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The Award-winning Journal of the Michigan Osteopathic Association

Spring 2007, Volume 18, Number 2

Patient Safety

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Safe Harbors, Smoother Waters Ahead

for Michigan Patients, Physicians & Hospitals

by Chris Henning

Alexander Pope said it first: To err is human.

Centuries later, the Institute of Medicine (IOM) repeated it, loudly and clearly, in its 1999 groundbreaking report, "To Err Is Human: Building a Safer Health System." Between those two nearly identical yet unrelated pronouncements? Too many medical miscues, too many costly mistakes, and too much grief and heartache to measure. IOM's landmark study suggests there are as many as 44,000 to 98,000 *preventable* deaths and 1 million injuries occurring annually in our nation's hospitals and health care facilities.

While the toll of medical error unveiled in the IOM report was staggering both to those inside and beyond the health care arena, there also could be heard almost a collective sigh of relief from health care practitioners nationwide. How so? Because for all the adverse events occurring daily, the industry is weighted on the side of good, ordinary people trying to do extraordinary things in sometimes less-than-optimal conditions. But the system itself is rife with constraints that make it near impossible to do anything about errors or potential errors, short of a career-ending confession.

Besides exposing the inevitability of human error and imperfect science, the IOM report brought into the open the opportunity to examine what practitioners knew was there all along: the inherent problems of a complex system supported by intricate processes ultimately designed to help people – which sometimes hurts them. And with the IOM report seeing the light of day, organizations such as the Michigan Osteopathic Association (MOA) are taking the lead to reduce errors and create a "safe harbor" for patients and practitioners alike. "We have to move beyond the advice of attorneys to be silent about mistakes," says Dennis Paradis, executive director, MOA. "We're going to do the right thing at the right time and for the right reason." Sometimes, he says, that may be against the caution of legal advice – clearly a departure from the "way things were."

medical liability climate works against that. There is a need to create a safe harbor where this information can be exchanged without fear of being punished."

The airline industry is just one place where the creation of a safe harbor has allowed open reporting. Confidentiality was protected; workers were encouraged to report "near-misses" as well as any breakdown in systems; and accidents and "near misses" were reduced.

Nearly 20 years ago, the field of anesthesia took the lead and tackled medical errors on its own, in reaction to the number of deaths in the field as a result of anesthesia. The "revolution," as it was called, resulted in the development and usage of a medical device known as the "oxygen pulseoximeter," which determines whether a patient is receiving proper oxygen during surgery and that it is flowing properly so that the patient will awaken post surgery. The device greatly improved patient outcomes, but equally important to note from this example is the fact that physicians led the initiative of their own volition.

But other than these watermark instances, and what's occurring presently as a result of the IOM study and groups such as the Michigan Health and Safety Coalition (MH&SC), liability issues remain an obstacle to "fixing" broken systems in the health care industry, says Paradis. Not an impossible obstacle to overcome, but one, nonetheless, to consider in creating a culture of safety.

Design systems that make it hard for people to do the wrong thing and easy to do the right thing.

How are hospitals and physicians responding?

With open arms and open minds, says Paradis.

"Hospitals are providing more than lip service," he notes, "and physicians have taken up the challenge. Frankly, there's less animosity when someone steps up."

Creating a culture where practitioners can safely report medical errors, preventable adverse events, or "near misses" doesn't "absolve" a physician, for example, of liability, explains Paradis. Some errors will still lay the groundwork for lawsuits. These are some of the waves in the safe harbor to be calmed: how to diminish liability concerns while still creating a supportive, confidential and voluntary reporting system. "We want to have a meaningful system, one that is designed to improve patient safety and outcomes, not one that is designed to determine guilt."

"If you're going to detect and prevent mistakes in any system," says Paradis, "you have to be willing to talk about them, to share what you know has happened. The

"We need an environment, a culture where everybody can report when there is an accident or near-accident. By compiling information, we can self-educate and learn where we can avoid mistakes."

Paradis already had a seat around a table of "safe harbor" advocates within a month of the IOM report when he, along with representatives from Blue Cross Blue Shield of Michigan (BCBSM) and the Michigan Association of Health Plans: provider associations including the Michigan Health & Hospital Association (MHA), the Michigan State Medical Society (MSMS), the Michigan Nurses Association (MNA), the Michigan Pharmacists Association (MPA); employer groups including Daimler Chrysler, Ford Motor Company, General Motors, MESSA; and the International Union, UAW, in a meeting chaired with William C. Richards, Chair of the IOA Committee on Quality of Health Care in America and CEO of the W. K. Kellogg Foundation, did a walk-through on issues surrounding patient

safety as identified in the IOM report. That signaled the beginning of the MH&SC.

In 2004, Gov. Jennifer Granholm named the MH&SC to serve as the Michigan State Commission on Patient Safety and charged the group with identifying means to improve patient safety and reduce medical errors in the state. The group spent a year collecting testimony and preparing a report, which was given to the Governor in November 2005.

Diane Valade, director of the MH&SC and a loaned executive from BCBSM, was key to advancing the commission's initiatives. Stakeholders around the larger table – consumers from throughout Michigan, legislators, payers, regulating bodies, quality reporting agencies, among others – are making headway in changing minds and mindsets.

"One of the things we heard during public forums," she says, "was that people who suffer an adverse event aren't necessarily interested in suing. When they receive care and something goes wrong, they want organizations to be honest about it – when something happens, the hospital shares that information so it doesn't happen to somebody else."

The public forums, the coalition's work and, ultimately, the recommendations the group presented back to the Governor and legislature kept central one key issue: patient health and safety isn't about individuals who want to do bad, it's about systems that aren't perfect. "We're trying, through this process," she explains, "to create more perfect systems so the possibility of errors is reduced."

And in the seven years since the IOM report?

"It's been a learning process," says Valade. But one, she notes, that's come with notable advances and some pleasant – and meaningful – surprises.

Initially, for example, the coalition developed patient safety guidelines for several areas of care, including Intensive Care Units (ICUs). Among recommendations: that an ICU should be run by an intensivist, 24/7, tracking patients, minute-by-minute. Evidence showed that ICUs run by an intensivist have better outcomes, including fewer hospital-acquired infections (HAIs). HAIs are not only a severe threat to ICU patients, but also one of the most costly propositions for hospitals.

Michigan ICU physicians and nurses were convened and, subsequently, they developed an ICU toolkit that furthered the ICU guideline by focusing on process of care improvements. From there, a pilot project, run by MHA's Keystone Foundation, (see related article on page19-20) was created – a collaborative effort across hospital ICUs designed to create a culture of safety and

How can you create a culture of safety in your health care organization, medical practice or office?

- Create a system where anyone from CEO to delivery boy can raise a concern without fear of administrative retribution.
- Establish patient safety programs with defined executive responsibility.
- Focus on the system of health care, not the individual care providers, as the major cause of preventable adverse events.
- Make it safe for workers to report preventable adverse events.
- Implement voluntary, non-punitive systems for reporting and analyzing preventable adverse events.
- Assume people don't intend to do a bad job or to make an error but, given the right set of circumstances, anyone can make a mistake.
- Look past the easy answer that it was someone's fault to answer the tougher question as to why the error occurred; it is seldom a single reason.
- Create an atmosphere where staff constantly question if things can be done in a better, more efficient and safer manner.
- Never let "good enough" be good enough.
- Be relentless in the pursuit of finding ways to improve systems.
- Design systems that make it hard for people to do the wrong thing and easy to do the right thing.
- Implement proven medication safety practices.
- Provide incentives that demonstrate continuous improvement in patient safety.
- Focus performance standards for professionals on patient safety.

SOURCE: "Identifying Opportunities to Improve Patient Safety in Michigan; State Commission on Patient Safety, Michigan Health and Safety Coalition, 2005.

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web address: *www.mihealthandsafety.org*,
ICU toolkit: *www.mihealthandsafety.org/icu*

reduce HAI rates. This time, the results were staggering in a positive light: some hospitals in the study achieved a 0-percent infection rate, far beyond what anyone had anticipated – in fact, what no one thought was even possible – but clear evidence that "safe harbors" are not only possible but tremendously promising for patients, providers and payers alike.

And that promise has led to BCBSM looking to fund additional pilot studies in the ER and surgical arenas because, says Valade, "it's the right thing to do."

Never let "good enough" be good enough.

Currently, the coalition is also focusing efforts on establishing a State Center for Safe Health Care to serve as a focal point in the state and in creating PSOs – Patient Safety Organizations, "coordinating points" for voluntary reporting of preventable adverse events and near misses. Federal certification of PSOs will be required. Michigan hopes to create a model where all PSOs report to the Michigan Center for Safe Health Care, where aggregate reports can be created. Too, while reporting "sentinel" or "never" events already occurs through Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the coalition hopes to find a better way to capture the sub-level of information that will help determine what other systems or processes might have contributed to such an event so they, too, can be changed to avoid future events.

A lot of hands, a lot of time, and a lot of talent are gathered around and beyond the coalition's table, notes Valade. "The coalition can't do all the work," she says. "But we can set the stage for doing these types of collaborative projects."

No better example, or stage, than the one Doug Borruso finds himself on.

Rarely does a single issue cross party lines, line up payers and providers on the same side of the table, and deliver such promise to so many, he admits. But so it is when it comes to patient health and safety. In the last weeks of the 2006 legislative year, the House of Representatives introduced a five-bill package intended to solidify the government's seal on patient safety. There wasn't enough time to work through all the intricacies before the legislature finished, but there wasn't an empty seat in the house.

"Regardless of party affiliation," predicts Mr. Borruso, MOA Deputy Director, "all stakeholders will gather around the table and make this work the right way. This is a rather new phenomenon. What we're trying to do is of major concern, a good patient safety initiative."

A compelling initiative. No better time. And, perhaps, a new axiom: To err is human, to fix it, divine. ■

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STATE COMMISSION ON PATIENT SAFETY MICHIGAN HEALTH & SAFETY COALITION

- Blue Cross Blue Shield of Michigan
- DaimlerChrysler Corporation
- Ford Motor Corporation
- General Motors Corporation
- International Union, UAW
- Michigan Association of Health Plans
- Michigan Consumer Health Care Coalition
- Michigan Department of Community Health
- Michigan Education Special Services Association
- Michigan Health & Hospital Association
- Michigan Nurses Association
- Michigan Osteopathic Association
- MPRO
- Michigan Pharmacists Association
- Michigan State Medical Society