Opinion piece for Oregon Health News

Patient Safety Commission's North Star Goal

In January, 2008, the Board of Directors of the Patient Safety Commission quietly but resolutely offered a challenge to Oregon – **by the end of 2010 we would have the safest healthcare system in the country.** The Board called this challenge their North Star goal. In itself, it's a laudable statement, but some questions immediately come to mind: Is safety really a defining problem in need of an audacious goal? How could we ever hope to measure our progress? Why should the Commission tackle something so big?

First let's clarify the words *patient safety.* Some people use the phrase 'medical error' to define the problem we address. It's when you go to the hospital and get an infection after surgery. It's when your mom is in the nursing home and she falls. It's when you get the wrong medication from the pharmacy. Cumulatively this sort of patient harm represents a big problem. One in three Americans has personal experience. Upwards of 100,000 Americans die each year from preventable errors in hospitals alone. As an example of the economic waste, avoidable healthcare acquired infections add $4.5 billion to the cost of care in the U.S.

But, while we assume that Oregon's patient safety experience mirrors national data, we don't yet have the defining statistics. What we do know is cause for some concern. Earlier this year the federal Agency for Healthcare Research and Quality published a 2007 scorecard that ranked Oregon's overall healthcare quality as "average" (and performing slightly worse in 2007 than in 2006). Adding insult to injury, the Commonwealth Fund's Scorecard on Health System Performance ranks Oregon 36th in quality of care.

It's true that these composite measures of quality can be methodologically suspect. Source information is often derived from administrative data not designed to measure clinical outcomes. Individual scores are typically added together as if quality were a simple math problem. And, the measures focus on overall quality, not solely on patient safety (which is a component of quality). Yet these scorecards tap into something fundamental, and they offer a consistent message—Oregon is average.

Oregon average? But isn't Oregon populated with talented people working within a tradition of healthcare innovation? Isn't Oregon, at this very moment, in the midst of trying to re-imagine and re-form its health care system? So, why not aspire to something better?

And the role of the Patient Safety Commission? If you paid a visit to our offices the first thing you would notice (besides my reluctance to hang pictures on the walls) is that we are a small organization. In contrast, health care is a 19 billion dollar industry in Oregon. And even as we talk about Oregon's health care *system* we all know that the system isn't a single coherent entity. If you want to change the health system you will find no simple lever, no magic switch. What can a Commission do?

Well, for starters, we can offer the aligning goal and the well-chosen word. A big dream harnessed to concrete actions can be a powerful mix. In that spirit we've added our voice to the call for a heightened sense of urgency and a stronger vision of patient-focused quality.

Which is nice...but words are just words, right? So, what's next? For the Patient Safety Commission, we've been working on a measurement tool to calibrate patient safety efforts across the state and across the delivery system. We plan to benchmark our progress and offer our own summary measure. We are now testing our approach (which asks and then attempts to answer six fundamental patient safety questions).

The Commission is also helping to nurture new ways to think about patient harm. In the past health care typically dealt with medical errors by focusing on individual actors (sometimes sanctioning, sometimes protecting behind a wall of silence). Such approaches often miss the point. Certainly we want to hold people accountable. But accountability must address the core problems, and to do that we must take a close look at the common systems we work within.

In addition we continue to build our voluntary adverse event reporting program. The whys and wherefores of our reporting effort is a subject for another forum, except to say that our growing data base represents a systematic way to learn from mistakes, to eliminate unnecessary variation, and to introduce and champion best practices.

Finally, the Commission is helping to align existing patient safety efforts and to better use the tools and the best practices already available. Too often, health care has been organized into self-contained silos that address (and measure) quality only within those silos. The Commission is championing cooperative ventures that work across organizational boundaries.

We know this can be daunting work (we might be optimists but we are not naive). We also know that by ourselves the Commission will accomplish little. So, we now challenge others to take up the goal of becoming the safest state in the country. Over the next year we will hold a statewide conversation about patient safety. We'll direct our appeal to the nurse at the bedside and the CEO in the office suite. We'll talk about specific patient safety initiatives and about organizational culture. We'll search for better ways to measure improvement and to promote a frank discussion. We'll do it together.