STATE HEALTH POLICY

Briefing

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STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

State Case Study in Patient Safety: Pennsylvania

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The National Academy for State Health Policy (NASHP) was commissioned by the Betsy Lehman Center for Patient Safety and Medical Error Reduction to undertake research to identify national trends in state adverse event reporting systems and synthesize lessons for fostering continued improvement in patient safety in Massachusetts. NASHP surveyed adverse event reporting systems in 26 states and Washington, D.C., and conducted follow-up interviews with stakeholders in five states (Maryland, Massachusetts, New York, Oregon and Pennsylvania) to gather information about state patient safety innovations and broader collaborative work to address patient safety. The five states were selected based on their survey responses, including similarities and differences from Massachusetts, to inform patient safety activity in Massachusetts. This case study explores the role of three Pennsylvania entities as they relate to patient safety.

This case study explores the role of three Pennsylvania entities as they relate to patient safety, highlighting themes, initiatives, and challenges within the state. It examines the partnerships of various state stakeholders, describes the state's adverse event reporting system, outlines specific patient safety improvement initiatives, and summarizes how patient safety ranks as a statewide priority in Pennsylvania.

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Stakeholder Organizations

The Pennsylvania Patient Safety Authority, the Pennsylvania Department of Health, and the Pennsylvania Department of Human Services all work to improve patient safety statewide.

- The **Pennsylvania Patient Safety Authority (Authority)**[1] is an independent agency that administers the state's adverse event reporting system. It does not have regulatory authority over Pennsylvania facilities; its purpose is to collect and analyze data, educate and advise.
- The **Pennsylvania Department of Health's**[2] Division of Quality Assurance works to ensure quality care in both inpatient and outpatient facilities and determines compliance with the CMS Conditions of Participation throughout the state.
- The **Pennsylvania Department of Human Services (DHS)**[3] is the agency that oversees the state's Medicaid program, and lies within the Office of Medical Assistance Programs.

These three entities work together and with other partners in the state to ensure patient safety. Reports about events that caused patient harm (serious events) or occurred as a result of facility infrastructure failure are sent to the Department of Health. The Authority receives reports of serious events and incidents, or non-harm events. Health facilities provide this information only once, and the reporting system bifurcates the data to ensure that the appropriate agencies receive it. The Department of Health, in coordination with CMS surveyors, is responsible for surveying facilities; reports may provide information for the survey or prompt an additional visit. Pennsylvania Medicaid also partners with the Department of Health by funding Medicaid patient participation in several Department of Health programs.

Other partners include the Pennsylvania Hospital Association, the Pennsylvania Health Care Cost Containment Council (PHC4), the Western Pennsylvania Hospital Council, the Pennsylvania Medical Society, the Pennsylvania Anesthesiology Association, and the Pennsylvania chapter of the Association for Professionals in Infection Control and Epidemiology. A Medicaid representative is a member of PHC4 and advises in their work on hospital-acquired conditions, preventable admissions and readmissions, and hospital associated infection reduction.

Despite the partnerships among these state entities, the Authority is not involved in Medicaid's non-payment policies for adverse events. Medicaid asks for separate reports from facilities when determining whether to pay for an adverse event to avoid interfering with the effective system that is already in place at the Authority.

Pennsylvania Adverse Event Reporting System

Pennsylvania's adverse event reporting system is administered by the Authority and is independent of state budget; the system is funded through a facility assessment. Hospitals, ambulatory surgical centers, long term care hospitals, birthing centers, and abortion facilities are required to report events to the Authority, while nursing homes are required to report only healthcare-associated infections. Because the Authority does not have regulatory authority over facilities, it uses adverse event reports from facilities to inform publications, educational initiatives and training. Authority staff analyzes reports and provides guidance about steps that providers can take to prevent adverse events from happening in the future.

The Authority issues periodic public reports with aggregate data, including an annual report and quarterly journals, and also allows facilities to view and analyze their own reports. Root cause analysis and corrective action plan reporting are not required. Because the Authority acknowledges that simply collecting the data and releasing it periodically will not reduce adverse events, it is committed to education and actively working with and engaging facilities. In 2014, it educated approximately 10,000 Pennsylvania providers regarding patient safety topics. One example of the Patient Safety Authority's outreach to providers is its peer-reviewed, quarterly journal containing articles about actual events that took place in Pennsylvania healthcare facilities: *Pennsylvania Patient Safety Advisory*. This journal informs facilities about the data the Authority receives so that they can learn from past events and work to prevent future events from occurring. The journal also provides valuable clinical guidance about measures that facilities can adopt to improve patient safety.

Facilities are required to submit to the Authority any event that is determined to be reportable from 217 separate categories that cover both harm and non-harm events. Due to these broad guidelines, the Authority receives a large number of reports compared to the administrators of adverse event reporting systems in other states. In fiscal year 2013, the Authority received reports of 277,564 events.

Another reason for the high number of reports is that facilities are reporting more near misses each year. Near misses are of extreme importance to the Authority. A representative from the Authority stated that near misses can demonstrate what prevented an event and patient harm, which is valuable information that can be used going forward. The near miss data collected by the Authority influences the training that facilities undergo.

The Authority is working to standardize its reporting to improve compliance and the quality of reports. This involves developing a standardized definition of events. Eighty hospitals in the state are part of the Authority's standardized reporting for falls. This has made it easier for those facilities to report, improved the quality of data being reported, and added value to the analytical reports provided to the facilities since individual facility statistics can be compared to peer groups.

Patient Safety Improvement Initiatives

In Pennsylvania, when an adverse event occurs, all facilities must notify the patient or patient's family by letter. This method of disclosure is highly unpopular with facilities. A representative from the Department of Health stated that compliance regarding the disclosure letters proves more challenging for facilities than reporting.

There also are several initiatives hosted by the Authority that engage multiple facilities, such as the Statewide Falls Collaborative Project and the Partnership for Patients' Hospital Engagement Networks.[4] These collaborations cover multiple patient safety topics such as wrong-site surgery, mislabeling blood specimen events, surgical-site infections, central-line associated bloodstream infections, and adverse drug events.[5]

Another initiative underway in the state is the review and revision of reporting requirements. Because Pennsylvania has one of the largest reporting databases in the world according to a representative at the Department of Health, there are some technical issues that they are working to address in order to make the data more useful. Currently, in a few reporting categories, as much as 40 percent of serious events and infrastructure failures reported are classified as miscellaneous, making them difficult to use in data trends because they need to be individually searched. With revisions, there will be reduced miscellaneous reporting; everything will be sub-categorized. This will allow for more reliable data within the state.

Patient Safety as a Statewide Priority

Patient safety is of a high priority in the state of Pennsylvania, as demonstrated by the existence of a separate, private state entity that is financially independent of state government and dedicated to patient safety. Efforts to improve patient safety are approached through multi-system collaboration. The emergence of accountable care organizations within the state means that care is provided in many different locations, such as in physicians' offices; however the Authority does not collect reports from these types of facilities unless they fall under the hospital's license.

Next Steps

There are plans in place at the Department of Health to team up with the Authority to jointly train facilities and staff across the state on patient safety topics, specifically on what should be reported based on a set of principles developed by the aforementioned stakeholders. This has not been done in 11 years, and will require substantial collaboration.

Endnotes

1 For more information, please visit: http://patientsafetyauthority.org/Pages/Default.aspx

2 For more information, please visit: http://www.health.pa.gov/Pages/default.aspx

3 For more information, please visit: http://www.dhs.state.pa.us/

4 Hospital Engagement Networks (HENs) work at the regional, State, national or hospital system level to help identify solutions already working and disseminate them to other hospitals and providers: http://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

5 For more information, please visit: http://patientsafetyauthority.org/collaborations/Pages/home.aspx

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About the National Academy for State Health Policy:
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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