Improving Patient Safety In Rural Hospitals

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Work Group C—Notes: Roles of Local, Regional and Statewide Organizations In Creating a "Culture" of Safety"

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The following notes are highlights of a very rich discussion of the issues which this group of participants was asked to address. While there are many points of agreement; points of difference can be noted as well; time did not allow for a synthesis or resolution of these differences by the group.

I. Discuss the kinds of patient safety changes rural community hospitals can be expected to make and reasonable time frames to do so.

1. Remember that most rural hospitals are quite small, under 50 beds with census under 25.

2. Remember that there are also substantial differences in the way stand alone hospitals can access assistance compared to those in systems.

3. The expectation is that we can all do better and that we need to move past being defensive.

4. Benchmarking with similar facilities is very useful.

5. There is a lot we can do before tackling capital-intensive issues like CPOE (computerized provider order entry) such as best practices and changing our hospital's culture. We need to just role up our shirtsleeves and get to work.

6. We can immediately begin implementing WPSI's (Wisconsin Patient Safety Institute) 10 interventions to reduce medication errors.

7. Rural hospitals are not asking for a "get out of jail free card" (exemption from Leapfrog). Variation in practice is a key to decreasing errors and rural has many opportunities to do so. Many people choose to work in rural health; the second-class label is inappropriate.

8. We need to challenge the assumption, rarely backed by any data, that rural quality is lower.

9. The success stories all are based on an integrated approach—need to be creative to accomplish this—all concerned need to take ownership.

10. We need data driven, non-punitive approaches.

11. Consider the Joint Commission as a surrogate; in addition focus on the WPSI initial recommendation, *AHRQ's Making Health Care Safer: A Critical Analysis of Patient Care Safety Practices*.

12. Rural are not as consumed by competition, more opportunities for collaboration such as through RWHC. For example through a group purchasing approach, CPOE might be more doable.

13. The quality challenge for hospitals is not that different than that faced by industry; it requires a change in attitudes and in corporate culture. It is easy to be overwhelmed by the challenge of changing a large complex system; pick your spot. If rural mimic the approaches implemented in large urban facilities they are bound to fail. Focus on doing what is good for rural; much can be done, doing what you can.

14. Not all rural facilities are the same; we need to create a demand for assistance such as a best practices repository.

15. In rural facilities, many people wear multiple hats and this whole subject quickly becomes overwhelming—problem of not having, and less likely to get, dedicated resources.

16. This is a tough problem to get your arms around; the data is not clear on where to act first and there are many competing priorities, within and besides patient safety.

17. It can be very difficult to get energies focused given the many voices asking for a response.

18. There is a general and mistaken assumption that the solutions are the same in all settings (this is basically a misapplication of the "medical model") but sociology and anthropology tell us otherwise.

19. There is a bias against rural providers and it will be perpetuated until data is presented to contradict it.

20. The research data supporting CPOE was not from small rural hospital; it should be an open question whether this expensive investment is valid for these environments.

21. Local hospitals need to identify a physician advocate or champion to make any progress with the medical staff.

22. There is a great deal of interest in this topic by we as employers; a double standard (rural/urban) is not OK. Rural hospitals need to share resources and take more advantage of long distance learning opportunities.

23. We know that we can do better with medication errors; we are making more use of clinical pharmacists and working towards being able to implement CPOE in the long term.

24. We need good transfer agreements and better guidelines about when we can serve and when we need to transfer. We need better coordination with regional centers when patient is transferred in and transferred back.

25. We need an agreement in Madison to more readily get our patients admitted in Hospital X with HMO X when Hospital Y with HMO Y has a full ICU.

26. Patient safety needs to be a higher priority for our boards.

27. We can use the AHRQ compendium of "non esoteric, data proven practices" and work on implementing a few at a time

28. A lot of free stuff and less expensive audio-conferences are available which we need to make better use of.

29. I would pick these spots to begin: implementing the WPSI recommendations (short of CPOE for now) and see if some collaboration can be begun to further improve ICU care (clearer referral agreements and guidelines about when to transfer). These overlap with leapfrog but should be specific to the rural context.

30. The ER is very important in rural communities and is where we touch the most people—good place to focus.

31. To develop a culture of safety we need good data. We need trending of that data so that we can see the system improving. (A caveat was shared that when a hospital adopts a non-punitive approach it will see reported problems go up substantially before they are brought down).

II. Discuss what types of external incentives would be most useful to rural community hospitals to help them improve patient safety. Discuss which major stakeholders can influence rural hospitals to achieve patient safety improvements, and how stakeholders can help hospitals reach their goals.

1. There is a lot we can do statewide to assist the local hospitals—data, research and appropriate state policy changes. I heard a lot of data yesterday that simply wasn't relevant to small rural hospitals. We can provide financial assistance and help coordinate resources. We can combine data from ISMP (Institute Of Safe Medication Practices), MetaStar (the WI PRO) and JCAHO. We can do an analysis of equipment being used in Wisconsin such as which IV pumps are safest. We can pick an issue and focus regional and statewide support.

2. We participate as hospitals in MetaStar activities and in ORYX activities but we need the State Medical Society and American Medical Association to do more to incent physicians to get more involved with us.

3. We need legislation to deal with the barriers related to discoverability of quality improvement data.

4. Quality report cards come across as punitive; not sure how reconciled with creating a statewide culture of patient safety (which is not punitive). How can we be publicly accountable without being penalized?

5. One answer is that we can survey/publicize what safe practices are present as opposed to surveying/publicizing the incidence of problems. But there needs to be public accountability and reporting regarding egregious (extreme/gross/flagrant) errors.

6. The initial response to the IOM (Institute of Medicine) report was to reinforce the "Gotcha Culture."

7. We need to create a firewall between quality improvement data to be kept private and consumer data which is to be made public. There is not a consensus in our state about which data goes into which bucket.

8. The demand side (purchasers) doesn't help. I would suggest that we (purchasers) come to agreement nationally re (1) what data we expect to be disclosed and what kept private, (2) what do we do to educate the public and (3) that purchasers (CMS, insurers, Alliance, etc.) be more thoughtful about what they pay for. And I would focus first on #1 and #3.

9. We face the problem of moving back to discounted fee for service purchasing which is in a direction against an emphasis on purchasing quality.

10. Business needs to set standards for what it will buy and be prepared to take the flack when it drops a provider who can't deliver the quality requested.

11. But in a rural area, by and large the lever of dropping a provider group is not realistic.

12. Right now cost is going through the ceiling which makes it difficult for purchasers to focus on quality. But some elements of cost inflation are due to quality problems. At the very least, we should be focusing on the "low hanging fruit." From the purchasers perspective (and in the room we have purchasers representing over half a million individuals) we think we are already paying for Quality so not looking to pay more.

13. The "resort" to report cards comes from feeling we as employers have no other alternative; is intended as a catalyst to "get the ball rolling."

14. Employers are in an untenable position; the Minnesota state employee strike is just the beginning of things to come—we are all caught in the conundrum of needing to purchase both higher quality and lower price.

15. As employers, we need to educate employees to be better consumers, particularly as we increase "cost sharing" with them. As they have to pay more; they will be demanding more information about providers.

16. Leapfrog is a group of very large employers "picking some spots" to "get the ball rolling."

17. We need to establish a basic level of quality and those of us who can't maintain it need to get out of the business.

18. Employers frequently purchase insurance, not healthcare; what is the role of insurers in this discussion?

19. Actually it is interesting, sad to note, that we hospitals as employers/purchasers of insurance/healthcare pay no attention to quality, and just shop based on price.

20. Caveat to discussion re relevance to national picture—Wisconsin rural has more HMO market penetration and multi-specialty clinic based systems.

21. Another Wisconsin (upper Midwest difference) is the substantial Medicare/Medicaid cost shift to the private sector.

22. WPSI is an important and useful forum for the state to come together to create a state culture of patient safety.

23. Large amounts of energy/time currently go to JCAHCO guidelines of questionable value for a point in time survey rather than ongoing quality improvement processes integrated into the hospital's operations.

24. What we need is more of an effort to remove disincentives than the need to create incentives. This is more than words but a key conceptual difference.

25. Employers/insurers are desperate regarding the cost issue. It will lead (with or without an increase in "cost-sharing" with employees, to a substantial increase in the role of individuals as stakeholders in quality and patient safety. We are focusing on patients who need to have substantial interaction with the health care system and trying to educate them to do a better job of "defending" themselves.

26. Quality improvement provides us with a lot of good information but issues of validity continue to be a challenge within our hospital.

27. There are a lot of societal issues that we haven't addressed; our system is fundamentally not constructed to delivery quality. We (employers, payers, providers, patients) are all in the same boat—dialogues like this are good, we need more of them.

28. This is a very complex topic; over the last number of years we have removed a cloak which had been covering medical errors from public view leading to a sense of "betrayal" by the public and "defensiveness" in the medical community. This leads the public/purchasers to seek more data while it leads providers to feel afraid that people will think less of them as individuals. We all need to bring honesty but also respect and consideration of each other into an ongoing dialogue. There is no perfect set of behaviors and patients will make choices based on a variety of factors in addition to "data": experiences of friends and families, location, their own values, community support, personality of providers.

29. More dollars for quality seems wrong; money is only one part of a complex equation.

30. We are people; the patient safety challenge is "not the end of the world." It is in fact OK to say we are not perfect but that we can get better; we need to become comfortable trying to do better.

31. The points made regarding the many disincentives (punitive nature of our current systems) are well said.

32. Multiple and often contradictory external expectations really confounds hospitals with tight resources. We spend so much time and money on JCAHO; it is then discouraging to hear that doing well with JCAHO doesn't matter.

33. All our potential to improve quality and patient safety are in real jeopardy due to the workforce issues. The University and Vocational Technology Systems are key stakeholders that need to be much more involved in this dialogue.

34. Malpractice carriers for their part are sending mixed messages—encouraging providers to change and do a better job at identifying problems but they still have a "Gotcha" mentality.

35. It is a tough world (for all businesses/organizations); this is not about purchasers singling out hospitals but about hospitals coming up to speed, to get beyond the "victim mentality."

36. Leapfrog employers believe that they need (1) to create incentives for disclosure, (2) work in good faith to create safe harbors around QI data and (3) support malpractice reform.

37. Rural and urban consumers are more alike then different; they have many choices and are exercising them in larger numbers. The shift of a greater share of the costs of their health care or insurance to the consumer will draw them into being more involved in these issues and lead them to seek more information.

38. As someone responsible for public employee benefits I don't fully buy into the view that an increase in cost sharing will be significant (with unionized public employees) or in those situations where it happens, that it will lead to people making better decisions.

39. As a physician, I can assure you that many of my patients challenge my recommendations. Maybe I am trying to be too provocative but I would advise purchasers that "you are on your own" re the development of any system of public accountability—that we as providers will remain defensive and that no approach will ever have us satisfied and saying that it is fair.

40. Leapfrog is becoming increasingly sensitive to the provider perspective that multiple purchaser voices about what should or should not be disclosed is confusing and counterproductive.

III. Suggest questions related to the issue of implementing patient safety practices and standards that need to be answered by further research.

1. Do research in and about smaller hospitals, not just those convenient to or for the researchers.

2. Look at what variation we have in critical pieces of equipment and processes.

3. Look at how we can protect quality improvement data.

4. Look at what hospitals are currently doing and how we can best learn about their best practices.

5. Look at the issue of the legislative alternatives for limiting discoverability of incidence reporting.

6. Drill down into the data about the use/benefits of clinical pharmacists in smaller, rural hospitals.

7. We need more research about outcomes in rural hospitals and about the best measures and measurement processes.

8. How can education and training programs better prepare practitioners to help develop and be part of "cultures of safety?"

9. Hospitals can be seen as the point in the system where a lot of external resources come together; more research is needed regarding how we can reduce the variation in these inputs (pumps, uniform bar codes, etc.).

10. We need to direct more dollars directly to rural hospitals as seed dollars for patient safety initiatives (this was from an employer representative).

11. We need to pool data about smaller volume facilities to better understand the outcomes of rural ICUs (as an alternative to simply extrapolating from studies of much larger urban ICUs).

12. We need to better understand the relationship between staffing ratios and patient safety; the correlation between single task workers and patient safety;

13. We need to better understand how licensing and regulation is sometimes as much a barrier as support for safety. Example: single task workers were found to be very successful in nursing homes (better quality care), but this practice was in conflict with a current regulation, so these workers had to eliminated.

14. We need to see more collaboration between RWHC and WHA around this issue.