



buyers health care action group

BHCAG

Report on Hospital Patient Safety

January 2009



BHCAG and Hospital Patient Safety

Hospital patient safety is one of the most important priorities for BHCAG and its members. The coalition aims to hold providers to the highest standards of transparency and quality and has been a regional leader in the area of hospital patient safety for nearly 10 years. BHCAG primarily focuses on two specific initiatives – the Leapfrog Hospital Survey and Adverse Events Reporting – to further its goals for hospital patient safety.

BHCAG became a founding “frog” of the Leapfrog Group when it was formed in November 2000. The 1999 report by the Institute of Medicine provided Leapfrog with its initial focus – reducing preventable medical mistakes. The IOM report recommended that employers, as purchasers of health care, provide more market reinforcement for the quality and safety of health care. BHCAG is the regional representative for the Leapfrog Group, and disseminates the annual Leapfrog Hospital Survey in the state of Minnesota. In 2003, BHCAG supported new state legislation around Adverse Events Reporting and provided funding to assist the Minnesota Department of Health (MDH) in designing the reporting protocols. BHCAG participates in the Minnesota Alliance for Patient Safety, a multi-stakeholder partnership focused on improving the culture for patient safety and mobilizing community resources to improve patient safety. Though there are many other patient safety initiatives, BHCAG has determined these two initiatives to be of greatest interest and relevance to purchasers.

This report highlights the results of the 2008 Leapfrog Hospital Survey for Minnesota hospitals and summarizes the findings from the Minnesota Department of Health’s most recent Adverse Health Report released in January 2009. It also gives purchasers recommendations on how to use this information to influence the quality of health care and improve hospital patient safety.



What is The Leapfrog Group?

The Leapfrog Group is an employer driven initiative. Its members are comprised of major companies and other large private and public health care purchasers who provide coverage to more than 37 million Americans in all 50 states. The goal of its members is to “trigger giant leaps in the safety, quality and affordability of health care.” BHCAG uses The Leapfrog Group’s Hospital Survey to assess hospital patient safety.

The Leapfrog Hospital Survey

The Leapfrog Hospital Survey was introduced in 2001. Four “leaps” were identified to be part of the initial survey:

Computerized Physician Order Entry: Physicians order prescriptions through an electronic, versus paper, system.

ICU Physician Staffing: The ICU has a physician on staff at all times.

Evidence-based Hospital Referral: Referrals are made based on the number of procedures a hospital performs each year, giving patients access to the most experienced providers possible. The following procedures are included: Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Aortic Valve Replacement, Abdominal Aortic Aneurysm, Pancreatectomy, Esophagectomy, Bariatric Surgery and High Risk Deliveries.

Safe Practices Score: Hospital adheres to the National Quality Forum’s Safe Practices for Better Healthcare.

These leaps meet four important criteria:

1. There is scientific evidence that their implementation would significantly reduce preventable mistakes.

2. Implementation by health care providers is feasible in a short period of time.
3. Consumers can appreciate their value.
4. Health plans, purchasers and/or consumers can easily ascertain their presence or absence when assessing health care providers.

Over time, the survey has grown to include:

Efficiency of Care: Hospitals meet standards for efficiency, quality and resource use when treating Acute Myocardial Infarction, Pneumonia, Coronary Artery Bypass Graft and Pancreatectomy.

Hospital Acquired Conditions: Hospitals measure the rates of pressure ulcers and injuries that were not present on admission.

Never Events Policy: Hospital adherence to Leapfrog’s policy on Never Events.

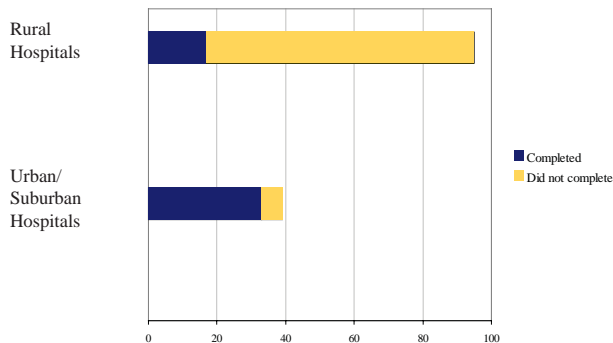
BHCAG introduced the Leapfrog Hospital Survey to Minnesota in 2001. The state was one of six regions to first roll out the initiative. Working in partnership with the Minnesota Hospital Association, there was agreement that all hospitals would complete the survey.

The Leapfrog Group now surveys over 1300 hospitals in 37 regions of the United States to measure their progress on “leaps” that improve the quality and efficiency of care, and, if fully implemented, would save lives and reduce serious harm to patients. In addition to measuring high-level quality and efficiency, adoption of these standards in hospital care would decrease the number of “never events”, also called adverse events, occurring in hospitals. BHCAG continues to distribute the survey annually and monitor hospital participation and improvement in Minnesota.



2008 Survey Results

In 2008, 33 out of 39 urban/suburban hospitals and 17 out of 95 rural hospitals completed the 2008 Leapfrog survey in Minnesota.



The graph below shows the percentage of Minnesota hospitals that fully met Leapfrog’s seven leaps. Not all of the standards described in the previous section apply to every hospital, and the chart reflects the percentage of hospitals achieving standards that *did* apply to them. For more information on the performance of individual hospitals, visit Leapfrog’s website at www.leapfroggroup.org.

While many hospitals may be in the process of meeting leaps, less than 50% of hospitals fully met the requirements identified by Leapfrog for most leaps. This low

percentage is of particular concern considering the fact that hospitals have been reporting on several of these leaps since 2001 and still little improvement has been made at many hospitals.

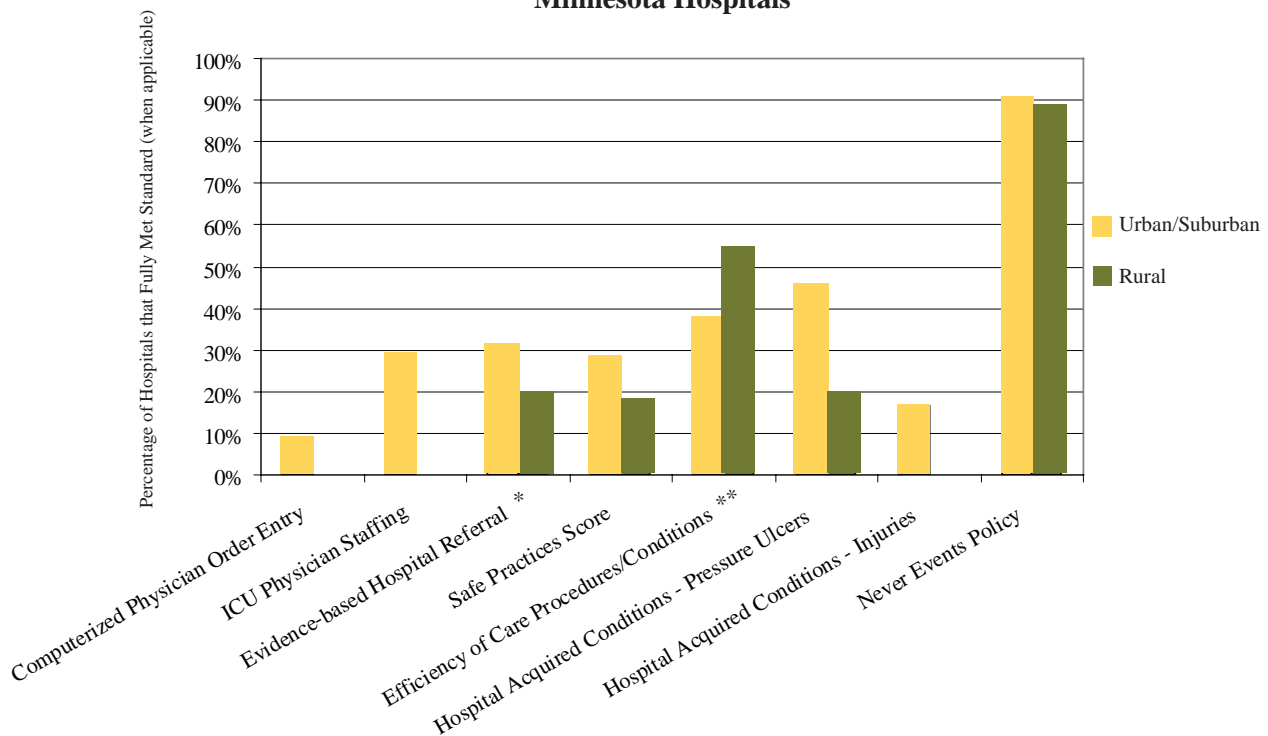
Providers and stakeholders must seek to understand what lies behind the scores in order to make positive change. One of the ways hospitals can improve is to learn from the best practices of top-performing hospitals. In addition to learning from their peers, hospitals can utilize the resources provided by state and national organizations to make progress on their patient safety goals.

Leapfrog’s “Highest Value Hospitals”

In 2008, The Leapfrog Group designated 13 hospitals as the “Highest Value Hospitals” in the nation based on a combination of their quality and resource utilization scores for coronary artery bypass graft (CABG), percutaneous coronary interventions (PCI), treatment of acute myocardial infarction (AMI), and pneumonia care. To make Leapfrog’s Highest Value list, a hospital had to have a top efficiency of care score for at least three of these four procedures and conditions. Three of the 13 “Highest Value Hospitals” for 2008 were in Minnesota:

- Fairview Southdale Hospital
- Park Nicollet Methodist Hospital
- Regions Hospital

2008 Leapfrog Survey Results Minnesota Hospitals



* The percentage shown reflects an average of performance on all of the conditions included in the category. For rural hospitals, the standard for Evidence-based Hospital Referral includes only Abdominal Aortic Aneurysm and Esophagectomy.

** For rural hospitals, Efficiency of Care Procedures/Conditions includes only Acute Myocardial Infarction and Pneumonia.

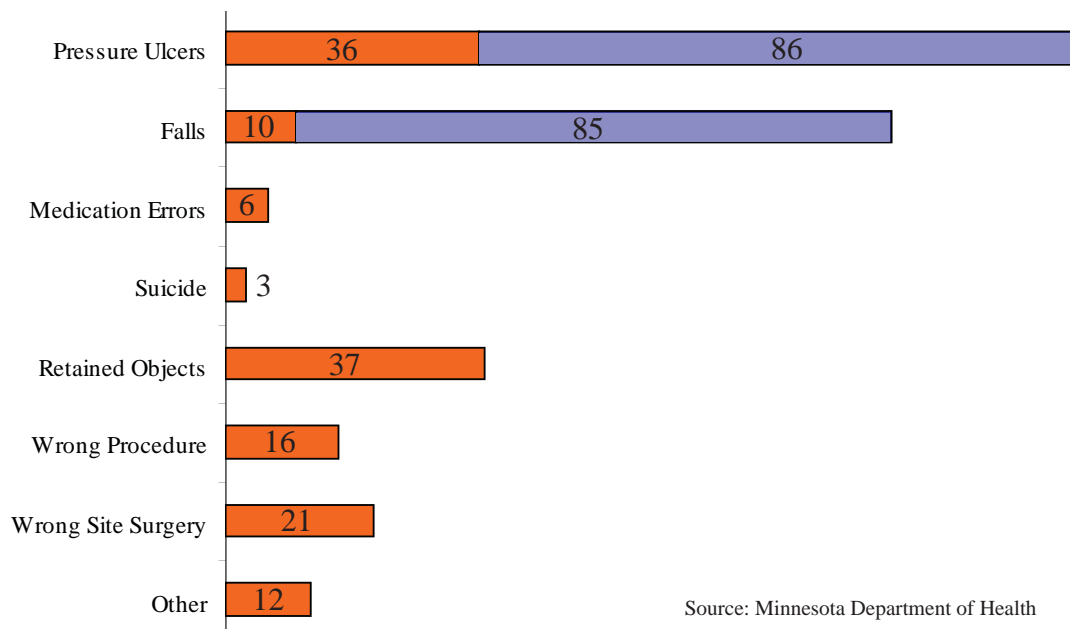
What are Adverse Events?

Adverse events, also called “never events”, are errors in medical care that should never take place. According to the National Quality Forum, they are serious, clearly identifiable and preventable. In 2003, Minnesota became the first state to pass a law mandating hospitals, community behavioral health hospitals and outpatient surgical centers to report adverse events. These health care organizations are required to report on 28 events including falls, pressure ulcers, retained objects and wrong site surgery. Additional information about these and other adverse events is given below.

2008 MDH Report on Adverse Health Events

Each year, the Minnesota Department of Health collects information from hospitals about the occurrence of adverse events. In 2008, 135 hospitals, 53 outpatient surgical centers and 11 community behavioral health hospitals were required to report adverse events under the law. Of these, 63 reported the occurrence of adverse events in their facilities. The following chart illustrates the number and type of adverse events. There was an expansion in 2008 of the definition of two adverse events (Pressure Ulcers and Falls), which led to a sharp increase in the number of events reported. Under the new definitions, 312 events were reported, compared to 125 in 2007. Had the reported events been based only on the old definitions, the number of reported events would have been 141.

2008 Adverse Health Events



Source: Minnesota Department of Health

Adverse Events Definitions

Pressure Ulcers: An area of the patient’s skin breaks down due to friction or lack of movement. Pressure ulcers are most common in the elderly or those who have fragile skin, incontinence, or certain chronic diseases that affect the circulation.

Falls: Patient death or serious disability associated with a fall while being cared for in a healthcare facility. Falls are more likely to happen to the elderly and to those with balance or gait problems, dizziness, and altered elimination or incontinence.

Medication Errors: Medication errors that lead to patient death or serious disability. These errors involve the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration.

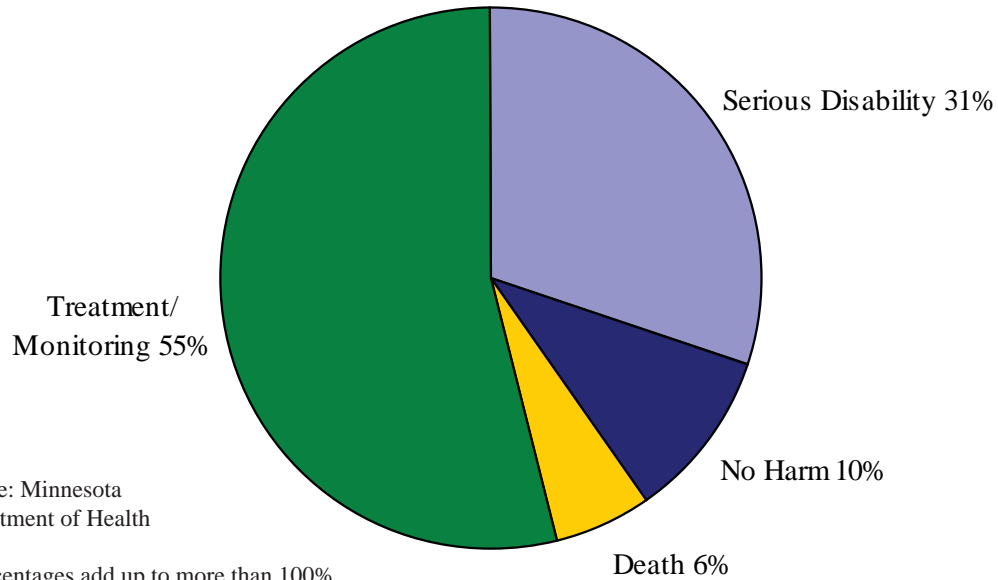
Suicide: Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.

Retained Object: Something that is left in a patient’s body after surgery, delivery of a baby, or another procedure. Small sponges and clamps are the most common retained objects.

Wrong Procedure: Wrong surgical procedure performed on the patient.

Wrong Site Surgery: Surgery performed on the wrong body part. The most common types of reported wrong site events involved radiation therapy, regional blocks or other injections, and dermatological or orthopedic procedures.

Outcomes of Adverse Events



Source: Minnesota
Department of Health

* Percentages add up to more than 100%
as some outcomes fall in more than one
category

The chart above illustrates the percentage of Adverse Events that led to the following outcomes: additional treatment and monitoring (55%), serious disability (31%),

no harm (10%) and death (6%). These figures reinforce the seriousness of Adverse Events and the importance of eliminating them from the health care system.



Trends in Adverse Events

Even without considering the expanded reporting in 2008, the number of adverse events increased nearly 13%, from 125 to 141. This is a frustrating statistic for providers, patients and purchasers. According to MDH, one reason that events are increasing is that a new culture of transparency is making hospitals feel more comfortable actually reporting events. Still, it is a concern that even after increasing their emphasis on safety, many hospitals are continuing to experience adverse events.

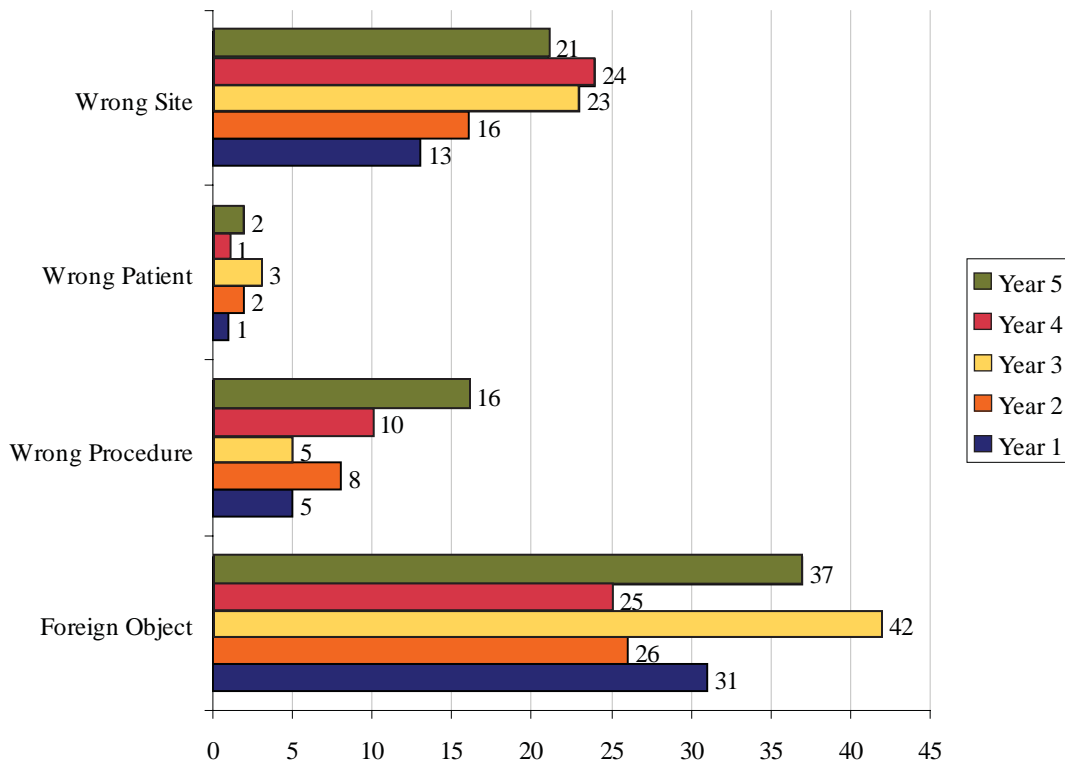
Certain areas have seen a reduction of events over the past 5 years. For instance, new initiatives have helped prevent retained sponges after childbirth. The number of retained sponges dropped from nine in the first six months of the reporting year to zero in the second half. In addition, the number of reported stage three and four pressure ulcers declined for the second year in a row.

As shown in the figure below of the most common adverse events, wrong procedure and retained foreign objects are on the rise. As with the Leapfrog Hospital Survey, it is important to understand not only how many of these events are taking place and their trends, but why. The MDH report states that the main causes of adverse events are:

- Communication
- Policies/procedures
- Environment/equipment
- Training

Some examples of system breakdowns include a lack of understanding of the roles, inadequately written rules, pressure to complete a task or process quickly, missing a step or a rule due to fatigue, environmental distractions, misunderstandings about expectations, or physical factors that prevent staff from carrying out the policy. Adverse events are also more likely to occur when providers, staff, or patients do not feel comfortable speaking up if a person has not followed a policy.

Adverse Events Trends by Type



Source: Minnesota Department of Health

Best Practices for Adverse Events Prevention

Because 2008 was the 5th year of MDH's Adverse Events Report, the organization decided to complete an evaluation of the reporting process and the lessons learned. MDH used this evaluation to analyze and highlight progress on best practices that it believes will decrease the number of reported adverse events. The evaluation also measured the degree to which hospital leaders emphasize safety as a priority today compared to 2003, when the reporting law was first introduced.

Over the course of 5 years, great strides have been made in communicating adverse health events data throughout different areas of provider organizations as well as with patients, families and other facilities. This transparency is a positive step and increases public awareness of hospital patient safety issues. Survey results also suggest that more should be done to encourage Leadership Walk Arouns, which influence the day-to-day culture within the hospital.

The results of MDH's evaluation show that positive progress has been made in changing behaviors and attitudes that affect patient safety. As seen in both the evaluation and the 2008 report, however, there is still room for improvement.

Minnesota Hospital Association: Calls to Action

The Minnesota Hospital Association provides resources to hospitals to improve hospital patient safety. In response to the Adverse Health Events Report, the MHA has developed the following protocol toolkits:

Safe from Falls: Preventing falls while in the hospital

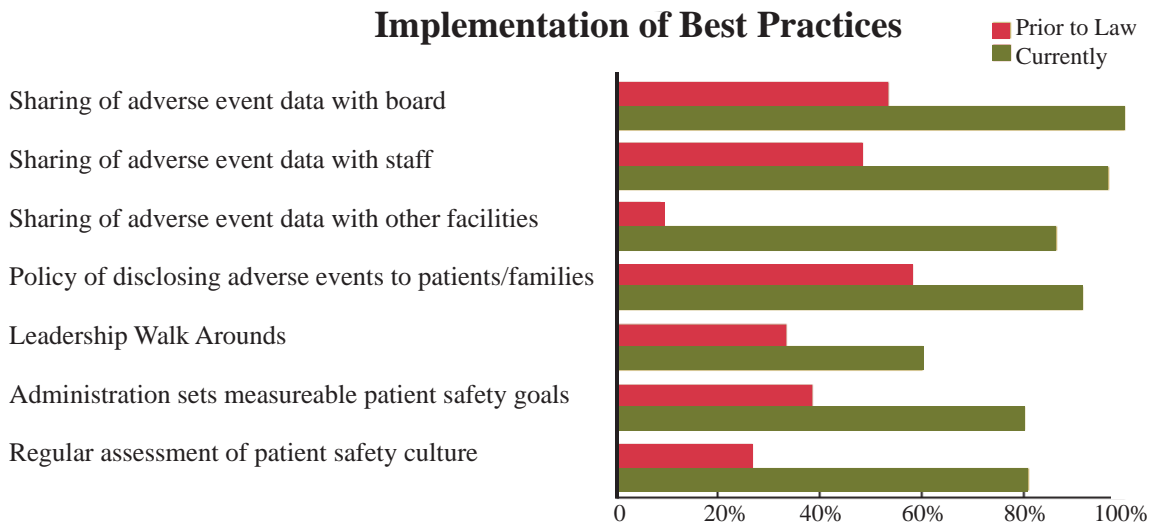
Safe Skin: Pressure ulcer prevention and skin safety

Safe Count: Preventing retained objectives such as sponges after childbirth

Safe Site: Preventing the wrong surgery procedure or surgery on the wrong body part

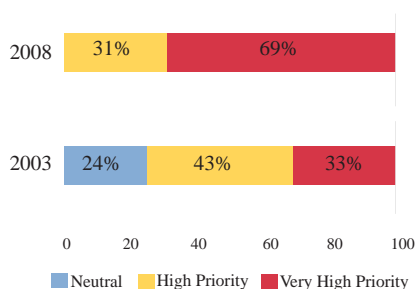
Hospitals also continue to engage in conversation with one another and with patient safety organizations in order to share learnings. Events such as the "Falls Prevention Day of Sharing", which took place in 2006, help providers develop best practices and improve care.

Implementation of Best Practices



Source: Minnesota Department of Health

Safety as a Priority



Source: Minnesota Department of Health

MDH found that the passage of the Adverse Events reporting law has helped to increase the feeling that safety is a very high priority among hospital leaders.

The Role of Purchasers in Hospital Patient Safety

This report has shown that while progress has been made in certain areas of hospital patient safety, most Minnesota hospitals are not performing at an acceptable level based on the results of these two measurement tools. Purchasers can affect change by learning more about the performance of individual hospitals on The Leapfrog Group's "leaps" and on adverse events. The list below outlines other strategies that purchasers can use:

Inform for Decision Making

- Communicate the importance of hospital patient safety in your benefits material
- Encourage enrollees to compare hospital patient safety performance before choosing a hospital
- Provide consumer decision support tools, such as easily accessible and understandable performance comparisons
- Ensure your health plans are promoting consumer awareness of hospital patient safety through both written and on-line materials and through their Customer Service lines
- Educate yourself on patient safety topics
- Promote access to hospital patient safety information by creating links on your intranet
 - www.leapfroggroup.org
 - www.health.state.mn.us/patientsafety/ae/09ahereport.pdf
 - www.health.state.mn.us/patientsafety/publications/09aheeval.pdf

Selective Contracting

- With Health Plans
 - Understand how your health plans:
 - Influence hospitals in their networks to improve patient safety
 - Use hospital patient safety results to structure reimbursement, incentives and rewards
 - Influence hospital referral patterns of physicians and medical groups in their networks
 - Identify potential billing for "never events" that occur in a hospital
 - Identify ancillary charges related to "never events" (i.e., anesthesiologist charges, surgeon charges, etc.)
 - Hold your health plans accountable for implementing the Leapfrog purchasing principles on your behalf

- Refuse to pay for "never events" nor allow billing to your employees
- Build "never event" payment language into your contracts

With Benefit Consultants

- Insist that nationally standardized Leapfrog questions are built into health plan RFPs and are heavily weighted in the scoring criteria
- Build support of benefits consultants and brokers to use and advocate for patient safety

Steerage

- Create hospital co-pay and co-insurance differentials based on patient safety performance

Other

- Recognize and reward providers for major advances in safety, quality and affordability
- Participate in public recognition and disseminate information about superior performance
- Meet with hospital executives from your high volume hospitals to discuss their patient safety performance



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7900 International Drive
Suite 1080
Bloomington, MN 55425
Phone: 952-896-5186
www.bhcag.com