By Barbara Ravage and Cynthia Kincaid

National EFFORTS FOCUS on PATIENT SAFETY

Plethora of Initiatives Represent a Work In-Progress

If the 1999 Institute of Medicine report *To Err is Human: Building a Safer Health System* sounded the alarm, the Centers for Medicare and Medicaid Services (CMS) have issued a final wake-up call to any hospital administration that is still napping.

The report estimated that medical errors were responsible for as many as 98,000 deaths each year, at a cost of nearly $29 billion. The initial response was a series of studies and initiatives that sought to quantify and rectify the problem. Jim Conway, senior vice president for the nonprofit Institute for Healthcare Improvement (IHI), calls it "a sea change within the health care industry as we are increasingly being held accountable for our outcomes by the federal government, state government, consumers, legislators, payers and employers."

CONTINUED ON NEXT PAGE

But if patient safety is the goal, there seem to be a dizzying number of roads to reach it. The National Quality Forum (NQF), a not-for-profit organization that sets national priorities and goals for performance improvement, came up with 28 Serious Reportable Events defined as "errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients" (See Sidebar). Some states have enacted legislation requiring reporting of incidents on the NQF list. Many of these events are included in the CMS final rule on hospital-acquired conditions (HACs) for which reimbursement will be curtailed. The NQF-endorsed "Safe Practices" further serve to identify and encourage practices that will reduce errors and improve care.

Following the success of their 2005-2006 "100,000 Lives Campaign," (a national effort that saved an estimated 122,200 lives in 18 months), IHI launched the "5 Million Lives Campaign," enlisting 4,000 hospitals to address interventions aimed at protecting 5 million patients from incidents of medical harm over a two-year period (December 2006 – December 2008). The Joint Commission issued a set of "National Patient Safety Goals," and The Agency for Healthcare Research and Quality developed survey tools to help hospitals assess their patient safety culture, track changes in patient safety and evaluate the impact of safety interventions.

"Medicare has made it very clear that if you are achieving great outcomes, you will be rewarded. But if your outcomes are poor, your reimbursement is going to suffer significantly as a result of that."
Jim Conway, Institute for Healthcare Improvement

Moreover, legions of consultants entered the field with services to assess, implement and monitor patient safety programs. Among those are the Leapfrog Group's "Hospital Quality and Safety Survey," which is a tool to address adverse events; the National Patient Safety Foundation's "Stand Up for Patient Safety" program; and Press Ganey's safety culture suite of measurement and improvement solutions.

Of concern, however, is what IHI's Conway terms "initiative overload," as hospitals try to adopt dozens of safety initiatives every year. "IHI, with the National Quality Forum, is seeking to prioritize the order in which to sequence these things," Conway says. "If it becomes an overwhelming burden and hospitals don't know where to start, or where to go, they can lose direction."

By and large, hospitals scrambling to address the issue have instituted reforms directed at processes and procedures, including computerized physician order entry (CPOE) systems and root cause analyses. As necessary as all of these are, they represent a scattershot approach to a complex problem. "All are based on processes and IT systems," according to Chris Hickey, vice president of customer service for Press Ganey. "It is crucial to develop a safety culture to serve as the matrix within which systemic operational reforms can take hold," he notes.

Nonetheless, he sees as a key index the size of the gap between how frontline staff and hospital management answer the question: *Does hospital management seem interested in patient safety only after an adverse event has happened?* "The slimmer that margin, the better performing the hospital is," he says. "If there's a huge gap, those are the hospitals that are making mistakes and their culture scores are pretty low."

The Los Angeles County Department of Health Services (LADHS) has been aggressively pursuing ways to underscore patient safety, including closing that perception gap. According to Kenneth Aaron, MD, corporate patient safety officer at Los Angeles County Department of Health Services, "If you don't know what's happening in your institution, then you have no idea how to make it safer." LADHS hospitals have established "Walk-Rounds," during which hospital administrators walk into the wards and nursing units and talk to the frontline staff. "In the past, the executive staff had been, to a certain extent, isolated and insulated from some of the frontline issues," says Aaron. "This is a way to go around and ask the staff what issues they know of that are making it unsafe to take care of patients. The trick is to ask the question, but the real trick is to do something about what they tell you. If done right, it can be a very powerful tool." LADHS is also establishing the role of Physician Patient Safety Officer at each of its hospitals to work with medical and hospital staff to implement evidence-based Patient Safety Practices.

Serious, Reportable… "Never Events"

Reimbursement Changes Regarding Hospital-Acquired Conditions

While full implementation of value-based purchasing awaits approval of Congress, CMS has already moved to restrict payments to hospitals for some of the hospital-acquired conditions (HACs) that are described as "never events." These are errors in medical care that are clearly identifiable, largely preventable, and serious in their consequences for patients.

Medicare will no longer reimburse at its higher rate for increased costs due to a list of HACs that can be found at www.cms.hhs.gov/HospitalAcqCond. In fiscal year 2009, CMS will add several conditions to the original list of eight promulgated in 2007, and more may be expected in years to come. In addition, CMS is actively encouraging states to implement these practices with respect to Medicaid.

CMS is also planning to restrict reimbursement for egregious surgical errors, beginning with surgery on the wrong body part, wrong procedure, and surgery on the wrong patient.

"While it may be some time before we can begin to assess the real impact of these steps on patient care," says CMS Acting Administrator Kerry Weems, "we are hearing from hospitals around the country about efforts they have undertaken in the past year to improve staff training and other measures to reduce the incidence of these preventable conditions." Weems adds that private payers are starting to adopt similar policies in their payment systems. "This is a win-win situation: better outcomes at less overall cost."

Getting buy-in from staff can be a daunting challenge. Parkland Hospital in Dallas has come up with a team-building approach called "Good Catch," which uses a baseball theme to promote a culture of safety by awarding points for identifying and reporting safety hazards that did not reach patients. A pilot program focused on three ICUs—dubbed the CPICU-Tigers, MICU-Royals and SICU-Pirates—because that is where a safety culture is imperative, according to Angelique Ramirez, MD, medical director for performance improvement and patient safety. Adapted from an initiative developed by fellow NAPH member The University of Texas M.D. Anderson Cancer Center, the goal of the Parkland program is "to transition from a reactive to a proactive approach, to find out about near-misses and opportunities to improve care prior to any harm coming to a patient," says Ramirez.

In all, 908 "Good Catches" were reported during the nine-week (nine-inning) pilot, many preventing multiple errors. For example, the main doors of the CPICU lacked an automatic door opener, making transport of patients and carts hazardous. Plans are now in place for a push-button door-opening system. Both MICU and SICU caught stocking problems on standardized crash carts carrying necessary life-saving equipment. As a result, all 118 carts were brought into line.

The result has been a strong reporting culture. "It's been a win-win-win across the board," Ramirez says, citing documented improvements for patient care and the hospital's overall report card, as well as a boost to morale. "It's helped prove that change can happen when you report more, and it validates how much time frontline staff spends doing things that make a difference in patient care."

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The National Patient Safety Foundation's "Stand Up" program, crafted for both inpatient and ambulatory settings, provides timely and important information on patient safety implementation strategies, along with practical tools and techniques to facilitate the incorporation of patient safety into the hospital culture and enhance existing safety and quality programs. NPSF proudly partners with several safety net and public hospitals, including a number of NAPH members. "We applaud their focus on patient safety and tireless efforts on behalf of their communities," says Diane C. Pinakiewicz, MBA, NPSF President. " ***For more information, contact standup@npsf.org or 413-663-8900. Visit online at www.npsf.org/hp/su.***