Doctor's Digest PODCAST Best Practices: Patient Safety "A New Approach to Patient Safety"

Hello and welcome to this new series of podcasts brought to you by the publishers of *Doctor's Digest*, bridging the gap between the business of medicine and the practice of medicine, with single-topic manuals that provide practical solutions from the experts.

A decade ago, we read for the first time the now-famous report from the Institute of Medicine called "To Err Is Human: Building a Safer Health System." At that time, the report stated, preventable errors in the healthcare system were responsible for the deaths of between 44,000 and 98,000 hospital patients each year. Just how far have we come in improving those statistics? Not very far at all, it would appear. According to the Consumers Union 2009 Safe Patient Project, "More than 100,000 patients still needlessly die every year in U.S. hospitals and healthcare settings—infected because of sloppy compliance with basic cleanliness policies, injured by failure to follow simple checklists for safety." As a result, the Consumers Union gave the U.S. a "failing grade" on certain aspects of creating a healthcare system free of preventable medical harm.

What is causing these lapses? The Joint Commission found that 70% of adverse events can be traced to a "communications problem." Dr. Alan Rosenstein, medical director of the West Coast office of VHA, a national network of not-for-profit hospitals working to improve clinical and economic performance, began examining the human factor in why people made mistakes. Eventually his organization's research showed that a full 50% of physicians "are just not good communicators" and that this inability "directly relates to patient safety."

The complexity of today's healthcare system doesn't help matters. With more new technologies, more specialists, and often multiple doctors treating any given patient, it is little wonder that communication errors occur. "When you have ten physicians collaborating on a patient [at any given time]," Dr. Rosenstein says, "think of the mishaps that could occur if they are not communicating."

Until recently, a gap in medical training resulted in "far less emphasis on creating safe systems of care" and more emphasis on doing the right thing for individual patients, according to Dr. Lisa Letourneau, executive director of Maine's Quality Counts, a project of the Aligning Forces for Quality (AF4Q) initiative. The hope was that better care for individuals would translate into better care for entire patient populations, but "that doesn't always happen," she says. It's one thing to seek quality care for an individual patient with diabetes; it's quite another to devise improvements in the system that will benefit the entire population of patients with diabetes. Developing best practices now helps doctors see the link between doing what they think is best for each patient and building a better system to make sure the whole population of patients gets safer, higher-quality care.

The $300-million AF4Q initiative offers new approaches to finding healthcare solutions. "The whole notion of [their] effort," Dr. Letourneau says, "is that change happens in a region and that change happens not because of one isolated thing here or there, but because of certain factors that actually drive change within a given community." Those factors include community leadership, performance measurement, public reporting of quality data, and quality improvement help for providers who are ready to make a change. Like the "it-takes-a-village" concept, what makes the AF4Q program work is that it combines the efforts of many people—community leaders, healthcare providers, and consumers—working toward a common goal with the measurement, reporting, and payment reform tools they need to achieve success.

How well is Maine's Quality Counts project working? The number of primary care practices in Maine that have been awarded blue ribbons—the symbol of quality and achievement in the AF4Q rating system—has increased notably. Among the 447 participating practices, those achieving two blue ribbons increased by 20%, and those achieving three blue ribbons increased by 35%. More than half the state's primary care practices have now earned two or three blue ribbons. Here's to a safer future for all our patients.