

Doctor's Digest PODCAST Best Practices: Patient Safety "Reporting Practice Errors"

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How much do you know about the requirements for reporting errors made in your primary care practice? A good place to update what you know is the Patient Safety and Quality Improvement Act of 2005. That act authorized the Agency for Healthcare Research and Quality (AHRQ) to spearhead the establishment of patient safety organizations (PSOs), which are public or private organizations that analyze patient safety data. The goal was for PSOs to become the repository of reporting errors in order to develop insights into the underlying causes. One of the most important features of this new initiative is that your privacy is protected so that you can report errors from your practice without risk. Although there is no guarantee that you won't be sued by a patient, the PSO's database cannot be used to discover errors. As stated on the AHRQ Website: "Communications with PSOs are protected to allay fears of increased risk of liability because of collection and analysis of patient safety events."

According to Dr. Bruce Bagley, medical director for quality improvement for the American Academy of Family Physicians, "The whole idea [behind the PSO] was [to create] a way to collect and systematically analyze errors." Having a central collection point for error data makes it possible to recognize patterns that might otherwise be overlooked. For example, if 50 separate doctors report the same error, but each one reports only a single instance of that error, the problem that caused the error may never be noticed. But in the new system, the data from many multiple sources begins to add up.

Today there are 66 PSOs collecting and analyzing this data. They can aggregate the errors, see if there are any systematic causes, then recommend system-wide solutions. Dr. Bagley points out that this method is much more valuable than simply punishing one individual who made an error.

At this stage, many programs are focusing on hospitals and large healthcare organizations rather than on private practices. Dr. Bagley says it's all so new that "there haven't been a lot of products [developed that are] very useable in the small practice." But there will be more small-practice applications eventually. In the meantime, small practices can get a head start by looking at programs designed for large facilities and adapting the components that are applicable to their own needs. Or they can look into patient safety programs that are tailored to physician offices, such as the National Patient Safety Foundation's (NPSF) Stand Up for Patient Safety, which delivers tools, information, and resources designed to help your practice—as well as larger institutions—to implement patient safety initiatives.

Currently, the Patient Safety Act and PSO reporting requirements are aimed mainly at hospitals and inpatient facilities and vary from state to state. Regulations for the ambulatory care setting lie ahead and will face greater challenges because of their size, number of contacts, and smaller infrastructures, according to Diane Pinakiewicz, president of the NPSF. "There really is no requirement" for many private practice physicians who aren't participating in a PSO, she says; many doctors are simply submitting their normal claims, then gathering performance data from those claims for their own use. In Maine, doctors are being asked to voluntarily submit clinical

data [as well as claims data], and instead of merely reporting that the practice saw a patient with diabetes and submitted a claim, they add such detail as this: “I am tracking diabetic patients through my clinical information system, which is an EMR or a disease registry. Now I can tell you that I have 120 patients with diabetes; and of those, X% were seen in the past year, X% were tested according to evidence-based guidelines, such as A1C testing and a foot and eye exam.” This kind of report supplies a whole different level of data from claims data alone.

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