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Corbett's budget will set back Pa.'s patient safety efforts

Earlier this month, Gov. Corbett submitted Pennsylvania's 2012-2013 proposed budget. As expected, reductions in spending were suggested due to our slow economic recovery along with a worthy desire to maintain a balanced budget in our state. However, I believe the governor's proposed budget clearly misses the mark when it comes to public safety and welfare by proposing to merge the Pennsylvania Patient Safety Authority (PSA) with the Pennsylvania Department of Health (DOH).

PATIENT SAFETY AUTHORITY
Commonwealth of Pennsylvania

The Patient Safety Authority was established under the Medical Care Availability and Reduction of Error Act as an independent state agency charged with taking steps to eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, and birthing centers. These facilities are required to report serious events that cause patient harm as well as non-harmful errors and near misses (errors that are corrected before they reach patients and cause harm). ECRI Institute, known widely for its expertise in medical error prevention, and the nonprofit organization I work for — the Institute for Safe Medication Practices (ISMP), serve as contractors to analyze these reports and suggest safety improvements that help facilitate their adoption across the state.

Independence from regulatory bodies is a hallmark of successful medical error reporting programs and error-prevention efforts. The PSA's reporting program borrows from the successful aviation model in that a separate, independent, non-regulatory agency receives and analyzes reports for learning purposes. While health-care professionals may be compelled to report medical errors that cause serious harm to patients, they are hesitant to report non-harmful errors and near misses to regulatory bodies like the DOH for fear they will be used for punitive purposes. In fact, the PSA was first established as *independent* of the DOH for precisely this reason. Error reporting under the DOH had generated very few reports and was incapable of providing new knowledge about the risks associated with health care and why they occur. Since its inception, the PSA reporting program has received more than 1.3 million reports, most of which (95 percent or more) are near misses and non-harmful errors. Yet, what we can learn from near misses and non-harmful events is precisely the information we need to take action to prevent errors *before* patients are harmed.

On the surface, consolidating the PSA within the DOH may seem like a good move. But there are several reasons why I feel a merger would seriously weaken the authority's effectiveness and immobilize further progress in improving patient safety.

- For one, it will put a serious damper on the reporting of near misses and non-harmful medical errors — an incredibly rich and necessary source of information for learning how to keep patients safe.

- It could also compromise the analysis of reports associated with specific types of medical error by ECRI and ISMP, which is necessary to identify the root causes of medical errors and the most effective error-reduction strategies.
- And it could also diminish the spread of best practices that can be achieved through collaboration with the Authority and other experts in the field.

The PSA's reporting program is unique in its capacity for *expert* analysis of the reports. ECRI and ISMP act as the content experts who understand human error, human behavior, and how the healthcare system is designed and works. They know how to interpret the information in medical error reports in a meaningful way and create road maps for improvement that can be realistically implemented. Their independence allows objective determination of the causes of errors and effective solutions absent any conflict of interest. If the PSA merges with the DOH (which will be facing a 4.6 percent cut in its budget), report analysis may be reassigned to DOH staff that is unlikely to possess the same level of impartiality and expertise as the current PSA reviewers and may overlook important details or misapply the science of safety when mandating risk-reduction efforts.

The PSA's effectiveness depends on having a positive, collegial relationship with hospitals and other providers. Many hospitals, on their own initiative, have enlisted the PSA's assistance to further their safety improvements. For examples, hospitals have invited PSA clinical liaisons into their operating rooms, their patient care units, and even their boardroom to educate trustees about their role in making their institutions safer.

A merger would discourage cooperation with PSA safety initiatives. For example, based on analysis of reports, the authority was able to determine the underlying causes of performing surgery on the wrong patient or on the wrong side (left vs. right), and the most effective prevention strategies.

The authority helped an initial group of 30 hospitals to reduce these errors by 73 percent and a second group of 19 facilities to go for one year without an error in their operating rooms. The authority's data helped to convince the FDA to require a change in the initial dose of hydromorphone, a powerful narcotic that, when confused with morphine, can cause a fatal overdose. After a report of a patient who almost wasn't rescued because his colored wristband was mistaken to mean "Do Not Resuscitate," the authority worked with a group of hospitals to standardize the meaning of color-coded patient wristbands and implement other measures to prevent this kind of miscommunication. The standard colors have since been endorsed by the American Hospital Association.

The authority's collaboration with Pennsylvania hospitals has helped reduce infections from catheters used to deliver drugs directly into the heart. Pennsylvania's infection rate is one-third below the national average, and during the last few years, Pennsylvania hospitals have reduced these infections by 24 percent. Such collaborative efforts, which begin with admitting to and owning the safety problem, would be threatened if the PSA were part of the hospital's regulatory agency.

As a result of its work, the authority is a widely respected model for other state agencies working to improve patient safety, making Pennsylvania the undisputed national leader on this critical issue. In fact, national meetings have been held so officials from other states could study the PSA and the division of responsibilities among other health-related agencies. The DOH serves an important role in helping to ensure the safety of our health care facilities — a regulatory role that by design is punitive and disciplinary in nature. This role is fundamentally incompatible with the PSA's complementary approach of educating, coaching, and facilitating collaboration among facilities to encourage reporting and improvement.

The relationship of trust and respect the authority has established with hospitals will be broken if this merger takes place, and I believe we would be taking a huge step backward in regards to patient safety.

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