**BCBSM AND BCN TESTIMONY TO**
**THE STATE COMMISSION ON**
**PATIENT SAFETY**
**December 1, 2004**

## A. Introduction

Blue Cross Blue Shield of MI (BCBSM) and Blue Care Network (BCN) thank the State Commission on Patient Safety (SCPS) for the opportunity to provide a health plan perspective as the State considers methods to achieve systemic improvements in the delivery of safe care to patients in all health care settings – specifically to reduce the number of preventable adverse events and near misses. BCBSM and BCN are health plans that cover 4.8 million lives in a state with a population of over 10 million people. Our mission is to provide access to high quality, affordable healthcare across the State.

Patient safety, a component of health care quality, is a critically important aspect of our mission and BCBSM and BCN look forward to working with the State of Michigan in our continuing efforts to improve patient safety.

## B. Background

In 1999, the Institute of Medicine (IOM) released an important report titled "*To Err is Human"*, which estimated that errors in hospitals alone cause as many as 98,000 patient deaths and more than one million patient injuries each year, at a cost of up to $29 billion (health and non-health care costs) each year.[1] The Committee's broad conclusion was that health care systems - not the individual health care workers - are to blame for the problem. And that the solution is to "design systems that make it hard for people to do the wrong thing and easy for people to do the right thing"[2]. The report set forth a national agenda for reducing medical errors and improving patient safety through the design of a safer health system. In its report, the Committee called for "a national commitment to achieve a threshold improvement in patient safety"[3] and proposed the development of the Center for Patient Safety within the Agency for Healthcare Research and Quality (AHRQ). To date, this center has not been created. AHRQ, however, has received additional funds to support patient safety research and the dissemination of research findings for practical applications.

In Michigan, key stakeholders responded to the IOM challenge by forming the Michigan Health and Safety Coalition (MH&SC). The MH&SC is diverse group of key healthcare stakeholders who regularly meet, on a voluntary basis, to develop systems level solutions to patient safety problems. Blue Cross Blue Shield of MI (BCBSM) has chaired and staffed the Michigan Health and Safety Coalition (MH&SC) since its inception in 2000. In addition to BCBSM, the MH&SC is comprised of physician, nurse, pharmacy, and hospital associations, employer and union groups, health plans, consumers, MPRO, and the MI

[1] [1] Institute of Medicine, *To Err is Human, Building a Safer Health System*, eds. Linda T. Kohn, Janet M. Corrigan, and Molly S. Donaldson, Washington D.C.: National Academy Press, Pg. 1, 2000.
[2] IBID, Pg. ix.
[3] IBID, Pg. 6.

Department of Community Health. The MH&SC's mission statement and fact sheet are provided as attachments to this testimony (Attachments 1 and 2).

## C. Recommendations

The IOM reported that it would be "irresponsible to expect anything less than a 50 percent reduction in errors over five years".[4] We are now at the five year point, and even though there have been sincere efforts to improve patient safety by healthcare stakeholders, there is still much work to do. To help expedite patient safety improvements across the state, BCBSM and BCN recommend the following broad strategy:

1. *The State of Michigan should create a Patient Safety Center to provide a comprehensive, centralized approach to patient safety.*

The Patient Safety Center would be charged with encouraging strategies in Michigan aimed at assuring optimal outcomes by a wide range of programs or initiatives designed to increase the safety of healthcare. Thus, if successful approaches are identified, the Commission could work to disseminate knowledge about such programs or initiatives and could help develop public policy recommendations designed to encourage their adoption. In the past five years, six states have enacted legislation supporting the creation of a state patient safety center to help address the problem.[5] The six states are Florida, Maryland, Massachusetts, New York, Oregon and Pennsylvania. These Centers are distinguished from other state public or private patient safety programs or coalitions by their authorizing legislation. The Patient Safety Centers have different governing structures, operations and activities but share similarities in their mission statements. Four of the Centers are housed within state government; two are located outside of, but have legislatively authorized affiliations with State Government. Authorizing legislation is important in describing working relationships and/or the autonomy the Center will exercise in the conduct of its work. Common roles of the Centers include educating providers about best practices to improve patient safety, fostering a culture of safety, developing collaborative relationships among patient safety stakeholders, and educating consumers about patient safety. It is highly recommended that patient safety centers be separate and distinct from state regulatory processes. A challenge is ensuring the level and reliability of funding for the Centers.

In Michigan, the Michigan Health and Safety Coalition provides a model for the State to consider.

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[4] IBID, Pg 4.

[5] State Patient Safety Centers: A new approach to promote patient safety. The Flood Tide Forum. Executive Summary. October 2004.

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In addition to creating a Patient Safety Center, BCBSM and BCN recommend that the state and other key stakeholders, including health plans, physicians and other providers of care, consumers and employer groups, focus on the following seven strategies to improve patient safety in Michigan, keeping in mind that there are no magic bullets for improving patient safety.

2. *Implement Information Technology Tools*

Implementation of information technology tools will help ensure that providers have ready access to a) health care information from the full continuum of care settings (e.g., hospitals, ambulatory care settings including physician offices, pharmacies, nursing homes) and to b) systems designed to prompt clinicians to consider evidence-based practices and patient safety alerts pertinent to each patient, at the point of care, to facilitate the provision of safe, high quality care. Examples of these tools include automated medical records, Computerized Provider Order Entry (CPOE), bar-coding, electronic prescribing with linkage to pharmacy claims datasets and automated drug safety monitors, patient laboratory values that are out of range, and clinical rates that need physician attention.

Information technology tools such as CPOE and other electronic information based approaches to embedding evidence-based guidelines into prompts and force functions at the point of care are important efforts in a comprehensive strategy to improve patient safety. Some of these tools are very expensive yet they are clearly linked with improved patient safety. In the experience of BCBSM and BCN, as health plans, we have developed several different approaches to improving patient safety in hospitals, physician offices, and community pharmacies, and other settings, and one of the biggest barriers to implementation of high technology tools is cost. And it goes beyond just the economic cost of implementing these tools. There is also a required need for a change in the culture of safety in these settings, as well as substantial training and re-engineering of clinical processes, which represent additional costs for providers.

A 2004 report prepared by eHealth Initiative, which looked at ways to reduce errors and adverse drug events in the ambulatory setting, stated that national savings from the universal adoption of electronic prescribing could be as high as $27 billion.[6] Despite the potential savings, current surveys estimate that only 5% - 18% of physicians and other clinicians are using electronic prescribing.[7] Key barriers to clinician adoption include startup costs, lack of reimbursement, and fear of reduced efficiency in the practice.[8]

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[6] Electronic Prescribing: Toward Maximum Value and Rapid Adoption. Recommendations for Optimal Design and Implementation to Improve Care, Increase Efficiency and Reduce Costs in Ambulatory Care. A Report of the Electronic Prescribing Initiative. eHealth Initiative. Washington DC. April, 2004. p 9.
[7] IBID
[8] IBID

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BCBSM is in early discussion regarding an e-prescribing strategy in Michigan. The program goal is to align physicians, employers, payers, Pharmacy Benefit Managers (PBMs), and pharmacies to improve patient safety, quality of care and cost-effectiveness. Traditionally, physicians provide a handwritten prescription to the patient, or fax/call in a prescription to the patient's pharmacy. An estimated 30% of the annual three (3) billion written prescriptions require the pharmacy dispenser to call the prescriber for clarification. In addition, adverse drug events (ADEs) can occur when there is a disconnect in the medication process. Drug utilization review (DUR) and plan design features also result in retrospective outreach to physicians.

With e-prescribing, an automated data entry system is used to generate a prescription, which is then printed, faxed, or electronically transmitted to the patient's pharmacy of choice. RxHub, a company that provides e-prescribing connectivity services, electronically links the physician who writes the prescription using "point of care" (POC) technology (available through a number of POC vendors), the pharmacy benefit managers (PBMs) who administer the prescription benefit and the pharmacy. When a physician writes a script, he/she will be able to check the member's pharmacy benefit, coverage/eligibility, clinical information (such as the health plan's formulary list) and potentially the member's medication history. Moreover, clinical considerations and plan benefit decisions can be reviewed at the point of prescribing, before the patient leaves the physician office, providing optimal delivery of care.

For employer groups, physicians, and third party payers, e-prescribing should:

- reduce expenses associated with adverse drug events,
- eliminate legibility errors associated with the prescription ordering process,
- potentially lower overall prescription costs resulting from increased use of generics and improved formulary compliance, and
- improve clinical and operational efficiency.

For pharmacies, e-prescribing would help:

- reduce pharmacy calls to physicians,
- expedite the prescription refill process,
- reduce patient wait times, and
- ensure HIPAA compliance and confidentiality.

BCBSM and BCN agree with the recommendations of the eHealth Initiative, which include the adoption and use of electronic prescribing through the deployment of appropriate incentives – both public and private. We encourage the State of Michigan to consider providing public incentives to promote adoption of electronic prescribing, to supplement incentives provided by third-party payers (i.e., reimbursement for utilization of electronic prescribing or for the information processed (Relative Value Units - RVUs), pay

for performance programs, defrayed costs, per-Rx fees). The eHealth Initiative recommended the following incentives to promote adoption of electronic prescribing:[9]

- Means to support innovation, research and training – usually provided through research grants, contracts and funding for pilot programs.
- Legislation that promotes and stimulates change, while at the same time recognizing and partially compensating for the time and effort required to realize change.
- Alignment of the incentives of all parties
- Recognition of the magnitude of benefit that can be realized if an imperfect health care system is improved.

3. *Implement Provider-led, Clinical-data-driven, Collaborative Quality Improvement Projects*

BCBSM and BCN recommend the implementation of provider-led, clinical-data-driven, collaborative quality improvement projects that are designed to identify and disseminate information about best practices among health care providers. BCBSM and BCN have been involved in several collaborative projects to establish clinical information systems/data registries that are used in the context of collaborative, inter-institutional consortia focused on quality assessment and improvement and devoted to catalyzing rapid-cycle Continuous Quality Improvement. The power of this approach has been demonstrated with the angioplasty CQI project involving 18 hospitals and their cardiologists. This project, the Blue Cross Blue Shield of Michigan Cardiovascular Consortium Angioplasty Continuous Quality Improvement Project (BMC2) has achieved dramatic reductions in rates of death and serious complications following angioplasty. BCBSM is planning to extend this model to other areas of care including general and vascular surgery, bariatric surgery, breast cancer care, and infection control. These projects clearly have the potential to improve patient safety and health care outcomes.

Specific examples include:

- BMC2 (mentioned above), an angioplasty continuous improvement project that has shown a 27% reduction in mortality within 18 partner hospitals;
- Michigan Society of Thoracic and Cardiovascular Surgeons Collaborative Quality Improvement Initiative with BCBSM and BCN;
- Collaborative Quality Improvement Initiative in Bariatric Surgery - M-Score, BCBSM and BCN; and

[9] IBID, p.15

- Michigan Health and Safety Coalition Infection Control Workgroup (MedMined) (expert panel being implemented in 4Q 2004).

4. *Implement Incentives/Pay for Performance*

BCBSM and BCN recommend the implementation of incentives/pay for performance that are designed to reward health care providers (e.g., physicians, hospitals, pharmacists) for improved outcomes related to patient safety. To make this work, performance standards and expectations for systematizing care to assure safe and high quality care must be established. Examples of BCBSM and BCN programs include the following:

- BCBSM Hospital Incentive Program: the patient safety component of the BCBSM Hospital Incentive program is currently worth 40 percent of the total incentive program (changing to 30 percent in 2005). Hospitals meeting patient safety measures related to the culture of safety in their institution, medication safety practices, National Quality Forum practices and patient safety technology receive a financial incentive;
- BCN Physician Incentive: provides incentives to physicians meeting measures related to preventive cares, pharmacy prescribing practices and member satisfaction; and
- BCBSM Physician Group Incentive Program (to be implemented in 2005): will focus on improving care of patients with selected chronic illnesses and implementing information technology to assure success in this regard.

5. *Implement voluntary, confidential, reporting, collection, analysis and dissemination of preventable adverse events and near misses using a standardized format across health care settings*

The implementation of voluntary, confidential, reporting, collection, analysis and dissemination of preventable adverse events and near misses using a standardized format across health care settings provides a mechanism to collect comparative data on the types and scope of health care errors, which can be used to implement improved safety practices. Only with standardization will data be available for aggregation, sharing and quality improvement. There is a place for a voluntary reporting system, and there are good examples of health system specific successes in Michigan using these systems, such as Trinity Health and the Veteran's Administration (VA). The healthcare industry should learn from the example of others – such as the aviation industry – and implement those reporting practices that have been proven to work. Healthcare resources are limited, and there is no reason to reinvent reporting requirements if they already exist.

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In 2002, BCBSM, as a member of the MH&SC, provided public testimony to the Institute of Medicine's (IOM's) Data Standards Committee. Key testimony included the following:

- Encourage the development of broad data standards – standards that address the structure and process of healthcare delivery in addition to clinical aspects.
- Information should be collected in such a way as to enable benchmarking by providers of care. Benchmarking is critical to enable providers to continuously improve the quality and safety of care.
- An adequate infrastructure to support data collection must exist. This means that there must be adequate access to capital by hospitals and others who will be collecting data.
- There should be administrative systems in place to ensure that data collection and review occurs in a non-punitive environment, is confidential, and has peer review protections.
- There should be a method for validating the data.

In its testimony, the following barriers to the development of reporting standards were noted:

- Existence of a punitive culture for reporting of events;
- Inability to maintain the confidentiality of the reporter;
- Multiple organizations promulgating different standards;
- Lack of standardized data fields for reports (e.g., definitions);
- Lack of peer review protections and state law restrictions, which affect the institution's ability to study adverse events;
- Lack of demonstrated safety improvements that were the result of event reporting;
- Lack of communication about what is done in response to an adverse event report; and
- Lack of infrastructure, including technology and funds to implements and continue to support data reporting related to patient safety.

The following factors were noted to help create the desired non-punitive organizational culture that was referenced earlier:

- Make it safe for people to report adverse events and near misses;
- Do not publish rates of adverse events and near misses at the individual provider level;
- Make it easy and very quick to report adverse events and near misses;

- Provide an opportunity within the event reporting system for clarification, but not alteration, of a report;
- Publicize positive changes that have occurred as a result of increased reporting of adverse events and near misses; and
- Celebrate organizations that dramatically increase reporting.

6. *Implement Medication Safety Initiatives*

BCBSM and BCN recommend the implementation of medication safety initiatives to help ensure the safe prescribing, dispensing and administration of medications across all health care settings. Many efforts have been focused on the inpatient hospital setting. BCBSM and BCN encourage an additional focus on the ambulatory care setting, including the physician office, community pharmacy, hospital outpatient and consumers. In a recent study published in the Journal of the American Pharmacists Association, researchers identified a 3.2% error rate on new prescriptions.[10] Annually, 0.1%, or 3.3 million errors are clinically significant.[11] As within the hospital setting, the key to improving patient safety is to address system issues rather than individuals. Factors that contribute to errors in the community pharmacy include: interruptions or distractions, lack of standardization, human factors, insufficient training, lighting and organization, sound-alike/look-alike drugs, poor prescribing handwriting, lack of patient counseling, workload and incomplete information. Pharmacy liability claims show that the most common types of dispensing errors is dispensing the wrong drug (49.3%), followed by wrong strength (25.9%), intellectual errors (17.1%) and wrong directions (7.7%).[12] Intellectual errors are the fastest growing type of error and are related to the clinical information pertinent to prescribing a drug for a given individual (e.g., whether a person with specific diagnosis, liver or kidney dysfunction, age, cognitive abilities, etc. should be taking a specific drug [DUR-type issues]).

Examples of hospital and community medication safety initiatives include the following:

- Identify and use standards and best practices for the safe use of drugs;
- Encourage pharmacies and hospitals to use self assessment tools (e.g., Institute for Safe Medication Practices Self Assessment Survey) to identify gaps in quality care and implement continuous quality improvement programs. BCBSM has used the Institute for Safe Medication Practices self-assessment in the hospital and pharmacy settings;

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[10] Flynn, EA, Barker, KN, Carnahan, BJ. National observational study of prescription dispensing accuracy and safety in 50 pharmacies. J AM Pharm Assoc 2003;43:191-200.
[11] IBID
[12] Pharmacists Mutual Insurance Company, 1989 – June 1997. www.phmic.com

- Provide incentives to use electronic prescribing, incorporating systematic approaches to alerting prescribers to potential, patient-specific drug-drug interactions and drug-disease concerns. Current regulations preventing the transmission of "true" electronic prescriptions (not faxes) must be addressed in Michigan (see Section C.2 for a more thorough discussion of electronic prescribing initiatives); and
- Create a new peer review process for errors that occur in the community pharmacy setting. The process used today is a punitive approach that dissuades the reporting of errors or near misses.

*7. Educate consumers*

BCBSM and BCN recommend that consumers be educated by a) sharing information on processes that may reduce future occurrences of preventable adverse events and near misses; and b) improving health literacy and communicating with low literacy patients to improve patient understanding of explanations about diagnosis and treatment options. Health literacy and communicating with low literacy patients is a major determinant of patients' understanding explanations regarding diagnosis and treatment. Michigan has close to a 50% low or no literacy rate for health information. This is a serious issue that underlies many patient safety concerns. Examples of health care literature targeted to consumers include:

- The MH&SC Web-based report that provides hospital-specific comparative information to consumers;
- The Leapfrog Group Web-based consumer reports;
- Agency for Healthcare Research and Quality (AHRQ) documents on the role of patients and providers in helping to ensure patient safety; and
- BCBSM and BCN member information provided through care management and member education programs. Information includes members in need of screening tests, abnormal lab values, drug-drug interactions, FDA recalled medications, and members with ten or more medications.

*8. Provide System-Wide Incentives*

In its testimony in 2002 to the IOM Patient Safety Data Standards Committee, BCBSM, as part of MH&SC, also discussed its position on systems level financial and non-financial incentives to improve patient safety. Key testimony included the following:

- Non-financial and financial incentives should be developed that support patient safety improvements in the state. Financing for capital expenditures, such as CPOE

require significant up-front financing. Public funding, at the state and/or federal level, will be necessary.
- Non-financial incentives are at least as important as financial incentives. The major non-financial incentive is enabling all key healthcare stakeholders to become part of the solution to critical patient safety issues. Externally developed systems that are simply imposed on those who are responsible to carry them out are bound to fail. Participation in the development of systems and the ability to have shared goals and a shared commitment to success are key.

Note: The importance of financial and non-financial incentives is also discussed in Section C.2.

In Michigan, BCBSM, BCN and the MH&SC have been able to realize quality and patient safety improvements through the collaborative efforts of key healthcare stakeholders. One successful project, called the MH&SC Hospital Referral Guidelines Project, resulted in the public dissemination of guidelines, development and implementation of a survey to assess baseline hospital performance compared to the guidelines, and release of this information to participating hospitals, health plans, and the public on the MH&SC Web site. Responses from providers throughout this project have been positive and demonstrate that non-economic incentives can produce important results. Our experience demonstrates that when providers are sitting at the table with health care plans and purchasers, and are treated as equal partners, deeper change and safer health care can result. BCBSM and BCN found that providers are very willing to be accountable for their performance and to take the lead on quality improvement and patient safety efforts.

## D. Conclusion

BCBSM and BCN thank the State Commission on Patient Safety for its work to produce a report for Michigan. We look forward to the next steps in the development of state patient safety initiatives.