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Special Report

Patient Safety: Grantmakers Join The Effort To Reduce Medical Errors

Foundations are well positioned to support these efforts at the local, state, and national levels.

by Lauren LeRoy and Katherine M. Treanor

Medical errors have been documented for many years, but the evidence had not captured the public's attention until the Institute of Medicine (IOM) report, To Err Is Human: Building a Safer Health System, was published in November 1999. The report placed patient safety firmly on the nation's health care agenda in part because of one startling statistic: Between 44,000 and 98,000 persons die in U.S. hospitals each year as a result of medical errors. The precise number of deaths and injuries that patients experience while receiving medical care is uncertain, but the magnitude suggested by the IOM study is clearly unacceptable.

Improving patient safety is a shared responsibility that depends on cooperation and action by private-sector organizations, consumers, and government. Health grantmakers are well positioned to support these efforts both locally and nationally.

Key Issues

Medical errors take many forms, from patient falls because of a lack of restraints, to mistakes in administering medications, to miscommunication among providers involved in a patient’s care. Medical errors occur in both inpatient and outpatient settings. Some errors have devastating consequences; others do not. Medical errors are not responsible for all poor outcomes but rather represent adverse events that could have been prevented given current knowledge.

Health care lags behind some other high-risk industries, such as aviation and nuclear power, in making error reduction and safety central to its mission. Some models and success stories, however, suggest that the IOM’s national goal of cutting errors in half over the next five years is within reach. For example, efforts to improve surgical anesthesia outcomes have reduced the error rate nearly sevenfold. Medication errors in the Veterans Health Administration have decreased by 70 percent since the introduction of a handheld, wireless bar-coding system.

Contrary to commonly held perceptions, medical errors are generally not the result of individual misconduct; they are caused by failures in the health care systems and organizations that we create. Health care is both labor and technology intensive. The potential for preventable adverse events is exacerbated by both the complexity and fragmentation that characterize health care delivery. The key to reducing medical errors, therefore, is to focus on improving the systems of delivering care. Experience both within and outside of the health sector points to looking for solutions that seek to understand the underlying causes of errors, learn from reported errors or close calls, and work to eliminate the conditions that contribute to preventable adverse events.

Shifting the focus from individuals to sys-

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tems presents perhaps the greatest challenge in reducing the rate of medical errors. It will require a change in both health professional culture and public expectations. Historically, the most common approach to addressing errors has been to assign blame. Doing so, however, is counterproductive and has led to an environment that inhibits discussion of mistakes and close calls for fear of reprisals. Additionally, this culture prevents the reporting and systems examination needed to discover and correct the causes of errors.

Grantmaker Activities

Increased interest in patient safety provides new opportunities for grantmakers that support programs to improve health care quality. It may also attract funders that have not previously seen a role for themselves in addressing quality issues, particularly funders at the local level, where much of the improvement in patient safety must occur.

Within this broader context of quality improvement, a number of grantmakers are pursuing improvements in patient safety. Their work takes place throughout the health care system, in hospitals, ambulatory care centers, nursing homes, and physicians’ offices. These grantmakers are also active in informing public policy development, in consumer education, and in advocacy. Because of its many facets, patient safety is an area in which foundations of different sizes and geographic focus can contribute. Some foundations might provide grants of several thousand dollars that support safety enhancement efforts within local hospitals, while others are able to fund national initiatives of millions of dollars.

Convening. Convening providers, policymakers, employers, consumers, and advocates to develop strategies to improve patient safety is one of the most influential roles that grantmakers can play. This is an approach taken by the Jewish Healthcare Foundation, which, in partnership with local health care and business leaders, launched the Pittsburgh Regional Healthcare Initiative (PRHI). Recognizing that the area’s health care organizations are essential to maintaining quality of life and a strong workforce in Pittsburgh, but realizing that economic factors, such as operating losses and consolidations, were placing them at risk, the PRHI is working to establish the region as a model of health system performance, taking advantage of information technology and modern management tools. The PRHI’s quality goals encompass three strategies: improving health care outcomes in five clinical areas, creating safer hospitals by eliminating medication errors and hospital-acquired infections, and discouraging excess hospital service capacity that reduces the quality of clinical care. To demonstrate support for these strategies, Pittsburgh’s leading health care organizations and employers have embraced two community charters. Each charter defines specific actions that they will take to reduce medical errors, increase patient safety, and improve overall health care quality. The Robert Wood Johnson Foundation (RWJF) has provided a $1 million grant to support the PRHI, reflecting the funder’s commitment to improving the overall quality of health care and its interest in supporting public/private collaboration.

Similarly, the W.K. Kellogg Foundation awarded a grant in 1999 to Harvard University to convene and mobilize national government, industry, academic, media, and consumer leaders to strategically improve patient safety. At the local level, the New York Community Trust contributed to the United Hospital Fund’s efforts to promote safety among New York City’s hospitals. The work includes reviewing the scope of medical errors and examining how providers, purchasers, regulators, consumers, and others respond to errors and enhance safety. This initiative will also convene health care leaders to identify and share best practices promoting patient safety within local hospitals.

Policy research. Grantmakers also can contribute to public policy on patient safety. The Commonwealth Fund has stimulated interest in medical errors and patient safety at both the national and state levels. As a funder of To Err Is Human, the Commonwealth Fund helped to bring these issues to national atten-
tion. Additionally, Commonwealth, along with the RWJF, provided support to the National Academy for State Health Policy to review states’ medical error policies and regulations and evaluate their error-reporting systems.6

### Educating and surveying consumers.
Grantmakers are also positioned to educate the public about the quality of care provided by health care organizations and professionals. The California HealthCare Foundation’s (CHCF’s) Quality Initiative, focused on bettering the health of Californians, includes development and dissemination of publicly reported quality data across health care settings; promoting and evaluating consumers’ and purchasers’ use of quality data; and accelerating quality improvement and public accountability through collaboration among consumer groups, providers, purchasers, and policymakers. Also, within the initiative, the foundation is developing a strategic plan to address patient safety. In the meantime, the CHCF plans to collaborate with the Agency for Healthcare Research and Quality (AHRQ) to translate a patient fact sheet on avoiding medical errors into several Asian languages.

Results of a consumer survey conducted by the Henry J. Kaiser Family Foundation and AHRQ were released in December 2000. The survey found increased public awareness of medical errors as a result of recent media attention, with medical errors becoming a leading measure of health care quality. Survey results suggest the opportunity for policymakers and others to make information on quality more readily available and the need to take care in assuring its validity and reliability.

### Improving delivery of care.
Improving health care delivery so as to reduce errors is another area in which all types of grantmakers can contribute. The CHCF commissioned a primer on computerized physician order-entry systems, a technology that has been shown to reduce medical errors and increase cost savings. The primer, developed by First Consulting Group, was distributed to hospital trustees, hospital executives, nursing administrators, and pharmacists throughout the state. The RWJF has supported a number of patient safety studies examining communication, teamwork, and professional culture in health care organizations. For example, one project will introduce medical students to the professional and personal implications and responsibilities related to medical errors.

### Research on medical errors.
Grantmakers are starting to take advantage of the momentum generated by the IOM report by funding research on how and why errors occur and on the development and evaluation of strategies to reduce errors. Aetna U.S. Healthcare and the Aetna Foundation awarded $840,000 in grants to researchers at five leading academic medical centers to examine topics such as reducing medication errors, improving safety for surgical patients, and controlling infection in long-term care facilities. One study, for example, is examining how tertiary care hospitals and their pharmacies collect information about medication events and errors. In a second program, surgeons, anesthesiologists, and nurses work collaboratively to resolve cross-disciplinary systemic problems affecting patient safety. The Blue Cross Blue Shield of Michigan Foundation is funding medical error research at the state level. It recently awarded approximately $500,000 to several Michigan researchers for epidemiological research, applied research, demonstration and evaluation projects, and strategies to disseminate best practices on reducing medical errors.

A number of grantmakers have also partnered with the Quality Interagency Coordination Task Force (QuIC) to help shape a national research agenda on patient safety. QuIC brings all federal agencies involved in pur-
chasing, providing, regulating, or examining healthcare into a cooperative effort to improve healthcare quality. In September 2000 it sponsored a National Summit on Medical Errors and Patient Safety Research to identify opportunities for publicly and privately funded research to obtain a better understanding of how and why errors occur and to design and promote safety-enhancing interventions. Private funders—including the Commonwealth Fund, Jewish Healthcare Foundation, the RWJF, the Kaiser Family Foundation, the CHCF, as well as Grantmakers In Health (GIH)—were among those hearing testimony at the summit.

The GIH role. Heightened concern about patient safety prompted GIH to stimulate grantmakers’ interest in addressing this issue. Consistent with its mission to help grantmakers improve the nation’s health, GIH thus far has focused on fostering collaboration among public and private funders on agenda setting and information exchange, as well as educating the broader field of health philanthropy on medical errors and patient safety and strategies for addressing these critical issues.

GIH’s participation in QuiC’s summit and in a second QuiC conference focused on concerns of clinicians and health system managers are examples of its efforts to identify potential roles and partnerships for health grantmakers. To raise the visibility of these issues within health philanthropy, as of this writing, GIH was planning an Issue Dialogue, funded by the RWJF, for late February 2001. This one-day working meeting sought to convene grantmakers, researchers, and experts from the public and private sectors to discuss the issues and explore steps that foundations can take to improve patient safety.

Continued Opportunities

Grantmakers are uniquely positioned to help to reduce medical errors and improve patient safety throughout our health care system. Beyond the programs described here, grantmakers can support demonstrations of promising interventions, education and training of health care professionals, and development of leadership for cultural change. Each of these efforts can be undertaken at the local, state, or national level and can involve a diverse array of new and established grantmakers with varying resources and programmatic focuses.

Medical errors and patient safety are relatively new funding areas for grantmakers, but foundations are likely to find many opportunities consistent with their broader grantmaking agendas. Since grantmakers as a whole support projects within virtually all aspects of the health care system, they are able to advance patient safety in both inpatient and ambulatory settings and to reach out to providers, the public, and other stakeholders. As grantmakers contribute to reducing medical errors and improving patient safety, they also can advance the broader quality agenda.

The authors appreciate the assistance of the grantmakers cited within this paper in providing information on their work.

NOTES

1. Institute of Medicine, To Err Is Human: Building a Safer Health System (Washington: National Academy Press, November 1999). The IOM defines medical errors as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” Errors resulting in injury are considered to be preventable adverse events. The Quality Interagency Coordination Task Force defines patient safety as “initiatives designed to prevent adverse outcomes from medical errors” and views safety as preventing errors, making errors visible, and mitigating the effects of errors.


3. Ibid.


5. Ibid.