



The Pennsylvania Patient Safety Authority

How it All Began



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THE LEGISLATION (MCARE ACT)

The Pennsylvania Patient Safety Authority (Authority) has come a long way since the Medical Care Availability and Reduction of Error (MCare) Act was signed into law in March 2002. But in order to understand the Authority and its mission, it helps to know where and why the concept for the Pennsylvania Patient Safety Authority was born.

The atmosphere in late 2001 leading up to the Act created the perfect storm for something, anything, to be done to help combat escalating medical malpractice insurance rates that were causing many physicians, particularly in specialized fields, to leave Pennsylvania for better options. Also hovering was the recent report from the Institute of Medicine (IOM) "To Err is Human" that showed between 44,000 and 98,000 preventable medical errors were occurring each year in the United States. This report coupled with the increasing medical malpractice crisis led to reforms in the legal system, insurance and patient safety.

As talks began in late December 2001 as to how Pennsylvania could reduce medical malpractice costs, it was clear what the main issues were: trial lawyers argued that medical malpractice costs would not be so high if patients were not being harmed from medical mistakes, doctors made the argument that they would be forced to do business elsewhere if insurance rates and medical malpractice cases didn't subside and hospitals conceded that patient safety in healthcare facilities could be improved.

All three of these components created the discussion around the MCare Act. The core groups involved in the discussion were: the Pennsylvania Medical Society, the Hospital and HealthSystem Association of Pennsylvania (HAP), the trial lawyers and the In-

surance Federation of Pennsylvania. Legislative staff were asked to set the parameters for the discussion. The group first convened in December 2001.

For the insurance component of the bill, the MCare (Medical Care Availability and Reduction of Error) Fund was developed to help physicians pay for medical malpractice judgments and a change of venue for claims was established through the courts with an Interbranch Commission on Venue created in the Act.

These two components in dealing with medical malpractice were crucial in getting the Pennsylvania hospital association on board. Those in the room negotiating the bill acknowledged that without these medical malpractice components the patient safety chapter probably would not have made it as a standalone bill. Once the hospital association acknowledged that patient safety could be better in healthcare facilities, the discussion began as to how the Authority would work.

CONFIDENTIALITY BOOSTS REPORTING

The model used for the Authority is based upon the one used in the aviation industry. A major hurdle was determining what from the reports would be confidential, and what would not. It was decided that no names would be mentioned in the reports. The premise for this confidentiality component was the same in the aviation industry — more reports would be submitted if people were not blamed in reports because a mistake occurred. The model is based upon evidence that errors are committed because of system failures that are carried out by people, not simply people committing errors. To eliminate errors, you must fix the system. If you simply fire the person who committed the error, you're masking the problem and most likely the error will occur again, only the next time by a different person.

FUNDING FOR THE PENNSYLVANIA PATIENT SAFETY AUTHORITY

A major factor in developing the Authority was funding. It was established that hospitals would have to pay for the Authority, but the hospital association would determine how to implement the funding. Without a steady funding stream, the Authority would not be as successful in conducting its educational mission. The hospital association decided a surcharge on the number of beds per hospital and the number of procedure rooms per ambulatory surgery facility would be the fairest way to fund the Authority. The funding formula is the same used by the Pennsylvania Department of Health for licensure fees. A five million dollar annual budget was estimated by the hospital association for the Authority's annual expenditures.

REPORTING DEFINITIONS LEFT OPEN FOR INTERPRETATION

Serious Events (events that cause harm to a patient) and Incidents or near-misses (events that do not cause harm to a patient) are collected by the Authority for analysis and educational purposes. The Pennsylvania Department of Health also receives these Serious Event reports in its regulatory role, as well as reports on Infrastructure Failures (non-medical events caused by weather, crime etc.). The Authority does not receive Infrastructure Failures and the department does not receive Incident reports. The definitions for a Serious Event, Incident and Infrastructure Failure were purposely developed by the group to leave room for interpretation so facilities would report more and afford more learning opportunities. However, facilities have asked for more guidance in reporting, and the Authority is planning to work with the Pennsylvania hospital association and the Pennsylvania Department of Health to develop educational initiatives to encourage consistency in reporting.

OPENING COMMUNICATION BETWEEN PATIENT AND PROVIDER

Opening communication between patient and provider was another "must have" for developers of the legislation. Leading up to the medical malpractice crisis in 2001, it was perceived less and less communication occurred between healthcare staff and patients for fear of litigation. A provision in the MCare Act calls for patients who have experienced a Serious Event to receive a disclosure letter regarding the event. As

an acknowledgment that some clinicians are better at communicating than others, the hospitals and ambulatory surgical facilities were given the discretion as to how the letter was written and by whom. While the Serious Event letter concerned some healthcare facilities, it was another important element of the MCare Act for improving patient safety and decreasing medical malpractice costs.

LEGISLATION ENACTED INTO LAW

After round-the-clock negotiations among the groups, a bill was hammered out in mid-February and signed into law as the Medical Care Availability and Reduction of Error (MCare) Act in March 2002. This landmark piece of legislation was credited in October 2010 with decreasing medical malpractice payouts in Pennsylvania by 61% since 2003.

NEXT STEP: DEVELOPING THE PENNSYLVANIA PATIENT SAFETY AUTHORITY

Once the MCare Act became law, the development of the Authority began in deliberate stages. By law, the Authority is governed by an 11-member board.

Several of the provisions in the MCare Act, such as calling for each healthcare facility to establish a Patient Safety Committee, were already being done by many healthcare facilities. The Act served to ensure that all healthcare facilities reporting under the MCare Act established the patient safety committee and included consumer advocates.

By law, the Authority had to select contractors to develop a reporting system and analyze the data. After a lengthy bid review process, in July 2003, the Authority announced its selection of ECRI Institute to design, develop and implement Pennsylvania's statewide reporting system. ECRI partnered with EDS (now HP) and the Institute for Safe Medication Practices (ISMP) to carry out this provision in the new law. ECRI is a non-profit health services research agency. HP is a leading international information technology firm and ISMP is a nonprofit organization that specializes in analyzing medication errors.

THE PENNSYLVANIA PATIENT SAFETY REPORTING SYSTEM (PA-PSRS)

In November, 2003 the Authority initiated the Pennsylvania Patient Safety Reporting System (PA-PSRS), the most comprehensive statewide reporting system

in the country. Twenty-two healthcare facilities volunteered to participate in a preliminary test phase of the new system. After a successful test phase, the Authority conducted 19 training sessions in 11 locations throughout the state. Over 400 Pennsylvania healthcare facilities participated in the daylong demonstrations and hands-on training sessions.

In June 2004, mandatory reporting was implemented in three phases across the state. In 2009, as the result of legislation enacted in July 2007, the Authority began collecting healthcare-associated infections from over 720 Pennsylvania nursing homes through an upgraded PA-PSRS system.

To date, Pennsylvania healthcare facilities have submitted over 1.3 million reports to the Pennsylvania Patient Safety Authority, making the database one of the largest in the country.

THE PENNSYLVANIA PATIENT SAFETY ADVISORY — AVOIDING THE DATA BLACK HOLE

The Authority recognized that in order to gain the necessary buy-in from Pennsylvania healthcare facilities for reporting, it had to ensure that data collected from them would not disappear into a black hole. The primary way the Authority communicates with healthcare facilities about the significant trends identified in the reports is through the award-winning Pennsylvania Patient Safety Advisory, a quarterly research publication with periodic supplements. The Advisory is free to all subscribers, is widely distributed via e-mail, and is available at the Authority's website www.patientsafetyauthority.org. Since the first Advisory was issued in March 2004, the Authority has published nearly 350 articles on a variety of clinical issues.

Each Advisory article contains data analysis and guidance so facilities can implement process changes within their institutions. Several of the Advisory articles are accompanied by educational toolkits, so facilities have evidence-based resources at their fingertips. Some of the educational toolkit topics include: the risks of color-coded wristbands, wrong-site surgery, skin tears, verbal orders, norovirus, behavioral health patient safety, airway fires during surgery, central line associated

blood stream infection (CLABSI) risk reduction and clostridium difficile (C-diff) strategies.

While the Authority's primary objective is to improve patient safety by educating healthcare facilities about the trends seen in the data, consumer tips are developed for articles when the data shows that patient participation could have helped prevent a medical error. Over 30 consumer tips and patient brochures are also available on the Authority's website encouraging patients to participate in their own healthcare.

The Authority's website has also been enhanced to enable users to quickly search for specific topics and to forward Advisory articles more easily. The website receives over 61,000 hits monthly.

Ninety-six percent of the subscribers to the Advisory are U.S. based, with a subscriber in nearly every state. Internationally, healthcare personnel in 29 other countries have also taken advantage of the lessons learned in Pennsylvania by subscribing to the Advisory.

THE PENNSYLVANIA PATIENT SAFETY LIAISON PROGRAM

In 2007, based in part on focus groups with Pennsylvania Patient Safety Officers (PSOs), the Authority developed a strategic plan to determine its next steps for improving patient safety. A major part of the plan included developing a Patient Safety Liaison (PSL) program, providing Pennsylvania healthcare facilities with consultants to help them improve patient safety in their facilities.

Led by the director of Educational Programs, PSLs are each located in one of six regions of the state: the northeast region, south central region, northwest region, southwest region, and Delaware Valley South and Delaware Valley North regions.

To date, the PSLs have visited or reached out to each healthcare facility reporting under the MCare Act — over 535 facilities. Hundreds of PSOs have received training from presentations provided by PSLs. Topics include: MRSA, root cause analysis, Patient Safety Officer Basic Foundation Course, Beyond the Basics, mislabeling of lab specimens, patient safety leadership and insights, teamwork, human factors, highly reliable organizations (HRO), wrong-site surgery and failure mode and effects analysis (FMEA) training.

There is no charge for PSOs and other healthcare staff from the facilities to attend the sessions. Feedback from the sessions has been very positive, often requiring added sessions or generating waiting lists for participation.

Collaboratives with Pennsylvania healthcare facilities are also a major educational initiative of the Authority's and the PSLs. Currently, the Authority is working with other healthcare facilities and organizations on the following collaborative topics: mislabeled specimens, wrong-site surgery, falls, CLABSI, surgical site infections (SSI) and patient safety training for executive management and boards of trustees.

The PSL program has been fully complemented with six PSLs since May 2010. Now that the program is fully staffed and each Pennsylvania healthcare facility has its delegated PSL, the Authority has the unique opportunity to receive feedback directly from the facilities on patient safety practices in their institutions. On a daily basis, the Authority receives information through the PSL program that helps facilities break down barriers and create working environments that are conducive to a culture of safety.

PASSKEY (PATIENT SAFETY KNOWLEDGE EXCHANGE)

To open up communication among PSOs in Pennsylvania, the Patient Safety Knowledge Exchange (PassKey) initiative was developed by the Authority in June 2010. It is a confidential, electronic forum that allows PSOs to share information, ideas and solutions. Information on the site is provided by PSOs and maintained by Authority staff. The PSLs encourage facilities to post as much information as possible regarding policies and procedures that have helped them improve patient safety in their facilities. The information helps other facilities learn from their success stories or failures. PassKey also allows facilities to ask questions and search for answers that may already be provided on the site.

JOHN M. EISENBERG & CHEERS AWARDS

In 2006, the Authority received the prestigious John M. Eisenberg Award for advancing patient safety and quality in the commonwealth. Presented jointly by the Joint Commission and the National Quality Forum (NQF), the award acknowledges the

Authority's impact in patient safety on a regional and national level. The award also recognized the Authority's efforts to make the Pennsylvania Patient Safety Reporting System (PA-PSRS) into a nationally recognized resource for education and learning about patient safety.

In 2010, the Authority received the Institute for Safe Medication Practices (ISMP) "Cheers" Award. ISMP honored six individuals, organizations and companies that have set a "superlative standard for excellence for others to follow in the prevention of medication errors and adverse drug events."

THE AUTHORITY JOURNEY CONTINUES

As shown, the Authority journey has been marked with many milestones along the way. Early in the journey, a near-miss report in which a patient almost died because a healthcare worker confused the meanings of the color-coded wristband placed on his arm. That near-miss raised the awareness of the risks associated with color-coded wristbands. As a result of that one near-miss, almost 40 states have standardized their wristband colors, giving Pennsylvania credit for raising awareness of the issue and providing the tools to produce change. In 2007, the Authority brought wrong-site surgery to the forefront by announcing that its data showed wrong-site surgery actual harm and near-miss events were reported every other day in Pennsylvania, and that Pennsylvania was not alone. Since then, the Authority has developed educational tools based upon evidence-based practices and currently is working with Pennsylvania hospitals to eliminate wrong-site surgeries. With over 350 Advisory articles in its archives, the Authority has provided Pennsylvania healthcare facilities and others, nationally and internationally, with information based upon real time data and evidence-based practices to help facilities implement process changes in their facilities. Each year, PSOs make process changes (over 600 in 2009) based upon analysis and guidance provided in Pennsylvania Patient Safety Advisories.

As the PSL program and educational initiatives continue to take shape, the Authority's journey will continue with more milestones and lessons learned that ultimately will be used to reduce medical errors and improve patient safety.