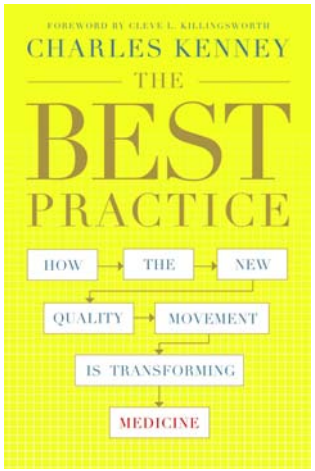


The Best Practice

How the New Quality Movement Is Transforming Medicine

Charles Kenney

Significant Progress: Movement Has…

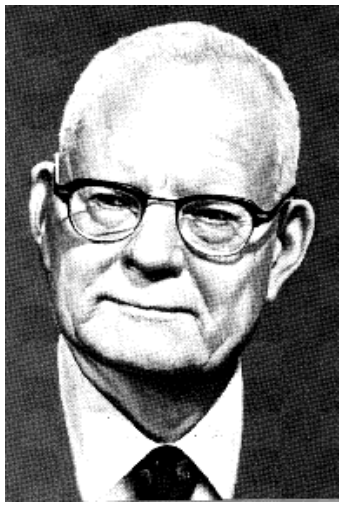
1. Established overwhelming substantive case for change needed to achieve quality/safety

2. Put quality/safety in the spotlight
   - Hospital-acquired infections
   - Medication safety
   - Evidence-based care
   - Best practices
   - Industrial quality techniques

3. Saved lives

The Vision: Systems Thinking

- Batalden/Berwick inspired by Deming – focus on system not individual. How can system work better?
- Could this approach work in health care?
- National Demonstration Project
- Key finding: The *absence* of systems thinking in health care



W. Edwards Deming

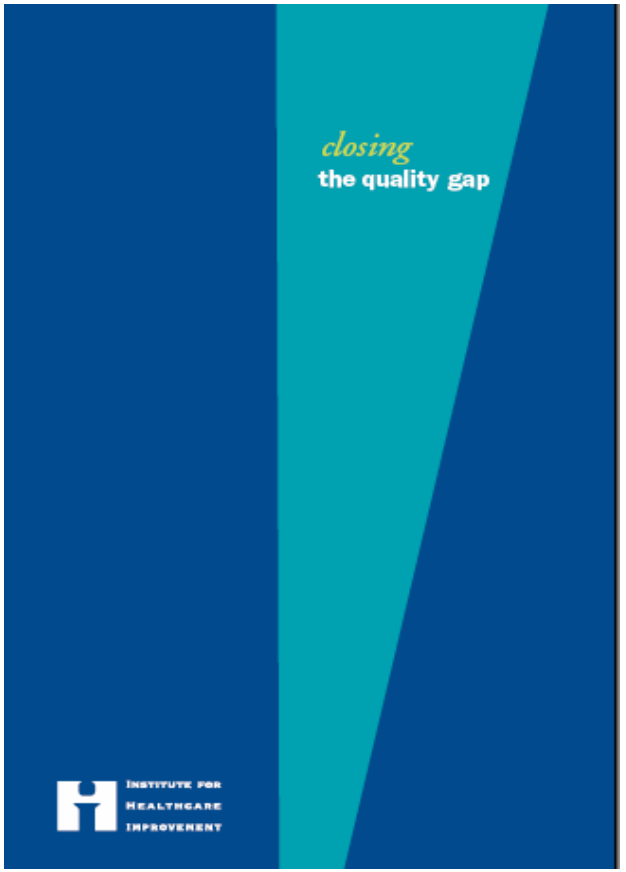
"You're the MD and you do a beautiful diagnosis. But what if blood is drawn from the wrong patient? What if you cannot read the x-ray? What if the pharmacist doesn't put the right thing in the bottle? We're talking about managing a system!"

Blan Godfrey, PhD, Bell Labs

A. Blanton Godfrey

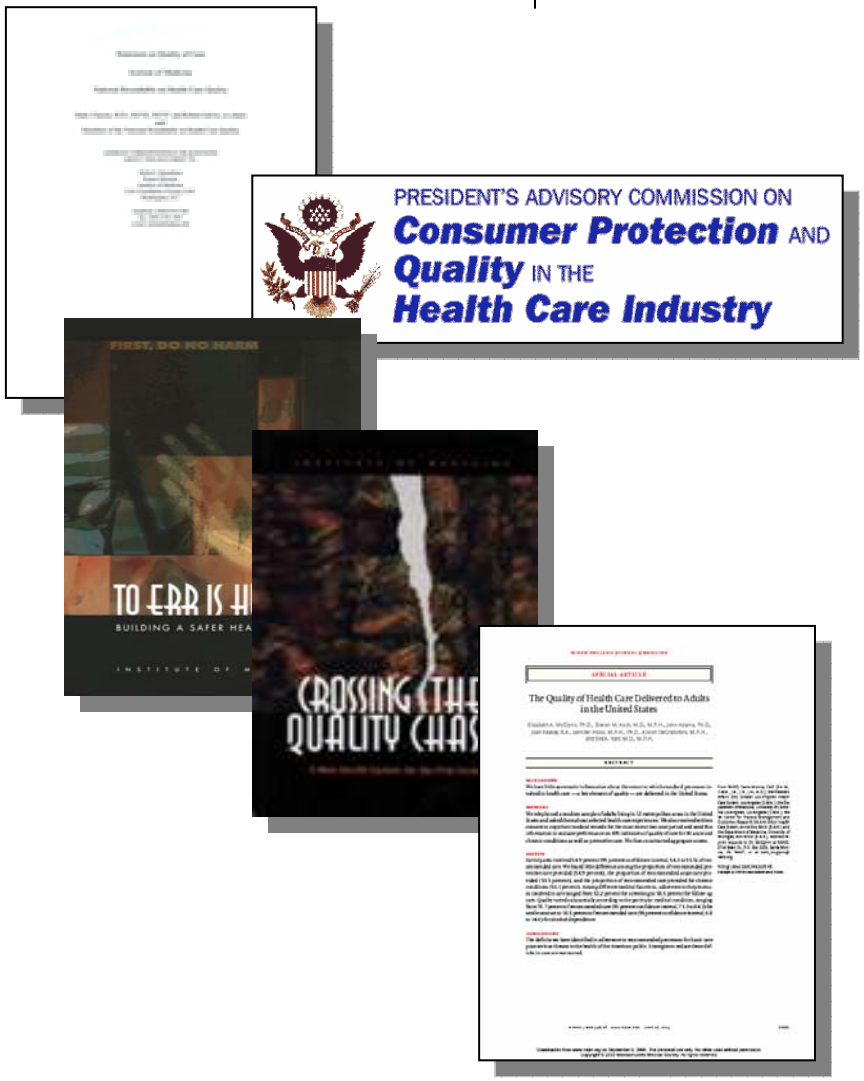
Visionaries: Birthday Club/IHI/Leape

- Late 1988 Birthday Club explores this "new way of thinking about health care"
- Develop organization to pursue quality agenda – birth of IHI
- Harvard Medical Practice Study – Lucian Leape and colleagues discover millions preventable medical errors



Movement's Substantive Foundation: Confirmed Birthday Club Thesis

- IOM National Roundtable on Health Care Quality – The Urgent Need to Improve Health Care Quality (1998)
- President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998)
- *To Err Is Human: Building a Safer Health System* – IOM (1999)
- *Crossing the Quality Chasm: A New Health System for the 21st Century* – IOM (2001)
- RAND: *"The Quality of Health Care Delivered to Adults in the United States." (NEJM 2003)*



Jarring Findings: Absence of Systems Thinking Results in…

- Reports dented longstanding article of faith that U.S. health care provides the highest possible quality/is the best in world
- *"… substandard care… unacceptable level of errors…" (President's Commission)*
- "*Serious/widespread quality problems throughout American medicine…" (Roundtable)*
- *System "routinely fails to deliver its potential benefits…" (Chasm)*
- David Lawrence, CEO, Kaiser Permanente: **"The chassis is broken."**

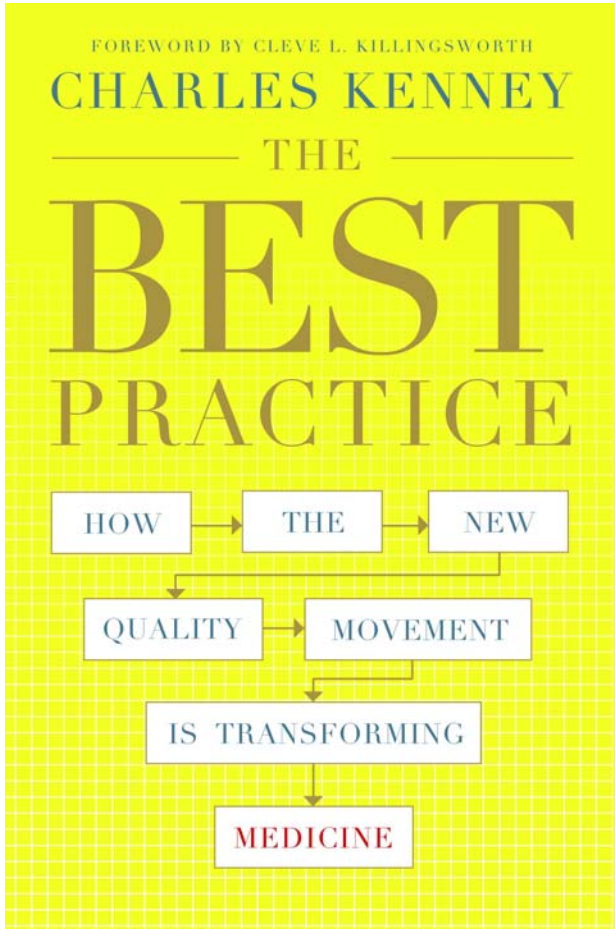
Call to Action

- *"Make quality improvement the driving force of the industry."* (Pres. Commission)

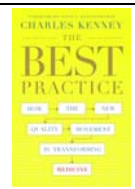
- *"Major, systematic… overhaul of how we deliver health care…"* (Roundtable)

The Best Practice

- Most did not respond to call to action
- *The Best Practice* is about some who did
  - Cincinnati Children's
  - Virginia Mason
  - Jönköping County
  - Kaiser Permanente
- *The Best Practice* is about them and their
  - Leadership – *The* essential element
  - Passion/determination to change
  - Courage



Cincinnati Children's Hospital Medical Center
Leadership



- Triumvirate
  - CEO, Jim Anderson
  - Board Leader, Lee Carter
  - Dr. Uma Kotagal, Director Health Policy/Clinical Effectiveness

Cincinnati Children's
change the outcome

"We're all united from frontline nurse to chairman of the board—we all have the same goal."

Uma's Strategy: Recruit Stars/Build Credibility

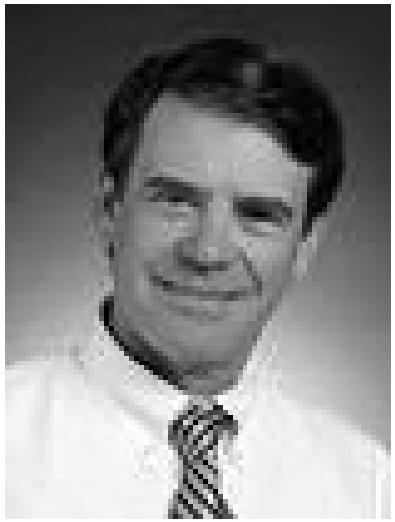
- Dr. Fred Ryckman – quality training at Intermountain, Salt Lake City
- Risky strategy
- Setting goal: Current rate 1.5 – 2% – What's the right target?
- Tackles surgical site infections – applies IHI bundle

0.5% !!

"Even though I thought it the most absurd thing I've ever heard of in my life, I agreed to do it if it would get me a moment of peace."

Transformative Experience

Dr. Ryckman: “I had spent my whole career doing what I needed to do *today* to try and save this kid’s life… Remove the liver in a donor, take it to the sickest kid, put in the new liver… I had worked on single individual patients. I remember… thinking if I could work on solving some of these quality problems you’re talking about *hundreds* of patients. The question was how can we do systems management and impact hundreds, *thousands* of patients?”



Virginia Mason Medical Center (VMMC): *Courage and Innovation*

- To Japan: *"Have you lost your mind?"*
- TPS empowers every worker to build in quality – "stop the line"
- Implement at VMMC – Nurse/doctor chemo treatment
- It's about the system – not the individual
- And it's about culture

Jönköping County, Sweden: A Learning Journey

- Sweden – generally better outcomes than US/lower cost
- Berwick: Jönköping quality work perhaps unparalleled internationally
- Qulturum – unique learning center; Göran Henriks
  - Baldrige process
  - Balanced Scorecard
  - IHI Breakthrough Series
  - IHI Pursuing Perfection
  - Dartmouth micro-system
  - Scania, Swedish truck maker, industrial quality techniques
  - Team to every IHI Annual Forum since 1996
  - Brent James Intermountain

Kaiser: Technology/Measurement

- "Any area of health care that has been measured has been improved" (George Halvorson)

KAISER PERMANENTE®

- Kaiser reflects positive trends toward
  - EHR
  - Measurement
  - Transparency
  - Competition
- Measurement + transparency = competition = quality improvement

Much Progress But Formidable Obstacles

- Two in particular –
  - Culture/attitude
  - Payment system (take it away, Don)

- Reflexive objection to quality movement – *What are you talking about?! We have the best docs, technology, hospitals…*

- Culture of health care – *"Often wrong, but never in doubt!"*

"Perfectly Perfect"???

- NYT July 29, 2008: Dr. Abigail Zuger:

  "The reformers are out to streamline the routines, retrain the workers and keep them permanently on display — an ant farm behind clear glass — to make sure things never get out of control again."

  "Incentives to minimize errors, complications and inefficiency will mount. Health care will become perfectly safe, perfectly smooth, perfectly perfect."

- Why would a doctor ridicule life-saving work?

Lack of Awareness/Understanding

- Paul Batalden: Too often physicians tended to be “in love with what they were doing and *to suggest that these smart people should do something different was an affront.”*
- Sorrel – Hopkins students – *To Err?*
- Far too many stakeholders unaware of these stories/the potential
  - Physicians/caregivers
  - Trustees
  - Administrators
  - Public officials
  - Patients

To Accelerate Change, Spread the Word

- Need to better communicate to the Dr. Zugers and others
- Need effective communications about the movement and about quality and safety – IHI, Commonwealth Fund
- But need much more –
  - Books
  - Articles
  - Blogs
  - Conferences to educate health care stakeholders and the public
- Need you to be messengers – help spread the word; tell the story – in telling the story we advance the cause