The Path Toward Achieving the IOM Goal of Transparency: What Do Hospital Executives Think about Reporting and Disclosure of Medical Errors?

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Harvard Quality Colloquium

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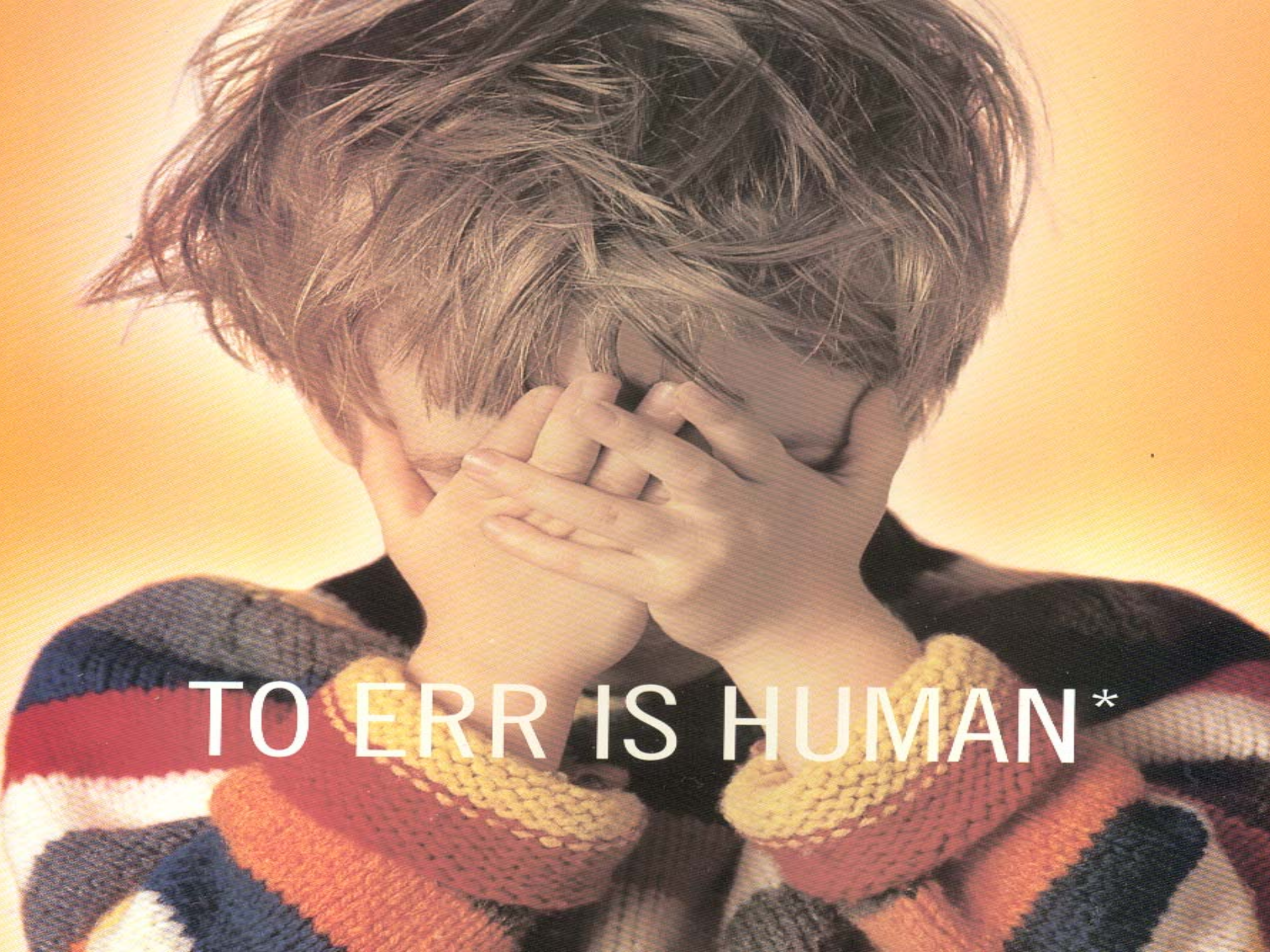
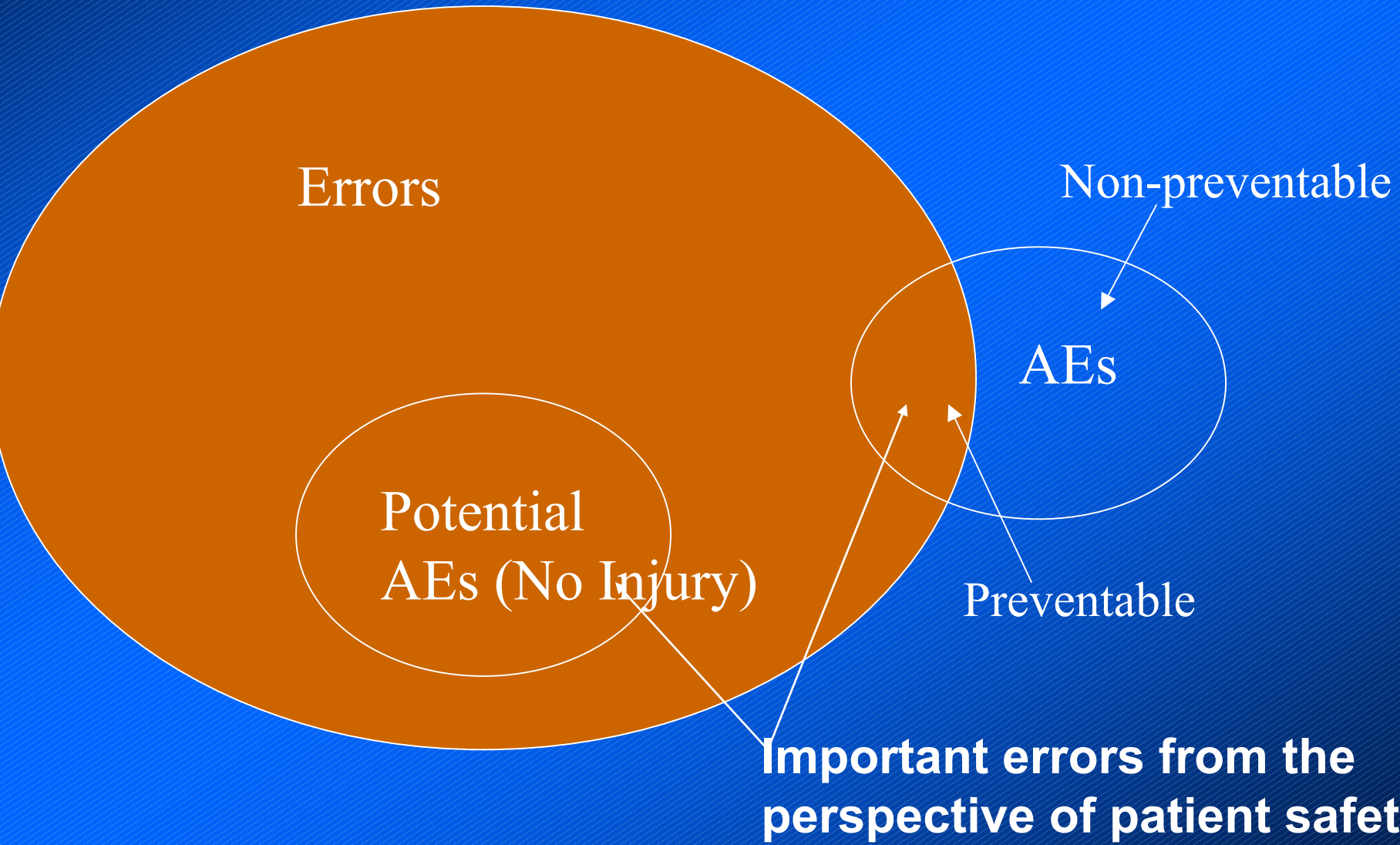

TO ERR IS HUMAN*

The IOM had 4 messages:

1. Errors are serious.
2. The system is at fault not people.
3. We need to redesign the systems, and the systems need to be transparent.
4. This is a national issue.

A Taxonomy of Medical Errors – What Should be Reported? Who Should Report? How Should They Be Reported?



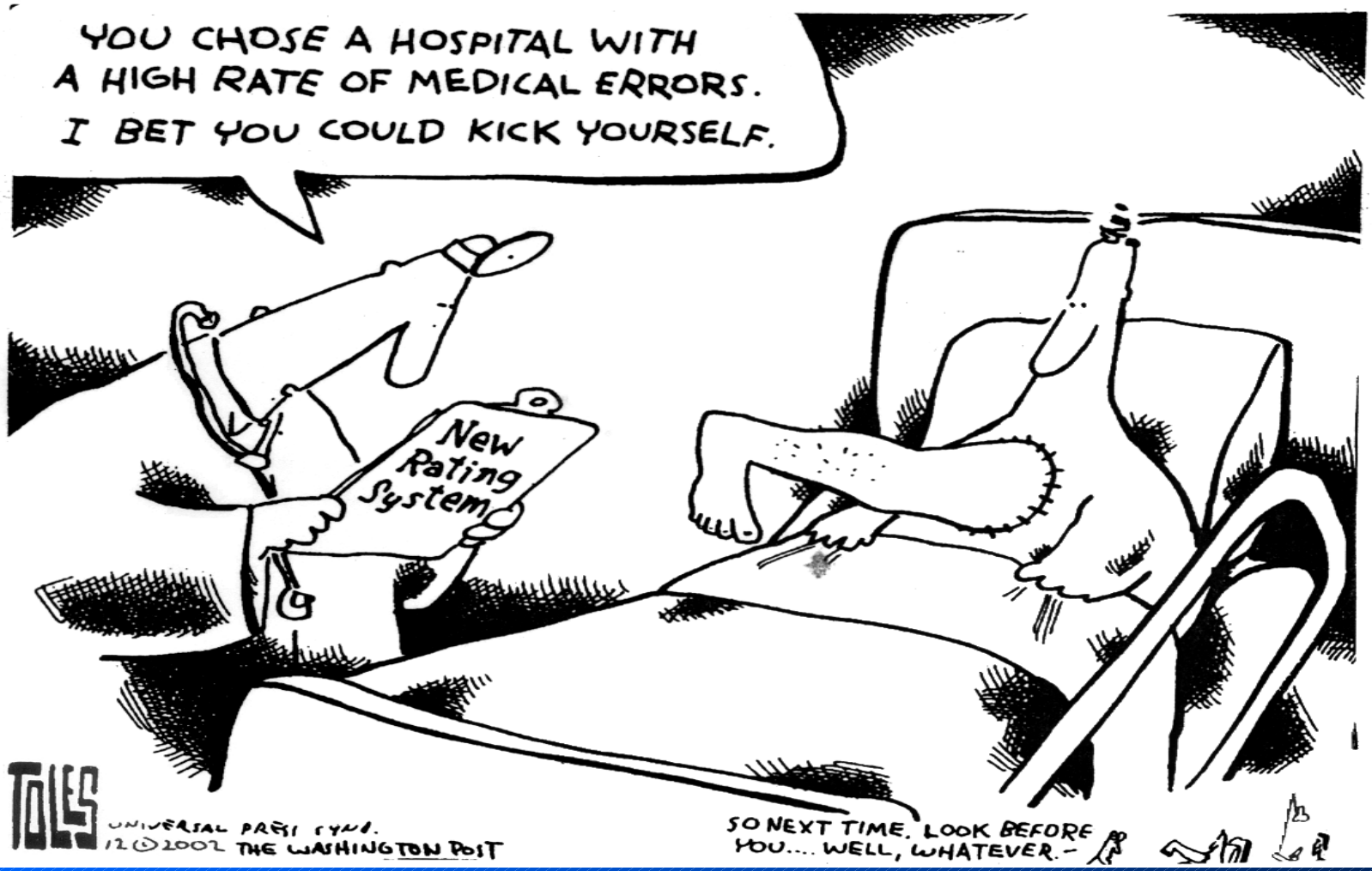
Background: States Have Begun to Report Medical Errors to the Public

- The IOM recommended establishing both mandatory and voluntary reporting systems
- Twenty-one states in 2003 had mandatory event reporting systems (NASHP, 2003)
- Under reporting has been a serious issue
  - facilities' lack of internal systems
  - uncertainty about reporting requirements
  - culture of non-reporting
  - fear of publicity and fear of liability.

Why Should States Collect Incident Reports?

- Learn patterns of errors before they result in widespread harm
- Keep hospitals and nursing homes accountable to the public
- Information to insurers on which to base selection of preferred providers

Another Possible Use of State Incident Reports: Informing the patient



Why Disclose to Patients?

JCAHO Standard (RI.1.2.2):
"Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes"

- Other Reasons
  - Ethical duty
  - Legal implications
  - Improve patient-physician communication
  - Reduce risk exposure
  - Improve provider state-of-mind
  - Improve quality of care

Massachusetts Department of Public Health AHRQ Patient Safety Grant Award

- Aim 1-Evaluate and Improve MARS
- Aim 2 - Develop and Implement Best Practices
- Aim 3 - Survey Hospital Leaders in 6 states
- Aim 4 - Survey recently hospitalized patients in Massachusetts about experiences in hospital

Aim 3 Objectives

SURVEY OF CEOs and COOs

- **Attitudes and experiences with state mandatory reporting systems**
- **Policies and practices with disclosure of errors to patients**

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ORIGINAL CONTRIBUTION

Error Reporting and Disclosure Systems
Views from Hospital Leaders

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Context The Institute of Medicine has recommended establishing mandatory error reporting systems for hospitals and other health settings.

Objective To examine the opinions and experiences of hospital leaders with state reporting systems.

Design and Setting Survey of chief executive and chief operating officers (CEOs/COOs) from randomly selected hospitals in 2 states with mandatory reporting and public disclosure, 2 states with mandatory reporting and public disclosure, 2 states with mandatory reporting without public disclosure, and 2 states without mandatory systems in 2002-2003.

Main Outcome Measures Perceptions of the effects of mandatory systems on error reporting, likelihood of lawsuits, and overall patient safety; attitudes regarding re-

State Sample - Spectrum of Reporting Systems as of 2001-2002

- Mandatory non-confidential
  - Massachusetts
  - Colorado
- Mandatory confidential
  - Pennsylvania
  - Florida
- Non-mandatory (at time of survey)
  - Georgia
  - Texas

All acute care hospitals in Massachusetts

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Random Sample of 50 hospitals in other states

Methods

- Questionnaire development via focused interviews with former hospital leaders and experts
- Cognitive testing
- Are hospital executives human subjects?
- Telephone interview administered by the UMASS Center for Survey Research: Winter, 2002-03
- Results weighted to reflect sampling and response rates

Outline of Interview

- Patient safety / Safety Culture as a hospital priority
- Attitudes toward mandatory state reporting systems
- Incident vignettes – What is likely to be reported?
- Attitudes and practices around disclosing medical errors to patients

Interview subjects: Hospital Patient Safety Leaders

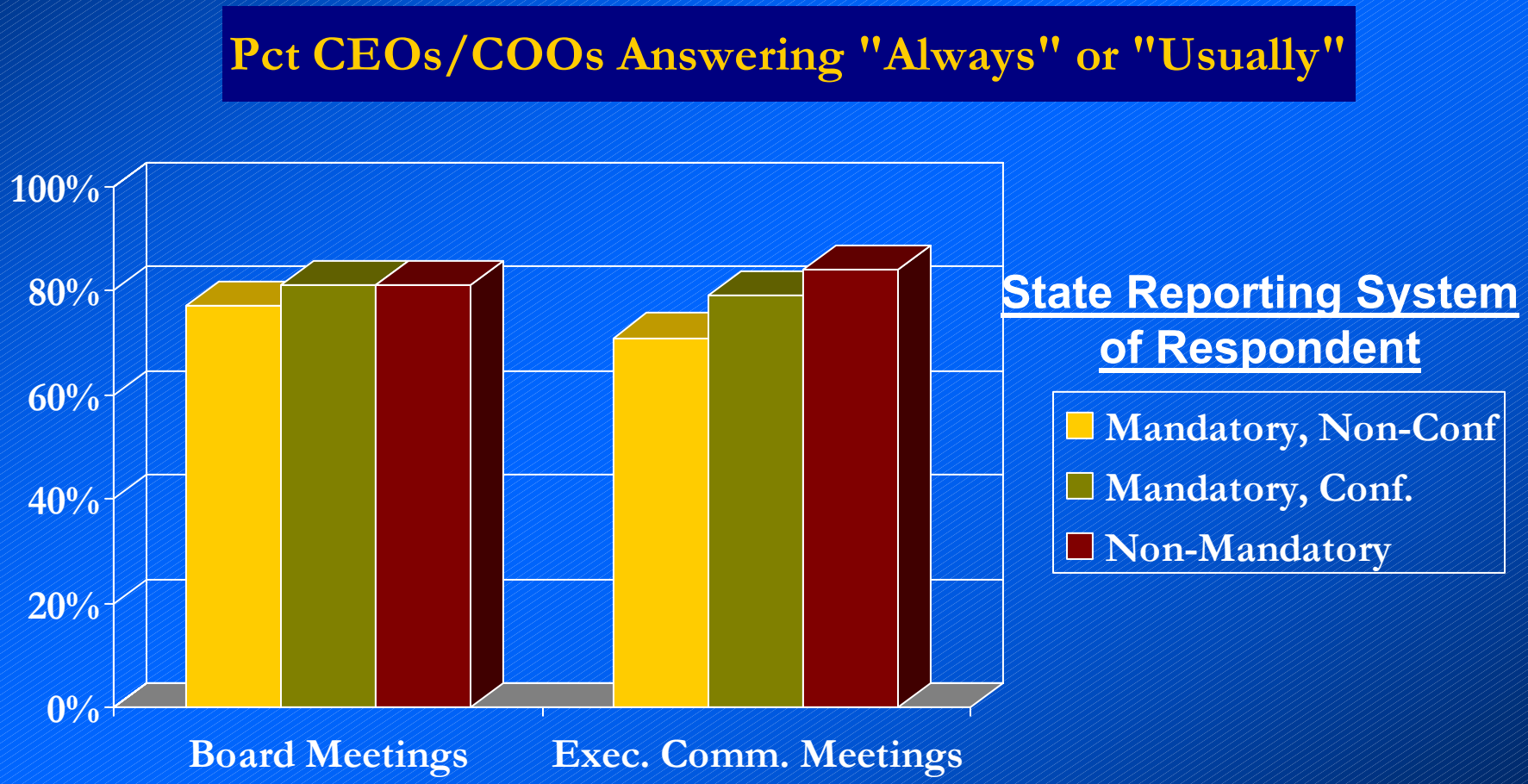
- Hospital Executives (CEOs, COOs)
- Any other safety leader
  - CMO or VP Health
  - Risk manager
  - Patient Safety Officer (if different from CMO)

Study Respondents

	CEOs/COOs n (%)	Any Safety Leader* n (%)	Total
MA	60 (79%)	72 (95%)	76
CO	34 (68%)	47 (94%)	50
FL	27 (54%)	45 (90%)	50
PA	26 (52%)	45 (90%)	50
GA	31 (62%)	47 (94%)	50
TX	27 (54%)	45 (90%)	50
Total	**205 (63%)**	**301 (92%)**	**326 (100%)**

*** - CEO, COO, CMO, Risk Manager, or Patient Safety Offcr**

"How often is the topic of patient safety on the agenda at…?"

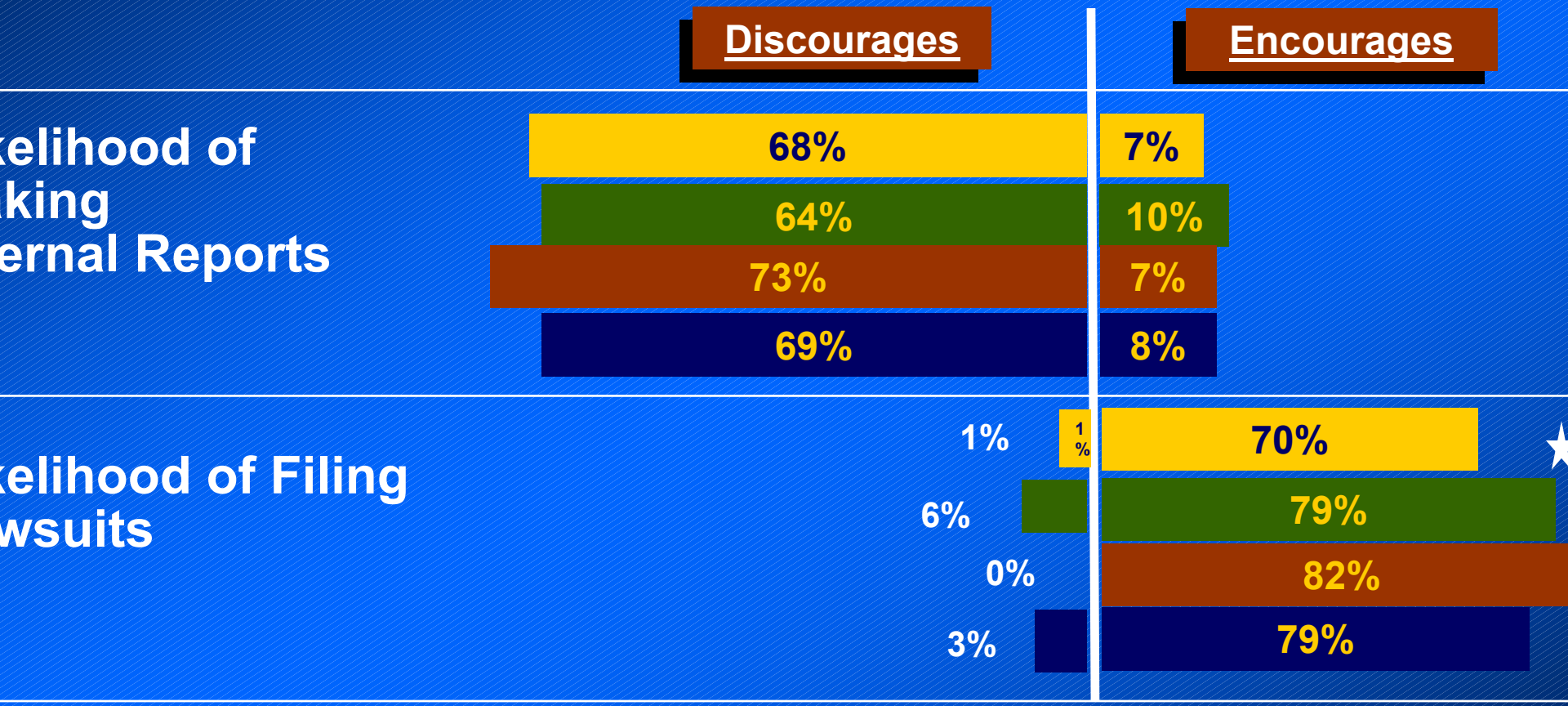


Patient Safety Culture in the Six Study States

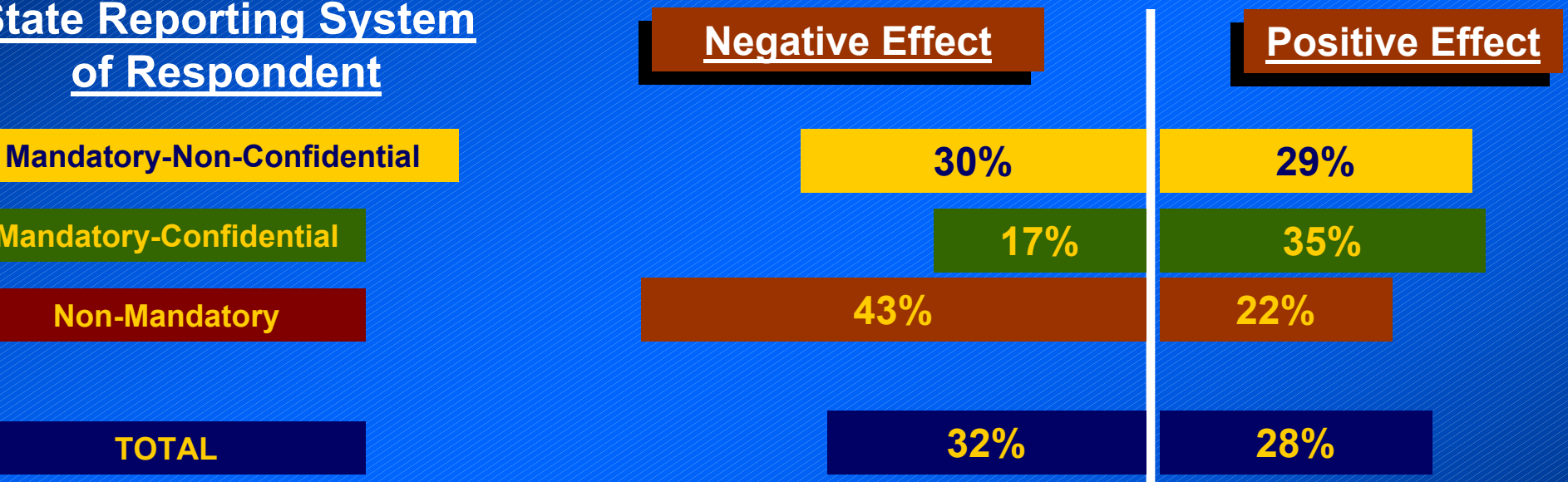
"In your hospital, how would you rate the priority of…?

	Percent of Hospital CEOs/COOs	
	Very High	High
Finding out about root causes when patients harmed	83%	16%
Identifying hospital procedures to improve safety	62	36
Protecting staff who report from negative consequences	60	36
Finding out who was at fault	37	33

Opinions About the Effect of State Mandatory Reporting Systems with Public Disclosure



What Effect Does a Mandatory State Reporting System (with Public Disclosure) have on Actual Patient Safety?



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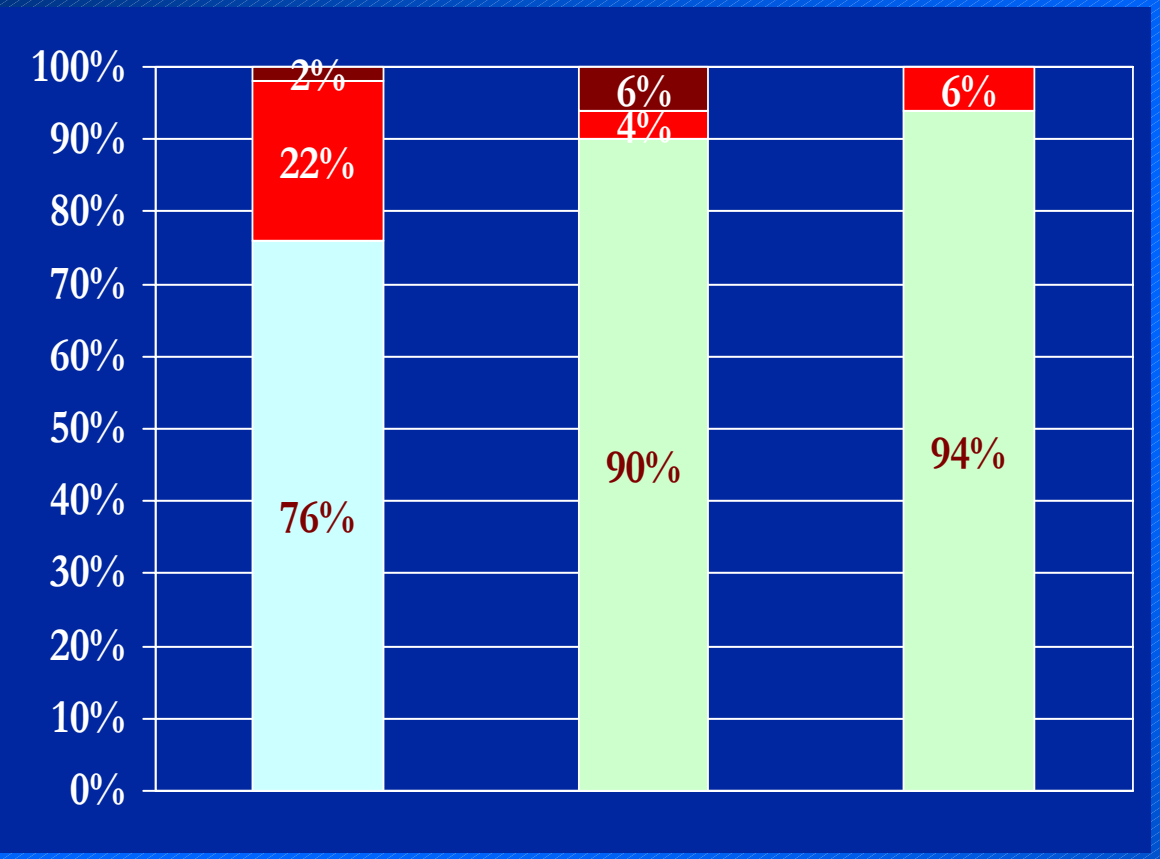
"Taking everything into consideration, which type of mandatory system would reduce errors the most? A system that…"



…makes public both the hospital and the individuals?

…makes public only the hospital name?

…keeps confidential both the hospital and the individuals?

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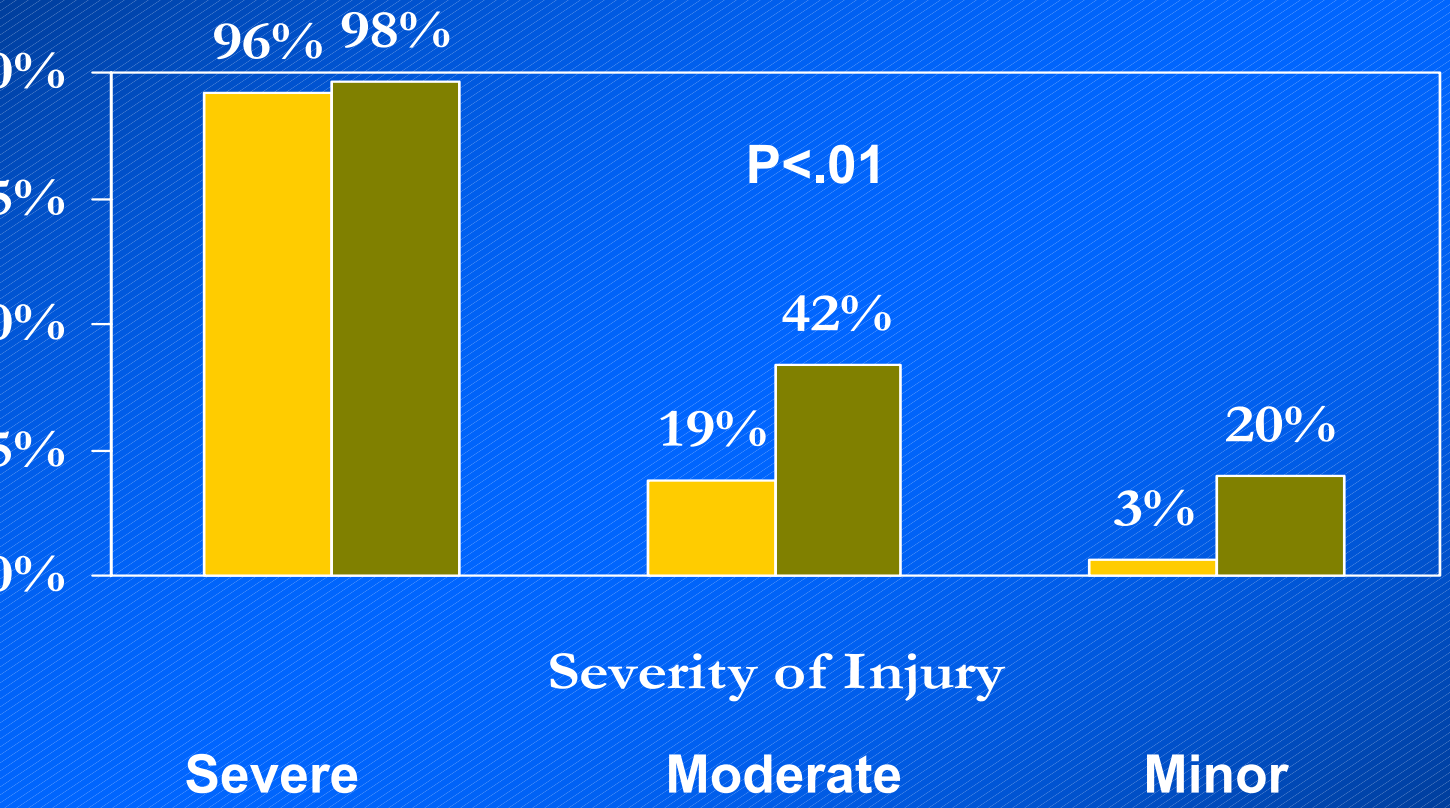
Vignette I

- A hospitalized patient is discovered to have a urinary tract infection. A physician orders Bactrim to treat the infection, not realizing that the patient has a previously documented severe allergy to this drug.
  - Severe Outcome - Coma
  - Moderate Outcome – breathing; rash; but resolves
  - Minor Outcome – No symptoms

How Often (Hypothetically) Would This Kind of Incident Be Reported to the "Agency"?

Vignette 1: Urinary tract infection, failure to note allergy

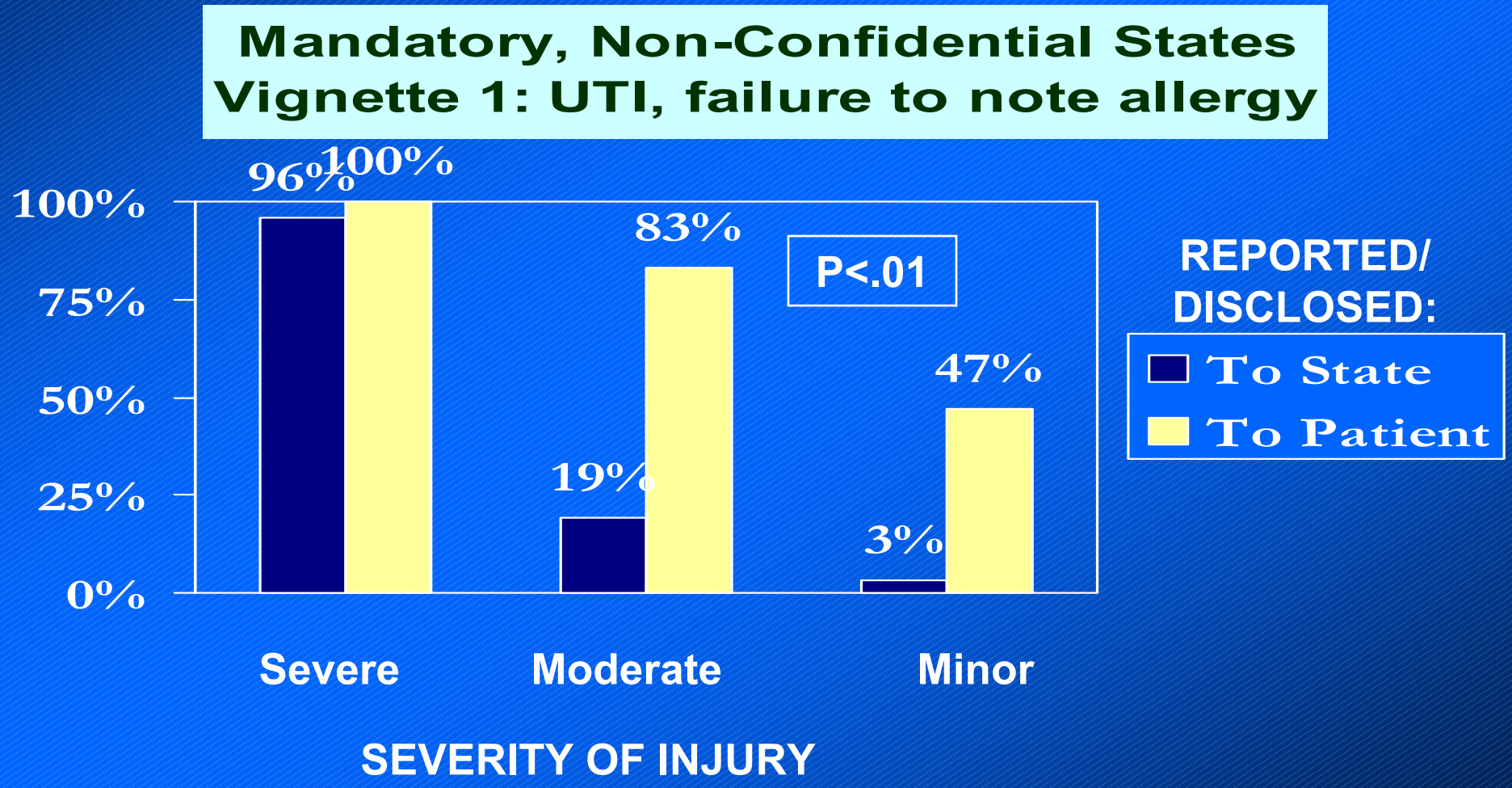


Type of State

Mandatory, Non-Confiden

Mandatory, Confidential

How Often Would This Incident 1) Be Reported the State Agency or 2) Be Disclosed to the Patient?



When Should the Agency Tell the Family About An Incident That's Been Reported?

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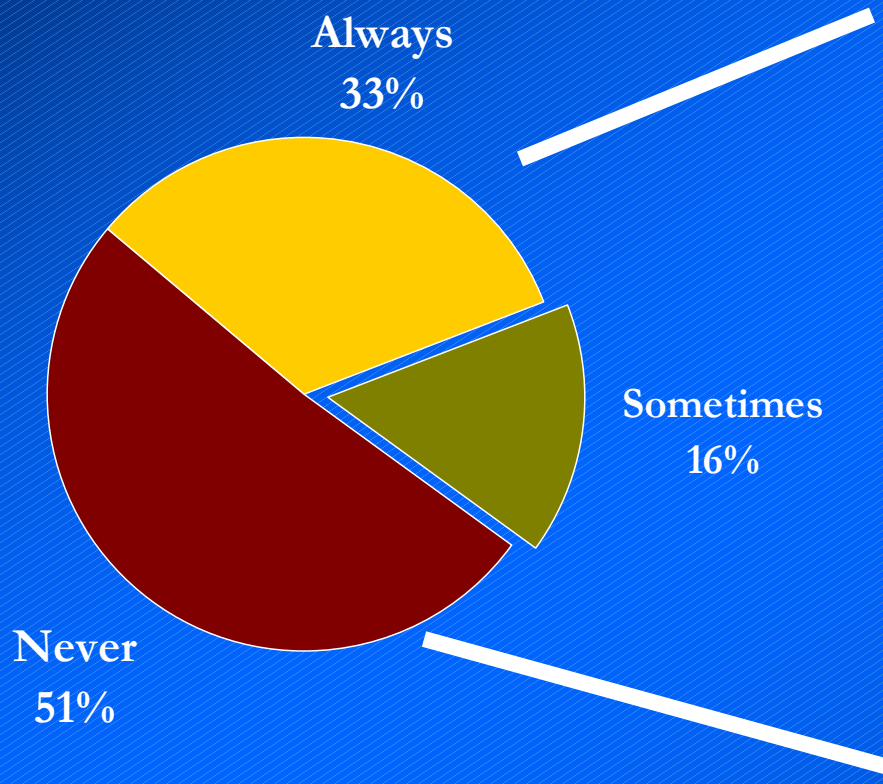
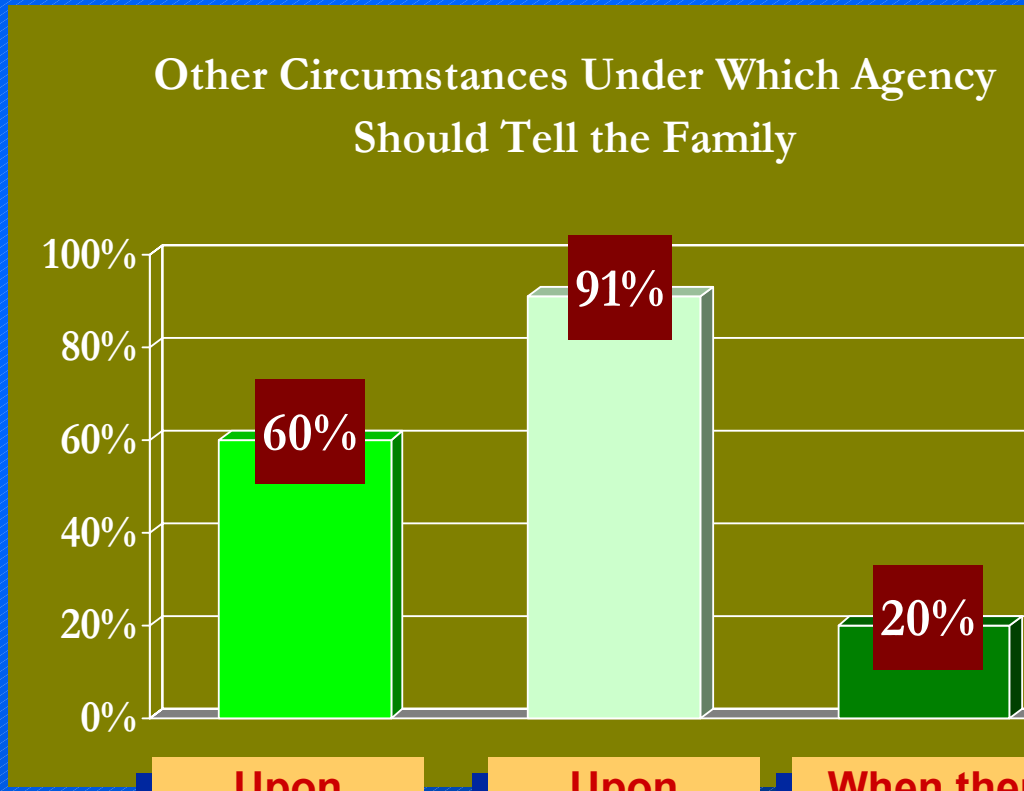




What Sorts of Events Are Disclosed Under Hospital's Policy?

Among 86% with a disclosure policy

	Percent of Hospital CEOs/COOs
Serious injuries believed to be result of error	98%
Minor injuries believed to be result of error	87%
Injuries that are not the result of errors	65%
Errors that do not harm patients	31%

Does Hospital's Disclosure Policy …?

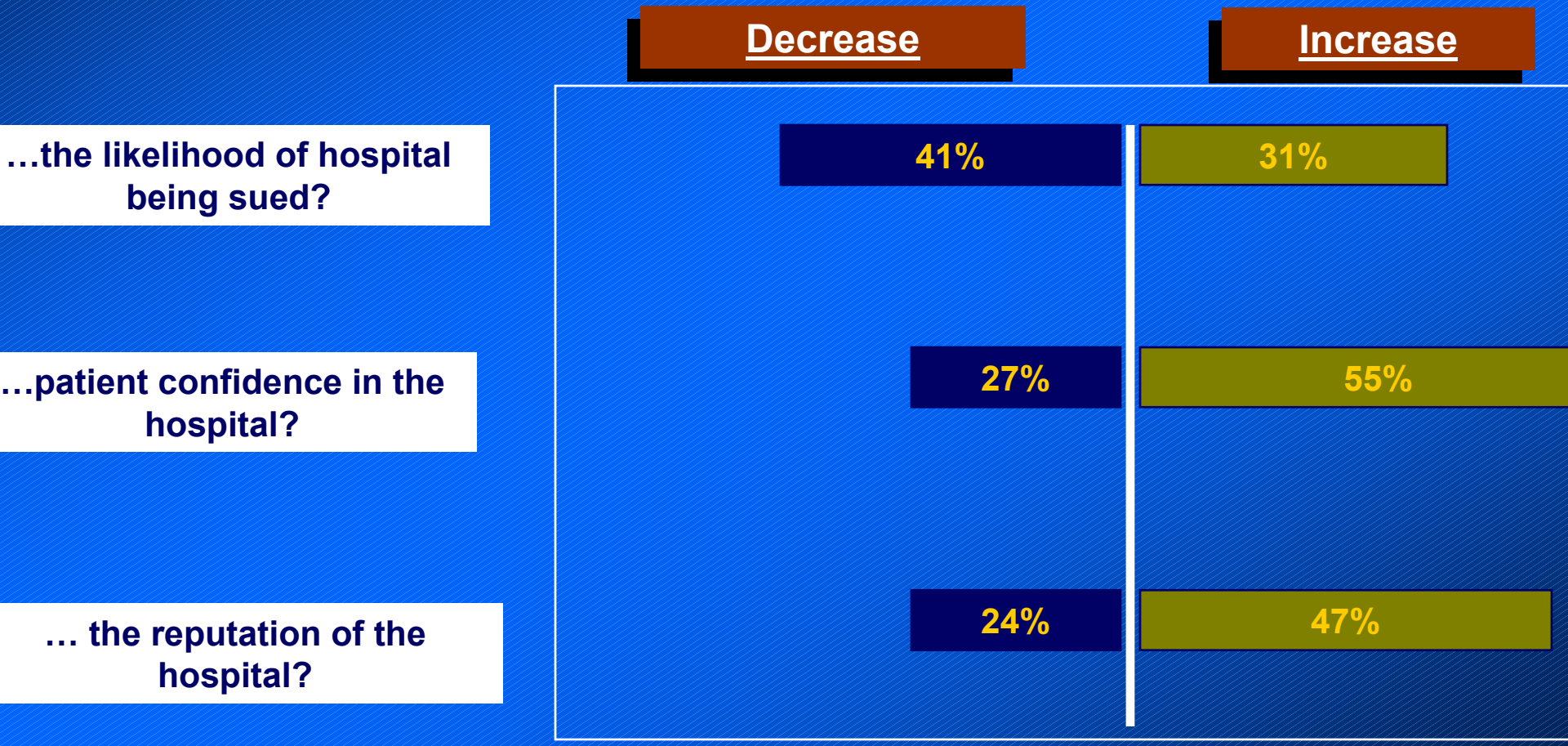
Among 86% with a disclosure policy

	Percent of Hospital CEOs/COOs
Address apologizing?	68%
Address adjusting fees incurred as result of incident?	31%
Mention possibility of compensation for damages?	8%

58% said that the hospital "always" or "usually" volunteers to cover additional costs (extended stay, test, procedures) that patient incurs as a result of the incident

87% of all hospital executives report that their hospital has run workshops or seminars to help staff learn about disclosure

Would an aggressive policy toward error disclosure in your hospital increase, decrease or have no effect on…"



Study Limitations

- CEOs/COOs may not be on front line of error reporting in their hospital
- 63% response rate may be subject to bias
- Perceptions are not the same as actual practice -- subject to social desirability bias

Summary and Conclusions - I

- Safety was relatively high on the agendas of hospital executives, but safety culture could improve
- Hospital executives did not generally perceive the val of mandatory state reporting systems, and had strong reservations about non-confidentiality
- To some extent, familiarity breeds acceptance
- States may be missing patient safety events importan enough to be disclosed to patients, and therefore potentially of value to improving patient safety.

Summary and Conclusions - II

- At the time of the study, few, if any, state agencies routinely informed the affected patient or family when an incident had been reported. Instituting such a practice would help foster the goal of transparency.
- Policies toward error disclosure was widespread, but content was limited.
- Further staff education in disclosure may be recommended

Practical Advice: Number 5 on Top Ten List of How Not to Do Error Disclosure

END of Presentation