

MMA QUALITY REVIEW

Physicians in pursuit of excellence

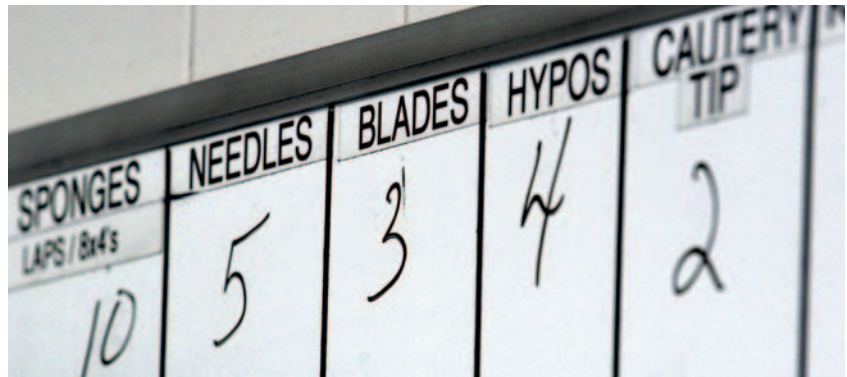
Learning from mistakes

IN JANUARY, the Minnesota Department of Health released its third annual adverse health events report, which requires hospitals to report the occurrence of preventable medical errors.

The report found a nearly 50 percent jump in the 27 types of errors that should never happen. The number of adverse events that occurred between October of 2005 and October of 2006 was 154 compared with 106 in 2004-2005.

The report also found that errors were responsible for 24 deaths—half of which were related to falls—and seven patients becoming disabled. Last year's report listed only 12 deaths.

In response, hospital leaders publicly expressed their regrets about the errors and took steps to prevent future adverse events. Here's a look at how some health systems have responded to specific medical errors at their hospital—errors doctors and other health care providers agree should never happen in the first place. ▶▶



Surgical teams at the University of Minnesota Medical Center, Fairview, haven't left an item in a patient for nearly two years. The hospital credits its success to a painstaking procedure for counting instruments that may serve as a national model.



Photos © Star Tribune/Minneapolis-St. Paul 2007

Inside this issue

- Safety experts say it's time for clinics to track errors.
- Congress passes Medicare pay-for-performance program.
- The statistical significance of errors.



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Deficient devices

Two people suffered from malfunctioning medical devices, one patient died at Saint Marys Hospital in Rochester and one suffered a serious disability at Immanuel St. Joseph's Hospital in Mankato, during the report's time period.

Michael Rock, M.D., chief medical officer at Mayo Clinic's Rochester hospitals, who was involved in the investigation of the incident at Saint Marys, said it occurred while a patient was being transferred to an operating room. A dial on an external box attached to the patient's pacemaker was bumped, and the pacemaker's setting was inadvertently adjusted. Doctors didn't realize what had happened, and the patient went into tachycardia and died.

The patient "simply couldn't tolerate the adjusted heart rate. There was no real fault with the device, per se," Rock says. "There are scenarios in an acute care environment where situations unfold rather rapidly, where those kinds of things can occur."

When such an incident does happen, Mayo Clinic has a series of steps it follows to prevent a repeat occurrence. The incident is reported to its physician-chaired sentinel event office, where it is immediately discussed and analyzed. The clinic's staff communicates with the family to let them know they are taking the situation seriously and are modifying their practices based on the recommendations derived from a root-cause analysis of the event.

In the case of a device malfunction, staff might see if in-house technicians can improve the product, or the clinic may approach the vendor or the Food and Drug Administration to tell them about the problem. In this case, Mayo's engineers helped modify the external box controls so a bump couldn't change the setting.

Both Mayo Clinic and the Mayo Health System have encouraged open communications about medical errors

so that doctors and nurses can quickly learn about them and employ the latest strategies for preventing them.

Mayo Health System created a Web site accessible by all of its providers where specific details of incidents or device malfunctions can be reported immediately.

Instrument lost and found

More than 40 of the 154 adverse events reported during the 2005-2006 time period involved leaving sponges and other surgical items inside patients during surgery. Such mistakes can lead to infection, obstruction, the development of scar tissue, pain, and other unpleasant consequences.

Between 2003 and 2004, staff at University of Minnesota Medical Center, Fairview, unintentionally left items in patients eight times. To improve its performance, the hospital teamed with the University of Minnesota's Center for Human Factors, which sent representatives to observe hospital practices.

It became clear to those observers that some clinicians disregarded the standard procedures for counting instruments or got distracted during counts, says Carol Hamlin, the hospital's director of departmental performance.

"The degree to which you can minimize those distractions is really important," she says.

To help minimize distractions, the hospital instituted Time Out for Patient Safety guidelines and a detailed statement listing potential interruptions and recommended ways of dealing with them.

Other changes that the hospital needed to make were not dramatic but have had a big impact. Fairview has always counted sponges, sharps (such as needles), and more than a dozen other items used in surgery. The scrub and circulating staff just needed training on the specifics of

MISTAKES continued on p. 12

Patient safety moves to the clinic

Doctor offices are the next frontier for those looking to reduce medical errors.

PATIENT SAFETY EXPERTS acknowledge that their understanding of patient safety in the ambulatory setting lags far behind that of hospitals.

In fact, patient safety science for clinics is so far behind hospitals that no one even knows for certain what types of errors tend to occur in clinics.

Last spring, the Institute for Clinical Systems Improvement (ICSI) tried to find information that might serve as a basis for developing more reliable processes in clinics. But it came up empty-handed, says Gary Oftedahl, M.D., ICSI medical director. “What we’ve encountered in the ambulatory setting is that this is in a very early and primitive stage,” he says. ICSI is now working with six medical groups to collect data about errors in clinics.

A major contribution of the quality movement has been the identification of the errors that take place in hospitals.

Robert Wachter, M.D., an internist and professor at the University of California-San Francisco, headed the patient safety panel formed by the Agency for Healthcare Research and Quality that came up with the evidence that led to the list of 27 events that should never occur in hospitals. This list formed the basis for Minnesota’s 2003 adverse events reporting law.

Now, he says, a similar effort should be made to identify and prevent errors in clinics.

“It’s not like we’ve fixed the hospitals,” Wachter says, “but we have dealt with some of the low-hanging fruit, and now it’s time to look at where patients get the vast majority of their care—in their doctor’s office.” He points out that for each hospitalized patient there are 27 office visits.

What is known

Although hard data about errors in clinics is lacking, physicians know from experience some of the trouble spots.

Diagnostic errors are particularly significant in the ambulatory setting, Wachter says. Blood in the stool caused by colon cancer may be misdiagnosed as hemorrhoids. Failure to order a mammogram may result in a missed case of breast cancer.



© iStockphoto.com/Sean_Warren

At Allina clinics, one nurse draws an allergy shot dose and another nurse checks it. The clinics started taking this precaution after Allina’s clinic safety reporting system found incidents of patients suffering allergic reactions to shots.

A recent analysis of 307 malpractice claims in which a diagnosis was missed in an ambulatory setting was published in the October 3, 2006, issue of the *Annals of Internal Medicine*. About half of those cases involved an error that seriously harmed a patient or contributed to his or her death. The most common problem was a failure to diagnose breast or colorectal cancer.

What led to these misdiagnoses? Common problems included failure to order an appropriate diagnostic test, failure to create a proper follow-up plan, failure to obtain an adequate history or perform an adequate physical examination, and incorrect interpretation of a diagnostic test.

Wachter says communication breakdowns and poor follow-through are other causes for errors—for instance, a lab test that comes back but never gets acted on.

Another problem is medication errors caused by poor handwriting or negative drug interactions, sources say.

One future strategy for tracking clinic errors may be to start with hospital patients and trace the error back to the clinic, Wachter says. For example, the case of a patient who is ▶▶

“We have to begin asking the questions, what errors do we need to prevent that are really bad? What do they look like? And how could we capture them?”

Robert Wachter, M.D.

►► bleeding internally because of an overdose of blood thinner should go in the clinic’s error column, not the hospital’s, even though the error may come to light in the hospital.

Although the decentralized nature of clinics and other factors make developing a reporting system challenging, it’s time for states to move in that direction, Wachter says. “We have to begin asking the questions. What errors do we need to prevent that are really bad? What do they look like? And how could we capture them?”

Allina’s experience

Minneapolis-based Allina Hospitals and Clinics is a leader in tracking errors in clinics. In 2003, it started asking nurses, physicians, and clinic staff to report errors, near misses, and other snafus that happen in its clinics.

“We’ve worked in the last few years to develop a robust safety reporting system,” says Lynn Berg, director of risk and safety for Allina Medical Clinic.

To start, Allina promoted the idea of a blameless culture and told everyone that they had a responsibility to report errors. It also encouraged all staff members to report anything that seemed amiss, no matter how small. Staff can make anonymous reports either by phone or online. Staff were educated about the importance of these reports and were encouraged to file them sooner rather than later. Allina also makes sure physicians who should see the reports do see them.

Allina also launched a campaign that encourages everyone in the organization to simply say “I need clarity,” when they feel uncertain about a directive or believe a mistake is occurring.

“It gave staff a catchy phrase that they could use without embarrassing the physician in front of the patient,” Berg says.

Through its reporting system, Allina detected problems with allergy shots and lab results, and has instituted new procedures to address both. Physicians now get a phone call and paper copies for all lab results that are positive for cancer. Entries must be made in the electronic medical record confirming that both the physician and the patient saw the results. If not, a staff member is flagged and he or she follows

up with the physician and the patient.

“The days are long gone when you tell a patient ‘If you don’t hear from me, everything is OK,’” Berg says.

To prevent allergy shot errors, Allina began doing eight hours of training about how to avoid such errors for nurses. It also started requiring one nurse to draw the dose and another to check it. Overall, the effort to encourage reporting has worked and so have the interventions, Berg says. ▴

By Scott D. Smith

MMA Quality Review Editor

What you can do

PATIENT SAFETY EXPERTS say even the smallest clinic can begin a safety-reporting program.

It can be as simple as making a form available and creating a committee that reviews reported incidents once a month.

The hard part, they say, will be creating a culture in which staff feel comfortable openly discussing problems. Resources for creating such a workplace are available at the Minnesota Alliance for Patient Safety Web site, www.mnpatientsafety.org. Click “Links and Resources” and then the Just Culture bullet.

Provided is a sample form you can use to track unsafe events in your clinic. Copy it for use in your clinic.



Patient/Visitor Safety Report

Label

1. Patient / Vistor Name:	2. M ___ F ___	3. Birth Date:	4. SSN #	5. <input type="checkbox"/> Clinic Patient <input type="checkbox"/> Visitor
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6. Clinic Site:	7. Occurrence Date:	8. Department: <input type="checkbox"/> Business Office <input type="checkbox"/> Laboratory <input type="checkbox"/> Radiology <input type="checkbox"/> Clinical Patient Care <input type="checkbox"/> Medical Records <input type="checkbox"/> Reception <input type="checkbox"/> Grounds/Public Area <input type="checkbox"/> Mental Health <input type="checkbox"/> Scheduling
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9. Area of Concern/Event (Check all applicable)

<input type="checkbox"/> Medications	<input type="checkbox"/> Radiology	<input type="checkbox"/> Chart Management: Test results, communicated to patient, etc.
<input type="checkbox"/> Vaccines	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Other: Specify

10. Was the event caught/discovered prior to patient involvement? Yes No

11. List staff initially involved in the event:

<input type="checkbox"/> Nurse	<input type="checkbox"/> Physician	<input type="checkbox"/> Lab	<input type="checkbox"/> X-ray	<input type="checkbox"/> Administration	<input type="checkbox"/> Other _____
<input type="checkbox"/> CMA	<input type="checkbox"/> Provider	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Reception	<input type="checkbox"/> Scheduling	

12. Describe the concern/event (give specific details; include procedure/process/treatment involved):

(Attach additional sheets if necessary.)

13. Describe the nature of the injury, or potential injury:

Was a provider notified? Yes No

14. What corrective action or follow-up, if any, was taken?

No corrective action or follow-up taken.

(Attach additional sheets if necessary.)

15. How/why do you think this occurred? What else was going on?

(Attach additional sheets if necessary.)

16. What could be done to prevent this type of event in the future (list 1 or 2 process or systems improvements that could have prevented this event)?

Person completing form (encouraged) _____
Date: _____

NEWS

YOU CAN USE

Seniors and doctors have a communication breakdown

Issue: Poor communication between seniors and doctors concerning drugs.

Research says: Forty percent of seniors responding to a survey sponsored by the Commonwealth Fund reported not adhering to their doctor's orders regarding their medications. In addition, a large percentage of elderly patients do not talk to their physicians about medication problems, including side effects, costs, and efficacy.

The researchers surveyed 17,000 low-income Medicare beneficiaries age 65 and older in all 50 states.

Medication noncompliance was more prevalent in patients with three or more chronic conditions. More than half were not taking medicines as directed, and one-third cited cost as a reason—many chronically ill patients spend more than \$100 per month out of pocket on medications. Nearly a quarter said they had not talked with their doctors about all of the different medicines they were using during the last 12 months.

Fast fact: More than 40 percent of seniors and 52 percent of those with three or more chronic conditions reported not taking their prescriptions as directed.

Put it into practice: The researchers concluded more and better talk is needed. The following are resources to help patients.

- MAPS My Medication List—a medication reconciliation form for patients, at www.mnpatientsafety.org
- Consumer Reports Best Buy Drugs—evidence-based quality data and cost information, at www.crbestbuydrugs.org
- Minnesota RxConnect Online—State of Minnesota information about drug prices, at www.minnesotarxconnect.com. ▀

Source: Wilson IB, Schoen C, Neuman, P, et al. Physician-patient communication about prescription medication nonadherence: a 50-state study of America's seniors. *J Gen Intern Med.*2007;22(1): 6-12.



Tips to try

Assess the safety of your practice

Are your patients provided with an up-to-date list of all medications they are receiving at the end of their appointment?

This is one question from the Physicians Practice Patient Safety Assessment, which was created to help physicians make their practices safer.

Physicians can download a free copy at www.physiciansafetytool.org or pay \$200 for an online version that will provide analysis.



Earn CMEs by learning about quality improvement

The Healthcare Improvement Skills Center is an online quality-improvement resource for health care professionals. This resource supports health care professionals' efforts to make systematic improvements in the care they provide by offering interactive learning modules.

Visit the Healthcare Improvement Skills Center at www.improvementskills.org.

Nominate an M.D. for the MMA's Physician Leadership in Quality Award

Watch for details at www.mmaonline.net in April or contact Rebecca Schierman, MMA manager of quality improvement at rschierman@mnmed.org.

Should medical students speak up?



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Issue: Medical students may be too beaten down to stop errors.

Research says: Medical students fear speaking up and the medical hierarchy discourages them from identifying errors.

The authors of an article on the role of medical students in preventing errors described the case of a student who noticed a surgeon about to cut into an unclean, unprepped arm but felt insecure about pressing the point. Another case highlighted a student who noticed a patient had a do-not-resuscitate order but hesitated to tell the treatment team until they had already started an attempt to revive the patient.

Fast fact: Approximately three-fourths of medical students reported having observed a medical error, yet only about half of the students reported the errors to a resident or attending.

Put it into practice: Train medical students to speak up when they see an error. ▴

Source: Seiden SC, Galvan C, Lamm R. Role of medical students in preventing patient harm and enhancing patient safety. *Quality and Safety in Health Care*.2006;15:272-6.

Glossary

Adverse event—Any injury caused by medical care. An adverse event does not mean error, negligence, or poor-quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not from underlying disease.

Error—An act of doing something wrong or failing to do the right thing leading to an undesirable outcome or significant potential for such an outcome.

Just culture—An organizational culture in which frontline personnel feel comfortable disclosing errors—including their own—while maintaining professional accountability. A just culture recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop shortcuts and “routine rule violations.” However, it has zero tolerance for reckless behavior.

Source: <http://psnet.ahrq.gov/glossary.aspx>

Antidepressants may increase suicide risk for youths

Issue: Prescribing antidepressants after hospitalization for depression.

Research says: Researchers analyzed suicide attempts and suicide deaths among Medicaid-insured children, adolescents, and adults from 50 states who received antidepressant drug treatment following hospitalization for severe depression. They found that children and adolescents hospitalized for depression were 52 percent more likely to attempt suicide if they took antidepressants after hospitalization than if they did not take the medications. The serotonin/norepinephrine reuptake inhibitor venlafaxine was associated with 2.3 times the risk of suicide attempts compared with no antidepressant drug treatment. Older tricyclic antidepressants were also significantly

associated with suicide attempts in young people.

Fast fact: Fluoxetine, the only antidepressant drug approved by the FDA for the treatment of pediatric depression, was not associated with suicide attempts or deaths in any analysis. ▴

Source: Agency for Health Care Research and Quality Research Activities, January 2007, No. 317. Olfson M, Marcus SC, Shaffer D. Antidepressant drug therapy and suicide in severely depressed children and adults. *Arch Gen Psych*. 2006;63:865-72.



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Q&A

Adverse events by the numbers



Photo by Steve Weverika

Diane Rydrych

“There are three kinds of lies: lies, damned lies, and statistics.”

The phrase, popularized by Mark Twain, suggests that even accurate numbers can be misleading. This can be the case in patient safety, where more reported errors are sometimes considered a good thing. Diane Rydrych, assistant director of the division of health policy for the Minnesota Department of Health, explains what Minnesota’s most recent adverse health events report can and can’t tell us about patient safety.

Q: What are the report’s statistical limitations?

A: The adverse events report tells us how often a certain set of events happens in Minnesota hospitals. But it doesn’t really give us an overall view of patient safety.

Q: How rarely do these 27 errors that should never happen happen?

A: They are quite rare. In 2005, there were more than 2.7 million patient days and somewhere around 700,000 hospital admissions. So that is 5.6 events for every 100,000 patient days.

Q: Given the rarity of these events, are the numbers statistically meaningful?

A: Yes and no. From the second to the third report, we jumped from 105 events to 154 events. Compared with almost 3 million patient days, it’s just not a statistically significant jump.

However, it is still important and helpful to look at events across years. In particular, it is good to see patterns in terms of where or why events are happening and to track any interventions. And obviously, we want the numbers to go down.

Q: If changes from year to year aren’t statistically meaningful,

are the events random, almost like being struck by lightning?

A: Every event that we have seen reported has been related to a systems issue. There has been a breakdown somewhere in the process. So, in that sense, they are not random.

Q: What about comparing facilities from year to year?

A: It’s tough to do comparisons there as well. One good example is Hennepin County Medical Center. They decided they were having an issue with pressure ulcers, so they developed an innovative approach where they have skin teams going out on rounds. At first, they saw quite an increase in the number they found. But now, as their program has continued, their numbers have gone down dramatically.

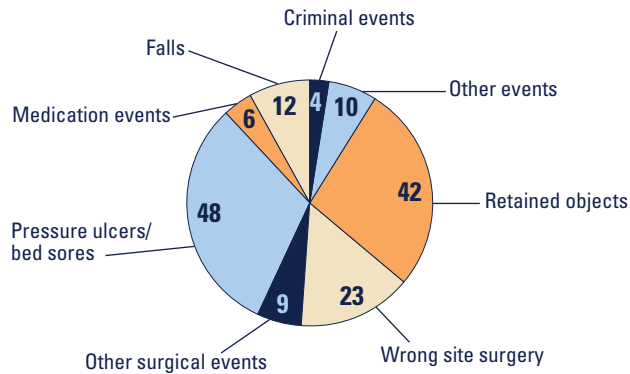
So for the average user [of the data], the tendency might be to say the numbers were higher so something must be wrong. But in this case, the higher numbers were a good thing.

Q: That’s interesting. Can higher numbers actually indicate progress?

A: My gut tells me that the numbers aren’t going up because [adverse events] are happening more often. I still think we’re at a point where they are going up because we are doing a better job of finding and reporting problems.

Reported adverse health events by category

October 7, 2005 - October 6, 2006



For more information about the adverse health events reporting system, visit www.health.state.us/patientsafety.

Another good example is retained objects in labor and delivery. In the past, labor wasn't considered an invasive procedure and wasn't included in the retained objects category. Now it is, and a significant number of the retained objects we see are in childbirth and delivery. So it's led to more reports, but also a lot of learning.

Q: This year, the number of deaths caused by adverse events doubled to 24. Could that increase be attributable to better reporting?

A: The deaths did go up this year, and a lot of them were due to falls. Falls are a continuing problem. However, it is possible that better reporting plays a role there as well. We've tried to communicate with facilities that unless you can say for sure that the death wasn't due to the fall, it needs to be reported.

Q: Some people have said a weakness of the report is that it doesn't include a denominator. Explain what this means and why this is the case.

A: Ideally, you would want to know, for example with medication errors, how many insulin overdoses there were per the number of times insulin was given. That tells you how well you are doing and where the problems lie. But we don't really know how often insulin is given in hospitals. Even with surgical events, which you would think would be easier, those categories also include invasive procedures, and there is not necessarily an easy way to come up with a denominator. So you had X number of wrong-site surgeries out of what? We don't know.

The denominator would help a facility focus more on where the problem is. And it would be easier for people to understand if we could say one out of every 1,000 procedures had a complication.

Q: Is it possible to risk adjust this report?

A: Risk adjustment is a way of trying to create a level playing field, so that the rates of a higher-risk population aren't unfairly compared with those of a lower-risk population.

The problem with adverse events is that it is not always clear what the risk factors are. When it comes to most of these events, they aren't due to any characteristics of the patients. It's because there's a communication breakdown or because of policies or procedures. It's not really about the patient but about the system. So you wouldn't be able to capture that with risk adjustment.

Q: Given the limitations of the report, what good is it?

A: At a really broad level, it has helped to foster discussion about events. And that didn't happen before. We used to have a blame and shame mentality, and people didn't feel comfortable talking about events or close calls. It also helps us to understand why [adverse events] happen. We collect information on the causes of every event as well as what is being done to prevent them. We identify trends and we look for areas where hospitals can work together to prevent them. I think that is how we will eventually see numbers go down in the long term.

Q: Does this report lead to lawsuits?

A: With our reporting system, the data are protected. We don't collect any patient-identifying information. Even if we had it, it is not public or discoverable. So there's nothing a lawyer could get out of our system. ▀

Sobering odds

- Odds of dying from a reportable adverse event in 2005 in Minnesota: 1 in 216,878
- Odds of dying from a fall while hospitalized in 2005: 1 in 433,757
- Other odds of dying in the United States in 2003:
 - From any type of fall: 1 in 16,881
 - By falling on a level surface: 1 in 487,186
 - From complications of medical and surgical care: 1 in 101,874
 - While flying: 1 in 391,981
 - By being struck by lightning: 1 in 6,188,298

Source: National Safety Council estimates based on data from National Center for Health Statistics and U.S. Census Bureau. Minnesota numbers derived by dividing state's 2005 population of 5,205,091 by number of adverse event deaths, 24.

MINNESOTA & NATIONAL ROUNDUP



Photo courtesy HealthPartners

Pat Stoneberg, R.N. (front) and Michelle Lamothe, C.M.A., review a patient record at the HealthPartners Specialty Center.

HealthPartners wins quality award

HEALTHPARTNERS has been awarded the National Quality Forum's annual National Quality Healthcare Award.

The award recognizes health care organizations that respond to the national call for quality improvement and accountability. For several years, HealthPartners has successfully used performance measurement to drive quality improvements and promote transparency. ▲

Imaging becomes hot topic

OVER THE PAST several months, Minnesota's health plans have adopted consultation or "prior notification" programs for imaging studies such as CT, MRI, and PET scans. These new programs require that physicians "consult" with a third-party vendor before ordering high-tech imaging tests.

The MMA has asked the health plans to withdraw their high-tech imaging requirements and seek a data-based communitywide solution to the increased utilization of costs associated with high-tech imaging.

The MMA has posted an imaging resource guide on its Web site to help physicians keep abreast of the latest guidelines. ▲

Imaging toolkit

VISIT www.mmaonline.net/News/high-tech-imaging-toolkit.cfm for links to online imaging resources including evidence-based guidelines, decision support tools, and physician education and quality-improvement resources.

Institute for Clinical Systems Improvement (ICSI) to hold annual conference

THE 10TH ANNUAL ICSI/IHI

Colloquium on Clinical Quality Improvement will take place May 16-18, 2007. This two-and-a-half-day event features experts who will share their knowledge. The theme is Redesign for Results: Quantum Leaps in Health Care. To register online visit www.icsi.org.

ICSI releases new guidelines

Guideline: Palliative Care (Released 01/2007)

Order Set: Subcutaneous Insulin Management (Released: 01/2007)

Protocol: Safe-Site Protocol for All Invasive High-Risk or Surgical Procedures (Released: 01/2007)

To view ICSI products online, visit www.icsi.org.

MHA and Stratis offer online hospital quality information



A JOINT MINNESOTA Hospital Association and Stratis Health Web site measures and compares Minnesota hospital quality in three areas: treatment of patients with heart attacks, heart failure, and pneumonia.

Visitors to the site can also compare Minnesota's hospitals based on the percentage of patients receiving the care they were supposed to receive, based on best practices. Visit www.mnhospital-quality.org. ▲

Improve your care with more than 170 quality measures

THE AMERICAN MEDICAL ASSOCIATION'S Physician Consortium for Performance Improvement has made 174 performance measures available to physicians. Measures provide doctors with quality yardsticks for such conditions as asthma, depression, osteoarthritis, diabetes, heart disease, and prenatal care. Physicians can integrate the measures into both paper and electronic health records.

For example, the consortium's Hypertension Measurement Set says that in 2000, only 47 percent of Medicare beneficiaries had their hypertension adequately controlled. It recommends measuring what percentage of hypertensive patients have a plan of care with this formula:

$$\frac{X}{Y} \times 100 = \% \text{ patients}$$

X=Patient visits with documented plan of care for hypertension
Y=All patient visits during which either systolic blood pressure equal to or greater than 140 mmHg or diastolic blood pressure was equal to or greater than 90 mmHg.

Find the AMA's quality measures at www.physiciansconsortium.org. ▀

Did your EHR get a stamp of approval?

THE CERTIFICATION COMMISSION for Healthcare Information Technology has certified more than 50 office-based health information technology products. Certification is a stamp of approval that physicians can consider when choosing an electronic health record system. All certified products are listed on www.cchit.org. ▀



HHS Secretary
Michael Leavitt

Transparency pact signed

LEADERS IN THE MINNESOTA business community met with Health and Human Services Secretary Michael Leavitt in March to discuss an initiative to make health care treatment decisions based on price and quality.

Companies that agreed to work toward this goal included 3M, General Mills, Supervalu, Health East, Park Nicollet Health Services, and the Minnesota Department of Employee Relations. ▀

Medicare to start bonus program

IN DECEMBER 2006, President Bush and Congress stopped a physician pay cut and authorized a new quality-reporting system that includes the possibility of physicians earning a 1.5 percent bonus payment.

Under the Tax Relief and Health Care Act of 2006, the Centers for Medicare and Medicaid Services (CMS) will implement a new physician quality-reporting system called the Physicians Quality Reporting Initiative that replaces the 2006 Physician Voluntary Reporting Program.

Reporting for the 2007 Physician Quality Reporting Initiative will begin July 1, 2007. To be eligible for a bonus of 1.5 percent of all your Medicare billings between July 2007 and December 2007, physicians must report on three of 74 performance measures for 80 percent of eligible patients. CMS will pay out the bonus in a lump sum in mid-February 2008.

Quality measures range from tracking the blood sugar levels of diabetics to screening women for osteoporosis. The list of 74 measures can be downloaded at www.cms.hhs.gov/PQRI on the Measures/Codes Webpage.

Eligible professionals who wish to participate simply have to report the quality measurement data as part of the claims they submit to Medicare.

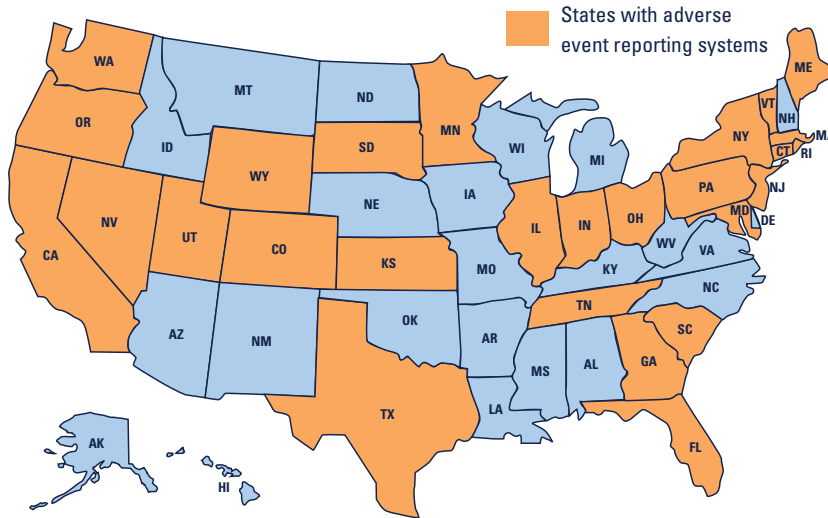
For more information, visit the CMS Web site at www.cms.hhs.gov. ▀

Medicare to help seniors choose highest quality doctors

MEDICARE ANNOUNCED in February it will start combining its quality data with quality data from health plans in order to paint a more accurate picture of the quality of services being provided by physicians to Medicare enrollees. It's contracting with MN Community Measurement to help with the project. Medicare did not announce when the data will be available.

States follow Minnesota's lead for reporting errors

THE 27 STATES HIGHLIGHTED in orange have adopted adverse event reporting rules and statutes. Minnesota was the first state to pass such a law.



Source: National Academy for State Health Policy

Two states, similar errors

Indiana's reporting law focuses on the same 27 adverse events that Minnesota tracks. As in Minnesota, objects left in patients during surgery and pressure ulcers were frequently reported errors.

Indiana's 2006 Adverse Events

Stage 3 and 4 pressure ulcers	23
Retention of objects after surgery	21
Surgery on wrong body part	8
Death or disability associated with a medication error	6
Death or disability associated with a fall	4
Death or disability associated with product or device	3
Criminal events.....	3
Other.....	9

Total = 77

Source: Indiana Department of Health

MISTAKES continued from p. 2

how to do that and support from the surgeons, nurses, and administrators to manage disruptions during their counting.

Prior to the start of a surgery, a circulating nurse or scrub technician counts out loud while actually looking at the items they are inventorying. They also call out the number of items they are introducing into the surgery field or table. Those items are counted and listed on a white board. After surgery, a team member counts items out loud

and repeats the procedure in reverse. All counts are completed before the surgeon closes the patient. If a count doesn't add up, the team goes through a series of detailed steps to locate the missing item.

The painstaking approach has produced results. Since implementing the plan in late 2004, there have been no known instances of unintentionally retained items during surgery.

Patient disappearance

Among the events reported this year were the disappearance of two patients. One patient

disappeared from St. Joseph's Medical Center in Brainerd and was later found dead. The other incident occurred at Hennepin County Medical Center. St. Joseph's was not available for comment. But according to the *Brainerd Dispatch*, St. Joseph's has changed how it reacts to a patient's disappearance. The hospital also changed its strategy for assessing a patient's risk of suicide, disorientation, or dementia, and has added 20 security cameras inside the facility and made other physical changes.

Jani Eyebolt, president and CEO at St. Joseph's, told the *Dispatch* that the hospital regrets that the incident happened and she is confident it will prevent future incidents.

Providers say it's difficult to publicly air mistakes, but the increased transparency is having a salubrious effect on Minnesota's hospitals.

"Most institutions are doing a very credible job now and are taking these events very seriously," Rock says. "I've seen a tremendous evolution over the last 10 years." ▀

Reducing pressure ulcers

HENNEPIN COUNTY MEDICAL CENTER'S (HCMC) pressure ulcer reduction program is highlighted as a success story in Minnesota's adverse health events report for 2005-2006. After attending pressure ulcer training in 2005, HCMC staff started rigorously checking patients for pressure ulcers and formed skin teams to manage the ailments that can seriously harm patients.

HCMC initially saw an increase in documented cases of stage 3 and 4 pressure ulcers; but after the new approach, stage 2 ulcers have declined by 57 percent. Read more about HCMC's approach in the Quality Rounds section of the May 2006 issue of *Minnesota Medicine*. ▀

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