

CULTURE AND THE ECONOMICS OF PATIENT SAFETY

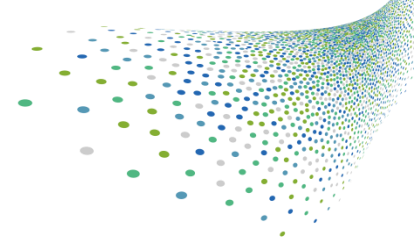
Luke Slawomirski
OECD Health Division



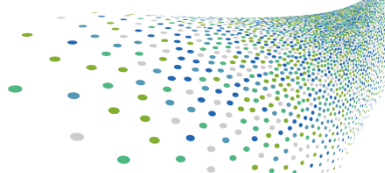
@LukeSlawomirski
@OECD_social



Key points



1. Organisational culture is a critical foundation for safety
2. Catalyst for, and function of, all policies & activities
3. We need to measure it & learn more about it
4. Leadership at all levels is critical (consistency, resourcing, communication...)



Collective values, principles, beliefs,
attitudes, relationships, symbols,
habits, behaviour, assumptions ...

Unwritten rules
'how things are done around
here'

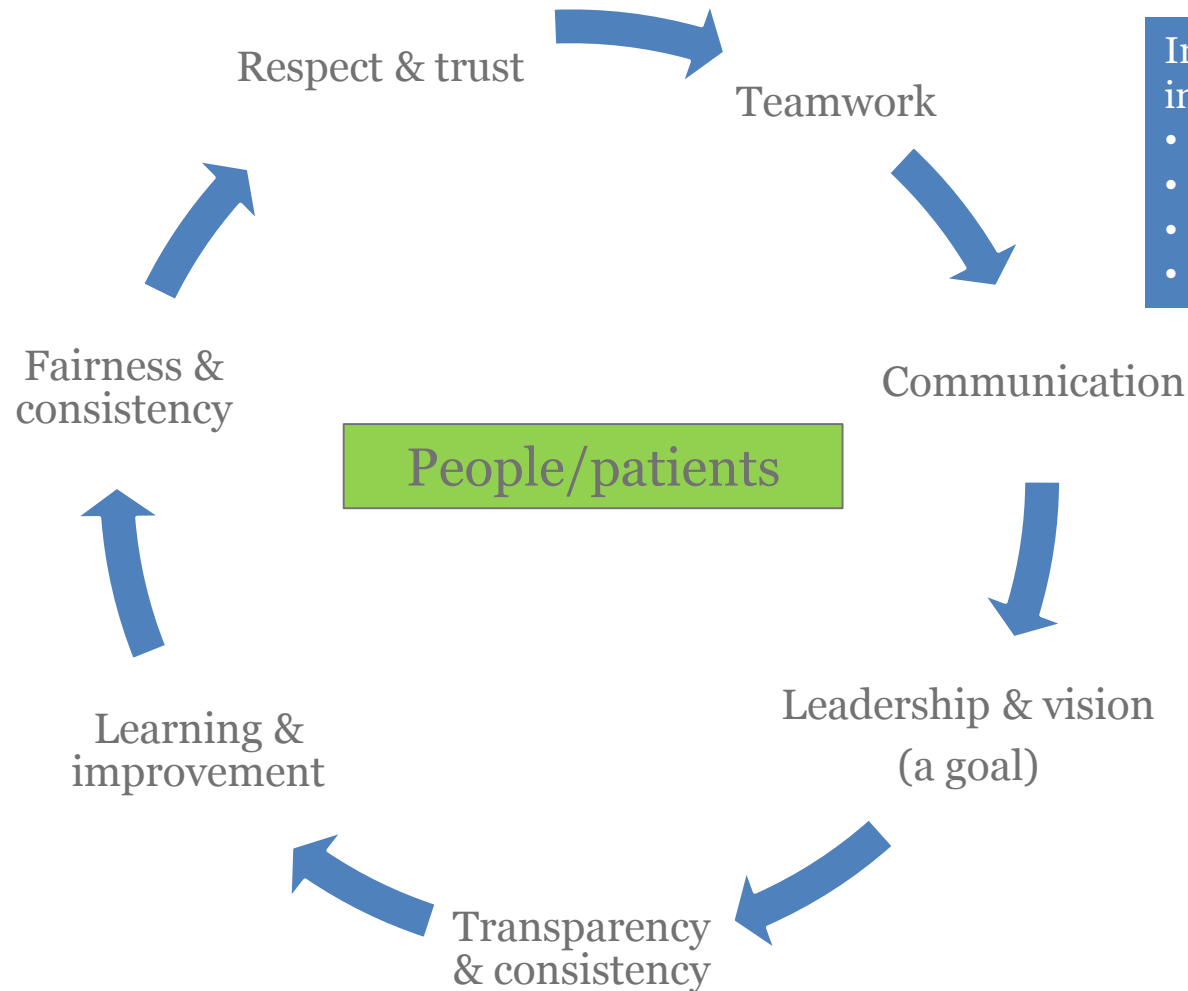
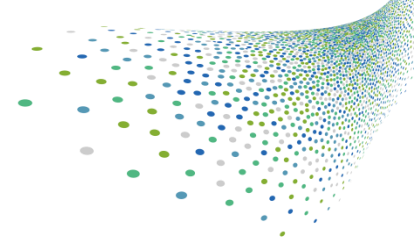


"Houses of ritual"
- J. Ovreteit

... how power is distributed
and managed?



‘patient safety culture’

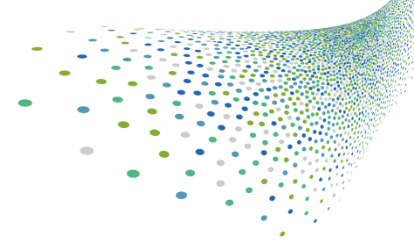


Industries where culture has influenced performance

- Aviation
- Mining, O&G
- Nuclear industry
- Automotive industry



The eating habits of culture ...

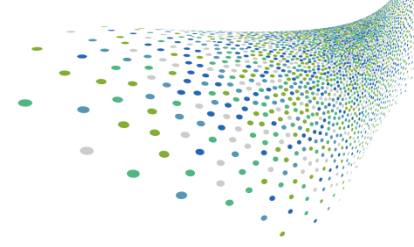


- Health care – complex, adaptive, unpredictable, fast
 - Immensely difficult to decompose - and prescribe all necessary behaviours and actions
- Culture: nebulous & intractable.... this may be its power
 - permeates *all* activities
 - Permits adaptation & flexibility for unpredictable situations

“Teach someone to fish...” → empower people to think, respond and collaborate in difficult circumstances towards achieving a shared goal



So how do we build it?



‘2.9 Building a positive safety culture’

Academics: $3.14/2.86=1.1$

Policy experts: $4.5/3.07=1.46$

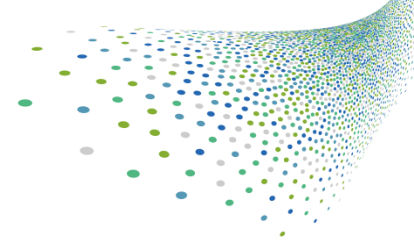
All: 1.35 → mid range of results

Culture mentioned by every respondent in comments

“...a culture that is open, free from fear, buoyant, and ambitious...”



The most popular selections in Pt II



•••	1.5 Professional education and training	14x
••	2.1 Clinical governance systems and frameworks	13x
••	1.1 Safety standards linked to accreditation and certification	11x
•••	2.5 Person- and patient-engagement strategies	9x
•••	1.6 EHR systems**	9x
••	1.9 National interventions based on specific safety themes	9x
•••	1.7 No-fault medical negligence legislation	8x
•	1.10 A national agency responsible for patient safety	8x

••	2.2 Clinical incident management and reporting systems	6x
•••	2.9 Building a positive safety culture	6x
•••	21.2 Public reporting	6x
•••	1.3 mandatory reporting	6x

Relationship Between Occurrence of Surgical Complications and Hospital Finances

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Bennett H. Lane, MS
Barry Rosenberg, MD, MBA
Stuart A. Lipsitz, ScD
David Sadoff, MBA
Dave Matheson, JD, MBA

William R. Hargrett-Nelson, MD
Mark Lesch, MD
Atul A. Gawande, MD, MPH

Importance The effect of surgical complications on hospital finances is unclear.
Objective To determine the relationship between major surgical complications and per-encounter hospital costs and revenues by payer type.

Design, Setting, and Participants Retrospective analysis of administrative data for all inpatient surgical discharges during 2010 from a nonprofit 12-hospital system in the southern United States. Discharges were categorized by principal procedure and occurrence of 1 or more postsurgical complications, using *International Classification of Diseases, 10th Revision*.

Results Among 12,345 surgical discharges, 1,111 (9.0%) had 1 or more complications. The mean hospital charges for patients with complications were \$39,017 higher than for patients without complications.

Conclusions Surgical complications are associated with higher hospital charges. The effect of complications on hospital finances is unclear.

Keywords Patient safety; Intensive care units; CUSP program; Teamwork climate; Collaborative model

Introduction Surgical complications are a major cause of patient morbidity and mortality. They are also a major cause of hospital costs and revenues by payer type.

Background The effect of surgical complications on hospital finances is unclear. The objective of this study was to determine the relationship between major surgical complications and per-encounter hospital costs and revenues by payer type.

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“...complications were associated with a \$39 017 higher contribution margin per patient with private insurance and a \$1749 higher contribution margin per patient with Medicare”

- non-Medicare → 3.2x profit
- Medicare → 2x profit

For editorial comment see p 1634.

Author Video Interview available at www.jama.com.

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WHO Surgical Safety Checklist
→ Positive change in OR culture
(levelling of power asymmetries?)
→ Safer care



ELSEVIER

Improving patient safety in intensive care units in Michigan[☆]

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Christine Goeschel RN, MP,
Christine G. Holzmuehler BSc,
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Robert Hyzy MD, Robert W.
Laura Morlock PhD, J. Bry

Johns Hopkins University, School of Medicine,
Michigan Health & Hospital Association,
Michigan Hospitals, USA

Keywords:
Patient safety;
Intensive care units;
CUSP program;
Teamwork climate;
Collaborative model

Abstract
Purpose: To improve patient safety in intensive care units in Michigan.
Methods: A patient-centered culture was developed and implemented in 16 intensive care units in Michigan.
Results: The patient-centered culture was associated with a 51% reduction in patient mortality and a 51% reduction in patient morbidity.
Conclusion: A patient-centered culture can improve patient safety in intensive care units.

A Multilevel Analysis of Patient Engagement and Patient-Reported Outcomes in Primary Care Practices of Accountable Care Organizations

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¹School of Public Health, University of California Berkeley, Berkeley, CA, USA; ²HealthCare Partners Institute for Applied Research and Education, Los Angeles, CA, USA; ³Advocate Health, Chicago, IL, USA

BACKGROUND: The growing movement toward more accountable care delivery and the increasing number of people with chronic illnesses underscores the need for primary care practices to engage patients in their own care.

OBJECTIVE: For adult primary care practices seeing patients with diabetes and/or cardiovascular disease, we examined the relationship between selected practice characteristics, patient engagement, and patient-reported outcomes of patient engagement.

DESIGN: Cross-sectional analysis of data from 16 randomly selected primary care organizations (ACOs) in California.

PARTICIPANTS: Patients with diabetes and/or cardiovascular disease (CVD) (n=4368) and received care from the 16 practices.

MEASUREMENTS AND MAIN RESULTS: Patient engagement was measured using the Patient Engagement Survey (PES). Patient-reported outcomes were measured using the Patient-Reported Outcomes Measurement Information System (PROMIS).

CONCLUSIONS: Patient engagement was positively associated with better patient-reported outcomes. The effect of patient engagement on patient-reported outcomes was stronger for patients with CVD.

KEY WORDS: Patient engagement; Patient-reported outcomes; Accountable care organizations; Diabetes; Cardiovascular disease.

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Teamwork climate;
Collaborative model

...a patient-centered culture was positively associated with fewer depression symptoms ... and better physical function scores.

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INTRODUCTION

Forty-six million Americans have diagnosed cardiovascular disease (CVD), diabetes, or both, representing a combined annual healthcare cost of \$354 billion.^{1–3} It is increasingly recognized that greater efforts to engage patients in their care are needed to improve outcomes for these populations.^{4–9} While there is a growing body of literature on patient engagement and patient-reported outcomes of care,^{10–13} little is known about what practices can do to encourage greater patient engagement and how such engagement might be associated with better patient-reported outcomes of care.^{14–16}

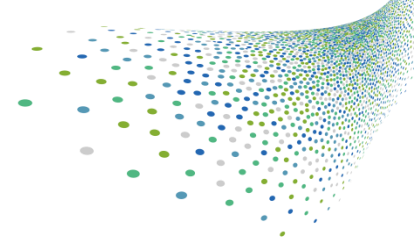
To address this gap in knowledge, we studied 16 primary care practices belonging to two large ACOs that implemented a variety of patient engagement initiatives for patients with cardiovascular disease (CVD), diabetes, or both. We



Every system is perfectly designed to achieve the results it gets
- Paul Batalden, IHI [...David Hanna, Arthur Jones]



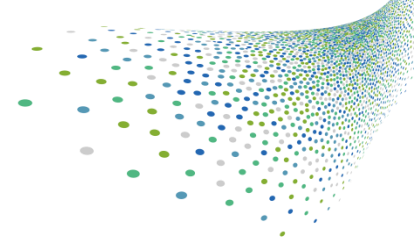
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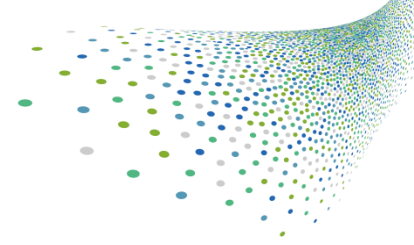
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Thank you
Vielen Dank

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