

A History of The Massachusetts Coalition for the Prevention of Medical Errors

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Authors: Leslie E. Kirle, M.P.H., James Conway, Randolph Peto, M.D., Lucian Leape, M.D., Connie Crowley-Ganser, R.N., Nancy Ridley, M.S., John Fromson, M.D., John Noble, M.D.

Introduction

The Massachusetts Coalition for the Prevention of Medical Errors was established in 1998 to develop a campaign in the Commonwealth to improve patient safety and reduce medical errors. The goals of the Coalition are to disseminate knowledge and information about the causes of sentinel events and develop strategies for prevention. The Coalition plans to drive improvement by making this information available to health professionals and health care institutions for use in their own quality improvement programs through a statewide campaign. This initiative seeks to strengthen the public's trust and confidence in the health care delivery system as well, by increasing awareness of error prevention strategies through public and professional education. Additional objectives include providing a forum to promote collaboration among organizations with the common goals of improving care and stimulating a coordinated series of spin-off projects.

The formation of the Coalition was a response to the increased focus on medical errors from the public, health providers, the media, and regulatory agencies. This increased focus has occurred in the context of several high profile cases of serious medical errors both in Massachusetts and across the country. The realization that these events occur in all settings, despite extensive oversight and quality monitoring mechanisms, caused health care leaders in Massachusetts to begin the process of rethinking how the industry looks at and learns from medical errors. Ultimately, the group concluded that if interdisciplinary practice and collaboration is a critical strategy to reduce errors (which it is), this collaboration must occur not only in the workplace but also among regulators, providers, associations, professional boards, and consumers.

This presentation provides an overview of the Coalition's formation and discusses its applicability to other states.

Methods:

Beginning in February, 1997, meetings were held with a small group of government agencies and health care providers to explore the feasibility of forming a statewide Coalition to reduce medical errors. The focus of these early meetings was on framing the problem and understanding the perspectives of the different stakeholders (i.e., providers,

regulators, public, and media). It took 18 months of learning, listening, planning, and trust building before the Coalition could be formally launched.

A review by the Coalition of studies of sentinel events reported from JCAHO, the Massachusetts Department of Public Health, and other researchers indicated that medical errors are typically the result of system problems rather than human error. It became evident through the study of root cause analyses conducted around each of the sentinel event investigations and published research that certain types of events, while rare, do share common underlying causes. If our group could identify certain conditions which might lead to the occurrence of a sentinel event and develop appropriate preventive strategies, a great potential existed for avoiding the resulting adverse outcomes. A Best Practices Subcommittee was appointed in February, 1998 to identify common types of sentinel events around which to develop prevention strategies.

Early in the formation of the Coalition, the group spent considerable time discussing barriers to error prevention initiatives. It became clear that there was no single forum for sharing information about the causes of errors and how to prevent them. Providers have been afraid to talk about errors in an honest way because of the atmosphere of blame and punishment that surrounds the occurrence of an error. The typical reaction to errors has been to assign blame to an individual or an institution and impose punitive measures. A punitive atmosphere only encourages people to hide mistakes, which makes it difficult for the industry to get a true handle on the types of errors that occur, their causes, and strategies for prevention.

In Massachusetts, no forum had previously been developed to talk about these issues because of concerns about liability exposure, sanctions, and disciplinary actions. The group acknowledged early on, the very real tension that exists between providers and the agencies that regulate them. In fact, this was the first time in this state that health care providers and government agencies had sat down together to talk openly about medical errors and what they could do together to prevent them. It was important for the group to acknowledge that each of the stakeholders brings a unique perspective with different responsibilities to fulfill. The shared goal of error prevention and patient safety has kept the group focused despite the different perspectives represented.

A related issue that the group addressed was the need for a non-punitive and confidential reporting system to learn about the types of errors that occur, their causes, and frequencies. While the self-reporting of medical errors without fear was seen as a major hurdle that must be addressed, the confidentiality and immunity in dealing with medical errors and reporting requirements were recognized by all as controversial. To ensure that the group did not get "stuck" on this issue, consensus was reached to focus on "best practices" and not on collecting data about errors. It was felt that enough data to fuel our mission was available through the literature, the state health department, and JCAHO.

As this grassroots effort began to grow, it was felt that a smaller group was needed to make decisions and guide the Coalition's formation and workplan. A Steering Committee was formed composed of key leadership organizations and individuals willing

to commit the time and resources to this effort. The state hospital association took the lead in providing the initial seed money and resources to launch the Coalition and move it forward.

As the official group was formalized, it became important to ensure that the group was well represented in terms of geography, segment of the health care industry, size, and type of practitioner. To date, the Steering Committee has taken the posture of including interested and committed participants on the full Coalition but has restricted the size of the steering committee.

The group has been eager to develop and disseminate best practice recommendations in several areas. Much time has been spent discussing the importance and method of eliciting broad-based buy-in and support from all members of the health care team. In response to this concern, the group has included a process for building consensus on best practices that includes front line workers, along with experts in the field. The group did not want to be in the position of making recommendations that in practice could not be implemented. It was necessary to remind the group that there may not be a single solution for preventing errors. What works in one institution may not work in another. In addition, it was felt that any potential interventions had to be focused on interdisciplinary practice since that is how care is delivered.

Results:

The Coalition was officially launched on July 31, 1998. A mission statement, structure, and process have been developed and 21 organizations have confirmed their commitment to the Coalition. s mission and goals (see attached list). The following actions have been taken:

- A media briefing was held to educate selected print media about the Coalition and its mission. This resulted in several positive stories in key newspapers and journals. It was an important first step in engaging the public in a meaningful dialogue about errors and strategies for prevention.
- A strong educational component has been built into Coalition meetings to increase awareness of and educate the group about efforts that are going on in the area of error prevention. Coalition members, along with external speakers, are sharing their work at each meeting.
- The first initiative . the prevention of medication errors . is well underway. This initiative builds on the Massachusetts Hospital Association. s (MHA) medication error prevention project. The project used a survey tool developed by MHA in cooperation with the Institute for Safe Medication Practices to gather baseline data on approaches to safe medication administration systems. Seventy-two percent of acute care hospitals have responded to this survey and the preliminary results are being used to develop best practice recommendations. The best practices will include educational programs sponsored by the Coalition and their

constituencies. Coalition participants are already working on ways of contributing to the first initiative by funding educational components of the campaign.

- Efforts are underway to develop guidance for patients and families regarding medication errors and patient safety. The development of a brochure with consumer tips is under consideration.
- A series of safety alerts is being developed by the Coalition based on known incidents in Massachusetts and across the country.
- Discussions are underway to hold a best practices educational program to showcase and share lessons learned and success stories in preventing medical errors.

Discussion:

The Coalition has been contacted by other states interested in replicating this model. Based on our experience, there are some guiding principles, which may help a state interested in forming a similar coalition. These principles include:

- Have a shared goal of making the health care system as safe as possible for patients, family members, and staff. This provides the "glue" that holds the Coalition together in spite of the differing and sometimes adversarial views.
- Obtain leadership "buy-in" and support from a broad-based group. The Massachusetts initiative has the commitment and support from the leadership and boards of provider, professional and regulatory organizations.
- Promote unrelenting communication between the key parties, particularly in the early stages to build trust and credibility.
- Establish a system that allows for input from clinicians to enlist their support for any practice and/or system changes that are recommended.
- Consider including consumers or consumer organizations in the process early on to get their input and feedback. Recognition and acknowledgement that patient safety is everyone's responsibility is an important step in the error reduction process.
- Do not reinvent the wheel. Recognize that there is a wealth of experience and knowledge in your state and nationally in the area of error prevention. Build on the expertise of others in developing interventions that work.
- Strike a balance between the desire for quick solutions and broad based "buy-in" from all parties. Find a way to build consensus.

- Consider when and how to engage the media but do not let the media drive the process.

Conclusions:

The evolution of the Coalition is a dynamic and continually changing process with new challenges encountered daily. The Coalition is getting ready to launch the first series of interventions in the area of medication error prevention. The next step will involve the development of an implementation and evaluation plan to determine the effectiveness of our efforts. While it is too soon to determine the impact of the Coalition on the reduction of errors, the Coalition has been successful to date in focusing statewide attention on the importance of patient safety and error prevention.

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