

Quality Improvement Organizations and Patient Safety

Protecting Patients from Medical Errors

As many as 98,000 Americans die each year from medical errors. That revelation in a landmark 1998 Institute of Medicine report alerted the nation to a significant challenge and spurred much of the health care industry to advance initiatives aimed at reducing medical errors.

Medicare's Quality Improvement Organizations (QIOs) have been at the forefront of these efforts. At the core of QIO quality improvement work is the development of processes and spread of clinical practices that improve patient safety and reduce medical errors.

Since 1997, QIOs have been helping establish and leading statewide collaborative partnerships to accelerate programs to keep patients safe. In recent years, they also have been focusing on specific safety challenges that unnecessarily harm patients and drive up health costs. Here's how QIO patient safety-related activities are making a difference:

Leading National Efforts to Make Surgery Safer

Since 2002, QIOs have been working with hospitals to reduce the incidence of surgical site infections. About 2.6 percent of nearly 30 million operations each year are complicated by surgical site infections; one-third to one-half of these infections can be avoided with appropriate use and timing of administering prophylactic antibiotics.

To prevent infections, QIOs have focused on helping hospitals administer antibiotics at the optimum time before surgery and this has improved patient care:

- In Nebraska, at BryanLGH Medical Center, appropriate use of prophylactic antibiotics for cardiac surgery patients soared from 50 percent to 100 percent.

- In Oklahoma, Mercy Health Center reduced its surgical site infection rates by 78 percent in patients receiving cardiac bypass, orthopedic, colon, and hysterectomy surgery, achieving 100 percent on-time antibiotic administration.
- In Colorado, 16 hospitals increased antibiotics delivered at the right time from 62 percent to 88 percent.

Building on this effort, QIOs began working in 2005 with hospitals and other partners to reduce the incidence of overall surgical complications by 25 percent by 2010. As key partners in the Surgical Care Improvement Project (SCIP), QIOs will work together with health professionals to make improving surgical care a top priority by offering education and training to increase the adoption of recommended practices for making surgery safer.

The QIO surgical infection program has helped create a foundation for measuring and reporting in this area, so that doctors and hospitals can evaluate and improve their performance.

QIOs also work hand-in-hand with health professionals to improve care for patients who suffer heart attacks, congestive heart failure, pneumonia and other conditions.

Studies have shown that hospitals that work with their QIOs are more likely to provide patients with appropriate, timely, and preventive care measures. The 2005 National Health Quality report found, “That there has been much more rapid improvement in some measures, especially where there have been focused efforts to improve performance. For example, measures for heart attack, heart failure and pneumonia showed an annual improvement of 9.2 percent. These are priority areas for Medicare, where hospitals have received special help from Medicare’s Quality Improvement Organizations.”

Some examples of how QIOs have helped hospitals improve safety:

- In Arkansas, the Sparks Regional Medical Center nearly doubled its use of life-saving beta-blocker drugs for heart attack patients, from 56 percent to 92 percent.
- Over 18 months, Russell County Medical Center in Virginia increased pneumococcal immunization screening by 56 percent.
- Truman Medical Center’s emergency department decreased the average time from patient arrival until antibiotic administration for pneumonia from over seven hours to just under three hours, a move that reduced hospital stays for patients.

At the state-level QIOs have been instrumental in creating and promoting initiatives to advance patient safety that affect all patients, not just those on Medicare.

States from Virginia to California are employing a variety of strategies to advance patient safety, working closely with QIOs to compile practice guidelines for patient safety; raise public awareness about patient safety issues; develop targeted projects for improving patient safety; and establish centers for patient safety that work to reduce mistakes in health care settings. A large majority of QIOs are also considering or have plans to seek certification as Patient Safety Organizations under the new federal patient safety law. Some of examples of what they’ve achieved:

- The Maryland Patient Safety Center, jointly led and funded by the Delmarva Foundation and the Maryland Hospital Association, has reached over 5,000 health care workers and senior executives through educational and training activities, safety culture collaborative seminars, and near-miss medical error reporting projects.
- The Virginia Health Quality Center, the state medical and hospital associations, and other partners have created a coalition to improve patient safety in the state. The coalition was instrumental in passing a patient safety law. The VHQC, the state QIO, is Virginia’s patient safety organization.
- In West Virginia, the QIO is working to improve patient safety in rural hospitals and critical access hospitals by providing a free, confidential medical error and near-miss reporting system and training on its appropriate use to health care professionals.