

**ALIGNMENT OF PENNSYLVANIA PATIENT SAFETY AUTHORITY
ACTIVITIES
WITH
NATIONAL PATIENT SAFETY PRIORITIES**

*Report Submitted by
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EXCERPT FROM EXECUTIVE SUMMARY

The Pennsylvania Patient Safety Authority has a comprehensive patient safety mandate as established under the Medical Care Availability and Reduction of Error Act of 2002 and seeks to further build on its successful track record in pursuit of this mission. To this end, the Authority has sought field and expert input as it assesses its alignment with national patient safety priorities and considers future direction and focus of its programs. This work involved a combination of interviews and assessments of the field. An excerpt of the findings, focused on alignment with national priorities, follows.

Alignment with National Patient Safety Priorities

The healthcare system is currently undergoing unprecedented change in its efforts to improve the value it delivers. Focusing on better health outcomes, better patient experience, and better cost containment, the associated efforts are complex, interdependent, and critical for the future viability of the healthcare system, as well as for the economy as a whole. Patient safety, and the systems theory and sciences that underlie it, is foundational to this work. The national priorities for the patient safety work reflect this.

The national patient safety priorities were identified and grouped as follows:

- Retain the focus on patient safety as the system reforms
- Support the healthcare workforce to enable them to focus on patient care and improvement work
- Continue to focus on the importance of culture
- Inform, engage, and support patients and consumers
- Commit to system and organizational transparency
- Promote broad adoption and effective use of HIT
- Promote continuous adoption and spread of patient safety work for proven improvements, across new settings, and for emerging issues

Particular attention was paid to the future role of surveillance and reporting systems in support of these priorities. Influencing factors included those related to workforce burden, impact of HIT, the debate on extracting vs. reporting, and the increasing interest in and capability for real-time risk identification and intervention.

Analysis of the Authority's portfolio indicated very strong overall accordance with the identified national priorities and trends as well as tremendous success with its programs overall. The Authority is viewed as a leader in the industry and its initiatives as effective in helping to advance the improvement work being done on the front lines in Pennsylvania healthcare facilities. The components of the Authority's program portfolio provide structure through which the national priorities can be further advanced, and each of these was assessed for that purpose with recommendations made for potential related initiatives.

Summary

As the Authority continues to advance its work on behalf of the citizens of Pennsylvania, it can feel confident that it is doing so in strong alignment with national patient safety priorities and in a manner that is considered, across the field, to be a model for facilitating meaningful change. The success of the Authority is made possible through strong leadership, earned support of the community, and constant attention to the emerging issues in the environment. Its work is critical and important both within and outside of Pennsylvania's borders, as the Authority contributes to the greater body of patient safety work occurring across the country.

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***EVALUATION REPORT
EXCERPT: ALIGNMENT WITH NATIONAL PATIENT SAFETY PRIORITIES***

This report reflects work done for ECRI Institute on behalf of the Pennsylvania Patient Safety Authority as the Authority seeks to ensure its ongoing alignment with evolving national patient safety goals. This work represents the perspective and patient safety expertise of the Consultant and other national patient safety experts, expert colleagues of the Authority, and stakeholder experts, as obtained by interviews focused on the matters under consideration and informed by ongoing research and involvement in the work.

NATIONAL PATIENT SAFETY PRIORITIES

As the healthcare system undergoes unprecedented restructuring as a result of the Affordable Care Act, patient safety is expected to remain both a critical driver of the change process and a foundational principle of the redesigned system.

The national priorities for patient safety as described here reflect this expectation and include an emphasis on moving improvement work forward at the organizational level while also driving change in the very structures of the healthcare system that influence, either directly or indirectly, the ability to deliver safe care to patients.

These priorities also recognize the need for the safety work to provide clear value in the current environment in order to remain relevant throughout this time of change. As with the principles underlying value-based purchasing, patient safety improvement work must generate value sufficient to justify the resources it consumes.

At a strategic level, the safety agenda will continue to provide focus, context, direction, and vision for a comprehensive spectrum of work required to not only make care safer but also move the system to an improved overall level of performance and responsiveness. At the operational level, value must be evidenced in effective translation of this agenda into improvement work that is responsive to the changing environment, the providers who work in it, and the patients and communities they serve.

There is impatience in the current environment that is felt across the stakeholder groups, as significant progress is critically needed to check the cost curve in healthcare while improving the health of the population and the patient experience of care. This triple aim has inherent in it the promise of safe care and optimized outcomes, and the patient safety work is expected to provide influence and leverage to help realize all of these goals. The

slow progress of this work, and attendant impatience, reflect the enormous challenges associated with making large-scale change in a complex environment. While the work is daunting, it is critical, and there is much hope that the structural reforms under way will provide needed incentive and momentum for faster forward progress.

The priorities identified in this report reflect current thinking in the field, as understood and organized by the Contractor and informed by the interviews and ongoing research undertaken for this project. They reflect that which the field considers to be important for the work to keep moving forward in support of the major improvements being sought for the healthcare system.

These priorities are followed by specific considerations regarding the evolving role of surveillance and reporting systems in this environment; an assessment of alignment of the Authority's broader portfolio with the defined national priorities; and, finally, observations and suggestions regarding those issues the Authority might consider as it continues to advance its work. Select comments from interviews are noted.

National patient safety priorities can be described as follows:

➤ ***RETAIN THE FOCUS ON PATIENT SAFETY AS THE SYSTEM REFORMS***

- ***Continue to reinforce patient safety as systems strategy for critical clinical and financial goals of health systems reform***
- ***Create the business case / financial rationale for patient safety***
- ***Ensure that care is integrated around the patient as the delivery system consolidates and new models of care are built***
- ***Continue to educate providers on embedding the patient safety discipline into clinical and business decision processes***

Continue to reinforce patient safety as systems strategy for critical clinical and financial goals of health systems reform

As healthcare reform takes shape under the auspices of the Affordable Care Act, the underlying presence of the patient safety discipline is felt throughout the work. The agenda for the Department of Health and Human Services' (HHS) Partnership for Patients, a key effector arm for reform, is an agenda of patient safety, shaping the initial phases of payment reform and cost containment around error reduction, safety improvement, and better patient experience of care. This movement away from volume-driven fee-for-service reimbursement is considered essential for the forward movement of the patient safety work and the system as a whole.

To ensure successful ongoing reshaping of the payment and delivery systems in this massive undertaking, it is felt be imperative that patient safety continue to be deployed as

a critical strategy across this work. The discipline not only consistently reinforces a systems approach to improvement, necessary for work of this scale and complexity, but very importantly focuses the work on the well-being of the patient by grounding it in the clinical imperative to do no harm, thus aligning it with a first order of priority of providers.

Patient safety experts will need to remain involved at the federal level. Organizations with patient safety missions will need to continue to promote the tenets of this work and its value and importance as a strategy for system reform. The healthcare workforce will need to keep this focus in their work as they navigate the changes to come.

Create the business case / financial rationale for patient safety

There is concern being expressed in the field about the potential for the patient safety focus to be lost in the throes of payment reform, as the associated financial implications have understandably become the primary focus of a struggling provider community.

These financial challenges will only become more significant and preoccupying as the delivery system reconfigures and providers assume responsibility for patients over time and across settings, requiring new and more complex financial systems. Payment methodologies will continue to change, risk will be borne differently, cost accounting will become more critical, and partnering considerations will have to include assessments of potential partner performance against patient safety criteria inherent in the new payment formulae. It is important that providers understand throughout this process that patient safety presents a strategy for the associated decision-making processes, not discrete, unrelated project work that can be dismissed as such.

The absence of a solid business case for patient safety compromises uptake of the discipline and provides, for many, the rationale for deprioritizing safety in a fiscally challenging environment. At the organizational level, this is exacerbated by siloed approaches to budgeting, with safety initiatives considered discretely, competing for resources with other programs, in budget cycles with short-term perspectives. In these situations, patient safety staff struggle to defend budget requests for improvement initiatives, and organizational safety programs stand the chance of being compromised due to budget concerns.

Experts in the field are stepping up their calls for a better articulation of the business case for patient safety and a crosswalk of patient safety priorities to fiscal priorities to better inform financial decision-making processes.

Ensure that care is integrated around the patient as the delivery system consolidates and new models of care are built

It is critically important that a patient safety focus be employed as providers make decisions regarding delivery system consolidation and reconfiguration. Delivery system redesign must produce care that is safer, better coordinated, and integrated in order to be viable and meet the requirements inherent in new payment methodologies. This requires a systems

approach, across the continuum, with the patient the focal point of the related efforts. From the patient perspective, care coordination is of primary importance. Care integration, from the perspective of the patient safety discipline, is not defined in organizational or governance terms but rather from the perspective of the patient. Care is not integrated until it meets the patient's needs, and this must happen across professionals, facilities, and support systems; be continuous over time and between visits; tailored to the patients' needs and preferences; and based on shared responsibility between patients and caregivers for optimizing health. (*Order from Chaos, Accelerating Care Integration, Leape Institute, 2012*).

Consolidation, partnering, and risk-sharing decisions need to be made with effective care integration as the goal. This is required to improve patient safety. Balance sheets will be a critical consideration in such decisions, but fiscal performance will be driven in significant part by how well care is integrated, how safely and effectively it is delivered, and how it meets the needs of the patient, as defined by the patient. Attention to the safety issues associated with transitions of care must receive priority consideration as these new relationships are formed. Payment reform will serve as a forcing function for this goal, and the patient safety discipline as a strategy to achieve it.

Continue to educate providers on embedding the patient safety discipline into clinical and business decision processes

Without a solid understanding of patient safety fundamentals and practice at the organizational level, it cannot be effectively considered and integrated into decision processes that drive priorities and resource allocation. These decisions in turn affect the ability of clinicians and staff to practice safe care and advance the improvement work. Ongoing provider-level education will continue to be indicated, as will the provision of clinical and administrative decision support tools based on the principles of systems design and safety science. This is critical not only for improvement to clinical process but also for sound business strategy and associated decision making needed to facilitate and support safer clinical processes.

➤ ***BETTER SUPPORT THE HEALTHCARE WORKFORCE TO ENABLE FOCUS ON PATIENT CARE AND IMPROVEMENT WORK***

- ***Reduce the burden of non-value-add work***
- ***Eliminate process waste and inefficiencies***
- ***Prioritize the well-being of the workforce***
- ***Integrate workforce safety and patient safety***
- ***Continue to work on culture***

Reduce the burden of non-value-add work

Most in healthcare are concerned about the increasingly onerous burden on the healthcare workforce, much of it a reflection of inefficient internal systems and onerous external

requirements. Too much time is spent on what many consider to be non-value-add work, dispiriting to the workforce and deflecting time and resources away from patient care and critical safety and quality improvement work. This burden takes many forms, as organizations are required to keep up with ever-increasing, externally imposed procedural and reporting requirements while simultaneously working to incorporate new medical, technological, and process advances into their work—work which cannot pause to accommodate any of this. There is tremendous concern presently about the burden of reporting and measurement, addressed in a further section of this report. Various systems engineering strategies are being used in attempts to streamline care processes and eliminate non-value-add work, and time spent responding to external requirements is causing an examination of value delivered by each.

Eliminate process waste and inefficiencies

Healthcare workers are dealing with waste and inefficiency that has been built into the system over time. Studies have shown that as much as 80% of a hospital nurse's time is spent on non-bedside activities. Even as waste is identified, efforts to streamline the work are not always as efficient as they could be. Far too often, the introduction and adoption of new / improved processes is not accompanied by the indicated elimination of old processes, thus adding to the inefficiency. It is on this inefficient platform that the workforce has had to build new patient safety practices, too often without having the proper time, education, tools, resources, or incentives to do so.

It is the responsibility of healthcare leaders to take care of the workforce and establish the conditions that allow for optimization of their skills as well as their work experience. This, by definition, requires attention to minimizing waste, inefficiency and non-value-add work associated with internal systems while simultaneously working to reduce wasteful processes in the external environment that translate internally into unnecessary burden. With respect to the former, many healthcare organizations are utilizing tools and disciplines like Lean, Six Sigma, Toyota production models, and the like to remove waste and inefficiencies. This systems-based work at the organizational level needs to be supported by leadership and appropriately resourced. With regard to externally imposed inefficiencies, healthcare leaders must be involved in the work needed to streamline system-driven requirements by working with agencies and organizations to ensure that proper balance is struck among the needs of the various parties in ways that can reasonably be supported by the workforce. It is important that, in doing so, the ability to ensure organizational accountability not be compromised.

Prioritize the well-being of the workforce

The patient safety field has recently placed a renewed focus on the well-being of the healthcare workforce, recognizing that its members must be cared for with the same level of commitment they are asked to make to their patients. Workforce, in this new work, is defined as including all of those contributing both directly and indirectly to the delivery of

care—the entirety of the team. Optimizing the well-being of the workforce is necessary to optimizing the patient care that it provides. This issue is covered in depth in the Lucian Leape Institute paper *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*.

The title of this work is important, as it calls on leaders to consider matters from the viewpoint of the workforce, which provides a different point of reference and therefore different insight than would otherwise be the case. It reflects the same underlying strategy, changing point of reference, as is used to better understand the patient perspective. When considered through this lens, workforce well-being takes on more deeply defined meaning that has both physical and psychological components. Physical well-being is concerned with traditionally defined workforce safety, expressed as freedom from workplace hazard as well as, more recently, freedom from physical violence. Psychological well-being is concerned with the protection, respect, and support needed by members of the workforce to be able to perform to their potential and work effectively in teams. This aspect of the work speaks directly to the cultural attributes of an organization, which provide the context and support for the safety work.

Through this workforce lens, non-value-add work becomes clear, as does the negative effect it has on the ability of the workforce to find meaning, and therefore joy, in what they do every day. Improving the workforce experience has a direct impact on the organization's ability to deliver safe, effective, and responsive care. Studies evaluating AHRQ's Surveys on Patient Safety Culture (SOPS) data and AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) data have found positive correlations between worker perception of the patient safety culture and patient perception of care. Further work is beginning to show the associated impact on patient safety.

Recent reports from the Occupational Safety and Health Administration indicate that healthcare has the highest rate of workforce (physical) injury across industries. Healthcare workers also experience high levels of burnout that result from issues related to overwork, frustration, and lack of job satisfaction, matters which speak to the absence of psychological safety and associated support. From a patient safety perspective, these workforce safety matters impact the focus and stability of the workforce responsible for the provision of safe, responsive care. From a financial perspective, implications include increased costs of workers compensation and turnover (recruitment, hiring, training) as well as potential penalties and/or lack of incentives under new payment systems as a result of the impact on patient safety and patient experience of care.

Integrate workforce safety and patient safety

Workforce safety is understood to be premised on the same underlying science as patient safety, and the potential opportunities for integrating these disciplines within organizations has been considered for some time. As the concept of workforce safety is expanded to include both psychological and physical considerations, the relationship between and interdependencies of the two are being understood in new ways, presenting opportunities

for integration not previously considered. With the mutual end goal of safer care delivery, the two disciplines can better define overlaps that present focus for integration strategies.

As a starting point, the commitment to transparency inherent in patient safety work must also be practiced with regard to workforce safety. Many argue that this transparency should extend to the public. Transparency in both areas must occur without inappropriate disclosure of information at the individual level, but the commitment to be forthcoming with respect to organizational performance is felt to be an important aspect of the improvement work.

While many organizations recognize the relationship between workforce safety and patient safety at the level of the underlying science, integrating the two operationally is a challenge. They are typically housed and managed separately and differently within organizations and have unique confidentiality issues related to the data they collect and report out. The connections between the disciplines are only now beginning to be understood and there is much work yet to do to describe the potential value of reorganizing processes to create new synergies. At present, some organizations are working to integrate dashboards to allow for monitoring workforce safety and patient safety metrics in ways that will facilitate identification of correlations between the two and associated opportunities for better coordination of efforts.

Continue to work on culture

Everything that is called for in support of the workforce requires a focus on culture. This is so critical to all aspects of the patient safety and improvement work that it continues to receive emphasis as its own priority when looking at the national agenda.

➤ ***CONTINUE TO FOCUS ON CULTURE***

- ***Create learning cultures grounded in safety***
- ***Ensure patient-centeredness***
- ***Improve systems for ensuring individual and organizational accountability***
- ***Restore respect***
- ***Embrace transparency***
- ***Continue to develop the right kind of leadership***

Create learning cultures grounded in safety

Culture is the context within which all improvement work must take place, and it can either serve to facilitate and encourage required change or impede it. There is no single factor more critical to the successful reshaping of the healthcare system than that of culture. It represents some of the most challenging work yet some of the most important. It has been and will remain a priority focus of the safety agenda for as long as there is change to be made.

Edgar Schein, a global leader in organizational theory, describes culture as simply the way people in an organization collectively do the work of the organization, given the resources they have and the conditions they are in. As such, the only way to change a culture is to provide better ways to do the work so that those better ways will eventually be adopted, replace the older ways, and comprise, de facto, a new culture. The challenge, of course, is that this requires the development of better ways to do the work, receptivity on the part of the workforce, willingness to eliminate old ways of doing the work, effectiveness on the part of leadership, and the time and patience to see this through.

The culture of medicine, and in fact of the entire healthcare system, is one of the most complex and entrenched of all industries. It is comprised of a variety of subcultures, including those of multiple, long-established (as well as emerging) professional clinical disciplines, all with competing sets of hierarchies, in organizational systems that evolved organically over multiple decades around a no-longer-relevant journeyman's model of care. Moving all of the pieces of the healthcare culture forward in a synchronized manner and with some semblance of urgency has been a challenge of enormous magnitude. While there have been significant victories, like breaking down the barriers to open disclosure with patients, there is, and will always be, much to do in this area.

This work has continued to evolve as the safety and improvement work has advanced. Beginning with a focus on moving from a culture of blame to a culture of safety, healthcare has embraced the models of high reliability and just culture and is now working on a more comprehensive concept of learning cultures, which is being championed by the Institute of Medicine. This implies an iterative process of improvement, which is the key to continuous, effective, and sustainable change and value creation. This is what the patient safety work seeks.

Ensure patient-centeredness

One of the major changes required of the healthcare culture is that of ensuring its centrality of focus on the patient. While always committed to the well-being and healing of patients, the healthcare system evolved around what providers needed in order to care for them. Patients stood on the outside as the systems to serve them, and the culture associated with those systems, evolved. The industry has now come to understand the value and importance of bringing patients inside and grounding work and culture by placing the patient's interest, defined by the patient, first. As with culture, a focus on the patient is a critical, cross-cutting issue and continues to hold its own place in the list of national priorities.

Improve systems for ensuring individual and organizational accountability

An important aspect of the work on culture is the evolving perspective on accountability and the models that are being designed to allow for its appropriate use in both measurement and improvement of performance. Accountability is imperative to ensure the ability to

make positive change, but the processes used in the past to hold providers accountable have focused more on sanctions than learning processes that would encourage improvement and growth. At the individual and organizational levels, new approaches to clinical, financial, and behavioral accountability are being called for. A focus on behavioral accountability has emerged as the importance of teamwork and effective communication to safety and overall performance is better understood. Clinical accountability measures are being assessed to ensure that they are measuring the right things and look at outcomes in a comprehensive manner. Fiscal accountability is also being redefined as payment mechanisms move from a focus on volume to a focus on value.

Restore respect

One of the more disturbing observations about the healthcare culture as it comes under examination is the absence of respect as a condition of the environment. Some of this is a byproduct of the training cultures associated with the clinical professions; some is caused by clashes between disciplines, and some by the pressures on the workforce. Regardless, a lack of respect disturbs teamwork, affects communications, negatively impacts patient experience of care, threatens safe practice, and saps the joy from healthcare organizations, which should be joyful places to work. Papers have been written on this, and work has begun to raise awareness of the issue and provide education and training to address it.

Embrace transparency

Transparency is another critical characteristic of a strong and healthy culture that is of such import at the moment so as to comprise one of the major patient safety priorities.

Continue to develop the right kind of leadership

Finally, as leadership sets the tone for an organization's culture and provides the permission and guidance for the many interdependent aspects of the safety work, there has been and will continue to be a focus on leadership development to ensure that those making resource decisions and establishing the work cultures are equipped to steer significant change. This includes education of boards as well as executive staffs.

➤ *INFORM, ENGAGE AND SUPPORT PATIENTS AND CONSUMERS*

- ***Raise public awareness and help consumers make choices***
- ***Engage patients at the level of care, the organizational level, and the policy level***
- ***Educate providers and strengthen care relationships***
- ***Organize care around the patient***
- ***Create a research agenda for patient engagement***

Raise public awareness and help consumers make choices

Patient engagement and consumer awareness remain priority issues at the national level and continue to represent a focus that is critical in its importance but exceptionally challenging in its effective realization.

Consumer engagement in the patient safety space is becoming increasingly more important. The term encompasses work associated with raising public awareness about patient safety, helping consumers make informed choices when selecting providers, and educating consumers before they touch the healthcare system and become patients, so that they are better prepared to participate as partners in their care. Traditionally, the American consumer has not been interested in healthcare until it is needed and, despite the scale of the patient safety problem, has not reacted to it strongly enough to cause the groundswell that would make it a public health issue, which it most certainly is. Efforts to raise public awareness about patient safety continue, with care taken to neither frighten patients nor undermine providers but rather to create the necessary vigilance required of today's patients.

The financial changes under way in the healthcare system are causing changes in consumer behavior. High-deductible plans and narrow networks have made consumers more price sensitive and increasingly desirous of assessing provider options in terms of both price and quality for the spend; in other words, they want to practice value-based purchasing now that there is more at stake financially for them. They are seeking information to help them make these decisions, but scant little is out there. Safety is important to them, as are outcomes and care experience, and the industry struggles with producing relevant, consumer-friendly information to assist in decision making. The Leapfrog Group is focused on this need and having some early success, but they, and the field, have far yet to go.

As payment reform takes hold, new numbers of patients are entering an overburdened system, and primary care practice is facing a demand it does not have the capacity to meet. Providers will become responsible for patients over time and therefore will be more concerned with "consumer wellness" than at present. Consumer-facing education and tools are needed to prepare patients for the new expectations associated with being part of the care team and advocating for their own safety, education best delivered to individuals in preparation for becoming patients rather than when they are sick and potentially less receptive to new learning.

Engage patients at the level of care, the organizational level, and the policy level

Patient engagement has appropriately received more attention than consumer engagement, but it is only beginning to be truly understood. It has taken a very long time to define patient engagement as a strategy rather than a goal and to appreciate the value it brings to the work. Engaged patients, partnered with engaged providers, create empowered relationships, and that is where true leverage for change lies.

Patient engagement is being defined and focused on at three levels. Patient engagement in the care process is manifested in shared decision making, the inclusion of the patient as member of the team, patient involvement in care plan design that includes consideration of patient preference and values as well as health status, and defined roles for the patient in safety practice, transitions of care, and the like. Emerging research indicates that effective patient engagement positively influences outcomes, costs, and patient experience of care, all considerations for both value of care process itself and provider payment in the new environment.

Engaging patients at the level of care is the most important level from the patient perspective. To achieve this requires knowing what matters to the patient. Much work has been done to understand this in general terms, with transparency/honesty, respect, and care coordination always coming out at the top of the list. The axiom “every patient is different” is important to honor but has also served as an excuse for not effectively addressing patient engagement with any of the systems tools and approaches we have used in other aspects of the patient safety work. The engineering principle of mass customization is being considered as a strategy for moving forward.

Patient engagement at the organizational level speaks to including patient voice in process design and organizational policy as well as on advisory councils, boards, and committees. This has given rise to important changes with high value for both patients and providers. Examples include family-activated rapid response calls, patient participation in rounding, patient-room white boards, and elimination of waiting hours. There are numerous examples of situations in which patient input resulted in changes to program strategies that in turn produced better process while saving money that would have otherwise been poorly spent.

Massachusetts led the way with its requirement for patient and family advisory councils in all hospitals, and other states are following suit. The field is only in the early stages of integrating the patient voice, but it is already proving to be a valuable strategy. Patient engagement at the policy level is also a goal of the patient safety work and has now become integral to the work of the Center for Medicare and Medicaid Innovation and the Partnership for Patients. The establishment by the government of the Patient-Centered Outcomes Research Institute and the AHRQ-funded development of a patient-generated error reporting system are but two additional examples of the influence the healthcare consumer voice at the policy level. More is needed in this arena, and all indications are that this will be the case.

Educate providers and strengthen care relationships

Increased patient engagement will only work if providers are receptive to it. This work must proceed, and engagement strategies be designed, with appropriate respect for constraints on providers’ time, but it cannot be stalled because of this. Providers also need to be equipped to be “receptor sites” for patient engagement, as it is counterproductive for patients to meet their responsibilities as engaged team members, only to be shut down by providers who either have no interest or lack the proper communication skills to make it

work. Emphasis needs to be placed on the patient-provider relationship at all times in this work, and strategies and tools for both parties need to be designed and deployed in tandem.

Organize care around the patient

Care integration, as noted previously, can only be accomplished if designed around the needs of the patient. This must be the principle around which the delivery system reorganizes and should serve as a key indicator for decision makers when evaluating partners during this process. As with the concern that the patient safety focus could be lost to financial considerations in the reform agenda, the principle of integrating care around the patient can be lost to market share, governance, and financial considerations as providers partner and consolidate. Systems designed around patient needs are the systems that will succeed into the future.

Create a research agenda for patient engagement

Finally, a research agenda for patient engagement needs to be developed and pursued to provide the intelligence needed to better address this vast area of need. Early research indicates that well-designed patient engagement techniques, like the use of decision support tools, can have a positive impact on outcomes as measured in a variety of ways. More study and knowledge is needed to propel this aspect of the patient safety work forward.

➤ *COMMIT TO SYSTEM AND ORGANIZATIONAL TRANSPARENCY*

- ***Provider to patient***
- ***Provider to provider***
- ***Organization to organization***
- ***Organizations to public***

Provider to patient

Today's public is demanding transparency from institutions and organizations across industries and sectors, positioning it as a right and the information as a public good. In no industry does this get more personal than in healthcare. While confidentiality of personal health information is important to patients and they are appreciative of the protections placed around it, lack of transparency with patients about information that is important to them with regard to their own care is unacceptable to them, as is their inability to get information they need to make good healthcare decisions.

In patient safety, transparency is viewed as a cornerstone principle for healthcare and healthcare reform. Safety science considers it an imperative characteristic of a safe culture, and this understanding has led to breakthrough changes in the system, not the least of which

has been the evolution of open disclosure with patients after an event. Transparency is a forcing function for honesty, both of which are required for a learning culture, particularly in a service industry like healthcare that delivers its value through human relationships that must be built on trust.

However, the work in transparency has been slow and selective. While the industry has moved to disclosure with patients after an event, there is still tremendous hesitancy to allow patients full access to their medical records and there is still reluctance to make “imperfect” data about safety and outcomes available to the public. Few documents are less transparent than a patient’s hospital bill if one is interested in understanding what things cost and what exactly one is paying for. The work to be done is extensive and must be pursued carefully as healthcare is a business rife with personal information that needs to be protected, surrounded by information that people have the right to know. Effectively navigating these boundaries will be key.

Transparency, like patient engagement, is being considered on multiple levels and is important at each one. Transparency between provider and patient should be absolute, as confidentiality is not an issue within that relationship. There is literally nothing that a provider has the right to keep from a patient about the patient’s condition or care. The days of a physician deciding how much a patient should know or can handle are gone, and appropriately so. A patient has a right to his or her own medical record—that does not mean the provider is required to explain this complex clinical document to the patient, but the provider has no right to withhold it either.

Being transparent with patients also implies being forthcoming. Patients should be fully informed about treatment options, risks, potential outcomes, implications of proposed care plans, and anticipated costs of proposed treatments by their providers. Not only is this the right thing to do, but it also helps ensure that the patient is prepared for any eventuality that arises.

Provider to provider

Transparency between providers is part of a culture of trust and respect and is necessary to ensure coordination of care and mitigation of errors, particularly those associated with transitions. It is also necessary for effective teamwork, which is another organizational imperative for patient safety and, in fact, for optimizing both care and workforce satisfaction. Transparency at this level, inside organizations, is also a must for error reporting and identification of risk so that improvement efforts can be appropriately targeted and pursued. If the organizational culture does not proactively support transparency, the staff cannot be expected to make headway in safety.

Organization to organization

Transparency between organizations has been defined in the safety space in relation to sharing of best safety practice and lessons learned so that others may benefit from an organization's experience. An example of this relates to the multiple neonatal deaths that occurred at a hospital system in Indiana some years ago. The hospital did all of the right things internally, including an effective root-cause analysis, proper communication with family, and correction of the process so that the error would not recur. What they did not do, to the subsequent chagrin of the CEO, was actively share what they had learned with the broader hospital community, only to watch the same thing happen at another hospital a short time later. Healthcare organizations should be transparent within their provider communities, share that which will potentially keep even one more patient from being harmed, and never compete on the basis of safety.

Transparency between organizations has taken on additional importance as the delivery system reorganizes. Partnering decisions will result in shared responsibility for patients' well-being as well as financial risk, and providers will want to be able to have full and complete information when making these decisions.

Organizations to public

The public has a right to know how providers are performing and the outcomes they are delivering so that they can make the best choices when managing their healthcare. As stated before, this transparency with consumers requires the availability of information that has yet to be developed.

Transparency with the public has also become more important with the continually rising costs of healthcare in a tight economy, the associated burden it is placing on payers, and the shifting of more of that burden onto the consumer, as previously noted. Cost and performance transparency will become increasingly important and will be demanded from the system in the new environment.

➤ *PROMOTE BROAD ADOPTION AND EFFECTIVE USE OF HIT*

- ***Improve ability to identify and manage risk and error***
- ***Ensure sharing of data for care coordination***
- ***Provide access to information for patients***
- ***Mitigate HIT-related error***

Improve ability to identify and manage risk and error

HIT systems hold tremendous promise for better management of patient care as well as of risk. The patient safety movement, and indeed the entire industry, has been anxiously awaiting its broad adoption while simultaneously recognizing that it will come with its own

associated risks, particularly in the short run. Nonetheless, it is an advancement that is inevitable and long overdue, and the field believes it will allow for great advances in patient safety.

The ability to have access to comprehensive, integrated, real-time data at the point of care is an exciting proposition. In addition to the inherent promise it holds for improving care, the opportunity it holds for proactive management of risk is significant. There are already demonstration projects where software applications are scanning clinical databases in real time, using predictive modeling algorithms to seek out precursors to harm for the particular conditions of the target patient cohort and producing reports and decision support to help guide clinicians away from potential errors. The opportunity to manage risk and intervene before something goes wrong is an ultimate goal of patient safety, and the potential for HIT to create a pathway for this is a game-changing concept for the system. This is one reason HIT adoption is a priority for the field.

Internal error reporting and associated investigation and root-cause analyses should also be made easier, as these systems should be able to extract relevant information through the use of automated trigger tools as those tools become more sophisticated. Whether extracting can ever completely replace internal voluntary reporting is as yet unknown, but the prospect of this helping to lessen the reporting burden is of great interest.

Ensure sharing of data for care coordination

As importantly, the promise that HIT holds for better coordination of care has also driven its priority status on the national patient safety agenda. When information is not effectively shared between providers, whether across shifts or across settings or over time, the risk of error rises significantly. Medication errors, diagnostic errors, procedure errors, care delays—all of these things and more can occur due to breakdowns in clinical information flow. It is anticipated that HIT systems, when interoperable or able to effectively share data through secure clouds, will be the key facilitator of better coordination and integration of clinical data and, thus, of care. Again, as the delivery system reconfigures and providers assume responsibility for patients over time and across settings, timely and complete flow of clinical information will be critical to safe and optimal care. The reorganization will demand coordination, and HIT capabilities will help facilitate it.

Provide access to information for patients

The broad adoption of HIT also carries with it greater opportunities for patient access to information. Patient portals have been well received by consumers, who use them to monitor and follow up on their health and care plans. Portals provide access to information patients need in order to be engaged. The system has not yet begun to tap the potential of this, which also gives the patient a way to ensure that critical information stays with them across care transitions and is present when it is needed. Patients with access to these and similar systems can follow up to ensure that test results have been received, for example,

and be part of the process to mitigate against diagnostic error. The potential for better engaging patients can be vastly improved in an HIT-enabled healthcare system, and this is one of the reasons it is important to continue to support this deployment. As HIT is rolled out, Meaningful Use requirements have been put in place by CMS to ensure that electronic health records are used to improve patient care. This is an important part of the strategy to help ensure that benefits from HIT deployment accrue to the patient.

Mitigate HIT-related error

With the introduction of any new technology, opportunity for error is present, and this is true also with respect to HIT adoption. This is an emerging issue in the safety field, and one for which the Authority provided early insights, as reflected in the *Pennsylvania Patient Safety Advisory* of December 2012, indicative of the important role the Authority plays in helping to identify system-wide safety concerns as they emerge.

The promise of HIT, which is significant for patient safety and includes the critical opportunity to better integrate care around the patient, is mitigated by the recognition that this advancement also brings with it the opportunity to introduce new risk and errors into the system and its care processes. What is unclear is the potential nature, frequency, and degree of such error or how to identify or categorize it as it manifests. As such, there is intense interest in HIT-related error reporting to allow for effective monitoring, and appropriate intervention, as this technology is deployed.

The Institute of Medicine, in its *Health IT and Patient Safety* report, calls for greater transparency, accountability, and reporting as HIT is rolled out and specifically recommends that the secretary of HHS establish a mechanism for both vendors and users to report HIT-related deaths, serious injuries, and unsafe conditions. Noting the variability of event reporting systems, the lack of clarity about HIT error reporting, and the current burden of reporting on the provider community, the IOM recommended that user reporting be voluntary. Vendor reporting, on the other hand, was called for as mandatory. The report called further for analysis as is currently performed on other event data in order to provide insights into vulnerabilities associated with HIT.

The Bipartisan Policy Committee on Health IT, in response to its charge to provide HHS with formal input into the administration's development of a regulatory framework for HIT, established five principles for an oversight framework, one of which stated "Reporting of patient safety events related to health IT is essential; a non-punitive environment should be established to encourage reporting, learning, and improvement."

AHRQ considers HIT error reporting critical and has developed version 1.2 of the Common Formats for this purpose.

The Authority is already looking at and analyzing what it determines to be HIT-related errors, and the *Advisory* article of 2012 speaks to the numbers of incidences (somewhat significant) as well as resultant harm to patients (insignificant). Most errors appear to be

related to the performance of the user rather than of the technology, indicating an opportunity for education. Michigan has seen that communication is almost always a factor in HIT-related events, but rarely in HIT near misses, where the cause is usually data-related.

There is clear confusion in the user community about the categorizing of an error as being HIT-related. Most view HIT as a potential root cause of an error more properly categorized for its manifestation, such as “medication error” being the reportable event when the wrong medicine was ordered due to incorrect use of an automated drop-down menu. Work conducted by RAND has shown that it is very difficult to get organizations to report HIT-related events because internal systems do not recognize them and are therefore not capturing them.

As effective adoption of HIT is a priority for the patient safety work, appropriate monitoring of its deployment and use will be critical, and identification of HIT-related error will be an important part of this process.

➤ ***PROMOTE CONTINUOUS ADOPTION AND SPREAD OF THE PATIENT SAFETY WORK***

- *For proven improvements*
- *Across new settings*
- *For emerging issues*

For proven improvements

A constant priority at the national level is the adoption and spread of the discipline as well as of the work that has been produced by it and shown to reduce harm and improve care. Most of these improvements have been made in the inpatient setting, where the work has been focused. It has long been recognized that making change, even evidence-based positive change, is difficult in these settings due to their complexity and cultures. However, it is impossible, at this point, to justify the lack of spread and adoption of strategies and processes that work across the acute care setting. Also concerning is the lack of sustainability of improvements over time. The lack of adoption is strengthening the call for accountability and being factored into consideration as new models of accountability are developed.

Much thought has been given to the challenge of spread and adoption. Part of the answer is to keep pushing on culture change and leadership effectiveness. Part of the answer is to ensure proper patient safety education in the curricula of the professions, in residency training, across the workforce, and at the board level. The workforce is a critical place to focus. An analysis done by NPSF after the first 250 candidates went through the examination for credentialing as a Certified Professional in Patient Safety showed that passing rates dropped precipitously within professional disciplines the closer the

candidate's job was to the point of care. Nursing professionals, for example, had pass rates ranging from 93% for executives to 50% for bedside nurses. This held true across other professional disciplines, seeming to indicate that training on the underlying science and its application is not being done at the point of care, where the improvement work needs to occur. This is also thought to be negatively influencing sustainability.

One of the most effective answers to spread has been the formation of large-scale collaborations like the 100,000 Lives Campaign of IHI, HHS's Partnership for Patients Hospital Engagement Networks (HENs) and state- or regional-level collaboratives such as those organized in Pennsylvania, California, and Michigan. These efforts couple education with execution tactics and strategies, offer peer support and learning, and are proving to be powerful effectors of change.

Across new settings

It is common knowledge that the patient safety work had its genesis in the inpatient setting and has continued to evolve primarily in that same space. The challenges have been significant for reasons already cited, but the nature of the harm in this setting and the amount of work to be done has kept the focus primarily there. There has long been intent to move this work into ambulatory care, physician office practices and long-term care and nursing homes. The patient safety issues in these settings are different, as are the infrastructures to deal with them, so the transfer of work cannot occur without proper tailoring. In the physician office setting, for example, safety concerns are primarily driven by malpractice concerns, which is why diagnostic error is at the top of the list. Their infrastructures are small and medium malpractice insurers, who have a vested interest in improving the risk profiles of underwritten practices and have developed safety programs for them targeted to these issues. As these practices partner with other providers and systems, it is hoped that the hospital partners will help these practices focus more broadly and deeply on patient safety as a comprehensive discipline that goes beyond risk management and risk mitigation. As well, it is hoped that efforts, such as those undertaken by the Authority in the long-term care sector, will help to spread the work across the entirety of the healthcare system. As care is better integrated, this will be imperative.

For emerging issues

As care evolves and work in patient safety gets more sophisticated, new issues will emerge. Diagnostic error, for example, is a fairly recent addition to the agenda, as are errors related to HIT. As these matters emerge, work at the national level includes supporting associated research and helping to spread related new knowledge so that it becomes part of the broader agenda for the work. Organizations such as the Authority can play a key role in helping to identify emerging safety issues and thus appropriately focusing forward improvement efforts.

NATIONAL TRENDS SPECIFIC TO SURVEILLANCE AND REPORTING SYSTEMS

The introduction of surveillance and reporting systems into healthcare was heralded as a significant step forward for patient safety. These systems have created important insights into medical error and near misses, provided focus for improvement efforts, driven broad adoption of important tools like root-cause analysis and failure mode and effect analysis, and helped to validate the need for patient safety work since it began to take root in the healthcare system. The creation of PSO protection under the Patient Safety and Quality Improvement Act in 2005 provided new opportunities for reporting and learning from aggregated event and near-miss data. Their formation has provided analytic capabilities beyond those available at the provider level and necessary for extracting the most value from the reporting process. This work has played a critical role in the safety space.

As the system undergoes extensive change, everything is being evaluated for value contribution in the new environment. While it is anticipated that reporting systems and PSOs will remain in place as configured for at least the next three to five years, there is already much discussion about the direction this work should take and how reporting systems can/need to evolve to best serve the goals of patient safety. This discussion is being driven in part by the anticipation of HIT adoption, the opportunities it will offer for proactive risk identification as well as event and near-miss data capture, and how that might affect the existing processes. This discussion includes consideration of trigger tools that have been developed to identify events through medical chart review. Many see future event capture systems as quite different from those currently in place.

There is general agreement in the field that it is important to identify, monitor, and analyze events and near misses for internal improvement work as well as for payment purposes. (Near-miss reporting is thought by many to be significantly more valuable than event reporting.) However, there are questions being raised today about the future value of external reporting and aggregation of this data as framed by the following concerns:

- The burden of reporting is considered to be too high at this point and is being blamed, along with measurement and rightly or wrongly, for keeping the workforce from doing the actual improvement work.
- The amount of externally required data per reported incident is excessive and much of it considered to be of value only for internal improvement work.
- The value derived in terms of learning is not deemed to be commensurate with the amount of work required.
- Inconsistencies in reporting do not allow for valid benchmarking and comparisons and raise questions about the usefulness of the aggregated databases.
- The vast majority of reported data is not new discovery; we are continuing to build databases of redundant information causing some to question the need to report every event.
- The information derived from the data is too far removed from point of care and point in time of incident.

- The healthcare system is increasingly more focused on accountability, which externally reported data cannot address.
- Consumer advocates feel that event reporting is skewed because it is reported rather than extracted; that it does not capture what is important to the consumer about events; and that the confidentiality around event reporting has never been in the interest of the patient.
- When adopted, HIT will allow for extraction rather than reporting (thought to be a minimum of five years out); the industry needs to start preparing for this.
- Some see focus shifting to real-time risk identification/harm prediction and intervention rather than reporting of events after the fact.

Even as these issues are being raised by some, there are others who believe that it is important that organizations continue to report every event in order to maintain the vigilance required to minimize errors and to identify trends and emerging safety concerns that become evident only when the database is of a certain size. CMS certainly finds value in the PSO structure, as evidenced by the impending Affordable Care Act requirements regarding PSO participation by hospitals as a condition for joining defined health plans that are part of insurance exchanges.

Once HIT is more broadly adopted, however, the manner in which event data is gathered may change, as may the relative value of external event reporting vis-à-vis real-time risk identification and preemptive intervention. Some combination of the two may be indicated, and current systems have some time to consider this as technology and the needs of the field evolve.

Moving forward, PSOs and other reporting systems should be giving thought to:

- The potential transition from reported data to extracted data; role of HIT in the reporting space and what this means for current programs
- The different values delivered by event reporting / analysis and real-time data risk identification / intervention, and how they could be used together
- The future opportunities related to near-miss reporting (will not be extractable from record)
- How to use existing programs to help providers manage challenges of delivery system redesign and associated transitions of care
- Becoming real effector arms for change informed by data
- Becoming/partnering with new QIOs focused solely on improvement work
- Moving analytics and actionable information closer to care
- Working closely with consumers and patients to determine how systems could be responsive to their needs

Going forward, the patient safety field will expect to see efficient, integrated systems that take advantage of HIT and software capabilities and combine real-time predictive risk capabilities with thoughtful approaches to event and near-miss monitoring that are focused and conducted close to the work. Information will need to support accountability efforts at both individual and organizational levels. The reporting organizations will need to be

effectors for change so that their value is clearly evidenced in the improvements they help to make.

ALIGNMENT OF THE AUTHORITY WITH NATIONAL TRENDS AND RELEVANCE AND VALUE OF ITS PORTFOLIO

For the past twelve years, the Pennsylvania Patient Safety Authority has put tremendous thought and effort into carrying out its legal mandate to reduce and eliminate medical errors across the Pennsylvania healthcare system. This work has evidenced itself in a variety of ways, not the least of which is the high esteem in which it is held by those who either use or know of its work. During the course of this engagement, the Contractor has interviewed scores of people—including national patient safety experts, expert colleagues of the Authority, national content and topic experts who have not worked with but are familiar with the Authority, board members, staff, patient safety liaisons, patient safety officers in organizations who work with the Authority—and in every conversation, without exception, the Authority was described as an exemplar and leader in its sector of the field and as an organization that continues to make a significant contribution to the patient safety work.

Select comments from interviewees include:

“The Authority is a true leader in the field. They have shown us how to use data to shape and support improvement efforts. I look forward to it continuing to lead thinking and action related to reporting and safety.”

Lucian L. Leape, MD, MPH, Adjunct Professor, Harvard School of Public Health
Chair, The National Patient Safety Foundation’s Lucian Leape Institute

“They do exceptional work and have set a standard not only nationally but globally.”

Don Berwick, MD
Gubernatorial Candidate, Commonwealth of Massachusetts
Former Administrator, Centers for Medicare and Medicaid Services
Former President and Chief Executive Officer, Institute for Healthcare Improvement
Founding Member, The National Patient Safety Foundation’s Lucian Leape Institute

“The Authority is a leader in creating value for providers by using data collected and analyzed to provide them targeted support.”

Janet Corrigan, PhD, MBA
Distinguished Fellow, The Dartmouth Institute for Health Policy and Clinical Practice
Member, The National Patient Safety Foundation’s Lucian Leape Institute
Former President and CEO, National Quality Forum
Former Senior Board Director for Health Care Services, IOM

“The Authority is far, far in front of others, doing it right and using information, put in terms providers can use, to make improvements... The Authority has a lot to teach others... The Advisories are wonderful... I have heard leading CMS staff express respect for the Authority.”

Nancy Foster

Vice President for Quality and Patient Safety Policy, American Hospital Association

“The Authority is a national leader in this space. They are identifying and articulating trends and can tell us what those are better than anyone...they know where stubborn issues lie and have information on how to fix them that is good as any.”

William B. Munier, MD, MBA

Director of the Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality

“The Authority has the best program in the US, by far...hospitals are very supportive...the liaison program is great. I would not change a thing.”

Michael R. Cohen, RPh, MS, ScD, FASHP

President, Institute for Safe Medication Practices

Member, Board of Governors, National Patient Safety Foundation

“The Authority has a solid mission, and is doing solid work.”

Maulik Joshi, Dr.P.H.

President, Health Research & Educational Trust (HRET) and Senior Vice President for Research, American Hospital Association

Member, Board of Governors, National Patient Safety Foundation

“They have a great history in measurement and transparency.”

Sam Watson, MSA

Sr. VP for Patient Safety and Quality, Michigan Health & Hospital Association

Executive Director, MHA Keystone Center for Patient Safety and Quality

Member, Board of Governors, National Patient Safety Foundation

“The Authority does great work.”

Deborah Donovan, RHIA, CPHQ, MLLS

Director Provider and Hospital Performance Management, Highmark

“The Authority is a leader across the country... They have a strong focus on analyzing near misses... The Pennsylvania hospital community is very proud and supportive of the Authority and wants it to continue and to evolve in its work to improve patient safety... Their work also is very helpful to HAP for its Hospital Engagement Network, and its quality curriculum and board education have been very successful... HAP's members have a high level of trust working with Authority on collaboratives... Their data analytics help them to help hospitals see the next curve...”

Paula Bussard, MHS, Senior Vice President, Policy & Regulatory Services
Kelly Hoover Thompson, Esq., Senior Director, Regulatory Advocacy
Hospital & Healthsystem Association of Pennsylvania (HAP)

“The Authority continues to be ahead of its time and its success is impressive. I have yet to run into anyone at a high level in a hospital with anything but positive things to say about their work and the Advisories that they issue.”

Erik D. Muther
Executive Director, Pennsylvania Health Care Quality Alliance

“The Authority’s work needs to continue because it does result in improved care”

Lois Gillette, RN, BSN, CPHQ
Vice President, Product Design, Midas+ Solutions

As noted in the previous section of this report, there is discussion among patient safety experts at the national level that expresses some concerns about the current burden and value of external event reporting. However, these very people expressed extremely positive impressions of the work being done by the Authority, positioning it as a leader in the field and clearly seeing that it has derived and delivered high value from the event reporting process, as evidenced by the programs in its portfolio. In addition, those who work directly with the Authority see high value in what it does, consider them trusted partners, and do not express the concerns heard in generalized discussions about event reporting systems. For this reason, even as the Authority is compelled to monitor the environment and be responsive to the arising issues related to event reporting, HIT-driven data extraction, and risk identification, it needs to protect the high value it is delivering and determine how best to meet its obligations under the law while responding to changes in the environment as they evolve.

The comprehensiveness and responsiveness of the Authority’s portfolio is the reason that its value proposition is so strong. The portfolio represents a keen understanding of the needs in the field and how best to use data and information to help those charged with doing the improvement work. This is exactly what the field is calling for as the very reason for reporting, and the general frustrations being expressed are a result of the absence of this level of value coming from most other such systems across the country. Time and again it

is stated that the only value in reporting lies in the application of the data for improvement work at the local level. If all reporting systems were using their information as the Authority does and were building similar portfolios, the discussions in the field would be much different.

For purposes of this report, the Authority’s programs were examined for alignment with the articulated national patient safety trends. A summary chart reflecting that alignment follows, along with discussion of each of the four sections of the portfolio.

	System Focus on Patient Safety	Support of Workforce	Focus on Culture	Patient and Consumer Engagement	Transparency	Adoption of HIT	Spread of Safety Work
Data Collection, Analysis, Guidance; Advisory and Website	ESA	ESA	SA	A, OI	SA	A	ESA
Training and Education Programs	ESA	ESA	ESA	A, OI	ESA	A, OI	ESA
Patient Safety and Quality Improvement Collaboratives	ESA	ESA	SA	A, OI	ESA	A, OI	ESA
Patient Safety Liaison Program	ESA	ESA	ESA	A, OI	SA	A, OI	ESA

Code: A = Alignment
 SA = Strong Alignment
 ESA = Extremely Strong Alignment
 OI = Opportunity for Improvement

Overall, alignment of the Authority’s work with national patient safety priorities is very strong and is evidenced across its programs as noted below.

➤ **Data Collection, Analysis, and Guidance Provided in the *Advisory* and on the Authority’s Public Website**

The Authority has what many consider to be the foremost event and near-miss database in the country and, indeed, the world. It also performs what many consider to be the premier translation of this type of data into discernable value for the system and for those on the front lines who are tasked with the improvement work. This significant repository of information, the learning derived from its continuous analysis, and the guidance developed from that learning are shared with the field via the *Advisory* and the Authority’s public

website and effectively used to inform all of the Authority's activities. The *Advisory* is made widely and readily available to the field and has a strong and solid reputation for being timely and informative. Pennsylvania facilities reported making over 1,200 process changes in 2012 alone based on *Advisory* articles and educational programs, evidencing the effectiveness of this knowledge dissemination strategy.

With over a quarter-million reports being submitted per year from over 1,200 Pennsylvania facilities, broad reported readership of the *Advisory*, and related improvement work being done across participating organizations, support within the Pennsylvania healthcare system for this aspect of the Authority's work is clear. Challenges with reporting inconsistencies are viewed as compromising to the goals of the reporting work, as is the general lack of support and engagement by the physician community. The Authority is recognized for working diligently on the former matter with the DOH and perhaps needing to consider better ways to positively impact the latter. Expansion of the reporting system into the acute non-hospital sector is also groundbreaking and another example of the Authority's leadership in the field. Along with the website containing additional safety information of interest and value to stakeholders, this aspect of the Authority's activities is directly aligned with the national priorities as follows:

- ***Retain the focus on patient safety as the system reforms***
 - *Extremely strong alignment as this patient safety work produces information that is used in the field and integrated into work processes, continuously reinforcing the safety discipline*
- ***Better support the healthcare workforce to enable focus on patient care and improvement work***
 - *Extremely strong alignment as this set of resources provides information and insight needed by the workforce to focus and address their improvement work*
- ***Continue to focus on culture***
 - *Strong alignment as Advisory articles consider the importance of culture in the articles and guidance and use of this information supports the goals of learning cultures*
- ***Inform, engage, and support patients and consumers***
 - *Alignment with opportunity for improvement as the information and guidance produced by these programs includes acknowledgment and understanding of the importance of patient/consumer engagement and there are some tips for consumers on the website, but more can be done to include patient perspective in the reporting process and formation of guidance, as well as identify opportunities for data output tailored to patient/consumer audience*
- ***Commit to system and organizational transparency***
 - *Strong alignment as the Authority is known for practicing transparency in its own work and promoting it as a patient safety tenet*

- **Promote broad adoption and effective use of HIT**
 - *Alignment as the Authority undertakes efforts to identify and analyze HIT-related errors in the event database*
- **Promote adoption and spread of the patient safety work**
 - *Extremely strong alignment as this work and, in particular, the Advisories constitute an effective knowledge dissemination strategy, are being used by facilities to make changes at the local level, and are shared across and outside of Pennsylvania*

➤ **Training and Education Programs**

Training healthcare staff on improvement work and effectively disseminating new learning in practical and actionable forms is a critical need that is not being adequately addressed across the industry today. The Authority’s successful efforts in this area are a further testament to its ability to translate the information it collects and analyzes into useful tools for the field. The effort undertaken through the needs assessment process to ensure that the programs are designed to target priority needs is commendable and speaks to recognition of the workforce voice. The continuous and significant growth in program offerings and attendance by staff across sectors and disciplines speaks to the value of the programs, as does the reported number of process changes made by facilities utilizing these programs along with guidance from the *Advisory*. Understanding the importance of educating board members and partnering to create a program to do so speaks to the Authority’s keen understanding of safety influencers and the critical role of leadership.

This aspect of the Authority’s activities is directly aligned with the national priorities as follows:

- **Retain the focus on patient safety as the system reforms**
 - *Extremely strong alignment as these training and education programs are safety focused and express the discipline in multiple ways across initiatives*
- **Better support the healthcare workforce to enable focus on patient care and improvement work**
 - *Extremely strong alignment as these programs are designed to support the workforce and there is evidence that they are being used across organizations for this purpose*
- **Continue to focus on culture**
 - *Extremely strong alignment as these programs include this focus in their content*
- **Inform, engage, and support patients and consumers**
 - *Alignment with opportunity for improvement as this portfolio does not presently include a focus on consumer/patient education*

- ***Commit to system and organizational transparency***
 - *Extremely strong alignment as these programs include transparency as an important tenet of patient safety work and the Authority is transparent in its process to identify areas of focus for this work, which it shares broadly*
- ***Promote broad adoption and effective use of HIT***
 - *Alignment with opportunity for improvement as educational programs related to HIT are considered (further discussed in the HIT section of this report)*
- ***Promote adoption and spread of the patient safety work***
 - *Extremely strong alignment as these programs attract increasing numbers of participants across increasing numbers of disciplines and, in concert with the Advisories, are driving change in organizations as reported by those organizations*

➤ **Patient Safety and Quality Improvement Collaboratives**

Recognition of the importance of targeting specific and complex clinical safety issues through collaborative initiatives is further evidence of the Authority’s good citizenship and leadership status in the safety field. Major advances in learning and spread occur through these types of efforts, and they help solidify the broader patient safety community, which benefits greatly from peer support as it does this work. The foci of these collaboratives and the array of partners involved represent sophisticated work on topics of critical current interest. Measurement techniques brought to bear provide evidence to justify adoption, paving the way for organizational acceptance of the designed improvement strategies. The Authority’s collaborative work on the important topic of HAIs stands out amid an impressive array of initiatives.

This aspect of the Authority’s activities is directly aligned with the national priorities as follows:

- ***Retain the focus on patient safety as the system reforms***
 - *Extremely strong alignment as these collaboratives are highly visible examples of teamwork-driven work that engages multiple stakeholders to address complex patient safety challenges*
- ***Better support the healthcare workforce to enable focus on patient care and improvement work***
 - *Extremely strong alignment as these collaboratives are tackling issues that the workforce faces but does not have the capacity to address and the resultant work provides insight and guidance to assist them*

- ***Continue to focus on culture***
 - *Strong alignment as cultural considerations are part of the deliberations as the work proceeds but also because the teamwork evidenced in these collaboratives is an important safety tenet and creates communities for change*
- ***Inform, engage, and support patients and consumers***
 - *Alignment with opportunity for improvement as patient voice should be part of every collaborative and also consulted as collaborative work is defined and prioritized*
- ***Commit to system and organizational transparency***
 - *Extremely strong alignment as the collaboratives function in a transparent manner and the work incorporates transparency into its deliberations*
- ***Promote broad adoption and effective use of HIT***
 - *Alignment with opportunity for improvement as the Authority considers opportunities to form HIT-focused collaboratives, as further discussed in the HIT section of report*
- ***Promote adoption and spread of the patient safety work***
 - *Extremely strong alignment as the collaboratives offer multi-organizational spheres of influence within which to advance and spread the work they do*

➤ **The Patient Safety Liaison Program**

The Patient Safety Liaison program directly addresses a critical need expressed time and again at the national level—the need for hands-on assistance for the people doing the improvement work inside healthcare organizations. Discussions with the patient safety liaisons for purposes of this project made it very clear that they are extremely knowledgeable about the patient safety work and passionate about helping those in the field move it forward. Discussions with the patient safety officers in the field reflect deep appreciation for access to these experts and for their willingness to assist them on most any patient safety matter with which they are struggling, including teaching patient safety content and process to other staff. It is also of value to the patient safety officers that they do not have to fund these positions out of their own budgets, which they view as insufficient for their needs. Discussions with others who know of the program also reflect strong support for the concept and see it as a key value of the Authority’s work. It is another example cited when those in the field speak of the Authority’s leadership. If review of the program indicates that it is delivering its value in an efficient manner, consideration should be given to its expansion. Also noted in discussions was a suggestion that the PSLs be deployed, at least for a portion of their time, in coordinated efforts to proactively promote work aligned with the focus of other Authority programs. This is thought to present reinforcing potential for the overall work. This should be considered and the opinions of patient safety officers sought in the process. The outreach to patients as part of this program process is to be commended.

This aspect of the Authority's activities is directly aligned with the national priorities as follows:

- ***Retain the focus on patient safety as the system reforms***
 - *Extremely strong alignment as this program is sending patient safety experts out into the field where they reinforce the discipline and its application*
- ***Better support the healthcare workforce to enable focus on patient care and improvement work***
 - *Extremely strong alignment as this is direct, hands-on support for the workforce*
- ***Continue to focus on culture***
 - *Extremely strong alignment as the PSLs understand and reinforce the importance of culture to the work*
- ***Inform, engage, and support patients and consumers***
 - *Alignment with opportunity for improvement as there is currently outreach to patients but much opportunity to assist hospitals in their nascent efforts to effectively engage patients in care process and at the organizational level*
- ***Commit to system and organizational transparency***
 - *Strong alignment as this is a tenet of the work both taught and practiced by the Authority*
- ***Promote broad adoption and effective use of HIT***
 - *Alignment with opportunity for improvement as there could be more emphasis on this critical issue with focused efforts of the PSLs helping workforce address needs related to understanding, reporting and mitigating HIT-related or -caused errors*
- ***Promote adoption and spread of the patient safety work***
 - *Extremely strong alignment as the PSLs are able to spread patient safety knowledge and practice as well as provide assistance in its adoption*

As the Authority looks to the future, recommendations for consideration are as follows (some directly from those interviewed):

- Consider pros and cons of error identification through record extraction vs. voluntary reporting and implications for current program; determine desired positioning/potential evolution of program and prepare thoughtful rationale in preparation for field discourse to come
- Consider concerns being expressed by some in the field about value of event reporting and consider implications of future technology-driven risk identification and early intervention programs; assess impact of latter on value proposition of former;

determine desired positioning and prepare thoughtful rationale in preparation for field discourse to come

- Make efforts to bring physicians into work; consider working to become voice of physician leadership for patient safety
- Increase focus on programs that provide support and assistance at point of work; be known as an effector arm; grow PSL program
- In conjunction with Patient Advisory group and supported by research and focus groups, develop programs of value to consumers and patients
- Consider a pilot or study of what consumers would value in an event reporting system and compare to what providers collect
- Consider value of becoming and/or partnering with new QIO entity
- Help define future sets of safety goals for the field
- Consider providing training/guidance to other PSOs or regional/state patient safety organizations to help them perform at Authority's level
- Conduct patient safety educational sessions targeted at finance staff and provide input for development of patient safety business case at national level
- Use knowledge base to create patient safety guidelines for providers to use as they consider potential partners
- Provide programs focused on HIT adoption
- Contribute to the debate on measurement
- Continue work on better standardization of reporting
- Consider whether there is an opportunity for event and near-miss database to contribute to big-data strategies in healthcare