Florida's Patient Safety Report

The impact of healthcare risk management

Florida Society for Healthcare Risk Management & Patient Safety

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Introduction

Chapter 395 of Florida Law states the control and prevention of medical accidents and injuries is a significant public health and safety concern. The Law furthermore states an essential method of controlling medical injuries is having a comprehensive program of risk management. Florida explicitly recognizes the key to such a program is employing a competent and qualified healthcare risk manager.[1]

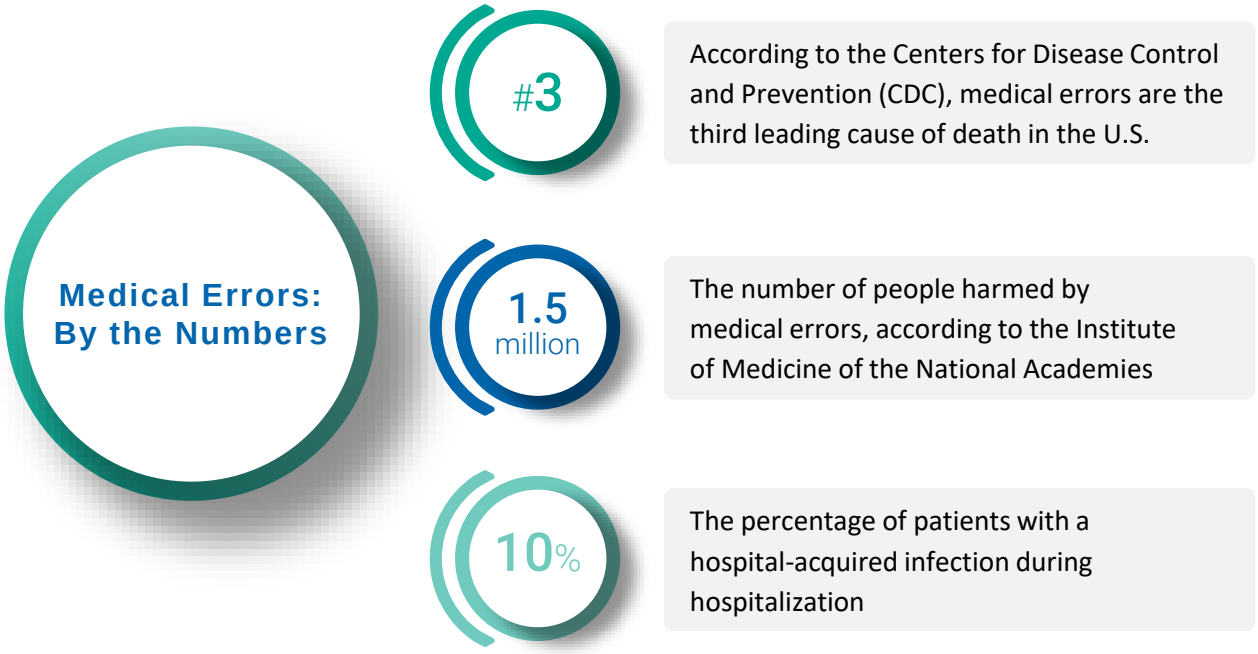
The Florida Society for Healthcare Risk Management and Patient Safety's *Patient Safety Brief* explains Florida's unique requirements and the impact of risk management/patient safety professionals (in Florida) to reduce medical error and preventable harm. The inferences included in this brief are based on a comprehensive literature review and reflect the analysis of state and federal data sets.

Patient Safety: A Work in Progress

In 1999, the Institute of Medicine released its landmark report, *To Err Is Human: Building a Safer Health System*.[2] This report, which focused on patient safety in health systems, stirred a still ongoing discussion relating to patient harm from medical errors. In the two decades since its publication, patient safety has taken an ever-increasing role in the public's mindshare. Medical errors, known within the industry as adverse incidents, have moved in recent years from internal reports to national headlines.

State legislators and regulators of healthcare facilities across the nation have headed the public outcry to address patient safety. And every year, in Florida specifically, patient safety has become a focal point of legislation.

Evidence and examples are abundant of the severe regulatory response to adverse incidents for healthcare administrators failing to address medical errors and patient safety. This regulatory action, often public, creates concern for consumers of healthcare and uncertainty for administrators and facilities alike.



[1] ss. 395.1097, F.S.

[2] Kohn KT, Corrigan JM, Donaldson MS. To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press; 1999.

The Business Case for Safety

An increasing number of **federal and state payment initiatives are linked to patient safety and outcomes**. These initiatives allow payers to deny, adjust, or retract reimbursement based on medical errors.

For instance, the Centers for Medicare & Medicaid Services has piloted models prohibiting reimbursement for hospital-acquired infections. What's more, in order to improve services for recipients, Florida's Medicaid program is studying Potentially Preventable Events (PPEs) and is adjusting payment accordingly.

The Solution: Healthcare Risk Management

Defining Patient Safety

According to the Institute of Medicine, patient safety is defined as "the prevention of harm to patients." The American Society for Healthcare Risk Management expands on this definition, noting that a Serious Safety Event (SSE), in any healthcare setting, is a deviation from a generally-accepted practice or process that reaches the patient and causes severe harm or death.

Given the dynamic nature of healthcare, organizations must evolve their infrastructure to address a wide range of safety issues. An essential method of controlling medical errors and adverse incidents is a comprehensive program of risk management that seeks to focus on preventable harm through the reduction of variation in care and processes. **A robust internal risk management program can reduce preventable harm and increase a safe environment of care for patients, families, and staff.**

The American Society of Healthcare Risk Management research indicates by defining and classifying serious safety events, healthcare systems can better determine the frequency and rate of preventable harm, understand what is contributing to the preventable harm, drive down variation, and use data to improve the culture of patient safety. In doing so, a health system moves from a reactionary approach to a behavior-based, high-reliability framework that prevents harm.

When a patient is harmed as a result of a medical error, risk managers are immediately engaged to assess and identify the circumstances that contributed to the error. Leading an investigation requires a level of competency and a skill set that includes excellent communication, active listening, and the ability to ask probing questions and gather information in a non-accusatory/nonpunitive manner.

With the public spotlight on patient safety, from both consumers and policy-makers, leaders in healthcare must support a system for controlling medical errors, adverse incidents, and preventable harm. Healthcare systems embracing a systemic approach to patient safety can reduce regulatory risk, bolster their credibility with the public, and create a culture of patient safety and reliability.

The Florida Model

Florida is unique from other states across the country as it requires all hospitals, ambulatory surgical centers and nursing homes to have an internal risk management program. Specifically, Florida Law requires healthcare facilities to have a risk management program to analyze the frequency and specific types of adverse incidents that occur and to develop measures to minimize the risk to patients.

While these requirements are exclusive to Florida, the *Journal of Healthcare Quality Research* indicates a standardized approach to safety and harm prevention, coordinated under a risk management framework, is critical in reducing adverse incidents. Healthcare risk managers continuously identify areas of risk, manage uncertainties, and ultimately focus organizational awareness on medical errors and the reduction of preventable harm.

Further, **Florida healthcare facilities are required, by law, to hire a risk manager** and for the risk manager to have education/experience in each of the following areas:

- Applicable standards of healthcare risk management
- Applicable federal, state, and local health and safety laws and rules
- General risk management administration
- Patient care
- Medical care
- Personal and social care
- Accident prevention
- Departmental organization and management

Risk Managers and Medical Liability

According to the American Academy of Emergency Medicine, Florida is a "dangerous state" for physicians and hospital systems, when it comes to medical liability.

In Florida, there were **1,906** malpractice claims reported in hospitals and **2,382** across ALL facility types in **2018**.

A highly-developed risk management program keeps healthcare workers out of the courtroom and at the patient's bedside, where they belong.

Risk managers reduce the frequency and severity of medical malpractice and patient injury claims.

Florida: A National Leader in Patient Safety

State and federal data sets only further substantiate the effectiveness of the Florida model on patient safety. To better understand the impact of Florida's legislatively-required internal risk management programs, one needs only to look at comparable states. **Comparing Florida to states with similar demographics and populations (California, New York, and Texas), there is clear evidence of the importance of risk management.** Those comparable states do not have a legislative requirement for internal risk management programs, and the analysis reveals higher reported adverse incidents and Higher Healthcare-associated Infections.[4] Moreover, the cumulative number of "Top General Hospitals" in Florida is equal to the combined amount of comparable states.[5]

[3] Fernández-Castelló A, Valle-Péreza P, Pagonessa-Damonte ML, et al. An Experience in Integrated Management of Clinical Risks. J Healthc Qual Res 2018.
[4] Data from the Centers for Disease Control and Prevention.
[5] 2019 Leapfrog Top Hospitals.

				
	Florida	**California**	**Texas**	**New York**
Population in Millions (2018)	21.3	39.6	28.7	19.5
Total Adverse Events (2016) – Most recent data[6]	470	1,282	1,396	2,315
HAI – Standardized infection ratio	0.60	0.68	0.77	0.71
# of Top General Hospitals	10	6	4	0

The Role of the Risk Manager in Patient Safety Culture

Most adverse incidents are preventable. Furthermore, research reveals **50% of medical errors are system driven**. While every health system's goal is to achieve total system safety, essential best practices are required to make improvements. The National Patient Safety Foundation found that **total system safety starts with health system leaderships establishing and sustaining a patient safety culture**. This type of cultural approach must be embraced at all levels and must be continuously updated to achieve lasting results. Leadership at the board level must be reinforced through more direct interactions with frontline providers.

An integral part of establishing a patient safety culture and the key to systematizing consistent patient safety performance is employing a healthcare risk manager. Both research and data show healthcare risk management's positive impact on the prevention of harm to patients caused by medical errors. This stems from risk managers proactively identifying and managing risks before an adverse incident occurs.

By investing in a qualified health risk manager, health systems have access to ongoing risk prevention. Moreover, health care risk managers can provide education and training system-wide. Adverse incident reporting systems alone are not enough to make a significant change in patient safety culture. Risk managers play a key role in patient safety by engaging with the frontline provider to provide appropriate follow-up to address specific safety issues and reinforce the importance of patient safety as an organizational imperative.

[6] Data from State Reporting Systems.
[7] Vincent C. Understanding and Responding to Adverse Events. N Engl J Med 2003.
[8] de Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA. The Incidence and Nature of In-hospital Adverse Events: A Systematic Review. Qual Saf Health Care. 2008.
[9] National Patient Safety Foundation. Free from Harm: Accelerating Patient Safety Improvement Fifteen Years After To Err Is Human. Boston, MA: National Patient Safety Foundation; 2015.

Beyond Patient Safety

Each year, health systems are exposed to ever-changing legislative mandates, business trends, and consumer expectations. This creates new challenges for leaders in healthcare. And while risk managers are at the forefront of providing strategies for curbing medical accidents and injuries, these managers are an underutilized asset in other areas of healthcare operations.

As healthcare moves from *volume* reimbursement to *value* reimbursement, risk managers are uniquely positioned to navigate these changes. Risk managers have skill sets that look beyond clinical risks to other risks affecting the organization. This includes providing insight on operational, financial, compliance, and legal decisions. By managing risk at the enterprise level, healthcare risk managers can establish a comprehensive framework that protects value and deals with uncertainty.

FSHRMPS – Promoting Leadership for a Safe and Trusted Healthcare System

The Florida Society for Health Care Risk Management and Patient Safety (FSHRMPS) is a statewide association comprising professionals working across the healthcare delivery spectrum to develop leadership for a safe and trusted healthcare system.

FSHRMPS is pleased to provide this Patient Safety Brief for the purpose of highlighting the benefits that accrue when healthcare facilities employ a competent healthcare risk manager and operate a comprehensive program of risk management. Our hope is that the information provided in this brief will be used by administrators, consumers, policy-makers, and other stakeholders to support the expansion of healthcare risk management at the enterprise level to reduce preventable harm and improve the patient safety culture.

FSHRMPS is considered the leading voice in Florida on issues related to Risk Management and Patient Safety. The goal of FSHRMPS is to "advocate" for public policy, benefiting patients through a safe, trusted, and accessible healthcare system. FSHRMPS seeks to collaborate with other organizations to ensure risk management is included in ways that improve quality and accessibility throughout the healthcare delivery system.