www.coloadopatientsafety.org
August 11, 2009

Interim Health Care Task Force

I. Introduction to the Colorado Patient Safety Coalition

a. Mission: To foster a culture of patient safety in Colorado
b. Participants : Over 1000 participants
    i. Consumers/patients/families
    ii. Health care providers
    iii. Quality improvement organizations
    iv. Regulators
    v. Researchers
    vi. Medical liability managers
    vii. Many others
c. Activities
    i. Annual "Do No Harm" Conference (November 13, 2009)
    ii. Patient Safety Awards
    iii. Patient Safety Policymaking

II. Quantifying Medical Errors

a. From 44,000 to 98,000 people die in hospitals each year as the result of medical errors.
b. Medical errors carry a high financial cost. The IOM report estimates that medical errors cost the Nation approximately $37.6 billion each year; about $17 billion of those costs are associated with preventable errors.

III. A Colorado-Specific agenda for Patient Safety

a. Generous Support from the Colorado Trust
b. A **Leadership Task Force** was convened
c. Colorado Patient Safety Agenda has identified three foundational elements of a patient safety agenda for Colorado as follows:

Embedding Safety Into Colorado's Healthcare Culture

Community-Wide Coordination of Care When Patients Are Transitioned Between Providers of Care

Fostering the creation of a Patient Safety Organization

IV. Questions?

From The Federal Agency for Healthcare Research and Quality at www.ahrq.gov

Medical Errors: The Scope of the Problem

An Epidemic of Errors

The November 1999 report of the Institute of Medicine (IOM), entitled *To Err Is Human: Building A Safer Health System*, focused a great deal of attention on the issue of medical errors and patient safety. The report indicated that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors.

Even using the lower estimate, this would make medical errors the eighth leading cause of death in this country—higher than motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516). About 7,000 people per year are estimated to die from medication errors alone—about 16 percent more deaths than the number attributable to work-related injuries.

The President ordered the Quality Interagency Coordination Task Force to make recommendations on improving health care quality and protecting patient safety in response to the IOM report. The Report to the President on Medical Errors was issued in February 2000. For more information on medical errors, select http://www.ahrq.gov/qual/errorsix.htm.

Where Errors Occur

Errors occur not only in hospitals but in other health care settings, such as physicians' offices, nursing homes, pharmacies, urgent care centers, and care delivered in the home. Unfortunately, very little data exist on the extent of the problem outside of hospitals. The IOM report indicated, however, that many errors are likely to occur outside the hospital. For example, in a recent investigation of pharmacists, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year in the State.

Costs

Medical errors carry a high financial cost. The IOM report estimates that medical errors cost the Nation approximately $37.6 billion each year; about $17 billion of those costs are associated with preventable errors. About half of the expenditures for preventable medical errors are for direct health care costs.

Not a New Issue

The serious problem of medical errors is not new, but in the past, the problem has not gotten the attention it deserved. A body of research describing the problem of medical errors began to emerge in the early 1990s with landmark research conducted by Lucian Leape, M.D., and David Bates, M.D., and supported by the Agency for Health Care Policy and Research, now the Agency for Healthcare Research and Quality (AHRQ).

From The Federal Agency for Healthcare Research and Quality at www.ahrq.gov

Public Fears

While there has been no unified effort to address the problem of medical errors and patient safety, awareness of the issue has been growing. Americans have a very real fear of medical errors. According to a national poll conducted by the National Patient Safety Foundation:

- Forty-two percent of respondents had been affected by a medical error, either personally or through a friend or relative.
- Thirty-two percent of the respondents indicated that the error had a permanent negative effect on the patient's health.

Overall, the respondents to this survey thought the health care system was "moderately safe" (rated a 4.9 on a 1 to 7 scale, where 1 is not safe at all and 7 is very safe).

Another survey, conducted by the American Society of Health-System Pharmacists, found that Americans are "very concerned" about:

- Being given the wrong medicine (61 percent).
- Being given two or more medicines that interact in a negative way (58 percent).
- Complications from a medical procedure (56 percent).

Most people believe that medical errors are the result of the failures of individual providers. When asked in a survey about possible solutions to medical errors:

- Seventy-five percent of respondents thought it would be most effective to "keep health professionals with bad track records from providing care."
- Sixty-nine percent thought the problem could be solved through "better training of health professionals."

This fear of medical errors was borne out by the interest and attention that the IOM report generated. According to a survey by the Kaiser Family Foundation, 51 percent of Americans followed closely the release of the IOM report on medical errors.

It's a Systems Problem

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivering care and not to blame individuals. Health care professionals are simply human and, like everyone else, they make mistakes. But research has shown that system improvements can reduce the error rates and improve the quality of health care:

Leadership Task Force Membership

NAME	ORGANIZATION	ROLE
Arja Adair	Colorado Foundation for Medical Care	Representing the Quality Improvement infrastructure of Colorado
Phyllis Albritton	Colorado Regional Health Information Organization (CORHIO)	Representing Colorado's Health Information Exchange
Scott Anderson	Colorado Hospital Association (CHA)	Representing Colorado Hospitals
Crystal Berumen	Colorado Hospital Association (CHA)	Representing Colorado Hospitals
Ned Calonge	Colorado Department of Public Health and Environment	Representing state government as both a purchaser and a regulator
Ellen Caruso	Home Care Association of Colorado	Representing home health agencies
Allison Daniels	Colorado Department of Public Health and Environment	Representing state government as both a purchaser and a regulator
Edward Dauer	Colorado Patient Safety Coalition	Representing CPSC as the Lead Organization
Jennifer Dingman	Persons United Limiting Substandards and Errors in Health Care (PULSE)	Representing consumers/patients/families
Cari Fouts	Colorado Rural Health Center	Representing the interests of rural Colorado
Marjie Harbrecht	Colorado Clinical Guidelines Collaborative (CCGC)	Representing health quality improvement infrastructure to improve and standardize processes of care
Val Kalnins	Colorado Pharmacists Society	Representing the interests of Colorado pharmacists
Mark Levine	Center for Medicare and Medicaid Services	Representing CPSC as the Lead Organization
Donna Kusuda	Colorado Hospital Association	Representing the interests of patients and hospitals
Mark Longshore	Center for Nursing Excellence	Representing issues of nurse workforce development
Donna Marshall	Colorado Business Group on Health	Representing the interests of the business community
Arlene Miles	Colorado Health Care Association	Representing the interests of Long term Care providers
Michelle Mills	Colorado Foundation for Medical Care (CMS)	Representing the Quality Improvement infrastructure of Colorado
Lynn Parry	Colorado Medical Society	Representing the interests of Colorado physicians
Laurel Petralia	The Colorado Trust	Program Officer

Richert Quinn	Colorado Patient Safety Coalition	Representing CPSC as the Lead Organization
Fran Ricker	Colorado Nurses Association	Representing Registered Nurses
Howard Roitman	Colorado Department of Public Health and Environment	Representing state government as both a purchaser and a regulator
Patty Skolnik	Colorado Citizens for Accountability (CCA)	Representing consumers/patients/families
Carol Anne Tarrant	COPIC Insurance	Representing Risk Prevention and Institutional Patient Safety
Sandeep Wadhwa	Colorado Department of Health Care Policy and Financing	Colorado State's Medicaid Program Director.
David West	Colorado Patient Safety Coalition (CPSC)	Representing CPSC as the Lead Organization
Lou Ann Wilroy	Colorado Rural Health Center	Representing the interests of rural Colorado