American Hospital Association
Physician Leadership Forum
July 19, 2011

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Dean
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http://jefferson.edu/population_health/  david.nash@jefferson.edu
http://nashhealthpolicy.blogspot.com/
Tobacco Smoke Enema (1750s-1810s)
The tobacco enema was used to infuse tobacco smoke into a patient's rectum for various medical purposes, primarily the resuscitation of drowning victims. A rectal tube inserted into the anus was connected to a fumigator and bellows that forced the smoke towards the rectum. The warmth of the smoke was thought to promote respiration, but doubts about the credibility of tobacco enemas led to the popular phrase "blow smoke up one's ass."

This Old Tool has been reintroduced in Washington D.C. by the New Administration. Are you starting to feel it
Health IT

Changes Coming

President Obama signed the health care reform bill in March, but its effect on information technology is just starting to unfold. Here's what you need to know. Page 18

iPhone sparks smartphone innovation pg. 25
FUTURE PRACTICE ALTERNATIVES IN MEDICINE
DAVID B. NASH, M.D.

IGAKU-SHOIN New York · Tokyo
REVIVE OUR BROKEN HEALTHCARE SYSTEM

Sanjayka Kumar, M.D., M.P.H.
David B. Nash, M.D., M.B.A.

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Sanjayka Kumar, MD, M.P.H., is a President (CEO) of the Health Management Group, Inc., and is a consultant and speaker in the area of healthcare management and policy. She has been featured in the media and on television at the local, state, and national levels.

David B. Nash, M.D., M.B.A.
David B. Nash, M.D., M.B.A., is the President and Chief Executive Officer of the American Medical Association (AMA), and a leading health policy expert. He has been recognized for his leadership in the development of innovative healthcare policies and programs.
“The institutionalization of leadership training is one of the key attributes of good leadership.”

John P. Kotter, Harvard Business School
... all hospitals are accountable to the public for their degree of success... If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am. College of Surgery
Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work
BY JOHN CAREY (P. 72)
Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition

- Breast Cancer: 75.7%
- Low Back Pain: 68.5%
- CAD: 68.0%
- CHF: 63.9%
- COPD: 58.0%
- Diabetes: 45.4%
- CAP: 39.0%
- Atrial Fibrillation: 24.7%
- Hip Fracture: 22.8%

Average: 54.9%

Number of Indicators: 9, 6, 37, 36, 20, 13, 5, 10, 9

Institute of Medicine’s Definition of Quality

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”
Half of what doctors know is wrong.

Can prevention kill you?
Is it ever O.K. for a doctor to refuse to treat a patient?
Are nurses expendable?
Should the results of an insidious experiment be ignored?
Are men the stronger sex?
What’s really responsible for the malpractice morass?
Can old-fashioned treatments still work?
Today’s debate: Medical errors

Why do so many still die needlessly in hospitals?

Our view:
Part-voluntary, part-mandatory reporting system can reduce deaths.

When a report came out last week from a private group claiming that nearly 200,000 hospital patients die each year from preventable medical errors, it promptly sparked a fierce controversy. The estimate was double the number found in a landmark study in 1999 by the Institute of Medicine (IOM), a federal advisory group, and the lead author of that earlier study went on the offensive. He charged that the new report used flawed research methods that inflated the fatalities. But why argue? The difference alone makes a more telling point: Five years after the IOM report drew front-page headlines and widespread outrage, there still is not even a sure way to measure the problem. And that appalling fact should concern any prospective hospital patient — which is to say, everyone.

This year, Congress is finally doing something, though hardly enough. Before the end of the year, it is expected to install new incentives for medical personnel to report errors. The new system, already approved by both houses, would allow doctors, nurses and other hospital workers to report mistakes anonymously. Independent analysts would then look for patterns and recommend changes. Lawyers and employers would be kept in the dark.

That’s an important step.

Suppose, for instance, that a nurse gives a patient the wrong pill because its name and packaging resemble a drug next to it on the hospital’s pharmacy shelf. Neither she nor the pharmacist will want to reveal the error, for fear of being punished or sued. The error likely will recur.

But if they can confidentially report the problem, experts can devise ways to improve the packaging and placement of medicines to reduce the risk of simple human error. Lives will be saved.

Six states that have set up similar procedures have seen a significant increase in reported mistakes. That’s clearly the right way to handle relatively minor mistakes, even when they result in some harm.

Even so, the picture will still be woefully incomplete — and patients will remain at risk — unless the reporting of errors that kill or cause the most serious injuries is made mandatory. Only 22 states currently have mandatory error-reporting systems. The others rely on hospital-industry watchdogs or malpractice lawyers to be on the lookout for mistakes. The argument over numbers is proof that leaving the solution to the courts is not a prescription for eliminating deadly errors.

Five years ago, the IOM recommended a two-tiered approach, part voluntary, part mandatory. It is still the most sensible compromise.

The question is why five years have elapsed with so little being done. With tens of thousands dying needlessly every year, the next life at risk may be your own.
WHAT DOCTORS HATE ABOUT HOSPITALS

An insider’s view of what can go wrong—and how you can improve your odds of getting the right treatment

BY NANCY GIBBS & AMANDA BOWER
CROSSING THE QUALITY CHASM

A New Health System for the 21st Century
Safe: avoiding injuries to patients from the care that is intended to help them.

Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely: reducing waits and sometimes harmful delays for both those who receive and those who give care.

Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.
Health Affairs

Still Crossing The Quality Chasm

The Ongoing Quality Improvement Journey

Making The Trade-Off With Costs

Two Perspectives On The Costs Of Medical Errors

Adverse Events: Ten Times More Of Them Than We Thought?

Our War On Central-Line Infections: A Model For Quality Improvement

Preventing Deaths At Ascension Health

Assessing The Premier Pay-For-Performance Experiment

PLUS:
Quality In The Public Health System

Jefferson. School of Population Health
Ten Commandments Cross the Quality Chasm

Current Rules
1. Care is based primarily on visits
2. Professional autonomy drives variability
3. Professionals control care
4. Information is a record
5. Decision making is based on training and experience

New Rules
1. Care is based on continuous healing relationships
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge is shared freely
5. Decision making is evidence-based

Don Berwick 2002
## Ten Commandments (cont.d)

<table>
<thead>
<tr>
<th>Current Rules</th>
<th>New Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. “Do no harm” is an individual responsibility</td>
<td>6. Safety is a system property</td>
</tr>
<tr>
<td>7. Secrecy is necessary</td>
<td>7. Transparency is necessary</td>
</tr>
<tr>
<td>8. The system reacts to needs</td>
<td>8. Needs are anticipated</td>
</tr>
<tr>
<td>9. Cost reduction is sought</td>
<td>9. Waste is continuously decreased</td>
</tr>
<tr>
<td>10. Preference is given to professional roles over</td>
<td>10. Cooperation among clinicians is a priority</td>
</tr>
<tr>
<td>the system</td>
<td></td>
</tr>
</tbody>
</table>

*Don Berwick 2002*
“Please listen carefully as our menu makes no sense.”
Health Reform Builds on the Current Quality Infrastructure

Improved Quality of Care & Lower Overall Costs

- National Quality Improvement Strategy
- Quality Measure Development
- Value-Based Purchasing
- Prevention and Wellness
- New Entities and Authorities
The Four Underlying Concepts of Cost Containment Through Payment Reform

<table>
<thead>
<tr>
<th>Tying payment to <strong>evidence and outcomes</strong> rather than per unit of service</th>
<th>“<strong>Bundling</strong>” payments for physician and hospital services by episode or condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement for the <strong>coordination of care</strong> in a medical home</td>
<td><strong>Accountability for results</strong> - patient management across care settings</td>
</tr>
</tbody>
</table>
Range of Models in Existence or Development

- **Current State:** Payments for Reporting
  - Incremental FFS payments for value
- **Bundled payments for acute episode**
- **Bundled payments for chronic care/disease carve-outs**
- **Accountability for Population Health**

Increasing assumed risk by provider

Increasing coordination/integration required

P4P, “Never” Events
<table>
<thead>
<tr>
<th><strong>Usual Care</strong></th>
<th><strong>Medical Home</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relies on the clinician</td>
<td>Relies on the team</td>
</tr>
<tr>
<td>Care provided to those who come in</td>
<td>Care provided for all</td>
</tr>
<tr>
<td>Performance is assumed</td>
<td>Performance is measured</td>
</tr>
<tr>
<td>Innovation is infrequent</td>
<td>Innovation occurs regularly</td>
</tr>
<tr>
<td>Includes only primary care</td>
<td>Includes mental health, PharmD’s and others</td>
</tr>
<tr>
<td>Navigation and care</td>
<td>Navigation and care</td>
</tr>
<tr>
<td>Management not available</td>
<td>Management are required</td>
</tr>
<tr>
<td>H.I.T. may or may not support care</td>
<td>H.I.T. must support care</td>
</tr>
</tbody>
</table>
Range of Models in Existence or Development

- Current State: Payments for Reporting
- Incremental FFS payments for value
- Bundled payments for acute episode
- Bundled payments for chronic care/disease carve-outs
- Accountability for Population Health

Accountable Care Organizations
Accountable Care Organizations

Key distinguishing characteristics:

1. Medicare patients
2. Provider driven
3. Includes specialists
4. No new $ - shared savings
What did we learn from the Physician Group Practice (PGP) demonstration?

1. An integrated organization
2. Expending resources on improving quality
3. Limiting unnecessary services
4. Dedicated physician leadership
5. Central role of Health I.T.
6. Manage population health
The “Triple Aim” under CMS

1. Better care for individuals
2. Better health for populations
3. Slower growth in costs through improvements in care
Driving Population Health Through Accountable Care Organizations

ABSTRACT Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients’ satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today’s health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.

Susan DeVore (susan.devore@premierinc.com) is president and chief executive officer of the Premier healthcare alliance, in Charlotte, North Carolina.

R. Wesley Champion is a senior vice president at Premier Consulting Solutions, in Charlotte.
The Tipping Point
How Little Things Can Make a Big Difference
Malcolm Gladwell
Ernest A. Codman, M.D.
Boston, Massachusetts
1869-1940
The President, Executive Board, Members and Friends of The International Society for Quality in Health Care and the Editors of the Society’s Journal, honour the distinguished life and acclaimed contributions of Avedis Donabedian, primary architect of the field of quality in health care and a life Member of ISQua, who died peacefully at his home in Ann Arbor, Michigan, USA on 9 November 2000.
IF HEALTH CARE IS GOING TO CHANGE, HIS IDEAS WILL CHANGE IT

DR. BRENT JAMES WILL MAKE IT BETTER

BY DAVID LEONHARDT
<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
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<tbody>
<tr>
<td>We don’t have time</td>
<td>We don’t have time not to</td>
</tr>
<tr>
<td>Quality costs money</td>
<td>Quality saves money</td>
</tr>
<tr>
<td>Use intuition and anecdote</td>
<td>Collect and analyze data</td>
</tr>
<tr>
<td>Defects come from people</td>
<td>Defects come from defective processes</td>
</tr>
</tbody>
</table>
Physicians as Leaders

Reinersten JL. Annals Internal Medicine

1. From star athlete to player – coach
2. Leaders change things
   ~ hazardous duty
3. Leadership is not victim hood
4. Leaders define reality
   ~ use of data
Physicians as Leaders

5. Leaders develop and test changes
6. Leadership takes courage
   ~ risk taking
7. Leaders persuade
8. Leaders are not daunted by the loudest negative voice
9. Leaders do much of their work outside of their immediate area of responsibility
Tools for Physician Leaders

1. Treatment standards and protocols
2. Leapfrog criteria
3. Hospitalist programs
4. Technology- CPOE, ambulatory EMR
5. Practice Profiling
6. Safety culture engineering
7. External benchmarking
How to Build Measurement into Practices

• Seek usefulness, not perfection in the measurement
• Use a balanced set of measures
• Keep measurement simple
• Use qualitative and quantitative data
• Write down operational measures
• Measure small samples
• Build measurement into daily work
• Develop a measurement team
A need for unified governance

**No American Quality Improvement Community**

- **Develop Performance Measures**
  - NCQA
  - AQA, HQA
  - CAHPS

- **Certify Performance Measures**
  - NQF

- **Implement Performance Measures**
  - JCAHO
  - CMS Plans

Multiple Public and Private Sector Stakeholders
100+ different P4P Programs

Source: Tooker/ACP
<table>
<thead>
<tr>
<th>Objective</th>
<th>Sub-Objective</th>
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<tbody>
<tr>
<td>No harm from care</td>
<td>Procedural competence, experience, medical knowledge, evidence-based medicine</td>
</tr>
<tr>
<td>No errors</td>
<td>Anatomy, physiology, pathology, etc., systems engineering, information systems, cognitive psychology</td>
</tr>
<tr>
<td>No delays in acute care</td>
<td>Pathology, process mapping, team function, information systems, procedural competence</td>
</tr>
<tr>
<td>Access chronic care</td>
<td>Information systems, communications</td>
</tr>
<tr>
<td>Ongoing preventive care</td>
<td>Epidemiology, surveillance</td>
</tr>
<tr>
<td>Curative of acute illness</td>
<td>Basic science, vocabulary, key concepts integrated around biologic homeostasis, pathology, resilience, evidence-based medicine</td>
</tr>
<tr>
<td>Cost-benefit analysis</td>
<td>Epidemiology, economics, statistics</td>
</tr>
<tr>
<td>Reduction of waste</td>
<td>Process engineering</td>
</tr>
<tr>
<td>Justice</td>
<td>Philosophy, public health, business, sociology</td>
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<tr>
<td>Cultural beliefs</td>
<td>Anthropology</td>
</tr>
<tr>
<td>Ethical values</td>
<td>Philosophy, religion</td>
</tr>
<tr>
<td>Communications</td>
<td>Psychology, Spanish language skills, humanities</td>
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<thead>
<tr>
<th>Dimension</th>
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<tbody>
<tr>
<td>Safe</td>
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<tr>
<td>Timely</td>
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<td>Effective</td>
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<td>Efficient</td>
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<td>Equitable</td>
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<td>Patient-Centered</td>
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**Objectives of Quality Medical Care**

Figure 1 Attributes of the Institute of Medicine quality objectives with related curriculum areas.
Evolution and Convergence of Physician Performance Measurement, CME, EBM and Maintenance of Certification
Continuing Medical Education (CME) and Continuous Physician Professional Development (CPPD): Evolution and Change

CME
- Intermittent
- Classroom lectures
- Face-to-face
- Content unrelated to practice
- Medical science only
- Focused on individuals
- (General) needs assessment
- Evaluation of knowledge

CPPD
- Continuous
- Self learning
- Web based
- Integrated into work-flow
- Also management; finances
- Also focused on team
- Performance based
- Change in performance; ROI
Convergence of Various Tools

- Physician Performance Measurement
- Continuing Medical Education
- Evidence Based Medicine
- Maintenance of Certification

CME Credits
Changing The Culture In Medical Education To Teach Patient Safety

By Darrell G. Kirch and Philip G. Bovbjerg

Darrell G. Kirch is president and chief executive officer of the Association of American Medical Colleges in Washington, D.C.

Philip G. Bovbjerg is executive associate dean of graduate medical education and a professor of anesthesiology and medicine at the School of Medicine, University of North Carolina at Chapel Hill.

ABSTRACT In 1999 a seminal Institute of Medicine report estimated that preventable medical errors accounted for 44,000–98,000 patient deaths annually in U.S. hospitals. In response to this problem, the nation’s medical schools, teaching hospitals, and health systems recognized that achieving greater patient safety requires more than a brief course in an already crowded medical school curriculum. It requires a fundamental culture change across all phases of medical education. This includes graduate medical education, which is already teaching the next generation of physicians to approach patient safety in a new way. In this paper the authors explore five factors critical to transforming the culture for patient safety and reflect on one real-world example at the University of North Carolina School of Medicine.

When a report on medical errors comes out, the response often is the question: “Why aren’t they teaching this in medical school?” As noted by the Institute of Medicine (IOM) a decade ago in To Err Is Human, one’s first reaction to a medical error is to blame someone. The report noted, however, that blame may be misplaced, because the conditions of the current health care delivery system can contribute to errors. Therefore, the IOM stated, a multilayered approach—one that addresses systems errors as well as human ones—must be taken to prevent medical errors. There is no “magic bullet” to fix this problem. Advancing patient safety requires a fundamental culture change in health care.

Medical education alone cannot accomplish this shift. However, critical elements of the change are evolving in the nation’s teaching hospitals and medical schools—collectively referred to as “academic medicine.” These institutions recognize that although they produce the best clinicians and scientific experts in the world and provide them with a great body of knowledge, today’s challenge lies in getting these experts to work well together in the clinical environment. Both individually and collectively as the academic medicine community, these institutions are changing their overall culture to bring about an environment more conducive to patient safety. They are putting processes in place to ensure that clinicians deliver care in optimal ways and, in doing so, are fostering the learning environment needed for resident physicians to become the central change agents for patient safety.

This paper provides an overview of this cultural change, identifies five factors critical to that change, and offers examples of how those factors are being implemented at the University of North Carolina (UNC) School of Medicine, one of the nation’s academic medical centers. Along with many other academic medical centers, the school is participating in the Agency for Healthcare Research and Quality (AHRQ) patient safety initiative called TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety).

TeamSTEPPS is a set of tools used to assess an institution’s readiness for change. The program offers patient safety training for health care staff
The Doctors Company Foundation
Young Physicians Patient Safety Award

Conferred in partnership with the Lucian Leape Institute at the National Patient Safety Foundation

Share your personal essay on how a patient safety event impacted your learning and growth.

The Doctors Company Foundation — created in 2008 by the largest national insurer of medical liability for physicians, surgeons and other health professionals — provides charitable grants to support patient safety research, forums and pilot programs, patient safety education programs and medical liability research. The Lucian Leape Institute was formed in 2007 to provide a strategic vision for improving patient safety. Composed of national thought leaders with a common interest in patient safety, the Institute functions as a think tank to identify new approaches to improving patient safety.

For the first time, The Doctors Company Foundation in partnership with the Lucian Leape Institute at the National Patient Safety Foundation presents The Doctors Company Foundation Young Physicians Patient Safety Award — an award to recognize young physicians for their deep personal insight into the significance of patient safety work. Individuals are invited to submit essays that will be judged by NPSF. Six winners of this prestigious award will be selected and will receive $5,000 plus registration and travel expenses to the NPSF Annual Congress.

WHO IS ELIGIBLE:
All third-year and fourth-year medical students, and first-year residents who were in a hospital setting as of June 2010 or later.

WHAT IS REQUIRED:
Submit an essay (500-1,000 words) explaining your most instructional patient safety event, one that resulted in a personal transformation. Go to www.npsf.org/npsfac/youngphys-11.php to complete the online form. The award will be presented at the NPSF Annual Congress, May 25-27, in National Harbor, MD (Washington, D.C).

WHEN IS THE DEADLINE:
Essays are due by 5:00pm ET, Monday, February 28, 2011. No phone or mailed submissions will be accepted.

WHERE DO I LEARN MORE:
Contact Sara Reardon at sneardon@npsf.org or go to www.npsf.org/npsfac/youngphys-11.php
Report to Congress

National Strategy for Quality Improvement in Health Care

March 2011
What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income
How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care
What are the major hurdles?

1. Replace pernicious piecework payment system
2. Re-align incentives
3. Create rewards for collaboration, coordination and conservative practice
4. Recognize the cultural barriers
Nash’s Immutable Rule

High quality care costs less!