Patient Safety – An Idea Whose Time Has Come

In 1999, the Institute of Medicine (IOM) published a report on patient safety titled "To Err is Human – Building a Safer Health System." The IOM estimated that between 44,000 and 98,000 people die in hospitals each year from medical mistakes, and said that more people die annually from medication errors than from workplace injuries. While the specific statistics have been, and continue to be debated, all parties to the debate agree that patient safety cannot be compromised, and that data collection plays a role in patient safety.

The IOM report, according to its summary, "sets forth a national agenda – with state and local implications – for improving patient safety through the design of a safer health system." IOM asks how we can learn from our mistakes, and offers recommendations including improved data collection and analysis. You can order the IOM report by telephoning 1-800-624-6242.

This paper suggests that Pennsylvania health care purchasers can do more than that. Purchasers have the opportunity to utilize hospital outcomes data to help focus attention on patient safety, and thus to improve the delivery of care to patients.

A National Expert's Perspective

Recently, PHC4 Council Members had the privilege of hosting one of the nation's foremost authorities on patient safety, James P. Bagian, M.D. He is Director of the Department of Veterans Affairs National Center for Patient Safety and is responsible for overseeing the program designed to assist in preventing medical adverse events in the nation's VA hospitals. He spoke to a packed house at the January 2002 meeting of the Council.

Dr. Bagian told the Council that most "disasters" in hospitals - unexpected deaths or very serious and unexpected illnesses or injuries - are often preceded by one or more "close calls" that are precursors to an adverse event. But when viewed with foresight, he said these mishaps offer improvement opportunities for health care providers. Using sports terminology for a big success, he said corrective actions taken as a result of identifying and reviewing close calls are often "a home run." He noted that hospitals and healthcare systems must be prepared to respond systematically and not punitively when these events occur.

According to Dr. Bagian, "The central focus of every hospital should be good outcomes and patient safety, and a system-wide approach that focuses on safety is essential to improving patient outcomes." He said the guiding principles of a system-wide approach include: an internal reporting system that is focused on improving outcomes, not simply on reporting events; risk reduction rather than punitive measures; confidential internal reporting of all close calls, and no public disclosure of incidents unless they involve "intentionally unsafe acts;" narrative reports that emphasize the conditions that led to the problem; identification of vulnerabilities in addition to statistics; open communication among all levels of the organization; and prompt feedback and "user-centered" solutions once a problem is noted. The system must have CEO support, and works best when implemented voluntarily by the leaders of the health care facility, he said.

A former astronaut and a private pilot, Dr. Bagian told the Council that the aerospace and nuclear power industries are two industries in the country with a system-wide "high reliability" approach to safety.

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This paper is provided as a public service by the Pennsylvania Health Care Cost Containment Council. PHC4 is an independent agency of state government, which offers data and information to health care purchasers and consumers. Using our data, purchasers can make better-informed decisions on health care.

February 2002

"Health care is not there yet," he said, although some hospitals are now on the right track.

Data Links to Patient Safety - Pennsylvania is a Leader

In Pennsylvania, though, we *do* have in place data and tools that can help. PHC4 receives and publicly reports *outcomes* data (patient treatment results) from health care facilities, and these reports can lead to purchaser questions and can help providers of care to avoid some hospital or health system events that compromise patient safety. When these reports are released, some hospitals simply attack the analytic methods. Others keep the goal in sight – improving patient safety – and respond constructively.

For example: In an early PHC4 *Hospital Effectiveness Report,* one hospital questioned why its mortality rates for patients with pneumonia were so much higher than similar hospitals. The staff began looking for a solution, not for errors. They found that one doctor in their system conducted one key test differently – and he had better patient outcomes. After conforming all physicians to his practice pattern, patient outcomes improved and the hospital consumed 15 percent fewer resources in treating its patients.

Another example: After the first PHC4 coronary artery bypass report was published, one Pennsylvania hospital with higher than expected patient mortality rates examined every step in the treatment process and found an area for improvement. The staff changed its approach, patient outcomes improved and these results were affirmed in subsequent PHC4 reports. As one Pennsylvania cardiac surgeon stated to the *Wall Street Journal*, "...even though we dreaded (report cards) for a long time...it's become part of the practice...it has helped us to move forward."

Patient outcomes data is a component of patient safety. Since 1989, Pennsylvania, through PHC4, has been a national leader in collecting, analyzing and reporting outcomes data. PHC4 publishes data including risk-adjusted rates of deaths, readmissions, complications, and length of stay. Risk adjusted means the data have undergone a sophisticated patient risk assessment to account for varying levels of patient illness upon admission to a hospital.

Using our reports, including the recently issued *Hospital Performance Report* (HPR), purchasers can examine data for information and insights. The HPR report includes readmissions data for the second consecutive year. Experts tell us that some readmissions may be the result of infections or complications – some of which are potentially avoidable. An updated coronary artery bypass report will be out soon. For the first time it will contain hospital-specific readmission data about cardiac surgery. We also have data and reports on hysterectomies and on complications from other procedures.

The Purchaser's Role

Events that compromise patient safety add costs for health care purchasers. The Agency for Healthcare Research and Quality (AHRQ) offers advice to individuals, which purchasers might find useful: Work with medical professionals, educate yourself and your employees, and teach employees that as patients, they must be active members of the health care team, taking part in key decisions. This means making sure that every doctor knows about every medicine a patient is taking, including prescriptions and over-the-counter medicines and dietary and herbal supplements. Make sure physicians know about any allergies and adverse reactions patients have to medications.

Whether patient safety is compromised by an incorrect prescription or a procedure performed on the wrong side of the body, or whether health facility internal procedures result in a medical occurrence that compromises patient safety, here is more of what experts including Dr. Bagian suggest. Use existing data to ask questions. Ask hospital personnel, including the patient advocate and top hospital officials: "Who is looking at patient safety? What is the process for the review? Is it system-wide? How can you demonstrate your commitment to safety?" Bagian told the PHC4 Council that "close calls" occur 20 to 600 times more frequently than adverse events. "The warnings are there," he said. Importantly, these warnings provide real opportunities for improvement through learning, not punishment. We all share the responsibility to use these warnings to look for health systems' problematic procedures - and to work within the systems for corrective, not punitive action.

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