The Business Case for Patient Safety

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The Impact of Harm on Costs: Highlights from a Literature Review

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Dartmouth Institute for Health Policy and Clinical Practice
Safety and Cost

- Highlights from a literature review conducted by Elliot Wakeam, MD, Clinical Surgical Resident at University of Toronto; Cabot Fellow at Brigham and Women’s Hospital

- PubMed Search; publications within last 5 years; in-hospital

- Definition of Error and Harm
  - All or most studies include: CLABSI, VAP, SSI, CAUTI, C.Diff
  - Some include: AHRQ PSIs (e.g., foreign body, DVT/PE, falls, pressure ulcer); iatrogenic hypotension; drug reactions; redundant tests
Achievable Savings: Adverse Events & Redundant Testing

EXHIBIT 3
Percentage Of Achievable Savings, By Type Of Adverse Event Or Redundant Testing In U.S. Hospitals, 2004

- Pressure ulcers: 3%
- Pneumothorax: 1%
- Falls: 11%
- Unnecessary tests: 34%
- Adverse drug events: 15%
- Thromboembolic disease: 12%
- Hematoma: 1%
- Unnecessary tests: 34%
- Pneumonia: 8%
- Surgical site infection: 3%
- Urinary tract infection: 5%
- Catheter-related bloodstream infection: 7%

SOURCE: Rates based on literature review and authors’ analysis of data from the National Inpatient Sample (NIS). The literature review is in the online appendix, at http://content.healthaffairs.org/cgi/content/full/28/5/1475/DC1.

From Jha et al Health Affairs 2009
# National Estimates of Cost

<table>
<thead>
<tr>
<th>Authors</th>
<th>Journal, Year</th>
<th>Main Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jha</td>
<td>Health Affairs 2009</td>
<td>Readily preventable adverse events contributed to $16.6 B of total in-patient costs Redundant tests: $8 B</td>
</tr>
<tr>
<td>Shreve et al for Milliman actuaries</td>
<td>Society of Actuaries 2010</td>
<td>2008 cost of errors estimated at $19.5 billion</td>
</tr>
<tr>
<td>Van Den Bos</td>
<td>Health Affairs 2011</td>
<td>Annual Cost of Measurable Medical Errors $17.1 B in 2008</td>
</tr>
<tr>
<td>Mallow</td>
<td>J. of Medical Economics 2013</td>
<td>Post-op Infection most costly in general pop’n: $569 M Pressure Ulcers most cost in elderly: $347 M</td>
</tr>
<tr>
<td>Goodman</td>
<td>Health Affairs 2011</td>
<td>Measured “Social cost” of inpatient AE: $336 B to $884 B</td>
</tr>
</tbody>
</table>
Meta Analyses

Zimlichman et al. *JAMA Intern Med* 2013

- Examined costs with most significant/“targetable” HAIs
  - Monte Carlo simulation used to estimate attributable costs and LOS
    - CLABSI $45,814
    - VAP $40,144
    - SSI $20,785
    - CAUTI $896
    - C. Diff $11,285

Total annual costs: $9.8 billion
Conclusions

- There is a well established relationship between safety and costs of inpatient hospital care

- National estimates of the cost impact of unsafe care:
  - $16 to $20 billion
  - $9.8 billion for infectious complications

- Social Costs?
  - How to value work-years lost and social impact
  - $336-$884 billion?
Seeking Perfection in Health Care: One Organization’s Experience

Gary Kaplan, MD, FACP, FACMPE, FACPE
Chairman and CEO
Virginia Mason Medical Center
Virginia Mason
OUR STRATEGIC PLAN

Patient

VISION
To be the Quality Leader and transform health care.

MISSION
To improve the health and well-being of the patients we serve.

VALUES
Teamwork | Integrity | Excellence | Service

Strategies

People
We attract and develop the best team

Quality
We relentlessly pursue the highest quality outcomes of care

Service
We create an extraordinary patient experience

Innovation
We foster a culture of learning and innovation

Virginia Mason Foundational Elements

Strong Economics | Responsible Governance | Integrated Information Systems | Education | Research | Virginia Mason Foundation

Virginia Mason Production System
The VMMC Quality Equation

\[ Q = A \times \frac{(O + S)}{W} \]

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste
Requirements for Transformation

- Improvement Method
- Technical & Human Dimensions of Change
- Sense of Urgency
- Visible & Committed Leadership
- Aligned Expectations
- Shared Vision
Aligned Expectations

VIRGINIA MASON MEDICAL CENTER PHYSICIAN COMPACT

Organizations’ Responsibilities

Foster Excellence

- Reward and recognize the best
- Acknowledge and reward contributions to patients and the organization
- Provide opportunities for growth, development, and leadership
- Create an environment of innovation and innovation

Lead and Align

- Create and maintain an environment of innovation and innovation
- Develop and support a vision for the future
- Manage and execute with passion
- Focus on outcomes and results
- Create a culture that supports teams and individuals
- Create a culture that empowers and engages

Physicians’ Responsibilities

Focus on Patients

- Practice at the highest level of clinical and professional excellence
- Maintain patients’ safety and quality of care
- Manage patients’ care with compassion and respect
- Create an environment that promotes patients’ safety and quality of care

Communicate with Caregivers

- Communicate clinical information in clear, timely, and meaningful ways
- Provide ongoing feedback and support for caregivers
- Provide ongoing feedback and support for caregivers
- Provide ongoing feedback and support for caregivers

Take Ownership

- Commit to the goals and objectives of the organization
- Demonstrate leadership and influence at the local, regional, and national levels
- Demonstrate leadership and influence at the local, regional, and national levels
- Demonstrate leadership and influence at the local, regional, and national levels

VIRGINIA MASON MEDICAL CENTER BOARD MEMBER COMPACT

Organizations’ Responsibilities

Foster Excellence

- Provide the resources, support, and opportunities to support excellence in patient care
- Promote value in patient care, including quality, safety, and efficiency
- Support innovation and development
- Support innovation and development
- Support innovation and development

Lead and Align

- Support innovation and development
- Support innovation and development
- Support innovation and development
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- Support innovation and development

Physicians’ Responsibilities

Foster Change and Develop Others

- Promote innovation and continuous improvement
- Provide opportunities for professional development and growth
- Provide opportunities for professional development and growth
- Provide opportunities for professional development and growth
- Provide opportunities for professional development and growth

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VIRGINIA MASON MEDICAL CENTER LEADERSHIP COMPACT

Organizations’ Responsibilities

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VIRGINIA MASON MEDICAL CENTER NURSE COMPACT

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NPSF National Patient Safety Foundation

www.npsf.org
The Virginia Mason Production System

1. The patient is *always* first
2. Focus on the highest quality and safety
3. Engage all employees
4. Strive for the highest satisfaction
5. Maintain a successful economic enterprise
Where We Have Been

2002
- Adopted TPS
- AMGA Acclaim award honoree Mrs. McClinton
- Established CME course – EBM
- Created Must Do Measures criteria, information flow and accountability
- First Top in region Leapfrog survey

2003
- Implemented PSA system
- First culture of safety survey
- Implemented First 5 year Strategic Quality Plan
- Adoption IHI 100,000 lives campaign

2004
- First Top in region Leapfrog survey
- First culture of safety survey
- Implemented First 5 year Strategic Quality Plan

2005
- HealthGrades Distinguished hospital award
- 1st major decrease in central line infections
- One goal
- First clinician disclosure training
- PSA system kaizen event
- Adopted mandatory flu vaccine policy
- CPOE adopted across the inpatient setting

2006
- 2nd series of Disclosure workshops
- Revised PSA database
- Just Culture training
- Published peer review article on PSA system
- CDC Immunization Excellence award
- QOC began reviewing all red PSAs

2007
- 1st major decrease in central line infections
- One goal
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- PSA system kaizen event
- Adopted mandatory flu vaccine policy
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- Revised PSA database
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2009
- Top Hospital of the Decade
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- Top Hospital of the Decade
- Top Hospital of the Decade

2010
- First Worker Safety Risk Register
- Second Patient Safety Risk Register
- Respect for People Training
- Standard of Care Process Kaizen
- Surgical time out ST PRA held
- SSI team McClinton Patient Safety Award winner
- PSA 3P
- Completed first Patient Safety Risk Register

2011
- Established Synchronized Ongoing Support Process
- Achieved target of 1000 PSAs reported in one month
- Began PSA Pointers

2012

2013

2014
Guiding Vision: Hippocratic Oath

First, do no harm

Priority Zero Defects

First priority, zero defects
Mistakes are Fixed at the Source

Within process

Just After

Just Before

Downstream

A

B

C

Poka-yoke

Self Check

Successive Check
Patient Safety Alert

Process for alerting a response team to immediately review and assess risk, develop and implement a corrective action plan.

Can be a discreet single event or an event having more complex issues.
Patient Safety Alert System 24/7

Dial 30000

Use the Web
40,000th PSA Reported

End of January 2014: 43,615
“Stopping the Line”
Organization-Wide Involvement

1. **Staff** report issues using the Patient Safety Alert System

2. **Leadership** investigates and resolves issues

3. **Board Quality Committee** review/approve closure of high-severity issues
This is a good question. He must have read the materials before the meeting.
Safety Innovation

Patient Safety Risk Register
April 2013

7,469 PSAs reported in 2012
1,319 PSAs with recorded injury
42% reporting increase over 2011

$865,860 total cost to VM
$564,599 in waived fees
$301,261 in indemnity payments

The top five risks to patients represent
70% of recorded injury
71% of total costs
56% of all reported events

Highlights
1. Coordination & Scheduling
   Highest volume of harm.
   Second highest number of events.
   115 patients had injury.
   The most common theme was a defect or delay in responding to an urgent or emergent clinical condition.

2. Medication Issues
   Highest reporting rate.
   366 patients had injury.
   More than half of these events were detected after the medication was given or after the intended delivery time.

3. Direct Patient Care Issues
   31% of total known costs.
   320 patients had injury.
   The most common themes and reasons for cost were falls, Aspiration, and Monitoring concerns.
   Almost all events (89%) occurred either on the hospital ward or at a medical office.

Information sources:
Patient Safety
Analytics
Financial Services
Claims

Staff Safety Risk Register
April 2013

10,957 reports in 2012
1,547 staff exposed to risk
497 staff reported physical injury
100 staff reported emotional injury

$544,461 in medical treatments
2,361 days lost to work

The top five risks to staff represent
63% of recorded injury
76% of total costs
85% of days lost to work

Highlights
1. Lifting
   Highest cost for treatment ($280,875).
   Most days lost to work (1,449).
   97 staff members reported lifting injuries.
   Last year also #1 for cost and days lost to work.

2. Physical abuse by patients
   Most reported events in a specific category (137).
   Half resulted in a physical injury to a staff member.

3. Invasive Injuries
   Mostly involved needles and blades.
   Largest number of staff injuries (98).

Information sources:
Employee Health
Human Resources
Security
Patient Safety
3rd Party Providers

NPSF
National Patient Safety Foundation®
www.npsf.org
Visual Control for Safety

5S Anesthesia Shadow Board - After
Standard Work Decreases Variability

Central Line Insertion Standard Work

Before

Dry:
- 30 sec scrub
- 30 sec dry
Wet:
- 2 min scrub
- 1 min dry

Maximum Barrier Protection
Thyroid
Angio Drapes

During

Transducer Kit in Top Drawer of Cart

Transducer Method

Manometer Method

After

“Approved to use
Date/Initial

Yellow – top of cart

Complete Paperwork

White – in chart progress notes
Safety Innovation

Synchronized Ongoing Support (SOS): An Integrated Response to Unanticipated Outcomes

1. Major unexpected clinical need; or
2. Major immediate family need; or
3. Urgent non-clinical support need

Dial ‘0’ for Patient Safety & Patient Relations

- Identify needs, just-in-time coaching
  - Patient advocate
  - Patient safety
  - Provider
  - Clinical team
  - Peer to Peer
- Assess needs, align resources, plan next steps
  - Administrator
  - Patient advocate
  - Mgr/Primary RN
  - RN supervisor
  - Spiritual care
  - Social work
  - Patient safety
- Support immediate needs of team
  - Area leader
  - Involved team
- Support needs of patient and family
  - Patient advocate
  - Tailored check-ins
  - Navigates needs
  - Coordinates follow up meeting
- Support needs of team member(s)
  - Team debrief
  - Tailored Check-ins
  - Spiritual care
  - EAP
  - Schwartz Rounds
- Star support ongoing
- Quality improvement
  - Systems review
  - Patient safety
  - PSA process
  - Care Review
  - Root Cause Analysis
  - Preparation
  - Follow up family meeting

Time zero - tailored
Within 30 minutes
Within 12 hours
Tailored to needs
Tailored to needs
Within 8 weeks

SOS – A standard response that is transparent, individualized and phased to promote restoration and growth for all touched by the event.
Effectiveness of Patient Safety Program

Total Number of Claims and PSAs reported
Maintain a Successful Economic Enterprise

Reduction of Hospital Professional/General Liability Premiums
## Cost of Poor Quality

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Additional Cost per Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-op Infection</td>
<td>$13,312</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>$8,730</td>
</tr>
<tr>
<td>Urinary Track Infection</td>
<td>$6,904</td>
</tr>
<tr>
<td>Fall with Injury</td>
<td>$13,300</td>
</tr>
<tr>
<td>Ventilator Associated Pneumonia</td>
<td>$40,000</td>
</tr>
<tr>
<td>Delirium</td>
<td>$16,303</td>
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</tbody>
</table>
Impact of Poor Quality on Margin

Fee for Service
- $$ paid for all services provided

Bundled Payment/DRG
- $$ paid for episode of care
- $$ cost of error subtracted from payment

Capitated/Accountable Care
- $$ organization accountable for all costs of care

$ MARGIN
Respect for People refers to how we treat each other as we work together to create the perfect patient experience.
Top 10 Ways to Show Respect to People

1. **Listen to understand.** Good listening means giving the speaker your full attention. Non-verbal cues like eye contact and nodding let others know you are paying attention and are fully present for the conversation. Avoid interrupting or cutting others off when they are speaking.

2. **Keep your promises.** When you keep your word you show you are honest and you let others know you value them. Follow through on commitments and if you run into problems, let others know. Be reliable and expect reliability from others.

3. **Be encouraging.** Giving encouragement shows you care about others and their success. It is essential that everyone at VM understand their contributions have value. Encourage your co-workers to share their ideas, opinions and perspectives.

4. **Connect with others.** Notice those around you and smile. This acknowledgement, combined with a few sincere words of greeting, creates a powerful connection. Practice courtesy and kindness in all interactions.

5. **Express gratitude.** A heartfelt “thank you” can often make a person’s day and show them you notice and appreciate their work. Use the VM Appliance system, a handwritten note, verbal praise, or share a story of “going above and beyond” at your next team meeting.

6. **Share information.** When people know what is going on, they feel valued and included. Be sure everyone has the information they need to do their work and know about things that affect their work environment. Sharing information and communicating openly signals you trust and respect others.

7. **Speak up.** It is our responsibility to ensure a safe environment for everyone at VM, not just physical safety but also mental and emotional safety. Create an environment where we all feel comfortable to speak up if we see something unsafe or feel unsafe.

8. **Walk in their shoes.** Empathize with others; understand their point of view, and their contributions. Be considerate of their time, job responsibilities and workload. Ask before you assume your priorities are their priorities.

9. **Grow and develop.** Value your own potential by committing to continuous learning. Take advantage of opportunities to gain knowledge and learn new skills. Share your knowledge and expertise with others. Ask for and be open to feedback to grow both personally and professionally.

10. **Be a team player.** Great teams are great because team members support each other. Create a work environment where help is happily offered, asked for and received. Trust that teammates have good intentions. Anticipate other team members’ needs and clearly communicate priorities and expectations to be sure the work load is level loaded.
Leapfrog Hospital Recognition

The scatter plot below illustrates how your hospital compares to others in the state and across the country on Quality and Resource Use. (Please note that a higher Resource Use score is better.) Refer to the National Efficiency Score Comparison chart to better understand how your hospital ranks in overall Efficiency compared to others. Leapfrog’s 2010 database contains 1,184 hospitals from 45 states.

Summary Scores
- Quality 90
- Resource Use 91
- Efficiency 90

National Efficiency Score Comparison

<table>
<thead>
<tr>
<th>Decile</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top</td>
<td>74 or better</td>
</tr>
<tr>
<td>2nd</td>
<td>66 to 74</td>
</tr>
<tr>
<td>3rd</td>
<td>61 to 66</td>
</tr>
<tr>
<td>4th</td>
<td>57 to 61</td>
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<td>5th</td>
<td>53 to 57</td>
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<td>6th</td>
<td>49 to 53</td>
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<td>7th</td>
<td>45 to 49</td>
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<tr>
<td>8th</td>
<td>39 to 45</td>
</tr>
<tr>
<td>9th</td>
<td>31 to 39</td>
</tr>
<tr>
<td>10th</td>
<td>Less than 31</td>
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</tbody>
</table>

Note: Decile score ranges are rounded to the nearest whole number.
“In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

Eric Hoffer
New Payment Programs:
The Cost of Harm Hits the Bottom Line

Janet Corrigan, PhD, MBA
Distinguished Fellow
Dartmouth Institute for Health Policy and Clinical Practice
Health Care Payment: Changing Context

- Service-Based (e.g., FFS)
- Bundled Payments (e.g., ACOs)
- Blended Payments
- Global Medical Payments (e.g., Medicare Advantage)
- Global Medical and Social Payments
Potential Impact of Preventable Harm on Hospital Bottom Lines

- David et al., *Value in Health* (2013)
  - 4 million injuries yearly in hospitals
  - Median marginal cost per error was about $892 for 2008 and $939 for 2009
  - ONLY pressure ulcers and CAUTI were Medicare “no pay” events, but they were among the most expensive in terms of overall costs

- Waters et al., *Amer. J. of Medical Quality* (2011)
  - Michigan Keystone ICU Patient Safety Program
  - Estimated cost of HAI: $12k to $56k
  - Average cost of safety intervention: $3375 per infection averted
Leveraging the New Payment Environment

- Communicating importance of investing in safety -- include estimates of cost impact along with stories that illustrate the human impact

- Setting safety goals -- include both reductions in harm and costs

- Reporting on performance --
  - Track and report on cost savings associated with safety interventions
  - Track and report losses associated with preventable AE

- Positive public relations -- communicate “days since” metric and cost savings

- Other ideas??
Questions?

To Ask a Question:
Type your question here and click 'Submit'
About NPSF

Tejal Gandhi, MD, MPH, CPPS
President
National Patient Safety Foundation
OUR VISION
Creating a world where patients and those who care for them are free from harm

OUR MISSION
NPSF partners with patients and families, the health care community, and key stakeholders to advance patient safety and health care workforce safety and disseminate strategies to prevent harm
Stand Up for Patient Safety Program

NPSF’s organization-based membership program:

- Providing tools, resources and education to help health care organizations launch, sustain and advance patient safety initiatives, including:
  - Complimentary continuing education programs for all staff
  - Ready-to-use toolkits
  - Production-ready patient materials

Learn more.
www.npsf.org/StandUp
Patient Safety Immersion Initiative

A powerful blending of three high-value NPSF resources for your team:

- Membership in the American Society of Professionals in Patient Safety
- Access to NPSF’s self-paced CE/CME Online Patient Safety Curriculum
- An opportunity to sit for the first evidence-based credentialing exam in patient safety (CPPS – Certified Professional in Patient Safety)

Learn more.
www.npsf.org/PSII
Ask Me 3®

Ask Me 3 helps patients be active members of their health care teams.

Learn more.
www.npsf.org/AskMe3

What is my main problem?

What do I need to do?

Why is it important for me to do this?

Diagnosis

Treatment

Context

Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation
Learn More

Contact the National Patient Safety Foundation

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**NPSF**

National Patient Safety Foundation®

www.npsf.org
Thank you for joining us!