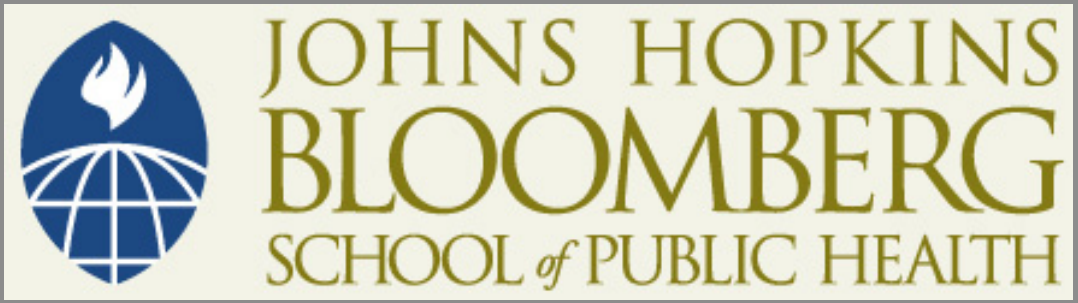

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Macrosystems: Policy, Payment, Regulation, Accreditation, and Education to Improve Safety

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Section A

Federal and State Efforts

Levels within American Healthcare

- Patient level
- Microsystems—small units of care delivery
- Organizations—house and/or support small units
- Macrosystems—influence the microsystems
  - Policy, payment, regulation, accreditation, professional education
  - Legislators, regulators, accreditors, payers, patient safety organizations, educators

Groups Contributing to Patient Safety

- Federal agencies
  - AHRQ, QuIC, FDA, IOM, VA, CMS
- Congress
- States
  - Licensing boards, health data organizations, legislatures
- Public/private partnerships
  - Leapfrog, NQF, state-based coalitions
- NGOs
  - IHI, ISMP, JCAHO, NPSF, philanthropies
- Professional and health care organizations

Federal Leadership

- Agency for Healthcare Research and Quality (AHRQ) is the lead federal agency for patient safety
- Center for Quality Improvement and Safety (CQuIPS)
- National Health Information Technology Coordinator, David Brailer (U.S. Department of Health and Human Services)

The Quality Interagency Coordination (QuIC) Taskforce

- Establish a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety
- Identify and learn from medical errors through both mandatory and voluntary reporting systems
- Raise standards and expectations for improvements in safety through the actions of oversight organizations, group purchasers, and professional groups
- Implement safe practices at the delivery level

Veterans Administration

- Universal bar coding of medications
- Electronic patient record (VISTA)
- System-wide implementation of safe practices
- Four patient safety research centers

Federal Policy

S. 544/H.R. 3205, the "Patient Safety and Quality Improvement Act of 2005"

- Establishes a confidential reporting structure for voluntary reporting of information on errors to patient safety organizations (PSOs)
- PSOs would analyze the data to develop patient safety improvement strategies
- Patient safety information confidential and legally protected

Payment Incentives?

- Centers for Medicare and Medicaid Services (CMS) launching important demonstration experiments of impact of improved payment on safety efforts
- Reward hospitals and physicians that achieve high levels of safety?
  - Central line infections, ventilator-associated pneumonia, surgical site infections

State Policy

- Efforts by states to ensure patient safety
- 21+ have mandatory reporting systems
- 30+ have some form of tort reform
- Enacted legislation creating state patient safety centers

Notes Available

Maryland Health Care Commission (MHCC)

- Patients' Safety Act of 2001 charged MHCC with studying the feasibility of developing a system to reduce the incidence of preventable adverse medical events
- Including a reporting system
- Preliminary recommendations to focus on systems, regulation, strengthening immunity protections, visibility

Pennsylvania Act 13

- The Medical Care Availability and Reduction of Error Act, signed March 20, 2002
- Requires reporting of serious events or incidents
- Provision of written notification to any patients affected by a serious event

Patient Written Notification

- Medical facilities are required to provide ***written notice*** of serious events to the patient or an adult family member ***within seven days*** of the occurrence or discovery of the occurrence of a serious event

Laws Protecting Apology

- California, Massachusetts, Texas, Colorado, Oregon legislatures passed laws allowing physicians to make statements of sympathy and condolence with the assurance that these statements would not be used against them later in court

Apology Protection

- The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident . . . shall be inadmissible as evidence of liability in a civil action

  — Section 1160, California Evidence Code (2000)

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Section B

Private Sector Efforts

Nongovernmental Organizations (NGOs)

- JCAHO
- NQF
- NPSF
- IHI
- Regional coalitions
- Public-private coalitions

National Quality Forum

- Public-private partnership to develop and improve quality measures
- Consensus process
  - Standards for mandatory reporting
  - High-impact, evidence-based safe practices
  - Taxonomy

NQF Safe Practices

- Originally published in 2002
- Thirty evidence-based safety practices
- JCAHO required hospitals to implement 11 of them in 2003 (e.g., improving patient identification, communication, surgical site verification)

Criteria for Selection

- Specificity
- Benefit
- Evidence for effectiveness
- Generalizability
- Readiness

Source: National Quality Forum. Safe practices for better healthcare: A consensus report.

Ten of Thirty NQF-Endorsed Safe Practices

- Verbal orders should be recorded whenever possible and immediately read back to the prescriber
- Use only standardized abbreviations and dose designations
- Patient care summaries should not be prepared from memory
- Implement a computerized prescriber order entry system
- Implement standardized protocols to prevent the occurrence of wrong-site procedures or wrong-patient procedures

Five More Safe Practices

- Utilize dedicated anti-thrombotic (anti-coagulation) services
- Adhere to effective methods of preventing central venous catheter-associated bloodstream infections
- Decontaminate hands prior to and after direct contact with the patient or objects immediately around the patient
- Identify all "high alert" drugs
- Dispense medications in unit-dose whenever possible

Purchasers and Payers

- Centers for Medicare and Medicaid
- Leapfrog Group

Leapfrog Group

- Purchasing consortium
- Represents 25 million lives
- 65 Fortune 500 companies
- Purchasing specifications

Purchasing Principles

- Educate and inform enrollees
- Compare at the provider level
- Reward superior provider value
  - Patient volume
  - Pay for performance
  - Public recognition
- Initially highlighted three tangible safety leaps

Leapfrog Purchaser Strategy

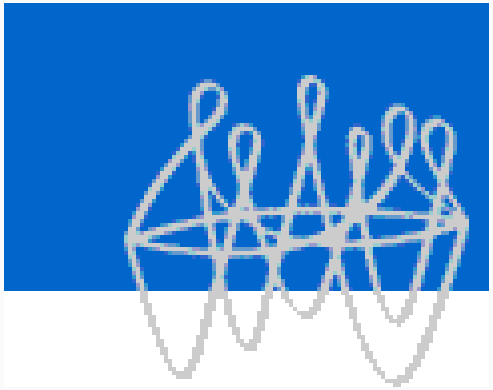
- Organized effort to buy right
  - Purchasing principles that strongly reward higher provider value
  - Purchaser accountability
    - Create a business case for providers
- Emphasize tangible safety leaps
  - Mobilize consumers and patients

Initial Safety "Leaps"

- An Rx for Rx
  - Computer physician order entry (CPOE)
- Practice makes perfect
  - Evidence-based hospital referral (EHR)
- Sick people need special care
  - ICU daytime staffing with CCM-trained physicians
- Fourth leap = NQF safe practices

National Patient Safety Foundation

- Nationally recognized forum
- Annual conference



www.npsf.org

IHI.org | A resource from the Institute for Healthcare Improvement

- Redesign systems for safety
- Demonstration projects
- Training
- Trigger tools

Statewide Patient Safety Coalitions

- In 17 states
- Diverse public/private memberships, including patients, professionals, and institutions
- Most mature: Arkansas, Georgia, Massachusetts (1998), Minnesota, Pennsylvania, Virginia, Wisconsin
- Laboratories for safety and quality improvement

Massachusetts Coalition for the Prevention of Medical Errors

Professions

- Work hour limitations
- Accreditation Council on Graduate Medical Education (ACGME)
- Defining competencies for resident physicians