

PROMISES UNDER PRESSURE

Leading the Way on Quality & Patient Safety



Issue

Providing the best possible health care in a safe, compassionate environment is the commitment every hospital makes to its community. But the public wonders if hospitals can keep this commitment in light of government cutbacks, increased demand for services and shortages of critical health care professionals. In this Internet-era, the public is hungry for information about the providers they entrust with their care and safety. Against this backdrop, policymakers are considering a gamut of options – new ideas, legislation, potential mandates and regulatory requirements – aimed at ensuring that America’s health care system can proudly attest to its quality and safety.

Hospitals continue to respond to the public’s questions about quality and accountability. On-going attention to systemic quality issues underscores the central role hospitals must play in helping to sort out what changes may be needed both within hospitals and within the delivery system as a whole, to ensure that we make good on our commitment to provide high-quality, safe care to every patient who walks through our doors.

AHA View

Hospitals and the public need to know if patients receive the right care at the right time in the right setting, and the AHA and its Board of Trustees are committed to helping answer that question. The AHA’s efforts focus on providing hospitals with information and tools that they can use to improve quality and patient safety; supporting legislative and regulatory reforms that will enable hospitals and their staffs to improve care; representing the field with accreditation and oversight organizations; and recognizing innovators in quality and patient safety. We continue to work with a variety of stakeholders – including hospital leaders and organizations representing physicians, pharmacists, nurses, consumers, researchers, and purchasers – to coordinate efforts to improve quality and patient safety.

Fostering Public Confidence through Quality Information. Pressure for publicly available information about the quality of hospital care is coming from every direction. Different sets of quality data are offered to the public by such organizations as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), insurers and other payers, the business community, consumer organizations, commercial enterprises that compile and sell “report cards,” and the media. The potential for confusing the public with incomplete, poorly analyzed, conflicting and even misleading information is enormous. These varied data are also expensive and burdensome for hospitals.

The AHA, the Association of American Medical Colleges (AAMC) and the Federation of American Hospitals (FAH) believe the public deserves candor about the hospital care provided and assurance that the information they get is accurate and helpful. To keep this promise, hospitals must continue to improve quality internally and be publicly proactive.

AMERICA'S HOSPITALS STANDING TOGETHER . . .

For the Patients and Communities We Serve





AHA View
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The issue no longer is whether quality data are to be made public – that is already occurring. For hospitals, the issue is finding a way to collaborate with others to forge a shared national strategy for accurate quality measurement and public accountability.

The AHA, AAMC and FAH brought together government agencies such as CMS and the Agency for Healthcare Research and Quality (AHRQ); professional organizations such as the American Medical Association (AMA), JCAHO and National Quality Forum; and consumer organizations such as AARP and the AFL-CIO, to agree on an initial set of quality measures to share with the public. This unprecedented voluntary effort, “Project Public Trust: The National Hospital Quality Information Initiative,” will help patients and families better understand how care is being provided by their hospitals for certain medical conditions. The initiative’s partners are working on several objectives: a voluntary data collection mechanism that minimizes the additional burden on hospitals, an ongoing process that gives hospitals a sense of predictability about public reporting expectations over time, and most importantly, ensuring that balanced, useful information helps improve quality and inform the public. Information on hospital performance will begin to be shared with the public this year, but further work will be necessary to create a more useful and robust set of information over the next few years.

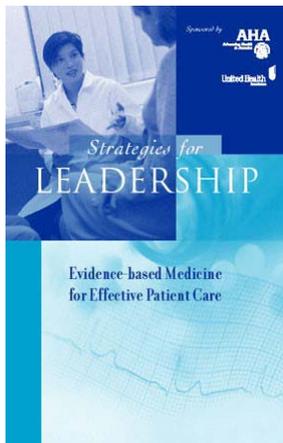
Medical Event Reporting. While media accounts frequently focus on isolated tragedies, hospitals and other providers know that improvements in safety can best be accomplished through the routine collection of data on errors and close calls. Hospitals are seeking better ways to understand the areas of vulnerability in the way care is provided by collecting and analyzing data to reveal the contributing factors, identifying underlying causes, and suggesting potential systemic changes that will reduce the likelihood of a patient being harmed in the future. Data collection on errors and close calls is vital to our efforts to improve safety for our patients, but we need to do more than just collect the data. Reporting is helpful only if it leads to changes in the processes of care, and those are accomplished by changes in human behavior or innovations in technology.

The AHA supports the Patient Safety and Quality Improvement Act (H.R. 663/ S. 720), introduced by Reps. Michael Bilirakis (R-FL) and John Dingell (D-MI) and Sens. Jim Jeffords (I-VT), John Breaux (D-LA) and Bill Frist (R-TN). **We also support the Patient Safety Improvement Act** (H.R. 877), introduced by Reps. Nancy Johnson (R-CT) and Pete Stark (D-CA). These bills would provide new legal protections to permit patient safety information to be shared with entities called Patient Safety Organizations (PSOs). The PSOs would work with hospitals and other caregivers to analyze information and facilitate the sharing of best safety practices to prevent medical errors. The legislation also creates a national voluntary database to be housed at AHRQ. The database would receive non-identifiable information from PSOs to help shape national research and policies in this area. H.R. 663 passed in the House, and prospects for the Senate are optimistic.



AHA View
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Tools and Resources. Since the Institute of Medicine issued its landmark report on medical errors more than three years ago, hospitals across the country have redoubled their efforts to better understand and identify specific causes of error and to take actions that will prevent any harm from reaching patients. To help hospitals achieve a safer environment and safer care delivery by fostering a “culture of safety,” the AHA has collaborated with other organizations, including our state association partners, to create numerous tools and resources.



For example, last year our *Strategies for Leadership Toolkit Improving Patient Safety* featured resources developed by the Veterans Affairs National Center for Patient Safety to help hospitals identify those aspects of care that may be at high-risk for causing patient harm. We also worked with the Health Research and Educational Trust (HRET), the Institute for Safe Medication Practices and the Commonwealth Fund to produce *Pathways for Medication Safety* – three field-tested tools for reducing medication errors (available at www.medpathways.info). More recently, we distributed, in conjunction with the UnitedHealth Foundation, *Strategies for Leadership Evidence-based Medicine for Effective Patient Care*, which focuses on the important role of evidence-based medicine in improving quality patient safety.

To learn more about the resources and materials that we have distributed to hospitals, visit www.aha.org under “Quality and Patient Safety.”

Recognizing Excellence. The AHA sponsors two awards that recognize excellence in quality and patient safety:

- *The Quest for Quality Prize.* In collaboration with McKesson Corporation and the McKesson Foundation, the AHA created this prize to recognize hospitals that have worked hard to create a culture of safety.
- *The Circle of Life Award.* With funding from the Robert Wood Johnson Foundation, the AHA, working with the AMA, the National Hospice and Palliative Care Organization, and the American Association of Homes and Services for the Aging, created this award to highlight organizations that set the standard for care at the end of life.

Developing Leadership Talent. Recognizing the critical role strong leadership plays in improving quality and patient safety, the AHA’s Health Forum and the National Patient Safety Foundation, in partnership with the American Organization of Nurse Executives, the American Society for Healthcare Risk Management and HRET, have developed the Patient Safety Leadership Fellowship. This yearlong program targets the next generation of health care leaders to develop and implement practices and strategies that enhance patient safety and quality.