History of Health Information Technology in the U.S.

History of Quality Improvement and Patient Safety
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

- Quality of care includes six main components

(2001)
Institute of Medicine Reports

• 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”
History of Patient Safety

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

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

• 1999/2001: IOM Reports released
History of Patient Safety

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

• 1999/2001: IOM Reports released

• 2000: Leapfrog Group launched
History of Patient Safety & Quality

• 2001: Agency for Healthcare Research and Quality (AHRQ) reorganized by US Congress
History of Patient Safety & Quality

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• 2002: Joint Commission released “National Patient Safety Goals”
History of Patient Safety & Quality

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• 2002: Joint Commission released “National Patient Safety Goals”

• 2004: Office of the National Coordinator for Health Information Technology established
History of Patient Safety & Quality

• 2009: The HITECH Act
History of Patient Safety & Quality

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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

• Institute of Medicine. To err is human: building a safer health system. 1999.
History of Quality Improvement and Patient Safety

References

Images


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