achieved have far exceeded our expectations, but they haven't been as widespread and as diverse as we need.

If we were to ask many healthcare leaders around this country to tell us how do they know they're safer than five years ago, it is likely we would either get no answer or "I believe I am", or a whole variety of different measures. As a country, we haven't made the investments needed to learn what it means to be safer, to prioritize our efforts, and to help providers reinvent healthcare. We've just said we want higher quality, safer care.

Our efforts now are like Brownian Motion, we're going in many directions. In the absence of goal-setting, in 2009 at the ten-year anniversary of the IOM, we will still not be able to answer the question, "Are we safer?" We need goals, very clear measurable goals to say, "Here is where we're going to prioritize. Here is where we're going to make the resources available to achieve these goals." Researchers and health care leaders need to make sure we develop interventions or programs that are meaningful for the front-line worker who is actually delivering care. We must also have an explicit strategy for spreading what works, including methods to put the information and implementation strategies and tools in the hands of providers throughout the country, along with clear expectations for achievement. Then, within a predetermined timeframe, providers should be held accountable for achieving the goals.

States such as Michigan need to use their voice to help raise the volume on the urgency of a national, goal-directed, funded agenda for quality and patient safety.

Moving forward

To cross the quality chasm between where we are and where we want to be, we need to be able to talk about our mistakes and our near misses so that we can learn from them. A basic understanding of aviation safety systems and processes can help us. The aviation industry operates in a high-risk environment and has learned how to create highly effective systems for safety over the past four decades.

A voluntary, non-punitive reporting environment has been a critical component of the aviation industry success story, and we need similar environmental protections in healthcare. We suggest that the role of state governments ought to be supportive of a national agenda for voluntary healthcare reporting systems, aligned at a federal level, so that care providers throughout the country can learn from each other, much as the aviation industry does.

The transformation of healthcare will only happen when the culture changes, and culture change is the most difficult thing in the world to accomplish. Culture in organizations changes incrementally, rather than all at once; change literature is quite clear on that. Large scale efforts uniformly fail. Rather, you change one small unit at a time, one heart, one mind, and it grows, and it takes time and it takes effort, but that's what it takes to change a culture. Organizational Culture, loosely defined as "the way we do things around here" never improves because of a mandate or piece of data. Cultures improve when those at the front lines can see and feel a new, better way of doing their work, of making a positive impact on those in their care. Creating a learning environment where it is expected that mistakes and close calls are shared, goes a long way toward creating a culture where safety is a priority.

The Science of Safety

The science of safety can be summarized in four points: (1) We will make mistakes. (2) We need to create a culture where mistakes are identified. (3) To maximize learning we must focus on systems rather than people. (4) Leaders control the potential to change systems. State leadership is needed to create an environment where clinicians can learn from mistakes.

There are two goals for safety education. One is to have caregivers become comfortable saying "I'm fallible. I'm going to make mistakes. That's just part of the human condition." Having acknowledged that, we need to strive to make our care harm-free rather error-free. The second is to get them to understand the idea of systems.

Individuals providing care need to feel good about their work and understand that their individual actions are just one part of a complex web of actions that "create" care. They need tools to help provide care that is safe, efficient, effective, timely and equitable. Their focus has to be laser sharp on the patient. In Keystone ICU the focus is on patients in intensive care units. Although ICU is an expensive and important area of care delivery, it is only a small area in the entire scheme of healthcare. *A convergence of major issues adds urgency to the need for tools to improve care in all settings.* In the face of a rapidly aging population, a shrinking healthcare workforce, increasing complexity of care delivery and wholly inadequate healthcare financing, the need for a rapid, significant and sustained investment in learning what works, sharing what is learned, and aligning incentives for high quality, safe care has never been greater.

Direction for the Future
In summary, there are three bold dimensions to the work that lies ahead.

The first dimension could be described as building capacity for quality and patient safety. That includes training health care providers and further training the research community who could lead these efforts. We must also build a body of evidence to support the wholesale transformation of the industry. Building capacity includes development of a non-punitive reporting system so we can learn where mistakes are happening, where patients are at greatest risk of harm. That knowledge will provide a platform for the second dimension of progress.

A second dimension is to develop and clear national patient safety goals and implement measures for those goals. As an industry, both at a national level and at an institutional level, we don't have a really clear idea of what it means to be safer, and we need to. Included broadly in this second dimension is alignment of payment for care. If we establish goals for quality and safety, that is what we should pay for. When the goals and national priorities are clear, and payment is aligned with performance measured against those goals, institution and provider specific, public reporting of performance in relation to the goals should be a requirement of licensure.

The third dimension is improving communication, which is at the core of culture change. IT infrastructure including an electronic medical record is part of that because it is not a tool to just help link us better, but a tool that has to be coupled with culture change and enhancing our ability to work together as human beings. The transparency needed to create a seamless system of care cannot be accomplished without standardization ……of IT

Leadership for the Future.

The leadership needed to facilitate these changes is multi-dimensional. There is a need to curb individual autonomy in healthcare. And that's an issue that medicine and society haven't been willing to wrestle with. We have placed tremendous value on what could be called the art of medicine at the expense of the science, and haven't been really willing to confront the challenge of saying practitioners should standardize the way we do things, like we have in aviation. So just because you're top of your class, or you're a skilled physician doesn't give you the freedom to do things your own way. Autonomy can't be used as a shield against accountability. We need accountability as well. It's absolutely critical.

Every industry that has become safe has had to switch from what might be described as a craftsman's attitude to an equivalent actor attitude. For instance, when we get on a plane we don't check out the credentials of the pilot. We take for granted that we've got a skilled pilot from flight to flight. We don't worry about that. And yet we're nowhere near that with practitioners, nurses or doctors. We worry about individual issues.
Really, it comes down to a leadership problem.

Leadership for reform, then, really needs to come from several different sources. In *Crossing the Quality Chasm* the IOM called for fundamental change at many different levels. We need to see change at the Federal level and we also need change at the state level. We need change in the health profession education, training and licensure. We also need change in the healthcare delivery system at the community level and the local level and in the micro-systems of care: individual care units in hospitals, physician's offices, clinics etc.

An overarching opportunity is for states like Michigan to call for and support coordinated leadership from all of these different major stakeholders rather than developing one more unique, state specific set of expectations for healthcare quality and safety.

<u>The Future is NOW. What Pace of Change?</u>

The menu of healthcare components needing overhaul is large, the best methods of reform aren't yet clear, and the temptation is to say we need to study more, learn more, and have more resources at our disposal before we tackle the looming issues. Yet the urgency of the need demands we increase our pace of change. Now.

The reality is that there's always the risk for harm whenever we change something. And so we need to be aware and cognizant that when we perturb a system that there may be some unanticipated negative effects. And we have to try to be thoughtful of those and think of them and protect against them or measure for them. At the same time, though, it's also important to realize that the status quo is causing harm. We need to change but try to do it in a wise way, and that's sometimes hard in healthcare. We need is some better sense that a clock is ticking, and while we learn it's our patients that are paying the price.

This state is in a unique position to help shape the national quality and safety agenda. Michigan has a strong tradition of voluntary hospital reporting, a leadership track record for collaboration to improve care in projects like Keystone ICU, an enviable assembly of healthcare stakeholders that are members of the Michigan Health and Safety Coalition, and a major insurer (Blue Cross Blue Shield of Michigan) with a progressive vision of how to support quality and safety improvements. That combination of forces with a shared vision could position the state to aggressively innovate and add to the body of knowledge necessary to demonstrate definitively, year after year, that healthcare is indeed safer. Taking the actions we have suggested will help advance recognition of Michigan as a national healthcare quality and safety leader. Locally, care for patients will improve. Globally, healthcare systems will improve as what is learned in Michigan is shared throughout the industry. We encourage the patient safety commission to recommend this level of state leadership.

Thank you again for the opportunity to share our thoughts with you.

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