

Patient Safety—Bridging the Gaps

Above all, do no harm—the simple yet powerful Hippocratic Oath symbolizes one of the cornerstones in healthcare delivery. Certainly, patients realize that providers are trained to help those who are suffering or in need, and that no doctor or nurse intends to

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cause harm. Yet each year, more Americans die from medical errors than from motor vehicle accidents, breast cancer, or AIDS¹. Astonishingly, the National Committee on Vital and Health Statistics reported that preventable medical errors account for 12-15 percent of total hospital costs, one in 25 hospital admissions result in patient injury, and three

percent of adverse events result in a permanent disabling injury, leading to one in seven deaths.

Medical errors and patient safety are certainly not new controversial topics. It isn't difficult to find news stories about patients who have had the wrong limb amputated, surgical tools found in patients years after surgery, or even the senior patient who mistakenly underwent an invasive heart study because of a mix up. The practice of medicine is a complex subject; treating patients often involves a variety of providers—doctors, nurses, pharmacists, and others, performing exhaustive procedures and repetitive tasks. As long as the practice of medicine involves human intervention, errors will occur. However, the number and severity of these errors can be drastically reduced.

Current progress in patient safety

From government agencies to private organizations, initiatives and workgroups have been established and progress is being made. The Agency for Healthcare Research and Quality, which is dedicated to ensure

Acknowledging that for the foreseeable future, medical errors will always be a part of practicing medicine, there is much room for the healthcare community to ensure error prevention and minimize medical error occurrences. Mishaps in medicine often result from a multitude of factors and forces. In fact, 17 distinct medical errors were found identified in the case of the above-mentioned senior patient who had underwent the unnecessary invasive cardiac procedure. In spite of discoveries such as this, both the government and the industry agree that medical errors are underreported. In a recent statement, the Food and Drug Administration (FDA) reported that it only receives about 4,000 reports each year from the 40,000-50,000 facilities required by the government to report deaths caused or possibly caused by medical devices.

Unlike other high-hazard industries such as aviation and nuclear power, the provider environment has traditionally resisted against reporting errors. Until recently, it was believed that medical errors could be traced to a single individual and that he or she would be "dealt with." This fear of reprisal, coupled with recent increased numbers of medical lawsuits and rising malpractice costs, has contributed to the underreporting of errors. Against this backdrop, physicians often practice defensive medicine by ordering unnecessary tests for fear of litigation while provider malpractice insurance premiums soar.

patient safety in public health, has devoted significant resources to conduct studies on various aspects of patient safety including piloting new technologies related to reducing medical errors, and ways to encourage

physicians to take leadership roles in patient safety. Similarly, the FDA has mandated measures such as mandatory bar coding of prescription drugs aimed at reducing medication errors. The Veterans Health Administration, a progressive organization and a pioneer in patient safety, has developed two sophisticated reporting systems and established the comprehensive National Center for Patient Safety. In conjunction with

efforts from federal and state governments, the private sector has also assumed an important role in reducing medical errors and improving patient safety. The Leapfrog Group, a coalition of more than 130 large public and private entities, mobilized employer purchasing power to initiate improvements in the safety of healthcare in both the payer and provider world.

Breaking the Barriers and Bridging The Gaps

Due to the numerous opportunities for committing medical mistakes during a typical treatment in today's care process, major chasms in areas such as error identification, communication, and education hinder the healthcare community from effectively limiting and preventing these mishaps from occurring.

Booz Allen Hamilton broke new ground when we built the Adverse Event Reporting System for the FDA, the first of such systems that is compliant with the international standard for electronic transmittal of safety data. Our long history with the FDA and our extensive collaboration with the International Conference on Harmonization, an international standards organization, allowed us to create

a system that promotes safety and maximizes the availability of adverse event information to healthcare oversight entities around the world. Our lessons learned and expertise in designing and building adverse event reporting systems can be readily applied to create intelligent information systems that will effectively promote accessible and secure medical error reporting, allow timely review of errors, and maintain high confidentiality of data transmissions. Since an error is often caused by an escalation of many events along the treatment process, Booz Allen's extensive data warehousing knowledge can facilitate the error analysis process through data mining and aggregation of information from disparate systems.

Changing service delivery models

One of the most important contributions Booz Allen has made to healthcare is helping the Department of Veterans Affairs (VA) move away from an older, hospital-based model of care delivery, to a more outpatient-focused system that relies on neighborhood clinics, home healthcare, and outpatient surgery to provide greater access and better service to the veteran population. Booz Allen's work included a number of studies to restructure service delivery and lead the change management process. Poor communication and misunderstanding of medical error consequences often contribute to under de-

tection and underreporting. Booz Allen experts possess in-depth industry knowledge and can assist in facilitating a collaborative environment for building a common consensus among different groups. We can assist organizations in developing effective internal and external outreach programs that clarify misconceptions about medical errors and are critical to creating an open and patient-safe environment.

In addition to working with government agencies, Booz Allen has built and maintains important relationships with healthcare clients in the commercial world. Leveraging our experiences from working with the government, Booz Allen assisted a large pharmaceutical company with re-

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engineering its adverse event reporting process and in the establishment an enterprise-wide adverse event reporting system. Our recent work with a children's hospital resulted in the development of a strategic

business vision for an incremental picture archiving and communication system implementation that aimed at minimizing cost and optimizing productivity.

Booz Allen and patient safety

Booz Allen is dedicated to improving the status of patient safety and reducing medical errors through identifying new ways to apply technology and knowledge, and fostering a culture of awareness and openness. Annually, Booz Allen contributes a significant portion of its profits to conduct extensive research and development efforts that explore new ways of tackling challenging issues like patient safety. Because medical errors can occur in a variety of treatment settings, measures that ensure patient safety need to be applied to all settings in the continuum of care. To meet these unique needs, Booz Allen relies on its staff of experts from a variety of healthcare backgrounds, which brings the added value of a

diverse approach. Booz Allen's health services experts are epidemiologists, technologists, physicians, nurses, public policy analysts, and other healthcare professionals with a wide range of experience working in both commercial and federal provider and payer settings.

Patient safety is an encompassing issue and requires participation from all who are affected. Our unique position and experience allows Booz Allen to bridge the gaps in today's patient safety efforts, serve the interests of both the private industry and the government, and achieve the common aspiration—delivering quality care to patients.

¹ Kohn KT, et al. To Err is Human Institute of Medicine, 2000.