TRUST IN HEALTHCARE

Webinar on Patient Safety Day
Thursday, 17th September'2020

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MECHANICAL vs. BIOLOGICAL

"HEALTHCARE IS DIFFERENT"

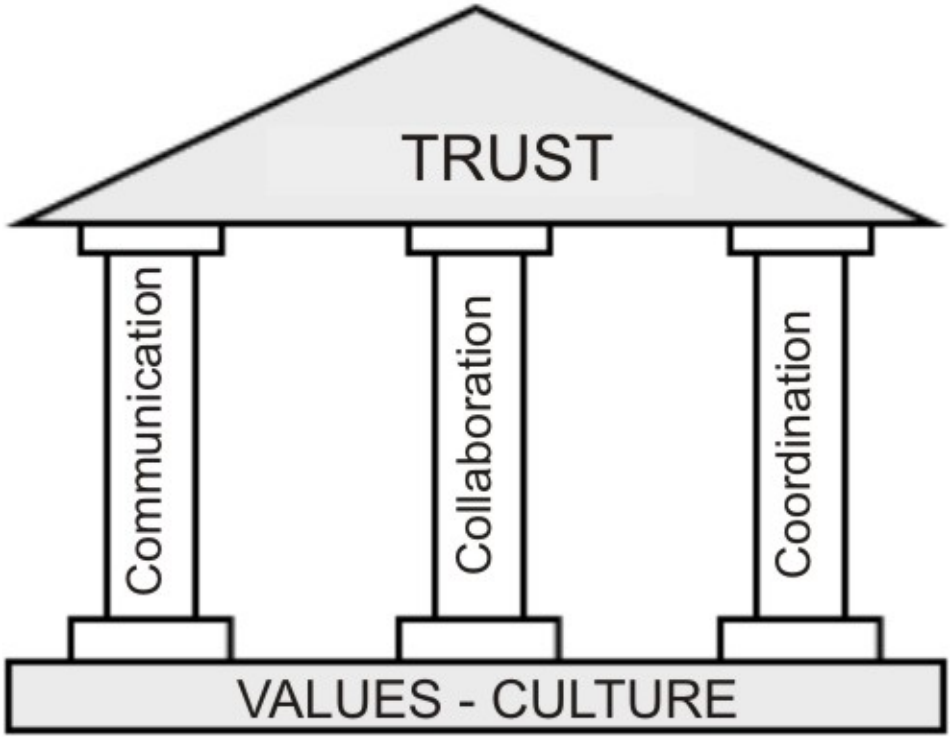
- If you throw a stone – can you predict where it will land?
- If you release a bird from your hand – can you predict where will it land?
- Complex Adaptive Systems defy linearity
- Nobility of Healthcare – Based on TRUST
  – Knowledge – Fiduciary – Beneficience

Missing Element in Healthcare Today?

- TRUST – WHY?
- Manifestations
  - Litigation
  - “Multiplicate” encounters
  - Violence
  - Dissatisfaction levels all around at unprecedented levels

“Ironically healthcare totally based on trust”

Healthcare Excellence



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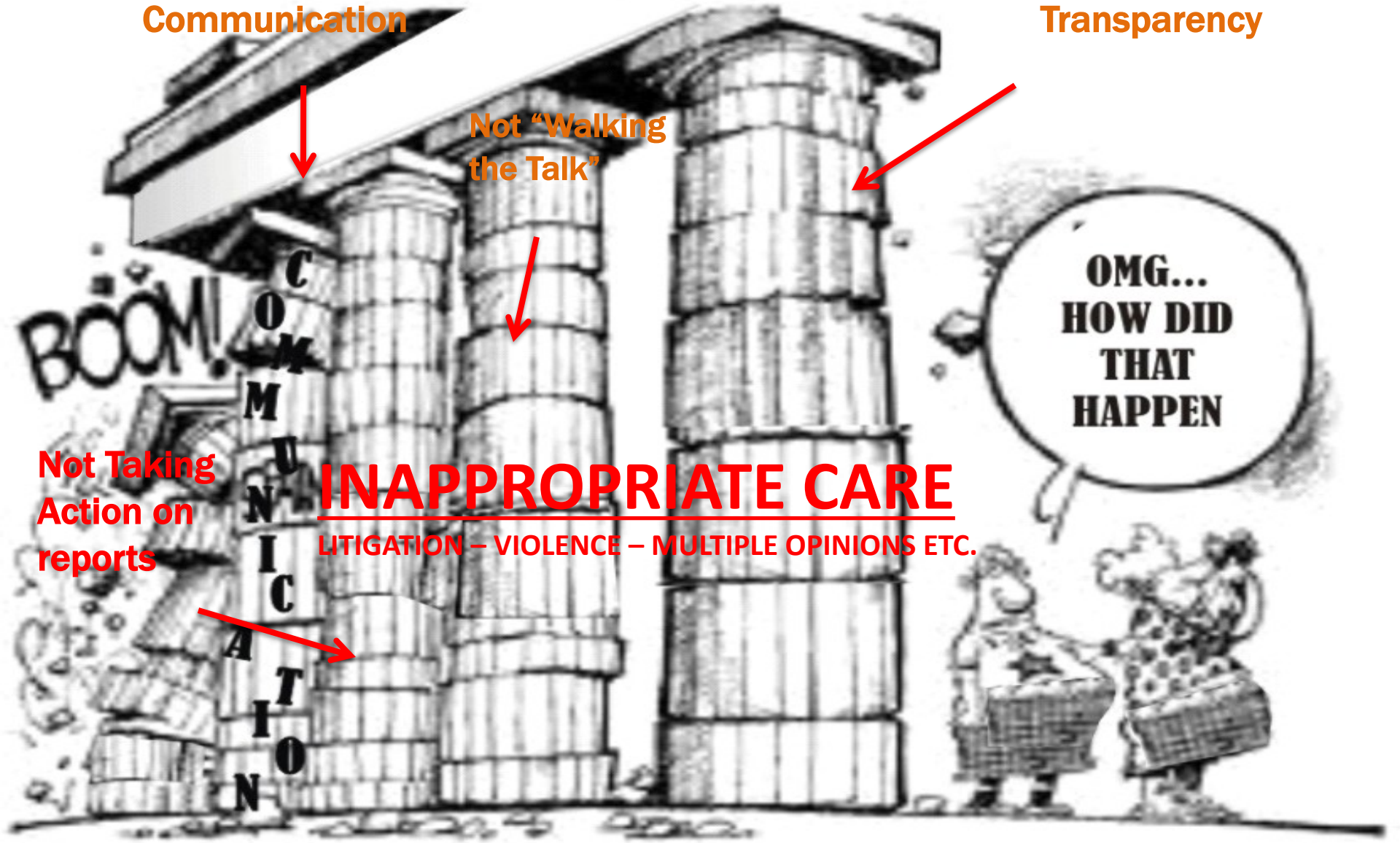
Trust Deficit




Lack Of Collaboration

Team work

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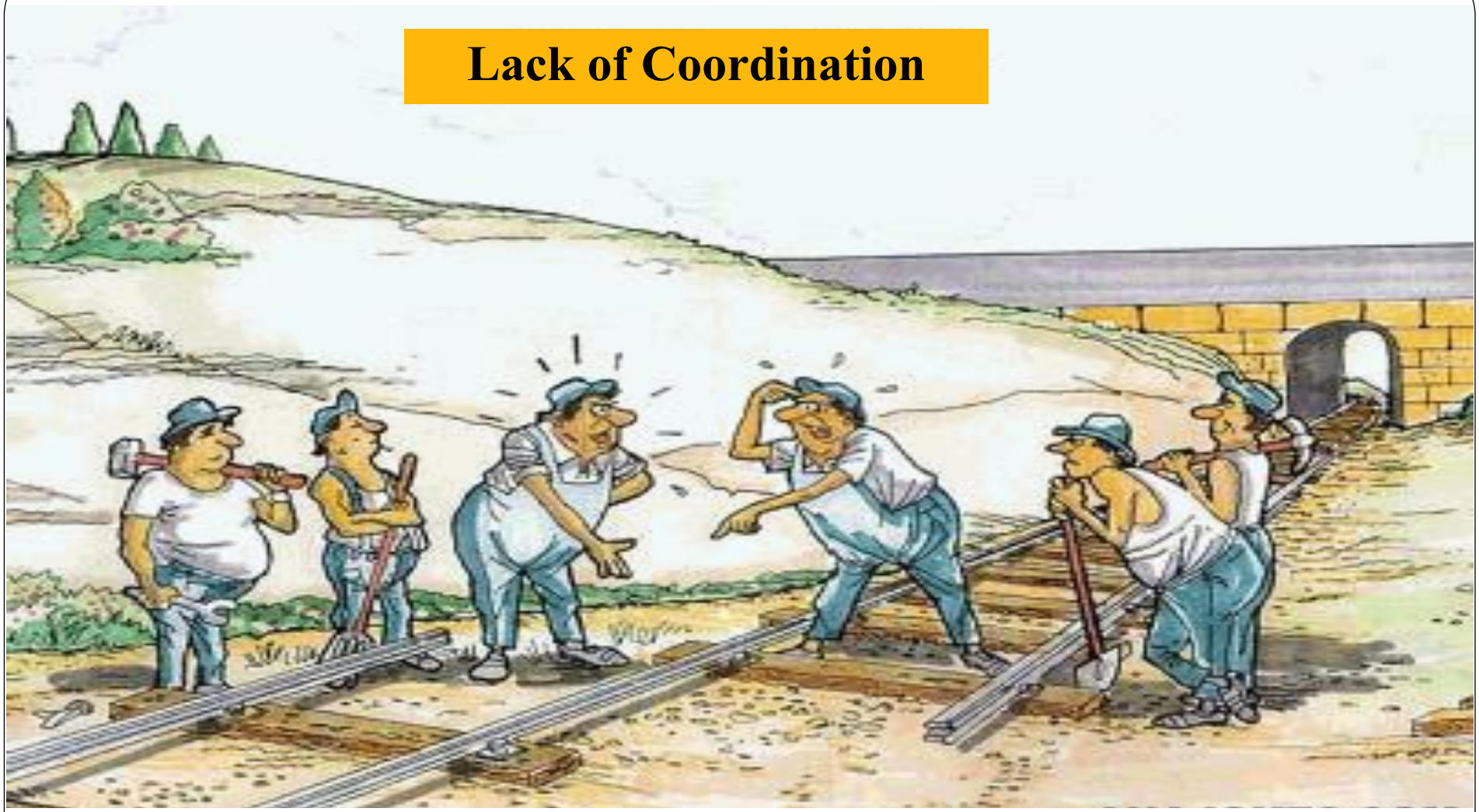
Lack of Coordination



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Patient safety

- The Safety Risks
  - Physical
  - Mental
  - Financial

Patient Safety Issues

- "Errors" – Adverse reactions, Interactions, Allergies and Prevention.
- HAIs, wrong site surgeries, medications
- Structural Aspects e.g. falls and injuries
- Primary & Secondary Prevention
- Financial - If Hospitalization is bankrupting, it is a Public Health issue
- Appropriate care – most critical

TABLE S-1 Estimated Sources of Excess Costs in Health Care (2009)

Category	Sources	Estimate of Excess Costs
Unnecessary Services	• Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion
Inefficiently Delivered Services	• Mistakes—errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion
Excess Administrative Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion
Prices That Are Too High	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion
Fraud	• All sources—payers, clinicians, patients	$75 billion

SOURCE: Adapted with permission from IOM, 2010.

Table 2. Cost Estimates by Waste Domain

Domain	Costs, $US Billion	
	Annual Estimates	Total Range
Failure of Care Delivery		
Hospital-acquired conditions and adverse events[18-22]	5.7-46.6	102.4-165.7
Clinician-related inefficiency (variability in care, inefficient use of high-cost physicians)[27,28]	8.0	
Lack of adoption of preventive care practices (obesity, vaccines, diabetes, hypertension)[23-26]	88.6-111.1	
Failure of Care Coordination		
Unnecessary admissions and avoidable complications[19,29]	5.9-56.3	27.2-78.2
Readmissions[30,31]	21.25-21.93	
Overtreatment or Low-Value Care		
Low-value medication use[12,32-35]	14.4-29.1	75.7-101.2
Low-value screening, testing, or procedures[14,36,37]	17.2-27.9	
Overuse of end-of-life care[38]	44.1	
Pricing Failure		
Medication pricing failure[8]	169.7	230.7-240.5
Payer-based health services pricing failure[39,40]	31.4-41.2	
Laboratory and ambulatory pricing[41]	29.7	
Fraud and Abuse		
Fraud and abuse in Medicare[42-44]	58.5-83.9	58.5-83.9
Administrative Complexity		
Billing and coding waste[45]	248	265.6
Physician time spent reporting on quality measures[10]	17.6	
Total		760-935

Table 3. Estimates of Savings From Interventions That Address Waste

Domain	Savings, $US Billion	
	Estimates	Total Range
Failure of Care Delivery		
Interventions to address adverse hospital events and hospital-acquired infections[46,47,49]	5.4	44.4-93.3
Incentives to increase physician efficiency[48]	47.5 million	
Integration of behavioral and physical health[50]	31.5-58.1	
Partnership for patients campaign[53]	3.4	
Standardized pathways in bundled payment models[51,52]	97.9-555.5 million	
Prevention initiatives to address diabetes, obesity, smoking, and cancer[25,26]	4.0-25.8	
Failure of Care Coordination		
Emergency department–based strategies[49,54]	3.8-7.4	29.6-38.2
Care coordination in accountable care organizations[55,56]	8.3-13.1	
Health Information Exchanges[57]	205-410 million	
Transitional care programs[58]	9.2	
Effective care management for medically complex patients[59]	8.0	
Overtreatment/Low-Value Care		
Optimizing medication use[34,35]	8.8-21.9	12.8-28.6
Prior authorization procedures[60]	250 million	
Pioneer accountable care organizations strategies to reduce overuse[13]	199.7 million	
Shared decision-making tactics to reduce unnecessary procedures[61]	3.2	
Expanding hospice access[62]	395 million-3.0 billion	
Pricing Failure		
Drug pricing interventions[63,64]	20.3	81.4-91.2
Insurer-based pricing interventions[39,40]	31.4-41.2	
Laboratory and office visit pricing transparency[41]	29.7	
Fraud and Abuse		
Recovery from convictions and fraud settlements[43,44,65]	2.1- 5.1	22.8-30.8
Legislative, administrative, and integrity strategies[65,66]	20.6-25.6	
Administrative Complexity		
Not applicable		
Total		191-282

Missed Focus

- **Inappropriate Care –IOM *(Now NAM)***
- Engaging Clinicians
- Engaging Patients
- The First Challenge – building trust to create culture.

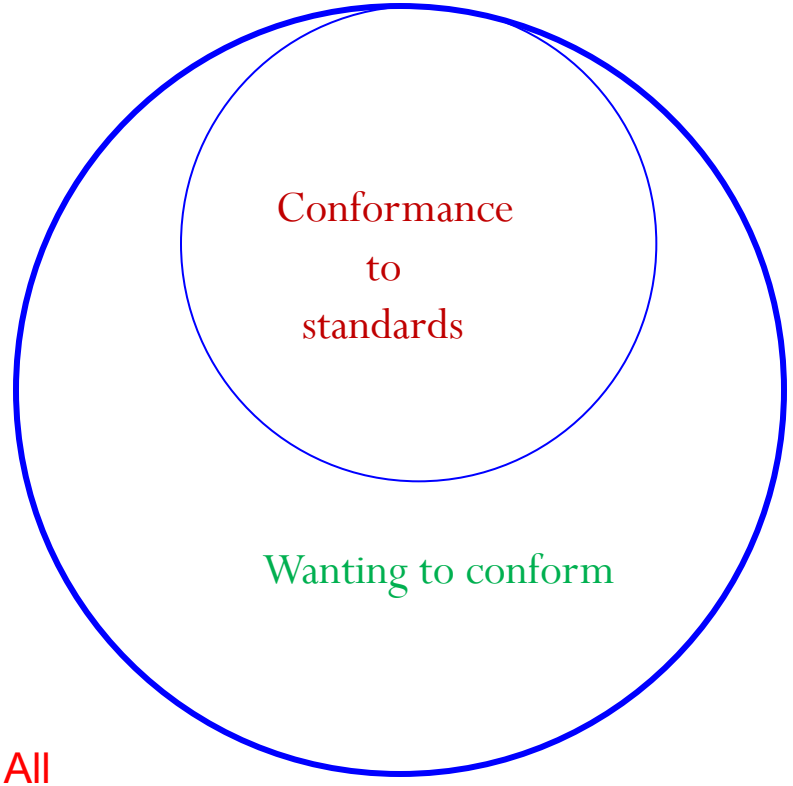
Current Consensus
– *The New Global Narrative*

- Various agencies like **NPSF, IHI, JAMA, AHRQ in US as also in Europe and globally**, as well as thought leaders, are coming round to the realization that creating a safety culture built on **trust and transparency** is a pre-requisite for sustained safer healthcare.

CONFORMANCE – EXCELLENCE

If "Quality" is…

Then Excellence is…



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Solutions

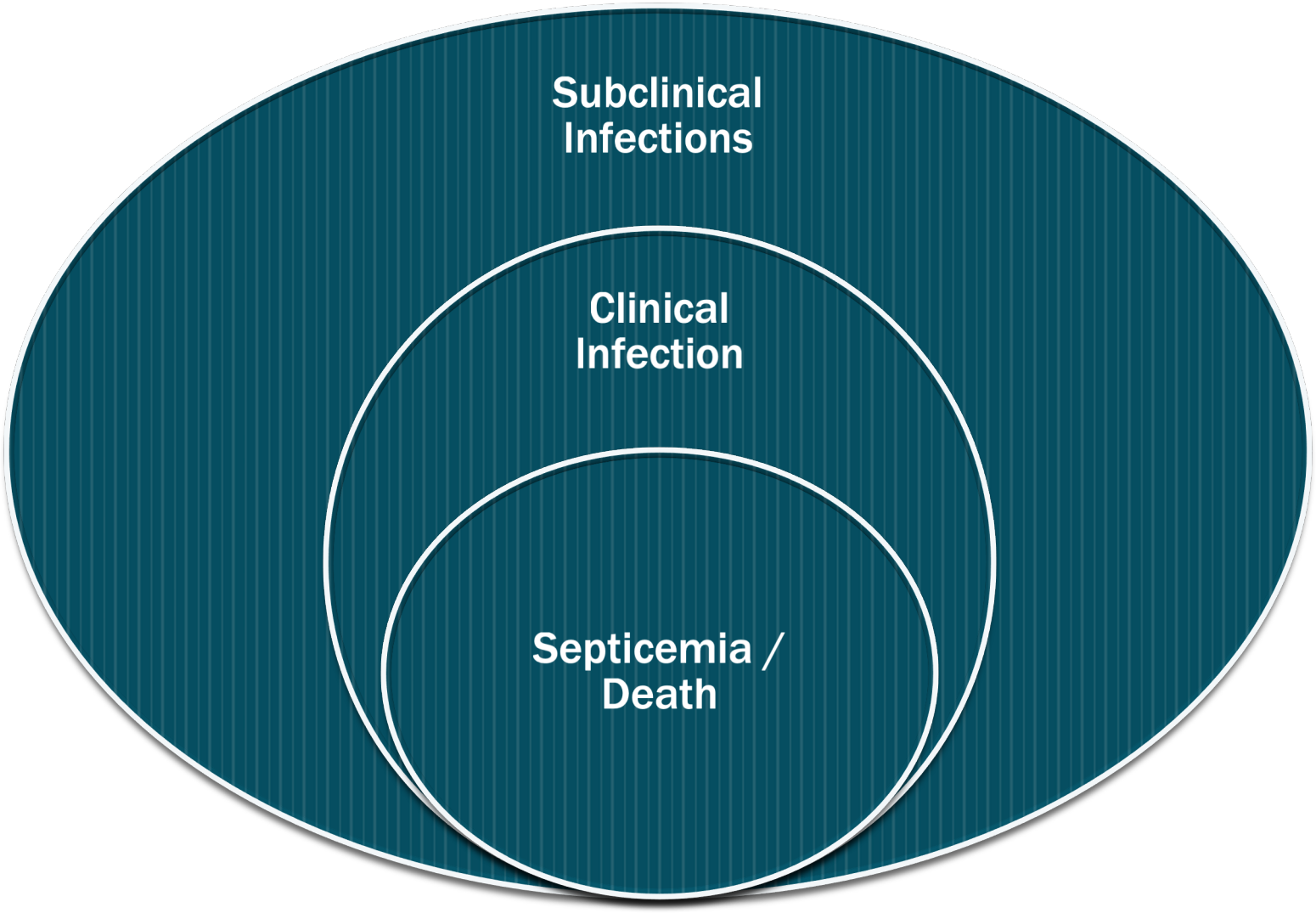
- Back to Basics – Building trust & creating culture
- Trust, Transparency, Transactions
- Actions to improve
  - Rewards & Recognitions
  - Solutions based approach

Solutions based approach

1. Fault-finding results in defensive reaction
2. In solution based approach we ask them to present the best practice that they have.
3. Analyze the reasons for best practice
4. Gently redirect to do the same in other areas needing improvement.

“ERRORS” TO PSIs

- Makes Situation more Objective
- Prevents Pre-judgement
- Searching for WHY through “What”, “Where”, “When” and “How” rather than “WHO”
- Begin Reporting with “Near Misses”



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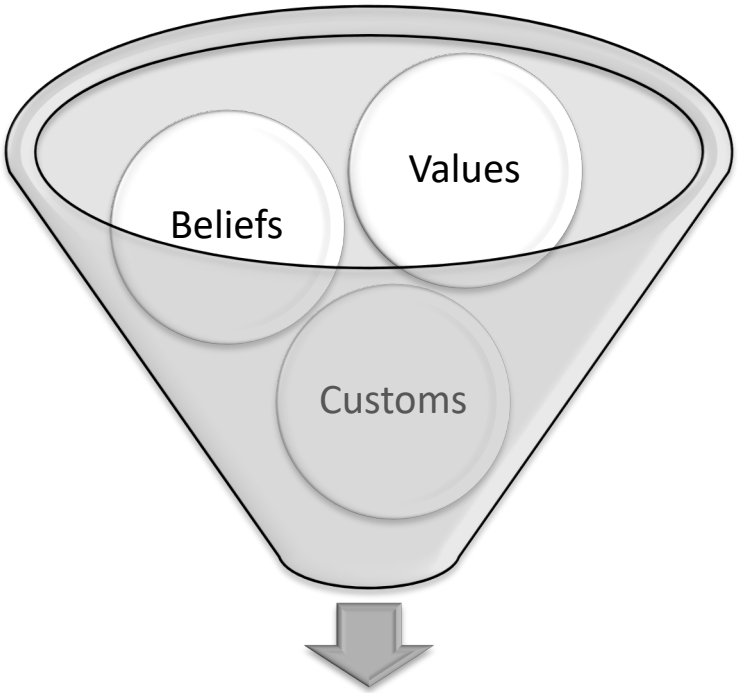
What is culture



Testing Safety Culture?

The way things are done around here….when no one is looking!

Stuart Matthews

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FAIRNESS ALGORITHM

1. Did the individuals intend to cause harm?
2. Did they come to work drunk or impaired?
3. Did they do something they knew was unsafe?
4. Could two or three peers have made the same mistake in similar circumstances?
5. Do these individuals have a history of involvement in similar events?

The *7 Steps to Patient Safety*

- **Step 1: Build a safety culture**
- **Step 2: Lead and support staff**
- **Step 3: Integrate risk management activity**
- **Step 4: Involve and communicate with patients and the public**
- **Step 5: Promote reporting**
- **Step 6: Learn and share safety lessons**
- **Step 7: Implement solutions to prevent harm**

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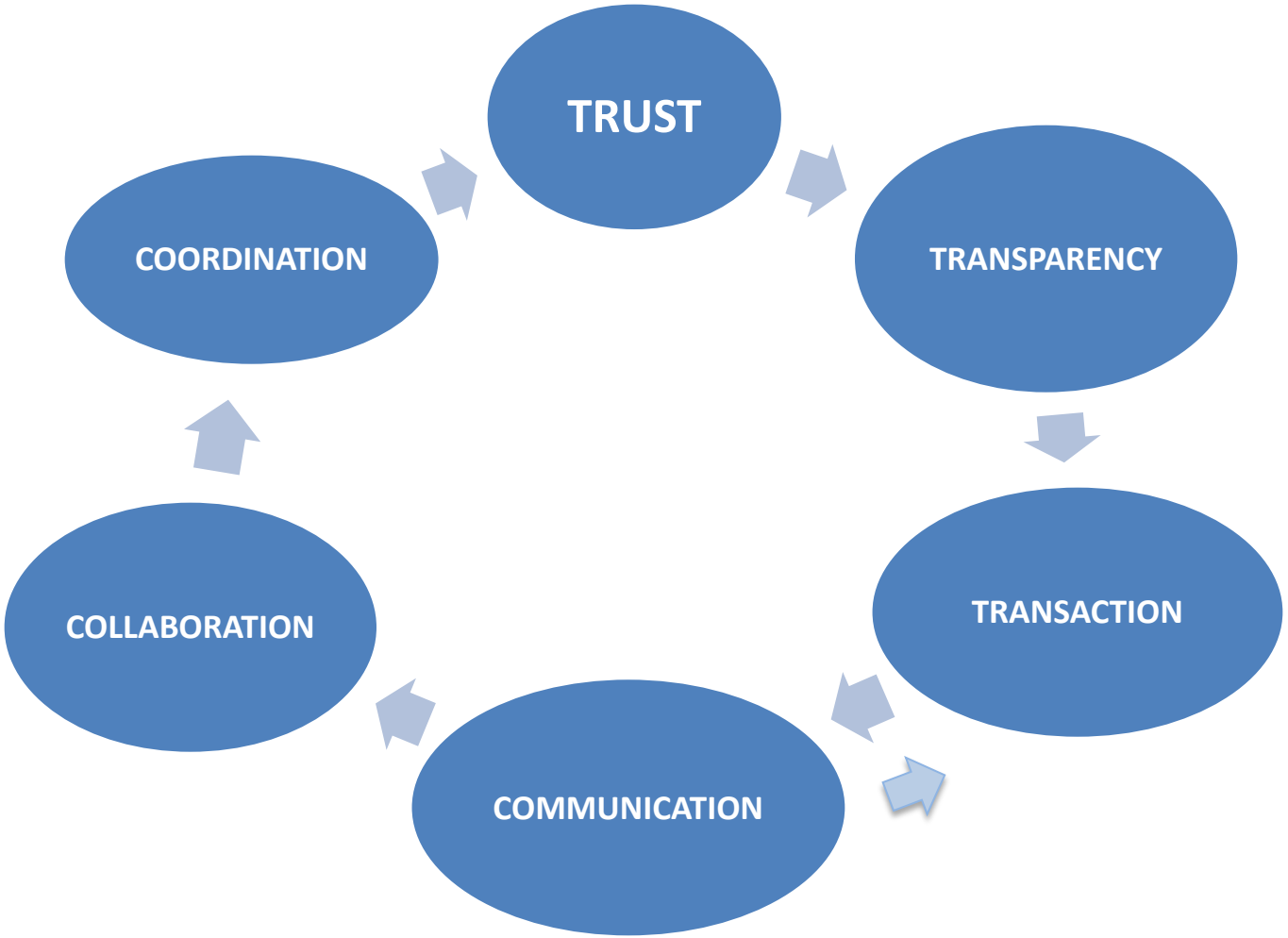
Virtuous Circle of TRUST



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Test of Trustworthy HCO

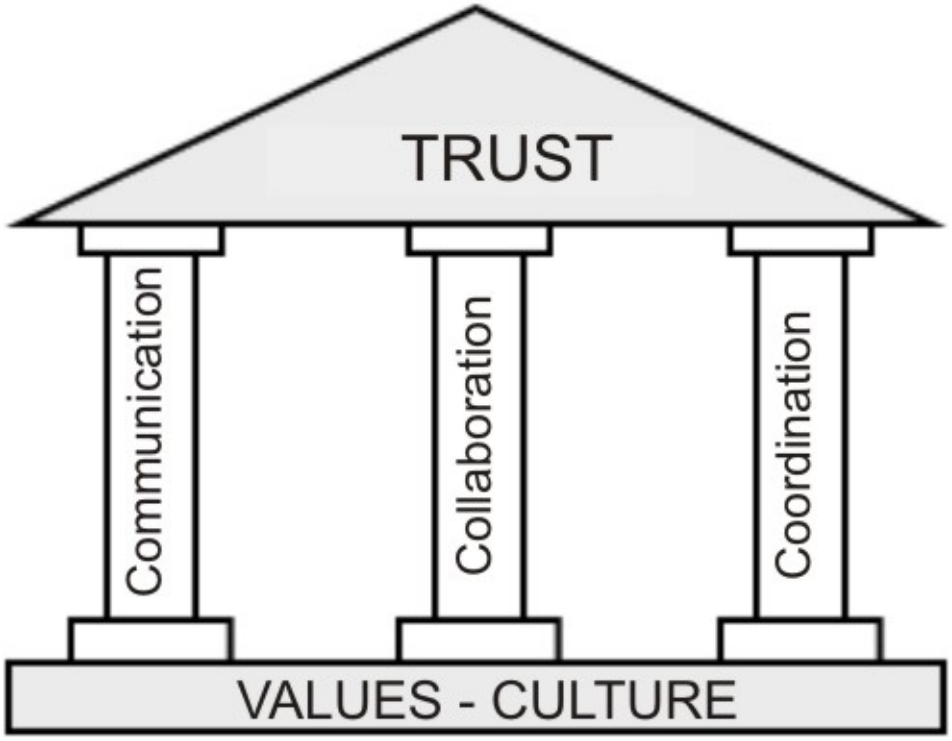
- My Mom's Principle:

Would I get my Mom treated here if required?

OR Better Still

This is the first place I would take my Mom to for treatment.

Healthcare Excellence



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Take Home Message(s)

- Build TRUST
- Through TRANSPARENCY and
- TRANSACTIONS (Communication)
- Build INTERLINKAGES
- Stress BALANCE
- Consensus Based Guidelines

“TINA Factor”

Future – HCOs!
– Enter at your own risk

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Let us for our own sake, join hands

THANK YOU

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