Curriculum Development Centers Program

Awardee of The Office of the National Coordinator for Health Information Technology

History of Health Information Technology in the U.S.

History of Quality Improvement and Patient Safety

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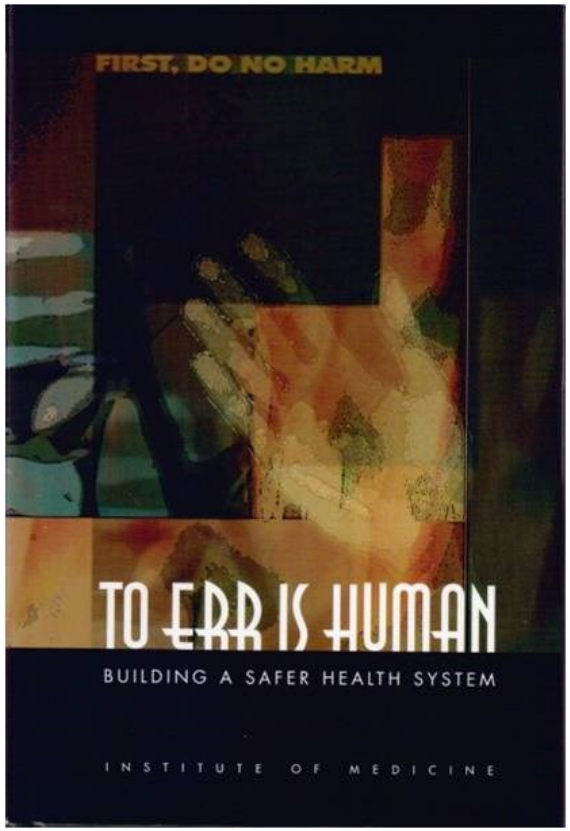
History of Quality Improvement and Patient Safety Learning Objectives

- Describe conditions and notable publications concerning patient safety and quality improvement from 1959 to the present
- Describe the background to the Institute of Medicine reports on patient safety
- Summarize the main findings from several Institute of Medicine reports on quality, patient safety, and health information technology (HIT)
- Describe various ways in which HIT has evolved to improve quality or enhance patient safety

Institute of Medicine Reports

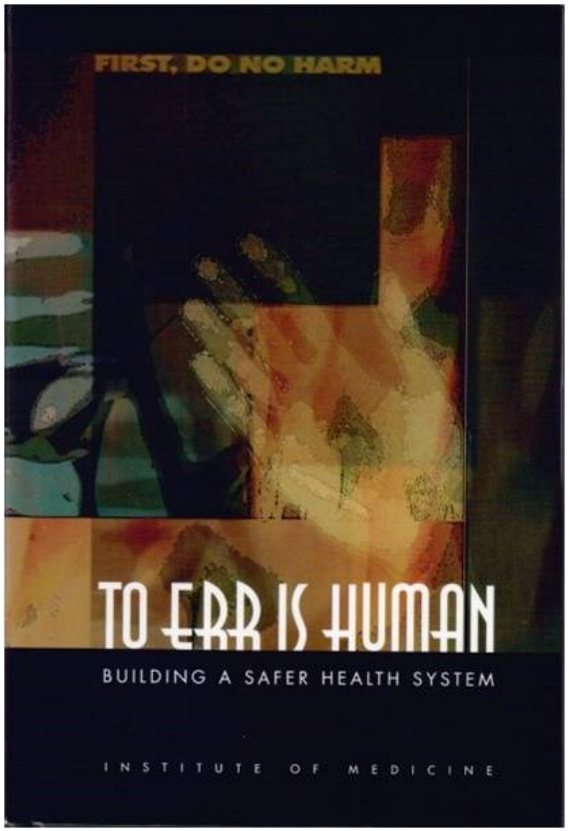


(1999)

Institute of Medicine Reports

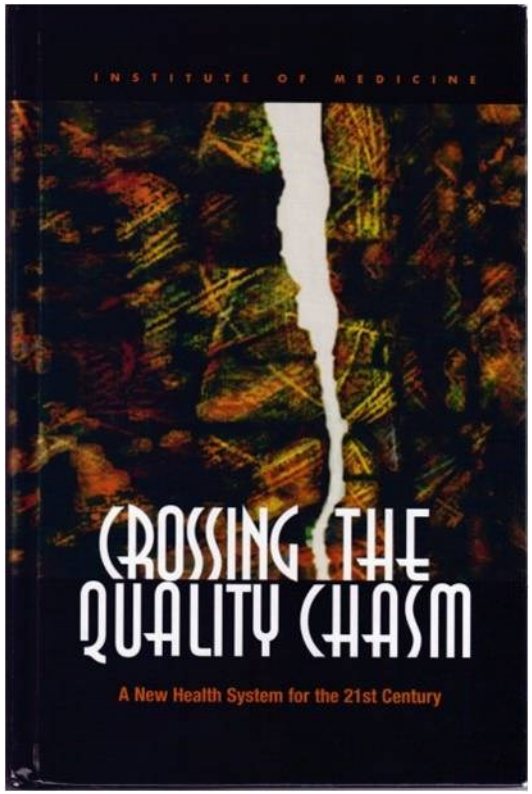
- Medical errors kill up to 98,000 people annually

- Errors result from a **faulty system** not faulty individuals



(1999)

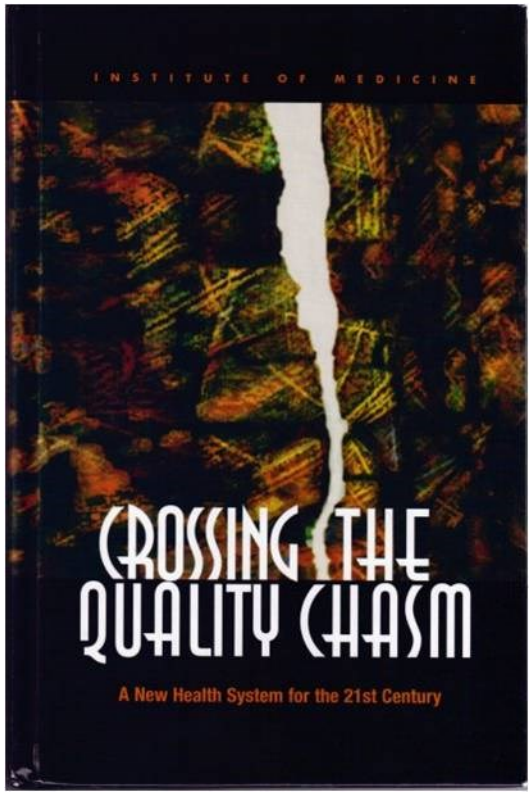
Institute of Medicine Reports



(2001)

- Quality of care includes six main components

Institute of Medicine Reports



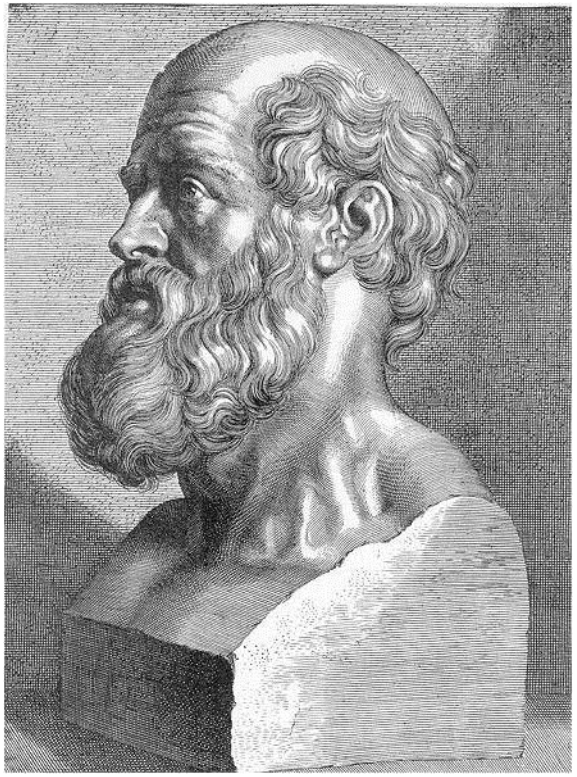
(2001)

- Quality of care includes six main components
- Quality is suboptimal
- Health IT **can help** improve quality in many ways

History of Patient Safety

- 460 BC
- Hippocrates, Greek physician
- Widely considered the father of western medicine
- Hippocratic oath:

  "First, do no harm"



Source: (Wikimedia)

History of Patient Safety

- 1959: “Diseases of Medical Progress: A Study of Iatrogenic Disease” by Robert Moser

History of Patient Safety

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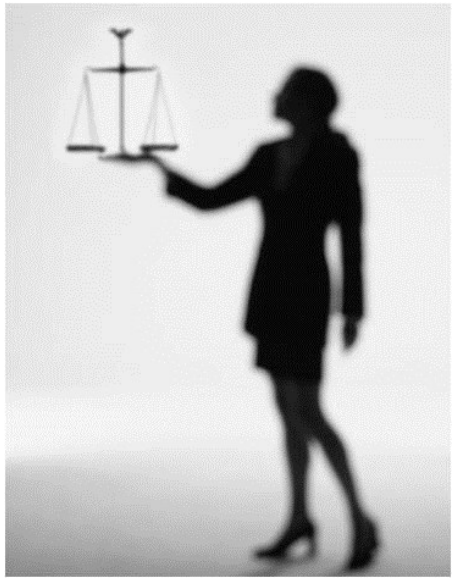
- 1980s and 90s: Medical errors reported in the popular press

History of Patient Safety

- 1959: “Diseases of Medical Progress: A Study of Iatrogenic Disease” by Robert Moser
- 1980s and 90s: Medical errors reported in the popular press
- **1990: “Human Error” by James Reason**

History of Patient Safety

- 1991: Harvard Medical Practice Studies completed



Sources: (Brennan et al., 1991)
(Leape et al., 1991)

History of Patient Safety

- **1994: “Error in Medicine” by Lucian Leape published in JAMA**

History of Patient Safety

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- **1999/2001: IOM Reports released**

History of Patient Safety

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- **2000: Leapfrog Group launched**

History of Patient Safety & Quality

- 2001: Agency for Healthcare Research and Quality (AHRQ) reorganized by US Congress

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- 2001: Agency for Healthcare Research and Quality (AHRQ) reorganized by US Congress
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- 2009: The HITECH Act

History of Patient Safety & Quality

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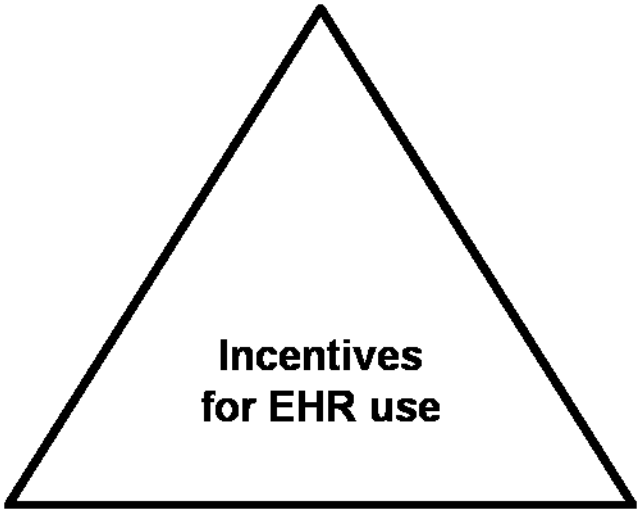
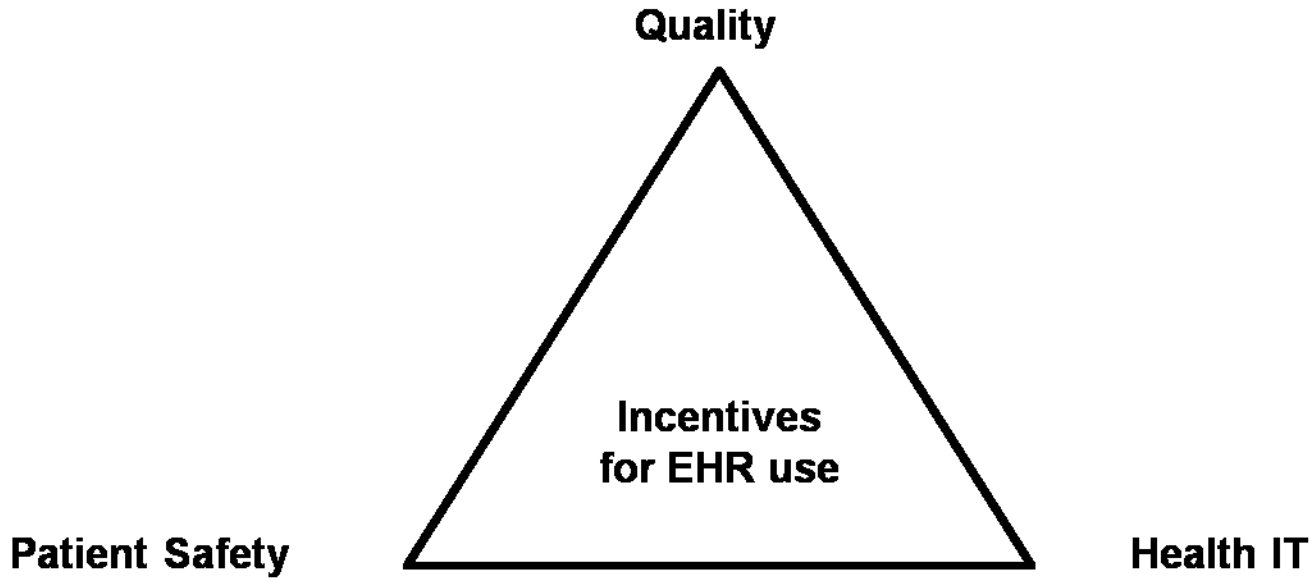


History of Patient Safety & Quality

- 2009: The HITECH Act



IOM Report 2011

- Potential of HIT to create harm
- Need for better information about the failures of HIT systems
- Recommendation: Federal government should create new agency to investigate safety of health IT systems

History of Quality Improvement and Patient Safety Summary

- History of Quality Improvement
- Patient Safety key milestones

History of Quality Improvement and Patient Safety References

References

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- Institute of Medicine. To err is human: building a safer health system. 1999.
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- Reason J. Human error. Cambridge: Cambridge University Press;1990.

History of Quality Improvement and Patient Safety References

Images

Slides 3,4: "To Err is Human" book cover, Kohn LT, Corrigan JM and Donaldson MS, (eds). "To Err Is Human: Building a Safer Health System" Committee on Quality of Health Care in America, Institute of Medicine, Washington DC: National Academies Press, 1999. Source Name: Image used with permission from National Academies Press.

Slides 5,6: "Crossing Quality Chasm" book cover, Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century, Washington, DC: National Academy Press, 2001. Source Name: Image used with permission from National Academies Press.

Slide 7: Bust of Hippocrates, Available from: http://en.wikipedia.org/wiki/File:Hippocrates_rubens.jpg Source Name: Wikipedia Commons/Courtesy National Library of Medicine

Slides 8, 11, 18: Clip Art, Available from: Microsoft clips online Source Name: Used with permission from Microsoft