Embargoed Until Noon, 10/21/09

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MISSOURI HEALTH PROVIDERS MARK A DECADE OF PROGRESS SINCE RELEASE OF IOM'S "TO ERR IS HUMAN" REPORT

JEFFERSON CITY, Mo. — In 1999, the Institute of Medicine released a watershed report on patient safety, "To Err Is Human: Building A Safer Health System." The report launched a quiet revolution in health care that, after a decade of action, has led to a culture of increased patient safety and quality throughout the health care delivery system.

The report addressed both the causes and effects of medical errors. Researchers concluded most medical errors are caused by faulty systems, processes and conditions. According to the report, "mistakes can best be prevented by designing the health system at all levels to make it safer — to make it harder for people to do something wrong and easier for them to do it right." Moreover, the lack of well-designed systems had a tragic effect — the death of as many as 98,000 patients annually through medical errors.

Quality improvement systems are not new to health care. Since 1983, Primaris, Missouri's Medicare quality improvement organization, has worked with providers and patients to improve the care delivery system for Medicare recipients. In addition, Missouri hospitals had identified and began addressing the problem of medical harm before the IOM report. In 1997, the Missouri Hospital Association hired a quality improvement professional to assist hospitals in improving their quality and patient safety programs. In 1999, before the release of the "To Err Is Human" report, MHA convened a statewide taskforce on health care quality. These actions were the opening salvos in the patient safety revolution that was to follow.

"The IOM report focused a bright light on patient safety," said Herb B. Kuhn, MHA president and CEO. "It was the impetus for a decade's worth of progress in

establishing systems to reduce patient harm from medical errors and additional focus on increasing the quality of care throughout the health system."

The development of evidenced-based care practices has been a core component of efforts to improve the quality of patient care. In 2003, the Joint Commission — the nation's primary hospital accreditation organization — established the first national patient safety goals. The next year, MHA published the state's first voluntary, hospital-specific quality indicator reports.

Also in 2004, Gov. Bob Holden appointed a 16-member commission to address patient safety. Hospitals, physicians and quality improvement advocates were appointed to serve. The Missouri Commission on Patient Safety's recommendations spurred the formation of the Missouri Center for Patient Safety in 2005. The center provides solutions and resources to improve patient safety and quality.

"Before the Missouri Center for Patient Safety was established, there was no single venue in the state for access to information on patient safety best practices," said Rebecca G. Miller, MHA, CPHQ, FACHE, executive director of the Missouri Center for Patient Safety. "Now, we are better able to coordinate statewide patient safety campaigns, conduct root-cause analyses of medical errors and develop systems to avoid incidents of medical harm."

Since its inception, the center has been a catalyst in Missouri's quality improvement and patient safety movements. In 2006, the center worked to create an annual Missouri Patient Safety Month to recognize patient safety efforts in health care. The center held its inaugural Patient Safety Conference in 2007.

The center also has coordinated state and national patient safety campaigns. In 2007, it organized the Missouri Just Culture Collaborative to increase error reporting and achieve an appropriate balance between a "blameless" culture and an "accountable" culture in support of patient safety objectives. It also launched the "Banding Together — for Patient Safety" initiative designed to encourage health care providers to adopt a statewide color coding system for hospital wristbands. Two years ago, the center, MHA and Primaris partnered to act as the state's coordinating bodies for the Institute for Healthcare Improvement's "5 Million Lives Campaign."

"Having a venue for best practice research and system design is critically important to achieving a high quality health care system," said Richard A. Royer, CEO of Primaris. "The Missouri Center for Patient Safety has provided Missouri's health care community a

setting to launch and coordinate quality initiatives and conduct independent research on the root causes of medical mistakes."

Last year, the Missouri Center for Patient Safety was one of the first 10 organizations nationwide to be federally designated as a patient safety organization. The recognition allows the center to collect and report information about medical errors, by focusing on prevention.

Increasing medical error reporting is an important component of reducing patient harm. In 2008, the MHA Board of Trustees unanimously endorsed a set of recommended actions in the event of a serious medical error, also known as an "adverse event." The board recommends hospitals take three actions following a serious adverse event — inform the patient; report the incident to a patient safety organization, like the Missouri Center for Patient Safety; and waive the patient's bill. The board's action represents a commitment to ensure that adverse events do not happen, and, in the rare occasion when they do, to put the patient first. This year, the state's Medicaid program,
MO HealthNet, began requiring all participating providers to report medical errors and contract with a federally-designated PSO.

Also this year, the Missouri Center for Patient Safety has launched several evidenced-based, patient safety initiatives. The "Missouri Safe Surgery Saves Lives — DASH!" encourages providers to adopt a surgical checklist designed by the World Health Organization that has proven to reduce surgery-related complications by one-third and patient deaths by 40 percent when implemented. In addition, the center has coordinated the STOP BSI Collaborative that uses an evidence-based system — the Comprehensive Unit-Based Safety Program — developed at Johns Hopkins University to evaluate and improve patient safety in hospitals by reducing central line associated bloodstream infections.

"When hospitals, physicians and patient safety experts work together to implement quality improvement programs, patient care improves," said C.C. "Cork" Swarens, executive vice president of the Missouri State Medical Association. "The Missouri Center for Patient Safety's programs have increased access to expertise communitywide."

The "To Err Is Human" report encouraged a revolution in health care design and delivery. Efforts to increase quality and reduce patient harm have fundamentally changed the culture of health care. The Missouri Center for Patient Safety and its partners remain committed to identifying and implementing systems that improve the quality and safety of health care for all Missourians.

A private, not-for-profit corporation, the **Missouri Center for Patient Safety** is dedicated to fostering change throughout Missouri's health care systems. Based in Jefferson City, the mission of MOCPS is to improve health care quality and patient safety in collaboration with health care providers, physicians, purchasers, consumers and government. MOCPS is a federally-recognized Patient Safety Organization. More information is available online at www.mocps.org.

The **Missouri Hospital Association** is a not-for-profit association in Jefferson City that represents 153 Missouri hospitals. In addition to representation and advocacy on behalf of its membership, the association offers continuing education programs on current health care topics and seeks to educate the public, as well as legislative representatives, about health care issues.

For over 150 years, the **Missouri State Medical Association** has represented Missouri physicians to the public, media and government. MSMA offers assistance to further the field of medicine through an organized professional membership comprising more than 6,500 physicians and medical students.

Primaris is a nonprofit, health care firm with 25 years experience working to improve healthcare for Missourians. Its mission is to improve health care delivery and outcomes by promoting excellence, advancing knowledge and developing innovative solutions for physicians, other providers, businesses, government, patients and consumers. Online at www.primaris.org.