6th Annual National Conference on Quality in Health Care

An International Perspective: Improving Care for the Next Decade

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IHI Mission

The Institute for Healthcare Improvement is a not-for-profit organization driving the improvement of health by advancing the quality and value of health care.

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IHI Vision

The Institute for Healthcare Improvement is a premier integrative force, an agent for profound change, dedicated to improving health care for all. Our measures of success include improved safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

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Today: An Update From Two National Projects

- US Pursuing Perfection
- UK NHS Transformation

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What would a transformed organization look like?

- A place with no needless…
  - Deaths
  - Pain
  - Delays
  - Helplessness
  - Waste

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The Overarching Aim

The purpose of the health care system is to reduce continually the burden of illness, injury, and disability, and to improve the health status and function of the people of the United States.

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The Chain of Effect in Improving Health Care Quality

Patient and Community	Experience	Aims (e.g., safe, effective, Individualized, prompt, affordable)
Microsystem	Process	Simple Rules/Design Concepts (e.g., science-based action, systems customization)
Organizational Context	Facilitator of Process	Design Concepts (e.g., Building relationships)
Environmental Context	Facilitator of Facilitators	Design Concepts (e.g., financing, regulation)

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Challenges We Still Face After The First Two Years

- Results at the system level
- Improving reliability from
  - 10^{-2} to 10^{-3} in focused areas
  - 10^{-1} to 10^{-2} across the organization
- Dramatically improving physician relationships
- Making health care the safest place to work
- Committing to patient-centeredness
- Scaling up to “all”
- Building a business case for improvement

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Results at the System Level

- “Legal Seafoods” Measures
- Moving the Dots

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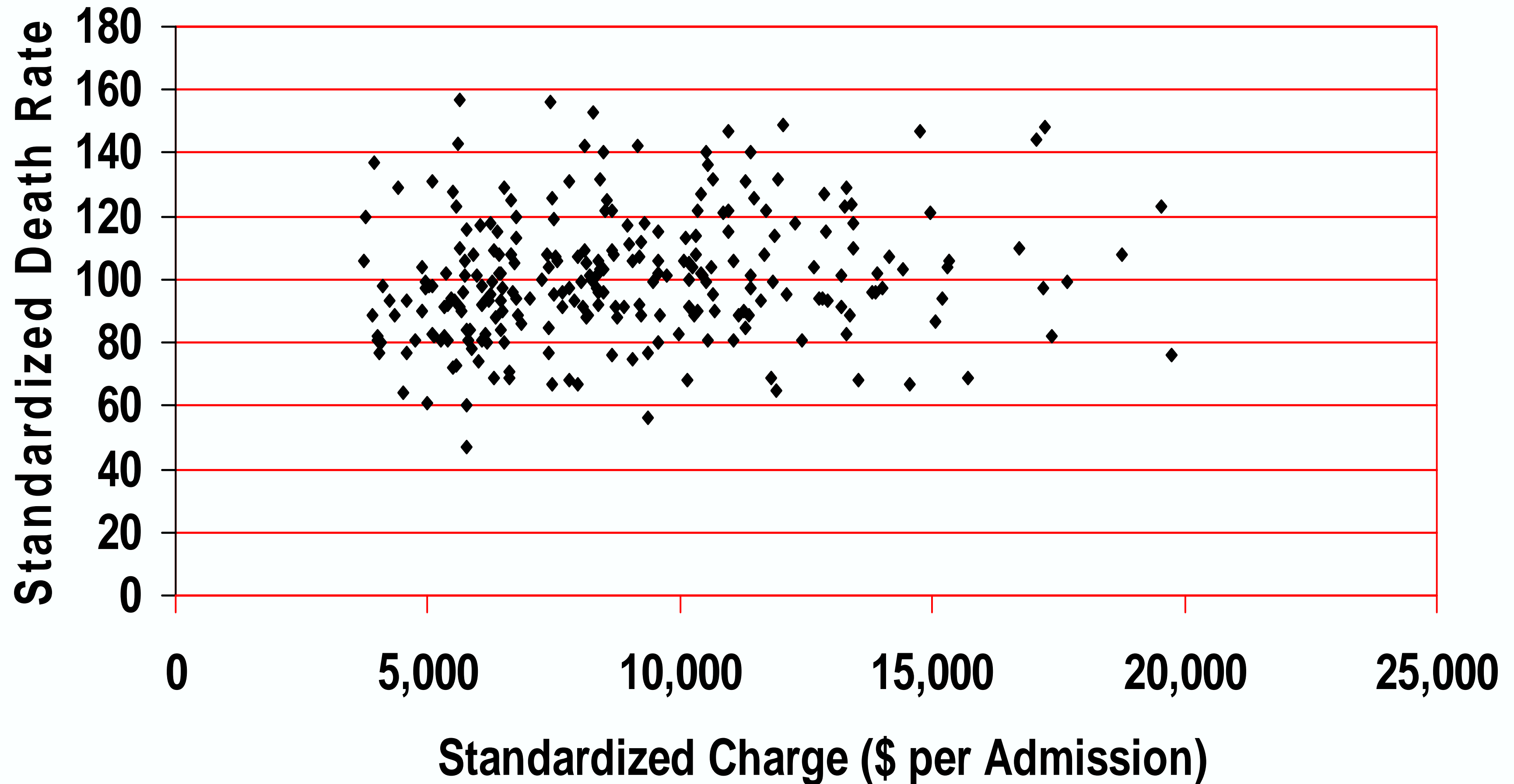
Hospital Death Rate

(Standardized for Age, Sex, Race, Payer, Admission Source & Type)

vs Charge per Admission

(Standardized for Age and Diagnosis) -- AHRQ 1997 Data



Stages of Facing Reality: “To live divided no more”

- “The data are wrong”
- “The data are right, but it’s not a problem”
- “The data are right; it is a problem; but it is not my problem.”
- “I accept the burden of improvement”

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2x2 Matrix for Review of Last 50 Deaths

Comfort Care only		In ICU	Not in ICU
	Yes		
	No		

Results can be sent to MoveTheDot@IHI.org
Aggregated results of all hospitals will be sent back

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2x2 Matrix for Review of Last 50 Deaths Results for First 25 Hospitals

Comfort Care only		In ICU	Not in ICU
	Yes	40 **3.0%** (0-14%)	179 **13.3%** (0-40%)
	No	548 **40.6%** (16-64%)	583 **43.2%** (18-64%)

Results can be sent to MoveTheDot@IHI.org
Current aggregated results of all hospitals will be sent back

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ICU Admission

CCO ONLY	ICU Admission: Yes	ICU Admission: No
Yes	■Execution of a "policy" limiting use of ICU for comfort care only ■High capability for pain and symptom management on the patient care units	■Alternatives in the community to hospitalization ■Best practices in End of Life care
No	■Best practices in ICU care for three time categories ■ED-ICU interface	■Customization of care by risk group ■Reduction of adverse events ■Resolve system issues such as slow response time

POINTING THE FINGER

Both doctors at the scene and those in supervisory roles told federal investigators that other individuals or departments were responsible for managing the patient's treatment during the seizure. The patient did receive anti-seizure drugs, but not in high enough dosages.

Neurosurgeon
Said epilepsy staff or medical intensive care unit (MICU) staff are responsible for post-operative care.

Epilepsy specialist #1
Said MICU staff or neurosurgical team were responsible for managing care during the seizure.

On call that night

Epilepsy specialist #2
Said MICU staff was responsible for care.

Patient's primary doctor, but not on call that night

Neurosurgery resident
Assumed the seizure was being managed by the MICU fellow and the epilepsy fellow on the phone.

Epilepsy fellow
Said she was only a consultant. She was not at the hospital and assumed bedside doctors would manage care.

On phone

At bedside during seizure

PATIENT

MICU director
Said MICU staff don't assume responsibility for surgical patients; the responsibility belongs to the surgical staff.

MICU attending
Said neurological staff was responsible for managing care during the seizure.

MICU fellow
Thought the seizure was being managed by neurosurgical resident at bedside and epilepsy fellow on the telephone.

Two MICU nurses
Could not recall who was managing the patient's seizure.

MICU charge nurse
Said surgical teams are responsible for surgical patients.

GLOBE STAFF GRAPHIC / SEAN McNAUGHTON

“Legal Seafoods” Measures Big Dots

* 3rd Available Appointment

•$ per Admission
•$ Per capita

* Voluntary Turnover

* Mortality Rate

* Adverse Drug Events

* Functional Outcomes

* Patient Satisfaction

Improving Reliability From…

10^{-2} to 10^{-3} at the project level

(10^{-1} translates to less than 90% reliability; 10^{-2} improve to between 95-98% reliability)

10^{-1} to 10^{-2} at the system level

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10^{-2} to 10^{-3} At The Project Level

- Identify performance problems and link senior leadership, clinical guidelines, strong improvement model and microsystem teams

- Can usually move performance from 70% to over 90% (10^{-2})

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10^{-1} to 10^{-2} At The System Level

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitive to operations
- Committed to resilience
- Deference to expertise

Managing the Unexpected, Karl Weicke

Challenges We Still Face After The First Two Years

- Results at the system level
- Improving reliability from
  - 10^{-2} to 10^{-3} in focused areas (well underway)
  - 10^{-1} to 10^{-2} across the organization
- Dramatically improving physician relationships
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UK Case Study: Modernizing the NHS

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"We believe this is the most ambitious, comprehensive and intentionally funded national initiative to improve health care quality in the world. Early data shows that the NHS is not broken. It shows capacity to improve. With the increased financial commitment and the "quality" reforms in place, it is reasonable to expect that the NHS will continue to show significant progress in meeting the health needs of patients."

The Nuffield Trust for Research and Policy Studies in Health Services, London

Positive Quality Results: Clinical Quality Improvements

- Heart Disease
  - Deaths from heart disease fell by 14% since 1997
  - Number of heart surgeries rose by 13% in 2001-02, and another 11% in first six months of 2002-03
- Cancer
  - Death rate from cancer reduced by 6.5% over 3-year period
  - Increase of 91% in suspected cancer patients being seen by specialist within 2 weeks of urgent referral by GP
  - In calendar year 2002, 94.4% of breast cancer patients received their first treatment within 1 month of diagnosis

Positive Quality Results: Clinical Quality Improvements

- Access and Choice
  - Long waits (more than 15 months) for hospital operations; were radically reduced from 8,075 to 9 (Oct 2001-Sept 2002)
  - Reduction of 61% in waits for hospital admission (Oct 01-Oct 02)
  - By Sept 2002, 77% of people seen within 4 hours in A&E
  - Long waits for outpatient appointments (over 26 weeks) reduced by 99% from 92,800 to 716 (Sept 01-Sept 02)
- Patient-centered environment
  - Refurbishment of 1,325 GP premises by October 2002
  - Nine major new hospitals opened from October 2001-September 2002
  - 100,000 patients receiving improved food services daily

NPDT National Primary Care Development Team

Primary Care Collaborative NHS

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Patients in Practices Covered by the Primary Care Collaborative

Components of Advanced Access

- Understanding profile of demand
- Adjusting the handling of demand
- Matching capacity to demand
- Contingency plans

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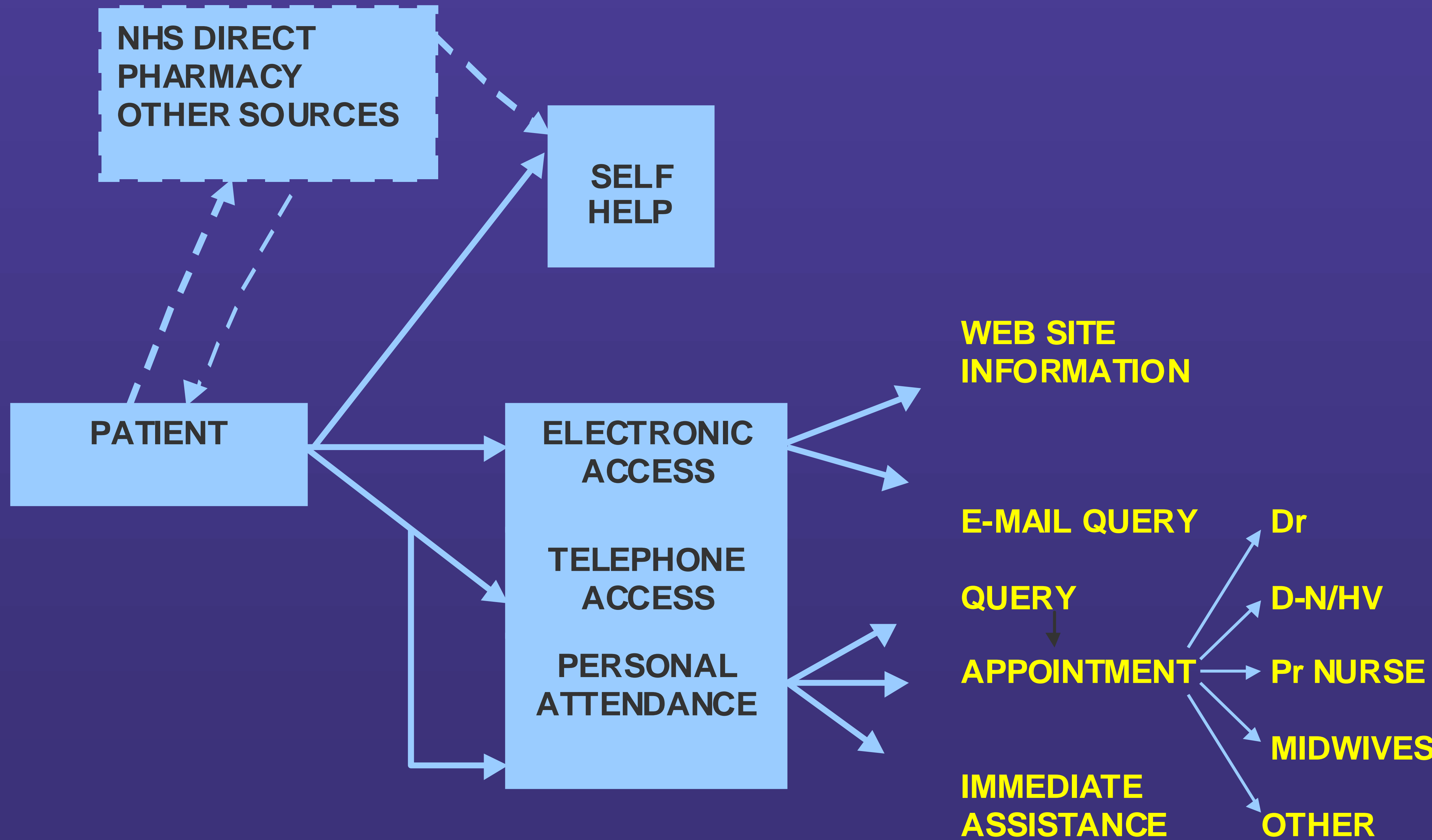
NHS DIRECT
PHARMACY
OTHER SOURCES
SELF HELP
PATIENT
ELECTRONIC ACCESS
TELEPHONE ACCESS
PERSONAL ATTENDANCE
WEB SITE INFORMATION
E-MAIL QUERY
QUERY
APPOINTMENT
IMMEDIATE ASSISTANCE
Dr
D-N/HV
Pr NURSE
MIDWIVES
OTHER

GP 3rd Available Appointment Trends
First, Second,Third and Fourth Wave practices

"Quality Agenda" Recommendations

- Create a National Quality Information Centre (QuIC)
- Publish an Annual National Quality of Care Report
- Engage citizens and patients
  - Develop a comprehensive strategy fro involving patients and the public, underpinned by research evidence
  - Develop a strategy for providing information fro patients and the public
  - Facilitate shared (patient-professional) decision-making through appropriate training of clinicians and support for motivated an interested patients
  - Develop and evaluate robust mechanisms to engage local communities in NHS governance and policy-making

"Quality Agenda" Recommendations

- Engaging the Professions
- Support Primary Care Trusts
  - Give PCTs organizational stability, critical mass and infrastructure support
  - Clearly define how the public and patients can be most effective in developing the service. Disseminate examples of good practice
  - Strengthen the commissioning function of PCTs n terms of management support, information and analytical expertise, clinical involvement and the development of effective working relationships with local NHS Trusts

The Nuffield Trust for Research and Policy Studies in Health Services, London

"Quality Agenda" Recommendations

- **Refine the Inspection and Accreditation Strategy**
  - The CHAI model should be clarified, explicitly evolving from simply and inspection approach which is concerned with guaranteeing minimally acceptable standards, to also encompass accreditation, which seeks to identify exemplary standards of care
  - Two types of quality standards should be developed
    - Core standards
    - Uniform standards

Levels of Leadership in the Transformation of Organizations

- Transform yourself
- Transform your team
- Transform your organization
- Transform your profession

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