LEADERSHIP CHALLENGES IN PATIENT SAFETY

Kenneth W. Kizer, MD, MPH.
California Hospital Patient Safety Organization Annual Meeting
Sacramento, CA
April 8, 2013
Discuss some of the challenges faced by health care leaders in addressing patient safety, highlighting these challenges with personal experience in designing one of the nation’s first – and the largest - health system patient safety programs.
What is the Institute for Population Health Improvement?
Established as an independent operating unit in the UC Davis Health System in mid-2011; has since developed a diverse portfolio of funded activities >$70M

Population health – the intersection of public health and the clinical sciences

New value-based health care payment models require that population health management be a core competency for health care systems

Serves as a resource for:

- Health care reform
- Clinical quality improvement
- Building health leadership capacity
- Developing clinical intelligence
- Health policy

Assists government health-related agencies design, implement and administer programs

Promotes understanding of the multiple determinants of health and appreciation of health being a function of the totality of one’s circumstances
SELECTED IPHI ACTIVITIES

- Provide technical assistance in quality improvement and other support to the state Department of Health Care Services for Medi-Cal (California’s $60B/yr Medicaid program)
  - Medi-Cal Quality Improvement Program
  - Evaluate the Delivery System Reform Incentive Payments (DSRIP) Program
  - Design the CA-specific Evaluation of the California Medicare-Medicaid Dual Eligible Demonstration Program
- Manage operations of the California Cancer Registry
- Manage the California Health eQuality (CHeQ) Program - California’s Health Information Exchange Development Program
- Provide technical assistance and support for multiple statewide chronic disease prevention and surveillance programs
- Conduct a statewide assessment of surgical adverse events
- Conducting various population health research programs
  - Use of the OncotypeDx Genetic Assay in Medi-Cal Beneficiaries with Breast Cancer
  - Evaluation of Opiate Overdose Prevention Policies (in collaboration with CHPR)
- Investigate the feasibility of developing Community Paramedicine
- Partnering with California Health & Human Services Agency on a CMMI-funded Payment Reform Model for the California
Is American health care safer than it was 15 years ago?

Is American health care as safe as it should be?
Assessing Patient Safety Progress

The Urgent Need to Improve Health Care Quality
Consensus Statement
Institute of Medicine
National Roundtable on Health Care Quality
1998
Assessing Patient Safety Progress

“The Institute of Medicine's 1999 report on medical errors galvanized the public and health professionals. Before then, providers, health care organizations, and policymakers lacked the understanding and incentives to generate the changes in culture, systems, training, and technology to improve safety. Since 1999 there has been progress, but it has been insufficient. Stronger regulation has helped, as have some early improvements in information technology and in workforce organization and training. Error-reporting systems have had little impact, and scant progress has been made in improving accountability.”

Assessing Patient Safety Progress

“Five years ago, the Institute of Medicine (IOM) called for a national effort to make health care safe. Although progress since then has been slow, the IOM report truly “changed the conversation” to a focus on changing systems, stimulated a broad array of stakeholders to engage in patient safety, and motivated hospitals to adopt new safe practices. The pace of change is likely to accelerate, particularly in implementation of electronic health records, diffusion of safe practices, team training, and full disclosure to patients following injury. If directed toward hospitals that actually achieve high levels of safety, pay for performance could provide additional incentives. But improvement of the magnitude envisioned by the IOM requires a national commitment to strict, ambitious, quantitative, and well-tracked national goals.”

“Publication of the report *To Err is Human* was associated with an increased number of patient safety publications and research awards. The report appears to have stimulated research and discussion about patient safety issues, but whether this will translate into safer patient care remains unknown.”

“.... Despite a decade of work, we have no reliable evidence that we are any better off today. .... Since the IOM report was issued, there have been countless task forces, conferences, editorials, and even episodes of Oprah focused on patient safety. But action on key recommendations has been sluggish, leaving us without reliable means to track our progress or hold the local health-care systems accountable for ending preventable patient harm. We have failed to make the systematic changes in health care needed to end preventable medical harm.”

To Err is Human – To Delay is Deadly.

Ten years later, a million lives lost, billions of dollars wasted.

Consumers Union

May 2009
“December 1, 2009, marks the tenth anniversary of the Institute of Medicine report on medical errors, *To Err Is Human*, which arguably launched the modern patient-safety movement. Over the past decade, a variety of pressures (such as more robust accreditation standards and increasing error-reporting requirements) have created a stronger business case for hospitals to focus on patient safety. Relatively few health care systems have fully implemented information technology, and we are finally grappling with balancing “no blame” and accountability. The research pipeline is maturing, but funding remains inadequate. Our limited ability to measure progress in safety is a substantial impediment. Overall, I give our safety efforts a grade of B−, a modest improvement since 2004. “

With all increased awareness and activity, why isn’t health care measurably safer?
PATIENT SAFETY LEADERSHIP RESPONSIBILITIES AND CHALLENGES
Challenges to Improving Patient Safety

- Fear of negative repercussions from uncovering or disclosing adverse events
  - Negative publicity; harm to image; shame
  - Malpractice liability concerns
  - Financial issues
- The complexity of health care
- Knowledge and technology gaps
- Health care payment methods
- The culture of medicine
- Physician concerns about autonomy and authority
- Lack of clear goals
- Scarcity of measures with which to gauge progress
- Lack of leadership at the hospital and health plan level
Development of the VA Patient Safety Program

Developed within the context of the transformation of the VA health care system, which has been cited as the largest and most successful healthcare “turnaround” in US history.

CASE (FIELD)
Turnaround at the Veterans Health Administration (A)
by Amy C. Edmondson, Brian R. Golden, Gary J. Young
Source: Harvard Business School
20 pages. Publication date: Jul 20, 2007. Prod. #: 008061-PDF-ENG

Investigates the challenges that Dr. Kenneth W. Kizer confronted in seeking to create organizational change at the largest integrated health care system in North America, the Veterans Health Administration (VHA). Kizer was appointed as the Under Secretary of Health, to oversee the VHA, in 1994. Upon Kizer’s arrival, it was immediately apparent that the management style that pervaded the VHA was ineffective and out of date. At the same time, the VHA faced inefficient health care delivery systems ... Read More »

YALE SCHOOL OF MANAGEMENT
Program on Social Enterprise

YALE CASE 07-017 FEBRUARY 15, 2007

Veterans Health Administration
Dr. Kizer Considers Radical Surgery on an Ailing System

Allison Mitkowski
Jonathan Feinstein
Development of the VA Patient Safety Program

- Build an organizational infrastructure to support patient safety
  - Established the National Patient Safety Center
  - Implemented a system-wide electronic health record (CPRS-VistA)
  - Implemented Bar Code Medication Administration
  - Implemented a medical error and near-miss reporting system
- Establish a culture of safety
- Implement known ‘safe practices’ to improve patient safety
- Produce new knowledge about patient safety
  - Created and funded 5 new ‘Patient Safety Centers of Inquiry’
  - Established a patient safety research program
- Partner with other organizations to promote more rapid problem solving of patient safety issues
  - Created the National Patient Safety Partnership
  - Co-funded the Harvard Executive Session on Medical Error
  - Supported the National Patient Safety Foundation
## Leadership Responsibilities and Challenges for Patient Safety

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<tr>
<th>Responsibility</th>
<th>Challenge</th>
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<tr>
<td>1. Understanding and facing reality</td>
<td>➢ Fear of negative repercussions from uncovering and disclosing errors</td>
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<td></td>
<td>✓ Negative publicity/media coverage; harm to image; shame</td>
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Leadership Responsibilities and Challenges for Patient Safety

Responsibility

1. Understanding and facing reality

Challenge

- Fear of negative repercussions from uncovering and disclosing errors
  - Negative publicity/media coverage; harm to image; shame
  - Malpractice concerns
  - Financial issues
  - Personal consequences

“If you do this, you need to understand that you will be the first casualty if it goes south.”
Leadership Responsibilities and Challenges for Patient Safety

Responsibility

2. Create a vision of a new reality; create expectations
3. Engineer the change strategy and plan
4. Be patient safety literate
5. Bring a new perspective; question traditional practices and assumptions; expose common traps in thinking

Challenge

- Complexity of health care
- Requires knowledge of:
  - Complexity theory and complex adaptive systems
  - Normal accident theory
  - High reliability organizational theory
  - How to change culture change
  - Safety culture, safety climate
  - Teamwork principles and practices
- Knowledge gaps in how to provide safer care
Development of the VA Patient Safety Program

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Leadership Responsibilities and Challenges for Patient Safety

Responsibility

6. Articulate and demonstrate a commitment to safety
   a. Align safety with core objectives
   b. Prioritize safety goals and harmonize competing goals
   c. Clarify leadership responsibilities for safety for all levels of the organization

7. Build infrastructure and capacity; find and allocate resources (educational and knowledge management, human, financial, partners and collaborators, other)

Challenge

- Multiple competing priorities
- Not enough resources (time, money, personnel, etc.)
- Clarity of goals
- Knowledge gaps
- Different needs at different levels of the organization
What Else was Going on in VA Health Care at This Time?

- Implementing universal primary care
- Closing acute care hospital beds (55%, 28,986 beds)
  - Reduced ‘Bed Days of Care per 1000 patients’ by 68%
  - Reduced in-patient admissions by 350,000 per year
- Reducing staffing (12%, 25,867 FTEs), but increasing the number of caregivers
- Opening >300 new community clinics; reducing waiting times
- Increasing number of patients treated (24%, >700,000 new patients)
- Implementing a National Formulary (improved evidence-based drug utilization and reduced purchase price of pharmaceuticals by $650 million/yr)
- Implemented a system-wide electronic health record (CPRS-VistA)
- Implementing a new global budgeting “payment” system
- Reducing operating costs, waste and bureaucracy by >$1B/yr
  - 2,793 forms (72%) eliminated
  - Merged 52 hospitals into 25 local multi-campus facilities
- Decreasing per patient annual expenditures by 25.1%
Leadership Responsibilities and Challenges for Patient Safety

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<td>8. Ensure frontline and broad staff engagement</td>
<td>➢ Health care’s historical culture</td>
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<td>9. Build and sustain trust; commit to transparency</td>
<td>➢ Physician concerns about autonomy and authority</td>
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<td>10. Define and shape the culture; create the new norm</td>
<td>➢ Health payment methods</td>
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<tr>
<td>a. Identify what is valued</td>
<td>➢ Multiple competing priorities</td>
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<td>b. Promote a culture of ownership, empowerment and shared responsibility that supports innovation and learning</td>
<td>➢ Not enough resources</td>
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<td>c. Nurture collaboration and teamwork;</td>
<td>➢ Health care’s 24/7/365 role makes it challenging to reach parts of the work force</td>
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<td>d. Ensure appropriate recognitions and rewards are made to reinforce desired behaviors and outcomes</td>
<td>➢ Changing culture is hard and requires consistent leadership over a prolonged period of time</td>
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<td>e. Visibly demonstrate commitment; “walk the talk”</td>
<td>➢ Fear of negative repercussions from disclosing adverse events</td>
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<td>11. Be the chief communicator</td>
<td>➢ Lack of a strategic communications plan</td>
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<tr>
<td>a. Preach the vision</td>
<td>➢ Health care’s 24/7/365 role requires both conventional and unconventional communication modalities</td>
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<td>b. Tell ‘your story’</td>
<td>➢ Competing perspectives and agendas</td>
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<td>c. Ensure values are incorporated into operational policies and practices</td>
<td>➢ Lack of trust</td>
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<td>d. Be a bridge between the boardroom and the bedside</td>
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REPORT OUTLINES MEDICAL ERRORS IN V.A. HOSPITALS
700 DEATHS IN 19 MONTHS
Sweeping Self-Examination by Department Sees Range of Mistakes and Abuse

By ROBERT PEAR
WASHINGTON, Dec. 18 — Federal investigators have documented almost 3,000 medical mistakes and mishaps in less than two years at veterans hospitals around the country, and more than 700 patients have died in those cases, the Department of Veterans Affairs says in a new report.

The accidents and deaths occurred from June 1997 to December 1998, in the first 19 months of a new policy that requires employees to report medical errors and "adverse events." Since then, the department has been getting such reports at a rate of more than 200 a month.

The problems include medication errors, like prescribing or dispensing the wrong drugs, the failure of medical devices, a rise in infections, errors in blood transfusions, surgery on the wrong body part or the wrong patient, improper insertion of catheters or feeding tubes, and a variety of "therapeutic misadventures" that caused serious injuries or deaths.

A sign of what could be expected if all hospitals had to report their errors.

At the same time, the veterans health care system had a reputation as hidebound and bureaucratic. But under Dr. Kizer, it emerged as a national leader in efforts to improve patient safety.

The report's author, Dr. James E. McManus, a surgeon from New York City who is the veterans department's medical inspector, said in an interview that "the adverse events reported by the V.A. were so serious that 24 percent of the patients died. One in four died." The study found 1,821 errors in the first 19 months of mandatory reporting, and 710 deaths.

The number of deaths in 1999 has not been determined. While each hospital analyzes its own cases, the department has not yet analyzed this year's figures for the nation as a whole.

As medical inspector for the Department of Veterans Affairs, Dr. McManus is a sort of watchdog and ombudsman, continually evaluating the quality of care provided to veterans. The department runs the nation's largest health care delivery system, with 172 hospitals, 132 nursing homes and more than 850 outpatient clinics.

Dr. McManus and other health care experts said they believed that the prevalence of errors at veterans hospitals was similar to that at other hospitals. "I don't think it's any different from the private sector," Dr. McManus said.

Dr. Dennis S. O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations, which inspects 90 percent of hospitals in the United States, said he knew of no other health care system that collected such data.

"The V.A. is doing the right thing," Dr. O'Leary said.

Dr. Donald M. Berwick, a member of the study panel convened by the National Academy of Sciences, said, "The first sign of a serious endeavor to deal with errors is that the number of reported errors should go way, way up."

The joint commission encourages private hospitals to report "unexpected occurrences" involving death or serious injury to patients, but it does not require such reports. Since January 1995, the commission says, 714 such events have been voluntarily reported. The Department of Veterans Affairs has tallied a much larger number of accidents in just 19 months of mandatory reporting.

The Institute of Medicine, an arm of the National Academy of Sciences, said last month that medical errors killed 44,000 to 98,000 people a year in hospitals alone. More people die from medical mistakes each year than from heart attacks, breast cancer or AIDS, it said. The institute said Congress should require hospitals to report mistakes with state governments, disclosing any medical errors that cause death or serious harm.

The population served by veterans hospitals is, on the average, somewhat older than the population served by community hospitals, and men account for a larger share of the patients. Experts who served on the academy's study panel said the reporting requirements of the veterans health care system were an example of what they had in mind for hospitals in general.

The academy said the nation could and should reduce medical mistakes by 50 percent over the next five years. But no one knows how many mistakes are now made, so it will be difficult to measure progress toward that goal. The veterans department study suggests that the numbers may be higher than many people have assumed.

"When you seek out problems and errors, you find them much more frequently," Dr. Kizer said. "But no one really believes that errors happen more frequently at V.A. hospitals. We must uncover and define the full extent of the problem before we see progress."

Of the 2,032 "adverse events" analyzed by the Department of Veterans Affairs, 171 were medication errors, in which patients received the wrong drug or the wrong dosage of a drug or the wrong medication. Patients died in 22 of these cases.

Dr. McManus, the medical inspector, said he believed such drug errors were "greatly underreported."

The veterans agency defines "adverse events" as untoward incidents, illnesses or injuries caused by treatments or directly associated with care provided by the department.

Hospitals varied greatly in the number of errors they reported. Dr. McManus's report did not analyze the reasons for the wide variation.

Veterans hospitals in the New York City area reported the smallest number of errors (37), even though this is the second largest district of the veterans health care system, after Southern California. The New York City hospitals reported 2.3 "adverse events" for every 10,000 veter-
A healthy accounting
Veterans Affairs shows what can be done

Last month, a distinguished panel of experts recommended mandatory reporting of medical mistakes in an effort to reduce the estimated 50,000 to 100,000 deaths that result from such errors annually.

No one argued with the findings or the recommendations, but many doctors and hospital officials noted that in the existing atmosphere, such change would be hard to implement. Just a few weeks later, however, came a report from the Department of Veterans Affairs, which runs the nation's largest health-care delivery system, demonstrating that mandatory reporting can be accomplished.

Under the leadership of Dr. Kenneth Kizer, serving as undersecretary of the department from October 1994 to June 1999, employees at the 172 VA hospitals, 132 nursing homes and more than 650 outpatient clinics were required to report errors that resulted in serious problems or death.

Veterans Affairs has nationwide data for less than two years, but already the numbers are staggering — 3,000 medical mistakes that caused more than 700 deaths. The mistakes included prescribing or dispensing the wrong drugs, failed medical equipment, problems with blood transfusions and surgery on the wrong body part or on the wrong patient. Reported errors also included abuse, falls and suicides that may have been preventable with treatment for depression.

It is not likely that the VA hospitals are unique in the size and scope of mistakes that people make, and the numbers give some indication of what to expect if hospitals and doctors across the country begin reporting such problems.

The Veterans Affairs experience indicates that it can be done, despite defensive doctors and fears of liability. That is the necessary first step as recommended by the Institute of Medicine. Through dissemination and analysis of the information, systems can be improved to make sure the mistakes are not repeated.

The federal government under President Clinton quickly embraced the report and promised action as the largest purchaser of health care. Now private insurers and other big purchasers of health care also are getting in on the act. Executives of the nation's biggest companies have organized The Leapfrog Group to urge employers to make medical error reduction a top priority. They hope to do that by providing information to workers about which hospitals do the best job and steering employees to those hospitals. Pittsburgh's Working Together Consortium Health Care Initiative had already identified preventing medical error as a priority even before the federal report.

Given the breadth of the problem, with mortality figures that surpass deaths caused by breast cancer and car accidents and AIDS, there is no doubt that the effort is worthwhile.

And with the current focus on patients' rights and how to improve both the quality and cost effectiveness of health care, the time seems to be right. Thanks to the trailblazing of the VA, perhaps the momentum for real change exists as well.
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| 12. Maintain focus on the vision, strategic plan and long-term view | ➢ Scarcity of measures with which to gauge progress  
➢ The real world, day-to-day exigencies and distractions |
Achieving requisite improvements in patient safety requires doing many things well, but above all else it requires changing the culture of healthcare, which requires strong and determined healthcare leadership.
QUESTIONS ?