

TESTIMONY
STATE COMMISSION ON PATIENT SAFETY
MICHIGAN HEALTH AND SAFETY COALITION
NOVEMBER 15, 2004

I would like to thank the “Commission” for the opportunity to present my thoughts and recommendations concerning improving patient safety in Michigan. My testimony represents my personal viewpoints and does not reflect that of any organization with which I am affiliated; however, I am hopeful that as president-elect of the Oakland County Osteopathic Medical Association, that I shall have the opportunity to take a leadership position in patient safety efforts.

I am an osteopathic family practitioner with a master’s degree in public health. For the past seventeen years I have been involved in healthcare quality improvement and the adjunctive patient safety activities in a small local healthcare system. I have participated in national healthcare quality and safety initiatives including one of the early national healthcare collaborative projects sponsored by the Institute for Healthcare Improvement (Reducing Adverse Drug Events) under the aegis of Drs. Lucien Leape and Donald Berwick.

While many of the presenters to the Commission focus on hospital care, I would like to focus my remarks on the office setting where the bulk of health care is rendered as it appears sufficient nationally driven efforts through accreditation agencies have engaged these providers. While my comments involve the office setting many of them can be extrapolated to the hospital or health system level.

Currently, small clinical practices provide significant portions of all health care provided to Michigan patients. These practices are usually comprised of one to four licensed practitioners with some care provided by midlevel licensed allied health professionals and some care provided by unlicensed physician extenders (e.g., medical assistants). One must recognize that individuals practicing in this environment lack sophisticated systems for identification of patient safety issues or events; indeed, this is not a primary focus given the daily pressures of conducting clinical practice and completing the increasing myriad of associated paperwork, authorizations, and the like. Analogous to the situation that now exists in hospitals involving shortages of registered nurses and ancillary personnel, many practitioners’ offices have been unable to locate and hire sufficient appropriately educated and trained individuals to meet the demand. As in hospitals, a downward delegation to less qualified personnel continues despite the increasing complexity of medical therapy.

Communication issues contribute to increased patient risk related to this increased complexity. This may involve failure to transmit information across the health care continuum between facilities, practitioners, and patients. Information may be lost, mis-directed, late, unavailable when needed, or misunderstood. Particularly with patients,

with the tendency for healthcare professionals to speak in unfamiliar terminology and with a reticence by patients to tell their care providers that they do not understand.

The health care quality and safety literature frequently references aviation and nuclear power industry as models for risk reduction and safety improvement given their high complexity, risk and track record. In advocating this model, safety experts espouse a concept of a “culture of safety”. This represents the first step in achieving a safer health care environment. However, even in their structured environments hospitals and health systems demonstrate variable success in implementing a culture of safety despite their ability to hold individuals responsible and accountable. This suggests that creating a statewide culture of safety in health care represents an enormous challenge.

Recognizing that the Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, National Committee for Quality Assurance, Joint Commission for Accreditation of Healthcare Organizations, American Osteopathic Association and other accreditation agencies, health insurers, health plans have multiple efforts engaging hospitals, health systems, and practitioners in healthcare safety and related quality initiatives, to add redundancy at a state level will not provide additional patient benefit.

Every system is perfectly designed to deliver the outcomes it produces. Therefore, to have meaningful impact on patient safety will require a second order change.

RECOMMENDATIONS

1. Create a statewide culture of safety. First, the Commission should establish a definition of patient safety that health care practitioners willingly embrace. While the Commission has references the National Patient Safety Foundation definition “The prevention, elimination or mitigation of patient injury caused by health care errors”, practitioners may internalize this adversely by interpreting this as flaws in their performance akin to medical negligence or inadequate personal performance. The concept of error needs re-definition for individual acceptance. Second, in conjunction with safety experts, healthcare leaders, and frontline practitioners, identify patient safety issues and develop a priority index relevant to each aspect of care in the clinical continuum: hospital, ambulatory clinic or office, nursing home, pharmacy, etc. Third, identify the practitioner type involved in the priority index. Fourth, develop and implement a communications plan to make practitioners aware of the index and the rationale behind it. Fifth, develop effective education curricula or modules addressing each element in the priority index. Sixth, re-design the professional peer review process to make it safe to conduct substantive review without casting aspersions. Develop a process for conducting in small facility settings. Engage professionals in the concept of true root cause system analysis without aim, blame and shame. This does not mean absence of accountability for negligence or egregious acts.

Seventh, develop and implement a statewide anonymous, non-punitive voluntary reporting system, preferably web-based or other electronic system, for actual or potential adverse medical outcomes or events using a simple format that collects only essential information concerning the event. This will require making it “safe” to report. Seventh,

identify trends or other significant opportunities to make care safer and share that information in a meaningful way with potentially similar impacted practitioners or institutions. Eighth, publicly celebrate identified safety improvement ideas generated.

2. Education. The Institute of Medicine's 1999 report stimulated discussion concerning patient safety and identified issues not previously discussed widely. This increased awareness has not as yet been embraced by many health care practitioners. Health care safety is in itself a discipline and has not as yet been widely incorporated into educational programs. In the short term, a patient safety continuing education requirement for all Michigan licensed healthcare professionals should be mandatory as part of the continuing medical education requirement for licensure as has become practice for some other states (e.g. Florida). The courses could be either stand-alone, in conjunction with other scientific educational sessions conducted by the relevant professional state association, or through an on-line tutorial course. The course content should be standardized by license type and approved by the licensing board. In the long term, the professional schools should have as requirement patient safety courses and training as a basic curriculum requirement prior to graduation.

3. Communication with patients. The literature suggests, and a study by the American Medical Association Foundation (Helping Your Patients Understand) demonstrates, that patients frequently lack understanding of medical information provided by physicians and other health care providers. This represents use of medical jargon and other language not comprehended by patients and leads to significant potential and actual medically adverse occurrences. Education and training for communicating at the patient's level will help mitigate this risk. Involving patients or their care givers increases the responsibility and ability to participate in the care process and to act as a final checkpoint to avoid a potential misadventure.

4. Communication with other practitioners. The investment in clinical information systems must increase with incentives for small and medium sized practices to invest in this technology. Open architecture software support systems within the confines of HIPAA and other aspects of protected information to make information available across the continuum would contribute to reduction. Similarly medical decision support software incentives would further reduce risk. Pending such availability provide recommendations for practical manual systems to ensure follow-up and follow-through for results and interventions for facilities and practitioners.

5. Align incentives for practicing evidence-based clinical guidelines through all payors – creating “centers of excellence” in disease management or recommended preventive care with financial incentives for performance. These incentives must represent longitudinal performance, not annual, with demonstrated compliance over time.

6. Fund patient safety/risk reduction demonstration projects involving small to medium size practices or a collaborative of small to medium size practices. These would require specific goals with a demonstrated return on investment. Disseminate successes to others in the provider community.

COMMENT

Voluntary reporting lacks adequate vigor and reliability for extensive patient safety and care improvement; however it can serve as a test of change and may serve for anecdotal improvement opportunity and to engage practitioners in the value of reporting. If practitioners identify sufficient value from the voluntary process, it may serve the intent of mandatory reporting. The use of the data must be most judicious in this application. Given the current practitioner distrust and associated litigation with adverse medical events, a mandatory system of reporting at this juncture might serve to disengage the practitioners that are most needed in the effort to change this aspect of the health care delivery system into a safer, more effective clinical practice.

SUMMARY

To effect patient safety improvement requires creation of a statewide culture of safety, a non-punitive peer review and reporting process, effective feedback on safety issues, dissemination of ideas on patient safety, required education and training for licensed health care professions, institution of patient safety curricula in professional schools as a requirement for graduation, demonstration projects to engage the practitioner community, and aligned financial incentives for the practice of evidence-based clinical guidelines through disease management and preventive services.

CONCLUSION

For meaningful improvement in patient safety to occur, second order change will be required. This means a fundamental attitudinal shift in the practitioners understanding and use of safety related data including a willingness to share information about events. Until the practitioners feel the environment non-punitive and safe for reporting and systems are in place to effectively use the results of reporting, little change can be expected.

Again, I would like to thank the Commission for this opportunity to provide input concerning the issue of patient safety in Michigan.

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