
Landscape of Maine Patient Safety Activities

A Report to the Dirigo Health Agency's Maine Quality Forum

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EXECUTIVE SUMMARY

Landscape of Maine Patient Safety Activities

"Patient safety refers to the freedom from accidental or preventable injuries produced by medical care. Practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events." (Agency for Healthcare Research and Quality)

The purpose of this report *Landscape of Maine Patient Safety Activities* is to provide the Maine Quality Forum and the Dirigo Health Agency with baseline information that identifies the scope and depth of current patient safety initiatives in Maine. The State Health Plan identified the need to document the current patient safety efforts and compare Maine's patient safety efforts to similar efforts in other states.

The landscape review of patient safety activities in Maine includes data collected through three different lenses. First, the team completed an environmental scan of patient safety activities in other states and explored the various configurations of formal organizational patient safety activities. Second, a convenience sample online survey was conducted with Maine healthcare stakeholders to gather specific information about activities and needs for additional efforts. Finally, follow-up interviews were conducted with key informants to gain a deeper understanding of the Maine landscape of patient safety activity.

Environmental Scan of State Patient Safety Activities

Patient safety is an area of focus for all healthcare organizations. While some organizations address patient safety on their own, within their own profession, or within their organizational setting, some states have organizations that include a broader stakeholder involvement. To understand the context in which Maine's patient safety activities are currently occurring, a review was conducted of how other states are approaching patient safety.

- Maine's patient safety activities are primarily structured through healthcare provider groups, organizations and systems. Other patient safety activities occur through partnership and collaborative groups, state agencies, professional and trade associations and grant projects.
- States typically address patient safety and quality using different types of organizations, partnerships, and funding mechanisms. All states are involved in patient safety to some extent, but many are specific in focus. A few states support patient safety in a comprehensive population-based agency with public funds.
- Most privately supported patient safety organizations target specific types of healthcare providers or settings of care.

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- Patient Safety Organizations (PSOs) were developed as a part of the federal Patient Safety Act of 2005 to provide legal protection for reporting patient safety and quality data. The Agency for Healthcare Research and Quality oversees the designation. Currently there are 30 states that have designated PSOs, which often have more than one PSO, since PSOs may target a very specific population (76 PSOs total). PSOs primarily focus on data collection and analysis of patient safety data (adverse events).
 - Maine has only one organization with the federal designation PSO. Specialty Benchmarks, located at Pineland Farms, is a private, for-profit firm which contracts with anesthesiology practices across the country to collect and analyze quality data.

While some states have organized themselves to provide broad spectrum and population-based structure to patient safety activities, most states rely on partnerships with stakeholders for patient safety infrastructure. These public-private partnerships bridge diverse and specific activities through many different organizations and provider groups. Specific topic-driven patient safety activities are often dependent upon funding by the healthcare setting, trade associations, or grant funds. Groups with the federal designation “Patient Safety Organization” typically engage with targeted settings of care and may choose to focus entirely on data collection and analysis of adverse events, rather than undertake improvement activities or provider and consumer education. Funding sources of the various organization types are subject to grant availability, public fund support and membership fees. Financial sustainability varies from model to model, yet infrastructure support remains a concern for most models of patient safety organizations.

Online Survey

An online survey was designed by the research team in consultation with Dirigo Health Agency and Maine Quality Forum staff. The purpose of the survey is to expand understanding of the involvement, scope and impact of patient safety activities from the perspective of individuals who are involved in the provision of healthcare in Maine. In September 2011, 758 people and 26 key contacts at organizations/groups were sent emails and invited to participate in the survey. The online survey was “live” for 2.5 weeks and 316 respondents completed the entire survey.

- For organizations that are involved in patient safety activities, the top three types of activities involve quality improvement, communication improvement, and staff education and training.
- Most organizations use their own budget to support patient safety activities, but about a quarter receive funding from grants and about ten percent receive government funding and/or fees. Half reported a dedicated staff person to patient safety, while some others report using a committee
- About two-thirds of organizations that are involved with patient safety activities engage consumers in patient safety activities. Of those who engage consumers in patient safety activities, about two-thirds share their patient safety data with Maine consumers.

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- Most organizations provide or participate in training on patient safety (93%). The majority of these trainings on patient safety are designed and conducted at the organizational level. About three quarters of respondents belong to a collaborative that addresses patient safety (73%).
 - The top five priority areas in patient safety were infection control and prevention, medication errors, adverse events, patient safety culture, teamwork and communication. These five areas were top priorities at both the organizational and state level. Infection control and prevention is the topic of highest interest and activity
 - Survey respondents indicated interest in a state role with training for healthcare providers, and education for both healthcare providers and consumers.
 - Participants report organizational activities and training focused on infection control and prevention; infection control and prevention is high priority area for additional activity.

Key Informant Interviews

The key informant interviewees included quality and safety leaders from hospitals, home health, primary care, healthcare organizations, and state agencies, as well as, hospital administrators and clinicians. The purpose of the interview was to expand upon the findings of the online survey and ask some clarifying and follow-up questions. Each key informant was asked to discuss the five most mentioned topics of interest from the survey: infection control, medication errors, adverse events, patient safety culture, and teamwork and communication. The three emergent themes from the qualitative interviews are summarized below.

Patient safety education represents a new and developing discipline which presents a challenge for Maine's healthcare community to catch up and keep up with this growing body of knowledge, skill set and attitudes.

- Educational institutions in Maine should be preparing the healthcare professional workforce to enter the field with patient safety knowledge, skills and attitudes.
- Current Maine healthcare professionals need training to gain basic patient safety competencies. There is widespread interest and demand for ongoing professional education in specific topics or best practices.

The Maine healthcare community is facing a tremendous challenge to *engage, empower and educate Maine consumers* regarding patient safety and quality.

- It is difficult to figure out how to get the public's attention about patient safety. Attempts to engage, empower, and educate patients, families and consumers at the point of care are challenging, particularly during the window provided in the acute care setting.
- Care of the patient occurs across an evolving continuum. Most patient care occurs outside of the acute care hospital, yet the focus on patient safety is primarily in-patient.

As patient safety policies, programs, and activities have taken hold in the Maine healthcare community, *many efforts are segmented* in silos with organizational or professional boundaries that diminish the economies of effort, the spread of best practices and the benefits derived from common data sharing.

- Clinical roles and silos influence practices in patient safety. Topic-driven collaborations by healthcare systems, professional organizations and grant activities have been very successful in improving patient safety practices in Maine.
- There is some consensus that state agencies and state-wide organizations could boost local and regional efforts to improve patient safety through coordination of healthcare professional training, public outreach, uniform reporting standards, and policy dialogue.
- The State or another state-wide organization can play an important role in providing infrastructure for improvement efforts

Conclusions

This report provides a view of patient safety efforts in Maine through three different lenses. The environmental scan suggests that state agencies and the Maine healthcare community are very active in addressing certain patient safety topics. Other states offer a more comprehensive approach, notably partnerships that bring broad based financial and human resource support to population-based improvement strategies. Maine currently does not have an organization with Patient Safety Organization (PSO) federal designation other than one private firm which contracts with anesthesiology practices around the country.

Survey results indicated extremely strong interest in basic education and training in patient safety both for current healthcare professionals and those individuals in the higher education pipeline. Patient safety is a recent discipline and there is in fact, some catching up to do. These results were confirmed by the key informant interviews. Many respondents believe that there is strong value in state-wide educational efforts and see a role for state leadership to drive this endeavor. The importance of sharing data to learn from errors and near misses was a recurring theme and may require the impartiality of a state-supported or PSO group to achieve wide-spread and transparent usefulness.

The control and prevention of infections has become one of the most pressing patient safety problems in healthcare due to the emergence of antibiotic resistant organisms.¹¹ The federal government and other healthcare payers are exerting financial pressure on healthcare providers as they begin to reduce or stop payment for services related to healthcare associated infections. With the delivery of healthcare services continuing to move from hospitals to ambulatory care, homes, and other settings, infection and infection control cannot be understood as clinical issues to be contained within the walls of the hospital. Infection control and prevention and antibiotic resistance are now a community concern that requires coordinated and sustained action through partnerships of stakeholders empowered through community-specific data and evidence-based strategies. As surveillance and incidence data and measures and become more standardized and available to providers, payers and consumers are driving increasing attention to the problem and urging action.

The overwhelming expression of interest and need for infection control and prevention education and improvement work may reflect the “canary” of the patient safety infrastructure within Maine. Healthcare associated infections are essentially moving targets with evolving clinical guidelines, diagnoses and treatments. Both healthcare providers and consumers have knowledge deficits and have yet to fully embrace best practices that can help control the spread of infection. Yet, at the same time, state agencies and healthcare organizations have devoted significant resources to prevent healthcare associated infections. Without the infrastructure of a comprehensive and population-based organization, these efforts may not be as effective as they could be. The expressed needs and frustrations of the survey respondents can be considered a symptom of a fragmented approach that falls short of addressing a significant and urgent patient safety issue.

Specific recommendations are detailed in a separate section in the report.