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American Hospital Association Physician Leadership Forum July 19, 2011

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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


HealthData
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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


INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING
The Economist
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Evolution and depression
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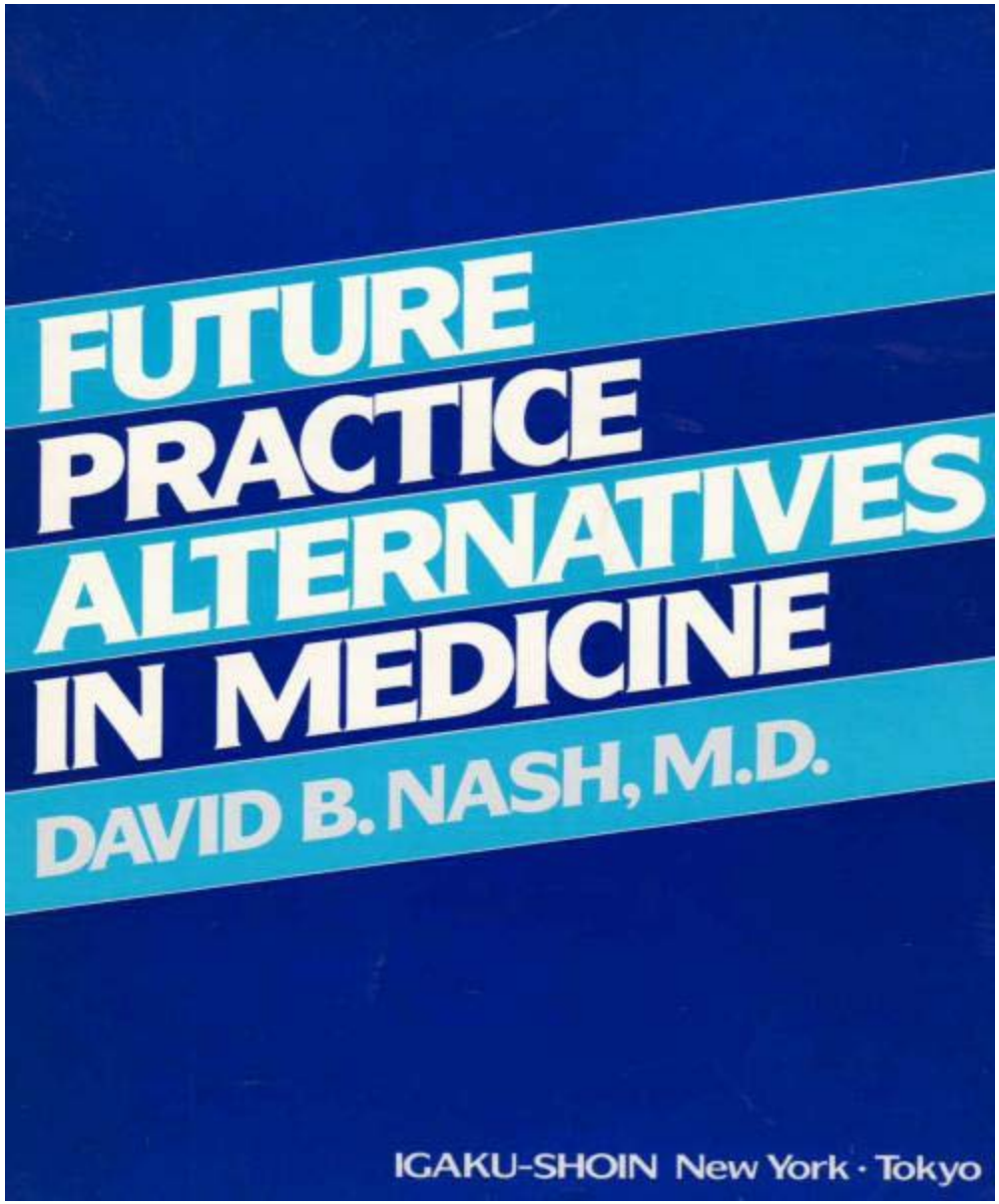
Economist.com
Reforming health care
This is going to hurt
US$6.99 • C$7.99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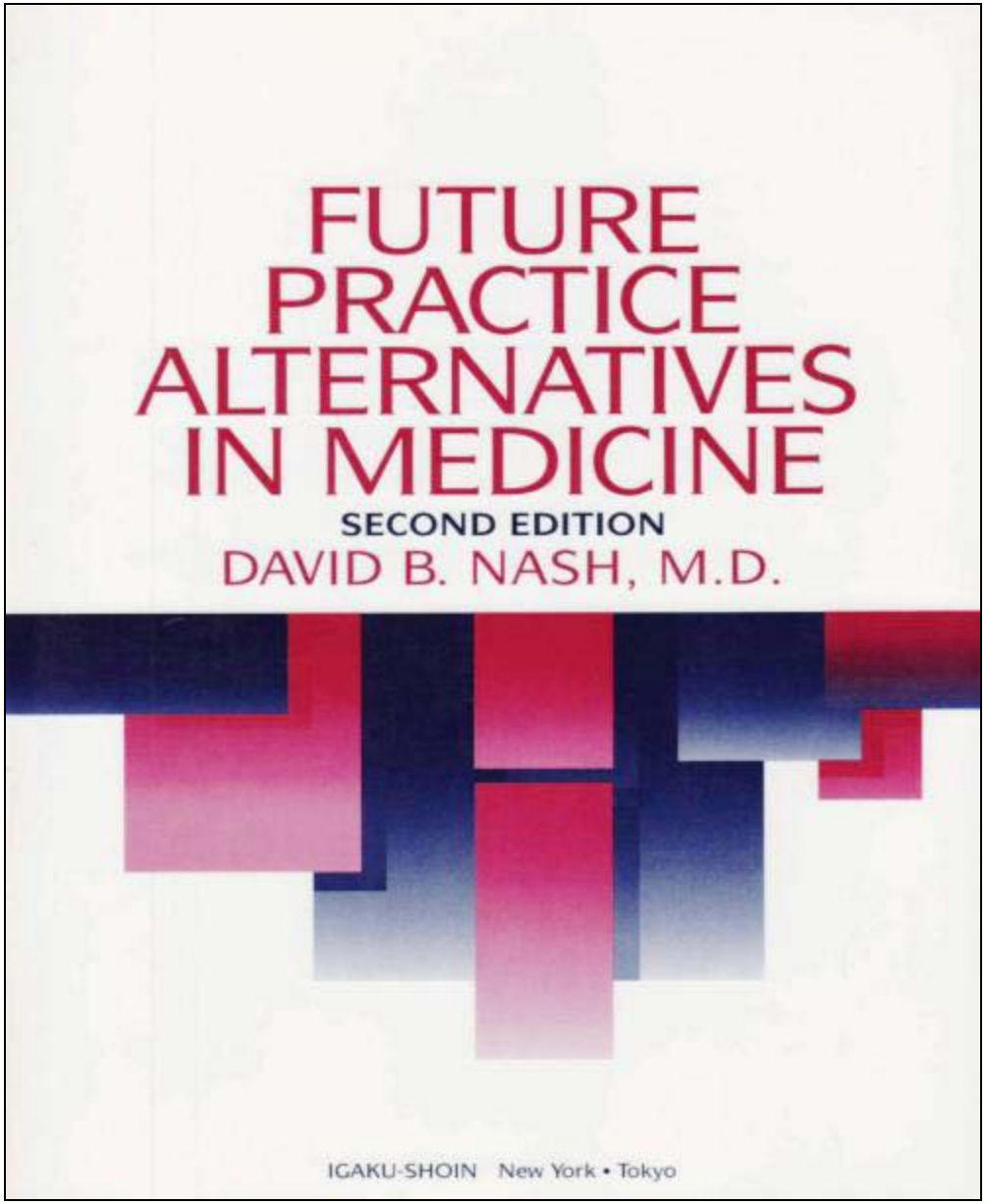
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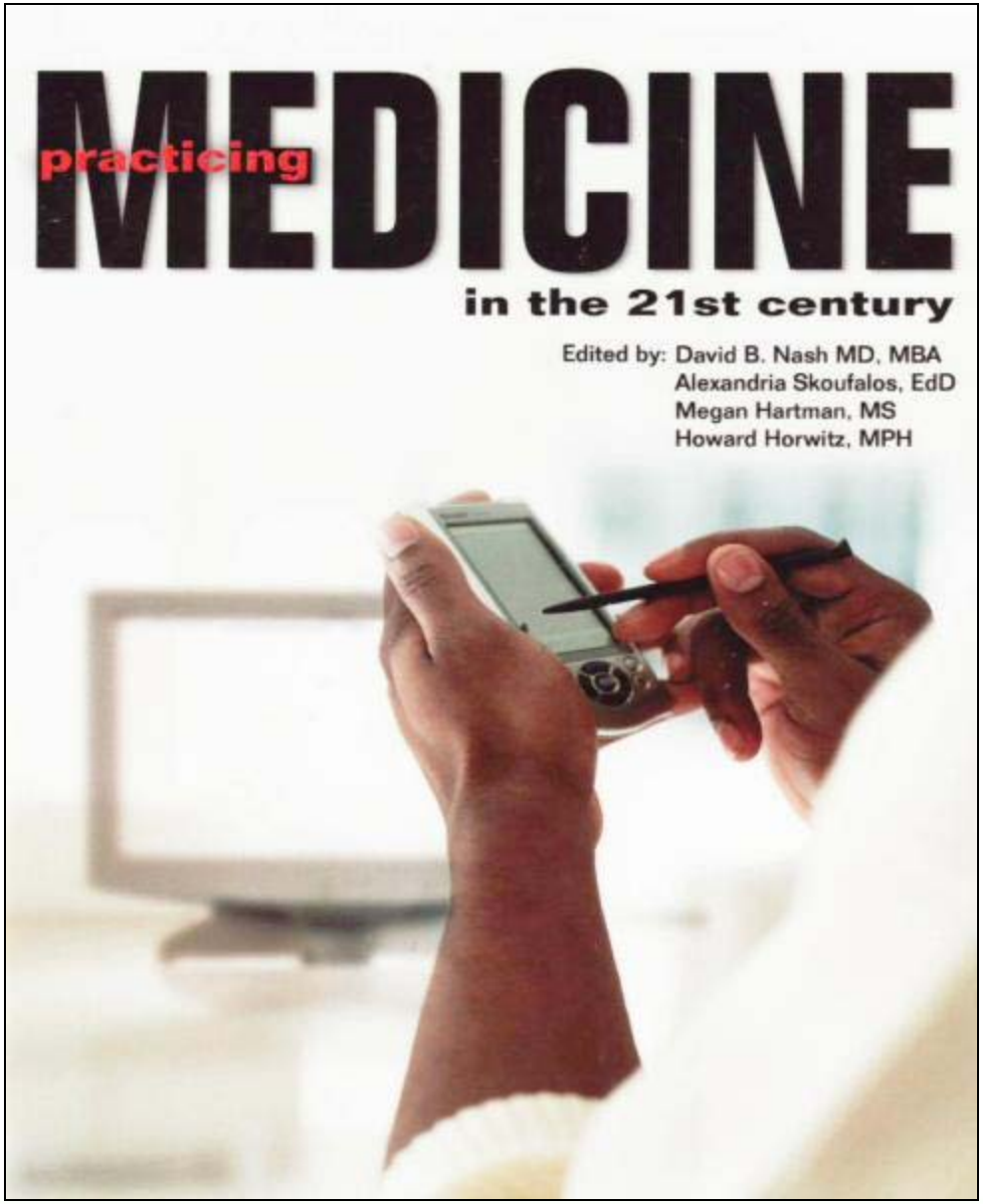
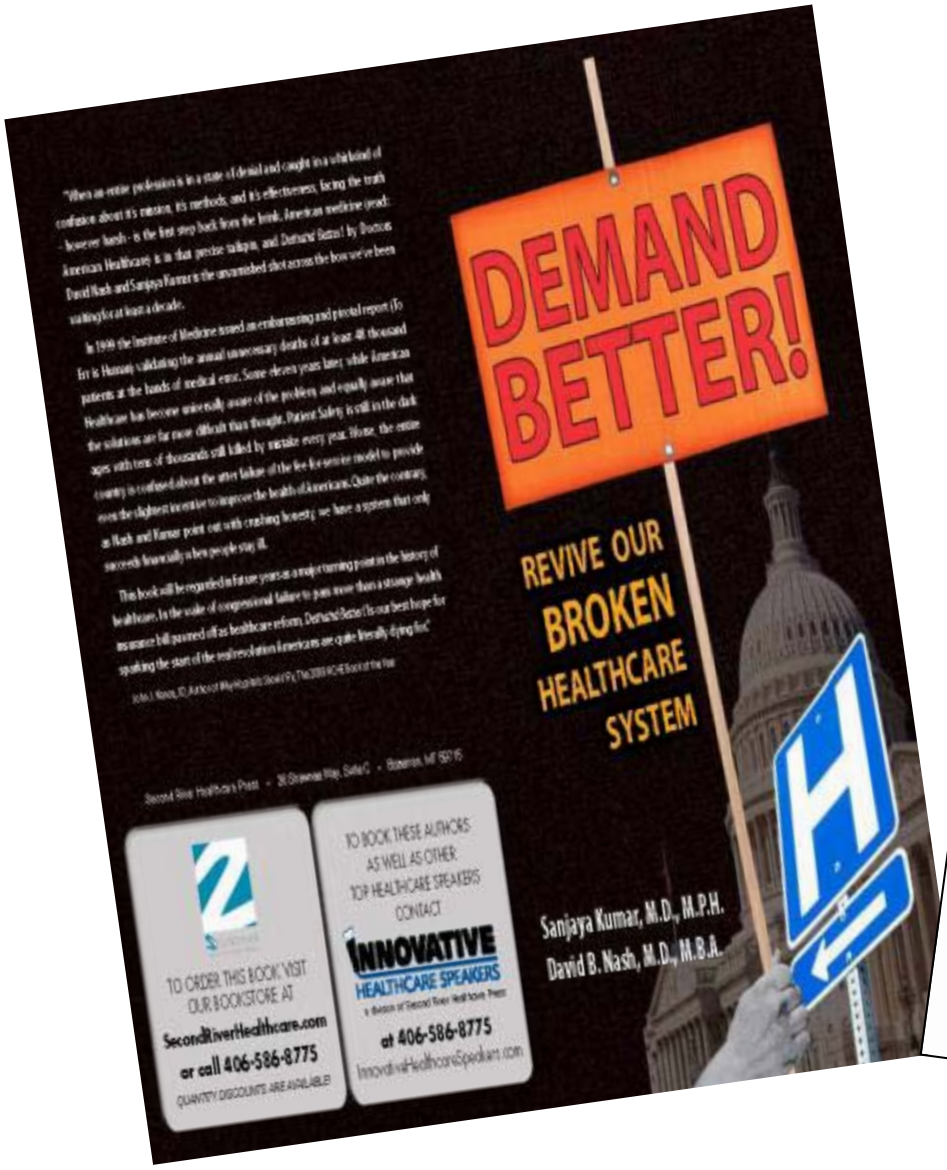

practicing
MEDICINE
in the 21st century
Edited by: David B. Nash MD, MBA
Alexandria Skoufalos, EdD
Megan Hartman, MS
Howard Horwitz, MPH



DEMAND BETTER!

REVIVE OUR BROKEN HEALTHCARE SYSTEM

Much of the healthcare debate is centered on cost – the skyrocketing cost of direct patient care, the cost to insure millions of currently uninsured people, the administrative costs that eat up a large chunk of every healthcare dollar, the cost of defensive medicine to avert malpractice lawsuits. The core driver of the cost problem, however, is a set of largely unchallenged beliefs about the safety and efficacy of our healthcare system. How can it be that we spend more than $2700 billion each year on medical care that fails to improve patients' health and often harms them?

The problems are cultural. We collaborate in a collective mythology about American healthcare. We "know," for example, that modern medicine is largely backed up by solid science. We boast that our delivery system is superior because we offer access to more and newer services than any other country. We've focused a great deal on safety improvement over the past decade and we trust that our healthcare will rarely harm patients. Our physicians and hospitals are poised to deliver the right care that is expertly coordinated. Our medical schools set the envy of the world and offer the very best training of future physicians. All of this we know.

There is no easy fix to these problems, of course. But there is a best place to look first: on quality. This is a book about debunking healthcare myths through the lens of quality: what it is and is not, why it is lacking, too much of our present system and how to reclaim it. Poor healthcare quality derives from uncertainty in clinical decision-making, from pressure on unexplained variation in physician practice patterns, from still inadequate accountability for quality and patient safety, from payment for piecework and from medical training curriculum that is decades behind the curve. Reclaiming quality by addressing each of these deficiencies will transform the economics of our healthcare system. Greater safety, effectiveness and efficiency is possible.

This is not a utopian critique. It is based on a quality revolution that is already underway and is gradually transforming the way medical care is delivered in the US. It didn't need mandates from politicians, although it will need their support to achieve fruition.

This is a pivotal moment in American healthcare delivery marked by tremendous innovation and accelerating improvements in quality and safety. Much of that innovation is aimed directly at "busting" our counterproductive myths on several fronts: improving physician decision-making, building a better research base to compare the effectiveness of different treatments for the same medical condition, devising accountability mechanisms that work, piloting second-generation pay-for-performance models, paying greater attention to quality improvement in medical training curriculum and expanding access to quality care in non-traditional venues.

A quality and safety revolution in healthcare delivery has begun. Physicians have various tools to help them make better decisions. Hospital and physician report cards are multiplying although they need to be redesigned to leverage the power of transparency. Comparative effectiveness research is in its infancy in the US, but has been jumpstarted by recent stimulus funding and agenda-setting. Pay-for-performance initiatives continue to evolve, but they need to be supplemented with bundled payments serving physicians and hospitals to reverse perverse incentives of the fee-for-service system, to minimize errors and waste and to drive superior outcomes. Today's physicians need medical training that teaches them how to close the quality feedback loop and practice collaborative, patient-centered care.

Even the reader who thinks he or she knows all about some of the topics in this book will appreciate the manner in which DEMAND BETTER! integrates these topics into a cohesive appraisal of our problems and cutting-edge solutions that are of great interest to them. DEMAND BETTER! synthesizes for the healthcare executive the many trends, initiatives, reports, organizations and policies that look beyond our healthcare myths and stand on the front lines of the quality and safety revolution.

About the Authors

Sanjaya Kumar, M.D., M.P.H.

Sanjaya Kumar, MD, MPH, is President, CEO and Chief Medical Officer of Quantros, Inc., a leader in web-based healthcare quality, data management and patient safety applications. Quantros products are used in one out of every three U.S. hospitals.

Dr. Kumar is a driver by an agenda aimed at improving the quality of care provided to patients by today's evolving healthcare delivery systems. He has been the clinical lead on many cooperative clinical quality improvement projects.

Dr. Kumar serves on numerous quality improvement committees, task forces and working groups, both at the national level and state levels and is a frequent speaker at national healthcare conferences and meetings. Dr. Kumar has been published widely in peer reviewed medical journals and has framed various healthcare industry conferences.

Dr. Kumar authored the book *Fatal Care: Survive in the U.S. Health System* which was published in 2008.

David B. Nash, M.D., M.B.A.

David Nash is the Founding Dean and the Dr. Raymond C. and Doris N. Grandjean Professor of Health Policy at the Jefferson School of Population Health.

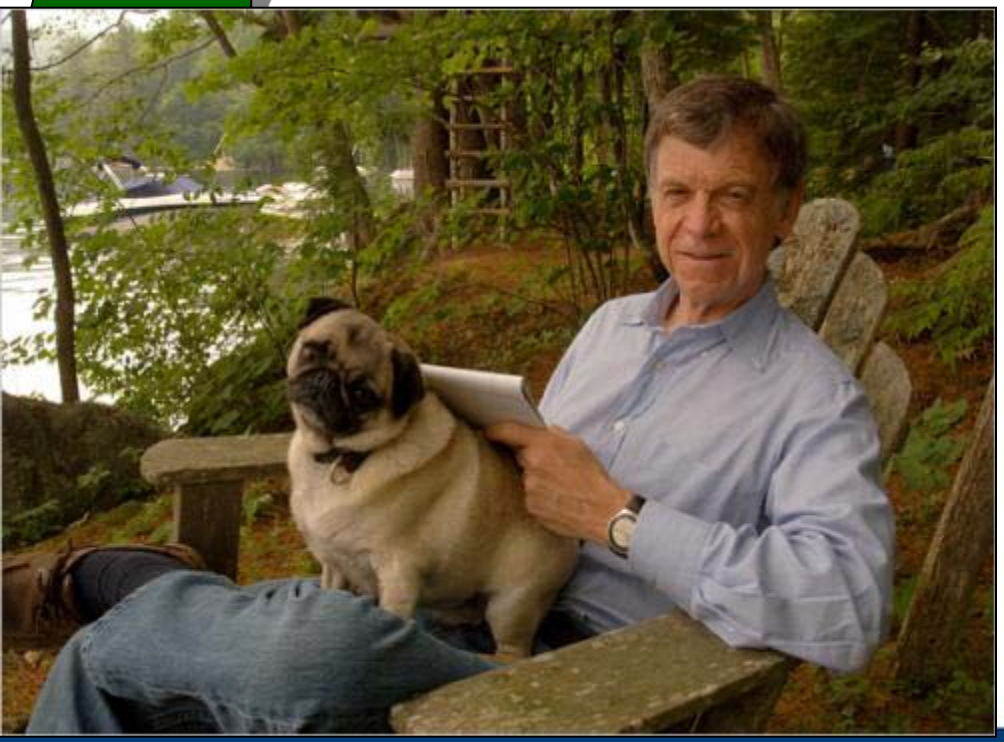
Dr. Nash is a board certified internist who is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement and has been repeatedly named to Modern Healthcare's list of the 100 Most Powerful Persons in Healthcare.

He is a consultant in both the public and private sectors. In December 2009, he was named to the Board of Directors for Humana Inc, one of the largest publicly traded health and supplemental benefits companies. He recently was appointed to the Board of Main Line Health – a four hospital system in suburban Philadelphia, PA. From 1998-2008, he served on the Board of Trustees of Catholic Healthcare Partners, Cincinnati, Ohio where he chaired the Board Committee on Quality and Safety.

Through publications, public appearances, his blog and an online column on *WebMD Today* he reaches more than 100,000 persons every month.

Dr. Nash received his BA in economics (Phi Beta Kappa) from Vassar College, his MD from the University of Rochester School of Medicine and his MBA in Health Administration (with honors) from the Wharton School where he was a former Robert Wood Johnson Foundation Clinical Scholar.

“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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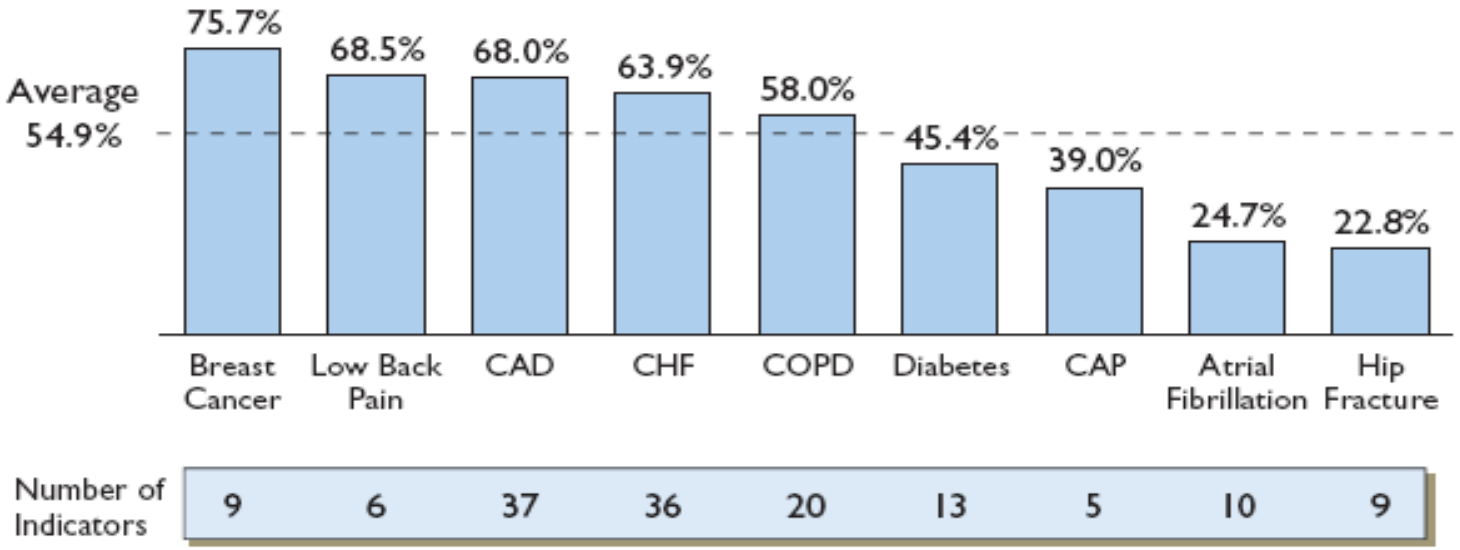
Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition[1]

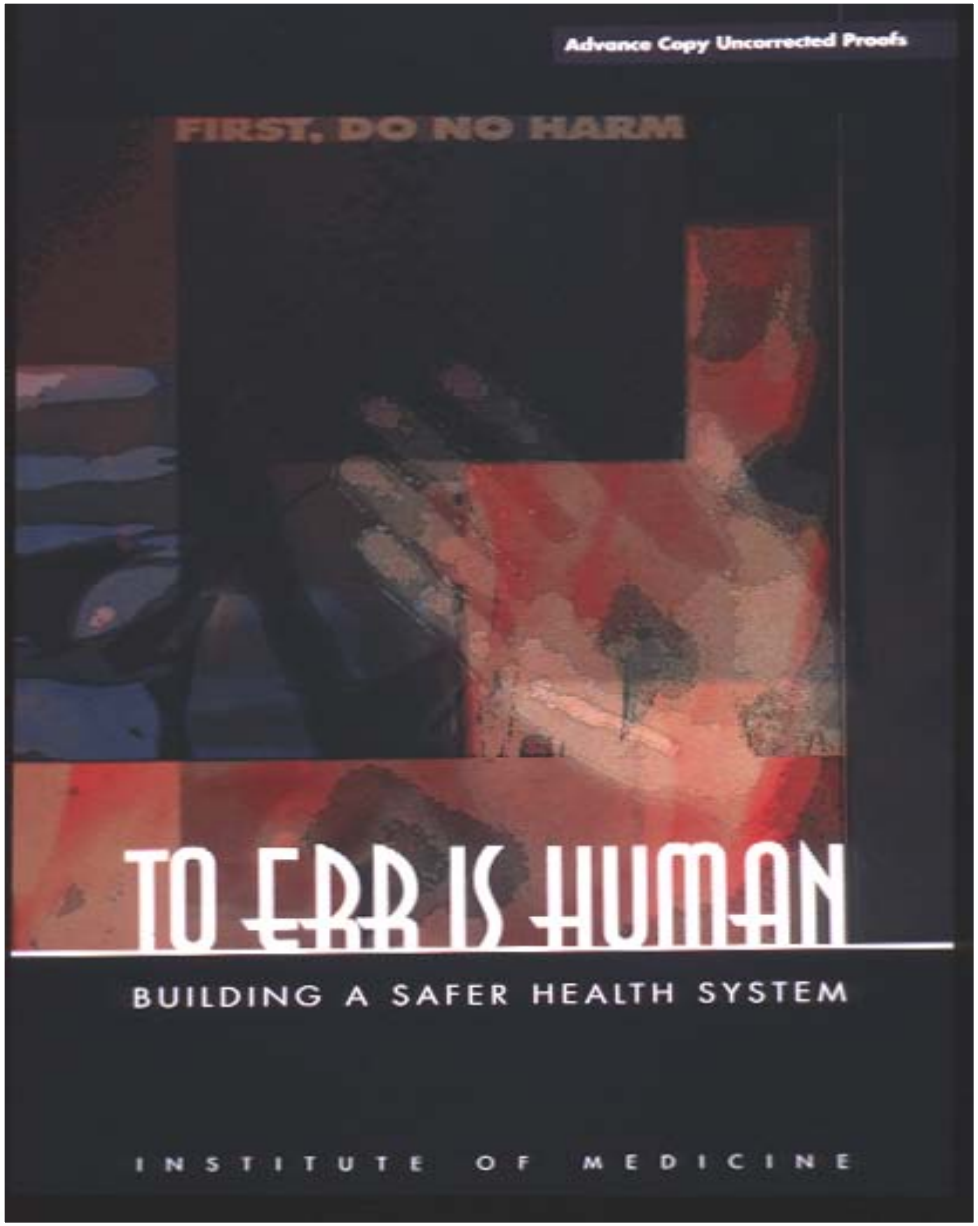


Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*. June 26, 2003: 2635–2645.

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."

Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. March 2001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FIRST, DO NO HARM
TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM
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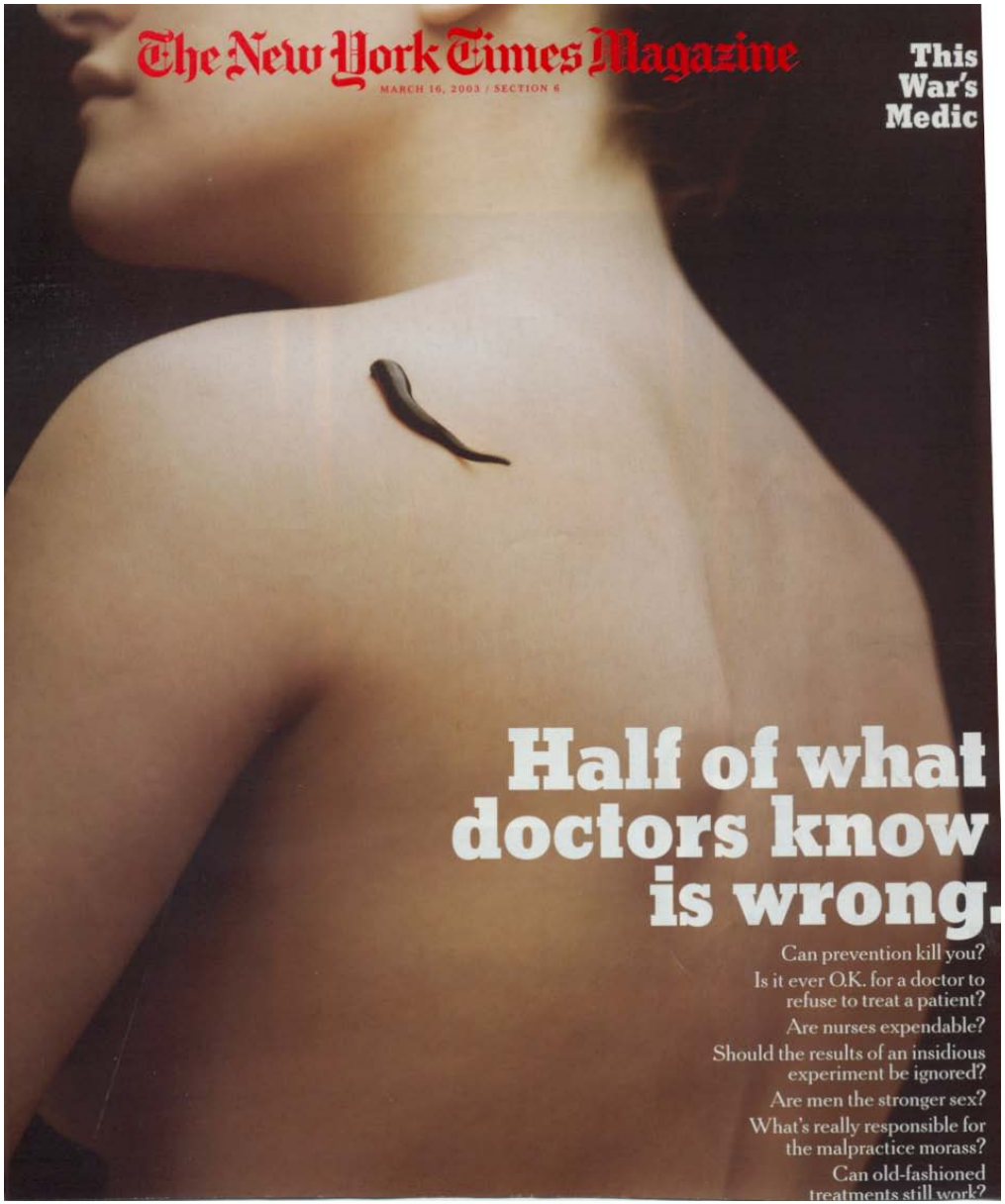
The New York Times Magazine
MARCH 16, 2003 / SECTION 6
This War's Medic
Half of what doctors know is wrong.
Can prevention kill you?
Is it ever O.K. for a doctor to refuse to treat a patient?
Are nurses expendable?
Should the results of an insidious experiment be ignored?
Are men the stronger sex?
What's really responsible for the malpractice morass?
Can old-fashioned treatments still work?

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—Allen H. Neuharth, Founder, Sept. 15, 1982

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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.

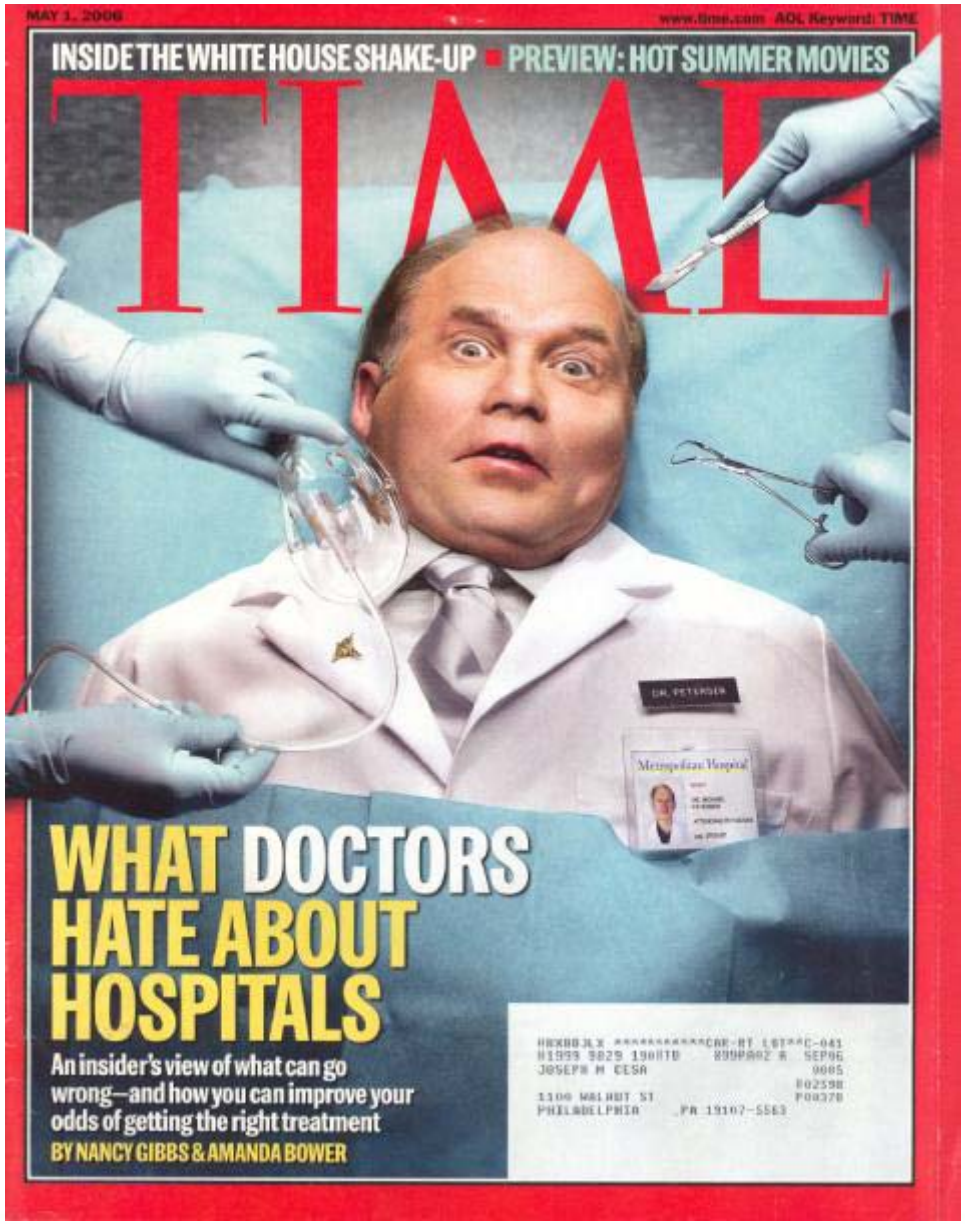
The question is why five years have elapsed with so little being done. With tens of thousands dying needlessly every year, the next life at risk may be your own.

Mistakes cost lives

Highlights from a new study of medical errors involving Medicare patients hospitalized from 2000 through 2002:

- Out of 37 million hospitalizations, 1.14 million "safety incidents" occurred.
- 263,864 deaths were directly attributed to the incidents.
- The safety incidents accounted for $8.54 billion in additional Medicare costs.
- Nearly 60% of safety incidents involved the failure to diagnose and treat conditions that developed in the hospital, bedsores and post-operative infections.

Source: HealthGrades' "Patient Safety in American Hospitals" study released July 27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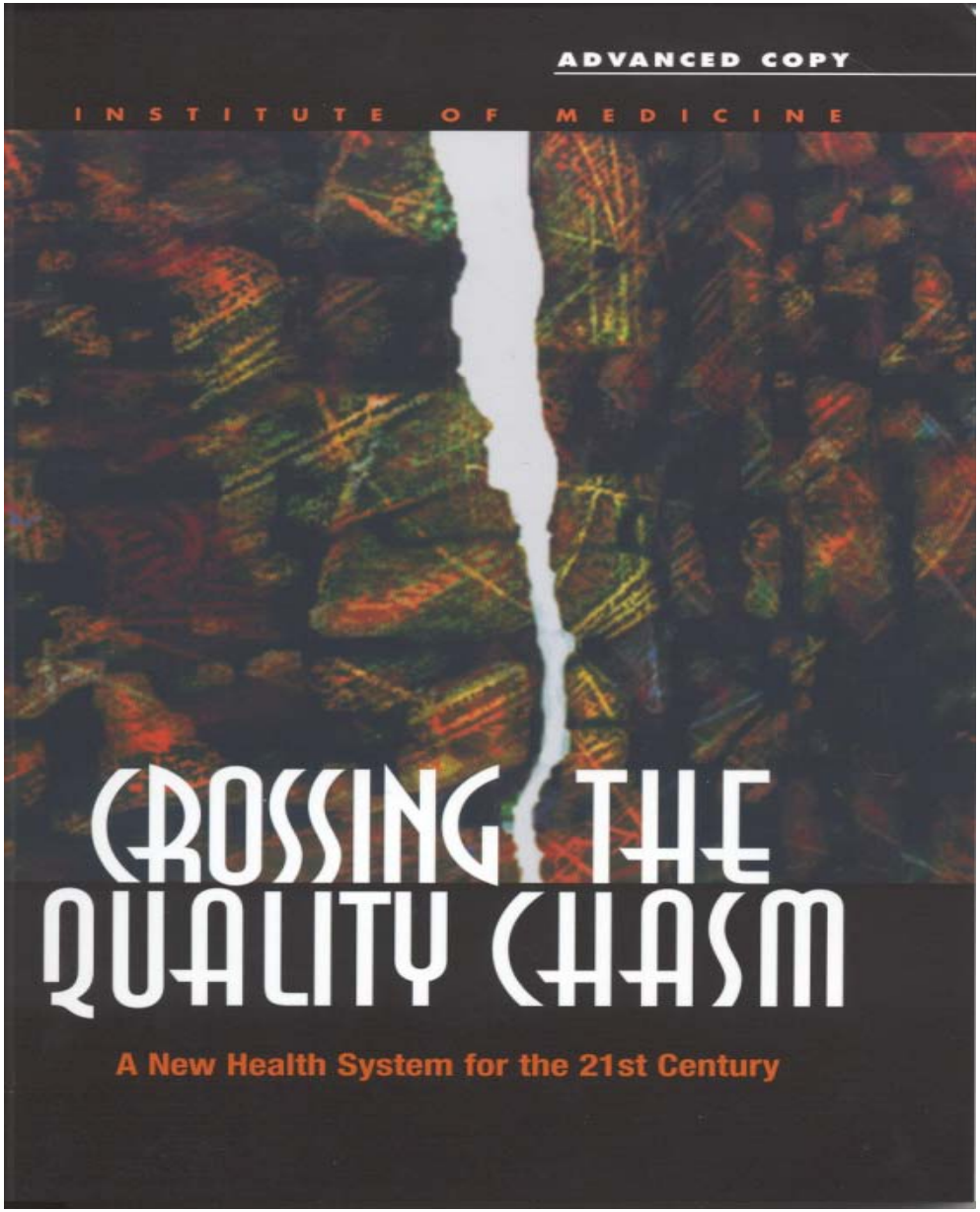
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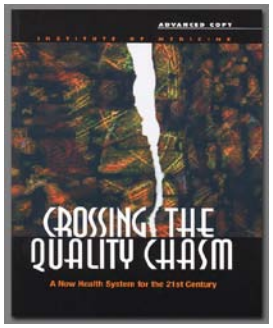
CROSSING THE QUALITY CHASM
A New Health System for the 21st Century

Institute of Medicine Report 2001



Key Dimensions of the Quality Healthcare Delivery

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.**

Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. March 2001; 5-6


APRIL 2011 VOL. 30 NO. 4
Published by Project HOPE
PATIENTS' VOICE IN QUALITY
Floyd J. Fowler Jr., Carrie A. Levin & Karen R. Sepucha
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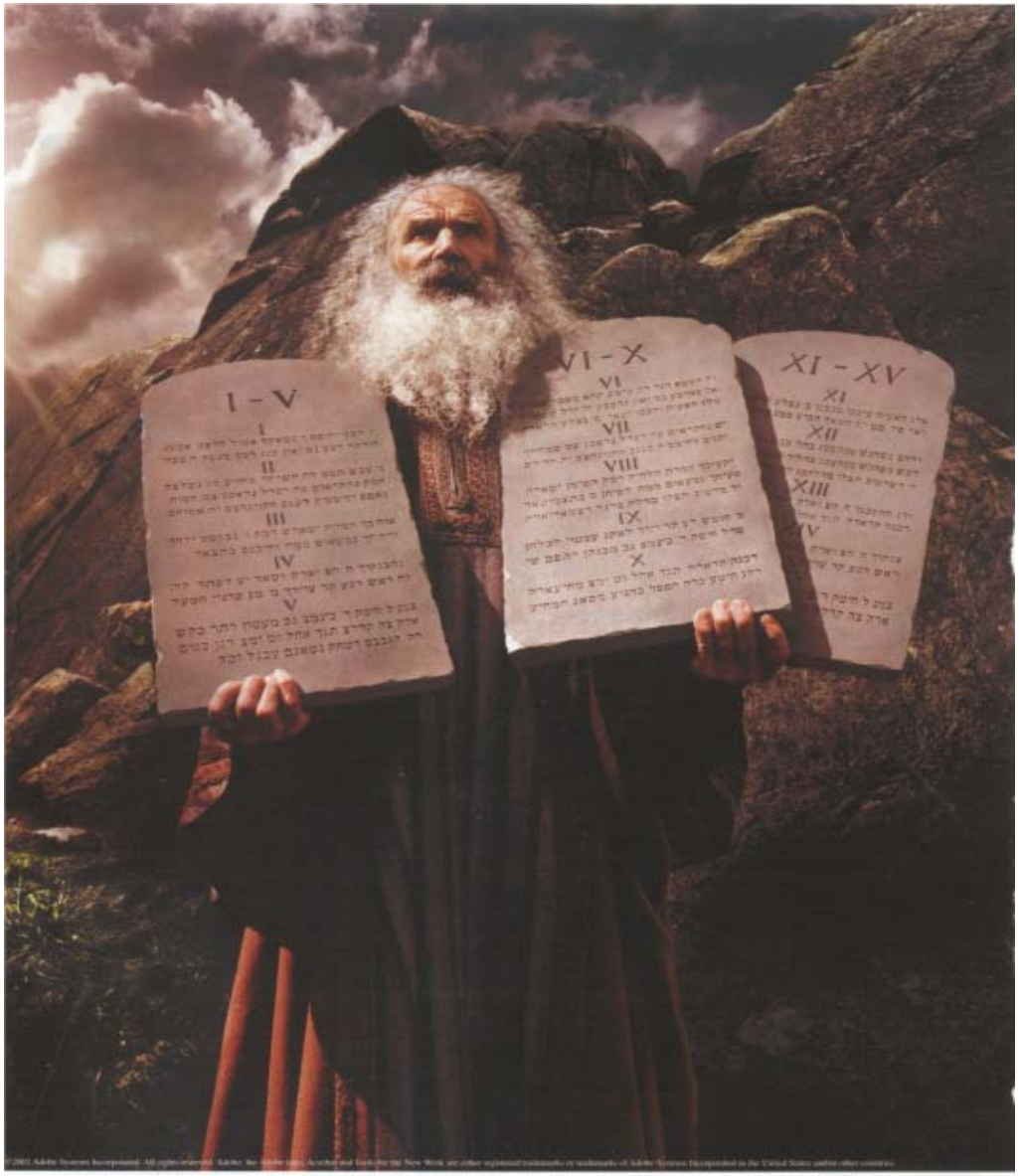

I - V
VI - X
XI - XV

Ten Commandments Crossing the Quality Chasm

Current Rules	New Rules
1. Care is based primarily on visits	1. Care is based on continuous healing relationships
2. Professional autonomy drives variability	2. Care is customized according to patient needs and values
3. Professionals control care	3. The patient is the source of control
4. Information is a record	4. Knowledge is shared freely
5. Decision making is based on training and experience	5. Decision making is evidence-based

Don Berwick 2002

Ten Commandments (*cont.d*)

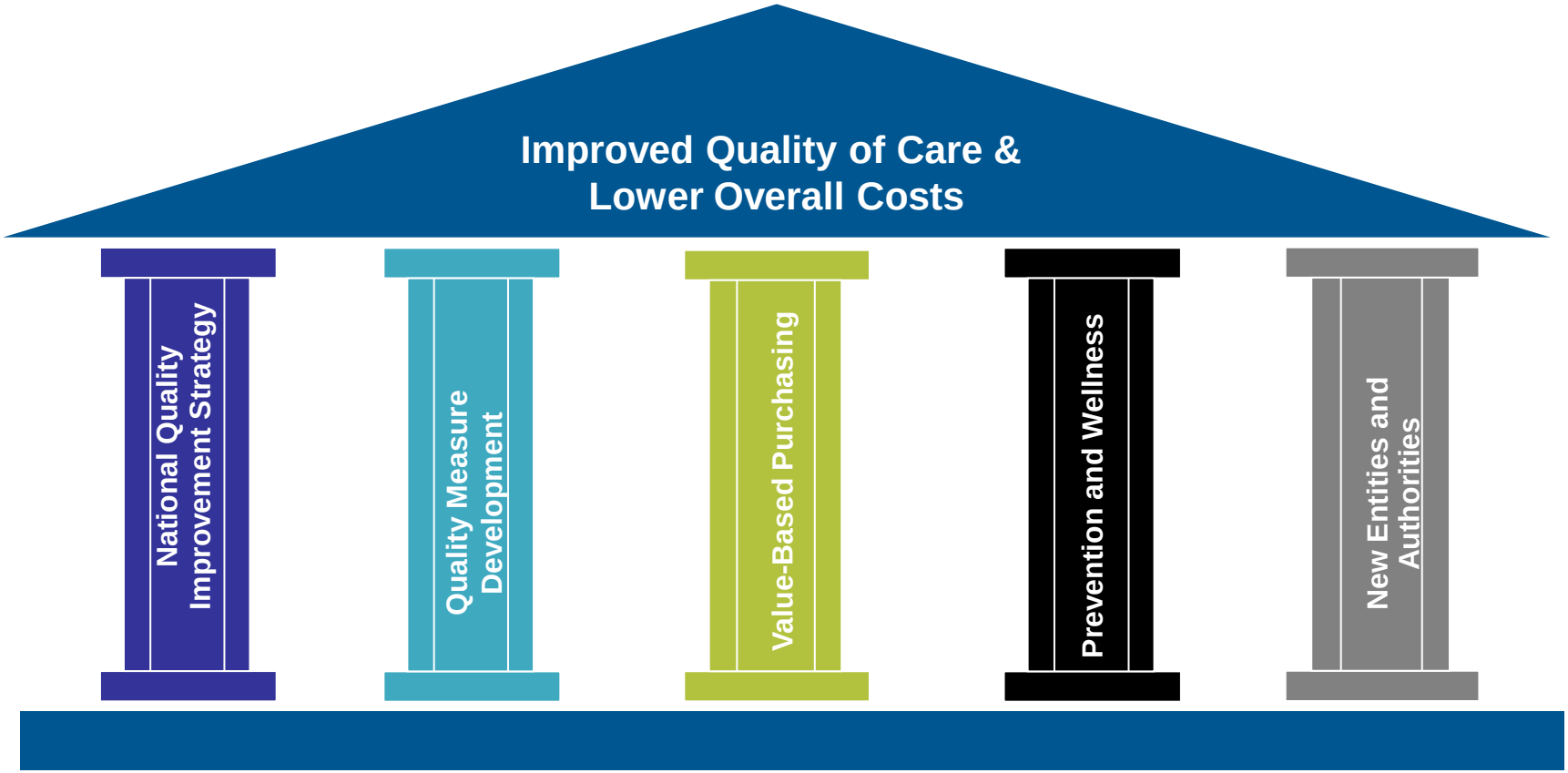
Current Rules	New Rules
6. "Do no harm" is an individual responsibility	6. Safety is a system property
7. Secrecy is necessary	7. Transparency is necessary
8. The system reacts to needs	8. Needs are anticipated
9. Cost reduction is sought	9. Waste is continuously decreased
10. Preference is given to professional roles over the system	10. Cooperation among clinicians is a priority

Don Berwick 2002

George Abbott, John Caldwell, Scott Arthur Masear, Rod Rossi, and P.C. Vey

“Please listen carefully as our menu makes no sense.”

Health Reform Builds on the Current Quality Infrastructure



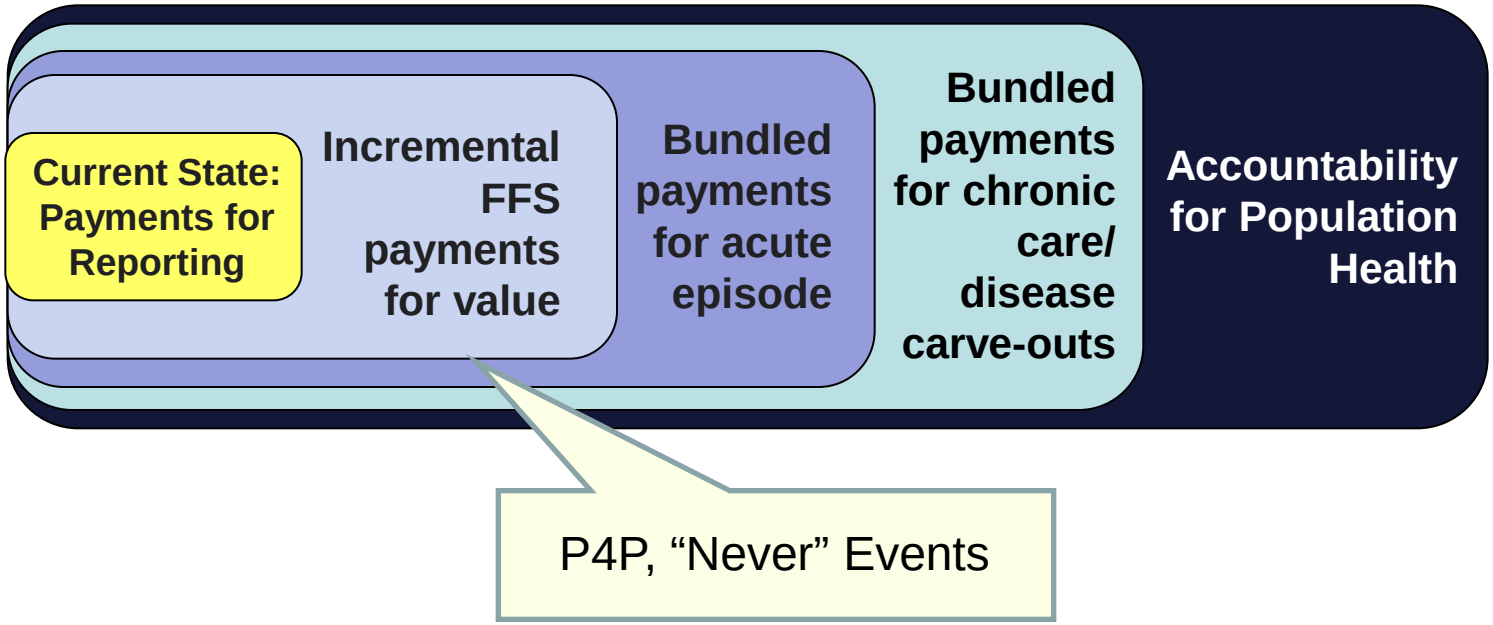
The Four Underlying Concepts of Cost Containment Through Payment Reform…….

Tying payment to **evidence and outcomes** rather than per unit of service	**"Bundling" payments** for physician and hospital services by episode or condition
Reimbursement for the **coordination of care** in a medical home	**Accountability for results** - patient management across care settings

Range of Models in Existence or Development

Increasing assumed risk by provider

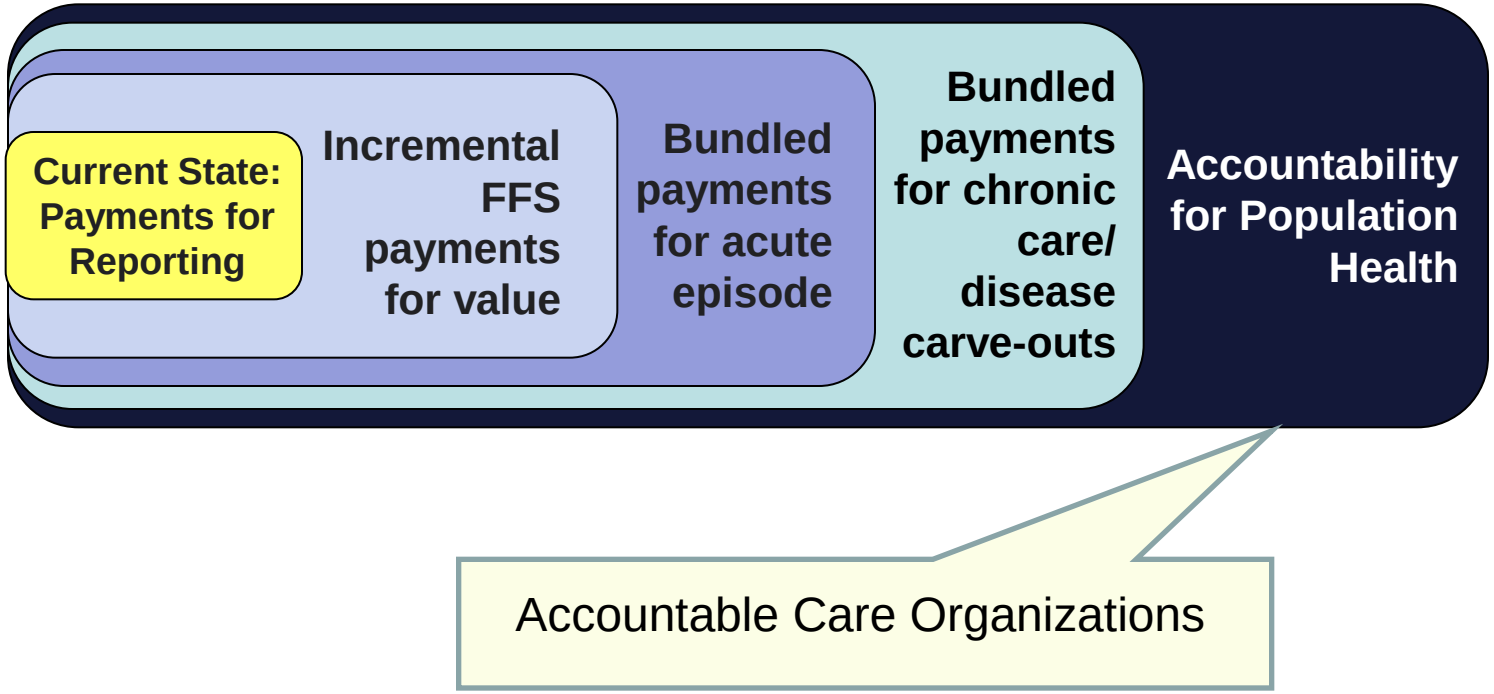
Increasing coordination/integration required



The Medical Home is Something Fundamentally Different

• **Usual Care**		• **Medical Home**
Relies on the clinician	→	Relies on the team
Care provided to those who come in	→	Care provided for all
Performance is assumed	→	Performance is measured
Innovation is infrequent	→	Innovation occurs regularly
Includes only primary care	→	Includes mental health, PharmD's and others
Navigation and care	→	Navigation and care
Management not available	→	Management are required
H.I.T. may or may not support care	→	H.I.T. must support care

Range of Models in Existence or Development



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

By Susan DeVore and R. Wesley Champion

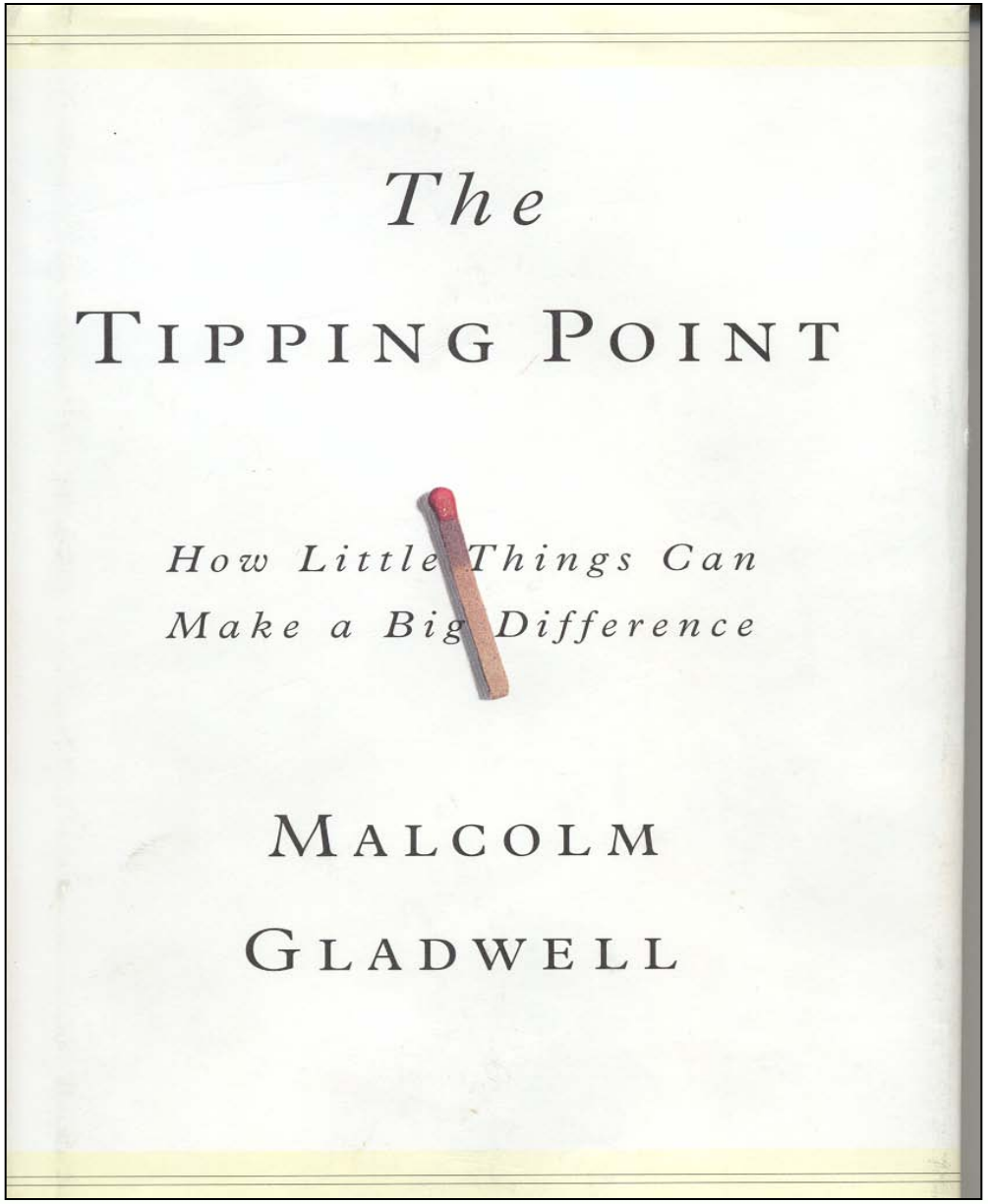
Driving Population Health Through Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0935
HEALTH AFFAIRS 30,
NO. 1 (2011): 41-50

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.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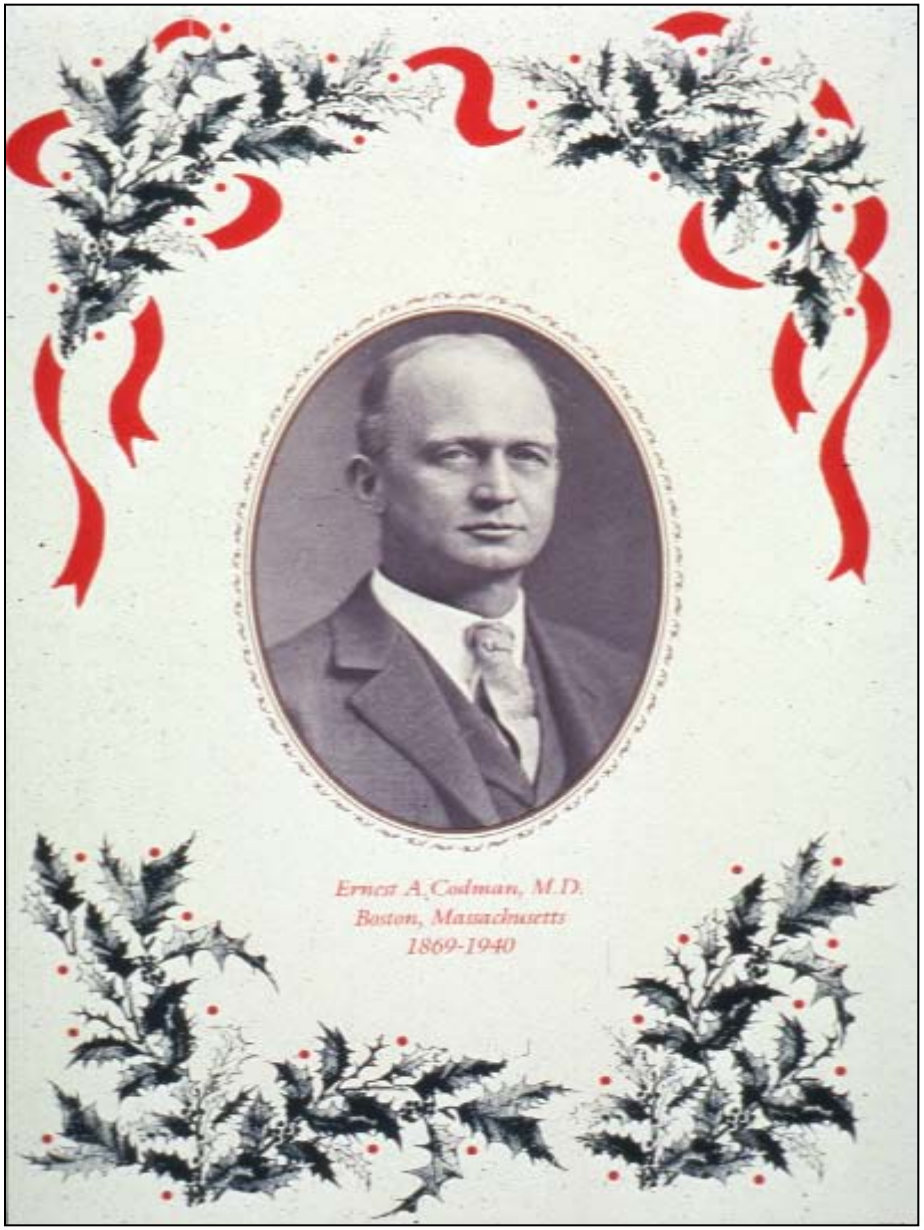
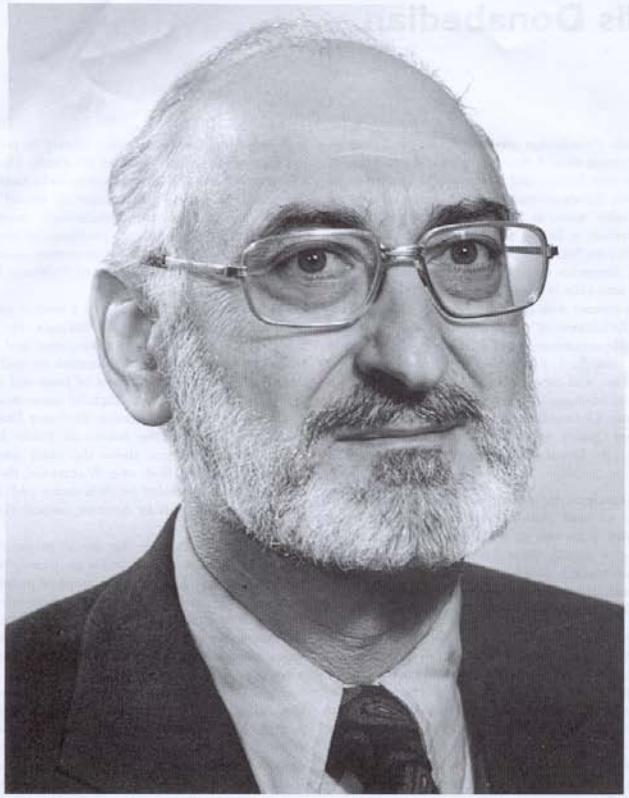
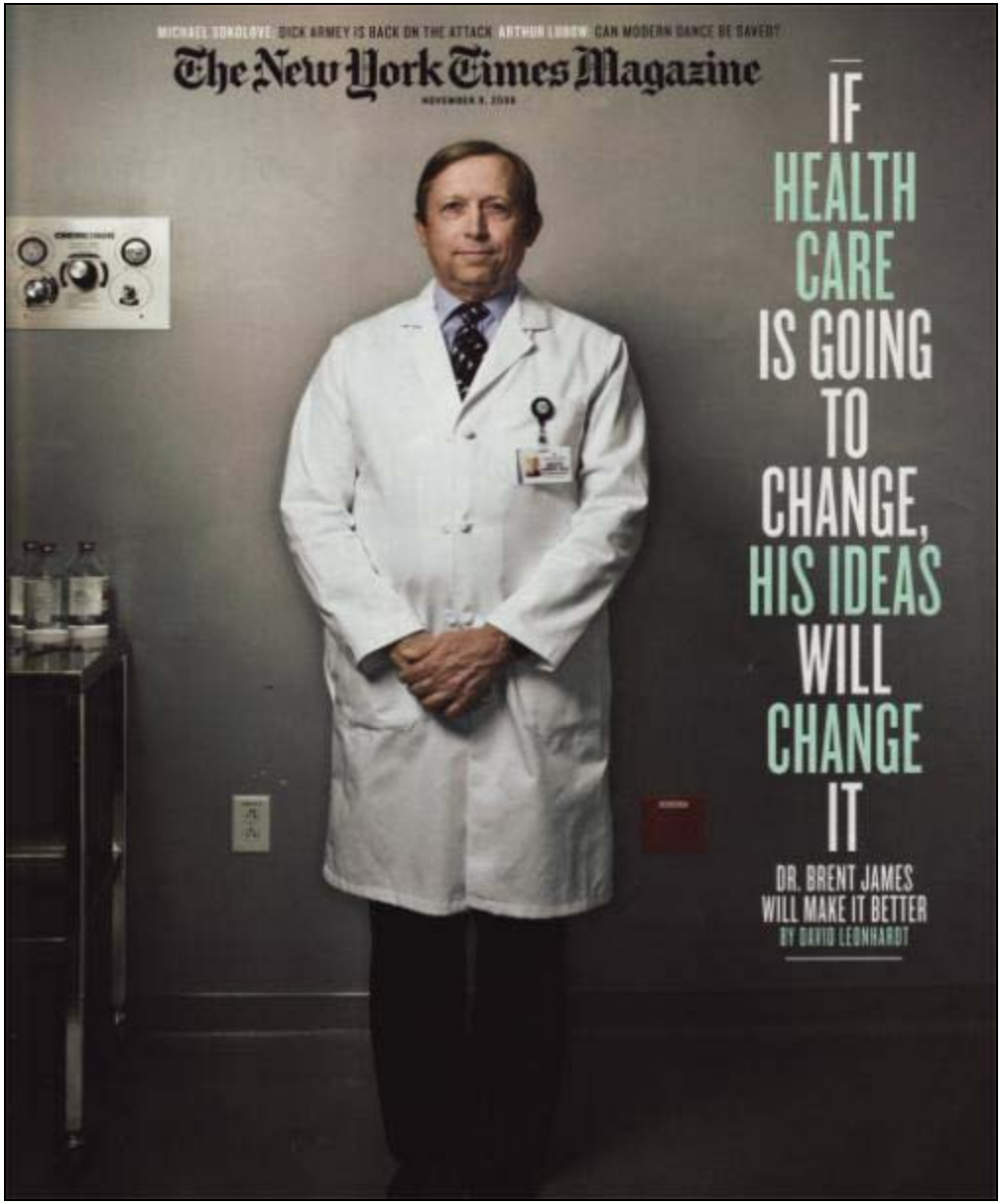

Ernest A. Codman, M.D.
Boston, Massachusetts
1869-1940

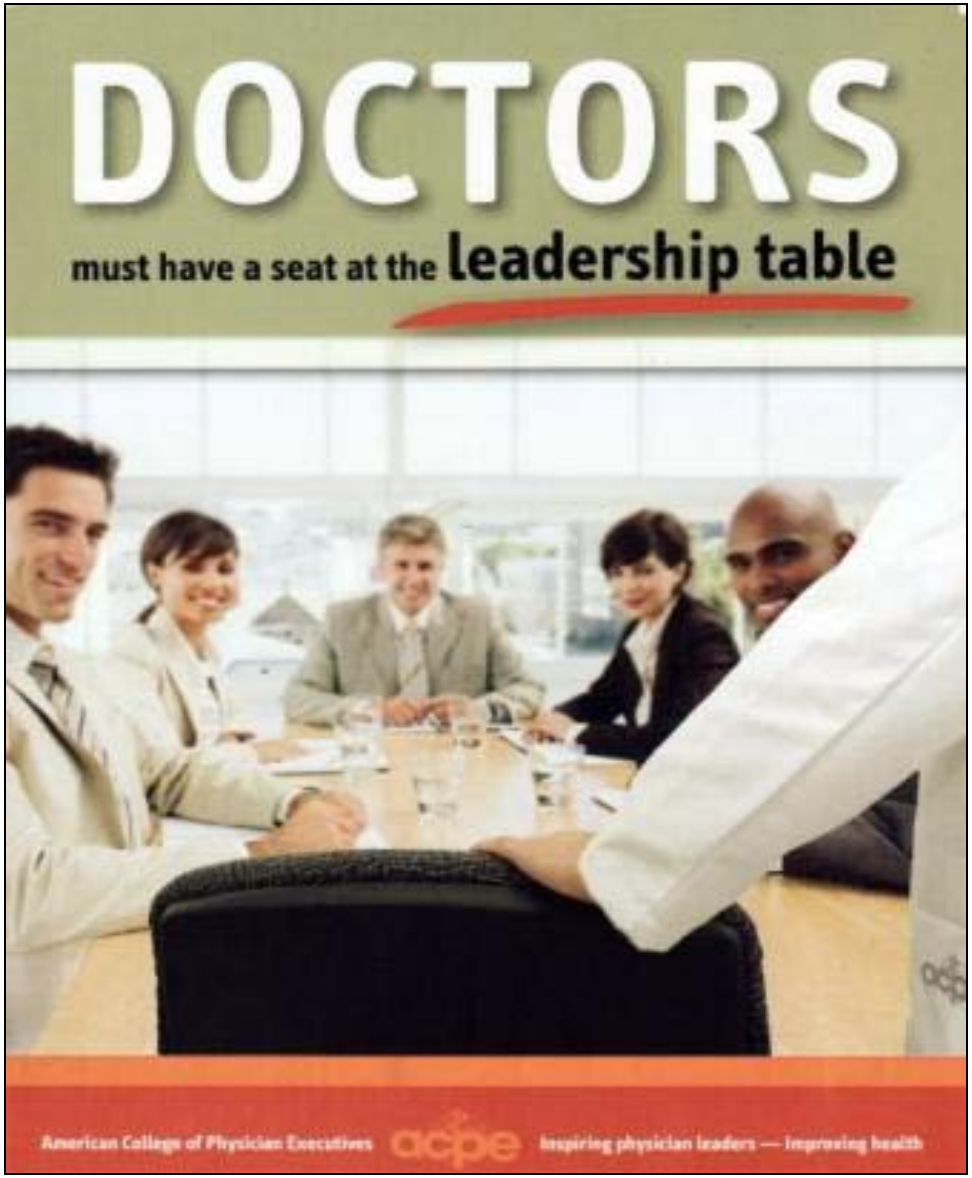
International Journal for Quality in Health Care 2000; Volume 12, Number 6: pp. 451–454



Avedis Donabedian
7 January 1919–9 November 2000

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.


MICHAEL SOKOLOVE: DICK ARMEY IS BACK ON THE ATTACK ARTHUR LUBOW: CAN MODERN DANCE BE SAVED?
The New York Times Magazine
IF HEALTH CARE IS GOING TO CHANGE, HIS IDEAS WILL CHANGE IT
DR. BRENT JAMES WILL MAKE IT BETTER
BY DAVID LEONHARDT


DOCTORS
must have a seat at the leadership table
American College of Physician Executives
acpe
Inspiring physician leaders — Improving health

Old	*New*
We don’t have time	We don’t have time not to
Quality costs money	Quality saves money
Use intuition and anecdote	Collect and analyze data
Defects come from people	Defects come from defective processes

Physicians as Leaders

Reinersten JL. Annals Internal Medicine

1998; 128: 833-838.

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

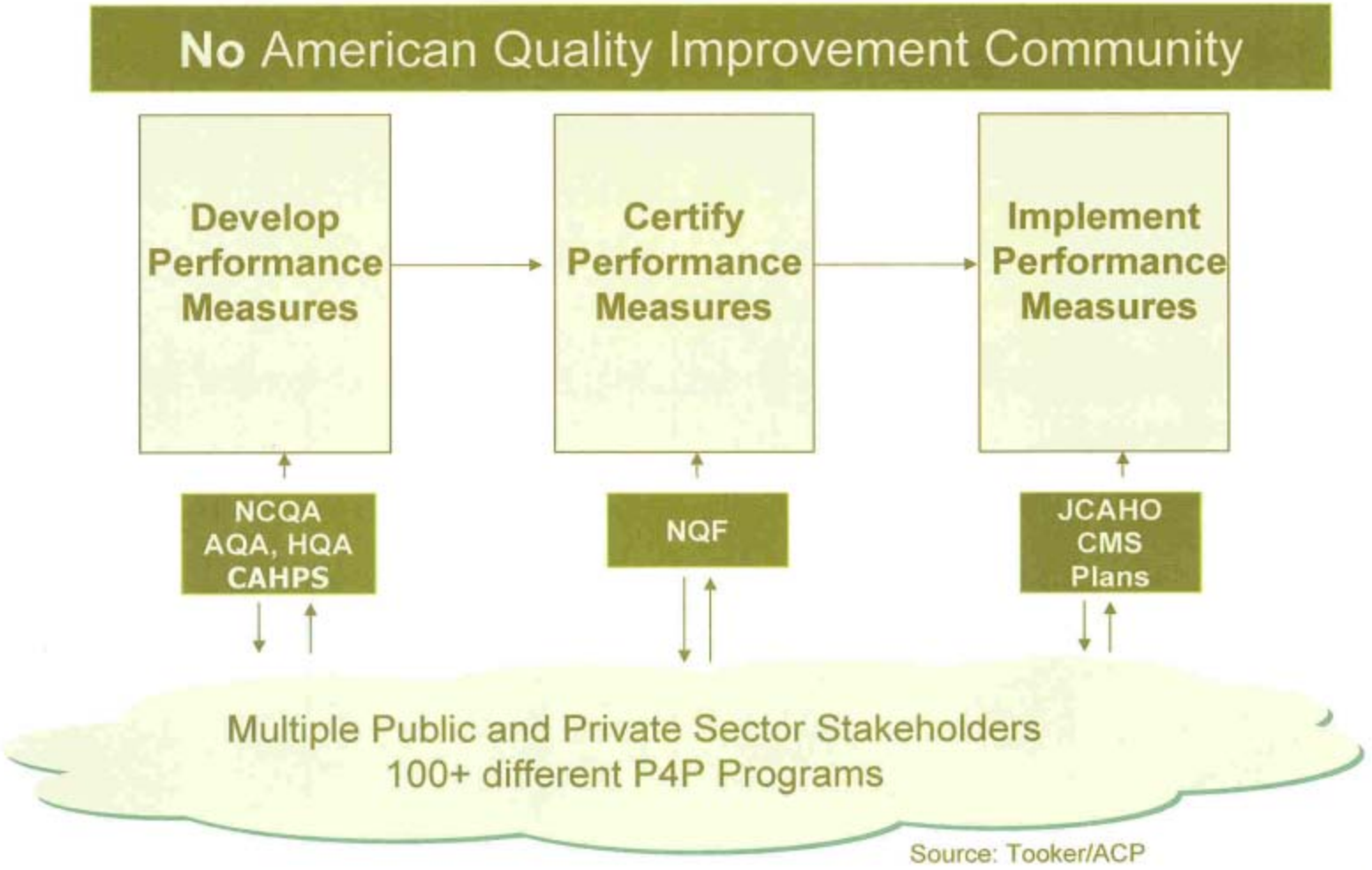
Tools for Physician Leaders

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



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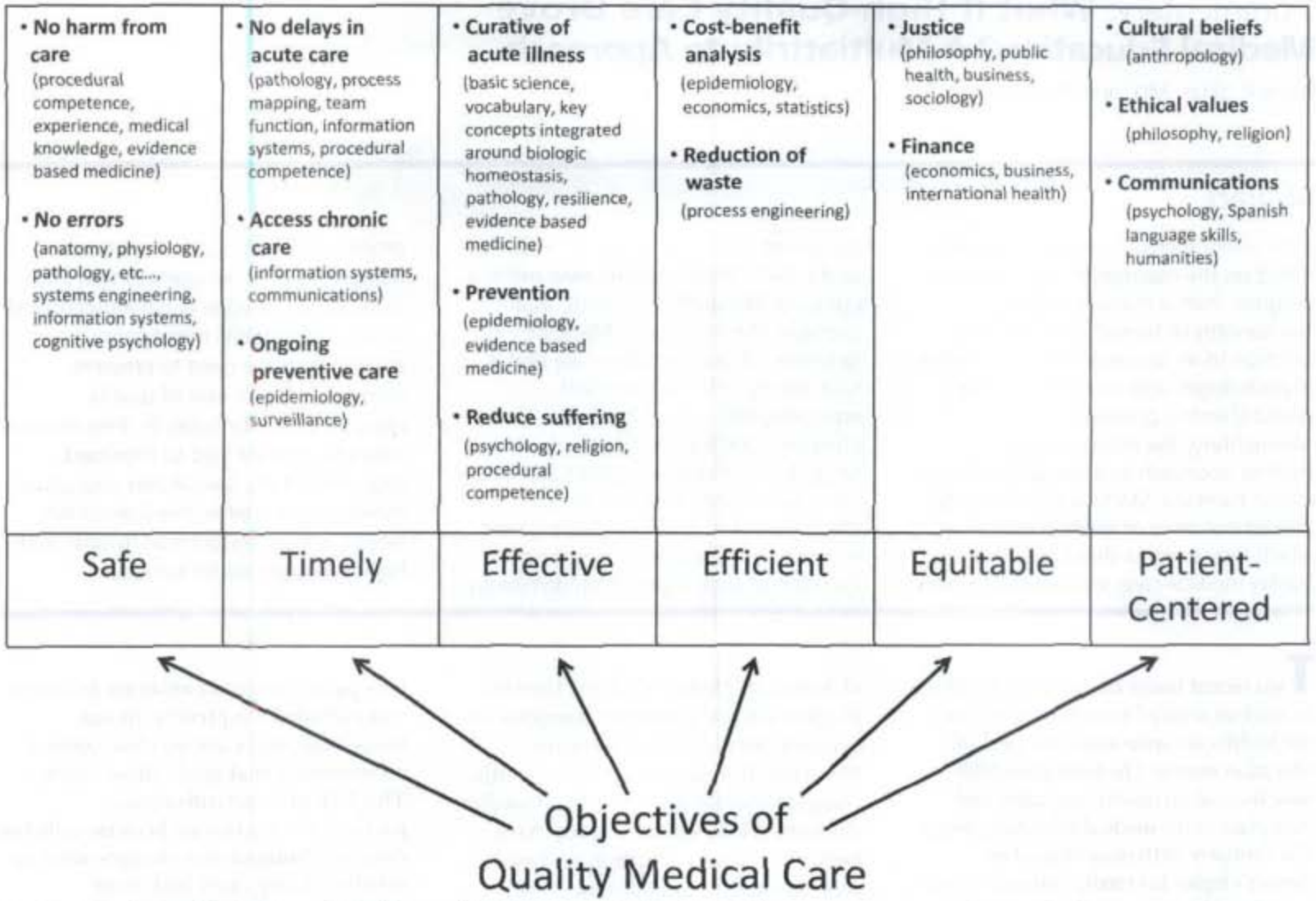
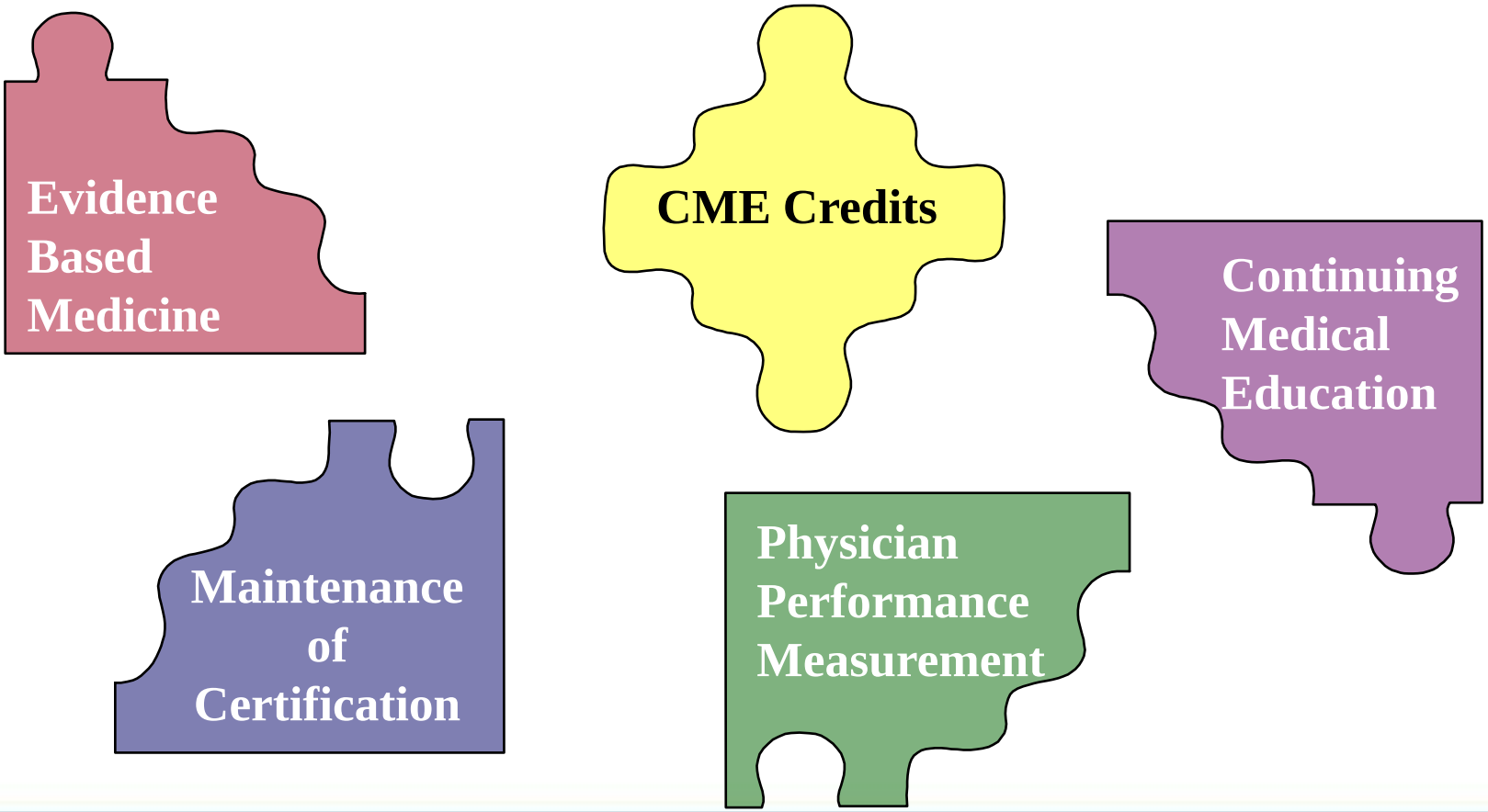


Figure 1 Attributes of the Institute of Medicine quality objectives with related curriculum areas.

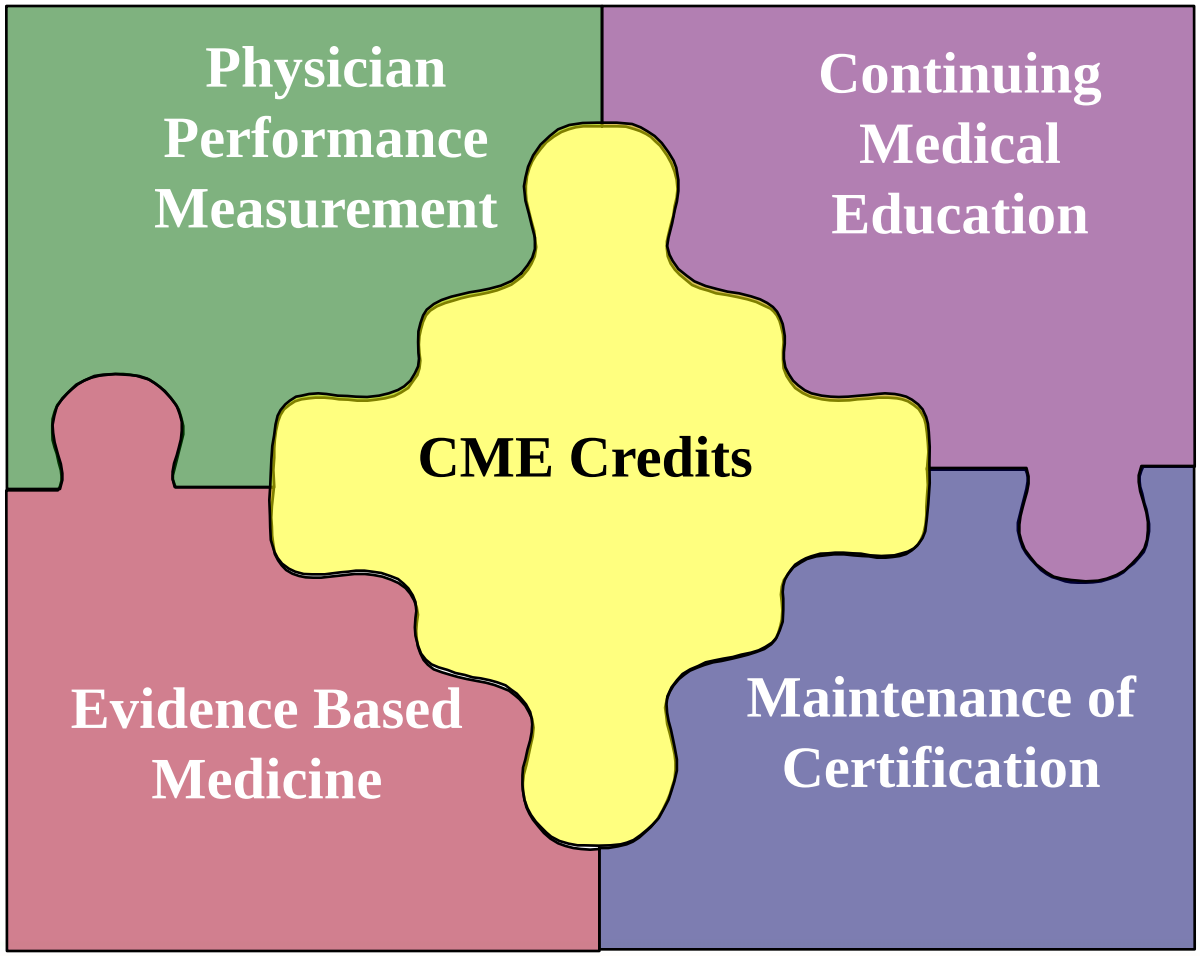
Evolution and Convergence of Physician Performance Measurement, CME, EBM and Maintenance of Certification



Continuing Medical Education (CME) and Continuous Physician Professional Development (CPPD): Evolution and Change

CME	→	CPPD
Intermittent	→	Continuous
Class room lectures	→	Self learning
Face-to-face	→	Web based
Content unrelated to practice	→	Integrated into work-flow
Medical science only	→	Also management; finances
Focused on individuals	→	Also focused on team
(General) needs assessment	→	Performance based
Evaluation of knowledge	→	Change in performance; ROI

Convergence of Various Tools



By Darrell G. Kirch and Philip G. Boysen

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Changing The Culture In Medical Education To Teach Patient Safety

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Philip G. Boysen is executive associate dean of graduate medical education and a professor of anesthesia 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.**

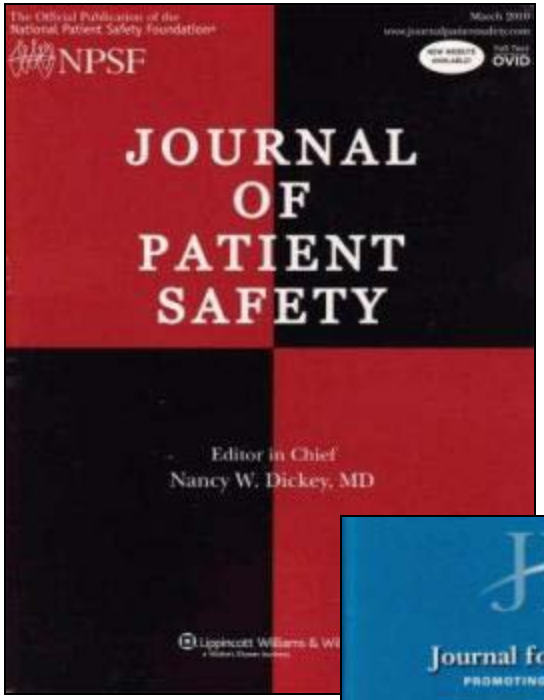
When a report on medical errors comes out, the response often is the question: "Why aren't they teaching this in medical school?" As noted by the Institute of Medicine (IOM) a decade ago in *To Err Is Human*,[1] one's first reaction to a medical error is to blame someone. The report noted, however, that 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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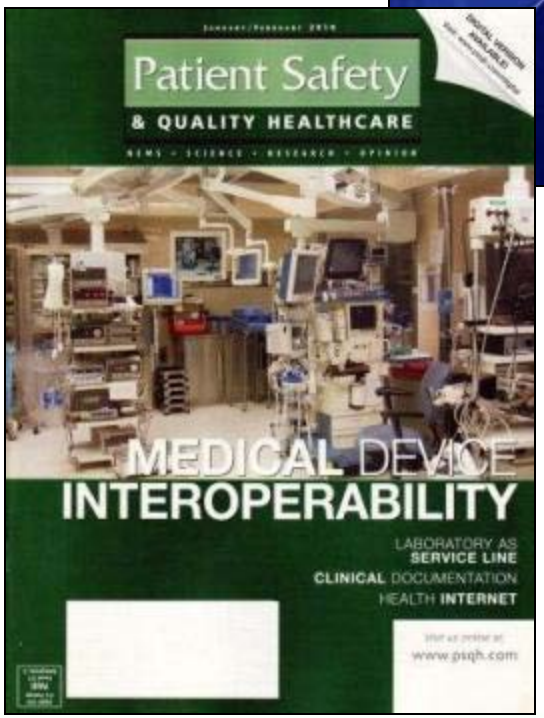
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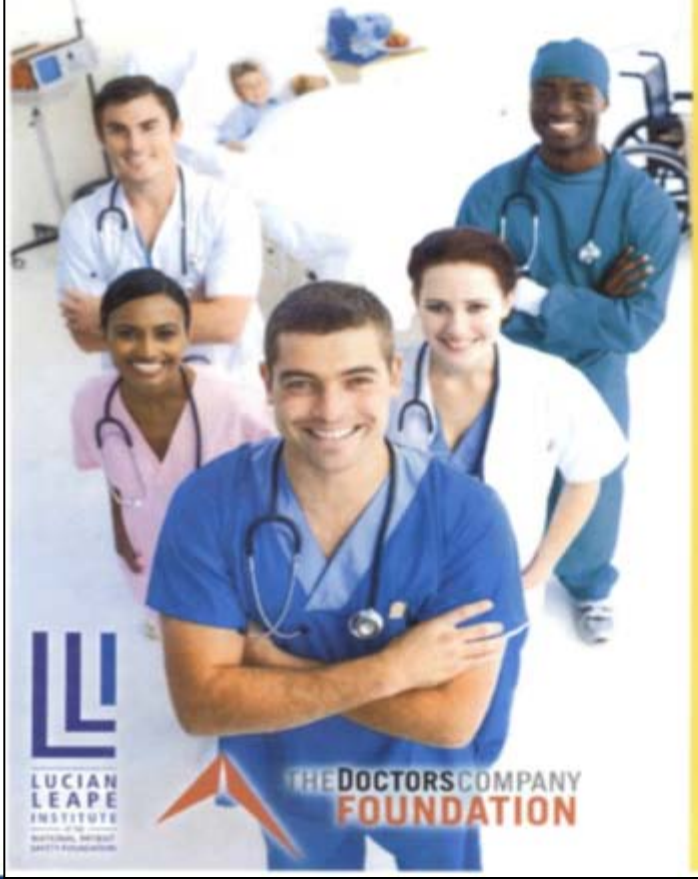
The Doctors Company Foundation
Young Physicians Patient Safety Award

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/younphys-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, DC).

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 sreardon@npsf.org or go to www.npsf.org/npsfac/younphys-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

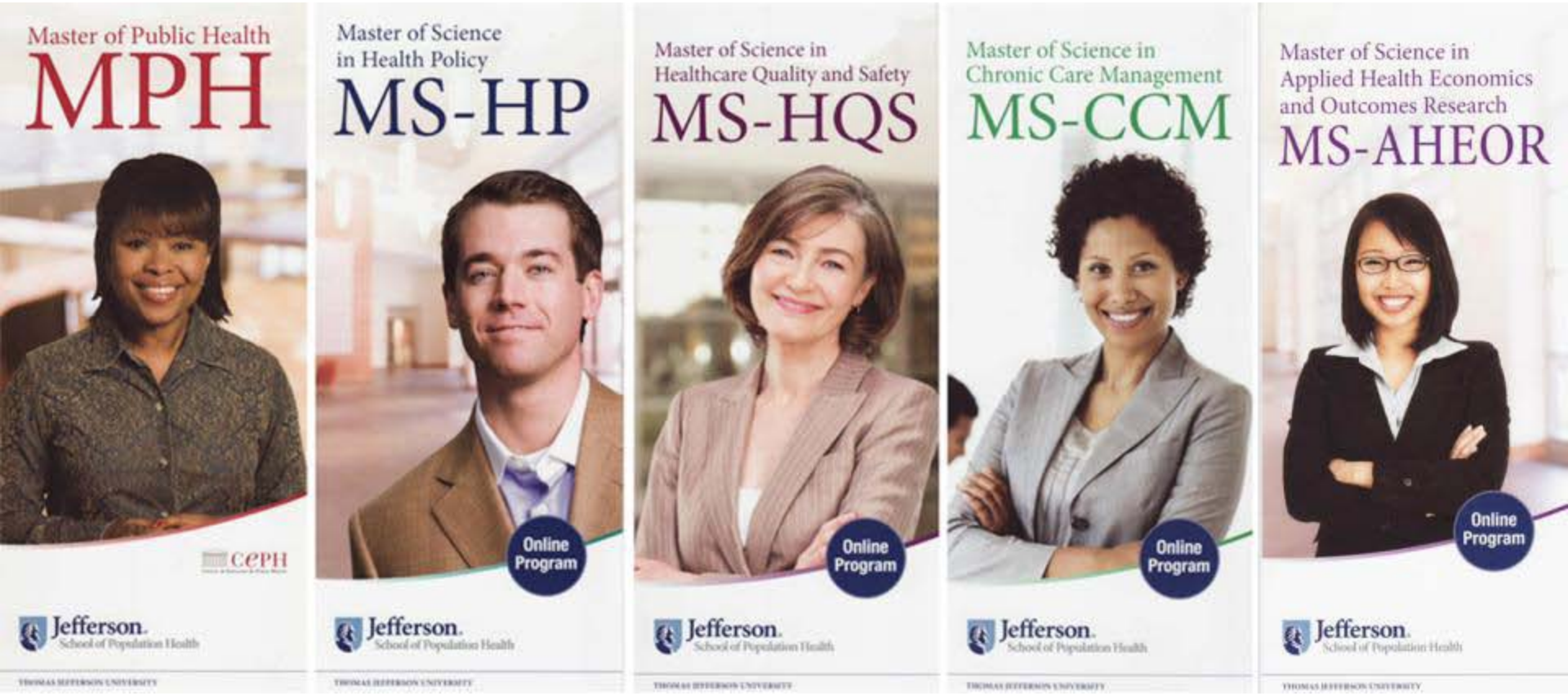
How Might We Get There?

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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High quality care costs less!

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ZEN

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THE ART OF MOTORCYCLE MAINTENANCE

AN INQUIRY INTO VALUES

ROBERT M. PIRSIG