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Proposed Changes to the Patient Safety Authority's Independence Raise Important Policy Issues

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As Pennsylvanians, we all want to continue making much needed strides in patient safety. Governor Corbett's budget, which merges the Pennsylvania Patient Safety Authority with the Department of Health (DOH), raises important public policy issues about the best way to do this. The Authority was established in 2002 as an independent agency under the Medical Care Availability and Reduction of Error Act (MCARE), signed by Governor Schweiker. It was charged with gathering and analyzing reports of medical errors and near misses and, importantly, with using that information to reduce harm to patients seeking care in Pennsylvania. The results have been highly successful: over 1.5 million reports have been submitted and hundreds of opportunities for improvement have been issued by the Authority, available on a public website.

There are numerous examples of the Authority's impact. By collecting and analyzing data from across the state, it discovered the causes of performing surgery on the wrong patients or the wrong parts of their bodies, thereby helping one group of 30 hospitals reduce these horrible events by 73% and a second group to go a year with absolutely none. It helped convince the FDA to change the labeling requirements for hydromorphone, a powerful narcotic which, when confused with morphine, can cause a fatal overdose. It helped reduce infections from central lines—catheters used to deliver drugs directly into the heart—so that Pennsylvania's rate is one-third below the national average. Pennsylvania hospitals reduced these infections by 24%.

While we assume that the Authority's work would continue after the merger with the DOH, the merger could significantly diminish the Authority's effectiveness. It may:

- **Weaken reporting of patient safety concerns.** The Governor and the Legislature established an independent Patient Safety Authority to carry out a non-punitive, learning-based reporting program to encourage hospitals to share information on "near miss" events, which had they not been caught in time, would have injured patients. They believed that hospitals would fail to share this information with the DOH out of fear that reports would be used for regulatory and enforcement purposes. Instead, the Authority treats "near misses" as a learning opportunity and to encourage better practices. Doctors, nurses others who work in healthcare need to be able to learn from near misses, especially before these events result in harming patients. This technique is used successfully in the airline industry, and keeps travelers safe.
- **Diminish collaboration and the spread of "best practices" across hospitals and other providers.** Effective improvements in safety rely on positive, collegial relationships with hospitals in which improvements can be discovered and put into practice. Many healthcare providers have, on their own initiative, sought the Authority's assistance in furthering their own safety improvement efforts. They invite Authority staff into their operating rooms to critique their implementation of practices to prevent surgical errors. They invite the Authority into their

board rooms to educate hospital trustees on their role in making their institutions safer. Whether these opportunities for improvement would be lost if the Authority becomes a department within the DOH - the providers' primary regulatory agency - is an important policy question.

- **Lose the trust that made the authority a leader in protecting patients.** The relationship of trust between the Authority and hospitals is a valuable asset, built over many years and making Pennsylvania a model for other states and nations. The Patient Safety Authority earned the prestigious John M. Eisenberg Award for advancing patient safety and quality, and the National Academy of State Health Policy held a national meeting in Harrisburg so officials from other states could learn from Pennsylvania's successes. Serious study should precede taking action to break up what has been a winning team in Pennsylvania.

The DOH serves a vital role in ensuring the safety of our healthcare facilities. It is a regulatory one, based on taking enforcement action. Whether a single agency can most effectively serve dual roles – learning and enforcement - needs to be examined.

Because we have something that is working well now, structural changes should be thoroughly weighed and evaluated to preserve current benefits that work to save more lives and prevent more injuries to patients. We urge the Legislature and the Executive branch to jointly consult the Commonwealth's provider institutions that pay for the Patient Safety Authority through fees levied upon them. We urge the Governor and Legislature to conduct a study of provider institutions so that they can anticipate the effects of the proposed merger and base their policy decisions on the evidence. The merger appears imminent, and the effect of making a wrong decision is significant for patients.

Note: ECRI Institute, a non-profit organization, contracts with the Authority to collect and analyze its safety reports.