

Medical Error Prevention and Patient Safety



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HealthAmerica HealthAssurance



- *Founded 1974*
- *660,000 members in Pennsylvania (and growing!) All products (Medicaid start-up)*
- *NCQA accredited with Excellent ratings on HMO, POS, M+C*
- *One of the top 15 in HEDIS in the Nation*
- *Largest plan owned and operated by Coventry Corp. (CVH)*

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First Error



*Me
working
on this
talk*

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IOM 1999



- *98,000 Deaths related to Medical Errors in hospitals each year.*
- *Cost of 37.6 Billion dollars per year*
- *17 Billion dollars are preventable*
- *Half of the Preventable errors are direct health care costs.*

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Defining the Problem



- *Errors: Agreeing on a Definition*
 - *Size and Scope depends on the constituency*
 - *There is no standard terminology*
 - *Measurement becomes problematic*
- *Error: 'failure to complete a planned action as intended or the use of a wrong plan to achieve an aim'.*
- *Not all errors result in harm.*

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Defining the Problem



'Accidents' are events that involve damage to a defined system that disrupts the ongoing or future output of that system'.

Disasters are generally made up of multiple small failures that cascade.

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Measures



- *What markers?*
- *How do you measure?*
- *'Estimated' baselines — The IOM recommended a 50% decrease by 2005*
- *'Mandatory' Reporting, Multiple States*
- *Malpractice, Failure to follow guidelines, 'regional variation'*

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Where do these fit?



- *Botched" surgery. (Disaster!)*
 - *Wrong leg amputated — the 'O-rings'*
 - *Wrong ABO type transplant*
- *Complications of Surgery (frequency? Error?)*
 - *Post operative infection — wound/pneumonia*
 - *Post operative bleeding — wound/DIC*
 - *Post operative death due to PE/MI*
 - *Return to Operating Room*

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Measures



- *Impaired physician (multiple definitions)*
- *Faulty device*
- *Good device — bad outcome (MRI)*
- *Wrong drug:*
 - *An antibiotic? Right, Wrong, Time*
 - *Really wrong drug*
 - *Not the best drug — Legionnaire's Disease*
 - *Wrong treatment with good outcome?*

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Measures?



- *Diluting chemotherapy*
- *Error in judgement*
 - *Delay in surgery?*
- *Delay in Definitive Treatment?*
- *Inadequate knowledge*
 - *Of the treatment/disease*
 - *Of the patient — Addiction, multiple physicians writing Rx., allergies, history.*

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History



- *A one year prospective survey to identify adverse outcomes due to error during care in the field of general surgery:*
- *Identified 36 cases among 5,612 surgical admissions to the Peter Bent Brigham Hospital.*
- *In 23 cases the initiating mishap had occurred in another hospital before transfer.*
- *In two thirds the mishap was due to an error of commission:*
 - *an unnecessary, defective or inappropriate operative procedure.*

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Surgery



- *Twenty patients died in hospital.*
- *Eleven deaths were directly attributable to the error.*
- *Five of the 16 survivors left the hospital with serious physical impairment.*
- *A satisfactory outcome was achieved in only 11 cases (31%).*
- *The average hospital stay was 42 days with duration ranging from one to 325 days.*
- *Total cost for the 36 patients was \$1,732, 432*

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Surgery



- *“We suggest that all hospitals develop comprehensive methods to identify and prevent these costly and unnecessary events” (THIS SOUNDS LIKE IOM!)*
- *Couch, N.P., Tilney, N.L., Rayner, A.A., Moore, F.D. (1981).The high cost of low-frequency events: the anatomy and economics of surgical mishaps. New England Journal of Medicine 11:*

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Australia 2002



- *28 hospitals, 14,179 records from 1992.*
- *The AE rate for surgical admissions was 21.9%*
- *Disability that was resolved within 12 months occurred in 83%*
- *13% had permanent disability*
- *4% resulted in death*
- *48% of Adverse Events were highly preventable*
- *The AE rate depended on the procedure and increased with age and LOS*
- *International Journal for Quality in Health Care 14:269-276 (2002)*

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United States



- *Review of malpractice claims and incident reports of retained surgical sponge or instrument filed between 1985 and 2001. (NEJM, 2003)*
- *54 patients in Massachusetts. 61 retained foreign bodies.*
- *Estimates 1/1000 to 1/1500 surgeries best guess*
- *37 required re-operation (69%), one died*
- *Factors Identified*
 - *Emergency procedures or unexpected change in procedure.*
 - *Higher body mass index*

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Where are we going?



- *There are multiple causes and factors that influence Medical Errors.*
- *No one solution will suffice*
- *Focus to date has been on hospitals*
- *Attacking the problem on multiple fronts is necessary.*
- *Even then...*

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Solution #1



- *Argue the numbers:*
 - *Defensive mode: Not a solution*
 - *The IOM report numbers*
 - *Assumptions, Extrapolations, Data validation*
 - *Bias (Hindsight Bias)*
 - *Documents — Medical Records*

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Where are we going?



- *Legal and Regulatory — Reporting*
- *Associations — Encouraging*
- *Industry — Requiring*
 - *Leapfrog Group recommendations*
 - *Direct physician order entry*
 - *ICU staffing*
 - *Evidence based referrals*
- *Carriers — In the middle*

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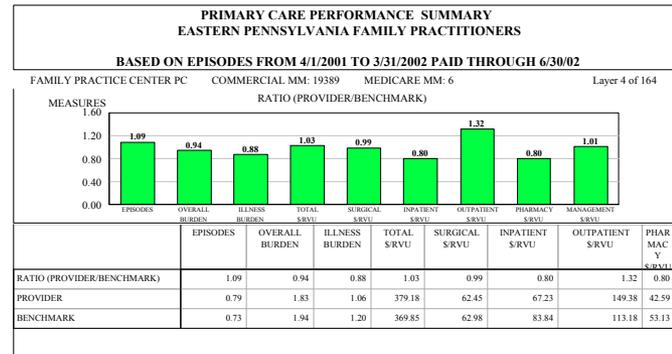
- *Initial contact with all of our provider facilities — What are you doing? Specifically in relation to the Leapfrog group recommendations and other safety initiatives (2000):*
 - *We have a QI committee*
 - *No response*
 - *Extensive response with plans.*

- *Direct physician order entry*
 - *Not in budget*
 - *No “A” system identified*
 - *Looking into it*
- *ICU staffing*
 - *Not in budget, not the way medicine is practiced in our community (rice bowl approach)*
- *Centers of excellence (see our contract)*

- *Organization of forums for discussion*
 - *Pennsylvania Medical Society, Hospital Association of Pennsylvania*
 - *Physician General*
 - *Managed Care Association*
 - *National Committee for Quality Assurance*
 - *PaHC4*
 - *Pittsburgh Regional Healthcare Initiative*
- *Outcomes: Dialogue ongoing, Support for initiatives.*

- *Development of individual constituency forums. Role of Education and Input*
 - *Provider Advisory Council*
 - *Broker Advisory Council*
 - *Facility Advisory Council*
 - *Employer Advisory Council*

- *Educate*
 - *White paper on Medical Errors*
 - *Web site and newsletter support for patient safety initiative “Tips to prevent Med Errors”*
 - *Agency for Healthcare Research and Quality*
- *Physician residency rotation in Quality and Managed Care*
- *Physician profiling system*



- *Credentialing — One 'problem' at a time?*
- *Quality improvement program — tracking and trending incidents and occurrences.*
 - *Numbers?*
- *Payment incentives? Incenting good quality*
- *Not paying for poor quality.*
- *Guideline dissemination — Does anybody read them?*

- *Another Query to all facilities as to the willingness to participate in the Leapfrog group error reporting. (2002)*
 - *Thinking about it*
 - *It isn't here yet*
 - *No response*

Conclusion



- *I have more questions for you than answers*
- *Attacking Medical Errors on multiple fronts seems to be the best tactic*
- *Substantial improvement will not be forthcoming without patient involvement*
- *The Leapfrog group initiatives need to be continually pushed*
- *The 50% reduction by 2004 seems Herculean*

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Conclusion



*'It is a mistake to confuse activity
with progress'*

We have a long way to go.

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Finished!

