

## Recommendations

These recommendations take into consideration testimony originally coded to 02 (MeasCrit),<sup>1</sup> 08 (PerfBench),<sup>2</sup> 21 (DrgStand),<sup>3</sup> 22 (MedPrac),<sup>4</sup> and 28 (SafeStand),<sup>5</sup> as well as other sources, as noted.

- L1. Develop a common vocabulary around patient safety performance that facilitates sharing, comparing, analyzing and evaluating data.
  - o L1a. Establish statewide standards for safety performance, benchmarks by which to measure progress, and expectations of excellence.
  - o L1b. To the greatest extent possible, develop Michigan's patient safety standards and goals consistent with emerging national measures and standards.
  - o L1c. Develop standards for safety practices, adverse events and near misses.
  - o L1d. Standardize data definitions and specifications to facilitate comparison of progress across organizations.
  - o L1e. Hold health-care providers and organizations accountable for collecting data relevant to their particular settings and patient populations.
  - o L1f. Aggregate data from health-care providers and organizations to inform the ongoing analysis of safe standards and provide feedback regarding performance progress.
  - o L1g. Support these activities through strategic communication and education.
- L2. Encourage purchasers and payers to provide incentives for meeting or exceeding safety performance targets.

## Rationale

According to the federal Agency for Healthcare Research and Quality (AHRQ), "Sustained data measurement is the foundation for sustained quality improvement."<sup>6</sup> Hospital-acquired (nosocomial) infections, adverse drug events, and postoperative complications of care are only some of the measures used to learn about patient safety in the United States.<sup>7</sup>

There is a growing national consensus that a single, standardized set of performance measures would simplify and improve compliance with data collection.<sup>8</sup> A set of such core measures would also reduce the number of what are often seen as competing and conflicting standards.<sup>9</sup>

While it is critical that the full range of Michigan's perspectives on patient safety performance measures be communicated to those making decisions at the national level, it is also imperative that Michigan not wait for a complete set of national standards to emerge before acting.

According to the *National Healthcare Quality Report (2004)*, Michigan scores above average in only 24 of 178 (13%) measures considered. On 44 (25%) of the standards Michigan is considered average. Unfortunately, Michigan scores below average on 20 (11%) of the measures and is unable to provide enough data for scoring on 18 (10%) of the measures.<sup>10</sup>

Michigan must do better. Once the common vocabulary, data collection/analysis guidelines, and solid feedback mechanism are designed, health-care organizations must be held accountable for collecting data and acting effectively on the feedback they receive.

Feedback to health-care providers may include benchmarks, defined by the Institute of Medicine as a way to compare oneself or one's organization against the "best in class."<sup>11</sup> In the testimony, one provider noted that the calculation of benchmarks should follow an established methodology, including peer-group defined benchmarking.

Payers can support change through performance measurement by providing Incentives for providers that meet or exceed the benchmarks and demonstrate improvement over time.

## Evidence for harm reduction

The translation of evidence-based guidelines for care and feedback from performance measurement systems into clinical or organizational practice is the subject of much current research. Several studies have found that a focus on only the creation and distribution of these guidelines has little effect on clinical practice.<sup>12 13 14 15</sup> However, in line with the recommendation above, there is a large body of evidence that suggests measures with patient-specific feedback or computer-generated reminders do have a significant impact on the improvement of patient safety.<sup>16 17</sup> Additionally, in a recent study by Solberg et al. (2000), it was found that breaking down financial, cultural, and organizational barriers, both internal and external to the health-care organization, can improve widespread compliance with evidence-based standards.<sup>18</sup> Only with strong leadership will such measures to be adopted, collected, assessed, analyzed, and eventually generate feedback that prompts improvement to reduce patient harm.

## Assessment

### Advantages

- Because this issue is high on the national agenda, it would be to Michigan's advantage to participate actively as national standards are developed.
- Measurement breeds measurement. When measurement is incorporated with clinical practice, the process of practicing safe care allows that measurement to occur through data collection.<sup>19</sup> If the burden of measurement is decreased through national standards and data collection is increased, there will be a greater opportunity to more accurately determine the quality of care that is being delivered.<sup>20</sup> When the data is available to the health-care organizations and feedback is provided, they will have the opportunity to address performance concerns within their establishments, prompting continuous improvement.<sup>21</sup>
- Standardized measurement and benchmarking prompt improvement by encouraging providers to learn from broad trends in the data and compare themselves against the "best in class." Using a common set of goals and data definitions—what should be measured and how it should be measured—also facilitate collaboration and comparison of progress among collaborators.

### Barriers

- As numerous studies have suggested, one barrier to the adoption of standardized performance measures is the lack of universal information technology (IT) systems.<sup>22 23 24 25</sup> Without compatible IT systems, the patchwork of methods, standards, and definitions for collecting, coding and exchanging data present a formidable barrier to comparable measures. A number of groups are working on this problem, but progress is slow.<sup>26</sup> This issue will be addressed in greater detail when the Review Panel discusses recommendations regarding "Information and Communication Technology."
- Translating standards and guidelines into clinical practice is a challenging method of improving clinical care.<sup>27</sup>
- The establishment of benchmarks alone does not guarantee performance improvement. Low benchmarks, which may come about due to poor performance from all health-care organizations involved, may jeopardize statewide improvement expectations.

## Implementation

### Further research

- Experts in various clinical areas need to be convened to conduct further research on standards of patient safety that are not only measurable, but feasible to report by the health-care organizations in the long run.

### Legislation and/or administrative rules

- Amend the Public Health Code to consolidate the standards of patient safety that are applicable to all settings of health-care delivery.

### Resources

- In order to enact this recommendation, intellectual manpower will need to be recruited to assist in not only the development and improvement of national standards, but also improving these standards in the state of Michigan.
- Depending upon the clinical area focused, an average time for abstracting a medical record by a professional using a standard tool that encompasses 3-4 quality indicators varies between 40-90 minutes. Collecting such information on a reasonably sized sample, and reporting the required data elements would be tremendously burdensome on all providers of health care. Patient safety indicators should not rely on abstracted information.

### Incentives

- Conducting demonstrations of paying for performance, developing a core set of standardized measures, or instituting flexibility in delivery of care through waiver programs could all be used as incentives for adhering to patient safety measures.<sup>28</sup>

### Specific steps and target dates

Following adoption of these recommendations, the following steps will take place.

- Within 9 months the Michigan Partnership for Safe Health Care will convene the first of a series of summits of health-care stakeholders to assess current performance measures in use in the state and identify a core set of performance measures consistent, to the extent possible, with emerging national measures and standards. Summit participants will define the measures' purposes, definitions and data collection and analysis methodologies. They will also identify a central organization to aggregate and analyze the data and provide feedback to participating providers. As part of this process, summit members will determine whether existing legal protections are sufficient for this important activity or whether new protections should be sought.

## Testimony overview

### Summary

The recommendations above were compiled from 56 testimonies: 14 originally coded to Measurement Criteria; 7 coded to Performance Benchmarks; 2 coded to Drug Standards; 17 coded to Medication Practices; and 16 coded to Safety Standards.

### Key findings

- Safety measures in Michigan should be developed using national standards and should not be started from scratch.

- Benchmarking should be supported by all payers, including ‘centers of excellence’.
- Safety measures should be developed in consensus with the stakeholders.
- Use of computerized medication tracking systems for safe practice of medication administration should be supported.
- Safety standards should be developed for all settings of health-care delivery.

## Summary of additional research

Awareness of the importance of improving patient safety by creating event reporting systems, collecting event data in individual health-care facilities, and creating national standards for data collection has increased in recent years, according to the *National Quality Healthcare Report* of 2004. However, a national assessment of patient safety data is far from complete.<sup>29</sup> Further development of national standards and assessment of patient safety data is required. Although organizations such as the Agency for Healthcare Research and Quality (AHRQ) have formulated patient safety performance indicators using administrative data, more comprehensive measures, and the inclusion of adverse events and near misses in all settings of care delivery are needed.<sup>30</sup>

In the IOM report *Patient Safety: Achieving a New Standard for Care* (2003), it was noted that the federal government should be the driving factor in creating and disseminating national data standards.<sup>31</sup> The committee behind this report noted that Congress should provide financial support to agencies such as the Department of Health and Human Services, the Consolidated Health Informatics Initiative, the National Committee on Vital Health Statistics, AHRQ, and the National Library of Medicine to ensure this effort’s success.<sup>32</sup> In the first *Annual Crossing the Quality Chasm* summit, consensus was made that the private and public sector must also be a partner in accomplishing the goal of national standards. They recommended involvement through such means as “conducting demonstrations of paying for performance, developing a core set of standardized measures, or instituting flexibility in delivery of care through waiver programs.”<sup>33</sup>

## Review Panel Round One

### Scoring summary

In Round One, the Review Panel was asked to score each recommendation area on a scale of 1 to 5, where 5=extremely viable, 4=very viable, 3=somewhat viable, 2=potentially viable with changes, and 1=not viable for this project. Average scores for relevant recommendations considered in Round One:

- Measurement Criteria: 3.75.
- Performance Benchmarks: 3.0.
- Medication Practices/Drug Standards: 3.2.
- Safety Standards: 2.8.

### Notes

- The Review Panel noted that Michigan should be proactive in developing patient safety measurement criteria and that standardization is critical. Several reviewers emphasized that Michigan’s standards should be consistent with emerging national standards.
- Learning from each other should be emphasized in offering benchmarks to providers. Benchmarks must also be linked to improving safety.

- The two testimonies coded to Drug Standards were combined with Medication Practices and these were further merged with recommendations regarding “Information and Communication Technology.”

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## Endnotes

- <sup>1</sup> Code 02 (MeasCrit). The submitted testimony recommends development of empirical/data measures of patient safety using agreed-upon criteria.
- <sup>2</sup> Code 08 (PerfBench). The submitted testimony recommends adoption of performance benchmarks and measures related to patient safety practices.
- <sup>3</sup> Code 21 (DrgStand). The submitted testimony recommends development of standards to guide the design of processes and procedures related to the safe use of drugs.
- <sup>4</sup> Code 22 (MedPrac). The submitted testimony recommends adoption and implementation of medication safety practices.
- <sup>5</sup> Code 28 (SafeStand). The submitted testimony recommends establishment of standards, guidelines, principles, or rules by agencies with acknowledged authority over the health services providers referenced in the standards, guidelines, etc., to guide the design of processes and procedures related to patient safety.
- <sup>6</sup> Agency for Healthcare Research and Quality. (2004). National Healthcare Quality Report. Retrieved June 29<sup>th</sup> from <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx?id=5070>.
- <sup>7</sup> Agency for Healthcare Research and Quality. (2004)
- <sup>8</sup> Institute of Medicine (2004). 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities. Washington DC; National Academy Press.
- <sup>9</sup> Institute of Medicine (2004).
- <sup>10</sup> Agency for Healthcare Research and Quality. (2004). National Healthcare Quality Report. Michigan State Summary Table. Retrieved June 29<sup>th</sup> from <http://www.qualitytools.ahrq.gov/qualityreport/state/stateData.aspx?state=MI>.
- <sup>11</sup> Institute of Medicine (2001) *Crossing the quality chasm: A new health system for the 21st century*. Washington DC: National Academy Press.
- <sup>12</sup> Cabana, M., Rand, C. Powe, N. et al. (1999). Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement. *JAMA* 282(15)1458–65.
- <sup>13</sup> Hayward, R.S. (1997). Clinical Practice Guidelines on Trial. *Can Med Assoc J* 156,1725–7.
- <sup>14</sup> Lomas, J., Anderson, G., Karin D., et al. (1989). Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians. *N Engl J Med* 321(19),1306–11.
- <sup>15</sup> Woolf, S.H. (1993). Practice Guidelines: A New Reality in Medicine. III. Impact on Patient Care. *Arch Int Med* 153, 2646–55.
- <sup>16</sup> Dowie, R. (1998). A Review of Research in the United Kingdom to Evaluate the Implementation of Clinical Guidelines in General Practice. *Family Practice* 15(5), 462–70.
- <sup>17</sup> Grimshaw, J.M. & Russell, I. (1993). Effect of Clinical Guidelines on Medical Practice: A Systematic Review of Rigorous Evaluations. *The Lancet*, 342, 1317–22.
- <sup>18</sup> Solberg, L.I., Brekke, M. Fazio, J et al. (2000). Lessons from Experienced Guideline Implementers: Attend to Many Factors and Use Multiple Strategies. *Joint Commission Journal on Quality Improvement* 26(4), 171–88.
- <sup>19</sup> Institute of Medicine (2004).
- <sup>20</sup> Institute of Medicine (2004).
- <sup>21</sup> Institute of Medicine (2004).
- <sup>22</sup> Dwyer, C. (1999). Ideas and Trends: Medical Informatics and Health Care Computing. *Ann Int Med* 130(2):170–2, as cited in IOM (2001) *Crossing the quality chasm: A new health system for the 21st century*. Washington DC: National Academy Press.
- <sup>23</sup> Kleinke, J.D. (1998). Release 0.0: Clinical Information Technology In The Real World. *Health Affairs* 17(6):23–38, as cited in IOM (2001) *Crossing the quality chasm: A new health system for the 21st century*. Washington DC: National Academy Press.
- <sup>24</sup> McDonald, C. (1998). Need For Standards In Health Information. *Health Affairs* 17(6):44–6, as cited in IOM (2001) *Crossing the quality chasm: A new health system for the 21st century*. Washington DC: National Academy Press.

<sup>25</sup> U.S. Department of Commerce. (1994). *Putting the Information Infrastructure to Work. Report of the information infrastructure task force committee on applications and technology*. Washington, D.C.: National Institute of Standards and Technology, PB94-163383, as cited in IOM (2001) *Crossing the quality chasm: A new health system for the 21st century*. Washington DC: National Academy Press.

<sup>26</sup> Institute of Medicine (2001).

<sup>27</sup> Cabana, Rand, Powe, et al. (1999).

<sup>28</sup> Institute of Medicine (2004).

<sup>29</sup> Agency for Healthcare Research and Quality. (2004).

<sup>30</sup> Agency for Healthcare Research and Quality (2005). *Medical Errors and Patient Safety*. Retrieved July 11<sup>th</sup>, 2005 from [www.ahrq.gov/qual/errorsix.htm](http://www.ahrq.gov/qual/errorsix.htm)

<sup>31</sup> Institute of Medicine. 2003. *Patient Safety: Achieving a New Standard for Care*. Aspden P, Corrigan JM, Wolcott J, Erickson SM, eds. Washington, DC: National Academy Press

<sup>32</sup> Institute of Medicine (2003).

<sup>33</sup> Institute of Medicine (2004).