



Kenneth W. Kizer, MD, MPH: Health Care Quality Evangelist

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WASHINGTON—As president and chief executive officer of the 18-month-old National Quality Forum (NQF), Kenneth W. Kizer, MD, MPH, confronts a huge challenge: improving the quality of health care in the United States.

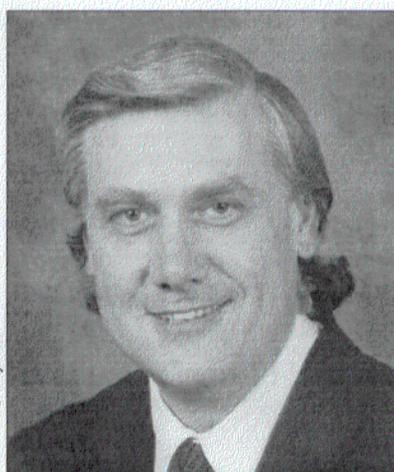
Formed in response to 1998 recommendations from a commission appointed by President Clinton, the NQF seeks to better health care from within, via consensus building, rather than from without, via regulation. With 110 member organizations after the first year of operation (and a goal of adding 200 more), the NQF brings government, health care practitioners, purchasers, and consumer groups to the same table to tackle a daunting array of issues. First up: projects aimed at reducing medical errors, including a compendium of evidence-based “safe practices” and a list of health care no-nos Kizer calls “never events.”

Few people appear better suited to these endeavors than Kizer. As head of the Veterans Affairs (VA) health system from 1994 to 1999, he transformed the nation's largest and most maligned health care system, with an annual budget of \$20 billion and a staff of 200,000, into a model of efficiency. “No one ever said, ‘Do what the VA’s doing’ before him,” said an NQF staffer. Before leading the VA, Kizer spent 7 years as California’s top health official. He began his career as an emergency physician.

JAMA: The NQF is tackling what appears to be a huge task. What needs to happen first?

Dr Kizer: Our primary goal is to improve health care quality, and to im-

prove quality we have to have measurement and reporting. It’s really quite simple conceptually: to improve something you have to know what you’re doing. And you have to be able to see, when you intervene, whether you’ve made a difference or not. That means we have to have reliable quantifiable indications that we can track and that get



National Quality Forum

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reported in a way that doesn’t add unnecessary burden to practitioners. For example, one of the projects we’re working on right now is a national summit on information technology and quality, because automated information management systems and computerized patient records are critical enablers for quality improvement.

JAMA: It sounds as if you think quality can be measured.

Dr Kizer: There’s no question that quality can be measured. One of the barriers to progress in this area has been the mind-set that you can’t measure quality. Such a belief is just wrong.

There are many aspects of quality that can be measured; for example, whether someone is on a β -blocker after a myocardial infarction is a process measure of quality. The data are clear that if you are [taking a β -blocker], you are about 40% less likely to have a repeat MI. There are many other things that can be measured, too.

JAMA: Does that mean a mandate for or a standardization of the kind of care people get?

Dr Kizer: Yes and no. It’s not that simple. If every person were the same, then it’d be easy to standardize. But they’re not. However, the scientific evidence is clear that there are certain things that do make a difference. Diabetics who have their hemoglobin A_{1c} monitored regularly and their treatment adjusted accordingly do better than those who don’t. So, should they have it monitored? Yes. Now, what you do for each person to get it [A_{1c} levels] down will be different.

So there are approaches to care that can and should be standardized so that everyone has the opportunity to receive the most appropriate evidence-based treatment. I think the confusion—and in some cases people use it as an excuse to not do things—stems from individual variation in the course of diseases. Treatment has to be tailored to the individual. But you can’t run away from the fact that certain things should be done if you have certain conditions.

JAMA: Is there a demand for quality? Do people want better health care?

Dr Kizer: There is a growing demand for quality and the demand is going to increase dramatically over the next few years. I believe, and I don’t



think I'm alone in this belief, that quality improvements should be the essential business strategy for health care. It's a little hard to make the case from a business perspective today, but I think that's going to change dramatically within the next 5 years.

Some people make the argument that consumers and purchasers aren't interested in quality. However, I think that in many ways this is just a failure on the part of health care providers to put quality in terms that consumers and purchasers understand and care about.

Medical errors are a great example of this. Most people have themselves experienced or know someone who has experienced a medical error, and they definitely relate to this quality problem. And they don't like it. I think that the medical errors area, while it's a subset of the larger quality issue, is a leader in the sense that it is really pushing the agenda, because it's something that everyone can relate to.

JAMA: *In the NQF newsletter there's an article about the VA hospital in Lexington, Ky, that became more open about medical errors, and their conclusion was that it saved money in the end.*

Dr Kizer: That's correct, and they're not alone in that experience, which is counterintuitive to what many people believe and contrary to the advice that medical risk management people often give. In Lexington they changed their policy because they had almost the worst malpractice litigation experience in their region. They said, "We're fundamentally doing something wrong." And they found that a policy of absolute disclosure, coupled with other things like apologizing and providing restorative care to make up for any error that caused patients harm, resulted in their malpractice cases going down substantially.

JAMA: *That seems like a departure from the normal medical culture that tries to hide errors.*

Dr Kizer: Historically, health care has tried to keep the occurrence of errors secret. But you know, when you think about it, a policy of openness makes a lot more sense. People, by and

large, are forgiving—if they know an error was innocent and if you're honest with them.

When a mistake occurs, what people want to know is, one, that it happened and, two, that you're sorry. Although they may know you didn't intend to do it, they need to hear the words, "We're sorry; we didn't want this to happen; and we're going to do everything possible to help you out." I think when people hear that—and, of course, the actions have to match the words—then they can be more accepting. They may not like it, but they're less likely to get angry, be bitter, and go hire a lawyer.

Most people sue because they think there was a cover-up, that they're being stiffed, or that people wouldn't talk to them and address their concerns honestly. I think the whole culture of secrecy, in part perpetuated by risk management attorneys, is misguided.

JAMA: *In Lexington, what was the response from the physicians and nurses who had to go to the patient and say, "I messed up"?*

Dr Kizer: At first, it was very counterculture. It required an explicit policy on the part of management and a committed effort by all of the clinical staff. What was reported in the *Annals of Internal Medicine* [1999;131:963-967] occurred over several years. And I think that's an important point. Not all doctors or nurses or anyone else is prepared to undertake the type of communication that needs to occur. You need to be sensitive to nonverbal communication and be completely open; it's a learned skill.

JAMA: *One of the arguments you're making is that this kind of openness will reduce costs in the long run. Is this true?*

Dr Kizer: While I think it ultimately will reduce costs, I don't think that's the reason to do it—and that's important to underscore. Cost reduction will be a beneficial side effect. The primary reason to do it is because it's the right thing to do. And it will result, ultimately, in fewer errors occurring. It will end up saving money, because with fewer errors there will be less rework and fewer mistakes to be fixed.

JAMA: *Tell me about your "never events" list. What kinds of items will be on it?*

Dr Kizer: This is intended to be a list of things that just should not happen in health care today. For example, operating on the wrong body part. Another example might be a mother dying during childbirth. That's such a rare event today that it's generally viewed as something that just shouldn't happen. Now, there's probably going to be an occasion now and then when it happens and everything was done right, but it's so infrequent that it means you have to investigate it every time it occurs. So "never" has quotes around it in this case. Now, wrong-site surgery is a different story—that should never happen. There's no way that you should take off the right leg when you're supposed to do the left one. So in this case, never really means never.

JAMA: *How many of these events will be included?*

Dr Kizer: That's an issue for [the NQF steering committee on "never events"]. Their charge is to develop criteria for inclusion and an initial list of such events that might form the basis of a national state-based [medical errors] reporting system. Events that will be listed have to be things that are absolutely clear; you can't argue, "Did it happen or did it not happen?" The events also will have to be "adverse events," things that really did hurt the patient. There are still some unresolved issues, but I expect that by the summer we'll be done or close to it.

JAMA: *Another of your projects is to develop a compendium of safe practices. How would that be used and put into practice?*

Dr Kizer: You might think of it as a guidebook. It will list a number of practices, and the evidence behind them, which hospitals or other health care facilities should be able to take and put into place, or operationalize, right away.

JAMA: *What does "operationalize" mean?*

Dr Kizer: "Operationalize" means putting it into use. Exactly what this means is going to be different depending on the practice. What we hope to



do is identify the practice and the evidence behind it, and then give some implementation guidance as to how it might be put into use or what others have found in doing it. I think health care is most vulnerable in the medical errors area, because we actually know a lot of things to prevent errors but those things aren't being done. And the public doesn't understand that.

JAMA: *Can you give some examples?*

Dr Kizer: Here are a couple of examples: How many times have you heard about a woman getting a Pap smear that turned out to have malignant cells, but she was never notified of the results? Her assumption was, "If I don't hear from the doctor, it's okay." Well, wrong. So, do we have processes in place so that when you have a test done, we make sure we close the loop and inform the patient of the findings every time, regardless of the findings? It's not hard. Indeed, veterinarians and car dealers have figured out that by simply sending people a card saying that Bowser needs his shots or that your car is due for service, a big chunk of them will follow up.

Another real simple one involves verbal orders. An ongoing source of errors is when a doctor gives a verbal order—"I want 20 mg of this"—and the nurse doesn't hear it correctly or misinterprets it. Well, have you ever watched a submarine movie? When the captain gives an order, they repeat it right back all the way down the line so there is no confusion about the order. How often do we use "repeat back" in health care? Rarely. There are a lot of simple things that can be done to reduce errors, and for many there's no cost, but they simply aren't done in health care.

We know that doctors' handwriting is a source of confusion. Matter of fact, here's an area where you can probably make a very good economic argument for change. I know one hospital has done a study—I don't know if they're going to publish it or not—in which they actually tracked how much time ward nurses spent preventing errors because they couldn't read a doctor's handwriting. The hospital docu-

mented how long the nurses were on the telephone, tracking down the doctor, making sure the order was right. What the investigators found was that in about 10% of the cases, the nurses couldn't even tell who the doctor was, but most important was the fact that nurses actually spent hours clarifying orders so as to prevent errors. So errors didn't happen because of the doctor's handwriting, but it was only because nurses spent so much time preventing them from occurring. In this case, you can make an economic argument about how much illegible handwriting was costing the hospital.

JAMA: *So even though the concept of quality seems very pie-in-the-sky, you're talking about concrete ways to improve it.*

Dr Kizer: There are very practical, very sensible, ways to improve quality, but it all starts with measurement. Measuring performance, measuring change, and measuring results.

JAMA: *Will the challenge be in disseminating this information and getting people in the field to implement it?*

Dr Kizer: I think what you'll actually see is that once the information on "safe practices" is available, there's going to be a huge demand for it. Some of that demand will come from health care providers, but it's also going to come from the public and purchasers of care. I can readily visualize *Good Housekeeping* and *Woman's Day* and other magazines, with [articles on] "25 Ways to Be Safe in Your Hospital" or "How to Protect Yourself in the Hospital." They will present it in different ways, but I think there will be a significant consumer-driven demand for the information. It is important for hospitals and physicians to understand this consumer demand. Those who have put the interventions in place will be ahead of the curve. Those who are saying, "Oops, I've got to get going," will probably find themselves disadvantaged in the market.

JAMA: *Are you encouraged so far by the response to your efforts?*

Dr Kizer: It's still a mixed bag. I made about 100 speeches or other presentations last year, and saying that

quality should be our essential business strategy just doesn't connect with everybody. Some folks don't get it. There are others who see it very clearly, and who recognize multiple reasons why. One of these reasons is cost. If you look at what's happening with health care costs, with inflation and costs going up for the third year in a row, combined with new technology and new drugs, and recognizing that all the easy cost reductions have been done, what you're left with is the centrality of improving the quality of our service. Indeed, there is substantial real-world experience that shows if you actually focus on improving quality, you reduce costs. For example, the Institute for Health Care Improvement has demonstrated very nicely the ability to save money, increase service satisfaction, and improve quality all at the same time. And the typical range of savings they're seeing on their projects is 30% to 35% [Berwick DM. *As Good as it Should Get: Making Health Care Better in the New Millennium*. Washington, DC: National Coalition on Health Care; 1998].

JAMA: *Then how come everybody isn't doing it?*

Dr Kizer: Probably because it's a bit counterintuitive and it requires that you think longer term. Too many people think, "If I have to improve quality, it's going to cost me money." However, quality problems are divided into overuse, underuse, and misuse. And from the overuse and misuse point of view, if you improve quality you're clearly going to save money. Improving underuse is probably going to cost money, at least in the short term. But even so, quality improvement overall should result in a cost savings.

JAMA: *It sounds as if you spend a lot of time out on the stump.*

Dr Kizer: There's a certain amount of evangelizing that goes with the turf. A lot of what we're trying to do is change the culture of medicine. Whether it's getting people to talk about errors in an open, nonpunitive environment or take on the larger quality issues, it's all part of the same continuum: improving health care. □