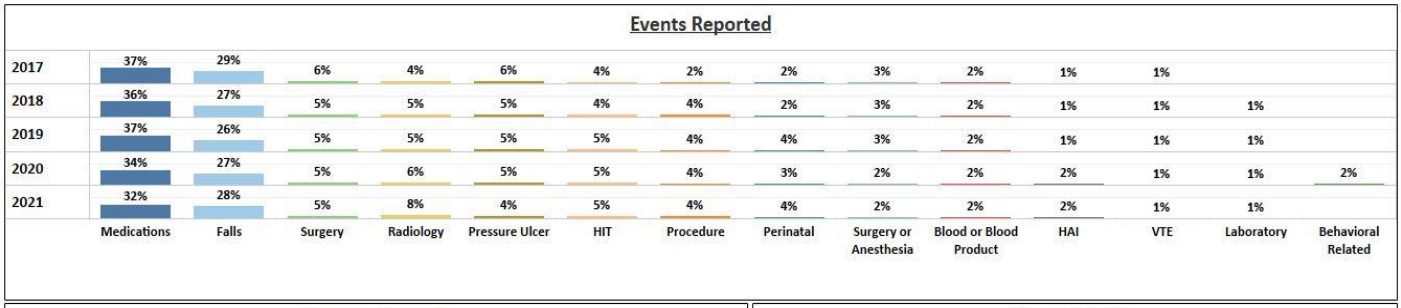
PATIENT SAFETY LEARNINGS

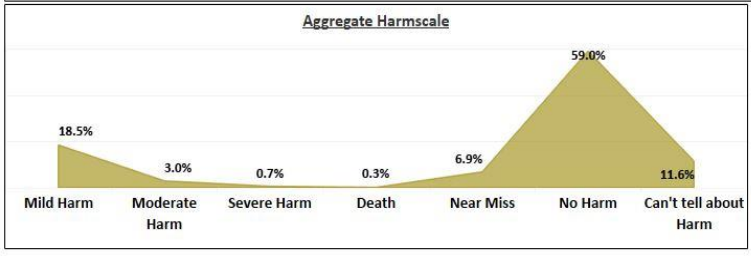
DO I HAVE YOUR ATTENTION NOW?

As many of you know, Clarity PSO has been receiving AHRQ Common Format data from several of our providers since 2010. These past 11 years have provided invaluable data and learning that addresses everything from harmful event rankings to the costs of care related to safety events. In this latest report, we'll use a broad brush as we paint a picture of the impact of this reporting. Then we'll highlight a few critical pivots that have generated great learning moments for our PSO providers across the country.

Though the AHRQ Common Formats were initially developed with acute care hospitals in mind, Clarity PSO has been able to use some of these data elements and cross-apply them to just about any healthcare setting. As you've perhaps seen in previous reports, we've produced analyses in both ambulatory care and specialty areas. So while this report consists primarily of hospital data, the same story can be told across the continuum of care.

The first piece of analysis we'd like to share is an overall view of the event-type-specific Common Format reports with a slightly modified set of categories so that we can highlight some very specific events that are more frequently reported.

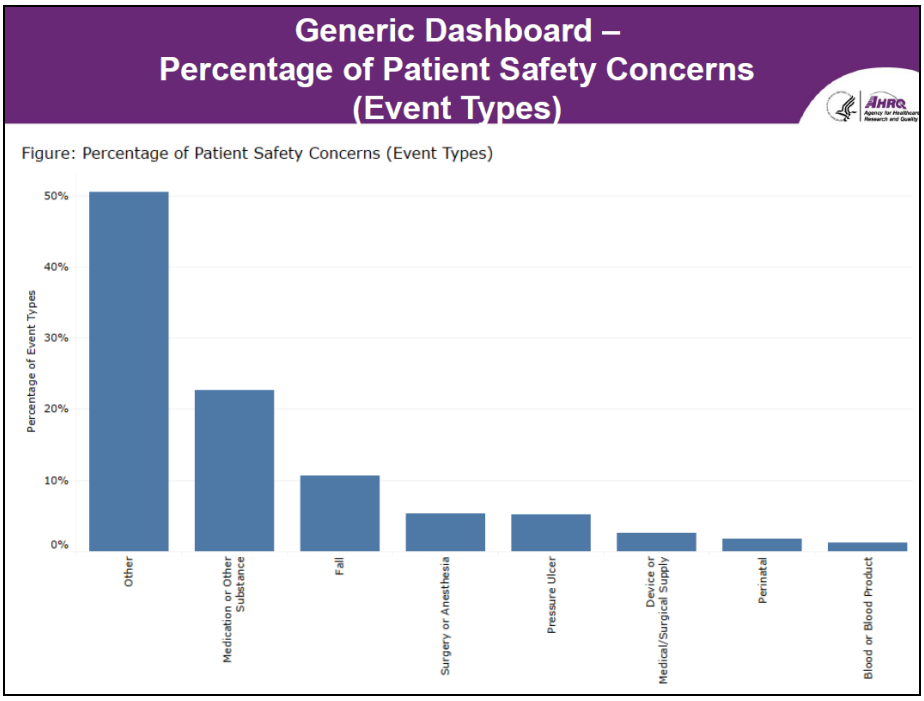




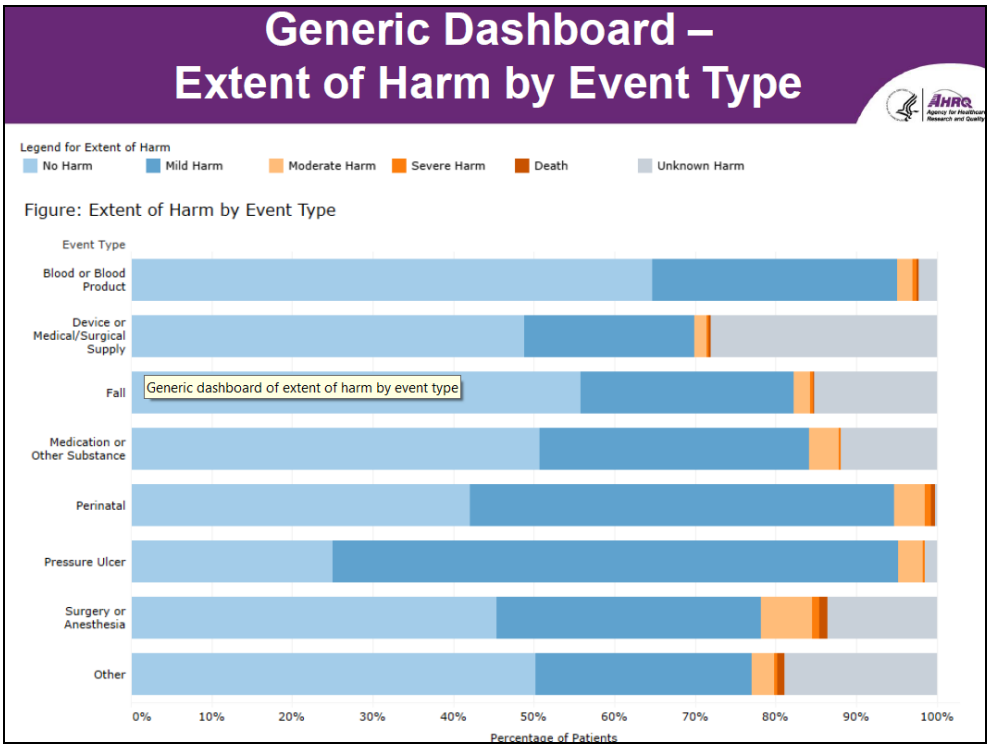
Harmscale By Year

	2017	2018	2019	2020	2021
No Harm	61.3%	62.2%	62.3%	61.5%	61.5%
Mild Harm	20.0%	17.9%	17.7%	17.0%	17.7%
Near Miss	8.7%	8.1%	8.2%	8.1%	6.3%
Can't tell about Harm	5.9%	7.2%	7.3%	9.1%	10.3%
Moderate Harm	3.2%	3.7%	3.6%	3.1%	2.9%
Severe Harm	0.7%	0.7%	0.6%	0.8%	0.9%
Death	0.3%	0.2%	0.2%	0.3%	0.3%

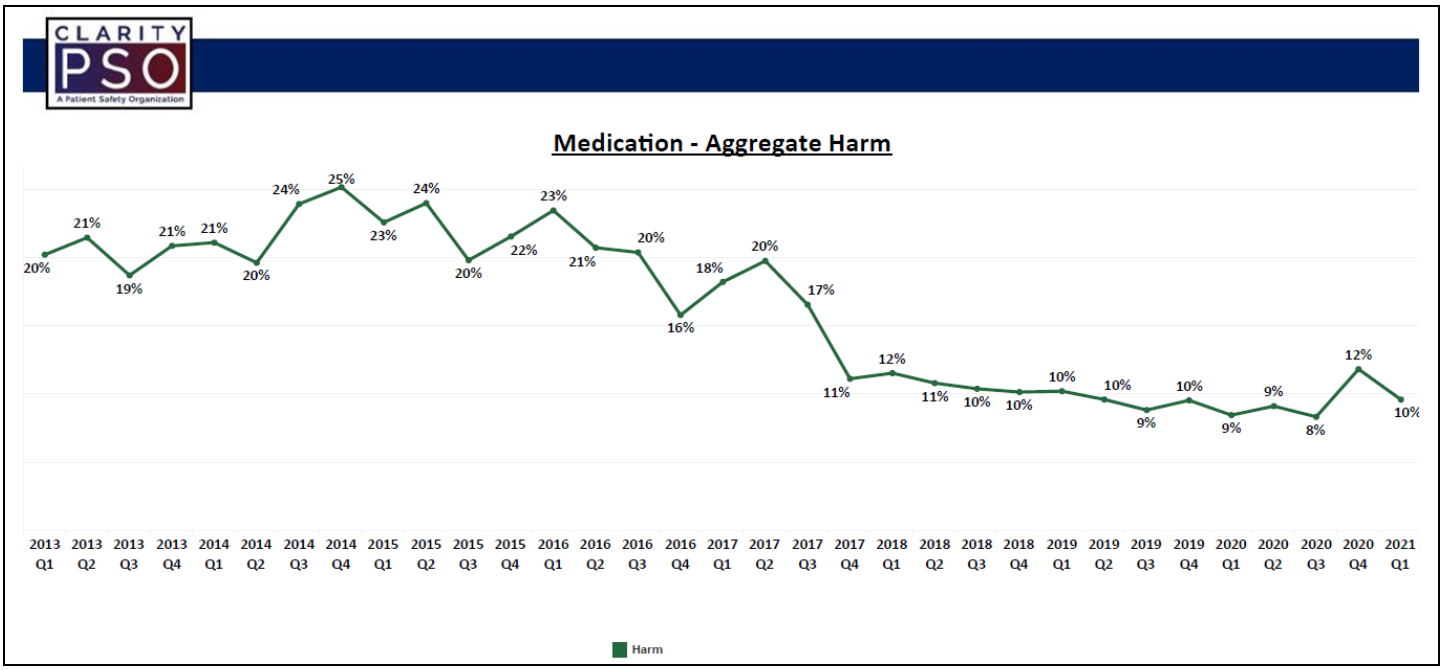
As both Clarity PSO and AHRQ collect more data, it's interesting to see the parallels between these data and the frequencies of what is being reported across the country. The chart on the following page represents data from 14 of the then 93 PSOs that were reporting to the NPSD through 2020.



Similar patterns are seen in the comparison of Clarity PSO harm reporting and NPSD harm reporting.



These graphs and analyses are a great starting point to dive into specific clinical topics and areas, and indeed that is the intent of Common Formats. By generalizing and aggregating categories of data, trends begin to emerge, and it is that big picture of patient safety that shows us where we may want to focus our attention. For example, medications are very highly reported events. According to NPSD data, 15-20% of such events involve either harm or uncertainty of harm. At Clarity PSO, that frequency is lower, around 10-12%, as seen in the chart below.



However, this wasn't always the case. Several years ago we made a concerted effort to focus on meds and harm. We focused on reports and webinars that identified issues such as high-harm events, risk-alert meds, and best practices. Best practices focused on the administration of meds, hand-offs, and communications. The results were astounding. In the following several reports, we recognized a reduction in medication harmful events that saved over $7M in two years. These were dollars that did not have to be spent on additional care as a result of a safety event. This is the power of PSO aggregated data.

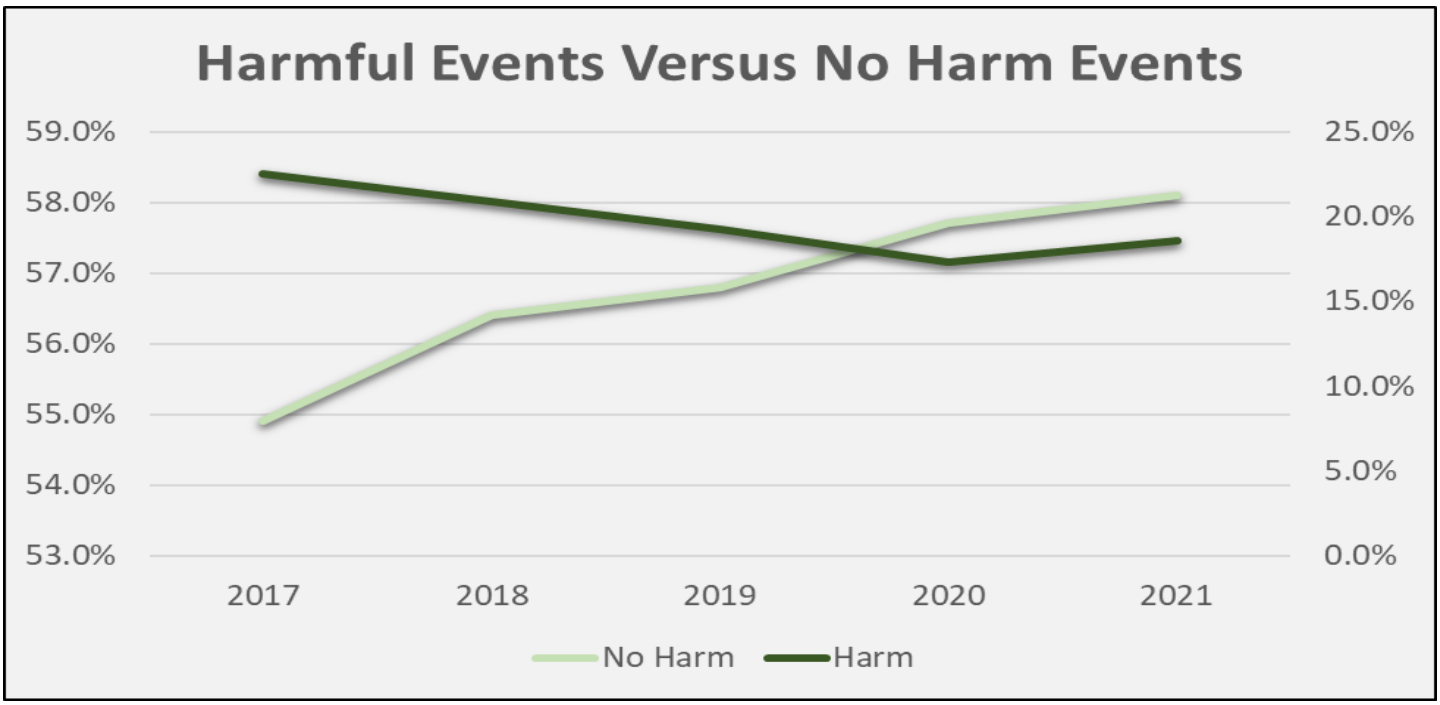
Taking harmful event reports a step further, we can leverage success in one area (such as the medication events example) and apply concepts to other areas. Though the specifics are different because clinical safety manifests itself in so many ways, there are still principles of error pathways that spread throughout the entire system of care. As healthcare professionals we continually hear that a certain health system or specialty of care is unique with respect to its provider-peers. This is absolutely true from a clinical knowledge and skills perspective. However, from an overall safety perspective, we are all subject to the same human errors, and the same manifestations of error pathway development.

Over the last several years, we have tried to represent this sentiment to our PSO participants: that safety culture, safety reporting, and proactive safety initiatives really do make the difference. We explain that it is ok if you see increases in your reporting. Afterall, if you really want to know what's happening, staff have to be able to freely tell you what's happening. Still today we often hear from senior leaders in healthcare organizations

that they become concerned when they see increases in the number of events being reported, as if it indicates that there is an increase in poor performance. This is a misconception. In fact, if you conduct good and deep analyses as we've been discussing in this series of reports, it becomes clear that increased reporting is a sign of a safer organization.

Clarity PSO has conducted focused reviews to identify good performers (as evidenced by consistent reporting and active safety engagement). We followed these providers over time and have recently seen a shift in their reporting. There are three components of this reporting shift: (1) Overall number of events reported increased; (2) Overall number of no-harm events increased; (3) Overall number of harmful events decreased.

Clarity PSO has coined this the "Inverse Safety Reporting Effect" (ISRE), and it can be seen in the following graph:



Data are never perfect because safety events are largely self-reported and people can make mistakes. This is unavoidably true. The power of data aggregation is that it paints a bigger picture to reveal the bigger truths, and it makes a strong case for the work of PSOs. The transformation of safety in healthcare is a journey, not a destination. It starts with better and deeper analysis of our current safety data, and that means developing and applying new tools to harness data from more sources, more efficiently, with fewer errors.