Interview on USA quality trends and issues with **Robert Wachter**

To get a picture of how Quality Improvement has developed in the US John Øvretveit interviewed Bob Wachter, an influential medical specialist who has been part of many national Patient Safety initiatives in the last 10 years. An expert who, from those experiences, is able to give an overview of developments across the Atlantic.

By: J. Øvretveit

Professor Wachter, could you give us an idea of the vantage point from which you have been observing quality and safety initiatives over the last years?
I am a practicing general internal medicine specialist at an academic medical centre, in charge of UCSF inpatient services and head of about 50 hospitalists employed by UCSF. I was principle investigator on the AHRQ 2001 review of evidence on patient safety and am chair-elect of the American Board of Internal Medicine. I've also taken part in a number of national quality and safety committees, and I edit the US government's two leading patient safety websites. So, I have been involved in different levels of the health system for some time.

Over the last 10 years in the USA, what would you say has made the biggest difference for patients, of all the national and regional initiatives, programmes, and organizations – maybe you could mention 2 or 3 which had an impact?
This period starts with the very influential Institute of Medicines report in 2001, 'To Err is Human.' This was a credible organization forcefully describing a national problem which demanded attention. The report was covered in the media, widely discussed and taken up by the President. It also contributed to resources being made available to the Agency for Healthcare Research and Quality, which is a key government agency in the USA for funding research and development work in this area, and this organization has been an important part of the infrastructure we need to support the work. They have contributed to best practices, indicators and culture survey measures and other essential research-based tools and, as these are tax-funded, they are freely available.

Which initiatives had very little effect, and possibly were not worth the costs or effort?
I have to say that, if we ask what evidence is there that, in the years since 'To Err is Human', significant improvements have been made, it is slightly disappointing. Recent research has shown high adverse event rates continue. Also, I have for some time advocated to pay more attention to diagnostic errors and their consequences. I do not have any reason to think that these have been reduced significantly.
But on the positive side, we are measuring more, and have indicators which can provide some evidence, and there are some outstanding successes. In some places hand hygiene compliance is considerably higher, and central line-associated blood stream infections have been virtually eliminated in some ICUs. Generally, awareness of safety issues has been transformed and is a routine agenda item for most senior boards and managers, and is in the minds of most care-givers.

Robert Wachter is chief of the medical service, University of California, San Francisco, UCSF Medical Center, and is associate chair of the UCSF Department of Medicine.

Do you think the new emphasis on value based purchasing will make a big difference to quality activities and results?
Of course money talks, but we should not overemphasize this. The key really is clinical professionals changing their behaviour and processes, and they are not driven to do this by the financial agenda. People want to work in a high quality and safe service, and are attracted to one with a good reputation for quality. But ultimately it is about making quality part of one's professional role and also seeing that quality is a systems issue, not just one concerning personal competence.

There are a number of issues in getting good routine quality measures which are comparable – the USA has a variety of measurement systems and seems to have made some progress, especially in tying measures to finance. What would be your suggestions for developing indicators that are meaningful, low cost and comparable.
There are the obvious requirement to select scientifically valid indicators which can be used for improvement in everyday work. But beyond this, there is the need for good information technology, which can reduce the time and costs of collecting the data and then provide timely feedback. We have been very slow in adapting IT to do this and to design this as a part of new systems. The US government grants are increasing the amount and quality of IT, and the requirements for these grants, called 'Meaningful Use' standards, may in part help quality improvement.
There was a debate about making indicators public and comparable, but that is largely in the past: the benefits are greater with public comparisons, and transparency drives people to make better measures. Generally, the public have not so far used the comparisons as much as purchasers and professionals. There is also the tendency to concentrate on what can be easily measured, but I do not think this distracts attention from the less easily measurable aspects of quality.

Nederlandse samenvatting
Professor Robert Wachter, medisch specialist en hoofd medische zaken in een academisch medisch centrum in de VS, is zeer betrokken bij kwaliteit van zorg en patiëntveiligheid. Volgens hem is het rapport 'To Err is Human' van doorslaggevende betekenis geweest voor het onder de aandacht brengen en verbeteren van patiëntveiligheid. Maar, anno 2012 blijkt dat er nog steeds sprake is van te veel (gevallen van) vermijdbare schade en te veel fouten in diagnostiek.
Bij het continu en duurzaam verbeteren van de kwaliteit en patiëntveiligheid blijft het gedrag van de klinische professionals de sleutel tot verbetering. Daarnaast is het belangrijk om te investeren in goede indicatoren en informatietechnologie om dataverzameling voor registratie en feedback te ondersteunen, waarmee vervolgens de transparantie en vergelijking van de kwaliteit van zorg verbeterd kunnen worden. Dit wordt verder ondersteund door een continu accreditatieproces, zoals in de VS is ingezet via de Joint Commissie. Dergelijke ontwikkelingen spelen in de VS nog in ziekenhuizen, maar worden nu en in de toekomst ook meer uitgebreid naar onder andere huisartsenpraktijken en verpleeghuizen.

Some people from outside quality improvement get the impression that the movement tends to rely on either inspection or accreditation or collaboratives. There does not seem to have been much development in large scale programmes for getting fast and widespread improvements – any comments on this?
As regards the main hospital accrediting organisation in the USA, The Joint Commission, the safety goals and indicators in their accreditation process had a large impact. Their emphasis given to safety got the attention of senior management because accreditation was important for hospital survival -- hospitals that lose accreditation may lose the ability to bill Medicare. In addition to these changes, accreditation has become more of a continual process rather than a visit every three years, and the possibility of an unannounced survey is in the minds of quality managers in most hospitals. As regards collaboratives, there are now many variations on this model which have been quite successful, and the campaign ap-proaches of IHI with its 100,000 and five million lives programmes is another positive development.

Do you have any observations about quality assurance and improvement in primary care and nursing homes in the USA?
There is far less improvement work going on outside of hospitals. Primary care doctors have been under pressure from various directions, and generally have not had the time and support to carry out quality projects. This may change in the future as the reforms, in theory, aim to expand primary care, and will introduce more coordination through 'medical homes.' Nursing homes are strongly regulated and this is supposed to ensure basic levels of quality, but it's only the large systems of nursing homes which really have the resources and expertise to drive quality programmes in this sector.

Professor Wachter has much more to say which is relevant to clinicians and quality specialists beyond the USA: His health blog is widely read at: http://community.the-hospitalist.org/. Robert edits the influential and useful safety web sites http://www.webmm.ahrq.gov/ and http://psnet.ahrq.gov, which together receive 3 million visits each year.