



August 5, 2009

A MESSAGE TO AHA MEMBERS: TEN-YEAR ANNIVERSARY OF IOM REPORT TO BRING INCREASED MEDIA ATTENTION

BACKGROUND

In November 1999 the Institute of Medicine (IOM) released its landmark report, *To Err is Human*, which estimated that as many as 98,000 people die each year in hospitals because of preventable medical harm. The report captured the attention of the public, policymakers and the media and was a call to action for hospitals and health care providers.

Today, in anticipation of the 10-year anniversary, media outlets are revisiting the report and gauging the progress we've made as a nation on the serious issues of quality and patient safety. In fact, media outlets are beginning to research this issue and prepare stories that will run in the coming weeks. The Hearst chain of newspapers and television stations is about to publish and air major stories, and we know other reporters are at work too.

With this renewed interest, it is critical that your hospital be prepared to respond to public and media inquiries about what has been done to improve patient safety in the 10 years since the IOM report. That is why the AHA is sharing information to help you prepare to answer questions from your community and the media. This advisory is one in a series of resources that will be coming your way in the months ahead.

We know that safety and quality improvement are an integral part of your organization's culture. We encourage you and your team to be familiar with your activities and policies and to be prepared to speak about patient safety and quality with the media, the public and the patients and communities you serve. This advisory includes some general themes and messages to consider when talking with reporters and the public.

OUR TAKE

As a field, hospitals have been working intensely to improve quality and provide the best care to patients. In the past decade, various safety organizations have been formed such as the Hospital Quality Alliance (of which the AHA is a founder) to further promote and improve our efforts. The anniversary of *To Err is Human* provides an opportunity for hospitals to share where we stand as a field and to highlight the good work you are doing every day. As our nation debates health reform, quality and patient safety will be important components.

ACTION STEPS

- ✓ **Share and discuss this advisory** with your executive team, medical team, quality staff, board of trustees and public relations/communications professionals.
- ✓ **Review the [IOM report](#)** if you or team members are not already familiar with it. If your local media covered it at the time, revisit those stories and how they were reported.
- ✓ **Identify and be familiar with your quality improvement efforts and your hospital's progress.** Prepare a brief written summary of your hospital's patient safety and quality policies, procedures and programs. Describe how they are staffed and overseen and how you put them to work to make care safer, more efficient and effective. Use the document as an overview for the public (consider posting on your Web site), the press, your employees and volunteers.
- ✓ **Choose a spokesperson.** A good choice may be a physician, nurse or your director of quality – a person that is familiar with the efforts you have in place to ensure quality of care. You also may consider a board member who is engaged in your organization's patient safety efforts to demonstrate the importance of patient safety to your hospital.
- ✓ **Prepare the spokesperson to answer a series of tough questions:**
 - Is your hospital safer today than it was 10 years ago?
 - What are you doing as a hospital to improve safety?
 - Are you in support of mandatory reporting of hospital errors?
 - Are hospitals underreporting errors to the public?
 - How do I know if your hospital is safe?

Be sure to cite new programs, examples of improvements, collaborations and other leadership achievements. We know hospitals today are more focused on surgical safety, medication safety, disclosure and learning from mistakes, using IT, checklists and safety enhancing practices, but the public may not be aware of these efforts or understand why they are important.

KEY MESSAGES

- **Today – almost 10 years after the IOM report – hospitals are safer and more transparent.** Can we do even more? Yes. And, hospitals are constantly assessing and improving quality of care and implementing better patient safety systems that are transparent to the community.
 - The Hospital Quality Alliance is a national public-private collaboration that is committed to making meaningful, relevant and easily understood information about hospital performance accessible to the public and to informing and encouraging efforts to improve quality. Consumers now can get information about hospital quality at www.hospitalcompare.hhs.gov. Physicians, nurses and other clinicians also use the data to improve what they do for patients.

- ***To Err is Human* was a call to action to which hospitals readily responded.** Over the past decade, hospitals have taken numerous steps to develop a “culture of safety” within their organization where clinicians feel they can talk about mistakes and near misses away from an environment of blame.
 - Hospitals have increased their efforts to communicate effectively with nurses, physicians, patients and the communities they serve.

- **There have been Herculean efforts on the part of hospitals, physicians, caregivers, patients, Congress and government to establish best practices to ensure quality care is provided to all.**
 - For example, the vast majority of hospitals have participated in a variety of collaborative projects designed to enable dramatic improvements in the safety of care, such as the Keystone Project aimed at reducing infections, the Surgical Care Improvement Project, and the Institute for Healthcare Improvement’s 100K Lives Campaign.
 - Many hospitals have joined or are in the process of selecting one of the newly federally certified Patient Safety Organizations (PSOs) to reduce the incidence of events that adversely affect patients.
 - Since the IOM report, nearly every hospital has appointed a patient safety officer and established procedures for deeply examining events that led to patient harm (called root cause analyses). These

help organizations understand what can be done to change practices so that future incidents can be avoided.

- Hospitals have adopted a variety of technologies and practices that support safer care, including electronic health records and prescription order systems with embedded systems to alert clinicians to potential dangers, barcoding systems that ensure the medication being given is the one that was ordered, bedrails and monitors to alert the nursing staff who can prevent patient falls, and a variety of other improvements in care.
- **Hospitals take patient safety seriously and are making great strides.** With all that we do, can the possibility of human error ever be eliminated?
– Of course not. Hospitals are human institutions – people caring for people. But we can and do work to improve the quality of care provided.

NEXT STEPS

In the coming weeks and months the AHA will work to provide you with more information on this issue as it develops. We anticipate a series of conference calls to help members learn from our experts and share ideas about the progress that has been made on patient safety. You also can visit the AHA's [Hospitals in Pursuit of Excellence](#) for field-tested practices, tools, education and other networking resources.

If you have questions regarding this advisory, please contact Matthew Fenwick, associate director, media relations, at (312) 422-2820, or Nancy Foster, vice president for patient and safety quality at (202) 626-2337. For more information, visit www.aha.org.