SustiNet Health Partnership

Healthcare Quality & Provider Advisory Committee

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AGENDA
April 15, 2010
Provider Advisory Committee
Sustinet Board of Directors

Review of minutes
Review of next meetings and potential external speakers
Review of agenda

Key topic area: Safety

Discussion
Transparency and Accountability needed: Bad things happen in the dark. Sunlight is the best disinfectant.

Do all the changes with Sustinet contribute to a culture of safety and quality with the patient at the center?

The modern patient safety movement began in 1994 when Dr, Leape began to address patient safety challenges and then in 1999 IOM report To Err is Human energized advocates across the country.

Adverse events are injuries resulting from medical care as opposed to adverse outcomes arising from underlying disease

Errors are acts of commission – doing something wrong or acts of omissions – failure to do the right thing.

General Principles of patient safety

Prevention of errors – systems thinking such as the check list
Simplification and standardization
Improving communication
Transitions and handoffs – the most common in health care
Teamwork and communication strategies
Look to aviation to finds ways to dampen down hierarchies

Look to military – crew resource management – he who knows can make the decision – not who has rank

Patient empowerment and education

Language barriers and health literacy
What patients need to be responsible for
Access to data and hospital and physician information
Independent patient advocate at each hospital
Addressing billing fraud
Access to usable information for decision making

Reporting systems of errors

Anyone can report
Just culture
Reporting made easy
Narratives used to talk about incident – personalize
Feedback that is immediate and relevant
Sustained leadership
Hospital Board involvements
Culture of safety
Possible use of AHRQ's Patient Safety Indicators so that we will KNOW if we are making a difference?

Auditing of information submitted by hospitals and physicians

Adverse Events in Hospitals

Frequency of adverse events

Just a few
100,000 deaths
IOM – one medication error per patient per hospital day
100,000 healthcare acquired infection deaths annually

Dramatic underreporting of adverse events in hospitals
93 % not reported
In CT probably 4600 adverse events and about 267 reported
Public needs access to easy to use data on hospitals

Over Use

Overtreatment – Brownlee
The Treatment Trap – Rosemary Gibson
Steve Smith – Newsweek article

Regulatory oversight – need to be independent transparent with stiff penalties.

FDA
Joint Commission
DPH's failures
Accreditation should be mandatory
Audit audit audit

Institute for Healthcare Improvement – whatever they say!

Trigger tools
Hospital Board Involvement

Education

Dr. Leape's – patient safety needs to be taught in medical schools
Implementation of science based medicine
Academic detailing/not pharma detailing
Continuing update of knowledge and skills; no mechanism to insure competence
Is CME working? – no one thinks it is

Physician practices

Conflicts of interests – financial ownership or technology
Cottage industries
Errors of omission as well as errors of commission.
How do private practices assure patient safety

Marketing
Conflicts of Interests
Electronic documentation for patient
Patient safety indicators

Consider bringing in guests: Dr. Steve Smith (unnecessary care); Dr. James Conway (IHI) safety; possible expert guests from New Jersey, which has done good work in this area.

Plan for next meeting

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