Rhoads Oration

Samuel D. Gross, M.D.
Chair of Surgery,
Jefferson Medical College
Founder, Philadelphia
Academy of Surgery and
American Surgical Association

Jonathan E. Rhoads, M.D.
Chair of Surgery,
University of Pennsylvania
President, Philadelphia
Academy of Surgery and
American Surgical Association

Leading Ourselves Out of the Chaos of the Current Healthcare Crisis

John R. Clarke, M.D.

Professor of Surgery, Drexel University

Clinical Director for Patient Safety, ECRI

Clinical Director PA Patient Safety Reporting System

Drexel

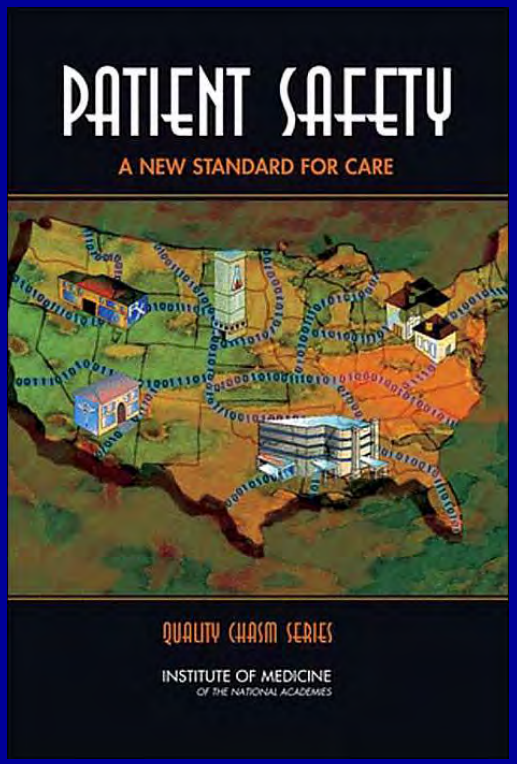
ECRI Institute
The Discipline of Science. The Integrity of Independence

COMMONWEALTH OF PENNSYLVANIA
PATIENT SAFETY AUTHORITY

From the Perspective of:

- ACS Board of Governors
- ACS Patient Safety and Quality Improvement Committee
- Institute of Medicine
  Committee on Patient Safety Data Standards
- National Academy for State Health Policy Advisory Group
- National Quality Forum Executive Institute Task Force
- Pennsylvania Governor's Office of Health Care Reform Advisory Panel on the Quality of Health Care

Institute of Medicine Committee on Patient Safety Data Standards



Federal Patient Safety & Quality Improvement Act of 2005

Governor's Office of Health Care Reform Advisory Panel on the Quality of Healthcare

Prescription for Pennsylvania

Concerns of the ACS Fellows

"The B/G meetings were quite interesting, but focused on reimbursement and liability issues …" Linwood Haith

America's Lagging Health Care System

NYT 10/11/07

Americans are increasingly frustrated about the subpar performance of this country's fragmented health care system, and with good reason. A new survey of patients in seven industrialized nations underscores just how badly sick Americans fare compared with patients in other nations. One-third of the American respondents felt their system is so dysfunctional that it needs to be rebuilt completely — the highest rate in any country surveyed. The system was given poor scores both by low-income, uninsured patients and by many higher-income patients.

The survey, the latest in a series from the Commonwealth Fund, is being published today on the Web site of Health Affairs, a respected health policy journal. Researchers interviewed some 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States.

Given the large number of people uninsured or poorly insured in this country, it was no surprise that Americans were the most likely to go without care because of costs. Fully 37 percent of the American respondents said that they chose not to visit a doctor when sick, skipped a recommended test or treatment or failed to fill a prescription in the past year because of the cost — well above the rates in other countries.

Patients here were more likely to get appointments quickly for elective surgery than those in nearly all the other countries. But access to primary care doctors, the mainstay of medical practice, was often rocky. Only half of the American adults were able to see a doctor the same day that they became sick or the day after, a worse showing than in all the other countries except Canada. Getting care on nights and weekends was problematic.

Often the care here was substandard. Americans reported the highest rate of lab test errors and the second-highest rate of medical or medication errors.

The findings underscore the need to ensure that all Americans have quick access to a primary care doctor and the need for universal health coverage — so that all patients can afford the care they need. That's what all of the presidential candidates should be talking about.

Overall Views of the Health Care System in Seven Countries, 2007

Percent reported:	AUS	CAN	GER	NETH	NZ	UK	US
Only Minor Changes Needed	24	26	20	42	26	26	16
Fundamental Changes Needed	55	60	51	49	56	57	48
Rebuild Completely	18	12	27	9	17	15	34

Source: 2007 Commonwealth Fund International Health Policy Survey

Quality Chasm

S afety

T imeliness

E fficacy

E fficiency

E quity

P atient-centered

Prescription for Pennsylvania

Prescription for Pennsylvania is a set of integrated practical strategies for improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost.

Right State | Right Plan | Right Now

From the Governor's Office of Health Care Reform

July 9

Health insurance average: $12,106

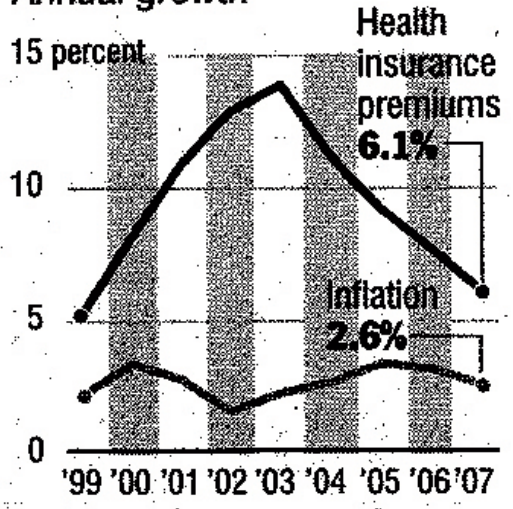
By Jane M. Von Bergen
INQUIRER STAFF WRITER

Health insurance premiums for the average family topped $12,000 in 2006 — more than the cost of an economy car — according to an an-

Paying a Premium

Health insurance premiums rose 6.1 percent this year, a slower growth rate than in 2006 but still more than twice as fast as inflation.

Annual growth



SOURCE: Kaiser Family Foundation

Associated Press

showed:

Health insurance average: $12,106

By Jane M. Von Bergen
INQUIRER STAFF WRITER

Health insurance premiums for the average family topped $12,000 in 2006 — more than the cost of an economy car — according to an an-

Every Year

2007 Chevrolet Aveo

MSRP: $9995 - $13510
City Mileage: 27 mpg Hwy Mileage: 37 mpg

Research, Photos, Reviews, etc
Build with Options
Get Chevrolet Aveo Price Quote

2007 Hyundai Accent

MSRP: $10415 - $15015
City Mileage: 32 mpg Hwy Mileage: 35 mpg

Research, Photos, Reviews, etc
Build with Options
Get Hyundai Accent Price Quote

2007 Kia Rio

MSRP: $10770 - $14595
City Mileage: 32 mpg Hwy Mileage: 35 mpg

Research, Photos, Reviews, etc
Build with Options
Get Kia Rio Price Quote

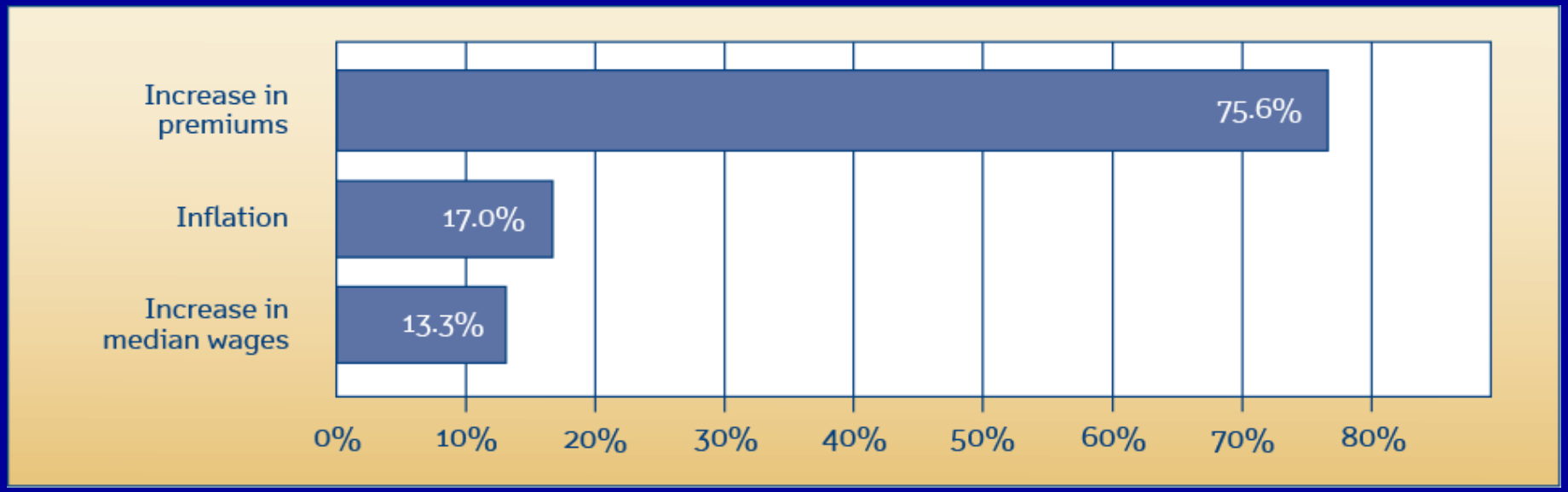
2007 Toyota Yaris

MSRP: $11150 - $14250
City Mileage: 34 mpg Hwy Mileage: 40 mpg

Research, Photos, Reviews, etc
Build with Options
Get Toyota Yaris Price Quote

From the Governor's Office of Health Care Reform

Pennsylvania's Employees and Pennsylvania's Businesses Cannot Keep Up with Health Care Inflation



% Increase in Family Health Insurance Premiums vs. Inflation and Increase in Median Wages in PA Between 2000 and 2006

philly.com

179th Year, No. 90

July 8/29/07

Census' take on health, wealth

Health-care coverage: The number of people without health insurance continues to rise.

By Stacey Burling
INQUIRER STAFF WRITER

In a move sure to enliven the debate on health care, the U.S. Census Bureau released new data yesterday showing that the number of people without health insurance is continuing to rise.

Forty-seven million people — 15.8 percent of the population — are now uninsured, up from 44.8 million, or 15.3 percent, in 2005.

For one of the richest countries in the world "to have 15.8 percent of our residents without health-care coverage is horrible," said Ann Torregrossa, director of policy for Gov. Rendell's office of health-care reform. "Something has to be done."

Health-care advocates were especially concerned about an increase in the number of uninsured children. One in nine children — 11.7 percent — lacks insurance. In 2005, 8.0 million, or 10.9 percent, had no health-care coverage.

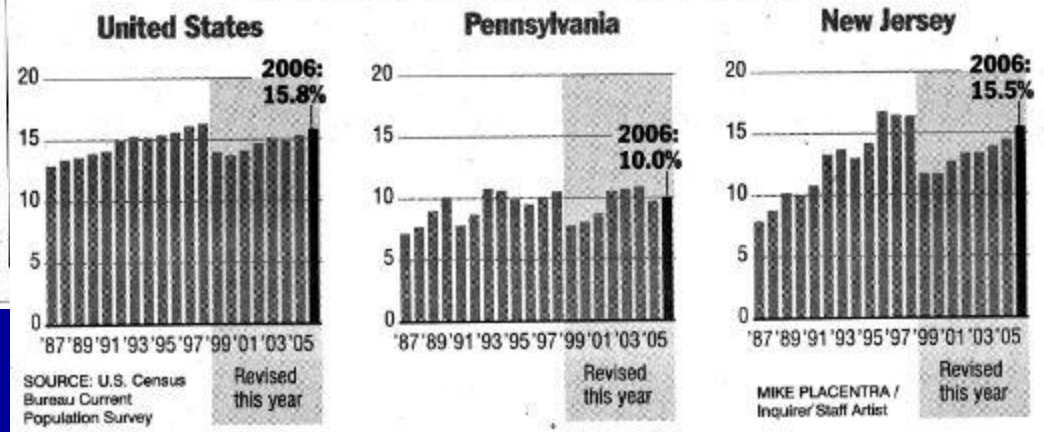
Congress and President Bush are wrangling over funding for the

See **UNINSURED** on A4

Health Insurance Coverage

The Census Bureau began collecting data on health insurance in 1987. Since that time, the number of people without health coverage has slowly risen.

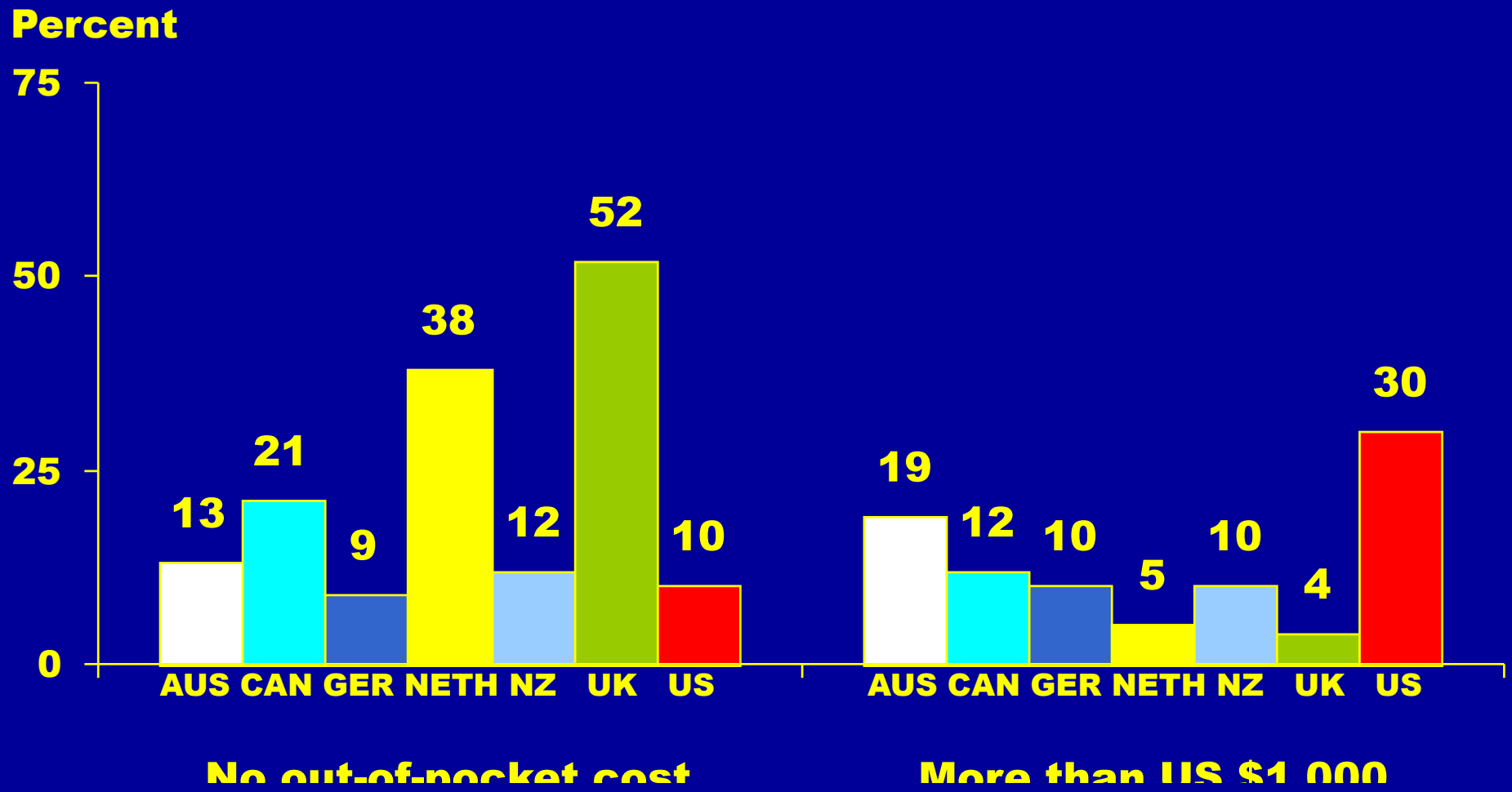
Percentage of people not covered by health insurance



SOURCE: U.S. Census Bureau Current Population Survey

MIKE PLACENTRA / Inquirer Staff Artist

Out-of-Pocket Medical Costs in the Past Year



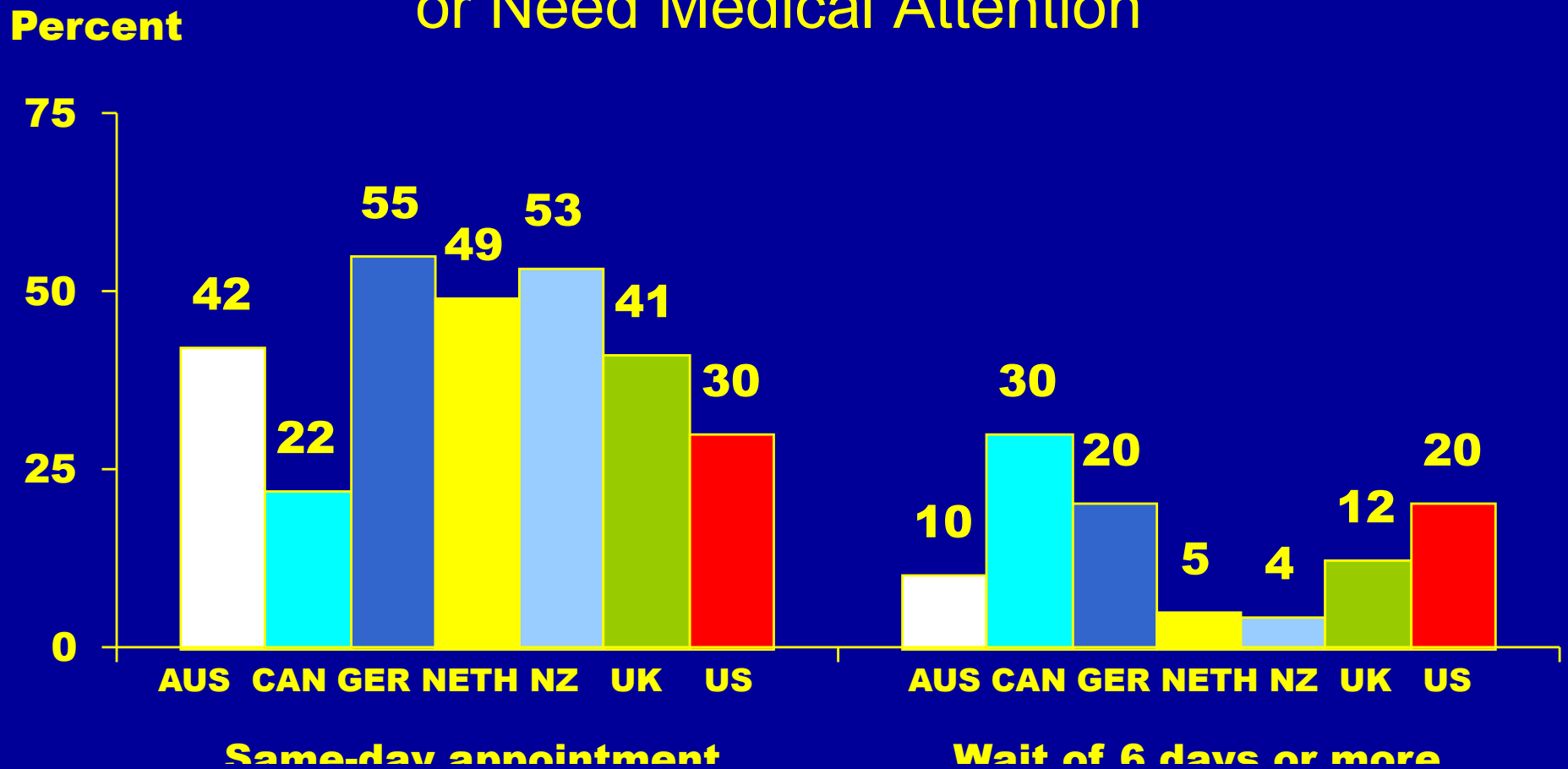
Source: 2007 Commonwealth Fund International Health Policy Survey

Cost-Related Access Problems

Percent in past year due to cost:	AUS	CAN	GER	NETH	NZ	UK	US
Did not fill prescription or skipped doses	13	8	11	2	10	5	23
Had a medical problem but did not visit doctor	13	4	12	1	19	2	25
Skipped test, treatment or follow-up	17	5	8	2	13	3	23
Percent who said yes to at least one of the above	26	12	21	5	25	8	37

Source: 2007 Commonwealth Fund International Health Policy Survey

Access to Doctor When Sick or Need Medical Attention



Source: 2007 Commonwealth Fund International Health Policy Survey

Care Coordination

Percent reported in past two years:	AUS	CAN	GER	NETH	NZ	UK	US
Test results or records not available at time of appointment	11	11	8	7	9	10	15
Duplicate tests: doctor ordered test that had already been done	10	5	15	4	6	5	14
Percent with either coordination problem	18	15	19	9	12	13	23

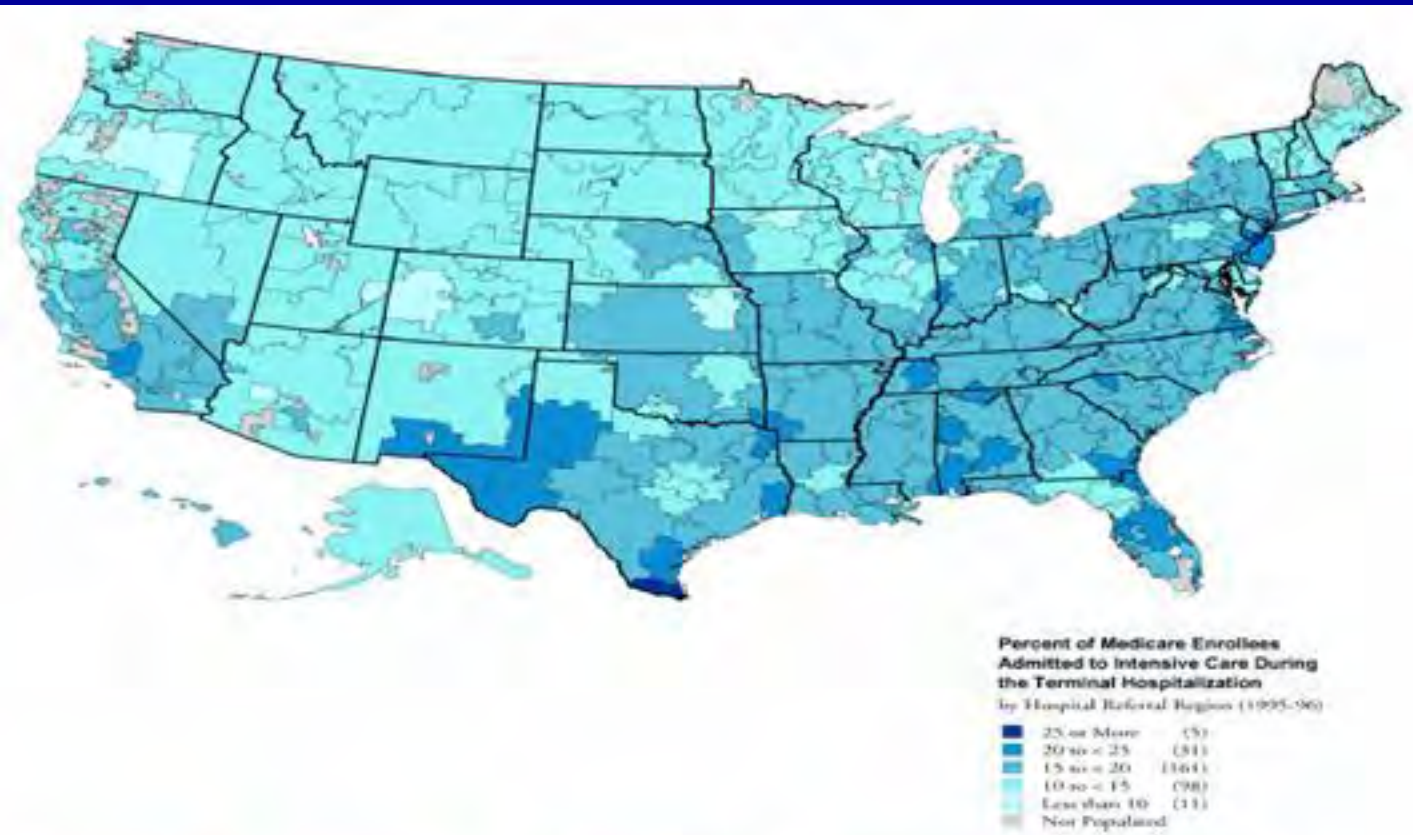
Source: 2007 Commonwealth Fund International Health Policy Survey

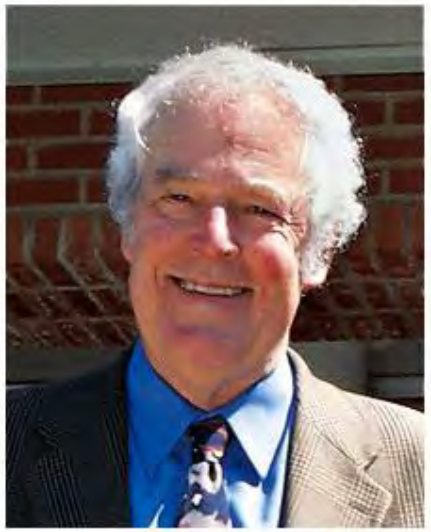
Care Management and Coordination for Chronic Conditions

Adults with a chronic condition reported:	AUS	CAN	GER	NETH	NZ	UK	US
Doctor gives you a written plan for managing care at home	40	33	22	31	35	30	61
Receive reminder for preventive/follow-up care	44	40	57	58	48	58	70
Often/sometimes receive conflicting information from different health professionals	14	16	19	13	19	18	22

Source: 2007 Commonwealth Fund International Health Policy Survey

Jack Wennberg
Practice Variation





Dr. John Wennberg

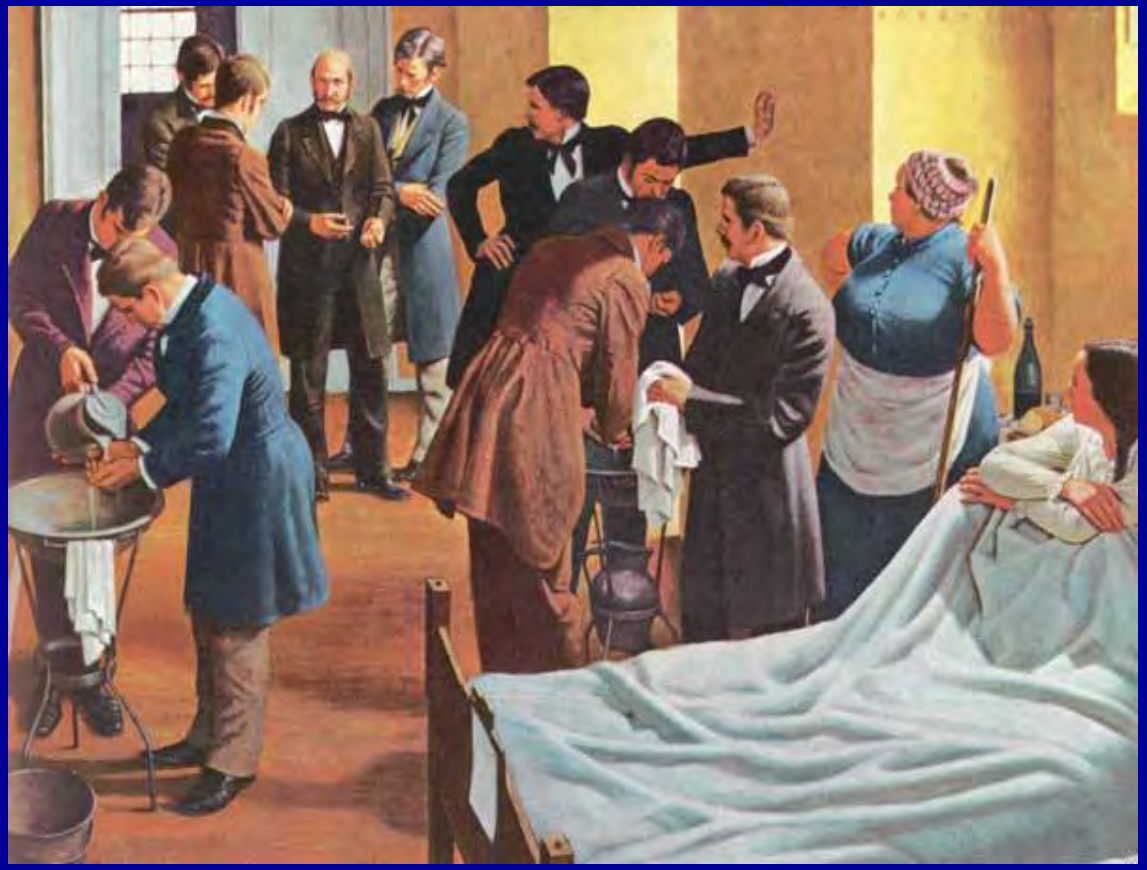
The Dartmouth Atlas

Failure to Provide Known Best Practice

Patients received 55% of recommended care

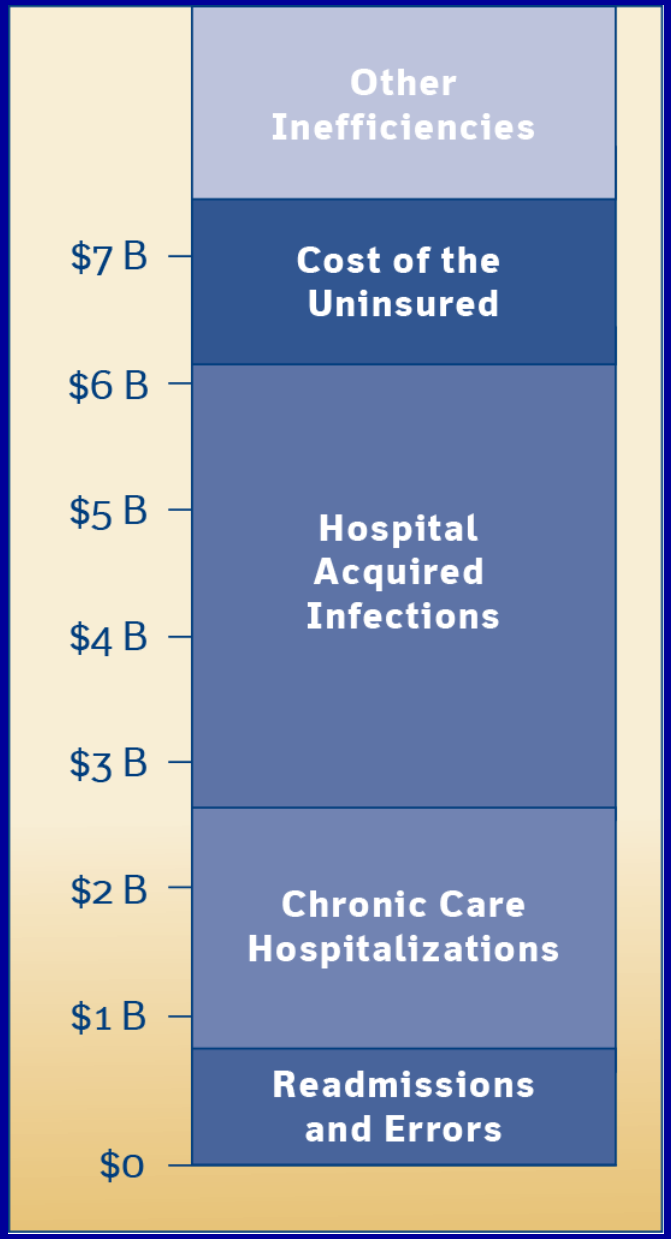
Elizabeth McGlynn
NEJM 2003; 348: 2635

(It's not what we don't know, it's what we know, but don't do)



Ignaz Semmelweis 1847

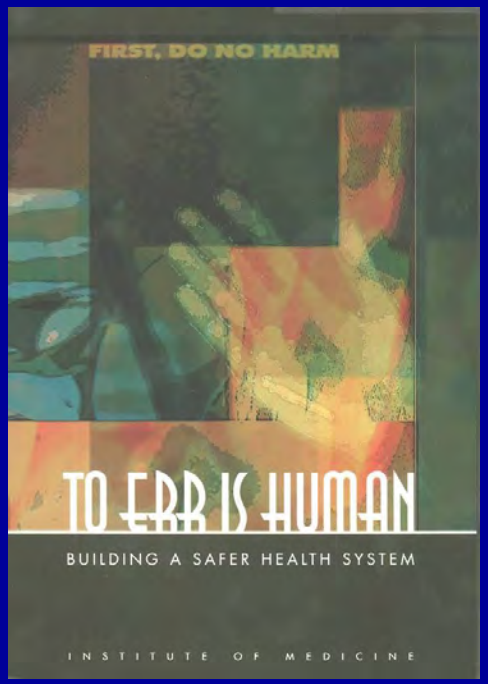
Prescription for Pennsylvania



The cost of inaction is far too great.

From the Governor's Office of Health Care Reform

Institute of Medicine Report To Err Is Human (1999)



44,000-98,000 deaths in hospitals each year from errors of commission

Medical, Medication, and Lab Errors

Percent reported in past two years:	AUS	CAN	GER	NETH	NZ	UK	US
Experienced medical or medication error	15	10	9	9	11	9	13
Experienced lab or diagnostic test error	11	12	4	8	9	10	14
Experienced any medical, medication, or lab error	20	17	12	14	16	13	20

Source: 2007 Commonwealth Fund International Health Policy Survey

PA PSRS
Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

Produced by ECRI Institute & ISMP under contract to the Patient Safety Authority

Complication	Number of Reports during Time Period	Time Period	Number per Year	Operations per Event (assumes 2,424,878 operations/year)
Retained foreign bodies (within incision)	60	12 months	60	1 per 40,415 operations
Wrong-site surgery (partial and complete)*	116	30 months	46	1 per 52,260 operations
Surgical fires	83	36 months	28	1 per 87,646 operations
Any of the three			134	1 per 18,087 operations

* Wrong-site surgery information is derived from the following detailed, scientific study, which was authored by PA-PSRS staff: Clarke JR, Johnston J, Finley ED. Getting surgery right. *Ann Surg* 2007 Sep;246(3):395-405.

Table. Risk of Three "Never Complications of Surgery"

This article is reprinted from the *PA-PSRS Patient Safety Advisory*, Vol. 4, No. 3—September 2007. The *Advisory* is a publication of the Pennsylvania Patient Safety Authority, produced by ECRI Institute & ISMP under contract to the Authority as part of the Pennsylvania Patient Safety Reporting System (PA-PSRS).

PA PSRS
Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

Produced by ECRI Institute & ISMP under contract to the Patient Safety Authority

Complication	Number of Reports during Time Period	Time Period	Number per Year	Operations per Event (assumes 2,424,878 operations/year)
Retained foreign bodies (within incision)	60	12 months	60	1 per 40,415 operations
Wrong-site surgery (partial and complete)*	116	30 months	46	1 per 52,260 operations
Surgical fires	83	36 months	28	1 per 87,646 operations
Any of the three			134	1 per 18,087 operations

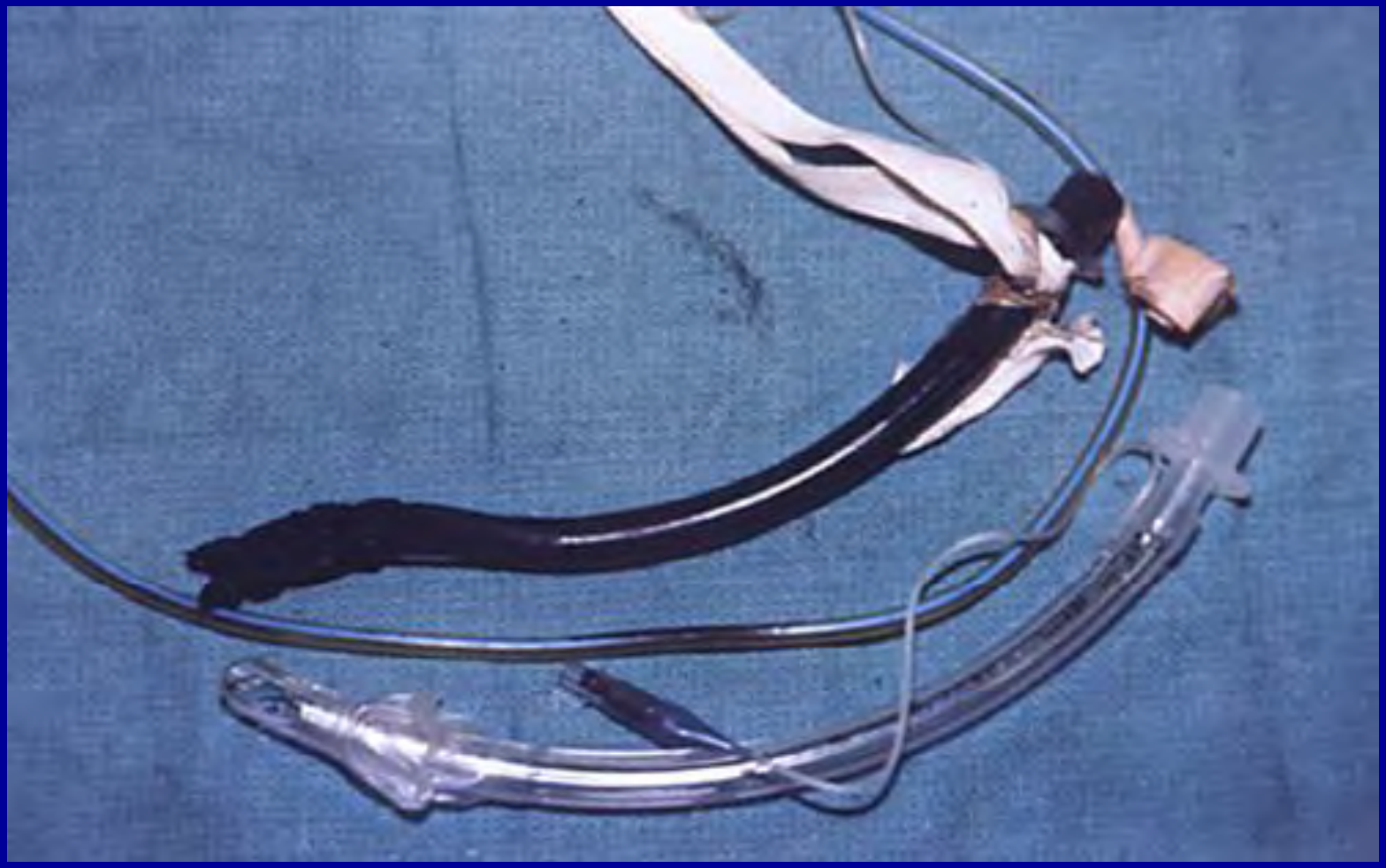
* Wrong-site surgery information is derived from the following detailed, scientific study, which was authored by PA-PSRS staff: Clarke JR, Johnston J, Finley ED. Getting surgery right. *Ann Surg* 2007 Sep;246(3):395-405.

Table. Risk of Three "Never Complications of Surgery"

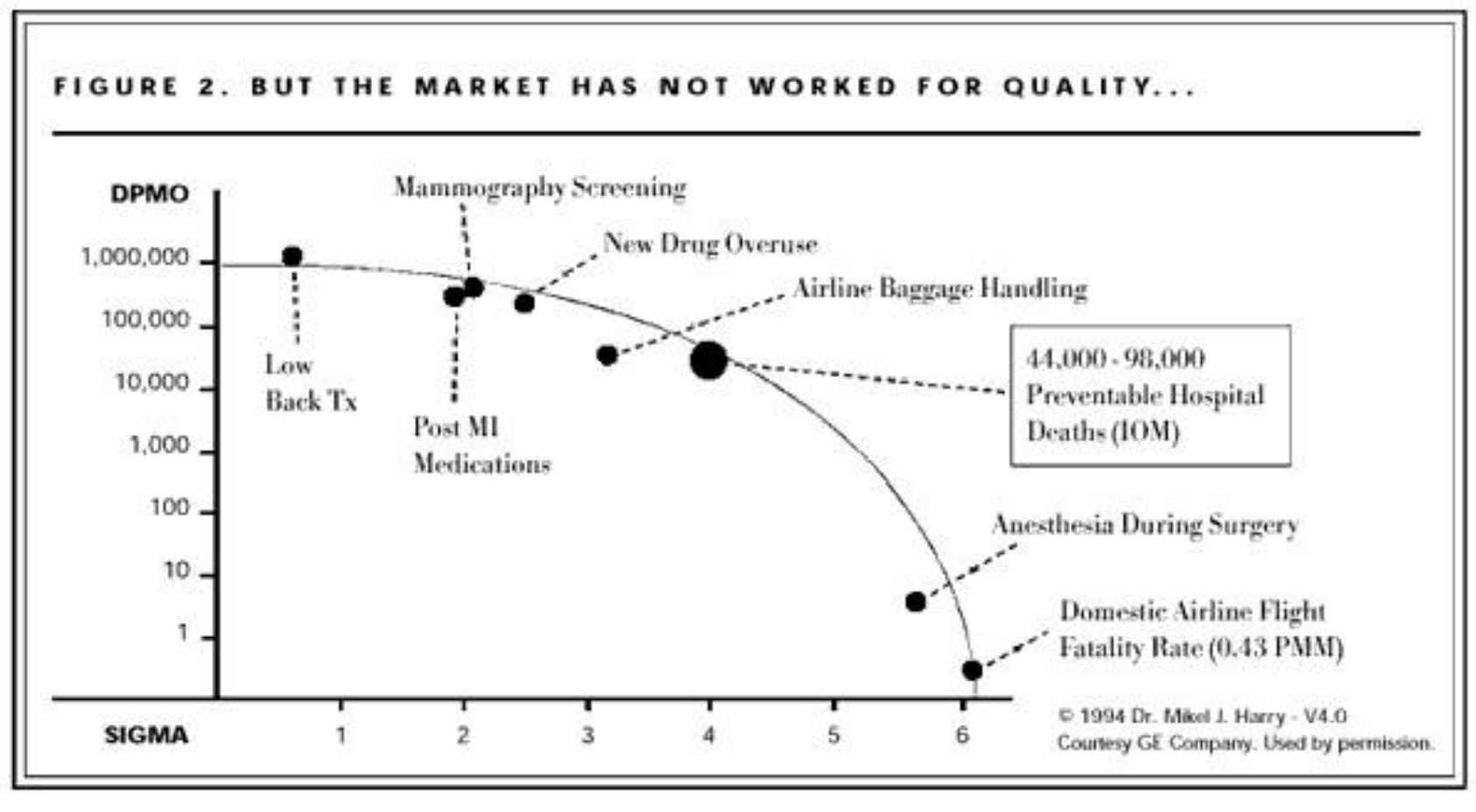
RFB 1 every 6 days
WSS 1 every 8 days
Fire 1 every 13 days

This article is reprinted from the *PA-PSRS Patient Safety Advisory*, Vol. 4, No. 3—September 2007. The *Advisory* is a publication of the Pennsylvania Patient Safety Authority, produced by ECRI Institute & ISMP under contract to the Authority as part of the Pennsylvania Patient Safety Reporting System (PA-PSRS).

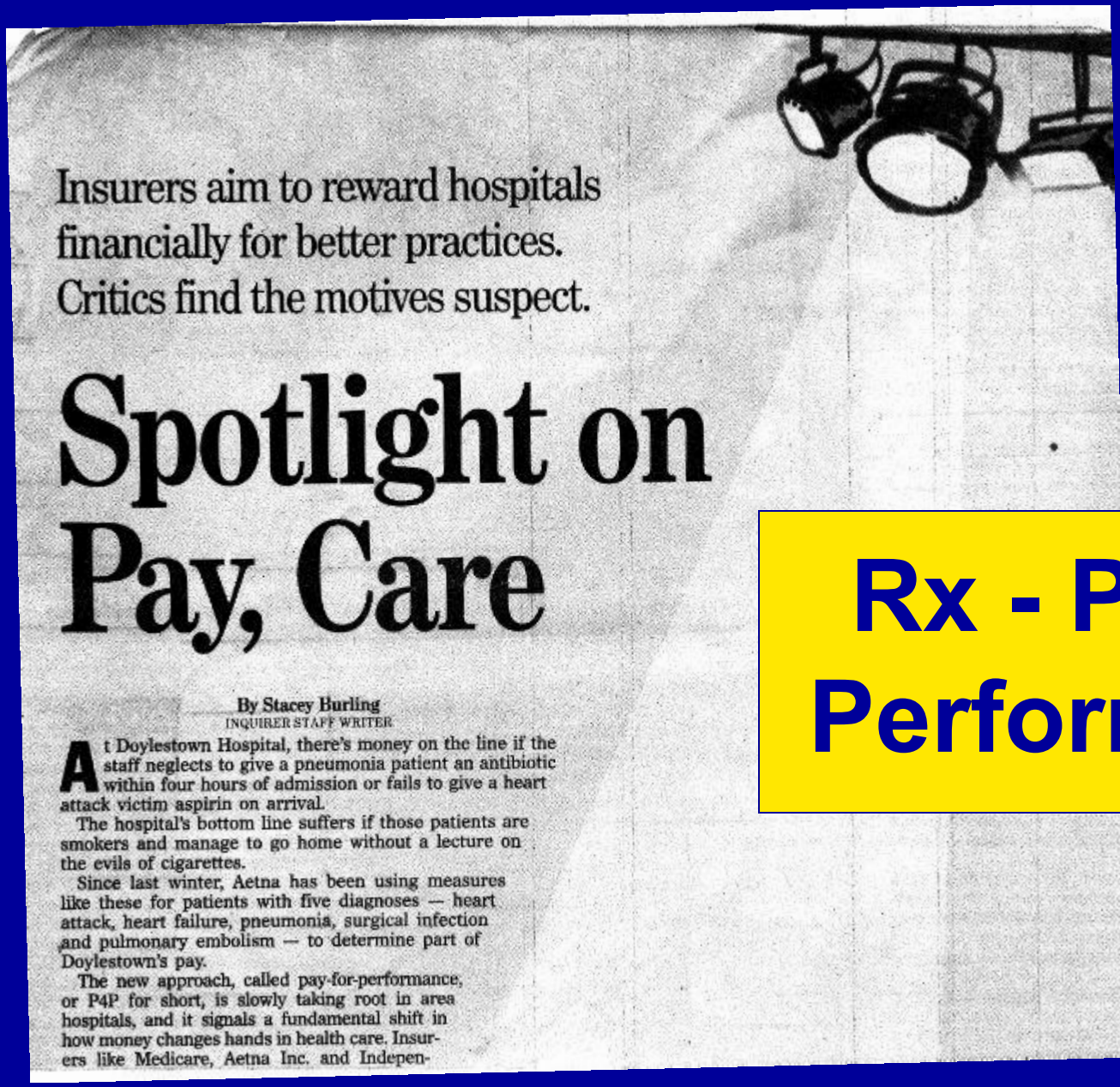
Result of entering the trachea with a Bovie during a tracheostomy



Reliability of Healthcare Delivery



From Milbank Memorial Fund. Value Purchasers in Health Care: 2001



Insurers aim to reward hospitals financially for better practices. Critics find the motives suspect.

Spotlight on Pay, Care

By Stacey Burling
INQUIRER STAFF WRITER

At Doylestown Hospital, there's money on the line if the staff neglects to give a pneumonia patient an antibiotic within four hours of admission or fails to give a heart attack victim aspirin on arrival.

The hospital's bottom line suffers if those patients are smokers and manage to go home without a lecture on the evils of cigarettes.

Since last winter, Aetna has been using measures like these for patients with five diagnoses — heart attack, heart failure, pneumonia, surgical infection and pulmonary embolism — to determine part of Doylestown's pay.

The new approach, called pay-for-performance, or P4P for short, is slowly taking root in area hospitals, and it signals a fundamental shift in how money changes hands in health care. Insurers like Medicare, Aetna Inc. and Indepen-

Rx - Pay for Performance

Rx - Public Reporting

NY Times 9/7/07

In Bid for Transparency, City Puts Hospital Error Data Online

By SARAH KERSHAW

The New York City Health and Hospitals Corporation, the nation's largest public health system, plans to begin publicly releasing data today on infection and death rates at its 11 hospitals, in response to widespread concern about deadly, preventable and costly hospital-acquired conditions and pressure to crack open the shrouded culture of many hospitals.

The city's move, driven by Mayor Michael R. Bloomberg's effort to make public health a centerpiece of his administration and by the hospital corporation's recent focus on improving patient safety, is a bold step in an industry that has long resisted transparency, experts said.

In posting the safety and performance information on the hospital corporation's Web site, www.nyc.gov/hhc, the public hospitals, which treat 1.3 million patients a year, are far ahead of the industry, health care experts and consumer advocates said.

"It does focus on the underbelly of health care," Alan D. Aviles, president of the Health and Hospitals Corporation, said in an interview. "But if you want to make improvements, you have to acknowledge the underbelly."

Tracking rates of infection and death in city-run medical centers.

The Web site allows the public to see the overall death rate, the rate of deaths after heart attacks, preventable bloodstream infections and pneumonia cases, among other measures, at the 11 hospitals.

"Others will draw courage from them," said Jim Conway, senior vice president at the Institute for Healthcare Improvement, a national advocacy and research group. "They are exposing themselves to considerable scrutiny."

Some of the information on the Web site has been reported to the state and federal governments, but has not been easily accessible to the public. Public re-

Continued on Page B6

Rx - Not Paying for “Never Events”

The New York Times

ARTHUR OCHS SULZBERGER JR., *Publisher*

Founded in 1851

ADOLPH S. OCHS
Publisher 1896-1935

ARTHUR HAYS SULZBERGER
Publisher 1935-1961

ORVIL E. DRYFOOS
Publisher 1961-1963

ARTHUR OCHS SULZBERGER
Publisher 1963-1992

The News Sections

BILL KELLER, *Executive Editor*
JILL ABRAMSON, *Managing Editor*
JOHN M. GEDDES, *Managing Editor*
JONATHAN LANDMAN, *Deputy Managing Editor*

Assistant Managing Editors

DEAN BAQUET
RICHARD L. BERKE
TOM BODKIN
SUSAN EDGERLEY
GLENN KRAMON
GERALD MARZORATI
MICHELE McNALLY
WILLIAM E. SCHMIDT
CRAIG R. WHITNEY

The Opinion Pages

ANDREW ROSENTHAL, *Editorial Page Editor*
CARLA ANNE ROBBINS, *Deputy Editorial Page Editor*
DAVID SHIPLEY, *Deputy Editorial Page Editor*

The Business Management

SCOTT H. HEEKIN-CANEDY, *President, General Manager*
DENNIS L. STERN, *Senior V.P., Deputy General Manager*
DENISE F. WARREN, *Senior V.P., Chief Advertising Officer*
ALEXIS BURYK, *Senior V.P., Advertising*
THOMAS K. CARLEY, *Senior V.P., Planning*
YASMIN NAMINI, *Senior V.P., Marketing and Circulation*
DAVID A. THURM, *Senior V.P., Chief Information Officer*
ROLAND A. CAPUTO, *V.P., Chief Financial Officer*
TERRY L. HAYES, *V.P., Labor Relations*
THOMAS P. LOMBARDO, *V.P., Production*
MURIEL WATKINS, *V.P., Human Resources*

CRISTIAN L. EDWARDS, *President, News Services*
VIVIAN SCHILLER, *Senior V.P., General Manager, NYTimes.com*
MICHAEL ORESKES, *Editor, International Herald Tribune*

Not Paying for Medical Errors

Medicare, the government insurance program for older Americans, has announced that it will soon stop paying hospitals for the extra costs of treating certain patients whose illnesses are compounded by preventable errors. The effort won't save much money at first, and it will impose additional testing and documentation burdens on many hospitals, but it should promote better care. If the initial steps are expanded, it could yield greater savings as well.

Under current payment rules, Medicare typically pays hospitals more for treating a surgical patient whose illness is complicated by an infection than it would if there were no infection present. That is true even if the infection is caused by sloppy sanitary practices in the hospital itself. The perversity of a payment system that actually rewards incompetence rather than penalizing it seems self-evident. So Medicare is clearly wise to start changing the incentives.

Starting on Oct. 1, 2008, Medicare will no longer pay extra for eight specific conditions that could generally be avoided if the hospital followed proven preventive procedures or common-sense precautions. Medicare will no longer pay hospitals to retrieve surgical tools or sponges left in a patient after the initial operation. Nor will it reimburse for extra care given patients harmed by incompatible blood or air embolisms, for treating bedsores developed in the hospital, injuries caused by falls in the hospital, infections caused by prolonged use of catheters in the bladder or blood vessels, or a surgical site infection after coronary artery bypass surgery.

One element missing from the initial steps is any penalty for the doctors who commit some of the errors. The hospital loses any extra payment for a second operation to retrieve an object left behind the first time, which seems appropriate given that nurses are supposed to keep track of all instruments and sponges. But an errant doctor, who may also be culpable, can get paid for operating again. In future years, Medicare needs to consider reforms in physician payments as well.

Hospital spokesmen are worried that some of the conditions are not entirely preventable and that some patients, for example, are prone to bedsores no matter how good their care. They also worry that they will have to absorb the costs of additional tests when a patient arrives to establish whether an infection is already present before a catheter is inserted. But these initial conditions were chosen with the help of experts in the belief that they could reasonably be prevented by following evidence-based guidelines. And the extra tests and documentation should help improve patient care.

Meanwhile, patient advocates seem pleased with the new rules now that steps have been taken to prevent hospitals from shifting the costs of preventable errors to patients or their insurers. Medicare officials will need to monitor the situation closely and be prepared to make adjustments if hospitals are unduly burdened. But they are clearly on the right track in seeking to prevent errors that harm patients and drive up the cost of health care.

July 8/3/07

Medicare won't pay for some mistakes.

A financial ouch for hospitals

By Josh Goldstein
INQUIRER STAFF WRITER

Last year, nine patients got infusions of the wrong type of blood at hospitals around the region, errors that typically added thousands of dollars in treatment charges paid by Medicare.

Hospitals will soon have to bear much of the cost of fixing their own mistakes. Medicare issued rules this month that will end payments for extra care resulting from certain medical mistakes starting Oct. 1, 2008.

The new rules prohibit passing these charges on to patients, so hospitals will end up absorbing the costs — and, Medicare hopes, working harder to prevent mistakes.

How Can We Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations
- Make the patent experience the focus of our practices

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations
- Make the patent experience the focus of our practices
- Continue learning throughout our lives

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations
- Make the patent experience the focus of our practices
- Continue learning throughout our lives
- Stay within our scope of usual practice

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations
- Make the patent experience the focus of our practices
- Continue learning throughout our lives
- Stay within our scope of usual practice
- Organize our practice at a higher level

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations
- Make the patent experience the focus of our practices
- Continue learning throughout our lives
- Stay within our scope of usual practice
- Organize our practice at a higher level
- Co-opt others onto our teams

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

- Lower expectations
- Make the patent experience the focus of our practices
- Continue learning throughout our lives
- Stay within our scope of usual practice
- Organize our practice at a higher level
- Co-opt others onto our teams

Concerns of the ACS Fellows

The B/G meetings were quite interesting, but focused on reimbursement and liability issues …” Linwood Haith

How Can We Maintain Our Income for Our Valuable Work Product

- Work longer hours

How Can We Maintain Our Income for Our Valuable Work Product

- Work longer hours
- Outsource work to cheaper labor

How We Can Maintain Our Income for Our Valuable Work Product

- Work longer hours
- Outsource work to cheaper labor
- Become more efficient
  - Develop a system for delivering care more reliably
  - Avoid complications

How We Can Maintain Our Income for Our Valuable Work Product

- Work longer hours
- Outsource work to cheaper labor
- Become more efficient
  - Develop a system for delivering care more reliably
  - Avoid complications

} Related

Where Should We Develop Systems for Reliable Delivery of Our Care

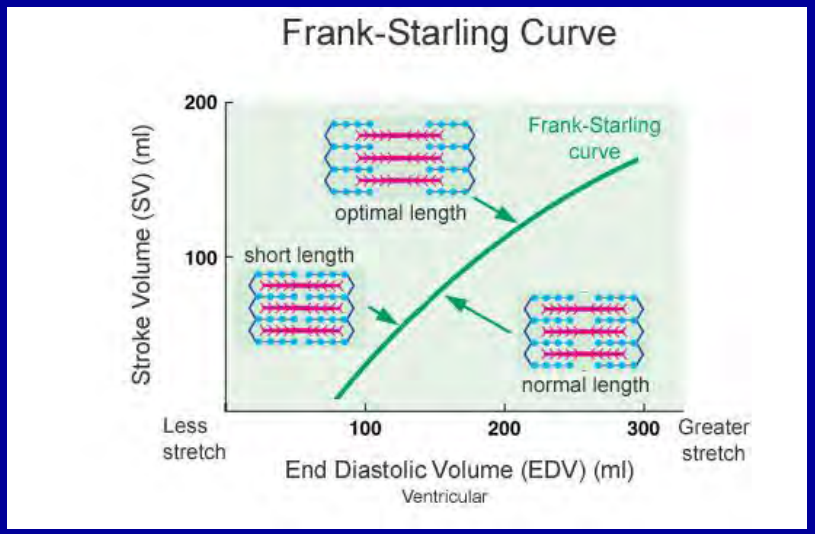
- Our offices
- Our hospitals
- Our operating rooms and ambulatory surgery centers

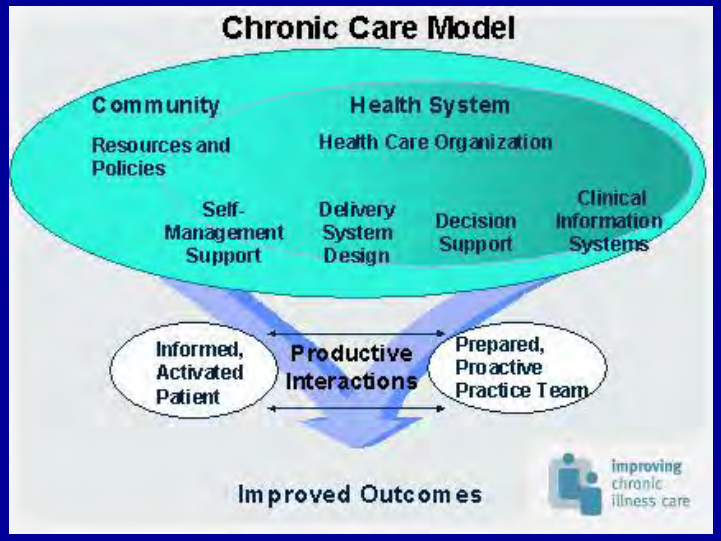
The Progress of Medicine

Biological Science

Empirical Science

Figure 7-1 Relief of dropsy (P Barbette, 1672)





Information Science

System Science

Traditional Medicine

- Individual physician
- Individual patient
- Individual treatment

Old Paradigm

- Personal responsibility
- Provider gives safe care
- Physician autonomy
- Reprimand provider error
- Work around system weaknesses


Modern Medicine - Patient-care team
Focus on outcomes
Complex treatment

Old New Paradigm

- Personal Team responsibility
- Provider gives Patient gets safe care
- Physician autonomy Standard use of best practice
- Reprimand provider Report system error
- Work around Fix system weaknesses

Old New Paradigm

- Personal Team responsibility
- Provider gives Patient gets safe care
- Physician autonomy Standard use of best practice
- Reprimand provider Report system error
- Work around Fix system weaknesses

Old New Paradigm

- Personal Team responsibility
- Provider gives Patient gets safe care
- Physician autonomy Standard use of best practice
- Reprimand provider Report system error
- Work around Fix system weaknesses

For the sake of the healthcare system - and our own sake - we must get involved in the development of a reliable system of delivering healthcare

High Reliability Organizations

- Team training
- Best known practice
- Standardize
- Reliable
- Reproducible
- Detect variation
- Correct variation

Pennsylvania Railroad

PRR

Standardization of the System

The Mayo Brothers
Best Practice (ca. 1892)

ATLS & Trauma Centers
Standardized Trauma Resuscitations (1980)

Committee on Trauma

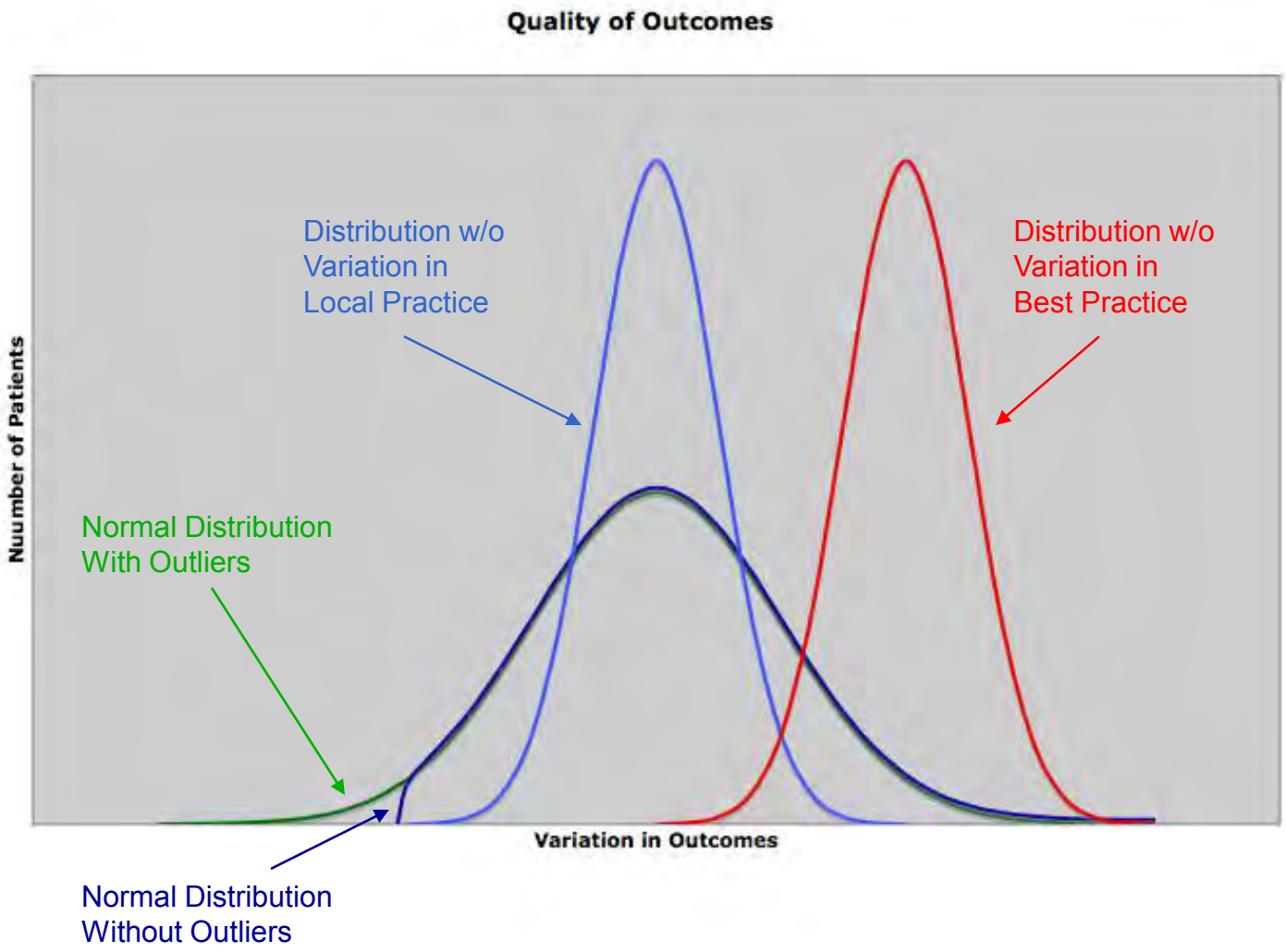
ADVANCED TRAUMA LIFE SUPPORT®

Developing Systems for Reliably Delivering Healthcare

- Standardize around best practice known (role for clinicians)
- Continuous quality improvement (role for clinicians)
- Variation occurs only in patient factors and resources

Why Standardize ?

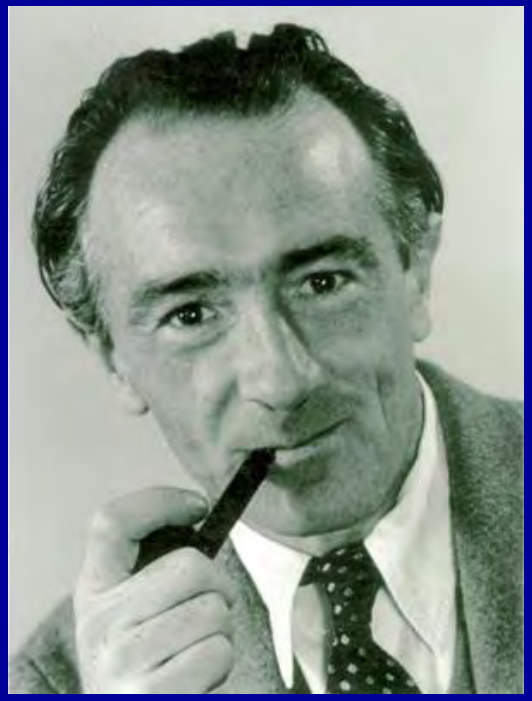
- In theory, only one best practice
- Variation without added value only adds errors
- Relationship between uniform processes & predictable outcomes
- Relationship between standardization & reliability
- Makes errors more obvious


Quality of Outcomes
Nuumber of Patients
Variation in Outcomes
Distribution w/o Variation in Local Practice
Distribution w/o Variation in Best Practice
Normal Distribution With Outliers
Normal Distribution Without Outliers

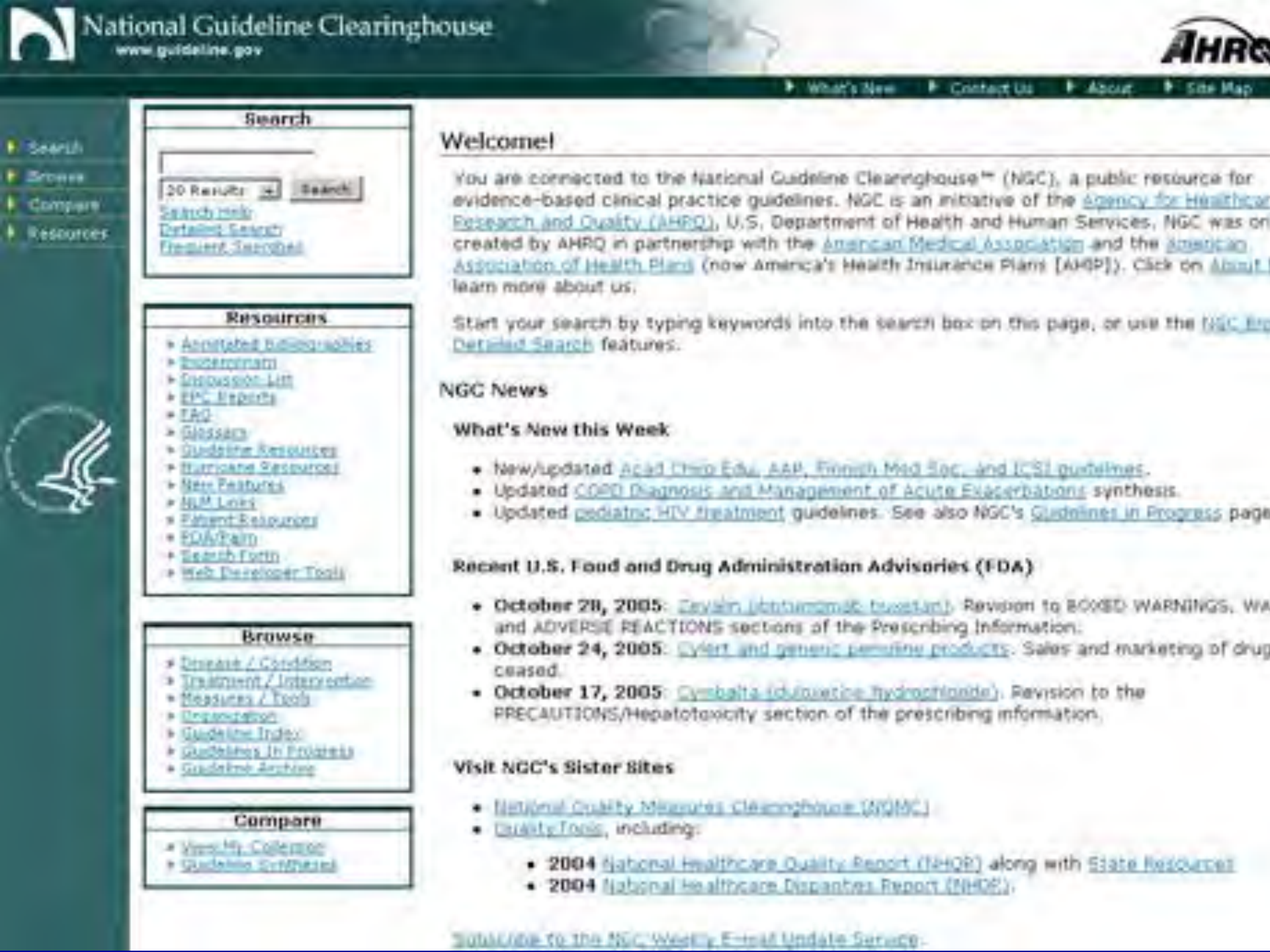
Where Do We Get Best Practices?

David Sackett
Evidence-Based Medicine (1992)

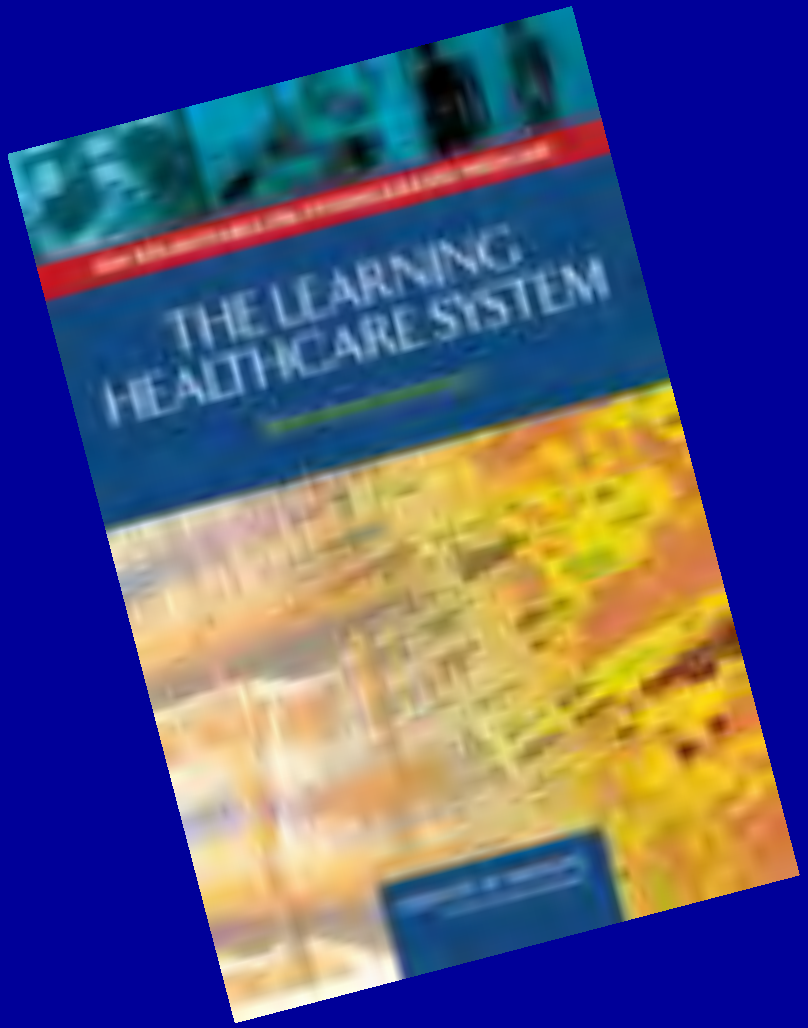
Cochrane Collaborative Systematic Reviews of Healthcare Interventions (1993)



Archie Cochrane (1908-1988)


National Guideline Clearinghouse
www.guideline.gov
What's New
Contact Us
About
Site Map
Search
Browse
Compare
Resources
Search
20 Results
Search
Search Help
Detailed Search
Frequent Searches
Resources
Annotated Bibliographies
Bookstream
Discussion List
EPC Reports
FAQ
Glossary
Guideline Resources
Hurricane Resources
New Features
NLM Links
Patient Resources
PDA/Palm
Search Form
Web Developer Tools
Browse
Disease / Condition
Treatment / Intervention
Measures / Tools
Organization
Guideline Index
Guidelines In Progress
Guideline Archive
Compare
View My Collection
Guideline Syntheses
Welcome!
You are connected to the National Guideline Clearinghouse™ (NGC), a public resource for evidence-based clinical practice guidelines. NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America's Health Insurance Plans [AHIP]). Click on About to learn more about us.
Start your search by typing keywords into the search box on this page, or use the NGC Browse or Detailed Search features.
NGC News
What's New this Week
New/updated Acad Chest Phys, AAP, Finnish Med Soc, and ICSI guidelines.
Updated COPD Diagnosis and Management of Acute Exacerbations synthesis.
Updated pediatric HIV treatment guidelines. See also NGC's Guidelines in Progress page
Recent U.S. Food and Drug Administration Advisories (FDA)
October 28, 2005: Zevalin (ibritumomab tiuxetan). Revision to BOXED WARNINGS, WA and ADVERSE REACTIONS sections of the Prescribing Information.
October 24, 2005: Cytotec and generic misoprostol products. Sales and marketing of drug ceased.
October 17, 2005: Cymbalta (duloxetine hydrochloride). Revision to the PRECAUTIONS/Hepatotoxicity section of the prescribing information.
Visit NGC's Sister Sites
National Quality Measures Clearinghouse (NQMC)
Quality Tools, including:
2004 National Healthcare Quality Report (NHQR) along with State Resources
2004 National Healthcare Disparities Report (NHDR).
Subscribe to the NGC Weekly E-mail Update Service.

Institute of Medicine Roundtable on Evidence-based Medicine



The Learning Healthcare System

Why Not Philadelphia Academy of Surgery ?

Thomas Jefferson University

UMDNJ

Where Do We Get Quality Improvement?

- Systems oriented M & M instead of personally oriented M & M
- Patient safety reporting systems
- Team training

Current System

Weakness

Identification through individual attention

Error trapping

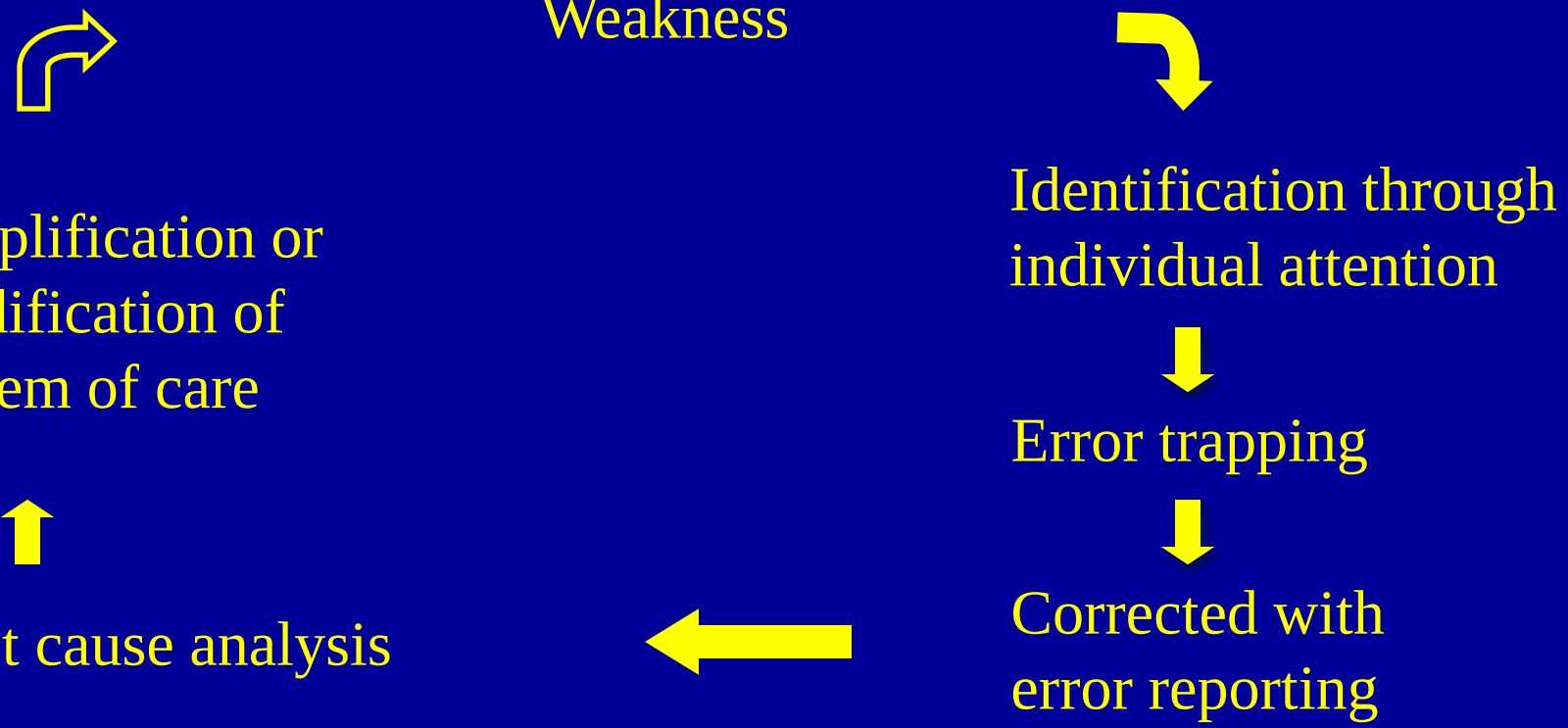
Corrected with work-around

Occasional failure (individual responsibility)

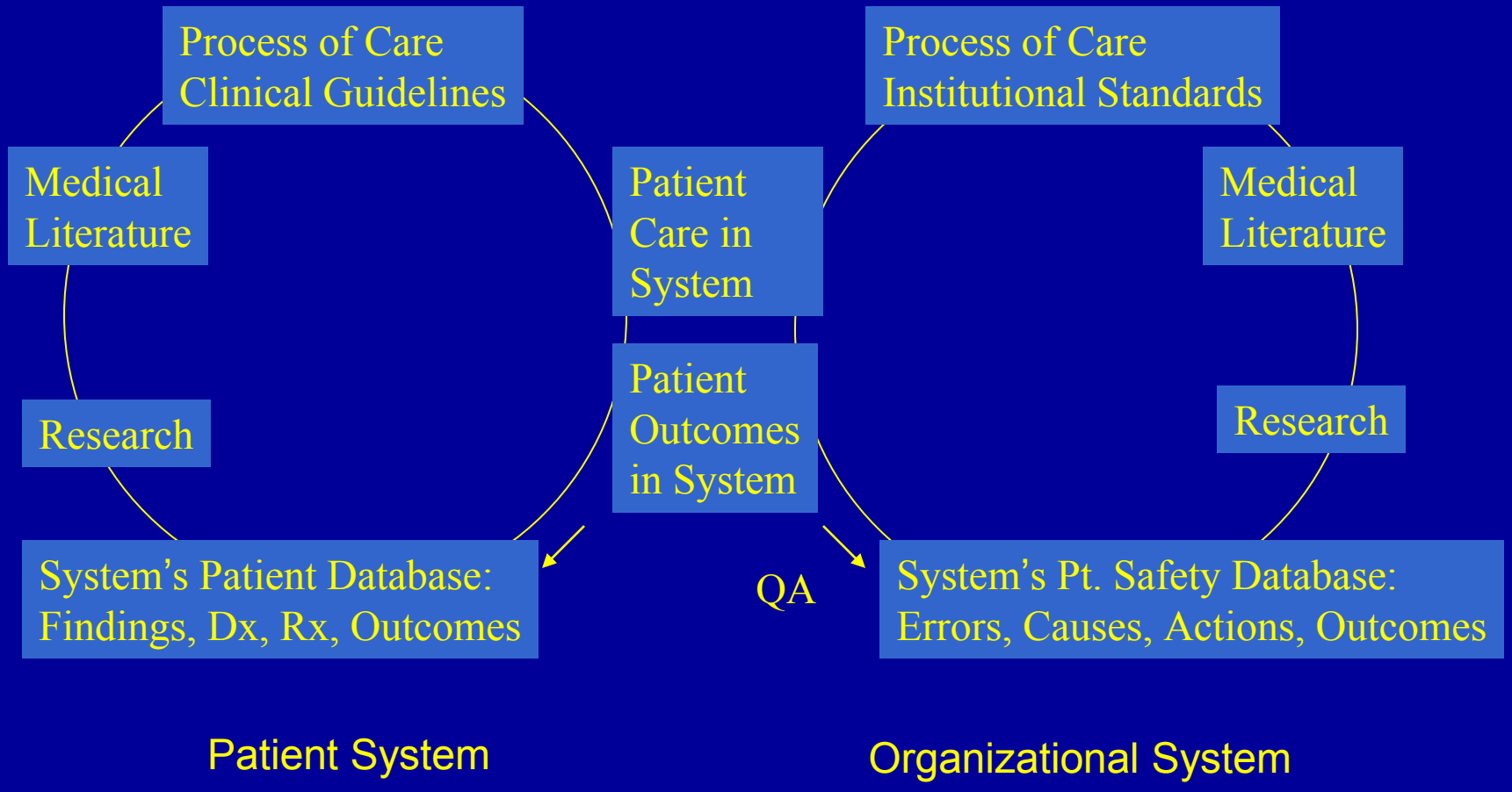
Change in policy

Increased complexity

Reliable Robust System



System-based Medicine



What is a TEAM?

A "TEAM" IS

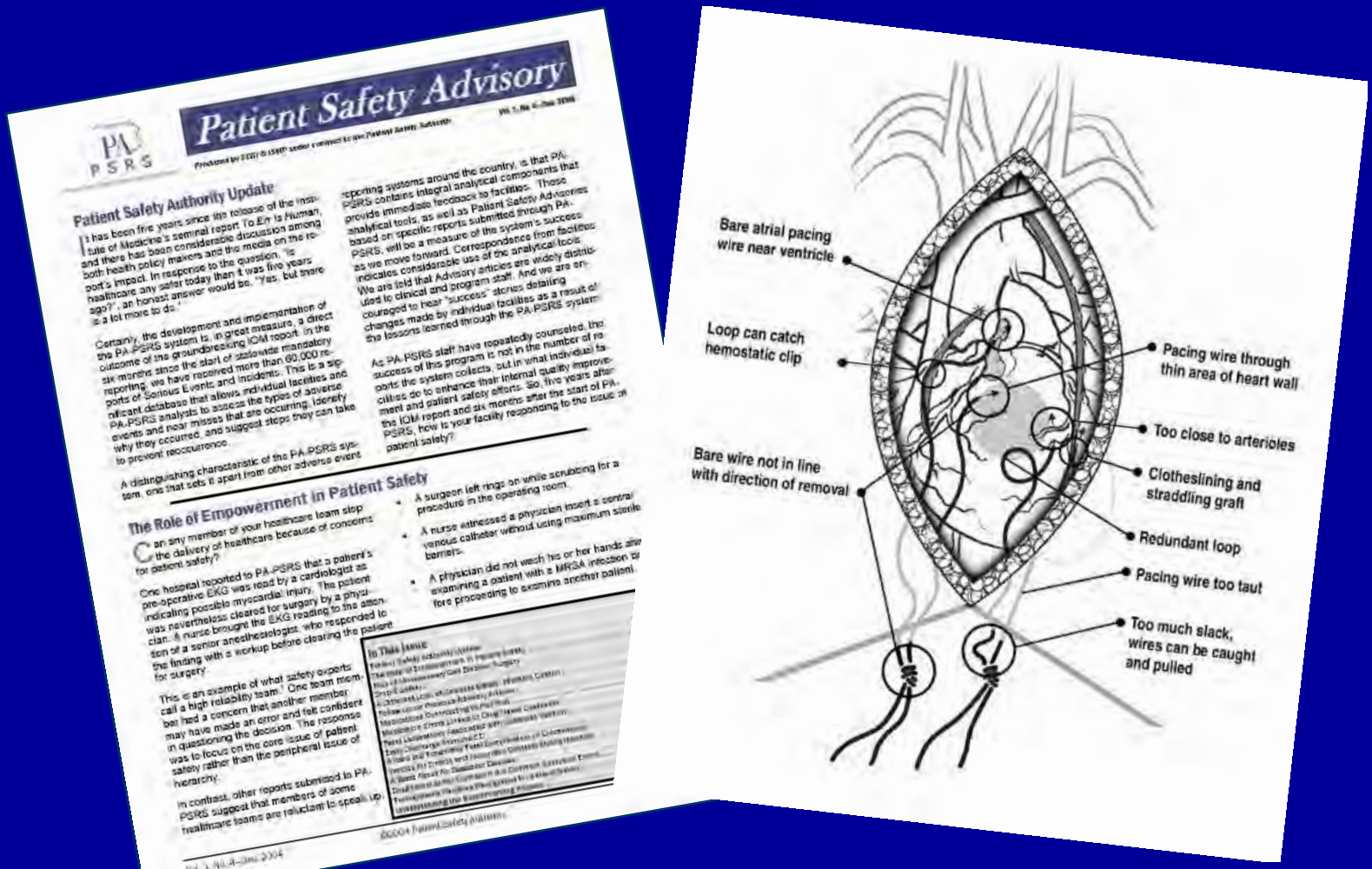
From Donald Moorman, MD
ACS Course on Safe OR Practices

- Two or more people who achieve a mutual goal through *interdependent* and *adaptive* actions
- Not a "group" which achieves its goal through *independent, individual* contributions

O.R. Reports to Pennsylvania Patient Safety Reporting System

Do the wrong operation --	46 times/yr.
Start a fire on the field --	28 times/yr.
Leave something behind --	60 times/yr.
Dehiscence --	83 times/yr.
Pneumothorax --	26 times/yr.
Occlusion of ureters or ducts --	19 times/yr.
Complications of positioning --	50 times/yr.
Compl. inserting tubes/wires --	28 times/yr.
Incomplete procedures --	32 times/yr.
Mismanaged specimens --	8 times/yr.

Pennsylvania Patient Safety Advisory



Correct Placement of Pacing Wires by James B. McClurken MD

American College of Surgeons Safe Operating Room Team Course

1. High-reliability organizations
2. System design
3. Teamwork
4. Communication
5. Distributing workload
6. Leadership
7. Retained foreign objects
8. Wrong-site surgery
9. Surgical fires
10. Neuropraxias & blindness
11. Pressure necrosis
12. Well-leg compartment synd.
13. Personnel safety

What We Each Can Do to Help Systematically Provide Reliable Care

- Achieve consensus about best practice
- Initially accept “best known practice” if needed
- Simplify process – eliminate unnecessary steps
- Help develop reminder systems & checklists
- Adhere to best practice
- Think of practice as team practice
- Report work-arounds
- Report practice deviations
- Assess best practice results and modify prn

What We Should NOT Do to Develop a System for Reliable Care

- Implement best practice standards without providers' input
- Implement without a plan for monitoring and review
- Use as quality or performance measures (consider co-morbidities & pt. preferences)

What We Need to Develop Systems for Reliable Care

- Leadership - hospital and professional
- Resources
- Cooperation
- Monitoring
- Mechanisms for system improvement

What the Academy Could Do to Develop Systems for Reliable Care

- Provide a forum for consensus on best practices when scientific evidence is insufficient
- Provide informal logistical support for regional team training outside the medical school environments

How We Can Lead Ourselves Out of the Chaos of the Current Healthcare Crisis

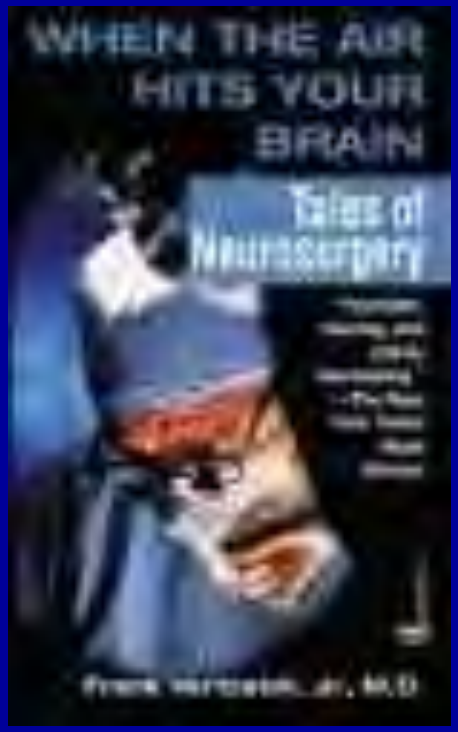
- Lower expectations
- Make the patent experience the focus of our practices
- Continue learning throughout our lives
- Stay within our scope of usual practice
- Become organized, not just careful
- Co-opt others onto our teams

Develop a System of Care

- Become organized, not just careful
- Work as teams
- Simplify
- Double check critical information
- Avoid risky behaviors
- Standardize around best practice
- Strive for continuous quality improvement

Rules for Residents

From *When the Air Hits Your Brain*
by Frank Vertosick, MD



"One look is worth a thousand phone calls from the nurse."

"Unless the patient is dead, you can always make him sicker."

Clarke's Rules for Residents

- As a last result, examine the patient
- Treat the patient, not the test result
- If you operate for pain, that's what you will find
- The more you treat a patient like a normal person, the more they will act like one
- For trauma: Relieve pressure; stop bleeding
- A CT scan with contrast gives a patient a 1 in 2500 chance of dying of a fatal cancer from the radiation

Rules for How to Be an Expert Clinician:

Think about the patient -

1. Listen to the patient's story
2. Understand what the patient is saying
3. Examine the patient
4. Read the chart
5. Check the literature
6. Assume responsibility for the patient's healthcare experience - even if you're not

Thank You!