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The Pursuit of “Perfect Care” Trustees’ Responsibility for Patient Safety and Clinical Quality

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HTNYS

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Hospitals are hazardous to your health.



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The Dilemma

Unaffordable

Unsafe

Impersonal

Uncoordinated

Wasteful

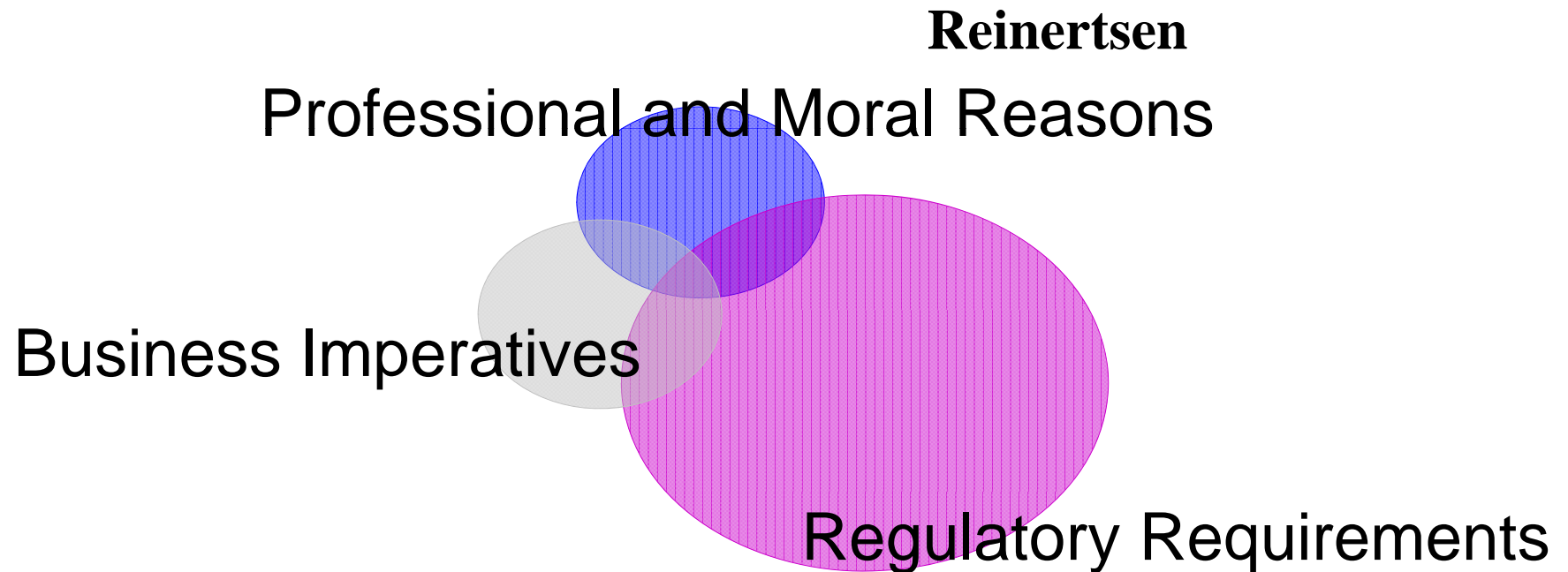
Overuse/underuse/misuse of
resources

CMS is driving the safety/quality
initiative via P4P



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Three Drivers for Hospitals to Improve Quality





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Exciting Developments

- Concept of ACOs/Medical Homes
- Toyota Lean
- Potential for balanced accountability
 - Effectiveness
 - Efficiency
 - Patient experience
 - Appropriateness



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- Culture of orders
- Don't think in terms of process, all change begins and ends with education
- See vigilance and memory as primary
- Don't communicate well
- Leadership styles of command and pacesetting



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Physician Culture

- Autonomy-expert culture
- Town hall democracy
- Decision-making
- Implications for peer review and process standardization



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The Data Dilemma

and

Importance of Real-Time Feedback



Administrators and doctors speak a different language.



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- Clinical outcome the important metric, not balanced accountability
- Apostrophe's attitude
- No understanding of medical economics
- Don't think systemically
- Don't appreciate procedural justice
- Want to fix things



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Vigilance and Competence





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Safety and Human Error: Challenges

- Medicine Views Errors as Failings That Deserve Blame/Fault
- Blame and Train Mentality
- Blind Adherence to Rules
- Corrective Actions Focusing on Individual
- No Blood No Foul Philosophy

- *Bagian*



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Failure to Follow Policy Is Rarely the Root Cause



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Safety Is the Moral High Ground



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**What Would the Response be if
the CFO Failed to Send a Bill
15% of the Time?**



Why won't we wash our hands?



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How Can We Get to the Status of Operating Room “Sterile Technique?”

**We need to demonstrate the will. Issues of
patient safety must be non-negotiable!**



I'm not going to
take it anymore!





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The Importance of Communication and the Disruptive Physician

Intimidation

Arrogance



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Key Issues . . .

- Migration toward the mean
- Mediocrity: Lose your best people
 - Productivity drives morale
- Excellence is a form of deviant behavior
- It's all about having the will



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Redundant Systems Versus Efficiency



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Conclusions

Structure, Process, Outcome

1. Intensivists and hospitalists
2. Employing physicians
3. Movement toward physician directors of “service lines”
4. Younger physician attitudes



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What Can You Do Right Now?

- Encourage open clear communication
 - Verbal
 - Written
- Pre-brief and de-brief
- Close call emphasis
- FMEA
- Cognitive aids and checklists
- Eliminate the “who’s at fault?” question as initial response
- Leadership responsibility

- *Bagian*