GORDON AND BETTY MOORE FOUNDATION

PATIENT CARE PROGRAM

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Peter Pronovost, MD, PhD, Director, Johns Hopkins University Armstrong Institute for Patient Safety and Quality

Thank you, George. I stand here humbled at the task before me and thankful that I have such an amazing team from the Foundation, from Hopkins, and frankly with all of you to help us walk along this journey.

Too many patients are harmed, they receive care that is not respectful, that wastes money on things that do not get them well. The reality is nobody wants this to happen, not patients and families, not clinicians, not health system leaders, not employers, not insurers and not technology companies. Nobody.

Then why are so many patients harmed, why do patients receive care that is disrespectful? Why are healthcare costs so high?

It is not for a lack of will or lack of effort. It is from a lack of leadership to coordinate and collaborate among all the various stakeholders.

In virtually every other industry technology has improved quality and lowered costs. Not so in healthcare. Healthcare productivity is flat. Healthcare professionals are stressed. And patients suffer.

Clinicians work with tools that do not serve their needs. Tools that do not talk to each other.

Consider Leah Coufal, a 12-year-old girl whose story was told in USA Today. Leah died of respiratory arrest while narcotics intended to ease her pain slowed her breathing until she stopped breathing completely. Everyone asks “how could this happen?” Yet it did.

Largely because the infusion pumps that drip narcotics into her blood do not routinely “talk to” the monitor counting breaths. If they did, when Leah’s breathing went below a critical threshold, the equipment could have sounded an alarm, and notified a clinician or, better yet, automatically stopped the narcotics.

Other industries rely much less on heroism by individuals and more on designing safe systems, using technology to support work. For a pilot, a plane’s cockpit today is much simpler than 30 years ago. Even though the planes are infinitely more complicated, the cockpit display is not–and by integrating technologies, it is far safer. Not so in healthcare.

Johns Hopkins just opened a state of the art new clinical building. We built the best hospital possible. We built the best ICU possible. Yet the best ICUs are not good enough. The ICUs look just about the same as they did 30 years ago. They are packed with potentially helpful devices that do not talk to each other and increases rather than decreases the risks for errors and makes us depend even more on heroic efforts by staff.

There is tremendous work to build upon to change this reality. Work you and others have led. Yet this work has not been coordinated and integrated and no one group alone can do this. We have to commit to work together.

We have seen what is possible when we do. We eliminated catheter infections at Johns Hopkins by using a paper checklist, and changing culture.

With funding from AHRQ, we did the same in Michigan. We saved lives, saved money and restored joy in clinicians work.

With continued AHRQ and philanthropic support, we have now spread this program state by state across the US, and these infections have been dramatically reduced. We demonstrated that by lazerly focusing on a goal, taking a systems approach and engaging patients and families and providing them with data, we could realize significant improvements.

Still this effort focused on one harm while ICU patients are at risk of dozens of harms. It is too burdensome, relying on heroism of dedicated healthcare professionals rather than safe design, using paper based checklists rather than automated clinical support tools. As a result hospitals work on one or two harms, while patients are a risk for over a dozen.

This new program, made possible through the generosity and vision of the Gordon and Betty Moore Foundation is about to change this. It's daunting.

The Foundation's new program will ensure Patients and families will be meaningfully engaged as part of the healthcare team, we will design a healthcare system that works to eliminate all patient harms and that will learn, improve and importantly, be accountable for the results it produces.

We will produce a model in the ICU. The project will form a mini Bell labs drawing upon the full richness of our university, bringing together an amazing and diverse team from the Johns Hopkins schools of medicine, nursing, public health, engineering, business, the Berman Ethics Institute and importantly the Applied Physics Lab, where Gordon Moore once worked. We are delighted to have University of California, San Francisco as an initial partner.

While this work builds upon prior improvement efforts, it differs in two fundamental ways.

First, it defines patient harm from lack of dignity and respect as a harm that is every bit as real and important as an infection.

Second, it works to reduce all harms, starting with the goals and working backward to design the kind of care patients deserve.

Now, I'm aware that when people hear the phrase "Systems Approach" there is more than a little confusion regarding what the term really means. Perhaps it's best to start out by itemizing what it is not.

It is not telling doctors and nurses to work harder.
It is not accepting harm as inevitable rather than preventable.
It is not working on a couple harms while patients are at risk for a dozen.
It is not only recovering when mistakes occur but also learning from them.
It is not providing care without clear goals, measures, and accountabilities.

What it is:
Imagine your loved one is admitted to the ICU after cancer surgery, you are actively involved in his or her care at a level comfortable to you, providing information about symptoms and concerns, knowing what is going on and actively participating in decisions.

Clinicians are using technology to predict what harms your loved one is at risk of suffering. Using technology the clinicians have a checklist of the 200 therapies your loved one may need to receive on any given day, to prevent harm. You can see when they are due, when they have been done. And most are automated because the devices monitoring care are connected.

You sleep well knowing the infusion pump would alert staff and shut off if your loved ones breathing slowed. You are confident that staff will have time to provide comfort for your loved one, listening to their concerns, holding their hand. You attend clinical rounds daily, or whenever you choose–sometimes by video conference sometimes in person.

You are provided a daily report on how well your loved one's symptoms were managed, how well the team performed those 200 things and the results it achieved. The staff continuously works to learn and improve. You can feel that the staff work as a team, and are joyful. You can feel you and your loved one are treated with respect and dignity. And amazingly, care is much less expensive.

All of this is possible today, technology is not a barrier. The engineers can do this now. The question is–do we believe and will we collaborate?

No doubt this going to be hard, but we've done it before for catheter infections. We know it can work.We need you, too. The generous Foundation grant is the catalyst for the type of sweeping change so needed.

We ask you to continue to build upon the great work you are doing and to join us on this journey. Patients can wait no longer, clinicians can wait no longer. The country needs this now.