

Patient Safety and Error Reduction Initiatives in the State of Washington and Recommendations for Action

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Abstract:

Patient safety and the reduction of medical errors have received considerable public and professional attention in recent years. Efforts to promote safety and reduce errors have actually been underway for many years—and include legislative and non-legislative based initiatives. A variety of heretofore relatively unpublicized efforts are underway in Washington state, and the medical profession has been supportive of such efforts, although significant progress is hindered by the current tort system which perpetuates a “blame and sue, don’t tell” culture. Several avenues of further leadership for the profession and the WSMA are available, and should be pursued.

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Patient Safety and Error Reduction Initiatives in the State of Washington and Recommendations for Action

Introduction and Overview of the Patient Safety Movement

In the last few years, patient safety has become the subject of much discussion in both the health services literature and the popular media. While there have been decades of research and quality improvement efforts among a relatively small cadre of health services professionals, it is only in the past five years that patient safety has “suddenly” become a widespread concern among health care professionals, purchasers, policy makers, and the public.

The modern patient safety movement places the patient—with emphasis on taking systematic steps to avoid harm—at its center, shifting somewhat away from the prior primary focus of the quality assurance or quality improvement movements.

This white paper, prepared for the Washington State Medical - Education and Research Foundation (WSM-ERF), summarizes the transition of health care improvement from the relatively obscure domain of clinical experts to the broad-based discussions occurring nationwide about the role of patient safety in our evolving health care system. It is intended to highlight current patient safety efforts underway in Washington state, identify the major impediments to reducing errors, and provide potential avenues to improved safety in the future.

It is important that definitions of key terms be clearly identified at the outset. Terms frequently used in discussions of improving patient safety are defined as follows:

PATIENT SAFETY. The Institute of Medicine, in its 1999 landmark study, *To Err is Human: Building a Safer Health System* (National Academy of Sciences, 2000), defines patient safety as “freedom from accidental injury.” In explaining that straightforward definition, the report notes “ensuring patient safety involves the establishment of *operational systems* and *processes* that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they do occur.” (Page 211.)

The report stresses that assuring that patients are safe involves more than just the absence of errors. Safety has multiple dimensions, including the following:

- “An outlook that recognizes that health care is complex and risky and that solutions are found in the broader systems context;
- “A set of processes that identify, evaluate and minimize hazards and are continuously improving; and
- “An outcome that is manifested by fewer medical errors and minimized risk or hazard.” (Page 58.)

The IOM report also notes, “safety is only relative in that it evolves over time and, when risks do become known, they become part of the safety requirements.” (Page 57.) The National Patient Safety Foundation (NPSF) regards keeping patients safe from harm as central to quality health care. The IOM report agrees, noting that safety is one aspect of quality—where quality includes not only avoiding preventable harm but also “providing effective services to [patients] who could benefit from them and not providing ineffective or harmful services.” (Page 155.)

Dozens of national organizations are involved in patient safety efforts. While these other organizations' definitions of patient safety may vary somewhat, the IOM definition will be used because it provides a basis not only to understand patient safety, but also to regard safety as an ongoing process in complex organizations.

PREVENTABLE ADVERSE EVENTS (health care errors that cause harm). The IOM report calls health care errors that result in injury "preventable adverse events." The National Patient Safety Foundation defines a health care error as "an unintended health care outcome caused by a defect in the delivery of care to a patient. Health care errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the health care team in any health care setting." (http://www.npsf.org/html/about_npsf.html).

NEGLIGENCE. A subset of preventable adverse events rises to the legal determination of negligence. Such a determination hinges on whether "the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question." (IOM report, page 28.)

The Harvard Medical Practice Study of hospitalized patients in 1984 published in 1991, cited by the IOM report, revealed that among adverse events, 58% were attributed to errors (preventable adverse events) and 27.6% were attributed to negligence. In studies published in 1999 of adverse events in Colorado and Utah occurring in 1992, among adverse events, 53% were attributed to errors, and 29% were traceable to negligence. (Page 30.) The IOM report declares: "Although some of these cases may stem from incompetent or impaired providers, the [IOM] committee believes that many could likely have been avoided had better systems of care been in place." (Page 30.)

The issues surrounding negligence are deeply intertwined with the legal issues of malpractice and the need for tort reform; the political debate about these issues often obscures the broader goals of patient safety. Moreover, fear over the possibility of being sued even for non-negligent events has in all likelihood slowed the diffusion of safe practices.

NEAR MISSES. Not all errors result in harm. Many health systems are now recognizing that the study of "near misses" presents an important opportunity to reduce the chances of similar events. Those with voluntary reporting programs often examine near misses or errors that have caused very minimal patient harm in order to identify and remedy vulnerabilities in systems before the occurrence of harm. (IOM page 87.)

A number of health systems have expanded from a specific emphasis on eliminating causes of near misses to reducing (and ideally eliminating) all preventable adverse events.

TYPES AND EXTENT OF ERRORS. To have a significant impact, patient safety efforts must closely examine multiple, very specific causes of potential errors. The IOM report (page 3) lists the kinds of errors that resulted in medical injury in the Harvard Medical Practice Study. Some 70% of the adverse events found in this study were thought to be preventable, with the most common types of errors being technical errors (44%), diagnosis errors (17%), failure to prevent injury (12%) and errors in the use of a drug (10%). (Page 36.)

Different studies over the years have used different classification approaches (see table on page 5 as an example), but all studies agree that eliminating errors will require multi-disciplinary approaches across a wide variety of service providers and settings.

The true extent of medical errors has become the subject of some debate, often distracting attention from the efforts to improve patient safety. The IOM report estimated that 44,000 to 98,000 Americans die each year as a result of medical errors in hospitals. (Page 1.) Further, "preventable injuries from care have been estimated to affect between three to four percent of hospital patients." (Page 5.)

While some commentators have quarreled with the extrapolations used in the studies cited in the IOM report, the consensus is that whatever the precise number, major system changes are needed—and that these changes will measurably improve preventable morbidity and mortality in health care facilities and office practices.

Types of Errors

Diagnostic

- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Treatment

- Error in the performance of an operation, procedure or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

Preventive

- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up treatment

Other

- Failure of communication
- Equipment failure
- Other system failure

Source: Leape, Lucian; Lawthers, Ann G.; Brennan, Troyen A., et. al. Preventing Medical Injury. Qual Rev Bull. 19(5) :144-149, 1993.

In the past half decade health systems have begun to place considerably more emphasis on identifying and correcting systemic problems that cause patient safety problems, with a corresponding de-emphasis on simply attributing errors to just a few “bad apples.”

HISTORICAL PERSPECTIVE. A broad array of health care improvement activities have been occurring for nearly a century, ranging from the Flexner Report in 1910 through quality assurance/improvement committees at individual hospitals to academic studies to extensive health care improvement activities at individual institutions and other entities (such as Group Health Cooperative).

There have been efforts at national standardization of patient safety guidelines through the Joint Commission for the Accreditation of Hospitals (now Healthcare Organizations-JCAHO), and more recently the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and others.

Until recently, despite frequently impressive achievements, these activities generally remained the exclusive domain of health care professionals and academic experts. Most purchasers, elected officials, and the public were only dimly aware of these efforts. Quality of care in the United States was assumed to be generally excellent—except for a few “bad apples” that may or may not have resulted in malpractice awards.

In *The History of the Patient Safety Movement*, the authors write that aside from anesthesiology (see sidebar, below), patient safety received little widespread and systematic attention until the mid-to-late 1990s. Even though the 1991 Harvard Medical Practice Study found that “3.7% of hospital patients in New York State were injured due to a medical error (with two-thirds of these errors potentially being avoidable),” the study did not capture public attention.

The specialty of anesthesiology has been a leader among the medical and surgical specialties in emphasizing patient safety. As early as the 1930s, prominent anesthesiologists in the United States began to collect statistics on anesthetic morbidity and mortality. In the 1970s and into the 1980s, data collecting on the causes of anesthetic injuries intensified, partly as a result of mounting malpractice costs. In 1984, the American Society of Anesthesiologists inaugurated the Anesthesia Patient Safety program with the mission to “assure that no patient shall be harmed by the effects of anesthesia.”

<http://www.apsf.org/newsletter/1996/fall/ed-histperspective.html>

The federal government, as a purchaser (Medicare and Medicaid), began exploring quality assurance and patient safety issues with its Professional Standards Review Organizations (PSROs) in the mid-1970s. They pioneered using aggregate statistical measures, such as hospital mortality rates, as proxy measures for patient safety—but quickly discovered that such broad measures were often more confusing than helpful.

In 1974, the Washington State Medical Association (WSMA) House of Delegates voted to become involved with the new PSROs. The WSMA designated six physicians to become incorporators of a non-profit corporation, sponsored by the WSMA, to plan and develop a statewide PSRO. That organization has now evolved into what is now known as Qualis Health.

In 1986, the WSMA founded the Washington Physicians Health Program (WPHP), which is funded by physicians’ licensure fees and considered a national model for rehabilitating physicians who pose a threat to safe patient care. Physicians in the program receive help to recover from substance abuse/addiction and/or other personal problems and then to remain in recovery. More recently the WPHP has added veterinarians, podiatrists, osteopaths and dentists to its program.

The program works on contract with the Washington State Medical Quality Assurance Commission and the other health professional boards. The WPHP has had a low relapse rate, attesting to its effectiveness in rehabilitating health professionals and also ensuring that those who cannot practice safely because of relapse do not continue to do so.

Private purchasers, notably the nation’s largest corporations participating in the Washington Business Group on Health, explored ways to promote improved quality and greater patient safety in the 1980s and 1990s—but these efforts were often stymied by the lack of standardized information and an inability to address very specific local safety problems with broad national programs.

The public, however, generally remained unaware of the growing concerns over patient safety, in spite of efforts by physicians who spoke out about patient safety issues, such as Dr. Don Berwick of the Institute for Healthcare Improvement and Dr. Arnie Milstein, co-founder of The Leapfrog Group for Patient Safety.

Beginning in the late 1990s, public awareness and concern about safety issues intensified with these notable events:

- The watershed report by the Institute of Medicine, *To Err Is Human: Building a Safer Health System*, mentioned earlier, documented the extent of unnecessary death and injuries caused by preventable

errors. The report was a jolt to provider and public complacency and made patient safety a national priority. The report strongly advocates that the way to safer care is through systems improvements and abandoning the culture of blame, a result of the current tort system.

- The death of Boston Globe reporter Betsy Lehman at the prestigious Dana Farber Cancer Institute from a chemotherapy overdose helped generate extensive media exposure on the issues of patient safety—and increased understanding that there are systemic ways to prevent medical errors. The “bad apple” theory of causation for poor patient care began to crumble.
- In 1997, the National Patient Safety Foundation was launched. Founded by the American Medical Association, CNA HealthPro, 3M and Schering-Plough Corporation, it is dedicated to the measurable improvement of patient safety in the delivery of health care. It aims to serve as a “central voice,” on patient safety and “lead the transition from a culture of blame to a culture of safety.” (http://www.npsf.org/html/about_npsf.html).
- The Institute for Healthcare Improvement was founded and has become a leader in promoting aggressive reforms at all levels of the system to improve patient safety.
- The Leapfrog Group, a national coalition of extremely large employers and public payers, issued a set of patient safety guidelines in 2002 that focused on computerized pharmacy ordering in hospitals, intensive care unit staffing levels, and minimum surgical volume levels for six categories of major surgery. Locally, Boeing, state government, and the Medicare program are all active participants in the Leapfrog Group patient safety initiatives. Starting in July, Boeing employees will be paying five percent more for their care, unless they use a select number of Washington hospitals that meet Leapfrog standards.
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the major standard-setting accrediting body in health care in the United States, has become more explicitly involved in patient safety issues. In 1996 JCAHO implemented its “Sentinel Event Policy” to help health care organizations identify such events and take steps to prevent their recurrence. JCAHO defines a sentinel event as “an unexpected occurrence involving death or serious physical—including loss of limb or function—or psychological injury, or the risk thereof.”
- In July 2002, JCAHO approved its first set of six National Patient Safety Goals, with 11 related to specific requirements for improving the safety of patient care in health care organizations. In July 2003, JCAHO’s Board of Commissioners approved the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™. Compliance with this protocol is required by all accredited hospitals, ambulatory care and office-based surgery facilities as of July 1, 2004. (<http://www.jcaho.org/accredited+organizations/patient+safety/facts+about+patient+safety.htm>).
- The malpractice insurance premium explosions of the past few years have yet again focused attention on patient safety issues, along with a growing awareness of the need for systemic improvements, not an evermore-expensive legal system intent on punishing “bad apples.” Increasingly, the public and the health care system are in agreement that patient safety is too important a concern to be left to the litigation system (which, studies have indicated, has no correlation to patient safety, other than the chilling effect it has on fostering a culture leading to more tangible advancements in safety and error reduction).
- Medicare has just launched a major patient safety initiative nationwide, with demonstration projects anticipated in most large urban areas of the United States. By January 2005, Medicare will be publishing patient safety information on almost every hospital in the United States on its Web site.

The items above are just a very quick sketch of some of the more salient events that have brought patient safety to the fore. There are now so many organizations actively involved in promoting patient safety and

system change that there is a concern over the possibility of conflicting standards and requirements. Some observers believe there may be far too many cooks in this kitchen, and that competition and lack of agreement may dilute efforts to achieve dramatically better patient safety

Initiatives to Improve Patient Safety in Washington State

Physicians, hospitals, researchers and others in Washington state are active leaders in promoting and carrying out an impressive range of patient safety efforts. To date these efforts are the initiative of individual institutions and organizations and lack any overall coordination or synthesis. This section samples activities of the Washington State Medical Association, the Washington State Hospital Association and Physicians Insurance A Mutual Company, the state's largest medical liability insurer. The Case Studies section (next) details more efforts by the WSMA and highlights individual clinics and hospitals.

Initiatives of the Washington State Medical Association

With some 9,000 members, the Washington State Medical Association (WSMA) is using its position as the state's largest professional medical society representing all physicians to encourage physicians and health systems statewide to look carefully at practices that enhance the safe care of patients. Through its Patient Safety/Error Reduction Initiative, it is involved in a number of safety activities.

- The WSMA is developing and promoting a patient safety curriculum for physicians based on the curriculum developed by the Massachusetts Medical Society (MMS). The MMS curriculum contains three modules that address medical error scenarios and perspectives on patient safety; medication safety systems; and case studies with root cause analysis of adverse events. This curriculum will be offered to WSMA members the summer of 2004, via the WSMA Web site—www.wsma.org.
- The association publishes articles in its lead publication, the monthly *WSMA Reports*, featuring patient safety and quality of care initiatives. Articles have highlighted what Washington health care institutions are doing to implement the “do not use” abbreviations, among the JCAHO national Patient Safety Goals. Other articles have featured what physicians and hospitals are doing to carry out the recommendations of *Crossing the Quality Chasm*, the successor document to the Institute of Medicine's *To Err is Human*.

The WSMA publication has also covered JCAHO sentinel events; the case reporting service by the Agency for Healthcare Research and Quality (AHRQ) where physicians and others can read about and learn from “near misses” and more serious errors; the Leapfrog Group; and how to communicate errors and “bad news” to patients. *WSMA Reports* has been publishing a column in each issue for the last 25 years by William O. Robertson, MD, on malpractice cases and what can be done to prevent them.

- The WSMA posts safety information for patients on its Web site (www.wsma.org). Modeled after information developed by the Colorado Medical Society, it addresses what patients can do to enhance the safety of their own care in the hospital, at the physician's office, at the pharmacy and at home. The WSMA Web site also offers links to other patient safety resources, such as the National Patient Safety Foundation, the Agency for Healthcare Quality and Research and others.
- The WSMA is working with the Washington State Patient Safety Coalition and Washington State Hospital Association on patient safety efforts. The WSMA is a founding member of the safety coalition, and senior staff serves on the coalition steering committee. The mission of the coalition, launched in 2002, is to reduce medical errors and improve patient safety in Washington. Its goal is to become a key resource for patient safety activities in Washington. Steering committee members besides the WSMA are the Department of Health, the hospital association, the nurses association, Group Health Cooperative, Swedish Medical Center and the Washington Health Foundation. In

2003, the steering committee developed a professional conference on wrong-site surgery and also published guidelines, in print and on the WSMA Web site, to prevent wrong-site surgery; this year it is focusing on medication safety. The steering committee also endorsed a surgical site infection project initiated by QualisHealth; 11 Washington state hospitals and four Idaho hospitals participated and have demonstrated measurable improvement in using antibiotics appropriately.

- The WSMA works with Physicians Insurance (PI) to develop error reduction strategies for the outpatient setting.

As directed by its House of Delegates, the WSMA has been involved for several years on quality, patient safety and physician accountability issues, treating them as linked topics in the quest to improve care delivered to patients. As a matter of policy, the WSMA supports programs that reduce medical errors (and a reporting environment that promotes the no-fault reporting of “near misses” and errors). It also regularly provides analysis, most recently on office-based surgery, to the Medical Quality Assurance Commission, the state agency that licenses physicians. The WSMA adopted and disseminated to physicians office-based anesthesia guidelines in 2001.

Initiatives of the Washington State Hospital Association

The Washington State Hospital Association (WSHA) has been actively tracking patient safety developments and alerting its members through a variety of efforts. In addition, the WSHA is currently considering adopting a program dedicated exclusively to patient safety to support and expand on the work already being done at individual hospitals around the state. With a formal program the WSHA would be better positioned to work with other state and national organizations to eliminate duplication. The program could also better advise hospitals on how to deal with multiple, overlapping requests from outside agencies. Finally, the program could serve as a public statement about hospitals’ emphasis on patient safety. Other state hospital associations’ programs have successfully helped shape the safety discussions within their states and helped to avoid the imposition of additional, unnecessary state regulation.

The WSHA board of trustees is discussing these options, with the intention of adopting one or a combination of options.

- Help hospitals adopt JCAHO patient safety goals. The goal of this program would be to urge all Washington hospitals and all large clinics to adopt the seven national Patient Safety Goals by the end of 2006, with an initial focus on three goals by the end of 2005. WSHA would work with WSMA to jointly decide upon the priority order of the goals. Where possible, hospitals and clinics could be encouraged to follow common procedures to meet these goals, especially with other local hospitals.
- “Safe table” program. This program, building on option one above, calls for sponsoring a blame-free, non-punitive forum for sharing, studying, and learning from medical errors and near misses at Washington hospitals and clinics. WSHA would become a Coordinated Quality Improvement Program under Washington law, so that hospitals could share information without fear of disclosure.
- Patient education program. This program would seek to educate patients about the questions they should be asking their hospital and their physicians in order to make sure they receive safe care. It could also help patients better understand that good care can sometimes have unsatisfactory outcomes. The program, in collaboration with other groups working on similar programs, would develop and distribute a form, a kind of medical record, for patients to record medications; their concerns; desires for treatment; advance directives; and from whom they receive treatment.
- Sponsor a comprehensive safety program. This option calls for a forum for sharing data and information to help hospitals assess their own standing in terms of safety, and to work with hospitals on ways to improve their performance. This program would build on the proposals offered above, but

with substantially more resources. Expected activities include: a survey of hospital CEOs and key hospital staff to assess and report back to the hospital on the culture of safety within their facility; working with individual hospitals on specific strategies to address safety issues in their facility; and investigating use of state discharge data to develop additional measures of safety, with reports back to each hospital on their data along with peer hospitals.

- Electronic medical records (via the Patient Safety Institute - PSI). This option calls for promoting the adoption of a broad-based system for sharing information among hospitals, physicians, and patients using a Web-based system that provides information on patients' medications and test results.

The system could yield information that would help reduce medical errors, especially when the patient receives care in multiple settings, including hospital emergency rooms. Unlike traditional data collection and distribution systems, the PSI data-sharing system does not accumulate and store clinical information; rather it gathers data from existing sources of electronic data in a method similar to the way Google, the internet search engine, gathers information on a search topic from disparate sources.

The PSI is already working with Delaware to become the first state in the nation to provide statewide electronic access to medical information at the point of care. While the work in Delaware is being done by state agencies, in Washington the proposal is to use a collaborative approach by working through the WSHA and WSMA. The Patient Safety Institute has installed its model at Swedish, and is also working with the Bellingham health care community.

Physicians Insurance and Patient Safety

Physicians Insurance A Mutual Company (PI) offers brochures, newsletters, practice aids, self-study courses and in-person seminars to physicians to help them practice more safely and avoid malpractice claims.

Physicians Insurance is accredited by the WSMA Medical Education Committee to sponsor continuing medical education for physicians. Most workshops are designated for Category 1 credit, and all of them fulfill the risk management education requirement mandated by the Washington Health Services Act of 1993.

PI's seminars on risk management and liability cover clinical topics known to be causes of claims. For example, its three-hour workshop *Ruling Out Misdiagnosis: Evaluation and Management of Chest Pain* educated primary care physicians on timely diagnosis of myocardial infarction, aortic dissection and pulmonary embolism. Other examples include *Fetal Monitoring: Evaluation and Risk Reduction*, and *Risk Management for Anesthesia*.

The new courses—*Pulling Together: Managing Handoffs, Conflicts, and Coordination of Care*, and *A Bitter Pill to Swallow: Medication Mistakes, Missteps and Malpractice* debut in October 2004.

Throughout the year, PI staff and physician leaders meet with physicians, staff, and clinic managers at their offices to discuss specific risk management concerns. In 2003, company risk managers visited 175 offices and clinics. In addition, PI responds to approximately 20 telephone calls per day concerning risk management issues.

PI gives each new physician policyholder a package of material including a *Physicians Risk Management Reference Manual*, samples of practice aids and brochures, and an explanation of PI's risk management services. For some specialties, PI also provides a copy of the *Timely Detection of Cancer* manual or *Minimizing Obstetrical Risk* manual. All risk management materials are also available to clinic managers and allied health care professionals who request them. Additionally, most of these materials are available on the PI Web site, at www.phyins.com.

Since its founding by WSMA in 1982, PI has sponsored the monthly column in WSMA Reports by William O. Robertson, MD, that covers malpractice incidents and offers suggestions for care improvement.

Case Studies

This section describes some of the many patient safety programs currently underway in Washington. The section begins with a roundtable discussion of the patient safety and error reduction strategies among the 41-member board of trustees of the WSMA in November 2003. These physicians, in organizations small and large across the state, are taking steps to improve patient safety. In the rest of this section is a sampling of individual clinics and hospitals that are developing and implementing innovative programs to improve patient safety and reduce errors.

Roundtable Discussion, WSMA Board of Trustees, November 2003

At the November 2003 meeting of the WSMA Board of Trustees, members participated in a discussion about steps they have taken in their own practices, clinics or hospitals over the past two years to improve patient safety and reduce errors. They also offered numerous suggestions on what the WSMA could do to further promote patient safety and error reduction.

A number of physicians commented that the goal of error reduction has become an accepted part of these physicians' practices; however, they also repeatedly cited the critical need to foster an atmosphere in all health care organizations to report and discuss near misses to improve care. A shortage of standardized data on particular procedures and quality issues was decried.

Physicians in two- to four-person to larger groups described regular evaluations and actions in their practices to improve safety. Prominently mentioned were incorporating electronic medical records, using clinical protocols for their diabetic patients and instituting rigorous review of third-party dictation. Others described reviewing prescriptions written in their emergency departments and the desire to use in the office prescription-writing programs and pre-printed prescriptions (for certain conditions) that have proven to improve accuracy and reduce errors.

In connection with implementing a number of desirable improvements, many cited cost as a significant barrier, as well as staff already too busy with day-to-day practice.

Among the most popular suggestions for further action by the WSMA:

- The WSMA should educate and communicate with physicians on the issue of patient safety, including highlighting particularly effective strategies.
- The WSMA should promote, in a positive way, the work of the Washington State Patient Safety Coalition, and help shift its focus to office-based practices. The Patient Safety Coalition could be used as a vehicle to promote a culture of safety and evidence-based medicine. In line with that, the WSMA could continue to promote the national Patient Safety Goals of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
- The WSMA should support the reporting of near misses to a non-discoverable forum where physicians could all learn from these incidents, seeking legislation, if needed, to make that possible.
- The WSMA should first survey on the use of electronic medical records and then take steps to leverage the use of electronic medical records and also community-based records. Both would help better coordinate patient care, particularly the hand-offs between physicians.

- The WSMA should work to improve the environment of physician practices—whether by working with insurers for better reimbursement and/or better data—to allow time, funds and up-to-date information on patient safety. The harried and pressure-filled atmosphere that many physicians work in is not conducive to optimal care. Insurers could share prescription data with physicians on a real-time basis to improve safety.

The Everett Clinic, Everett, Washington 1,200 employees; more than 210 physicians and other providers

The stated “core values” of The Everett Clinic include “doing what is right for each patient.” Influenced by *To Err is Human* and subsequent discussions about patient safety throughout the country, in 2001 the clinic’s leadership decided that, based on those core values, the clinic needed to take specific steps to address safety issues. The clinic strives to be a highly reliable organization; its leaders recognized that other such organizations were now talking about safety separately from quality.

Richard J. Rafoth, MD, gastroenterologist and associate medical director for quality, is leading the effort to change the culture of The Everett Clinic to emphasize safety. Taking a page from the Federal Aviation Administration/airline model, employees, including physicians, are encouraged to report problems for the purpose of making care safer, without fear of penalty or backlash. “It’s everybody’s responsibility to report,” said Dr. Rafoth.

The clinic has developed a simple intranet-based reporting system that takes an employee no more than 30 seconds to access and type in a three to four-line report about what he or she has observed. “We needed an easy way to report,” said Dr. Rafoth. He tracks, analyzes and follows up on these messages, makes changes, and reports back to the employee if requested to do so.

The clinic set up meetings with groups of employees, from small groups of 1-2 people to larger groups of 15-20, to let them know that reporting is regarded as a positive step because it can lead to safer care. The clinic stressed how important it was for all employees to tell what they know when things aren’t going right. It delivered the same messages in articles in its employee newsletter.

The clinic board of directors revised a clinic policy to make it explicit that unless an employee is under the influence of controlled substances or engaged in illegal activity, the reports cannot be used against them. It publicized the policy revision and persuaded the human resource department that the policy is a wise one. “It removes the fear factor,” said Dr. Rafoth. “But there’s a certain level of paranoia in all organizations and also the attitude that ‘you want us to rat on our fellow employees.’” Building a track record month by month is helping change attitudes.

The reports come under the clinic’s state-qualified quality improvement program—legislation to create the program was supported by the WSMA—and are not discoverable.

Dr. Rafoth has received reports on late radiology reports, lab values sent to the wrong place, the improper filling out of data sheets, and interpreters not showing up for scheduled appointments. He recently received a report from a float nurse who wrote that the sharps container on the back of a door was a potential hazard (a person almost got stuck). The clinic moved the container.

More than 90% of the concerns raised are systems issues, he noted. “They’re about the way we do our work.” He and a quality improvement employee read the reports and decide which department should address them. If it is a “medications” issue, it goes to one of the clinical pharmacists. The pharmacists have the authority to work with physicians to improve processes.

In the second quarter of 2003, Dr. Rafoth received seven reports. In the first quarter of 2004, he received 131. His goal is to have 600-700 reports per quarter. He is beginning to analyze the reports for clusters or patterns of problems. Over the next three to five years, he expects the clinic's malpractice exposure to decrease. "If I'm successful, it has to," he said. "It really is about changing the culture. You say the same message over and over and then you walk the talk."

Virginia Mason Medical Center, Seattle, Washington
5000 staff members; more than 365 physicians

Some three years ago Virginia Mason Medical Center (VMMC) embraced the management philosophy of "lean thinking," pioneered and applied by Toyota in its production system. Michael G. Glenn, MD, chief of surgery at VMMC and a member of the Washington State Patient Safety Coalition, explained that lean thinking is fundamentally about eliminating waste and improving quality. "We think that when we eliminate waste we make patient care safer," he said.

In one operational aspect of lean thinking, the medical center runs frequent week-long "rapid process improvement workshops," attended by physicians, other staff, and in some cases, patients who offer their perspective. One of the goals in every workshop is the reduction or elimination of defects. Workshop participants focus on developing "standard work," i.e., a detailed description of the safest, most efficient, and most reproducible way to perform a given task. During the week of the workshop, the group attempts to simultaneously carry out improvements. Groups often shorten or simplify complex processes that result in a simpler and safer system of care delivery. To ensure that employees engage in such "change" work, the medical center has promised that employees won't "improve" themselves out of a job.

When processes are simplified, "it becomes more obvious when problems or mistakes do occur, and they are easier to correct in real time, before they become 'defects,'" said Dr. Glenn. He and others involved in the workshops are working to extend improvements made via the workshops to all medical center departments. Ultimately, every aspect of the hospital and clinic's processes will be evaluated through the prism of lean thinking.

The medical center leadership believes that care must be safe 100% of the time. That doesn't mean that mistakes don't happen. It does mean "you don't send something along the [production] line until it's fixed," said Dr. Glenn. "That's how lean thinking at Toyota is applied. We're trying to adapt that philosophy to health care. Every provider needs to be an 'inspector,' as well as a deliverer of care."

The medical center also uses "patient safety alerts" (PSAs) to encourage employees to improve care. If an employee notices something unsafe or a process that hasn't gone well, he or she can initiate a PSA by notifying the Office of Patient Safety (formerly the Office of Risk Management), either by filling out a form on-line or by telling their supervisor or manager. The organization's traditional quality improvement (QI) program has essentially been rolled into the PSA program.

As an example, said Dr. Glenn, if patients experience an increased rate of complications from their IVs, "we would immediately try to figure out the root cause and make the necessary changes. The person who called this to our attention would not be hassled. Instead, we would celebrate that individual and thank him or her for making patient care safer. Basically, the idea is to create a culture of safety and get away from a culture of blame. We want everybody to be empowered to speak up."

It's too early to see an impact on malpractice claims, he said. "Our primary goal is to make health care safer. If we have a safer environment, we'll have fewer incidents; fewer claims will be a welcome side effect."

***Wenatchee Valley Medical Center, Wenatchee Washington
1170 employees and 170 physicians in seven clinics throughout North Central Washington***

The Wenatchee Valley Medical Center soon will begin using an electronic prescription-writing system developed by the Everett Clinic, and now in use there. The two clinics have collaborated on a number of projects over the past decade. With the prescription-writing system, physicians will be able to electronically prescribe and send the order to the pharmacy while automatically updating the patient's computerized medical record.

The patient safety benefits are numerous: the system generates legible prescriptions; it permits the prescriber to prescribe only feasible options (i.e., the prescriber cannot prescribe for 250 milligrams if the drug comes only in a 200-milligram form); it prevents prescribing drugs to which the patient is allergic; and with planned future enhancements it will prevent prescribing incompatible drugs. It can also be programmed to check the patient's insurer's formulary to make sure the drug is covered.

William Gotthold, MD, medical informatics officer with the clinic, said, "This system is designed to reduce the incredible effort that goes into avoiding a mistake by letting the computer help."

He expects the system to decrease the clinic's exposure to errors. "If you look at just the process, you can see that the software catches 'X' number of allergy problems or drugs that interact with each other. If we don't harm patients, we won't be sued." The prescribing system should be in full use throughout the medical center by the end of 2005.

At the medical center's 20-bed hospital, nursing supervisors review all charts daily to check whether drugs are delivered appropriately and whether labs are done on time. Pharmacists also review the charts, making sure they contain all relevant information so that caregivers can make the proper assessments. Rob Pollard, pharmacy director of the medical center, said that medication errors continue to decline.

The medical center medication error work group analyzes errors reported by nurses and others and then makes system adjustments. That's helped push the error rate down, too, he said, as has modifying the hospital's formulary. For example, where there are sound-alike and look-alike drugs, one may be removed from the formulary. Tylenol #3 was taken off the formulary because of its low efficacy, high incidence of patient allergies and high incidence of gastrointestinal upset. If a physician writes a prescription for Tylenol #3, Vicodin is now the therapeutic substitution.

The medical center has expanded its computerized medical record system so that when patients are hospitalized at Central Washington Hospital, the large community hospital in Wenatchee, physicians can access both their hospital and medical center records. Dr. Richard Tucker, medical director of quality and education, said, "One of our underlying theses is that errors occur when the physician does not have all the available data at the time of taking care of patients."

Other physicians in the community can also participate in the system via an organization called Community Choice. Dr. Tucker said that emergency department physicians "have a tremendous opinion" of the system because they now have immediate access to records on many of their ED patients.

The medical center's top management supports patient safety initiatives. "Lack of patient safety is an indicator of inefficient systems," said Dr. Tucker. "Making care safer eliminates waste and drives risk down. It's better for patients, and there's every financial reason in the world to do this."

University of Washington Medical Center, Seattle, Washington ***3500 employees; 700 physicians***

Like many other hospitals and medical centers, the 1999 report *To Err is Human* by the Institute of Medicine prompted the University of Washington Medical Center in Seattle to focus more closely on patient safety, including modifying the health system's entire operating plan to explicitly stress safety and quality. "Those issues are now the strategic glue around operations," said Julie B. Duncan, RN, director of quality improvement. The health system is actively promoting a culture of safety and attempting (within the constraints of the current tort system environment) to move away from a culture of "blame and shame," she said. "It's at least a three- to five-year undertaking."

Beginning July 20, 2004, on every desktop in every clinical area of the medical center—inpatient and outpatient—will be a Web-based electronic adverse event reporting system. With a click of an icon, anyone employed at the medical center can write up a near miss, a near harm or a harm event. The system will allow real-time notification of the event to those who need to know—managers, pharmacy, risk managers, quality managers and as appropriate, clinical chiefs. Those reporting can do so anonymously if they prefer; other centers have found that only about 10% choose to remain anonymous, partly because people want to find out what's been done to address their concerns. "Overall, we're promoting the concept of reporting as a way to make improvement; it's a blame-free non-punitive tool," said Duncan.

Physicians and others can still call the risk manager if an untoward event occurs, said Duncan. "They can do whatever is most comfortable for them. We wouldn't mandate that they change that. Convenience equals compliance. But others may be more comfortable with computers."

However physicians report, they are immune from discovery under the state quality assurance and peer review statute. "We would fall on our sword and die for that statute. Being without it would be the worst possible thing," she said. Even with it, some physicians are still reluctant to report for fear of being sued, she said.

Nonetheless, other academic centers that have implemented the same reporting system are finding it useful. The product was developed by the University Health System Consortium, an organization of some 100 academic medical centers, and is currently in use by 21 medical academic centers. Said Duncan, "In some cases, there has been a 300% increase volume of reporting. And there's been more process improvement around patient safety. It's wonderful; it's a concept whose time is come. But it wouldn't work if you had a blame culture."

The medical center, following recommendations by the Institute of Medicine, has redefined its performance expectations so that senior executives, department chairpersons, service chiefs and managers are accountable for safety and quality. Safety is a "distinct and clear line item," said Duncan. "Performance is measured against it." They are now receiving regular reports, called "dashboards" on how they are doing, so they can see where they are against benchmarks and identify areas of improvement.

Employee surveys include questions about safety, as do patient surveys. Every patient is offered a brochure detailing the role the patient plays in assuring his or her safe care. For instance, the brochure states that it is permissible to ask health care workers if they have washed their hands, and it encourages patients to ask about their plan of care.

Duncan is also developing a curriculum on patient safety that will eventually be presented to the entire staff and faculty. It will cover the JCAHO seven national Patient Safety Goals and other content, such as the importance of team concepts and effective communication.

Beginning July 1, 2004, for the first time the UW has an associate director for quality, a physician. He is to be part of a new system-wide "center of clinical excellence" where individuals with expertise in quality

improvement work together with analysts with expertise in collecting and analyzing the system's clinical data. The data will include patient safety indicators, clinical outcomes, and adverse events along with service data and patient satisfaction data. The center's experts will be available to work beside and consult with individual physicians, services and departments. Duncan and the new associate medical director for quality will co-lead the center.

***Lakeshore Clinic, Bothell, Totem Lake and Kirkland, Washington
153 employees, 25 providers in family practice and internal medicine***

Creating a culture of safety and decreasing the stigma associated with reporting errors are essential to Lakeshore Clinic's efforts to make care safer for patients. Tess Morton-Trask, RN, director of operations and quality improvement, says that the clinic's seven-physician governing board has been paying steadily closer attention over the past three years to system changes that will improve patient safety and quality. The governing board oversees and supplies resources to the quality improvement committee and the safety committee; both committees are represented by a number of areas within the clinic—critical for organizational change, according to Trask.

The board also reviews the clinic's data and progress toward the goals established by these committees. The board supports physician peer review, a process of reviewing feedback and data about each provider; if a problem area is identified, a plan is developed and followed until the problem is resolved. The closer scrutiny has been driven in part by escalating malpractice premiums and a desire to minimize their malpractice exposure. "Patient safety is really a test of how our entire organization and community function," she said. "It is truly the end product of putting the patient's needs in the middle of our mission statement, and more importantly, in our actions."

Despite good risk experience, the rising cost of the clinic's malpractice premiums means that safety efforts and other needed improvements don't get as much attention as Trask would like. "We're structurally thin," she said. "We need the community to understand that we need better compensation for organizational structure. We're juggling priorities."

The clinic has had an incident reporting system for several years, which any employee can use to report an error, a near miss or something more serious. More recently, the clinic has broadened its description of what constitutes an incident to now include any event that is considered inconsistent with routine operations and expectations, no matter how small. A physician is assigned to every incident involving a patient. Said Trask, "Patients aren't sicker today. But we have realized that the results of seemingly minor actions or mishaps have fairly significant impact."

Like the other institutions presented in this report, the clinic's policy is to look at errors primarily as system problems, rather than finding an individual to blame. The reason is pragmatic. "If you have a medical assistant who comes forward to say he or she has made an error, and you fire them, no one is going to report anything for a very long time," said Trask. "You have to be very careful and cautious and not overreact to an error." Instead, the clinic performs root cause analysis—"we ask why, and why and why" to figure out what has gone awry. More often than not, the underlying cause is correctable with better orientation, more education or more supervision, for example.

Patients routinely receive a follow-up to their complaints and requests, so that they know the clinic is listening to them. About half the time, the problems have arisen because of miscommunications or misunderstanding, she said. "Once we talk with patients and explain, they're happier."

Consumer demand has played a role in helping the clinic do a better job in delivering care safely. "It's a good thing," said Trask. "When patients come, they should get their medications injected by someone skilled; they should get the right medications at the right time; and they should receive lab results that are accurate and timely."

Within the next year, the clinic will implement an electronic medical record that will help improve care in a variety of ways, including generating recall lists to assure that patients receive appropriate follow up. Said Trask, "We'll also be able to automate our medical records audits to review for quality outcomes. Having access to this data will allow us to negotiate better health plan contracts which will support our organizational infrastructure."

The clinic is also beginning to use CHILD Profile, a statewide repository of immunizations, sponsored by the Washington State Department of Health. Providers with proper clearance can access patient immunization information in a shared, secure database, including immunization histories, recommendations of immunizations needed, recall lists and mailing labels for patients who have missed immunizations, vaccine usage reports, data for practice-specific immunization assessment reports and tracking of children eligible for state-supplied vaccine. If a child changes health care providers, the new provider may access the CHILD Profile immunization registry to review the child's record.

Trask said that although CHILD Profile is a good idea for patient care, the clinic still had to work to find the staff and time to input the data into the computer. "We use it because it is another way to automate our recall. It's a really hard sell to do things that don't result in that kind of win-win," she said.

The clinic's goal is to embed quality and safety into its entire structure. "It takes two to three years to get there," she said. "We're almost there. The medical community used to think of patient safety in just the hospital. But the more care is provided in outpatient settings, the more need there is for safety in the outpatient setting."

Sacred Heart Medical Center, Spokane, Washington 3200 fulltime equivalent employees, 800 physicians on staff

In addition to standard quality improvement and patient safety activities common in any large urban hospital, Sacred Heart Medical Center in Spokane has pioneered an innovative medication administration system. Starting with just a handful of beds five years ago, the hospital now uses a bedside bar-code medication administration system throughout almost the entire 600-bed institution to ensure that the bedside clinician gives the right patient the right dose of the right drug at the right time. The bedside administration system, possibly the only one in use in the state of Washington besides the Veterans Administration, has resulted in a significant reduction in medication errors, said Michael Wilson, president and chief operating officer of Sacred Heart.

The system, developed by Bridge Medical and adapted by Sacred Heart, automates the "five rights" safety check used by hospitals. At the bedside, the Bridge Medical software prompts the nurse to bar-code scan his or her name badge; the patient identification wristband to access the patient's medication profile; and all medications to verify that the drug, patient, dose, time and route all match. These checks are done looking at bedside computer terminals, at the point-of-care just prior to the actual administration of a drug.

"If you think about ways of eliminating medication errors, you need to ask how errors occur along the way from prescribing to administration," said Wilson. "This bar code technology makes a determination at all the key points." It also permits real-time confirmation of medication orders between pharmacy and nursing, which further reduces the potential for errors.

Sacred Heart served as an "alpha-testing" testing site for Bridge Medical. Setting up the system was a multi-stage, multi-year process that involved wiring the entire medical center to its master information system; computer terminals were then installed at every bedside. The hospital trained 1700 nurses and pharmacists in how to use the system. Today, 80,000 to 90,000 medications are bar-coded each month at the medical center; about 95% of their medications are bar-coded. The other 5% are mostly in vials too physically small for bar codes to be affixed. Wilson estimated the total cost from start up in 1999 to today at \$4.5 million.

Denise Dominik, director of performance improvement, said, “We had to do a lot of work to create a system that would work, including changing how pharmacy, nursing and respiratory therapy work together. It could be transferred to any institution, but it has to be integrated into your culture and your overall information system.”

The system is essentially failsafe—as long as the staff interprets the original handwritten prescription by the physician correctly, said Dominik. (In some cases, the medical center uses preprinted orders.) Nurses’ old Kardexes—handwritten orders often in pencil—have been replaced with electronically generated medication administration records (MARs) that physicians review when they round on patients. When the hospital compared the Kardexes with the MARs, errors were much more common with the Kardexes.

The medical center is also piloting a physician order entry system for prescriptions, but has chosen to concentrate first on nursing. The hospital continues to encourage employees to report errors and near misses, and it stresses that reporters will not be penalized. Beginning about a year ago, all of the institution’s vice presidents began to make regular “safety rounds” throughout the medical center in their areas of responsibility. Employees can discuss employee or patient safety issues and this approach has been well received by staff, said Dominik.

Impediments to Improving Patient Safety and Reducing Errors

No one wants to make a mistake, especially a mistake involving patient care. Yet, inevitably, errors do happen. The title of the Institute of Medicine study, *To Err Is Human*, summarizes the dilemma and the book discusses in detail many of the reasons that errors do occur in patient care. The case studies above illustrate how some health care organizations are addressing the reasons behind errors. But improving patient safety and reducing errors are still major challenges for many facilities and practices. At least five types of impediments to improvement exist:

- The current tort system and fear of a malpractice suit and punishment
- Lack of resources
- Lack of time
- Complexity of the health care system
- Rigid clinical boundaries

THE CURRENT TORT SYSTEM AND FEAR OF A MALPRACTICE SUIT AND PUNISHMENT. Fear of punishment—a culture of blame—has traditionally kept much of the discussion about patient safety cloaked in secrecy, even as health professionals more and more recognize the many benefits of discussing and learning from errors. It would be naïve to suggest that in a society as litigious as the United States the fear of punishment is unwarranted. At all levels of the health care system, people raising concerns about errors (especially their own errors) are justifiably afraid that identification of an error could cost them their job, their license, or their medical practice.

Coordinated multiple approaches applied in a thoughtful manner offer the best hope of improving the situation over time. Meaningful tort law reform would offer a huge boost to efforts to create a culture of safety. Besides offering tangible relief, it would signal that society believes that the “game of blame” must be curtailed in order for the health system to take steps to make care safer for everyone. The creation of “safe forums” for discussion of errors and near misses among professionals across all disciplines is another important step. Changing corporate cultures—in hospitals, medical practices, and elsewhere—to promote reporting all errors and to eliminate cultures of blame is yet another important approach. Several of the case studies in this report emphasize such culture change. The elimination of fear of punishment has

the potential to fuel great improvements in patient safety in all settings, but it will be a lengthy and time-consuming process.

LACK OF RESOURCES. Despite the fact that the United States spends well over a trillion dollars each year on health care, virtually every segment of the delivery system feels strapped for resources—especially for new programs. Two of the goals of the Leapfrog Initiative illustrate the point. There is no question that computerized pharmacy ordering in hospitals significantly cuts down on prescription errors and greatly increases patient safety. Similarly, having a trained specialist physician on duty in an intensive care unit reduces response time and thus improves patient safety.

The challenge is how to pay for these improvements that compete against numerous other priorities. Ever more expensive malpractice premiums and declining third party payments—whether from commercial insurers or the government—squeeze budgets of both hospitals (especially smaller hospitals) and physician practices. In physician practices, investments in patient safety programs and safety techniques (and the staff to run them) often come directly from physician earnings. While larger group practices can spread the costs of patient safety improvements across a number of physicians, smaller groups find these types of investments impossible.

LACK OF TIME. Financial pressures on physicians, hospital staff, and other health care providers usually require them to deliver services as quickly and efficiently as possible. Concerns about physician productivity are common in virtually every medical practice in the state, and all hospital personnel are increasingly urged to do more in less time. This emphasis on speed often has a price in terms of increased error rates—people do not perform at their best over the long run when they feel constantly pressured for time. Moreover, physicians may find themselves short of time even to keep abreast of new trends and techniques in medicine. While the “need for speed” is something of a cultural staple of American society, there is no question that haste and the feeling of lack of time in a medical environment are detrimental to patient safety.

One antidote to this impediment is the process improvement and “lean thinking” concepts that streamline processes to achieve increased efficiency (see, for example, the Virginia Mason experience in the case studies section). Rather than just having pressure to “do more” in a given period of time, process re-design changes how a task or set of tasks are done to make it possible to achieve the same (or better) patient outcomes with less resources.

COMPLEXITY. One of the major impediments to improved patient safety is the complexity of the health care system itself, which has evolved over the last fifty years towards ever more physician specialization and reliance on extremely sophisticated facilities, technology and medications. The benefits of this specialization and reliance are readily apparent. Less obvious are the negative effects. Except for basic primary care, patients now often deal with dozens of health care professionals in multiple settings to receive the care they need.

Effective coordination of care and the transfer of information among these professionals and settings are a recognized problem among health professionals; some health care communities—for example, in Wenatchee and Bellingham—are working improve the transfer of information and coordination of care across multiple settings. Larger communities face a more daunting task by the sheer volume of patients, physicians, other providers and health care entities. Patients are often at a loss how to navigate through a complex labyrinth, and third-party payments are generally insufficient for the patient’s primary care physician (or anyone else) to perform this coordination role.

A major tenet of patient safety efforts, therefore, is improving the coordination of patient care throughout the system and facilitating access to common, standardized information that is focused on the patient, rather than on the individual health professionals who have collected the information. The Patient Safety

Institute's work in this area is beginning to gain ground. The Washington State Hospital Association is considering becoming more involved in this work (discussed earlier).

CLINICAL BOUNDARIES. Traditionally, the boundaries of clinical care have been rigidly defined both vertically and horizontally. The vertical integration of a “care team”—in which a physician, mid-level providers (nurse practitioners, physician assistants), nurses, medical assistants, and front-desk staff all work as partners to ensure the best possible patient experience—is increasingly a reality in the best medical practices. But progress is slow, old habits and insensitivities die hard, and the vertical barriers to communication are often a root cause when errors do occur.

The horizontal fragmentation of care into what one observer has termed “medical silos” still occurs—as the patient is passed from primary care physicians to specialists to hospitalists to surgeons in the referral process. The transfer of necessary information in the left-to-right direction is often a challenge (leading to multiple, expensive and sometimes risky, tests)—the transfer of outcome information in the right-to-left direction is usually left entirely up to the patient, even in supposedly integrated systems. These clinical boundaries are reinforced and amplified by the complexity of the system and the lack of time and resources experienced by most health care professionals. The call for creating a “patient centered” health care system is a step in beginning to create permeable boundaries in our medical culture.

All five types of impediments work together in often very tangled ways to frustrate improvements in patient safety. The financial pressures causing the first two impediments (lack of time and money) often create a sense of competition among professionals and institutions that intensifies the medical silos and thwarts sharing of best practices. Efforts to create technology solutions to surmount communication barriers can divert scarce patient safety resources from other approaches, such as buying computerized pharmacy ordering or less high-tech approaches like the slow work of changing corporate cultures.

Nonetheless, improvements in patient safety have increasingly become a high priority—and a highly visible priority—for many health care practices and institutions in Washington and across the nation. To achieve the maximum benefits from this tremendous investment of resources, enhanced coordination and information sharing among these diverse efforts appears increasingly needed. This is a role for which the medical and hospital associations, working closely together, are well suited.

Because physicians and the WSMA have historically exerted efforts on behalf of patient safety and error reduction, and despite existing impediments to fully and optimally integrating such efforts into the day-to-day provision of medical care, the following recommendations are suggested.

Avenues and Recommendations to Improve Patient Safety and Reduce Errors

Legislation

State safety legislation. The WSMA supported a bill, passed by the 2004 state legislature and signed by the governor, which has important ramifications for physicians' efforts to make patient care safer. Until House Bill 6210—“An Act Related to Peer Review Committees and Coordinated Quality Improvement Programs”—was passed, small group practices could not avail themselves of the legal advantages of an in-house quality improvement (QI) program and a state-certified quality improvement process (QIP) used by groups of at least 10 physicians. HB 6210 lowers the number of physicians to 5 in a group practice that can qualify for QIP status. QI and QIP are seen as essential by hospitals and larger group practices already using them, because they allow error reporting without fear of discovery; thorough evaluations of errors; and the application of corrections to improve care.

HB 6210 also allows hospital and medical practice QIP programs to share information among them, and the shared information is not discoverable. Organizations will be able to learn from one another in ways

that have been impossible heretofore, and it will help raise awareness of patient safety improvements across the state.

Recommendation: The WSMA and other organizations should collaborate to help make the implementation of HB 6210 as broad and effective as possible. Every small medical practice in the state should be made aware of the opportunity to qualify for QIP status and be offered help in achieving that status. The WSMA and other professional organizations could provide the necessary forum to launch the new information-sharing programs allowed under HB 6210 and could disseminate best practices. In their publications and at their meetings, professional organizations could foster an environment that promotes a culture of safety. Numerous health care organizations are already taking steps; their efforts should be applauded and disseminated—to others in the health care field, to the public and to the legislature.

The WSMA also supported House Bill 2786 (“An Act Related to Improving Health Care Professional and Health Care Facility Patient Safety Practices”), which did not pass the legislature in 2004, but deserves to in the 2005 session. The bill would establish a patient safety account to help smaller organizations (hospitals and medical practices), with fewer staff and less money, carry out safety projects. Organizations could apply for grants to carry out improvement projects. The safety account would be funded from contributions of up to 1% from malpractice settlements and awards plus an assessment on professional licensing fees and a per-bed charge from hospitals.

Recommendation: The WSMA should continue to lobby the legislature to pass this bill. The relatively insignificant amount of medical liability lawsuit settlements and awards required for funding this effort could also be publicized in media campaigns and may help influence public opinion on the overall malpractice issue if the trial lawyers oppose even this tiny financial participation toward system changes to make care safer. The association should also look at other sources of funding.

Federal safety legislation. The U.S. House of Representatives passed H.R. 663 (The Patient Safety and Quality Improvement Act) in March 2003 by a vote of 418 to 6. The Senate Health, Education, Labor and Pensions Committee unanimously passed S. 720 (same bill title) in July 2003, but no final legislation has been passed by the Senate. The WSMA has urged passage of both bills. If the two bills were reconciled and passed they would help in these ways:

- Establish a confidential, voluntary reporting system in which physicians and other providers could report information on errors to organizations known as patient safety organizations (PSOs) without fear of lawsuits or punishment.
- Allow voluntary collection and analysis of error reports, and feedback to providers on patient safety improvement strategies.
- Allow a database or a network of databases to provide interactive evidence-based management resources for providers, PSOs, and others.

The bills would *not*:

- Preempt state or federal laws that require reporting of adverse or sentinel health care events that result in serious harm or death.
- Limit or affect the availability of any information or evidence that is currently available from sources other than the PSO and information that can be collected under other laws (e.g., medical records, state reporting requirements, etc.).

Many observers have argued that national patient safety legislation, perhaps a refinement on the bills above, would be helpful in promoting a culture of safety. The database envisioned above could provide information that would lead to a variety of improvement strategies.

Recommendation: The WSMA should continue to support HR 663 and S 720, or their successors in the 109th Congress if election year politics prevent action this fall.

Physician Leadership

All clinicians want to deliver safe care. And in fact, standards and therapy are better year after year; the health system continuously sets the bar higher. Physician and hospital leaders across the state, as evidenced by the case studies in this report, are already involved in a variety of patient safety initiatives. Physicians, working within their practices or departments, influence their peers to look at care and care processes more closely for opportunities to improve.

Greg Sorensen, chair of the Patient Safety Integration Team at Swedish Medical Center in Seattle, tells stories to his colleagues about patients, from the patients' point of view, to motivate them to think carefully about what they do on a daily basis and ask themselves if they can do better. "We are moving away from the paradigm of 'that's just the way it is,' to 'why does it have to be that way?'" he said. He acknowledges the common fears around being sued and the need to change the legal environment so that discussing errors can be done without recrimination. He also recognizes that the profound complexities of the health care system mean that processes that support the detection and correction of errors, without blame, are essential.

At the same time, he tells fellow physicians, nurses, therapists and others, for health care to be safer, care must become more reliable and more consistent. Physicians are listening to the message, he and others say; as more data on clinical performance and outcomes becomes available, that message will be reinforced. In the meantime, physician practices, no matter how large or small, can develop in-house processes so that, for example, they have a standard protocol for treating diabetic patients.

Dr. Sorensen and other physician leaders proffer this advice, paraphrased from noted management consultant Edward Deming, to help transform an organization and create a culture of safety: "Transform first the individual, yourself, and then become a teacher. And don't accept the way it has been, but pull people from the old way to new and better ways of doing things."

Recommendation: The WSMA should exert leadership by offering examples of innovative approaches and techniques to physician practices to help them enhance patient safety.

As noted earlier, the case studies in this report are just samples of the many patient safety activities taking place around the state. The diversity, creativity and high priority of these patient safety efforts are reassuring, and the physicians leading such efforts are to be applauded. More such efforts can be found, and should be publicized, so that learning can take place across organizational boundaries. Most institutions and practices are essentially reinventing the wheel on patient safety as they expand their programs. Greater sharing of successes, and the ability to learn from the mistakes and false starts of others, is needed as the patient safety movement matures in Washington.

Collaborative Leadership

To be truly successful, improvements in patient safety require the collaborative efforts of all participants in the health care system: patients, physicians, hospitals, other providers, purchasers, payers and government regulators. The problems are real, the potential solutions are many, and yet the possibility of becoming bogged down in multiple conflicting approaches to improving patient safety seems quite likely. The medical profession can and should take an extremely strong leadership role in these efforts and in demanding that a coordinated approach be adopted among all the participants. Working together, physicians and hospitals can shape the debate and ensure that real breakthroughs in patient safety can be achieved in the most cost-effective way.

Recommendation: The WSMA, with other willing organizations, should continue to provide leadership for the patient safety movement in Washington state.

The WSMA should promote active medical staff participation, sharing of information and support for patient safety programs. The WSMA could partner with other organizations on such things as “safe table forums.”

There appears to be a fairly narrow window of opportunity currently open for like-minded organizations to combine their efforts and lead the patient safety movement in the right direction. Without this strong collaborative leadership role, it seems likely that within the next year or two forces outside the health care system—either payer/purchaser initiatives like the Leapfrog Group or government directives from the Centers for Medicaid and Medicare, or both—will claim the leadership position in patient safety. That result would be unfortunate.

Top-down mandates do not necessarily result in actions that are in the patient’s best interest; although patient safety is often the stated goal, cost control is a compelling competing priority. Efforts such as the JCAHO national Patient Safety Goals are already helping to set standards. Further additional imposition of rules from afar will have the effect of further complicating already complex local efforts to improve patient safety. These unfortunate scenarios can be avoided with positive and assertive leadership now from physicians.