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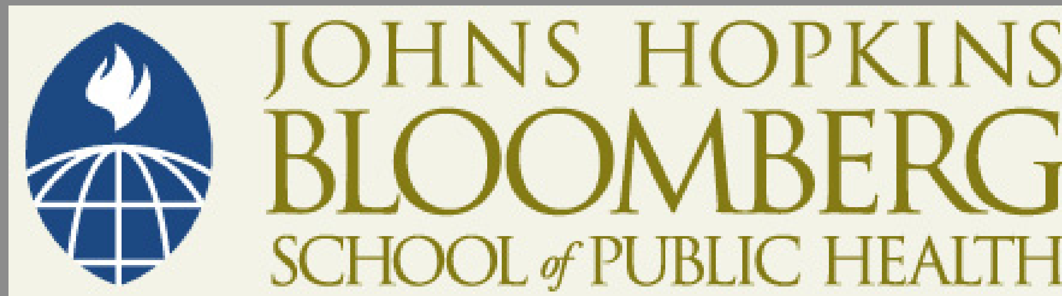


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# *The IOM Report(s)*


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# *Section A*

## To Err Is Human

# *Prior to "The" IOM Report*

- National Halothane Study
- Anesthesia Patient Safety Foundation
- Celebrated cases
  - Libby Zion
  - Betsy Lehman
- Harvard Medical Practice Study

# *Institute of Medicine Report (1999)*

- The problem is large
- Health care workers are not to blame
- Errors and safety are caused by systems

# A Systems Approach Is Necessary

- Errors are a leading cause of death and injury
- Blaming an individual does not change the factors and conditions that contribute to errors, and the same error is likely to recur
- Preventing errors and improving patient safety requires a systems approach
- Leadership, knowledge, and tools are needed

# Lesson 1: The Problem Is Large

- 44,000–98,000 deaths annually
- 7,000 death from medication errors
- Total cost of preventable adverse events is between $17 and $29 billion

Relative silence surrounds the issue

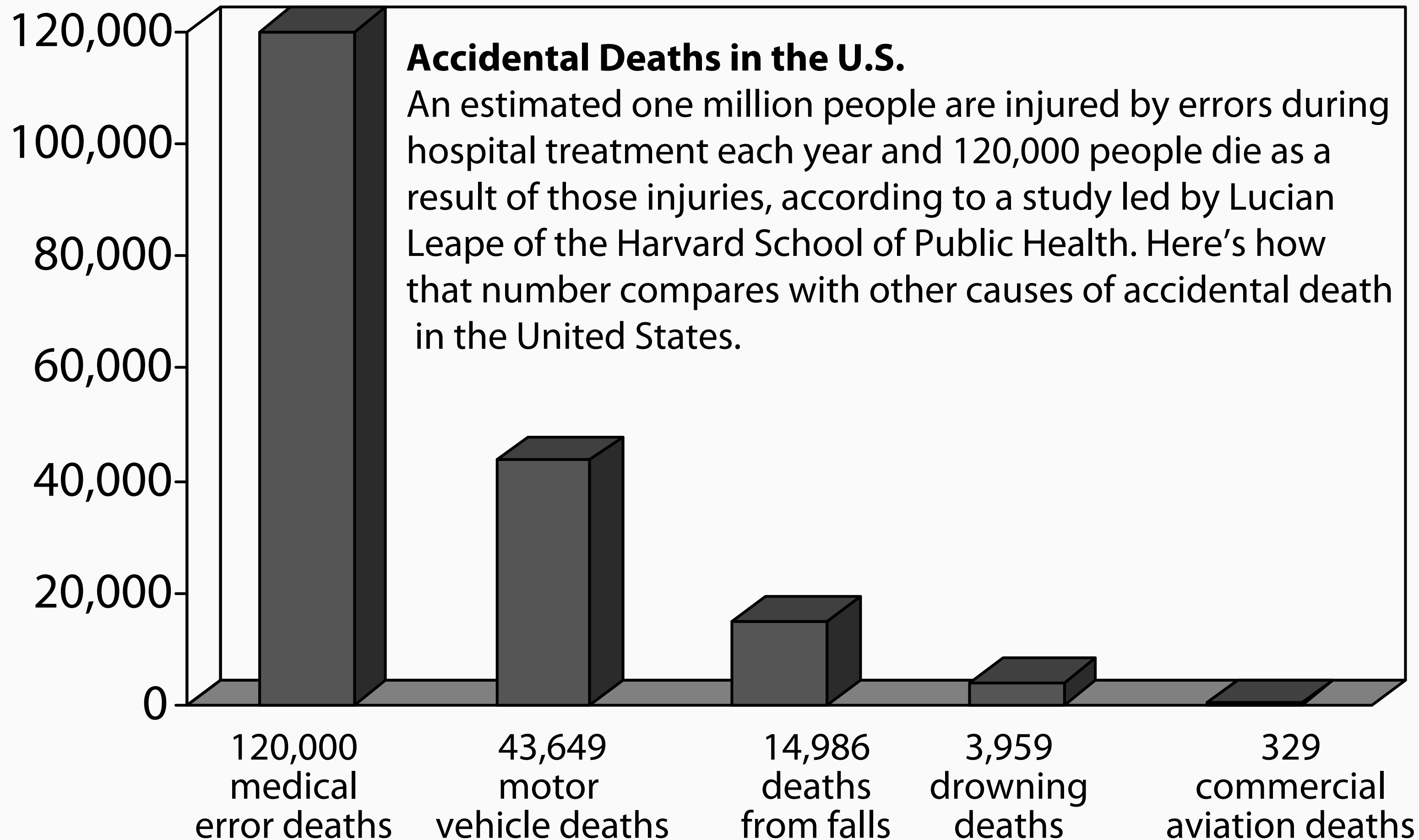
## *Lesson 1: The Problem Is Large*

- 44,000–98,000 deaths annually
- 7,000 death from medication errors
- Total cost of preventable adverse events is between $17 and $29 billion

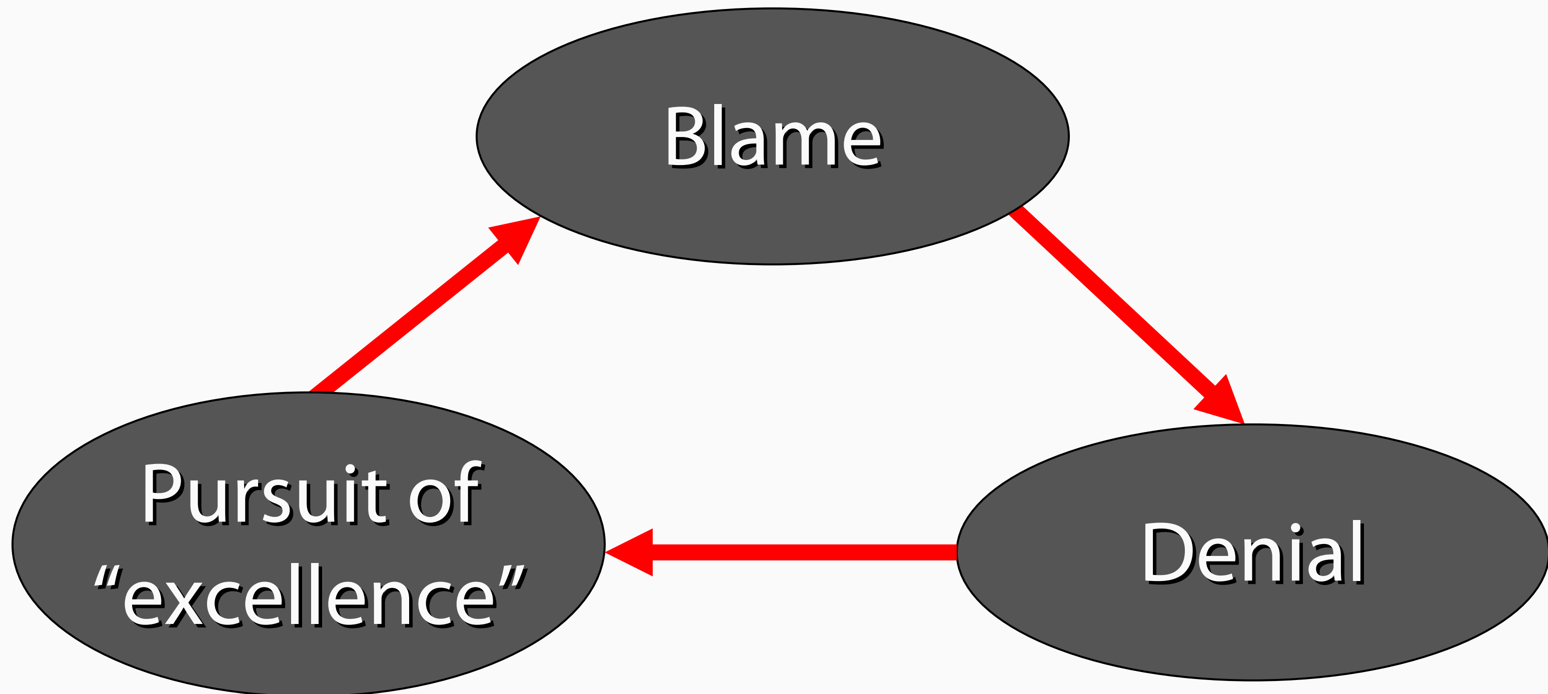
More than from motor vehicle accidents, breast cancer, or AIDS

# *Institute of Medicine Report, November 29, 1999*

- Errors kill 44,000–98,000 in U.S. hospitals each year



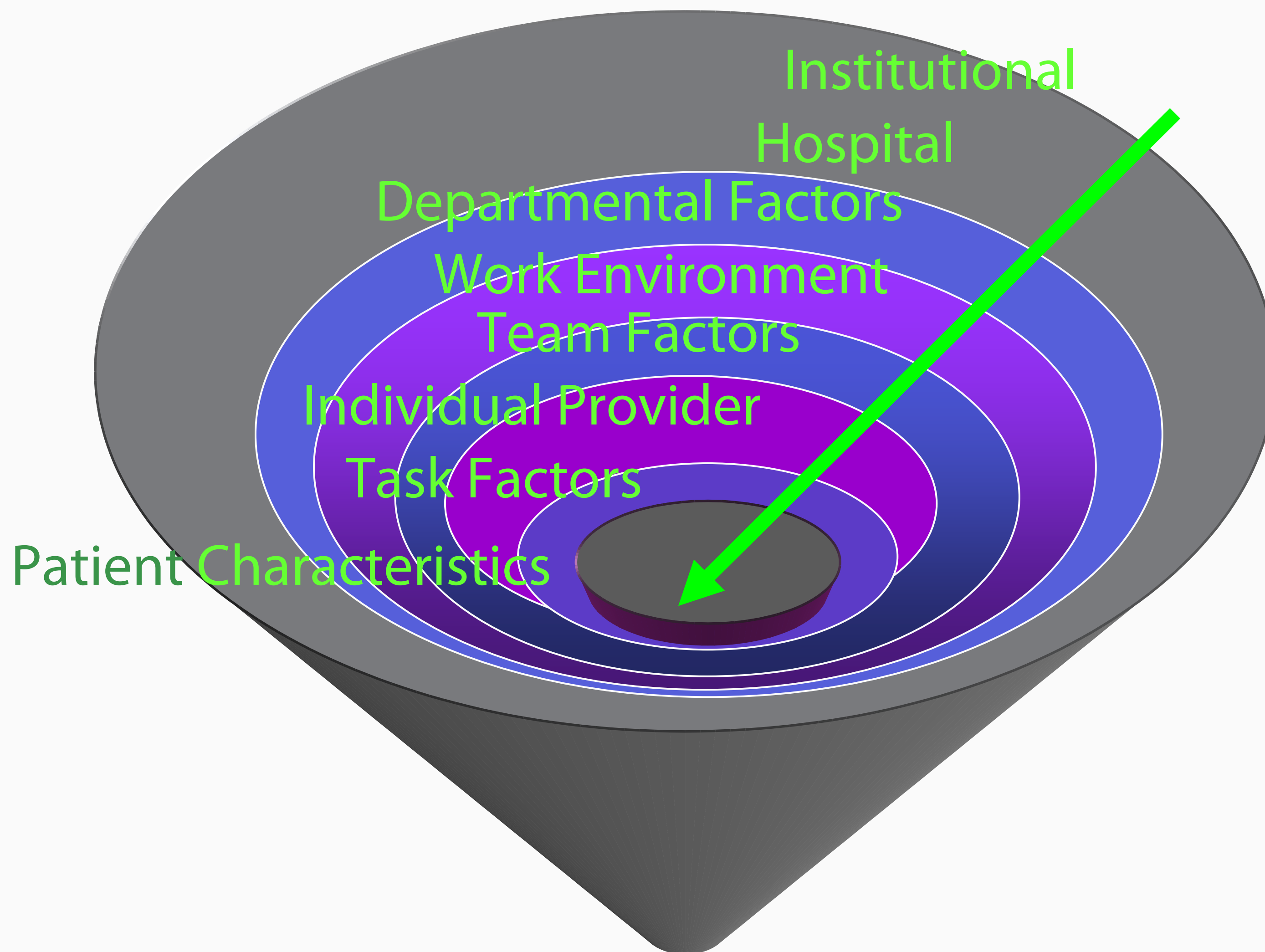

Source: The Philadelphia Inquirer and the National Safety Council.




The Vulnerable System Syndrome

Source: Reason. (1990).

# Lesson 3: Errors and Safety Result from System Factors



## *A Comprehensive Approach*

- Needed to achieve a 50% reduction in errors over 5 years
- Leadership at level of government and health care organizations
- Enhance knowledge and tools
- Break down legal and cultural barriers that impede safety improvement

## *Errors Can Be Prevented*

- To err is human, but errors can be prevented
- Safety is a critical first step in improving quality of care

# *December 7, 1999*

- December 7, 1999: President Clinton directed the Quality Interagency Coordination Task Force to respond with a strategy to identify prevalent threats to patient safety and reduce medical errors
  - Goal: Reduction in medical errors by 50% in next 5 years

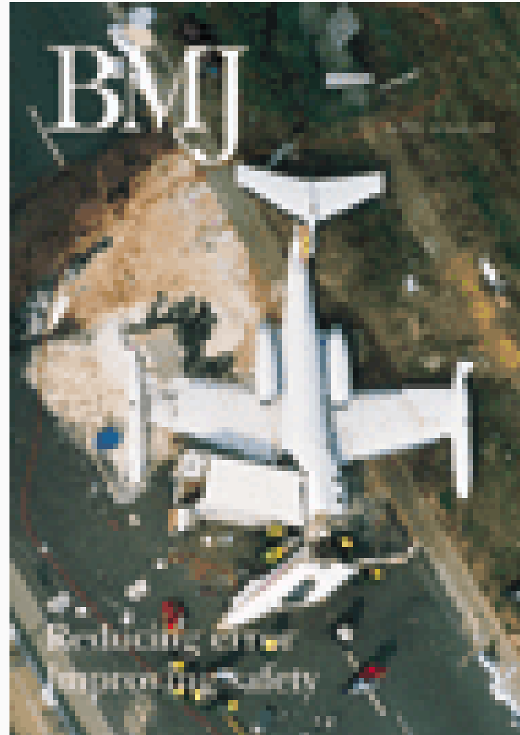
# *QuIC Report to the President*

- Report of the Quality Interagency Coordination Task Force (QuIC) to the President, February 2000
  - *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*

## *Steps Toward Increasing Safety*

- Center for Patient Safety formed within the Agency of Healthcare Research and Quality
- Funding provided for reporting systems
- Greater attention on patient safety paid by regulators and accreditors
- Greater emphasis paid to patient safety within health care organizations

# BMJ Devotes Issue to Medical Error




British Medical Journal,
*March 18, 2000*

# Ladies' Home Journal Publishes Article on Medical Error

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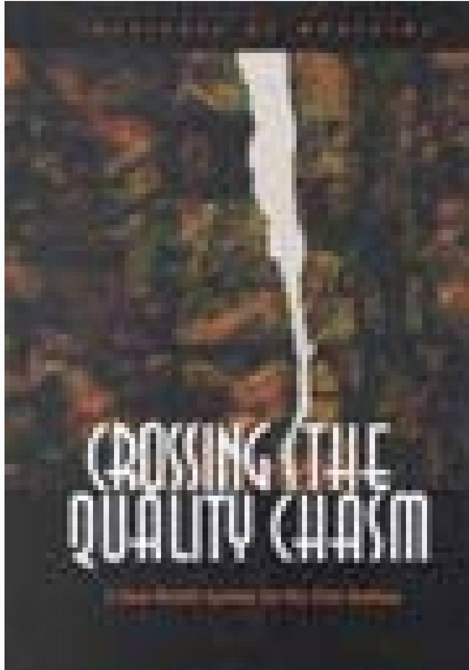
# *Section B*

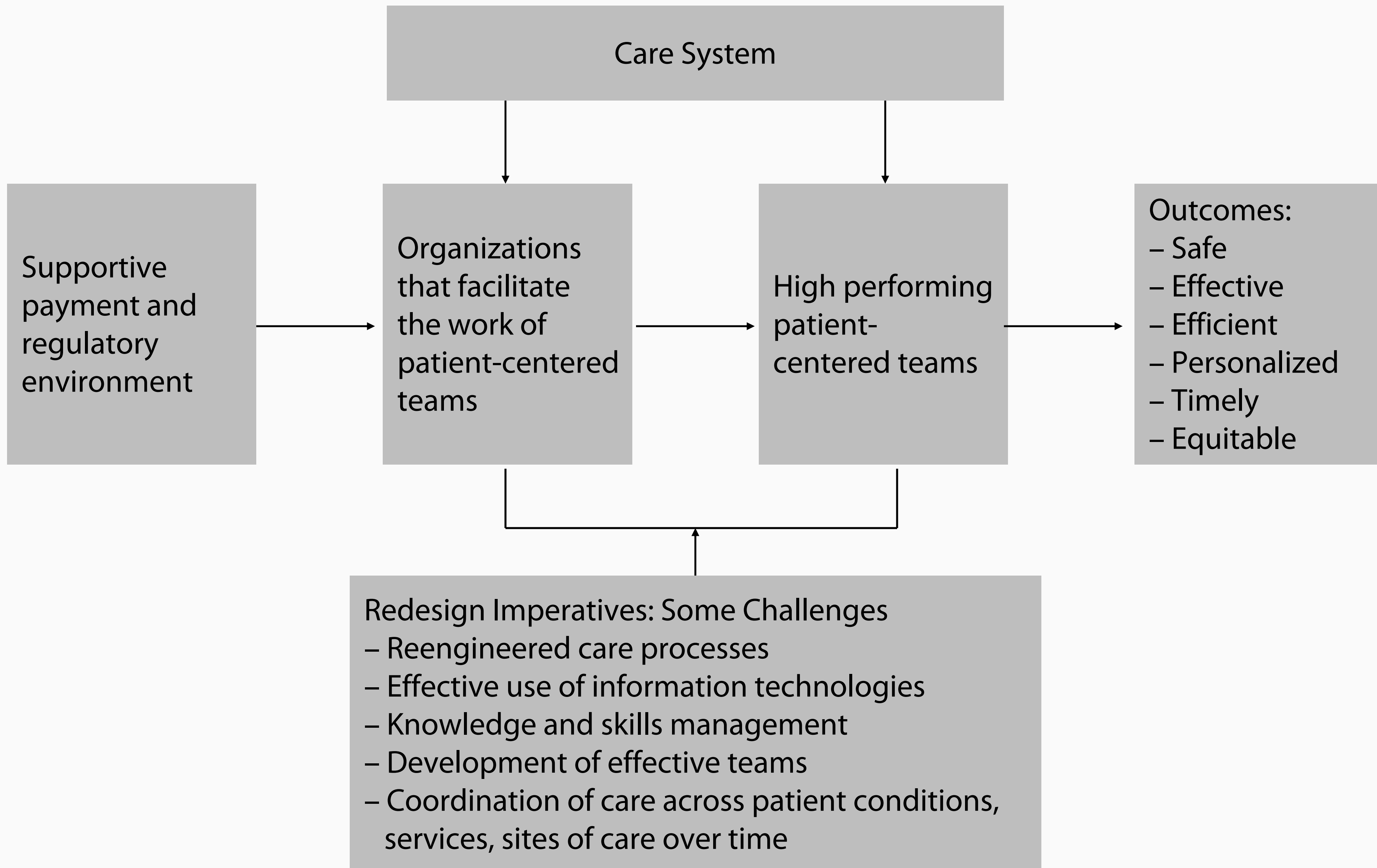
## Crossing the Quality Chasm

# A New Health System for the 21st Century




"Americans should be able to count on receiving care that uses the best scientific knowledge to meet their needs, but there is strong evidence that this frequently is not the case. The system is failing because it is poorly designed. . . . For too many patients, the health care system is a maze, and many do not receive the services from which they would likely benefit."

# Optimal Patient Outcome System




Source: The Institute of Medicine. (2001). Crossing the quality chasm.

# *High Quality of Care*

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

# Simple Rules for the 21st-Century Health Care System

| Current approach | New rule |
| --- | --- |
| Care is based primarily on visits | Care is based on continuous healing relationships |
| Professional autonomy drives variability | Care is customized according to patient needs and values |
| Professionals control care | The patient is the source of control |
| Information is a record | Knowledge is shared and information flows freely |
| Decision making is based on training and experience | Decision making is evidence-based |
| Do no harm is an individual responsibility | Safety is a system property |
| Secrecy is necessary | Transparency is necessary |
| The system reacts to needs | Needs are anticipated |
| Cost reduction is sought | Waste is continually decreased |
| Preference is given to professional roles over the system | Cooperation among clinicians is a priority |

# *Crossing the Quality Chasm*

- Redesigning the health care delivery system will require changing the structures and processes of the environment in which health professionals and organizations function in four main areas

# *Four Changes in Structure and Process*

- Applying evidence to health care delivery
- Using information technology
- Aligning payment policies with quality improvement
- Preparing the workforce

# *Evidence-Based Practice*

- Move from practice based on tradition to practice based on evidence

# *Information Technology*

- Electronic health records
- Reporting systems
- Automated treatment delivery systems

# *Payment Policy*

- Public and private purchasers should develop payment policies that reward quality
- Current methods provide little financial reward for improvements
- Compensation methods should be more closely aligned with quality-improvement goals

# *Preparing the Workforce*

- Change the way health professionals are trained
- Modify regulation and accreditation
- Use the liability system to support changes in care delivery

# *Essential Reading*

- To Err Is Human: Building A Safer Health System. National Academies Press, 2000
- Crossing the Quality Chasm: A New Health System for the 21$^{st}$ Century. National Academies Press, 2001