



IMPROVING PATIENT SAFETY THROUGH INCIDENT REPORTING

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BACKGROUND AND ENVIRONMENT

- Medical errors are estimated to be the 8th leading cause of death in the United States; estimates as high as 98,000 deaths per year ¹
- Deaths due to medical errors cost the country up to \$29 billion annually in direct medical costs, lost income, and productivity¹
- Medical Errors are responsible for 30% of the price of healthcare²
- The cost of medical errors is 10 –15% of a hospital’s annual operating budget²

¹2000 Institute of Medicine report, To Err is Human: Building a Safer Health System
²Healthcare Information and Management Systems Society, *Patient Safety Primer and Fact Sheet*, 8/31/06

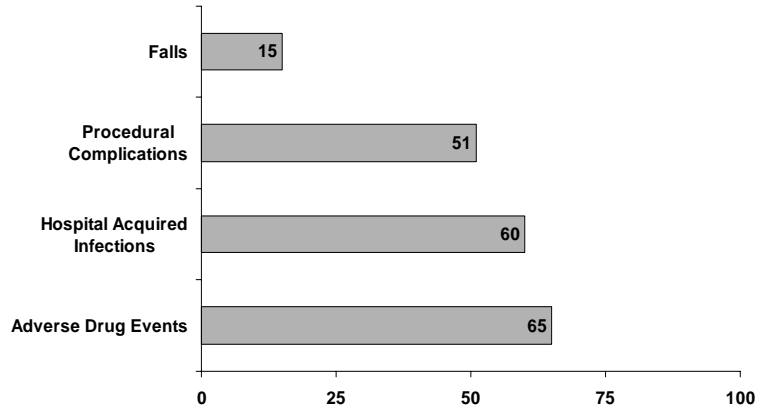


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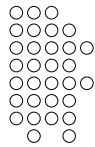
CURRENT ENVIRONMENT

Most Common Medical Errors in Hospitals (Per 1,000 Patient Visits)



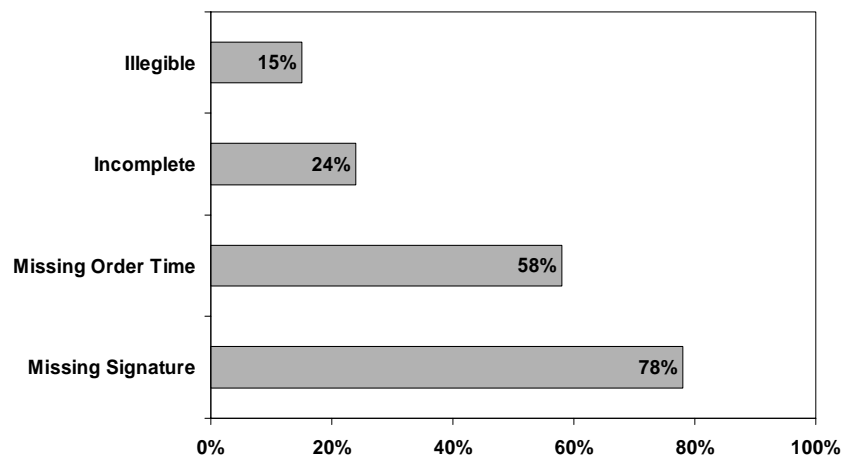
Source: Healthcare Information and Management Systems Society, Patient Safety Primer and Fact Sheet, 8/31/06

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CURRENT ENVIRONMENT

Errors Involved With Handwritten Physician Orders



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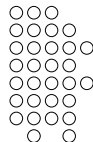
BACKGROUND AND ENVIRONMENT -- LEGISLATION

Patient Safety and Quality Improvement Act of 2005 (Public Law No. 109-41)

- Signed into law by President Bush July 29, 2005 in response to patient safety concerns
- The bill provides legal protection of information voluntarily reported to federally-certified Patient Safety Organizations (PSOs)
 - Federal government will develop and maintain the voluntary reporting system, work with PSOs to analyze data submitted through the system, and write an annual quality report based on this analysis
 - PSOs aggregate and analyze the reported information to develop strategies to improve patient safety

Source: *CRS Report for Congress, Health Care Quality: Improving Patient Safety by Promoting Medical Errors Reporting*

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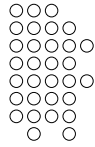
FEDERAL LEGISLATION

Patient Safety and Quality Improvement Act of 2005 (Public Law No. 109-41)

- The Patient Safety and Quality Improvement Act of 2005 addresses this recommendation and provides:
 - Full legal protection for information about medical errors that is voluntarily submitted to PSOs; accrediting bodies may not take an accreditation action against a provider based on the provider's good faith participation in reporting and cannot require a provider to reveal its communications with any PSO
 - Prevention of adverse employment action being taken against reporting individuals

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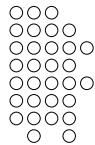


STATE LEGISLATION

- Mandatory reporting of adverse errors (injury or death) is currently required only at state level and only in certain states; 20+ states mandate medical error reporting by hospitals.

California	New Jersey
Colorado	Nevada
Connecticut	New York
Florida	Ohio
Georgia	Pennsylvania
Illinois	Rhode Island
Indiana	South Carolina
Kansas	South Dakota
Maine	Tennessee
Maryland	Texas
Massachusetts	Utah
Minnesota	Washington

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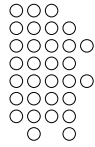
STATE LEGISLATION

- Health care providers are reluctant to report adverse events in part because of the fear that information will be used against them in malpractice litigation
- States have sought to quiet these concerns by passing laws to protect reported data from legal discovery by de-identifying data and receiving reports anonymously

Source: CRS Report for Congress, Health Care Quality: Improving Patient Safety by Promoting Medical Errors Reporting

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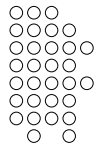


OTHER GOVERNING INFLUENCES

- The Institute of Medicine originally recommended the establishment of a national mandatory reporting system to hold health care providers accountable in cases involving serious injury or death
- The Institute of Medicine also recommended the development of voluntary, confidential systems for reporting of errors that resulted in no harm or minimal harm so that this voluntarily reported information could be used to identify trends and system problems, and develop preventative strategies

Source: CRS Report for Congress, Health Care Quality: Improving Patient Safety by Promoting Medical Errors Reporting

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REACTION IN THE HEALTH CARE INDUSTRY

- Hospitals have begun to establish incident reporting systems to compile anonymously reported patient incident data which can be easily transmitted to PSOs
- Data can be formatted for analysis, trending, and reporting to executive management

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CHARACTERISTICS OF VOLUNTARY MEDICAL ERRORS REPORTING SYSTEMS

- The American Academy of Family Physicians supported passage of the patient safety legislation and submitted principles for patient safety reporting
 - **Creating an Environment for Safety:** Non-punitive culture for reporting healthcare errors that focuses on preventing and correcting system failures, not on individual or organizational culpability
 - **Data Analysis:** Information submitted to reporting systems must be comprehensively analyzed to identify actions that would minimize the risk that the reported event could or would re-occur

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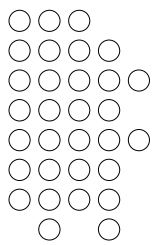
CHARACTERISTICS OF VOLUNTARY MEDICAL ERRORS REPORTING SYSTEMS

- **Confidentiality:** Confidentiality protections for patients, healthcare professionals, and health care organizations are essential to the ability of any reporting system to learn about errors and affect their reduction
- **Information Sharing:** Reporting systems should facilitate the sharing of patient safety information among health care organizations and foster confidential collaboration with other health care reporting systems
- **Legal Status of Reporting System Information:** Information developed in connection with reporting systems should be privileged for purposes of federal and state judicial proceedings in civil matters, and for purposes of federal and state administrative proceedings

Source: The American Academy of Family Physicians, "Principles for Patient Safety Reporting"



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KEY HEALTH CARE PROVIDER EXAMPLES

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VA PATIENT SAFETY INFORMATION SYSTEM

The Department of Veterans Affairs (VA)

- Manages one of the largest health care networks in the U.S.
- Recognized as a leader in the growing patient safety movement
- In 1999, VA established a National Center for Patient Safety (NCPS) to lead the agency's patient safety efforts and develop a culture of safety throughout the VA health care system
 - Developed an internal, confidential, non-punitive reporting and analysis system, the Patient Safety Information System (PSIS)
 - Permits VA employees to report both adverse events and close calls without fear of retribution

Source: CRS Report for Congress: *Health Care Quality: Improving Patient Safety by Promoting Medical Errors Reporting*

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VA PATIENT SAFETY INFORMATION SYSTEM

The Department of Veterans Affairs (VA)

- Drawing on the experience of aviation and other “high-reliability” industries, National Center for Patient Safety (NCPS) officials argue confidential, non-punitive reporting systems are key to identifying vulnerabilities and analyzing underlying systemic problems in health care
- Following Patient Safety Information System (PSIS) PSIS implementation, NCPS saw a 900-fold increase in the reporting of close calls, and a 30-fold increase in reporting of adverse events
- The PSIS now serves as a benchmark and is being used and emulated by other health care programs, nationally and internationally

Source: CRS Report for Congress: Health Care Quality: Improving Patient Safety by Promoting Medical Errors Reporting

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STANFORD HOSPITALS EVENT REPORTING SYSTEM

Stanford Hospitals and Clinics

- Created an online event reporting system well before enactment of legislation – Patient Safety Net (PSN)
- Intended for the reporting of any incidents, behaviors, practices and/or policies leading to actual or potential medical errors that may cause harm to any patient or employee
- Advantages of PSN over the prior paper-based system:
 - Fewer delays
 - Transmission to several departments simultaneously
 - Data analysis mechanism helps in identification of broad patterns of error

Source: Stanford Hospital and Clinics Medical Staff Update, Aug/Sept 2002, “Online Incident-Reporting System will Allow Hospital to Respond More Quickly, Identify Trends”

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STANFORD HOSPITALS EVENT REPORTING SYSTEM

Stanford Hospitals and Clinics

- System facilitates a more proactive approach to medical errors and other unanticipated incidents in line with quality improvement process and reinforces a culture of safety and care
- System supports employees' observation and reporting of clinical performance in a non-punitive manner
- System can be used to transmit patient safety data to the federally-certified Patient Safety Organizations (PSOs)

Source: Stanford Hospital and Clinics Medical Staff Update, Aug/Sept 2002, "Online Incident-Reporting System will Allow Hospital to Respond More Quickly, Identify Trends"

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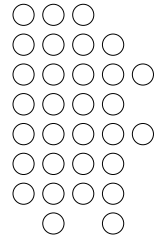


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GLOBAL COMPLIANCE CLIENT CASE STUDY