Putting Patient Safety into Practice: Strategies from Health Care's Front Lines

Quality is one of the most pressing issues facing the health care industry today, and reducing medical errors and heightening patient safety are critical to its improvement. The Institute of Medicine's (IOM) 1999 report, *To Err Is Human: Building A Safer Health Care System,* astounded the nation with its estimates that up to 98,000 Americans die each year as the result of medical errors, pinning the cause to systems problems rather than poor performance by individual health care practitioners. At a recent Grantmakers In Health (GIH) meeting on the subject, Lucian Leape, M.D., of the Harvard School of Public Health underscored this message, stating that – to tackle the problem successfully – we must correct those systems and make patient safety a national priority.

Over the last year Grantmakers In Health has brought the topic to grantmakers through a number of forums including an Issue Dialogue and corresponding Issue Brief (*Advancing Quality Through Patient Safety*), an Issue Focus and a Views from the Field published in the *GIH Bulletin*, a site visit to the Pittsburgh Regional Healthcare Initiative, and small group meetings to explore the formation of a funders group on patient safety. These meetings and publications not only furnished information on trends and research in the field, but also provided opportunities for funders to experience patient safety practices in action, to share work, and to explore the potential for collaboration.

Our most recent effort took place on February 27, 2002, when GIH convened a patient safety Roundtable Meeting which brought together grantmakers and their grantees, other funders, researchers, and practitioners. Supported by the Agency for Healthcare Research and Quality (AHRQ) and co-chaired by Dr. Leape and GIH president and CEO Lauren LeRoy, the meeting looked at specific error and patient safety issues and how researchers, hospitals, and health systems are working together to address them. The mix of grantmakers and grantees allowed attendees to draw upon multiple perspectives while learning about current work, emerging opportunities, and challenges to funding patient safety programs and research. Each of the tactics presented – developing leadership and fostering a culture of safety, advancing technological and operational improvements that reduce medical errors, and supporting research and the dissemination of findings – has led to improved quality of care and demonstrated how grantmakers can use funding strategies and research results to implement patient safety work within their own communities.

BAD SYSTEMS, NOT BAD PEOPLE

At the meeting, Dr. Leape noted that warnings about patient safety and medical errors have been visible throughout the 20th century yet largely ignored by the public, the media, and the medical establishment. All that changed with the IOM's 1999 report. "What we have now," Dr. Leape explained, "are incredibly buggy systems, incredibly error-prone systems, and conscientious hard-working, dedicated doctors, nurses, and pharmacists who spend their day working around these systems and not making the mistakes they are set up to make." Quality of care must become a "team sport" rather than an individual responsibility, and both health care administrators and practitioners must contribute to the process of creating systems that do not allow mistakes to occur.

Systems improvement is an area ripe for collaboration between and among grantmakers, health care organizations and academic institutions, health professionals, federal and state policymakers, patients, and advocates. Within this theme of collaboration, several strategies for foundation work on medical errors and patient safety emerged from the Roundtable Meeting. Each is summarized below.

- ***Dissemination of research findings and translation into practice:*** Dissemination and translation are two important areas in which foundations of all sizes and scope can readily participate. As Gregg Meyer, M.D., M.Sc., of the Agency for Healthcare Research and Quality (AHRQ) described at the meeting, the agency seeks to provide evidence-based information that health care providers, policymakers, and others need to improve quality and outcomes, control costs, and assure access to needed services. He also noted that AHRQ does not always have the financial resources or stakeholder relationships

that are necessary to get research findings incorporated into the everyday practice of medicine. As a result, AHRQ is working with foundations and other organizations at the national, state, and local levels to promote the translation of AHRQ research and findings into action. Dr. Meyer elaborated by sharing examples of how foundations can work with the agency by serving as "connectors" between research and practice by helping to get research findings to provider communities. Foundations can also help spread best practices and act as a trusted voice on patient safety issues.

- ***Technology:*** Foundations can assist health care providers reduce medical errors and improve patient safety by supporting both high and low technology and tactics. For example, in the area of medication errors, grantmakers can assist hospitals and health systems explore the benefits and feasibility of systems such as pharmaceutical bar coding and computerized physician order entry. Additionally, low and no-cost interventions that are known to enhance safety – such as involving patients more in their care and making routine use of order read back, checklists, and cross-discipline team training – can be supported by foundations through implementation and evaluation grants.

- ***Leadership and systems change:*** Leadership is critical to changing the "name and blame" culture historically associated with medical mistakes. A leadership team dedicated to system improvement can successfully reduce errors and improve safety, but it must involve both health care administrators and professionals at all levels, as well as patients and the public. Such a culture fosters an environment of safety and acceptability in reporting errors and learning from them. Grantmakers may be effective in this area by supporting health professions education, funding error reporting systems, and convening stakeholders to openly discuss how errors will be handled and how the organization's systems will be improved.

- ***Education:*** Because patient safety is a relatively new field, both current and future health care providers need to be educated on how and why errors occur, the importance of team training, establishment of a culture of safety, and implementation of best practices – those high- and low-tech strategies that we already know work. Foundations can play a key role in funding health professions education, including curriculum, faculty, and teaching tools. Additionally, foundations can play a critical role in public education. Grantmakers can take advantage of public education tools already in use, such as AHRQ's *Five Steps to Safer Health Care*, or assisting health care organizations and others develop messages urging patients to become actively involved in their health care by asking questions when they do not understand. Lastly, foundations can help consumers understand that reported rates of medical errors and adverse events will likely increase at the safest hospitals, not because they are making more mistakes but as a direct result of having invested in reporting systems and programs designed to identify errors, minimize their impact, and prevent future occurrences.

The foundations and other organizations involved in patient safety – as well as those that want to become involved – have an opportunity to assist with promising efforts and strategies. Their varying levels of experience, capacity, and financial resources will enhance the patient safety movement by bringing it to all levels of the health care system.

Grantmakers involved in patient safety, medical errors, or improving the overall quality of health care are asked to contact GIH with ideas for future programming and other ways we can be useful to their efforts. For more information on the subject or to submit suggestions, contact Katherine Treanor, program associate, at 202.452.8331 or by e-mail at ktreanor@gih.org.

SOURCES

Institute of Medicine, *To Err is Human: Building A Safer Health System* (Washington, DC: National Academy Press, 1999).

PUBLICATIONS

Agency for Healthcare Research and Quality, *Evidence Report/Technology Assessment: Making Health Care Safer: A Critical Analysis of Patient Safety Practices* (Rockville, MD: Agency for Healthcare Research and Quality, July 2001).

Quality Interagency Coordination Task Force, *Patient Fact Sheet: Five Steps to Safer Health Care* (Rockville, MD: Agency for Healthcare Research and Quality, January 2001).

Shine, Kenneth I., *2001 Robert H. Ebert Memorial Lecture: Health Care Quality and How to Achieve It* (New York, NY: Milbank Memorial Fund, 2002).

RESOURCES ON THE WEB

Agency for Healthcare Research and Quality
www.ahrq.gov

Institute for Healthcare Improvement
www.ihi.com

The Author P. Gold Foundation
www.humanism-in-medicine.org