

Opinions Commentary » *Rebecca Miller, Herb Kuhn, C.C. "Cork" Swarens and Richard Royer*

Not just for show

Missouri's safety efforts preceded IOM report, continue quietly today

The editorial in the Sept. 21 issue of *Modern Healthcare* (p. 22) suggested that recent patient-safety initiatives throughout the nation have been motivated by two factors—the specter of systemic health system reform and the 10th anniversary of the Institute of Medicine's report, *To Err Is Human: Building A Safer Health System*. It also contended that most of that activity has taken place in the past four months. We disagree.

To suggest that complex patient-safety systems could be created and implemented in four months is a disservice to both *Modern Healthcare* readers and the thousands of committed health professionals who labor to build a better-performing healthcare system. In fact, in the decade since the release of the IOM's landmark report, a quiet revolution has taken place in healthcare.

This revolution is "quiet" because new quality systems seldom get the attention that health technology or medical breakthroughs garner. They tend to be simple processes that, when implemented correctly, require little cost and are transparent to patients.

The IOM found most medical errors are caused by faulty systems, processes and conditions. According to the report, "mistakes can best be prevented by designing the health system at all levels to make it safer—to make it harder for people to do something wrong and easier for them to do it right."

Missouri's patient-safety efforts predate the IOM report, which verified those efforts. Missouri providers have embraced progressive approaches to address the causes of and solutions to medical errors. Since 1983, Missouri's quality-improvement organization, Primaris, has led efforts to improve care provided to the state's Medicare recipients. In the late 1990s, the Missouri Hospital Association retained a quality professional to support hospitals' internal quality-improvement systems and organized a statewide task force on healthcare quality. Hospitals and physicians also participated in former Gov. Bob Holden's Missouri Commission on Patient Safety in 2003.

The governor's commission spurred the formation of the Missouri Center for Patient Safety in 2005. The center provides solutions and resources to improve patient safety and quality. In 2008, the center was one of the first 10 organizations nationwide to certify as a patient-safety organization. This federal desig-



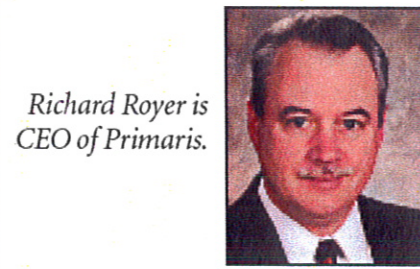
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nation allows the center to collect and report information about medical errors as it focuses on prevention.

Since 1999, the number of programs designed to improve patient safety and healthcare quality has grown phenomenally. And, when incorporated into the practices of healthcare providers, they have proven to decrease the risk of patient harm. Many Missouri healthcare providers have participated in the Institute for Healthcare Improvement's 100,000 Lives and 5 Million Lives campaigns focused on preventing medical errors.

At the state level, under the leadership of

the Missouri Center for Patient Safety, error intervention programs, such as the Banding Together for Patient Safety and the Missouri Safe Surgery—Saves Lives Dash, have reduced the potential for human error in patient care. In addition, the Just Culture Collaborative in Missouri urges all involved in healthcare to learn about ways to improve processes by encouraging the reporting of risky situations and medical errors rather than assigning blame after medical errors occur. Additional information about these programs is available online at mocps.org.

The past decade also has brought about an increased commitment from healthcare providers to report their performance on medical outcomes. In 2004, Missouri's hospitals published a voluntary report on healthcare quality, which is now required of all hospitals nationwide. And since 2006, hospitals have reported cases of hospital-acquired infection to the state.

Last year, the MHA board of trustees unanimously endorsed a set of recommended actions in the event of a serious medical error, or "adverse event." The board recommends hospitals take three actions following a serious adverse event: Inform the patient, report the incident to a patient-safety organization and waive the bill. The board's action represents a commitment to ensure that adverse events do not happen, and, in the rare occasion when they do, to put the patient first. This year, the MHA also worked with Missouri's Medicaid program to help implement a new regulation that requires the reporting of certain medical errors to a patient-safety organization.

As with any effort, there will be detractors who focus on the work that still needs to be done rather than the progress made. Missouri's healthcare providers and patient-safety advocates, however, are proud of the efforts achieved thus far. More important, we remain committed to continual, collaborative and measurable progress to ensure that patients receive the care they deserve.

It has been said that "in retrospect, all revolutions seem inevitable. Beforehand, all revolutions seem impossible." With lives in the balance, progress in patient safety is essential.

In Missouri, the only motivation necessary to sustain the patient-safety and quality revolution is the knowledge that the patients we serve are better for our efforts. In our state, the quiet revolution in quality and safety will continue. <<