

ISSUE BRIEF

ACHIEVE, AS A POLICY BRIEF, PROVIDES A FRAMEWORK FOR THE STATE OFFICE OF HEALTH CARE ACCESS TO ADDRESS THE CHALLENGES OF PROVIDING HEALTH CARE TO ALL CONNECTICUT RESIDENTS.

ACHIEVE

STATE OF CONNECTICUT OFFICE OF HEALTH CARE ACCESS

July 2001

Improving Quality and Patient Safety

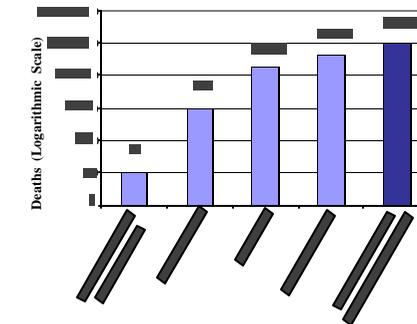
Improving quality and patient safety moved to the forefront of the national health policy agenda subsequent to the release of the Institute of Medicine's (IOM) 1999 report, *To Err is Human—Building a Safer Health Care System*.¹ The Institute is a part of the National Academy of Sciences that was created by the federal government as an advisor on scientific and technological matters. Statistics released in the IOM report estimate that medical errors during hospitalizations may take 98,000 or more lives each year. The report estimates \$8.8 billion is spent nationally on direct health care costs as a result of medical errors.

In addition, IOM predicts that these estimates may be understated since the IOM did not look at medical errors that occur in long-term care, emergency room and ambulatory care settings. The IOM report found that more people die from medical errors than from breast cancer, AIDS or motor vehicle accidents.²

Medical errors fall under the larger umbrella of health care quality. The IOM's committee on the quality of health care was formed in June 1988 to develop a strategy that would lead to a substantial improvement in the quality of health care over the next ten years. Decreasing and preventing medical errors and ensuring that patients are safe and receiving the best quality care are concerns at both the federal and state level. Included in the IOM report was a call to action to reduce the medical error rate by at least 50% over the next 5 years.

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Number of U.S. Deaths from Medical Errors Far Exceeds Other Causes



Source: National Transportation Safety Board, 1997 and National Center for Health Statistics, 1997

Patient safety and the need to reduce errors has become a priority among health care purchasers. The purpose of this ACHIEVE policy brief is to provide a framework for policymakers to consider how Connecticut might address the issue of medical errors and patient safety.

The State of Connecticut purchases health care for 180,000 employees, retirees, and their dependents, spending approximately \$465 million dollars annually. In addition, the Department of Social Services purchases health insurance for Medicaid and SCHIP beneficiaries. Overall State health spending consumes almost one third of the state's budget.

Quality and patient safety issues are of major concern to Connecticut as:

- A large **purchaser** faced with constraining health care costs,
- A **regulator**, with oversight authority over health care facilities and providers, and as
- An **educator** informing consumers and the public.

Patient safety is defined as freedom from accidental injury while undergoing medical treatment.³ The IOM defines quality as "... the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."⁴

There are three types of quality problems:

- **Overuse**- provides health services even though the risk exceeds their benefit.
- **Underuse**- fails to provide effective care that would improve outcomes.
- **Misuse**- provides appropriate care without the requisite skill, thus increasing the risk of complications.

The IOM report states that most medical errors are not the result of one individual but in the way our health care system is organized. AHRQ, the Agency for Health Research and Quality, is the lead federal agency charged with improving quality and safety of

health care services. AHRQ will award nearly \$50 million over the next few months to support further research on patient safety

The federal government is also asking private purchasers to make patient safety a priority when negotiating contracts.

Approaches to Improving Patient Safety

Currently, there is no strong incentive for health plans and providers to provide better quality since it generally does not increase their reimbursement or enrollment. Health plans and providers do not derive direct benefit from improved quality outcomes. Financial incentives are skewed since the cost of improvements falls to the health care provider and another party, such as the purchaser, realizes the savings.

If the marketplace does not reward providers for doing a better job, it will be difficult to solve the problems inherent in the health care system that lead to medical errors or adverse events. Purchasers must build a business case for quality. We have started to see some improvements as efforts are made to promote and reward providers with high-quality care.

Several large public sector state purchasers are starting to use financial strategies, such as performance rebates and financial incentives to promote increased quality. These strategies allow the contractor to earn more profits through increased quality goals and may benefit public sector purchasers by attracting more health plans and providers. Iowa, Massachusetts, and Rhode Island are three states that have led in this area. Iowa and Massachusetts attach incentives/disincentives to performance targets.

Rhode Island uses incentives to motivate improvements in Medicaid HMO performance.

The lessons that these states have learned include the following:

- Ensure the availability of the necessary human resources for the process of setting targets and then assessing performance.
- Identify a mechanism for budgeting the incentive payment funds so that they will be available when needed.
- Maintain close, collaborative relationships with contractors.⁵

Private health care purchasers are also making great strides by actively pursuing ways to measure and improve quality. Large employers are not only making decisions based on cost but also on quality of care. They are demanding quality in their contract requirements and using Health Plan Employer Data and Information Set (HEDIS) quality indicators, financial performance incentives and disincentives, and accumulating leverage by forming employer coalitions. Some employers are beginning to provide their employees with information that will enable them to choose their healthcare plans on the basis of value.

Patient Safety Initiatives

Several U.S. purchasers have banded together to develop a common set of purchasing standards to promote patient safety and quality. In early 2000 the Business Roundtable funded an employer-based initiative called the Leapfrog Group. The Leapfrog Group's mission is to trigger a giant leap forward in quality, customer service, and affordability of healthcare of all types.

Leapfrog Group members include the Business Roundtable, a Washington consortium of Fortune

500 companies, the Health Care Financing Administration and the U.S. Office of Personnel Management. Three state agencies, the Maine State Employer Health Plan, Commonwealth of Massachusetts Group Insurance Commission, and the Washington State Health Care Authority have joined this initiative.

Leapfrog's strategy is to develop a common set of purchasing principles that can be adopted by large purchasers and coalitions. The long-term goals are to reward vendors on the basis of excellence in quality and quality improvement and to educate the public on safety and quality.

The Leapfrog Group initially identified three "safety leap" areas and turned them into the following purchasing standards and estimated outcomes:

- ❖ Computer Physician Order Entry
 - *Physicians enter hospital orders through computer systems with error-prevention software.*
 - **Prevent 88% serious drug error.**
- ❖ Evidence-Based Hospital Referral
 - *Patients have superior outcomes in higher volume hospitals.*
 - **Over 20% mortality reduction for 7 complex treatments.**
- ❖ Physician Staffing in the Intensive Care Unit
 - *Physicians are certified in critical care medicine and manage intensive care units.*
 - **Over 10% mortality reduction.**

Leapfrog estimates that if all urban hospitals took up these three initiatives there would be a reduction of 58,000 preventable deaths and 522,000 medication errors. They plan to identify other safety areas for improvement as the opportunity arises.

The Leapfrog Group strongly believes that once the public becomes more aware of safety issues and the differences in safety among health care providers they will begin to demand more information and better quality.

A Snapshot of the Problem in Connecticut

Connecticut's portion of the \$8.8 billion spent on health care costs nationally is estimated to be **\$111 million annually**.

Utilizing the Office of Health Care Access hospital discharge data for fiscal year 2000 and extrapolating from the national figures in the IOM report yields the following Connecticut estimates.

- The number of adverse events statewide is **11,081 to 14,138 per year**.
- The number of preventable adverse events is **5,873 to 8,200 per year**.
- The number of preventable adverse events that result in death is **517 to 1,115 per year**.

Planning for Better Quality and Improved Patient Safety

The State of Connecticut, like other large purchasers, recognizes the business case for investing in quality health care, since better quality care directly relates to lower medical costs, improved clinical outcomes, and enhanced employee well-being and productivity.

Convening all state agencies that play a role in patient safety to develop a unified state approach is a logical first step toward improving quality by designing or building on strategies that promote the financial interest of health plans and providers.⁶ Purchasers must also establish a collaborative relationship with

their vendors and emphasize the need to collect credible, relevant, and understandable data. In considering how it might address the issues of medical errors and patient safety, the State has a responsibility to educate the public and implement a consolidated strategy to measure and report on quality. It can play a role and share knowledge and resources with providers and health care purchasers to reduce medical error and improve patient safety within the State. State government can unite with the private sector and the federal government to keep quality of care at the top of the health policy agenda and work to prevent the estimated one to three deaths per day in Connecticut.

Patient Safety and Related Websites:

National Patient Safety Foundation – www.npsf.org
 Institute for Healthcare Improvement – www.ihf.org
 Institute of Medicine – www.iom.edu
 Leapfrog Group – www.leapfroggroup.org
 Quality Interagency Task Force – www.quic.gov
 Agency for Health Research and Quality (AHRQ) – www.ahrq.gov
 National Quality Forum – www.qualityforum.org

¹Institute of Medicine, *To Err Is Human: Building a Safer Health System*, Washington: National Academy Press, 1999

²*Era of Errors*, Health Care Purchaser May 2000

³National Academy for State Health Policy, March 2001

⁴Health Affairs, May/June 2001, Vol 20, p.68

⁵Michael Bailit and Christine Kokenyesi, *Financial Performance Incentives for Quality: The State of the Art*, NHCPI,

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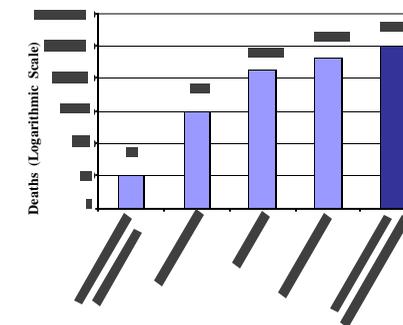
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