# QUALITY AND PATIENT SAFETY

## Objective

- **Enactment of patient safety legislation** that will help create a "culture of safety" in which doctors, nurses and others can share information when adverse events happen, engage appropriate outside experts in the analysis of patient safety concerns and together, enhance our knowledge of how to prevent medical errors.
- **Support S. 720, the "Patient Safety and Quality Improvement Act,"** introduced by Senators Jim Jeffords (I-VT), John Breaux (D-LA), and Bill Frist (R-TN). This legislation enforces the goal of improving medical safety by creating a voluntary, non-punitive environment in which caregivers may discuss and report medical errors without fear of reprisal.
- Provide **support and funding for academic medical centers** to adopt new technologies that can further patient safety efforts.

## Background

Quality and patient safety are the cornerstones of the commitment and mission of hospitals and caregivers. For years, hospitals, physicians, and other caregivers have worked hard to deliver the best care they can by incorporating innovative and effective quality improvement programs into their care delivery. But at the same time, America's confidence in the quality of the health care system continues to erode. The public wonders if government cutbacks harm hospitals' ability to deliver care. They question whether hospitals and health systems are adequately staffed. Patients are bewildered by treatment choices, concerned about whether they are making the right decisions and receiving the best care.

Several key events occurred during 1999 – 2001 that prompted public and private initiatives aimed at reducing medical accidents and improving patient safety:

- Publication of the 1999 Institute of Medicine's (IOM) report that found that 44,000 – 98,000 Americans die every year from preventable medical errors made in hospitals.
- The Business Roundtable's formation of the LeapFrog Group, designed to use market power to steer employees to "high-quality providers" that have implemented these safety measures: computer physician order entry (CPOE), evidence-based hospital referral, ICU staffing by physicians trained in critical care medicine.
- Publication of the second IOM report, "Crossing the Quality Chasm: A New Health System for the 21st Century," that aims to move the current health system to a more safe, effective, patient-centered, timely, efficient and equitable system of care. The IOM recommends Congress establish a $1 billion Health Care Quality Innovation Fund to support projects targeted at achieving the six goals outlined in the report.
- Soon-to-be published new Medicare Conditions of Participation that will require hospitals to engage in certain patient safety and quality improvement activities in order to serve Medicare beneficiaries.

- Approval of new patient safety standards by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that focus on the responsibility of hospital leadership to create an environment that encourages error identification and remedial steps to reduce the likelihood of recurrence and minimizes individual blame or retribution for involvement in a medical accident.

## Current Political Environment

**Congress:**
The following legislation was introduced in 2003 to address issues of quality and patient safety:

- **H.R. 663, the "Patient Safety and Quality Improvement Act,"** introduced by Representatives Michael Bilirakis (R-FL) and John Dingell (D-MI), which provides new legal protections to permit patient safety information to be shared with entities called Patient Safety Organizations (PSOs). The legislation also creates a national database to be housed at the Agency for Healthcare Research and Quality (AHRQ). HR. 663 passed the House of Representatives in March and the prospects in the Senate are optimistic.

- **S. 720, the "Patient Safety and Quality Improvement Act,"** similar in many respects to H.R. 663, introduced by Senators Jim Jeffords (I-VT), John Breaux (D-LA), and Bill Frist (R-TN) is similar in many respects to H.R. 663. The legislation proposes to encourage a "culture of safety and quality" in the United States health care system by providing for legal protection of information reported voluntarily for the purposes of quality improvement and patient safety. The legislation ensures accountability by raising standards and expectations for continuous quality improvements in patient safety through the authority of the Secretary of Health and Human Services.

At present, Senate Democrats lead by Senator Edward Kennedy (D-MA), the ranking member of the Senate Health, Education, Labor and Pensions Committee are seeking to tighten up several of the provisions that distinguish S. 720 from its near counterpart in the House, H. 663. For instance, S. 720 has a broader scope of information that is protected for legal including oral discussions and deliberative analysis. In addition, S. 720 is less restrictive in terms of who can become a patient safety organization (PSO), the entities both bills charge with analyzing the data.

## Advocacy Message

The University of California supports the enactment of patient safety legislation that will help create a "culture of safety" in which nurses, doctors and others can share information when adverse events happen, engage appropriate outside experts in the analysis of patient safety concerns and together, enhance our knowledge of how to prevent medical errors. The University strongly supported H.R. 663 and encourages the Senate to pass S. 720.