STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005

Category B: Identifying and Learning from Errors

Code: MeasCrit (02) – Development of empirical / data measures of patient safety using agreed upon criteria.

***Recommendation #**: 4*

The submitted testimony recommends standardization of all measures of patient safety including near misses and adverse events by an appropriate state level organization. These measurements should be finalized following national standards by the state level organization along with purchasers and payers.

Rationale:

Safe healthcare delivery requires just as much scientific rigor as conducting a clinical trial of a new drug. The problem with patient safety as described in the Health Grade Quality Study (2004) is that, "Without accurate measurement we can't significantly improve the quality of care."[1] They state one reason for this problem is that "defining, reporting, and using these measurements continue to be debated."[1] As documented by the Institute of Medicine (IOM) (2000) there is much concern to determine a standardized taxonomy for reporting adverse event and risk factors.[2] In IOM's (2000) report, the recommendation was made to standardize information on adverse events, which are directly related to patient safety. This was to be enacted by all the health care organizations.

The IOM (2000) reported three reasons for the use of this standardizing the format of reporting adverse events. First, standardization allows information to be monitored over time.[2] If there is not consistency over time in both the definitions and methods of collecting data on patient safety, the data cannot be combined. This hinders the ability to compare and improve patient safety concerns. The second reason cited is that a standardized system decreases the burden on health care organizations.[2] Many health care organizations operate in multiple states. By keeping the reporting and measurements standardized it enables the data to be transferred easily to other agencies and group purchasers.[2] Finally, the standardization of information allows for increased communication between the consumers and purchasers concerning patient safety.[2]

Although CMS and JCAHO have adopted standardized performance measures on patient safety for hospitals to report, these measures are not comprehensive and do not include all settings of care. The effects of un-standardized information have been noted. The IOM (2000) interviewed 13 states that had reporting systems to determine what needs should be met when creating these systems. The states documented that

the information they received regarding patient safety reports was not consistent and insufficient.[2] This finding suggests the need for more standardization. Standardizing definitions and risk categories enable pattern analysis to identify systematic issues related to public safety.

Evidence and/or information on comparable initiatives being carried out in other states:

Collecting data on patient safety is a task being undertaken by States, accrediting bodies, Federal agencies and other private organizations. Further efforts will be made by these bodies to create independent systems. Due to variation seen within the measures to prevent near misses and adverse events, the Patient Safety Task Force was created with the intent to reduce duplication and encourage a more "complete and comprehensive reporting of data".[3] This task force was created by the Department of Health and Human Services with the purpose to "coordinate the integration of data collection on medical errors and adverse events, coordinate research and analysis efforts, and promote collaboration within the Department of Health and Human Services to improve healthcare quality by preventing complications and injuries associated with healthcare delivery."[3] The Task Force is made up of representatives from the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC) Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS).

It is the mission of the Patient Safety Task Force to develop the necessary information to prevent harm to patients.[3] Their work will be used to create a coordinated reporting system. This system will ensure the ability of partnership and collaboration to reduce patient errors. Below are the specific goals of the Patient Safety Task Force, illustrating the effort to create a standardized system:

- *A coordinated reporting system that is easy to use for the person reporting errors and adverse events.*
- *A common vocabulary that enables data to be shared, compared, analyzed, and evaluated.*
- *A network for reporting that retains confidentiality of clinicians and patients and that allows access by each agency or organization that needs to use the reported information.*
- *An analysis and research function that allows the reports of errors to be evaluated, safety hazards to be identified, and safety improvements to be evaluated for their effectiveness.*

- *Information on the implementation of patient safety best practices within Federal programs.*
- *Information dissemination and technical assistance to public and private-sector organizations that use this information to improve patient safety.*
- *A report that evaluates the Task Force's progress toward meeting its mission.*[2]

Additionally, the IOM (2000) reported that the National Forum for Health Care Quality Measurement and Reporting was established to assist in creating standardized nomenclature, a taxonomy for reporting adverse events and standardized reporting formats.[2] More specifically, this Forum is a private-public partnership with the purpose of developing "a comprehensive quality measurement and public reporting strategy that addresses priorities for quality measurement for all stakeholders consistent with national aims for quality improvement in health care."[2] Through this mission they will not only identify a set of core measures, but they will promote that standardization of measurements.[2]

4a

An appropriate state level organization should determine which measures of patient safety are most appropriate to compare provide performance within a particular setting of care. All health care organizations should then be held accountable for collecting information on those standardized set of measures.

Rationale

Considering 98,000 preventable deaths occur each year because of medical errors, it is essential that measures are taken to improve patient safety.[2] By improving the safety environment, health care organizations can reduce the number of patient injuries that occur. The safety environment can be altered in many ways such as informing the staff of potential patient risks.[3] Yet, the health care organizations must screen for what these problems are, but more importantly, they must have standardized information when dealing with patient safety.

To approach this concern, Patient Safety Indicators (PSIs) were created by the Agency for Healthcare Research and Quality (AHRQ). In the process of creating these indicators, 326 articles relating to areas of patient safety were examined.[3] Based on this investigation, 29 indicators were created. While previous indictors were released in 2001 and 2002, all 29 evidence based PSIs were released to the public in 2003 to be used by U.S. hospitals and stakeholders wishing to improve patient safety.[4]

While these indicators have been created, the problem lies in their adaptation. It is important that PSIs be standardized between health care organizations to ensure patient safety. "PSIs, which are based on computerized hospital discharge abstracts from the AHRQ's Healthcare Cost and Utilization Project (HCUP), can be used to better prioritize and evaluate local and national initiatives."[3] The means to use these indicators are assessable in the regard that administrative data sets are available and the analyses of them are inexpensive. PSIs monitor the potential for medical errors over time, which further reinforces their effectiveness for the continuity and quality of care.[3]

The importance of monitoring these PSIs has been documented. In a study by Zhan and Miller (2003) it was estimated when considering 18 patient safety indicators for effects on excess length of stay and mortality, $9.3 billion excess charges and 32,591 deaths in the United States occurred annually.[5] Additionally, from 2000 to 2002, 81% of the total deaths caused by PSIs were actually attributed to patient safety incidents.[5]

Evidence and/or information on comparable initiatives being carried out in other states:

- The Agency for Healthcare Research and Quality created Patient Safety Indicators (PSIs) based on four components of health care, effectiveness, safety, timeliness and patient centeredness. [6] The purpose of PSIs is to screen for problems a patient might encounter while in the health care system. Twenty-nine indicators were established for both the provider and area level.

States such as Maine publicly display their averages based on the PSIs. In 2001, Maine reported on 26 indicators.[7] AHRQ publicly reported on performance indicators for 21 states that participated in the pilot project.

4b

"State of Michigan" should create a non-punitive reporting system, mandatory or voluntary, on patient safety elements needed to measure errors and near misses by all health care organizations that conduct business in the state.

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[1] Health Grades, Inc. (2004). Health Grades Quality Study: Patient Safety in American Hospitals. Retrieved May 3rd from http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf.

[2] IOM (2000). *To Err is Human: Building a safer health system*. Washington DC: National Academy Press.

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[3] Agency for Healthcare Research and Quality, (2003*). Patient Safety Task Force. Fact Sheet. July 2003.* Retrieved May 2nd, 2005 from http://www.ahrq.gov/qual/taskforce/psfactst.htm

[4] *Patient Safety Indicators, Version 2.1, Revision 1*. March 2004. Agency for Healthcare Research and Quality, Rockville, MD.

[5] Zhan, C. & Miller, M.R. (2003).Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization. *JAMA*, *290*(14):1868-74.

[6] Agency for Healthcare Research and Quality. (2003) AHRQ Quality Indicators – Guide to Patient Safety Indicators. Version 2.1, Revision 3, (January 17, 2005). AHRQ Pub.03-R203. Retrieved May 2nd, 2005 from http://www.qualityindicators.ahrq.gov/downloads/psi/psi_guide_rev3.pdf/

[7] State of Maine (2001). Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators Healthcare Cost and Utilization Project Nationwide Inpatient Sample and State Inpatient Databases, 2001. Retrieved May 3rd, 2005 from
http://www.healthweb.state.me.us/inpatient/2001/indicatorSafetyPatient.pdf