

# Protecting Patients: Advances and Future Directions in Patient Safety

**Victor J Dzau, MD**

President, National Academy of Medicine  
Chair, Institute of Medicine

Rosenthal Symposium  
December 10, 2015



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Leadership • Innovation • Impact | *for a healthier future*

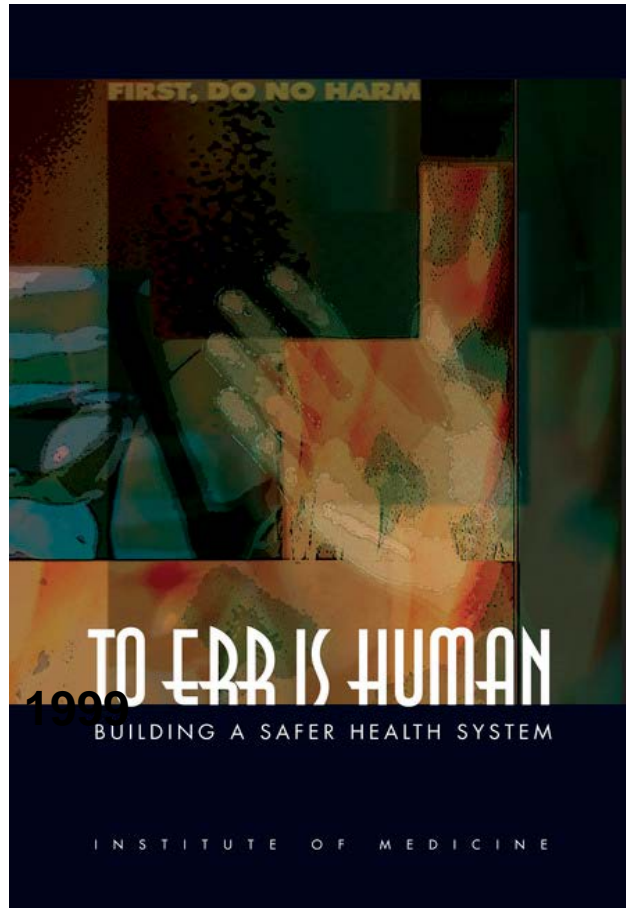
# Rosenthal Symposium

- 1996: The State-of-the-Art of Measuring Quality: Key Perspectives
- 1997: The State-of-the-Art of Measuring Performance in Health Care: Perspective of Purchasers
- 1998: The State-of-the-Art of Measuring Performance in Health Care: Perspective of Providers
- 1999: Measuring Performance in Health Care: Future Challenges
- 2001: Crossing the Quality Chasm: Findings from a New IOM Report
- 2002: Fostering Rapid Advances in Health Care
- 2003: Keeping Patients Safe
- 2005: Next Steps Toward Higher Quality Health Care
- 2011: New Frontiers in Patient Safety

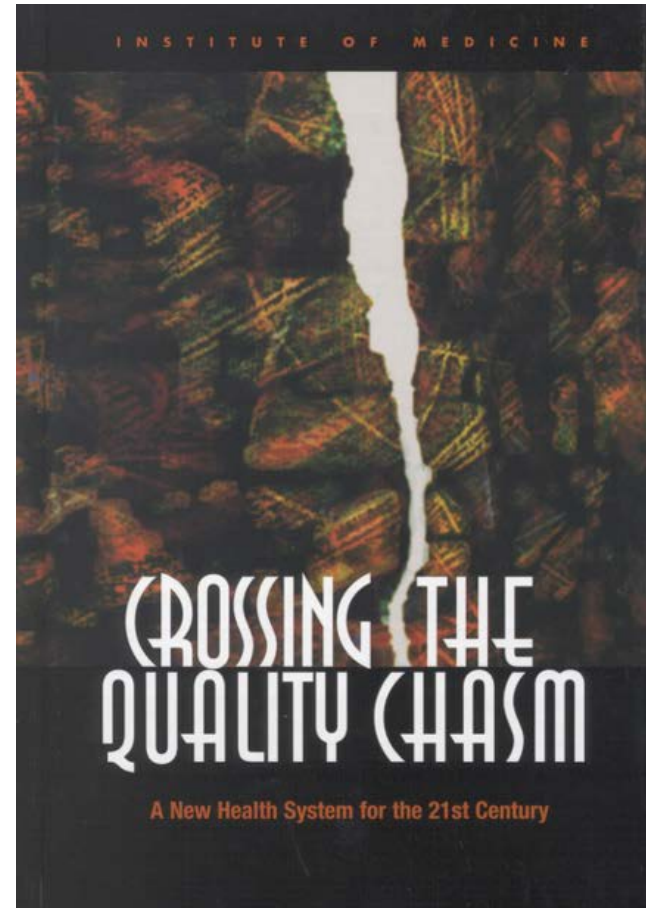


# The IOM Quality Chasm Series

## Foundational Reports



1999



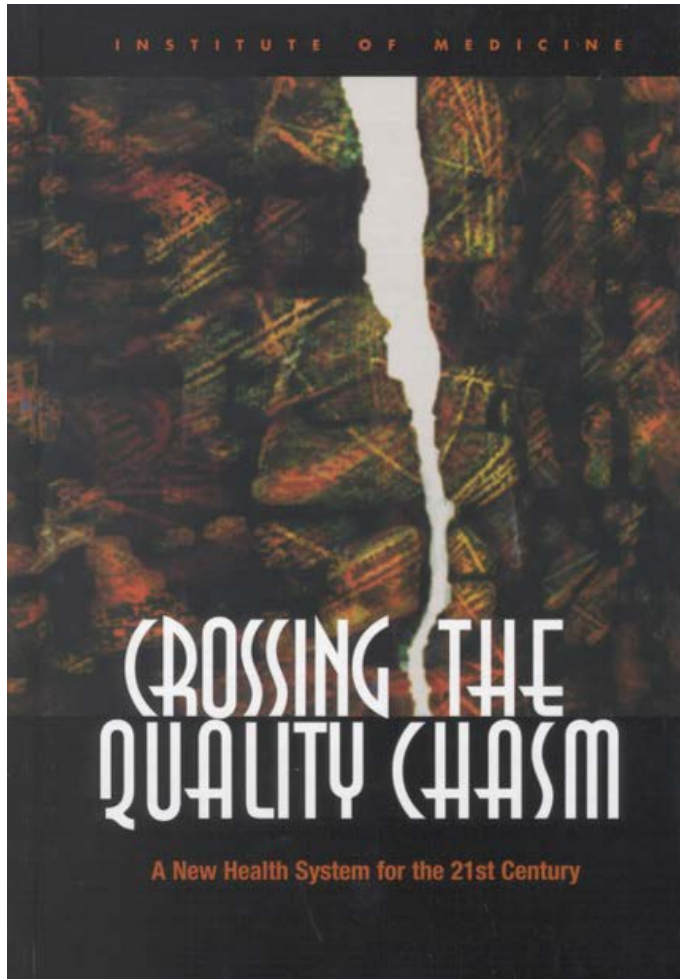
2001

# To Err is Human: Building a Safer Health System

- Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim
- 44,000 - 98,000 people die in US hospitals each year as a result of preventable medical errors
- Errors cost \$17 billion – \$29 billion per year in hospitals in the US
- The majority of errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them



# Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century (2001)



2001

- Described broader **quality issues** and defines six aims—care should be safe, effective, patient-centered, timely, efficient and equitable—and 10 rules for **care delivery redesign**



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# Committee on Quality of Health Care in America

William Richardson (*Chair*)

Donald Berwick

J. Cris Bisgard

Lonnie Bristow

Charles Buck

Christine Cassel

Mark Chassin

Molly Coye

Don Detmer

Jerome Grossman

Brent James

David Lawrence

Lucian Leape

Arthur Levin

Rhonda Robinson Beale

Joseph Scherger

Arthur Southam

Mary Wakefield

Gail Warden

Janet Corrigan, Project Director

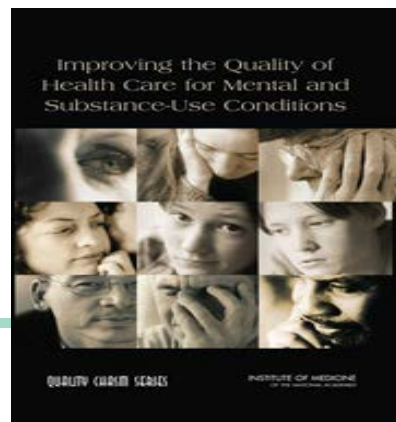
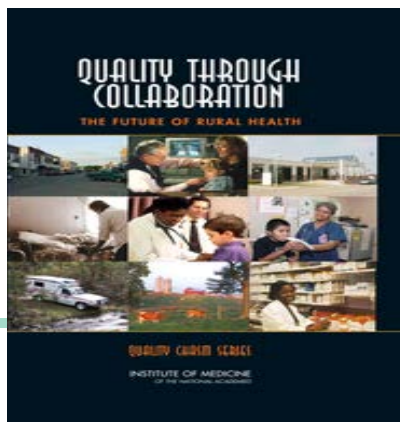
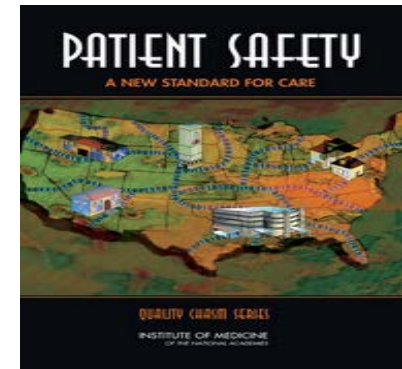
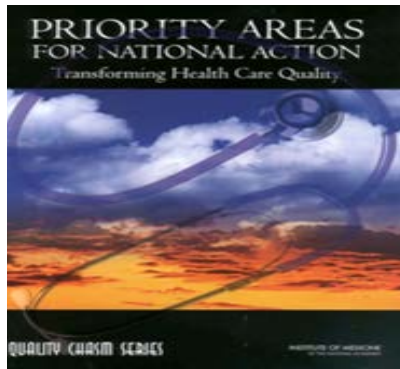
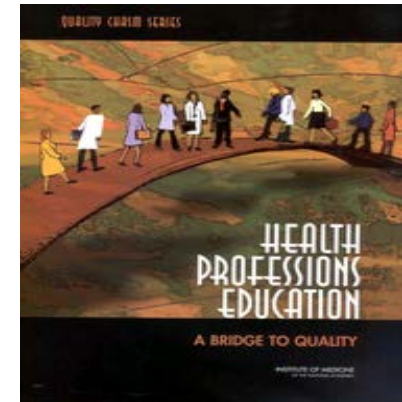
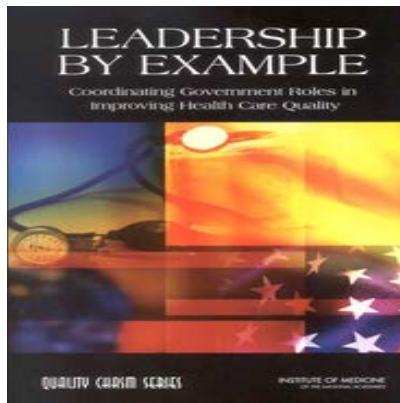
Molla Donaldson, Project Co-Director

Linda Kohn, Project Co-Director





# The IOM Quality Chasm Series



# One Hundred Sixth Congress of the United States of America

## AT THE FIRST SESSION

*Begun and held at the City of Washington on Wednesday,  
the sixth day of January, one thousand nine hundred and ninety-nine*

## An Act

To amend title IX of the Public Health Service Act to revise and extend the  
Agency for Healthcare Policy and Research.

*Be it enacted by the Senate and House of Representatives of  
the United States of America in Congress assembled,*

### SECTION 1. SHORT TITLE.

This Act may be cited as the “Healthcare Research and Quality  
Act of 1999”.

### SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Title IX of the Public Health Service Act  
(42 U.S.C. 299 et seq.) is amended to read as follows:

## “TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

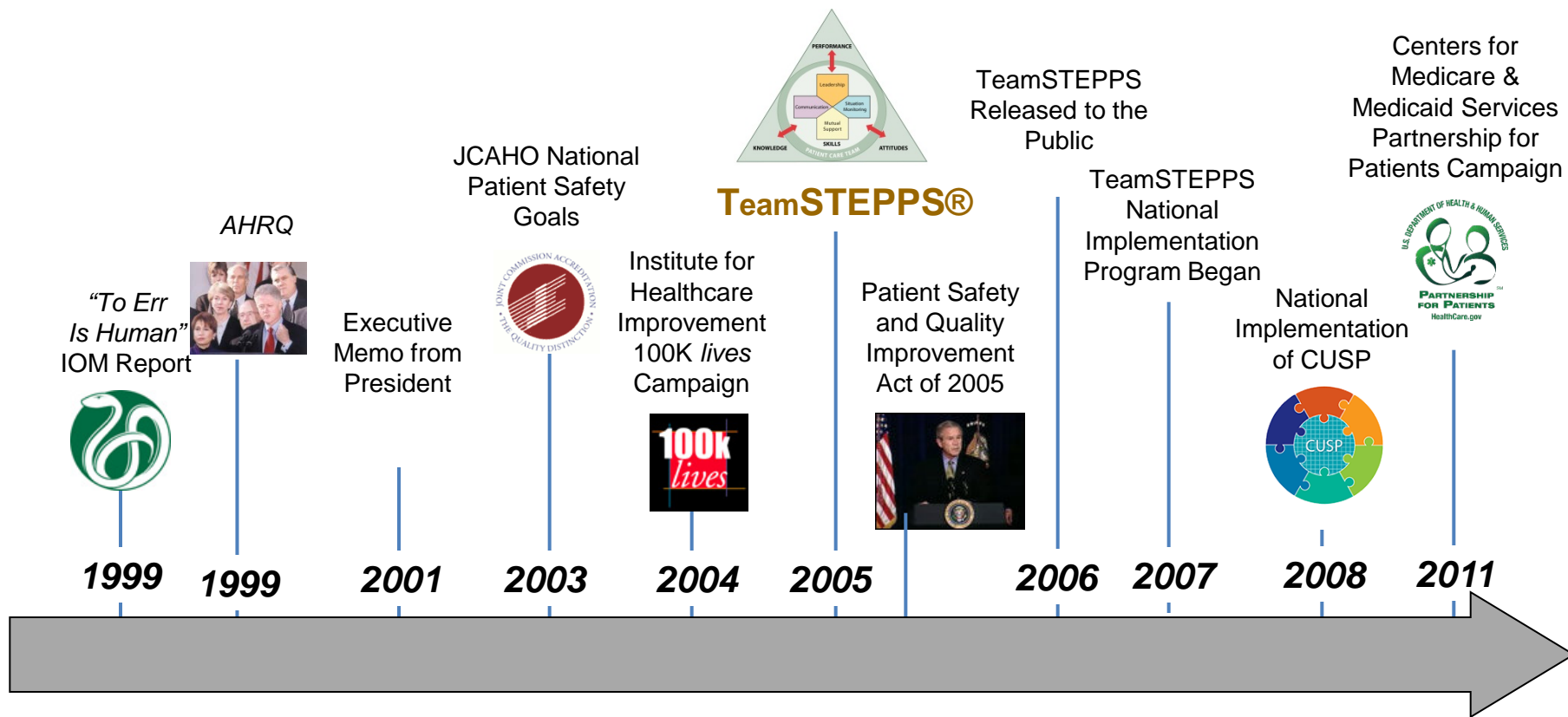
### “PART A—ESTABLISHMENT AND GENERAL DUTIES

#### “SEC. 901. MISSION AND DUTIES.

“(a) IN GENERAL.—There is established within the Public  
Health Service an agency to be known as the Agency for Healthcare



# National Response



# Patient Protection and Affordable Care Act: Key Quality Provisions

- Created a National Quality Strategy
- Established a Center for Quality Improvement and Patient Safety
- Established the Patient Centered Outcomes Institute (PCORI)
- Created the Center for Medicare and Medicaid Innovation
- Established a mandatory physician quality reporting program
- Requires public reporting on the quality of health insurance plans
- Requires additional reporting of patient data related to race, ethnicity, sex, and language
- Authorized numerous new payment and delivery models





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## Efforts To Improve Patient Safety Result in 1.3 Million Fewer Patient Harms

### Interim Update on 2013 Annual Hospital- Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013



Publication #15-0011-EF

ALTERNATE FORMATS

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This document provides preliminary estimates for 2013 on hospital-acquired conditions (HACs), indicating a 17 percent decline, from 145 to 121 HACs per 1,000 discharges, from 2010 to 2013. A cumulative total of 1.3 million fewer HACs were experienced by hospital patients in 2011, 2012, and 2013 relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level. Approximately 50,000 fewer patients died in the hospital as a result of the reduction in HACs, and approximately \$12 billion in health care costs were saved from 2010 to 2013.



# Medication Errors

## PERIOPERATIVE MEDICINE

### Evaluation of Perioperative Medication Errors and Adverse Drug Events

Karen C. Nanji, M.D., M.P.H., Amit Patel, M.D., M.P.H., Sofia Shaikh, B.Sc., Diane L. Seger, R.Ph., David W. Bates, M.D., M.Sc.

#### ABSTRACT

**Background:** The purpose of this study is to assess the rates of perioperative medication errors (MEs) and adverse drug events (ADEs) as percentages of medication administrations, to evaluate their root causes, and to formulate targeted solutions to prevent them.

**Methods:** In this prospective observational study, anesthesia-trained study staff (anesthesiologists/nurse anesthetists) observed randomly selected operations at a 1,046-bed tertiary care academic medical center to identify MEs and ADEs over 8 months. Retrospective chart abstraction was performed to flag events that were missed by observation. All events subsequently underwent review by two independent reviewers. Primary outcomes were the incidence of MEs and ADEs.

- Found that medication errors occurred in nearly half of all surgical procedures
- Found that one-third of all errors resulted in adverse drug events or harm to patients

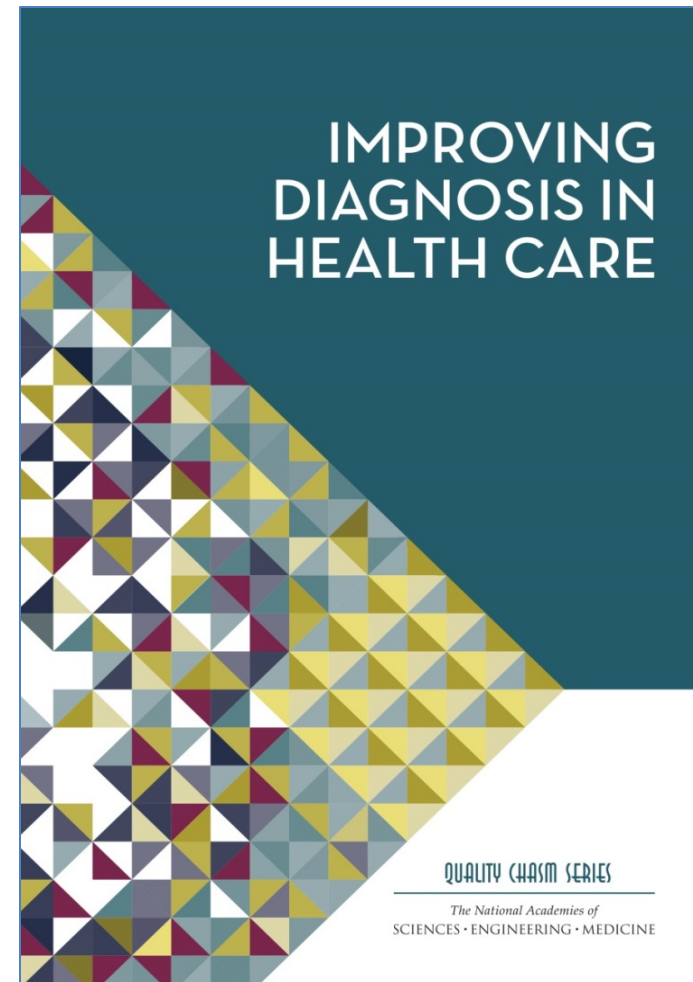


# The IOM Quality Chasm Series

The failure to:

- (a) establish an **accurate** and **timely** explanation of the patient's health problem(s)
- or
- (b) **communicate** that explanation to the patient

**“ It is likely that **most of us** will experience at least one diagnostic error **in our lifetime**, sometimes with devastating consequences.”**

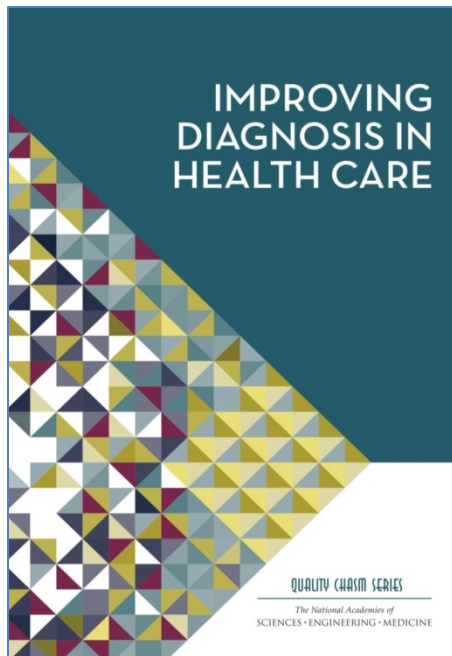


2015



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# Improving Diagnosis in Health Care



[nas.edu/improvingdiagnosis](https://nas.edu/improvingdiagnosis)



# Thank you

