Patient Safety and Quality Reporting by California's Community Hospitals

An Issue Summary

California's community hospitals are on the front lines of providing quality patient care, 24 hours a day, seven days a week, to all patients regardless of their ability to pay. High-quality health care provided in a safe hospital environment is a shared goal of hospital leaders, patient advocates, policy makers and health care consumers.

Hospitals participate in a variety of quality-improvement and patient-safety programs — all aimed at making sure patients are safe and receive the right clinical care at the right time in the most appropriate and efficient manner possible. Each hospital has unique patient populations and strategic quality-improvement programs to meet their priority needs.

Hospitals today are keenly focused on improving quality, surgical and medication safety, and other initiatives through the use of systems improvements, patient-safety checklists, safety-enhancing practices and information technology. Hospitals also participate in many patient-safety initiatives, such as those sponsored by the Institute for Healthcare Improvement, grant-funded patient-safety collaboratives, and federally designated patient-safety organizations.

The Issue

Ten years ago, the Institute of Medicine (IOM) issued a report, *To Err is Human*, assessing the quality of care provided in the nation's hospitals. The report estimated that as many as 98,000 people die annually in hospitals because of preventable harm. The IOM, and other well-respected health care organizations, recommend that hospital errors and adverse events be more systematically reported, and that more hospital quality data be made available to the public. The report captured the attention of the public, policymakers, media and health care providers.

Millions of patients are treated each year in California's 430 community hospitals, yet sometimes unfortunate medical errors or "adverse events" occur. While hospitals continually strive for quality improvement and zero adverse events, adverse events do occur. However, these occurrences are negligible. The number of adverse events reported by California hospitals annually is less than one quarter (.04%) of one percent of the more than 17.6 million annual inpatient hospital days recorded in the state.

California's community hospitals work every day to provide the safest patient care possible through the use of sophisticated systems, information technology and care protocols. However, in this most critical person-to-person environment, human errors do occur. When medical errors or preventable adverse events occur, information should be quickly and openly communicated to patients and their families. Hospitals also regularly report this information to the state, and to health-care-quality and patient-safety organizations that work with hospitals, to continually improve quality of care and patient safety.

Public Reporting Required by the State

California has some of the most rigorous and transparent public reporting regulations in the nation. Current state law mandates that hospitals report adverse events, hospital-acquired infections (HAIs), open heart surgery data and other quality measures to the California Department of Public Health (CDPH) or Office of Statewide Health Planning and Development (OSHPD). All of this data is publicly available today, and it will become even more accessible to consumers when the CDPH website is fully enhanced in the near future.

The National Quality Forum (NQF) has established a baseline of 28 serious reportable events considered the mostly preventable with the use of evidence-based guidelines. In 2006, the California Hospital Association (CHA) helped craft legislation (SB 1301) that established reporting requirements for serious adverse events in California based on the NQF serious reportable events. This law requires hospitals to report adverse events to CDPH, and requires CDPH to post the events on its website.

California law also mandates that hospitals:

- provide training and evaluate the effectiveness of infection-control programs,
- develop and implement policies to prevent patient-safety events (HAIs and adverse events),
- perform root-cause analysis whenever medical errors do occur and report such events to the hospital board of trustees,
- develop a "culture of safety" to encourage reporting of patient-safety events,
- establish a hand-hygiene program, and
- prohibit the use of tubing that can be connected to other tubing for which it was not intended.

To establish and maintain a "culture of safety" as recommended by the IOM report, ongoing quality improvement by hospitals also occurs as a result of learning from past mistakes. It is essential that caregivers can acknowledge when an error has occurred without the fear of being reprimanded or held liable for human error. This culture change is crucial to encouraging caregivers to come forward in order to identify changes needed to ensure patient safety.

In unfortunate situations when adverse events do occur and patients' lives are put in jeopardy (i.e., an event that either caused or was likely to cause serious injury or death), California law calls for financial penalties against hospitals. Since this law took effect in January 2007, there have been 140 administrative penalties (i.e., fines) assessed against California hospitals.

CalHospitalCompare.org

Transparency has become a centerpiece of the patient-safety culture in California. Patients and consumers across the state have access to a publicly available hospital quality report card on the www.CalHospitalCompare.org website. This independent hospital report card was developed by the California Hospital Assessment and Reporting Taskforce (CHART) and the California HealthCare Foundation. CHART members include hospitals, doctors, health plans, nurses, labor, consumer groups and employers. This online resource, considered to be the most robust hospital report card in the nation, provides consumers with more than 60 quality-of-care indicators. More than 240 California hospitals, representing 86 percent of all inpatient hospital admissions in the state, participate in CalHospitalCompare.org.

California Hospital Patient Safety Organization

The California Hospital Patient Safety Organization (CHPSO), created in 2006 by CHA, is a federally designated patient-safety organization dedicated to improving the quality of health care delivery and patient safety in California hospitals. CHPSO shares a commitment with California hospitals to reduce preventable, harmful events to patients and their families by providing a safe and secure reporting and educational environment. Members of CHPSO work together on quality-improvement issues relevant to their communities, while maintaining patient and provider confidentiality and legal privilege.

CHPSO provides hospitals the opportunity to share medical-error and safety-related information without risk of legal discovery. This "safe" environment enhances the richness of shared data, as well as the discovery of how patient safety issues occur and can be resolved. The ability to track trends and identify patterns through data analysis will direct the future work and intervention priorities for multiple public, private and nonprofit entities. CHPSO also will provide an opportunity to promote improved care delivery in California hospitals by providing priority direction to support, coordinate and augment existing and future collaboratives.

Policy Recommendation

California's community hospitals are on the front lines of care every day, and are under increasing scrutiny to provide more data and transparency on patient safety, quality of care and pricing.

CHA supports: 1) the consistent and meaningful reporting of accurate and timely data; 2) the thorough analysis of data and development of patient-safety programs that are designed to improve quality and reduce medical errors; and 3) the harmonization of federal and state quality activities and reporting. This is vital to maximizing the use and impact of hospitals' quality resources, and effective communication with patients.

CHA is committed to making hospital care in California the safest in the nation and encourages member hospitals to carefully consider participating in programs that are not aligned with federal or state programs or internal needs.