Patient Safety and Quality of Care

I. Issue and Background

Patient Safety has become a major issue in the public eye, due in part to the recent release of two reports published by the Institute of Medicine (IOM). In November 1999, the IOM released its first report, *To Err is Human: Building a Safer Health System* (the Patient Safety report). According to the landmark report, an estimated 44,000 - 98,000 Americans die each year from preventable medical errors, mostly due to error-prone institutional systems. The report called for a reduction in the medical error rate by 50 percent over the next five years. Patients began to question if physicians, hospitals, and long-term care centers were meeting the challenges of patient safety and quality care.

In response to the IOM report, the Quality Interagency Coordination Task Force (QuIC) was established. Three months later, the QuIC released *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*. The report advised President Clinton to: create a Center for Quality Improvement in Patient Safety for researching and developing national goals on reducing medical errors; require all Medicare participating hospitals to implement patient safety programs; and require states to administer a mandatory medical errors reporting system to be phased in over three years.

Another outgrowth of the report was the enactment of the Healthcare Research and Quality Act of 1999 (P.L. 106-129), which renamed, restructured and reauthorized the Agency for Health Policy and Research. The new agency, the Agency for Health Care Research and Quality (AHRQ), is required to conduct and support research and build private-public partnerships to: identify the causes of preventable health care errors and patient injury in health care delivery; develop, demonstrate and evaluate strategies for reducing errors and improving patient safety; and disseminate such effective strategies throughout the health care industry.

Expanding upon the first IOM report, the IOM released a second report in March 2001, entitled *Crossing the Quality Chasm: A New Health System for the 21st Century* (the Quality report). The report called for reorganization and reform of the currently inefficient and disjointed health care system for quality to markedly improve. According to the report, health care should be more patient centered, should focus on chronic conditions, and should be more technologically advanced.

II. Findings and Recommendations of the IOM Reports

*To Err is Human: Building a Safer Health System* (The Patient Safety Report)

The findings of the IOM study indicate that decreasing medical errors will require health care system-wide changes. To facilitate these changes, a four-part plan was designed that created both financial and regulatory incentives to achieve a safer health care system: (1) establishment of a national patient safety center, to set and track safety goals as well as research the cause of medical errors; (2) establishment of mandatory and voluntary reporting systems, to track errors, serious and otherwise; (3) request that accreditation groups, consumers, group purchasers of health insurance, and the U.S. Food and Drug Administration (FDA) all demand that patient safety become a primary concern, thereby raising expectations; and (4) creation of a “culture of safety” in health care organizations that
facilitates medical error reporting without blame, citing medication errors as a prime target in need of improvement.

To achieve the four-part plan, nine major recommendations are outlined in the Patient Safety report (IOM, 1999):

1. A Center for Patient Safety should be created within what is now the AHRQ.
2. Congress would establish a nationwide mandatory reporting system.
3. Development of voluntary reporting systems would be encouraged.
4. Legislation should be passed to extend peer review protection to data related to patient safety that are collected by health care organizations for internal use or used for the purpose of improving safety.
5. Performance standards for health care organizations should focus on patient safety.
6. Performance standards for health professionals should focus on patient safety.
7. The FDA should make the safe use of medications a primary focus.
8. Health care organizations should make a clear and visible commitment to patient safety.
9. Health care organizations should use proven medication safety practices.

Crossing the Quality Chasm: A New Health System for the 21st Century (The Quality Report)

The Quality report expanded upon the first IOM report, the Patient Safety report. According to the IOM, the Patient Safety report was a “call to action” to decrease medical errors and improve the safety of health care, while the Quality report was a “call to action” to improve the quality of the health care system in its entirety, in all aspects.

The Quality report proposes six aims for improvement; health care should become safe, effective, patient-centered, timely, efficient, and equitable. Furthermore, the U.S. Department of Health and Human Services (HHS) should track health care in the aforementioned areas and make an annual report to the President and Congress.

To reach the six aims for improvement, the following 10 principles or criteria are outlined to encourage patients, clinicians, and health care organizations to work together (IOM, 2001):

1. Patients should be able to receive care whenever they need it, not just via face-to-face visits.
2. Care should be based on individual patient needs and preferences.
3. Care should be patient-centered; patients should be involved in the decision-making process.
4. Clinicians and patients should share information; patients should have complete access to their own medical information.
5. Patient care should be based on the best available scientific evidence/knowledge.
6. Safety from injury should be built into the health care system.
7. Performance information regarding safety, evidence-based practice, and patient satisfaction should be available to patients so an informed decision can be made when selecting a health care deliverer.

8. Patient needs should be anticipated.

9. Resources should be used wisely; patient time should not be wasted.

10. Health care institutions and clinicians should strive to cooperate and coordinate care.

The Committee acknowledges the enormous amount of work that will be required to reach the goals set forth in the report. In an effort to reach those goals, it is believed that the health care system should focus the most attention on the types of conditions that affect the most people and account for the greatest health care services and expenditures; according to the Quality report, almost all of these conditions are chronic in nature. Therefore, it is recommended that the AHRQ identify the top fifteen priority conditions. As stated in the Quality report, care for these conditions needs to be a collaborative and multidisciplinary process.

The report also recommends increased funding; Congress should create an “innovation fund” of $1 billion to encourage research and other projects to help redesign the American health care system. In addition to increased funding, information technology must play a greater role in patient-clinician communication and in the health care delivery system in general.

III. AAPM&R Position

The AAPM&R recognizes that patient safety and quality of care are amongst the most important issues in health care today. AAPM&R strongly supports the reduction of preventable medical errors as an urgent and essential national objective and actively seeks to participate in developing policies to address this issue. To that end, AAPM&R has launched initiatives to address medical errors and patient safety as they pertain to the field of physical medicine and rehabilitation. AAPM&R’s efforts to date have included establishment of a Medical Errors / Patient Safety Task Force, letters to Congressional leaders and the Bush administration, and participation at the national level with organizations such as the Agency for Healthcare Research and Quality (AHRQ) to help support and advance patient safety initiatives. AAPM&R fully intends to partner with other groups to continue patient safety and quality of care policy development in the future.

According to the IOM, the problems of patient safety and quality care are largely due to an overly complex system of processes. AAPM&R believes that although physicians strive to provide quality care, the complexity of the system, the environment in which physicians work, and the often-complicated nature of the patients treated, challenge even the best physicians. The IOM and the AHRQ appropriately place emphasis on the need for a systems change.

Physiatrists treat patients with acute and chronic pain, persons who have experienced catastrophic events, resulting in spinal cord injury, amputation, or traumatic brain injury, rheumatologic conditions, musculoskeletal injuries, or neurological disorders such as stroke, multiple sclerosis, polio, or amyotrophic lateral sclerosis. Therefore, the main focus of physiatrists, with regards to patient safety and quality of care, is persons with disabilities.

According to the National Institute on Disability and Rehabilitation Research (NIDRR), there are an estimated 52 million Americans with disabilities, or approximately 1 of every 6 citizens, ranking disability among the nation's biggest public health care concerns (NIDRR, 2001).
People with disabilities as a group rank highest among groups with an increased need for short and long term health care services. People with disabilities have significantly higher rates of both physician visits and hospitalization compared to people without disabilities. Furthermore, the number of physician visits increases with severity of disability (LaPlante, 1993). It is believed that higher rates of physician visits and greater numbers of medical treatments will eventually lead to a higher likelihood of exposure to risk of treatment-based complications and medical errors in general. AAPM&R’s position on patient safety and quality of care includes the following principles:

**Research and Patients with Disabilities**

- AAPM&R supports the findings of the IOM Report but believes that there are specific concerns regarding the incidents of medical errors involving persons with disabilities which are not addressed in the report. Enhanced research is necessary to understand the source of medical errors in people with disabilities. AAPM&R urges the Administration and Congress to appropriate sufficient funding for medical errors reduction research including research specifically related to people with disabilities. Increased funding will foster the development of scientific knowledge and evidence-based medicine necessary to enhance the health, productivity, functional independence, and quality of life for persons with disabilities and chronic illnesses.

**Teamwork as a Model for Quality**

- Patient-centered care is one of the tenets of the IOM Quality report, along with team practice across integrated delivery systems. Teamwork is essential as it promotes communication amongst health care providers, thus reducing the likelihood of medical errors. AAPM&R maintains that one of the unique strengths of a physical medicine and rehabilitation physician is care and treatment of patients through an interdisciplinary approach. The teamwork within physiatric practice serves as a model for quality in effective patient-centered care. Physical medicine and rehabilitation physicians understand team roles and how to effectively manage team practice to promote quality of care. Research funds should be devoted to understanding the most effective and efficient approaches to team-based health care, especially care of the chronically ill and disabled.

**Sharing of Information**

- AAPM&R contends that the recommendations contained in the Quality report regarding “shared knowledge and the free flow of information” can only occur with revisions to existing regulations and procedures, such as the Health Insurance Portability and Accountability Act (HIPAA). Communication between providers should not be unduly restricted.

**Reporting of Medical Errors / Adverse Events**

- AAPM&R asserts that all health care organizations and settings, including long-term care and skilled nursing facilities, hospitals, and physicians’ offices, should have a patient safety program that facilitates the reporting of medical errors and other adverse events. Medical error reporting should be a requirement of an overall institutional quality improvement program and should be encouraged regardless of the outcome and without placing blame. Following a medical error or adverse event, the organization should seek to understand the cause or causes of the error and make
whatever changes are necessary to avoid error recurrence. In addition, health care organizations should examine institutional systems that may be contributing to errors.

- AAPM&R asserts that a patient safety and medical error reporting program can only be successful if the information obtained remains confidential to promote the greatest likelihood of communication amongst care providers to assist processes.

References


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