

# The Future of Patient Safety

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This November marked the fifth anniversary of the sobering Institute of Medicine (IOM) report, *To Err is Human*, prompting us now to review what issues it opened, what corrective measures have been taken, and what may lie ahead for the delivery of quality health care in the future. The IOM report highlighted the statement that a controversial 44,000 to 98,000 hospital deaths result annually from preventable medical errors, and it proposed a minimum goal of a 50% reduction in errors over the next 5 years. This report was followed in 2001 by the IOM's *Crossing the Quality Chasm*, which noted that more than 50% of patients with chronic conditions such as diabetes, asthma, congestive heart failure, and depression are currently managed inadequately. Factors contributing to this chasm include the lack of efficient systems for delivering the appropriate tests, medication, and education to the population at risk. In addition, there are complicating factors of literacy, underinsurance and lack of insurance, medication costs, and time pressures as physicians attempt to manage multiple problems simultaneously, often moving from one pressing patient concern to another,

without necessarily having the opportunity to step back and review the larger issues. It has been said that every interruption is an opportunity for error, and how many times is a physician interrupted in one day? Both of the IOM reports focused attention on medical errors—those of commission in the first report and of omission in the second.

The country—particularly the payers of the country, including businesses, health plans, and the government—are increasingly requiring that the value of medical services delivered needs to be proven with objective markers of quality care, including evidence-based indicators that have been shown to result in improved outcomes. A plethora of organizations is measuring these indicators; one initiative in particular is affecting nearly every hospital in the United States. Since August 2004, eligible hospitals throughout the nation have been reporting quality-of-care data to the Centers for Medicare and Medicaid Services; the data will give consumers information about performance in three areas—heart attack (acute myocardial infarction) care, heart failure care, and pneumonia care. Data on quality of care for each of these conditions address key questions related to appropriate care. (These indicators can be found at

[www.cms.hhs.gov/quality/hospital/.](http://www.cms.hhs.gov/quality/hospital/)) For instance: Was aspirin given to the patient for acute myocardial infarction, and was a beta blocker prescribed at discharge? Was an angiotensin-converting enzyme (ACE) inhibitor given to the patient with heart failure? Did the patient with pneumonia receive antibiotics in a timely fashion, and were oxygen levels assessed? Notice that none of these actions is what one might consider a “high tech” procedure with internal defibrillators, aortic balloon pumps, or mechanical ventilation. In fact, these steps might seem so simple that we would assume they are being administered appropriately already. Data across the nation, however, has shown they are not. Failure to systematize this care delivery nationwide has resulted in poorer patient outcomes (translation: premature deaths) and now in the coming year will result in a direct impact on reimbursement. Hospitals that do not achieve at least an 85% compliance with each of these core measures will lose 0.04% of Medicare reimbursement, a number that can quickly add up to a significant dollar amount. Other insurers and businesses are looking to follow this lead, with dollars directly at risk for the failure to consistently deliver care that meets current guidelines. This “pay for performance” trend is rapidly growing.

How can health care facilities achieve success in actual care delivery and outcomes? Good intentions, education, and hard work only go so far, hence the gap. Systems designed for hospital, long-term care, and ambulatory settings are needed to implement measures for quality care. Successful change will require the involvement of many health care professionals, including physicians, nurses, other health care providers, researchers, and administrators. It will require both identification of a problem and insight into addressing it. It will demand a commitment of the resources of time, money, and energy. And it will take a team effort to learn how to use the system effectively and consistently.

One would think that with Web sites of quality measures abounding, the informed consumer purchasing health care may be studying and comparing his or her options based on such measures. Efforts are increasing to make the consumer Web sites (such as [www.minnesotahealthinfo.org](http://www.minnesotahealthinfo.org)) more user-friendly, and payers are certainly highly attentive to quality markers. But John Rother, director of policy and strategy for the American Association of Retired Persons, has said that currently the top priorities of his constituency, in addition to financial issues and medication costs, are convenience in accessing care and finding a “good doctor.” A system with an excellent rating is not valued by a patient if he or she cannot easily make an appointment, and a high

priority is put on finding a “good” individual doctor who will spend time in the room with a patient (even though the ultimate outcome of a patient’s care may be far more dependent upon the quality of the system in which that physician practices than upon the physician’s individual talents and efforts).

How should one view the outcome of the past 5 years in error reduction and quality improvement? There is still a nationwide fragmented health care situation (too disjointed to call a “system”), still too many basic care standards unmet across the country. However, increasing attention has been brought to the issue. As a result, many hospitals are taking proactive steps to report and review errors constructively; more clinics are systematizing care delivery, be it with electronic medical records, computer-assisted decision making in the form of computer order sets, or visit planning; and more payers are relating reimbursement to markers of quality of care.

Not every patient fits neatly into a guideline; myriad complex and interacting medical and social issues arise with so many medical situations. But the increased morbidity, increased loss of life, and wasted dollars resulting from a failure to implement essential care efficiently is not acceptable. The better the design of a seamless care delivery system that attends to essentials, the more attention the physician can devote in the room with the patient, listening to

their concerns and mutually and creatively trying to address those all too numerous problems for which there currently are no published guidelines.