Institute for Healthcare Improvement

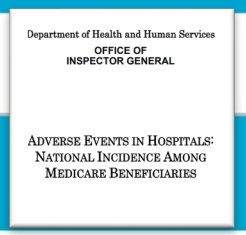
Deaths in Custody

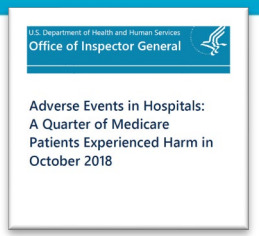
From individual accountability to safer systems

Kedar Mate, MD
President & CEO, Institute for Healthcare Improvement
Faculty, Weill Cornell Medicine

Has Patient Safety Improved?

Incidence of Patient Harm	2008	2018
Patients Who Experienced Harm Events	(n=780)	(n=770)
Adverse event or temporary harm event	27%	25%
Adverse event	13%	12%
Temporary harm event	13%	13%
Severity Level of Harm Events	(n=302)	(n=299)
Adverse events	42%	38%
Temporary harm events	58%	62%
Preventability of Harm Events	(n=302)	(n=299)
Preventable events	44%	43%
Not preventable events	51%	56%





https://oig.hhs.gov/oei/reports/OEI-06-18-00400.pdf

The third-leading cause of death in US most doctors don't want you to know about

Address 'Plane-Crash Level' Patient Harm, HHS Tells Hospitals, As Political Currents Swirl

Diagnostic errors linked to nearly 800,000 deaths or cases of permanent disability in US each year, study estimates

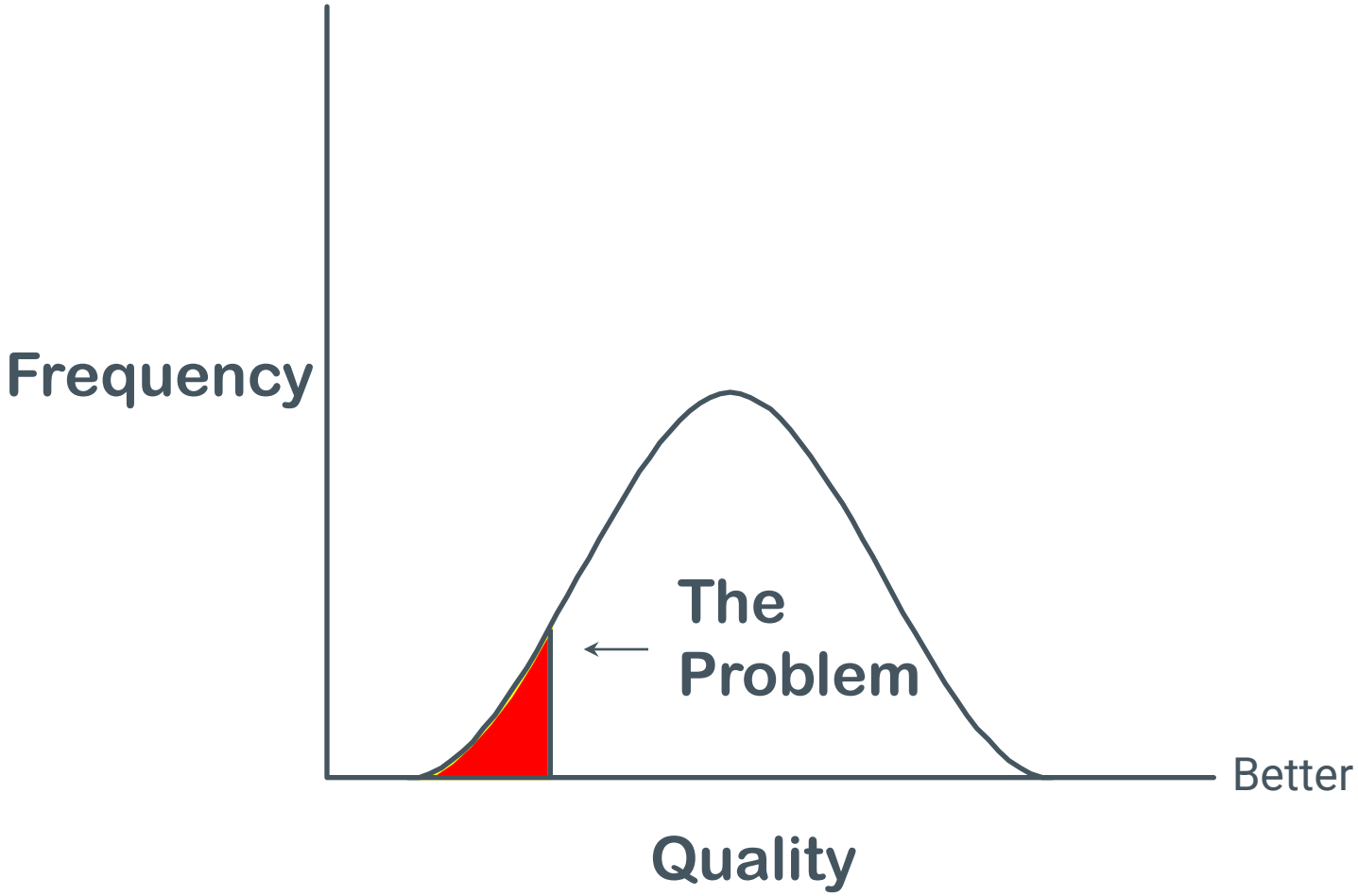
Medical errors kill thousands of people each year. But are hospitals getting any safer?

Medical Errors Are No. 3 Cause Of U.S Deaths, Researchers Say

795,000 Americans a year die or are permanently disabled after being misdiagnosed

Researchers: Medical errors now third leading cause of death in United States

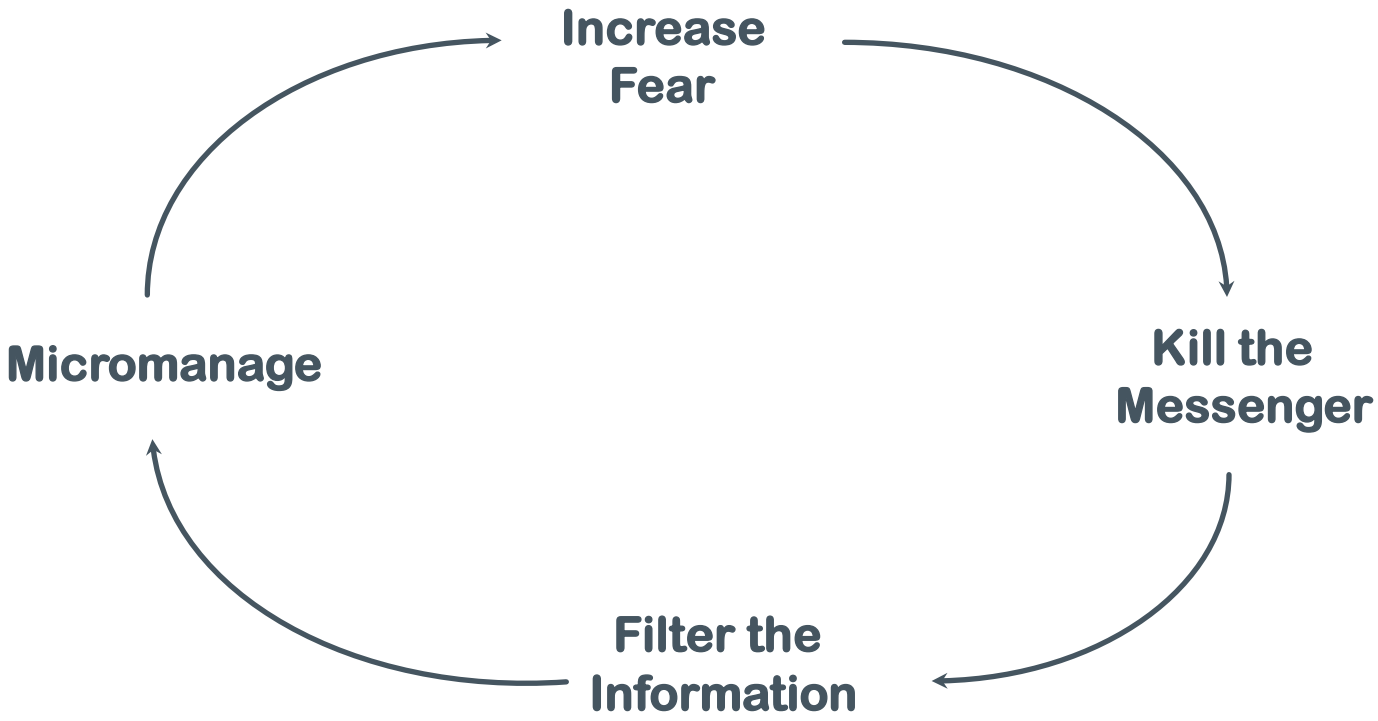
Competing theories: Bad Apples Theory



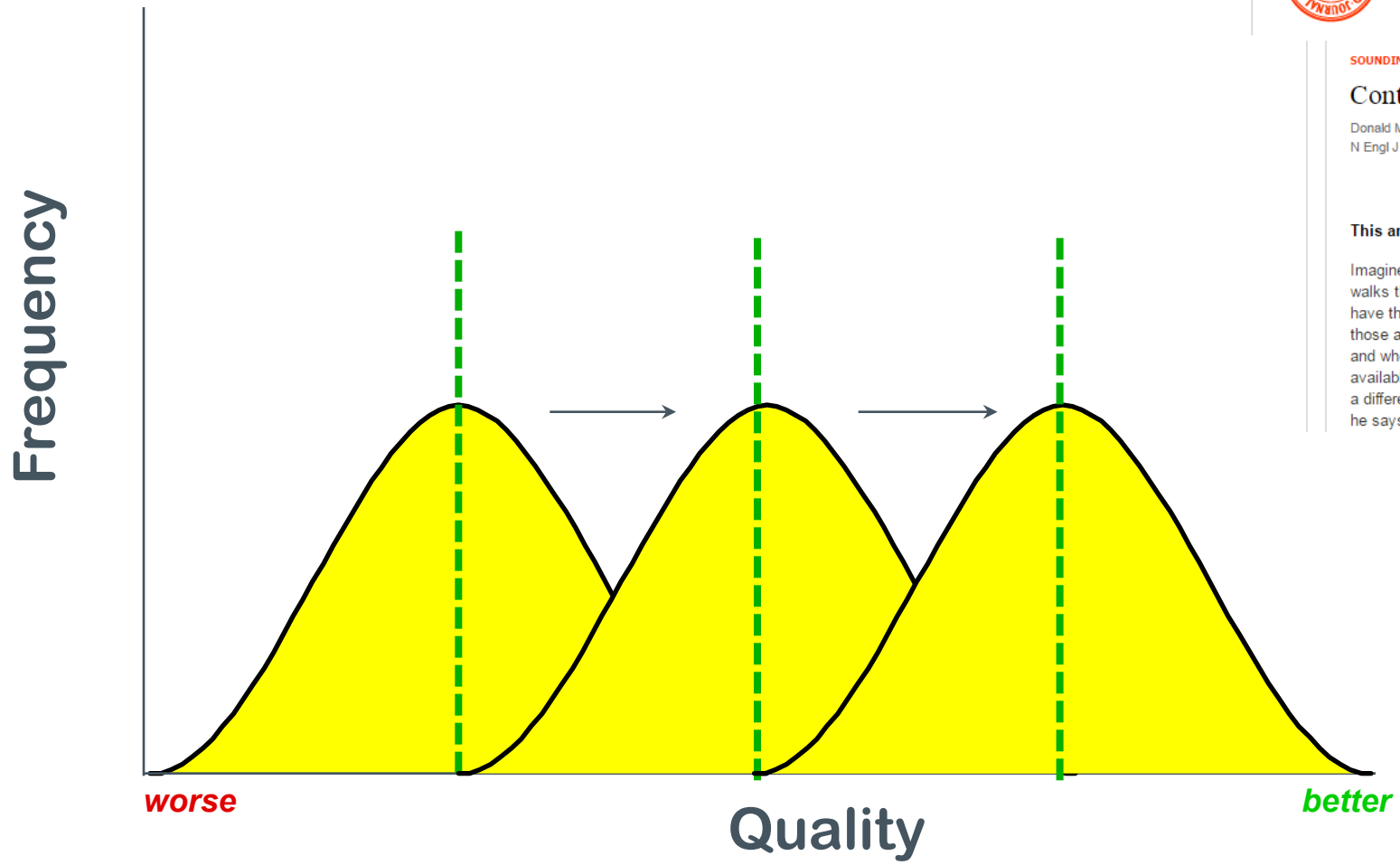
The Simple, Wrong Answer

BLAME SOMEBODY

The Cycle of Fear



Model 2: Continuous Learning & Improvement "Every Defect is a Treasure"



The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD ARCHIVE

Continuous Improvement as an Ideal in Health Care

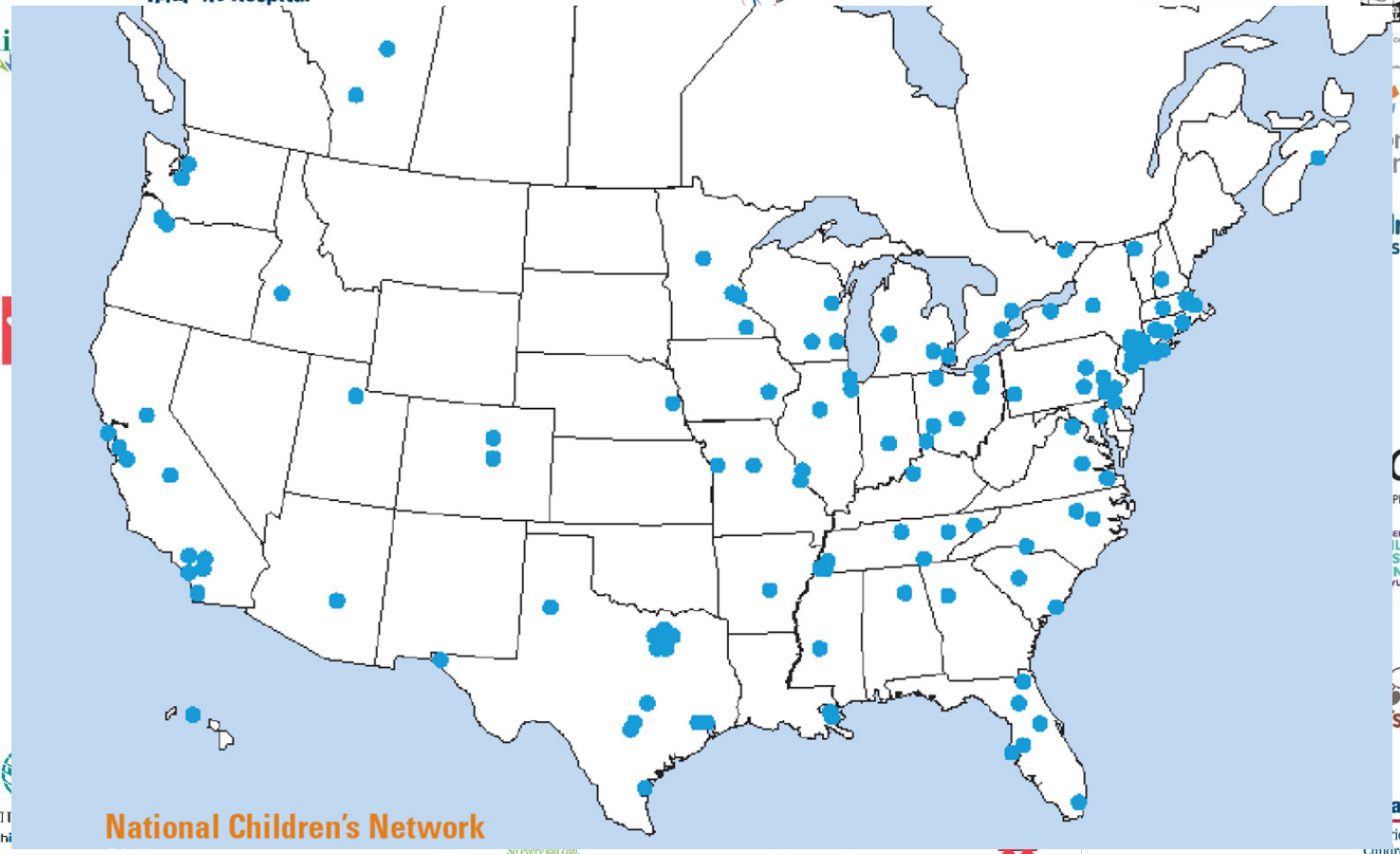
Donald M. Berwick, M.D., M.P.P.

N Engl J Med 1989; 320:53-56 | January 5, 1989 | DOI: 10.1056/NEJM198901053200110

Share:

This article has no abstract; the first 100 words appear below.

Imagine two assembly lines, monitored by two foremen. Foreman 1 walks the line, watching carefully. "I can see you all," he warns. "I have the means to measure your work, and I will do so. I will find those among you who are unprepared or unwilling to do your jobs, and when I do there will be consequences. There are many workers available for these jobs, and you can be replaced." Foreman 2 walks a different line, and he too watches. "I am here to help you if I can," he says. "We are in this together for the long . . .



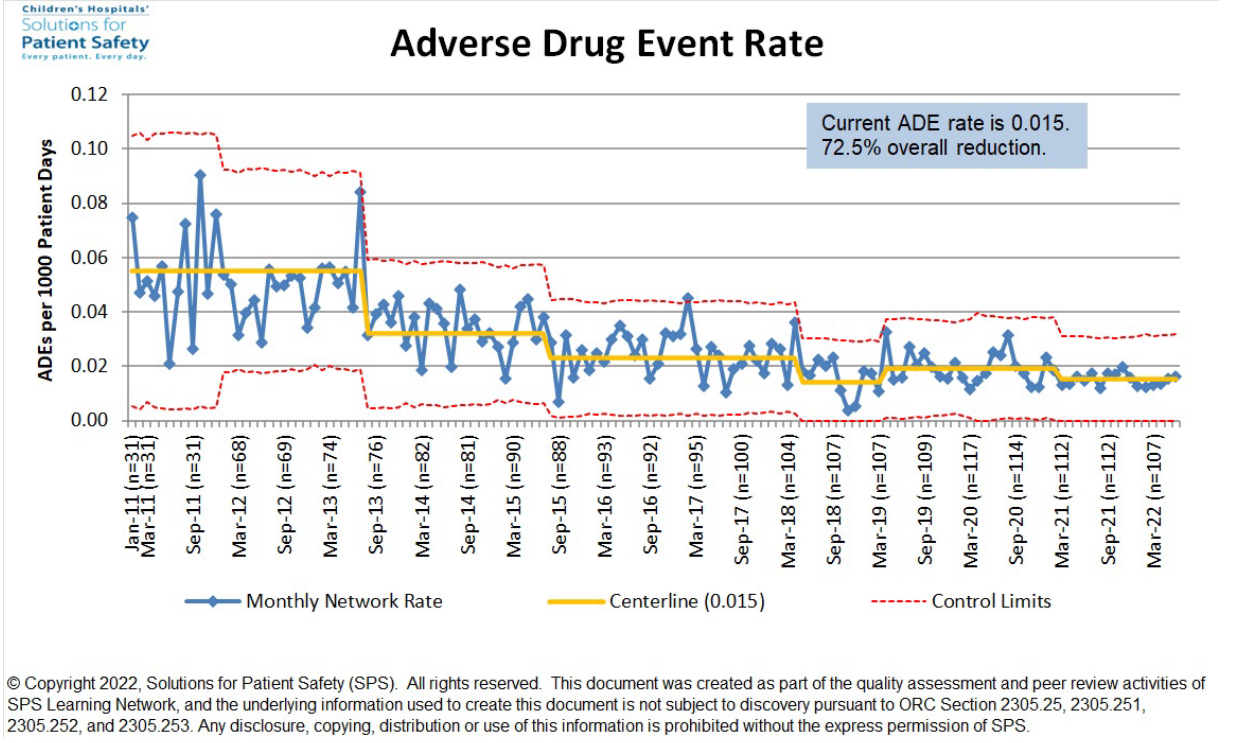
El Paso Children's Hospital
Children's Hospital of Michigan
DMC Detroit Medical Center
Texas Children's Hospital
Children's Hospital of The King's Daughters Health System
University of Michigan C.S. Mott Children's Hospital
Seattle Children's Hospital · Research · Foundation
Wolfson Children's Hospital
Children's of Alabama
St. Joseph's Children's Hospital BayCare Health System
Baptist Spence and Becky Wilson Children's Hospital
Riley Hospital for Children Indiana University Health
Children's Hospital
Connecticut Children's Medical Center
UR Medicine Golisano Children's Hospital
Cincinnati Children's
Mayo Clinic
Vidant Medical Center
East Tennessee Children's Hospital
Mercy Children's Hospital Mercy Health
Le Bonheur Children's Hospital
Texas Scottish Rite Hospital for Children
The Children's Hospital of San Antonio Christus Health
Arkansas Children's Hospitals · Research · Foundation
children's Hospital at Erlanger
University of Iowa Stead Family Children's Hospital
Geisinger Janet Weis Children's Hospital
Stony Brook Children's
IWK Health Centre
SSM Health Cardinal Glennon Children's Hospital
Yale-New Haven Children's Hospital
Miller Children's Hospital
Randall Children's Hospital
Akron Children's Hospital
Children's of Mississippi
Floating Hospital for Children at Tufts Medical Center
CookChildren's
WMC Health Maria Fareri Children's Hospital
dell children's medical center of central texas
A member of the Seton Family of Hospitals
Children's Healthcare of Atlanta
MUSC Children's Health
BaylorScott&White McLane Children's Medical Center
Nationwide Children's
When your child needs a hospital, everything matters.
CHaD Children's Hospital Dartmouth-Hitchcock
McMaster Children's Hospital Hamilton Health Sciences
University of Colorado Health Memorial Hospital
Children's Hospital of Wisconsin
Kids deserve the best.
St Luke's Children's
Lucile Packard Children's Hospital Stanford
Kapi'olani Medical Center for Women & Children
An Affiliate of Hawai'i Pacific Health
children's health Children's Medical Center
Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
A Lifespan Partner
Spectrum Health Helen DeVos children's hospital
Cleveland Clinic Children's
CHEO
Children's Hospital of Pittsburgh of UPMC
University of Minnesota Masonic Children's Hospital
NYU Winthrop Hospital Children's Medical Center
INOVA Children's Hospital
Doernbecher Children's Hospital Oregon Health & Science University
Gillette Children's Specialty Healthcare
Baystate Children's Hospital
CHOC Children's
Advocate Children's Hospital
Loma Linda University
SickKids The Hospital for Sick Children
duPont Hospital for Children
Monroe Carell Jr. Children's Hospital at Vanderbilt
Florida Hospital for Children
Cohen Children's Medical Center Northwell Health
Stollery Children's Hospital
Kaiser Permanente

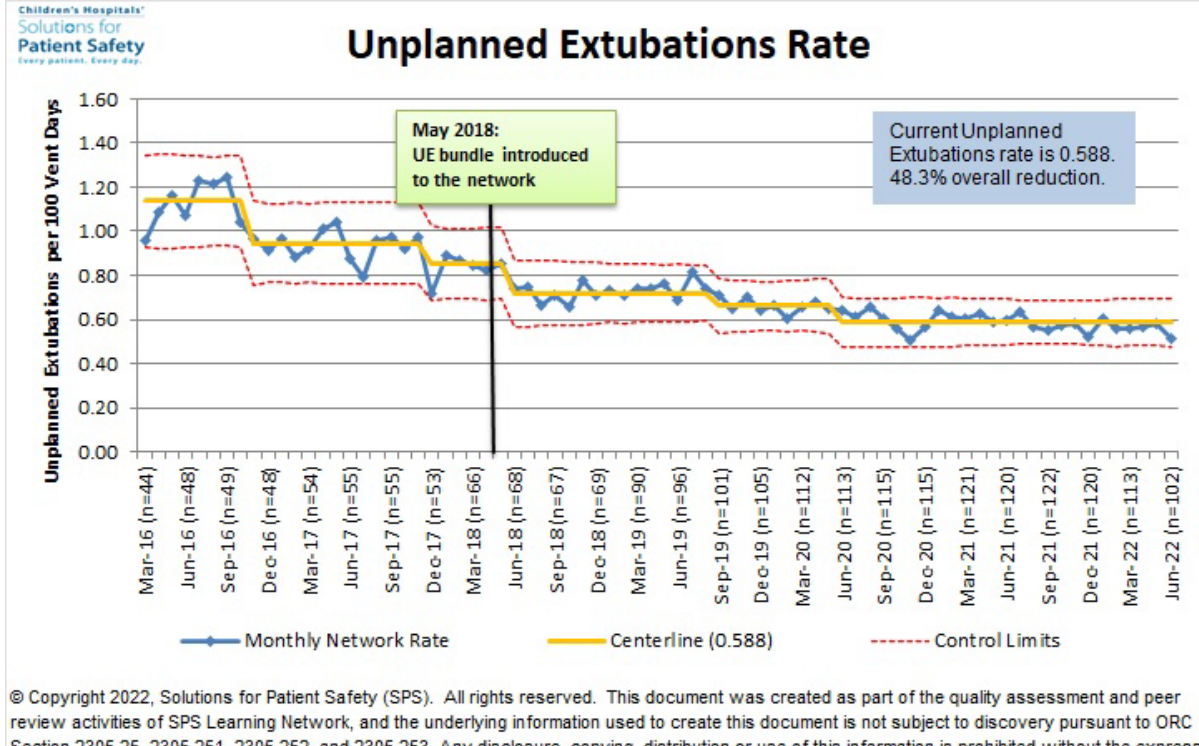
Solutions for Patient Safety

20,803 children spared harm

$382,572,473 saved

144+ hospitals working together





“The First Law of Improvement”

Every system is perfectly designed to achieve exactly the results it gets.

To get a different result, we must **change the system.**

Changing Systems…
Step 1 Choose Aims

“Aims create strategy; Strategy creates results” – Dennis Wagner, former CMS official

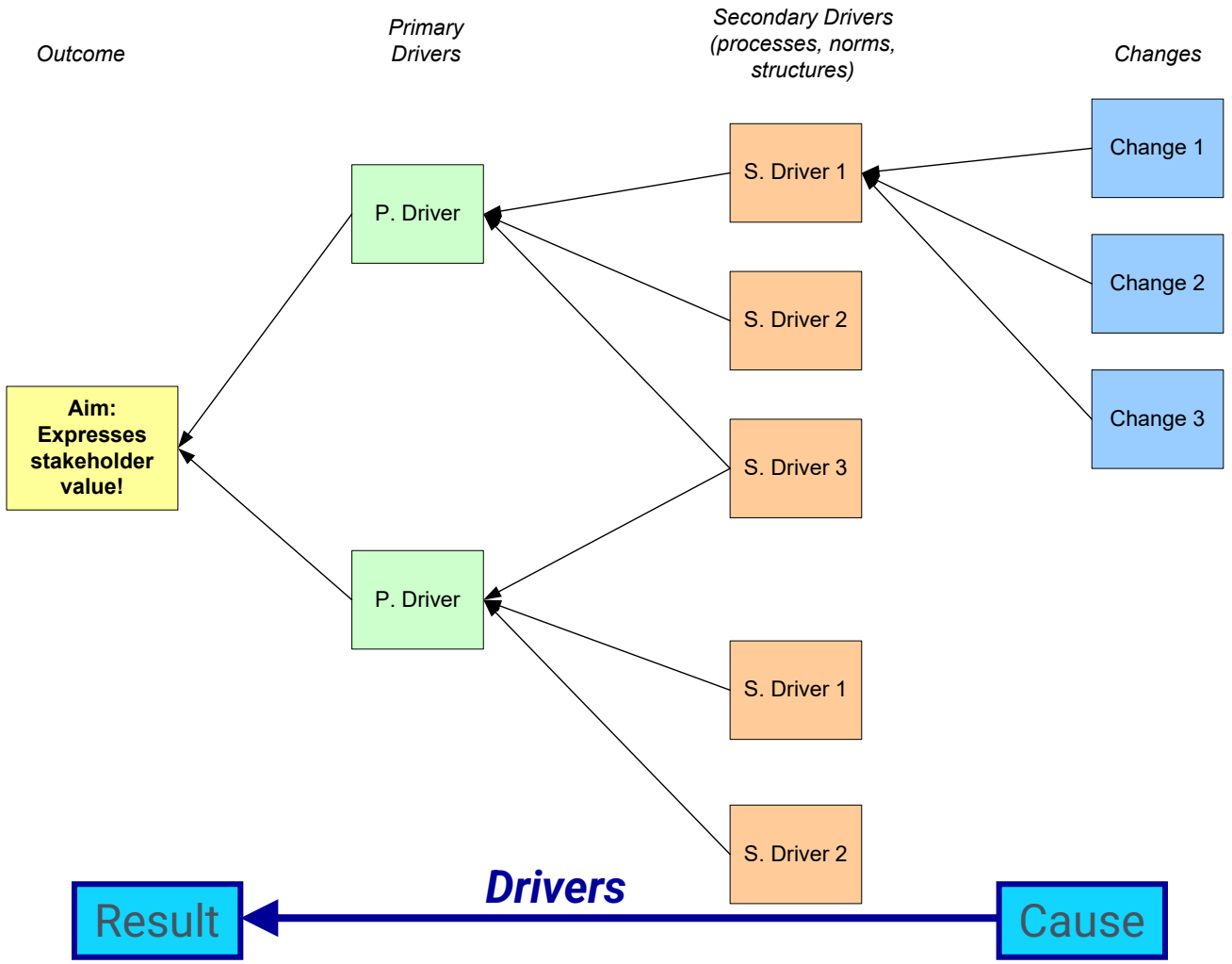
Aim = Seizure Free Days

To

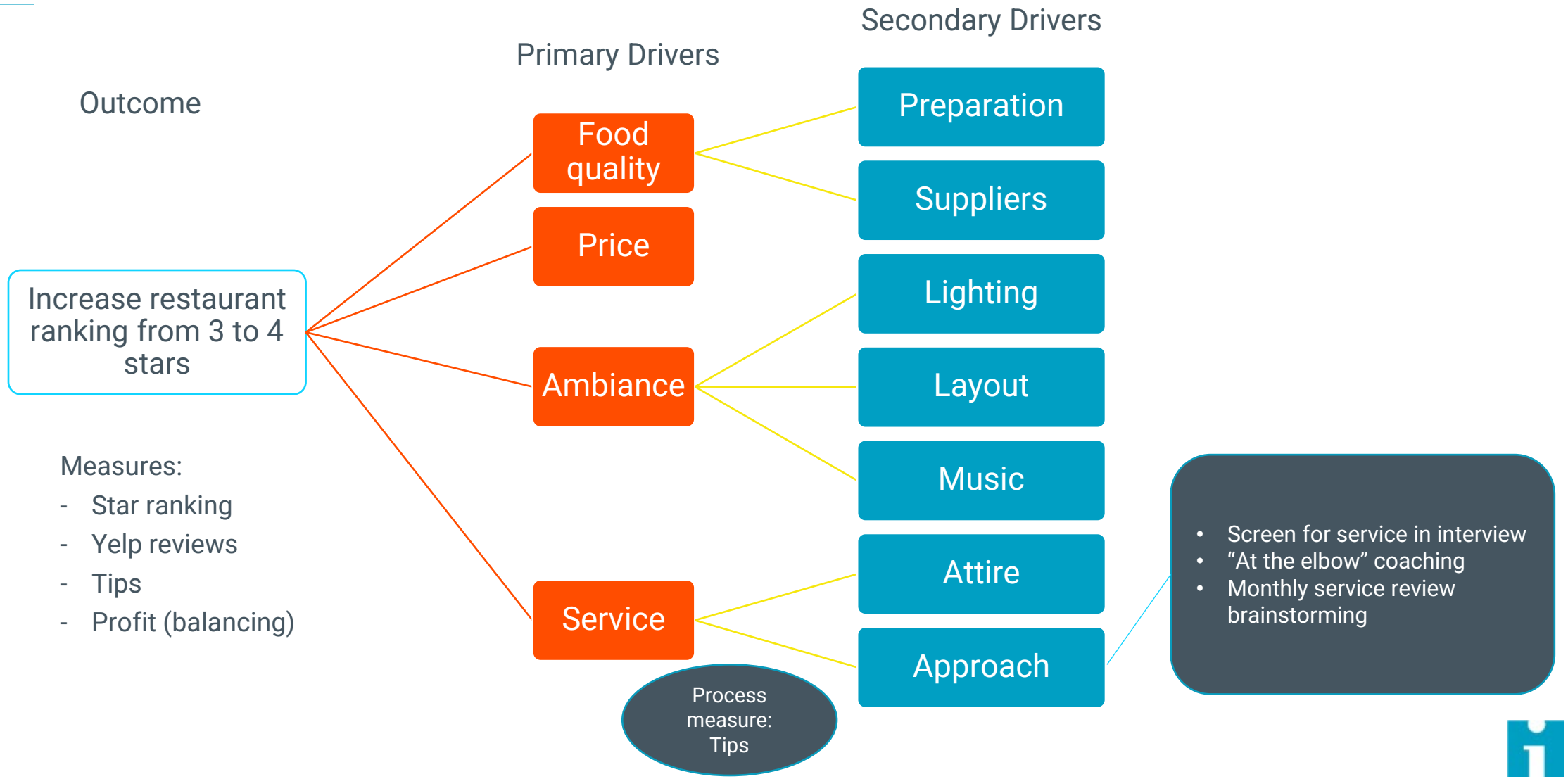
Aim = Healthy Days without a Seizure

Step 2:
Identify A Theory of How to Improve a System

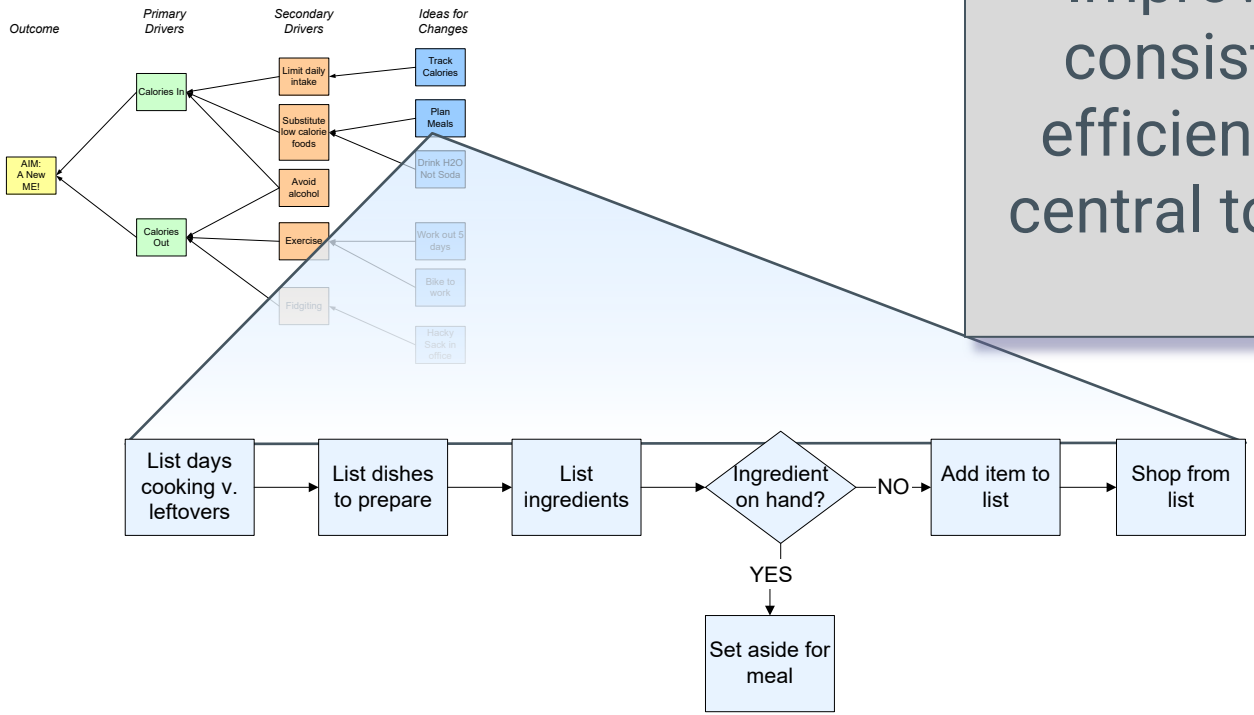
A Driver Diagram is a depiction of your theory for how to change a system



Example: improving restaurant ratings

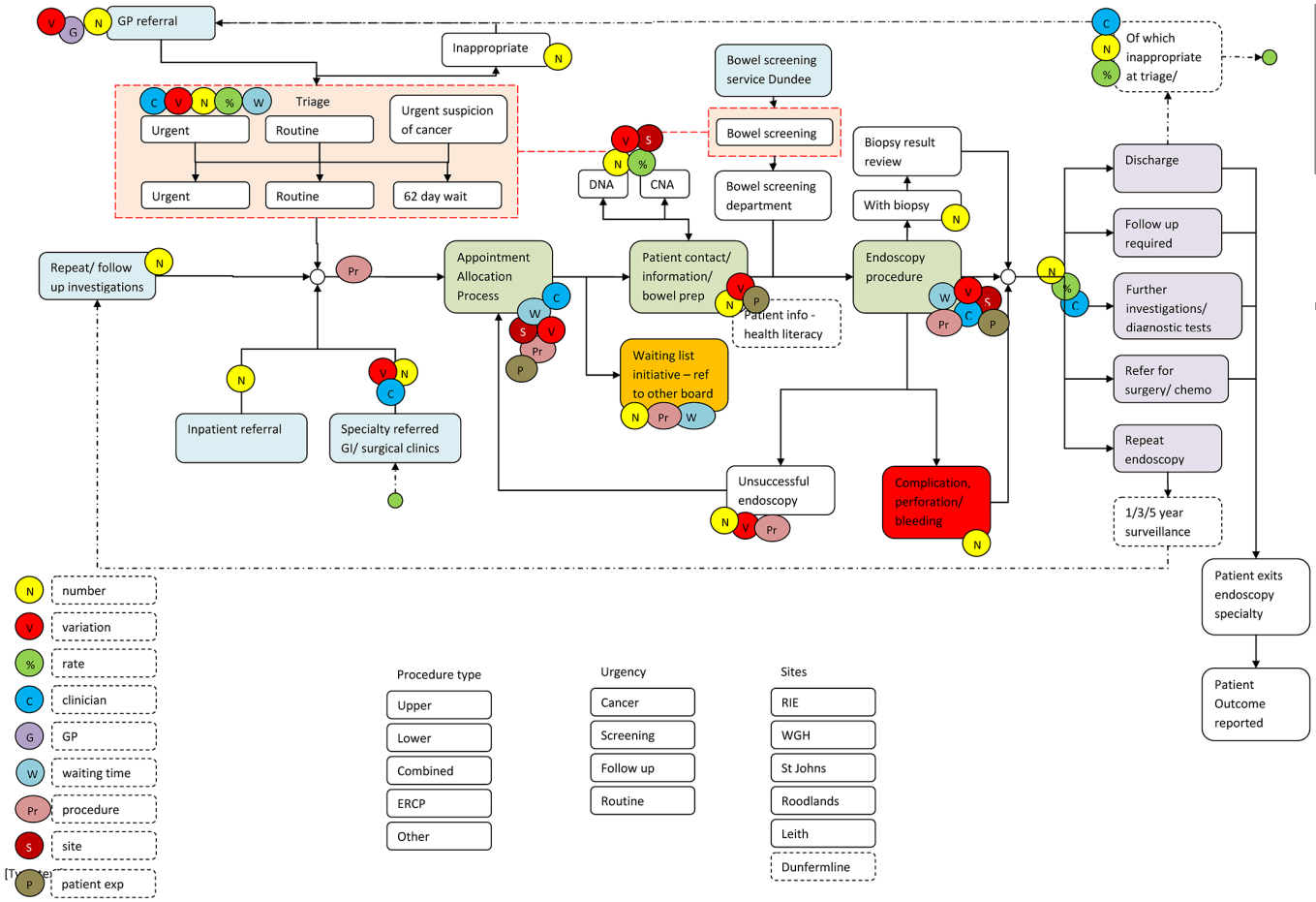


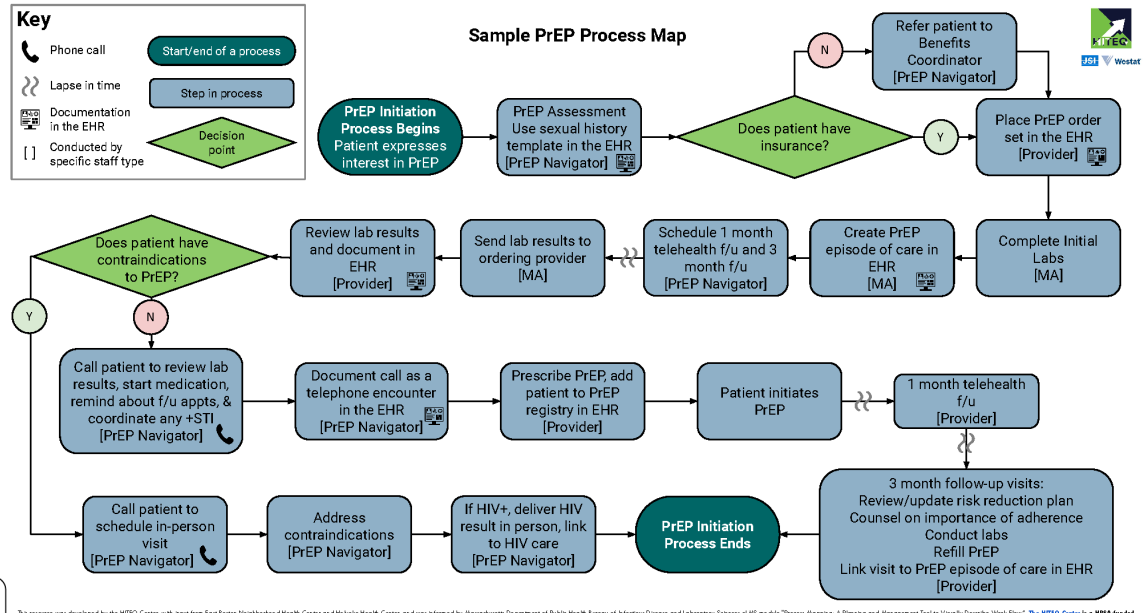
Drivers & Processes are Linked!



Improving the reliability, consistency, usability or efficiency of processes is central to improving system outcomes

Step 3: Understanding the system (1)





Understanding the system (2):
Probability of performing perfectly

No. of Steps	Probability of Success for Each Element			
	0.90	0.95	0.990	0.999
1	0.90	0.95	0.990	0.999
25	0.07	0.28	0.78	0.98
50	0.005	0.08	0.61	0.95
100	0.00026	0.006	0.37	0.90

Step 4: Improve the System – Simplification

Remove unnecessary steps

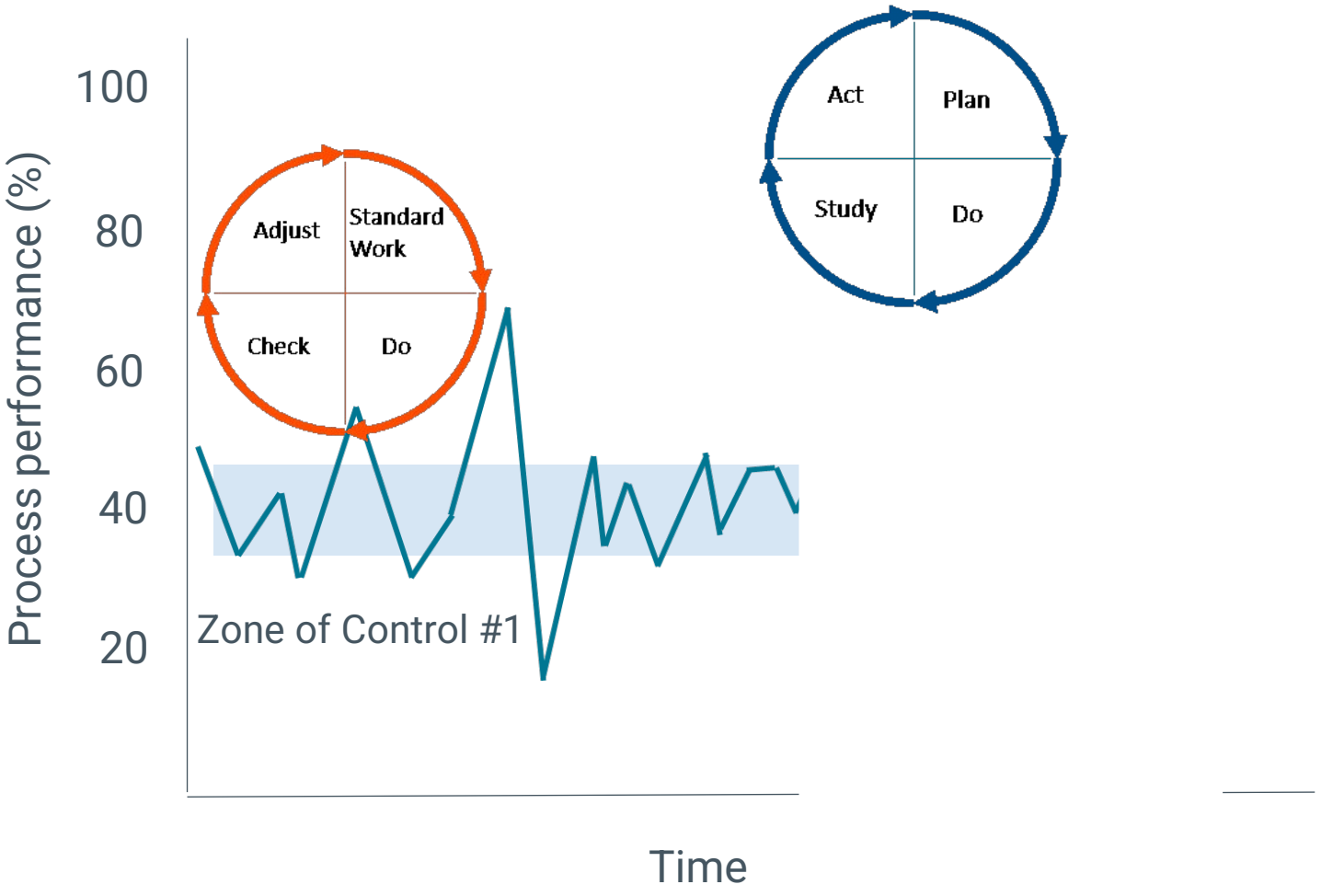
Tie unreliable to reliable

Automation


Hertz Gold Plus Rewards
Gold Plus Rewards
Customer Service
tz Gold Plus Rewards

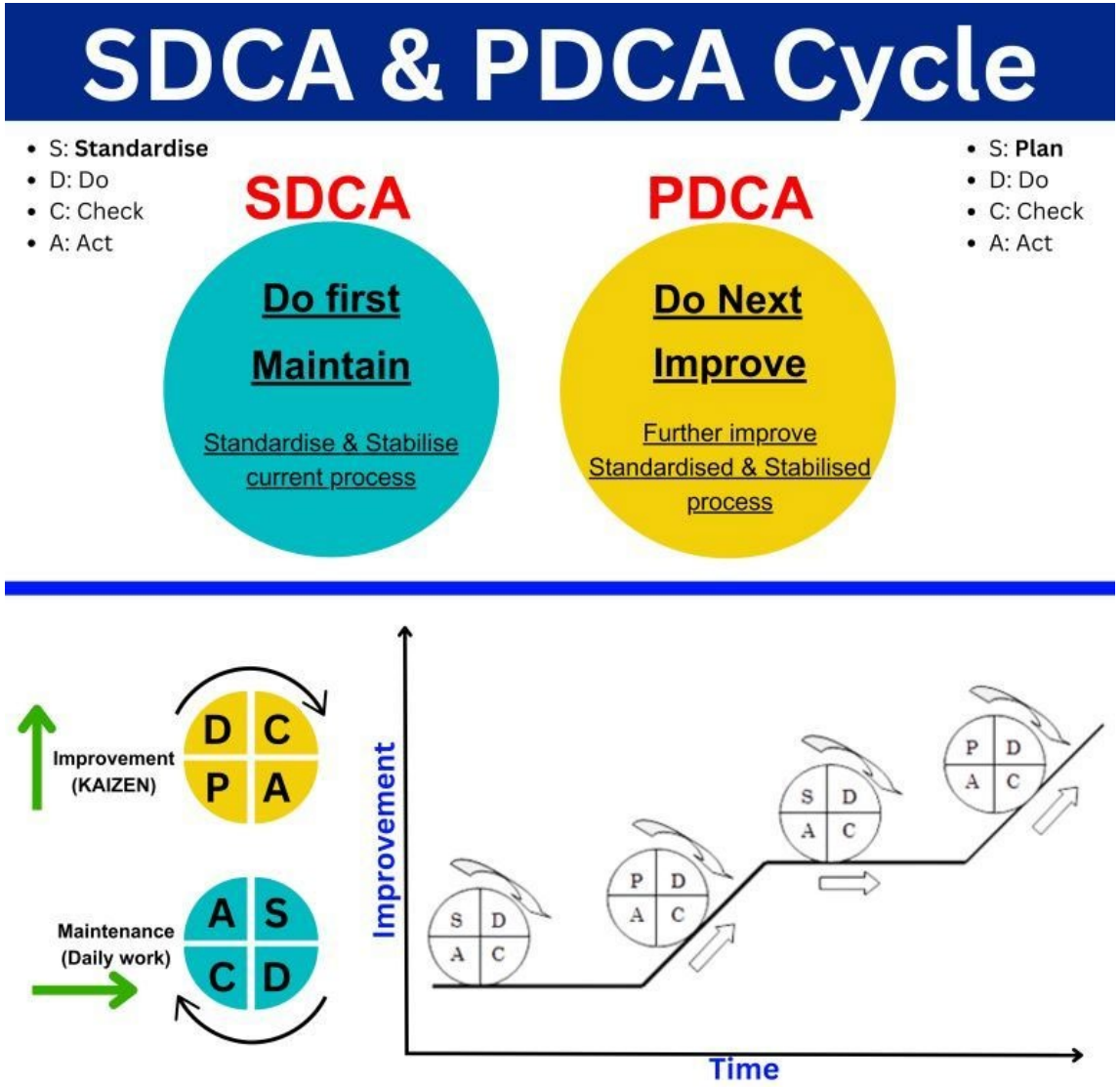
IMAGE: HERTZ

Step 4 Improve the System – Standardization

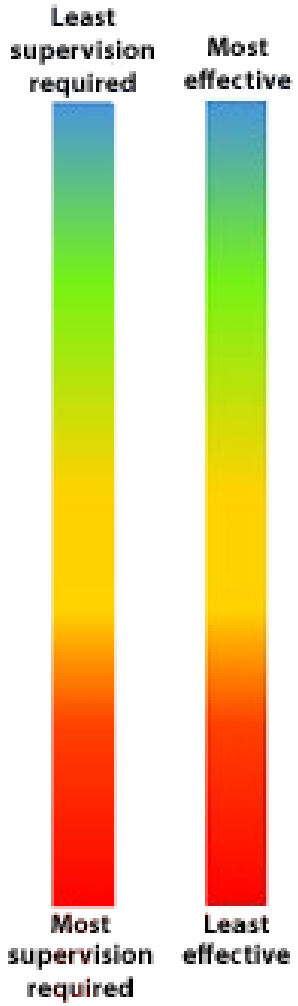


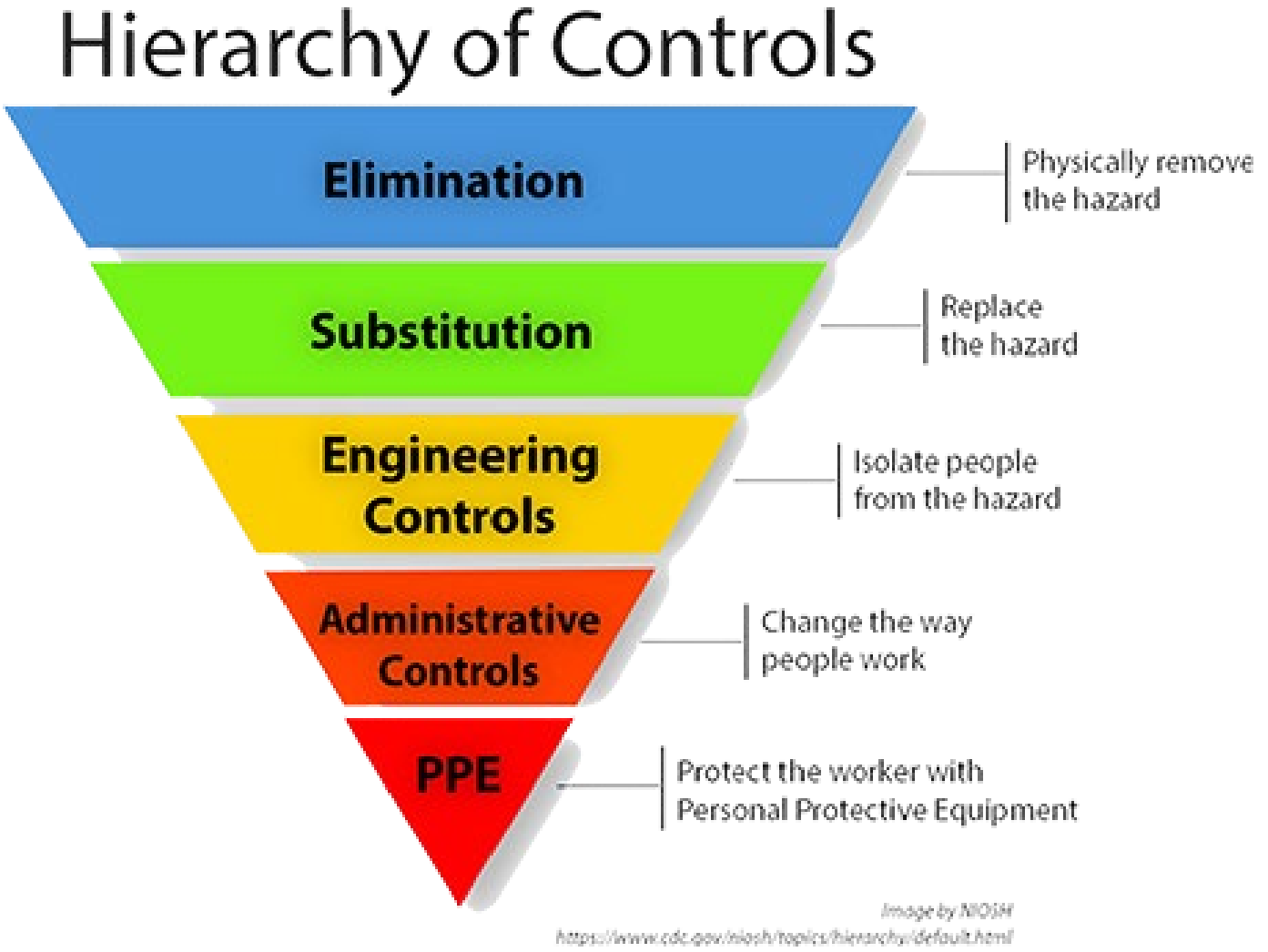
Adapted from Juran J, Godfrey AB, eds. *Juran's Quality Handbook: Fifth Edition*. New York: McGraw-Hill, 1999.

Step 4 Improve the System – Standardization



Step 4: Improve the System – Hierarchy of Controls






ATM

It’s the system…not the people

Step 1: Choose Aims

Step 2: Identify a theory of change

Step 3: Understand the system as it is

Step 4: Improve the system

A. Simplification

B. Standardization

C. Use Hierarchy of controls


Harvard Business Review

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To Improve Health Care, Focus on Fixing Systems — Not People

by Kedar S. Mate, Josh Clark, and Jeff Salvon-Harman

July 12, 2024

https://hbr.org/2024/07/to-improve-health-care-focus-on-fixing-systems-not-people

“

You do not rise to the level of your goals. You fall to the level of your systems.

JAMES CLEAR
Atomic Habits

Kedar Mate, MD

President and CEO

kmate@ihiorg

53 State Street
Boston, MA 02109
ihi.org

We will not rest until everyone has the best care and the best health possible.

Thank you