Michigan's First Patient Safety Organization Issues Inaugural Annual Report
1 message

Amy Morris <AMorris@mwadvocacy.com>  
To: Amy Morris <AMorris@mwadvocacy.com>

FOR IMMEDIATE RELEASE  
Contact: Ruthanne Sudderth
September 20, 2010  
(517) 703-8631, rsudderth@mha.org

Michigan’s First Patient Safety Organization Issues Inaugural Annual Report

MHA PSO examines efforts thus far to make health care safer for patients

LANSING, Mich. — Recruiting and educating Michigan hospitals, establishing patient safety evaluation systems and initial data collection activities highlighted the first full year of operations of the Michigan Health & Hospital Association (MHA) Patient Safety Organization (PSO). The organization today released its 2010 annual report that recaps the efforts of the organization since its inception.

Created in late 2008 after passage of federal and state patient safety regulations, the MHA PSO is working to make health care delivery safer for patients by collecting confidential, detailed data on medical errors (often called serious adverse events) that occur in hospitals. The data are then analyzed by patient safety experts, who work with hospital staffs to establish the root cause of an event and help implement best practices aimed at reducing and eliminating errors.

“Michigan has a tradition of voluntary, innovative and successful patient safety efforts that have led the nation by example,” said MHA President Spencer Johnson. “The MHA PSO is the most recent member of the MHA family of quality and accountability and we’re pleased to share news of its significant progress in its first year of operations.”

The organization has established statewide membership and launched data collection efforts. As analysis progresses and as additional data are collected, the state’s community hospitals will continue to build on and refine efforts and opportunities to further improve health care quality.

Initial data collection identifies patient falls and surgical errors as areas that are most suited for improvement interventions. Surgical errors are being addressed through a patient safety collaborative proactively instituted by Michigan hospitals in 2007. Opportunities to prevent patient falls have been undertaken in recent years, but hospitals are
confident more can be done.

— MORE —

“Patient falls continue to be a challenge for hospitals nationally, as do surgical events. These events, although very rare, are areas that can be improved because they often result from preventable causes,” said MHA PSO Board Chair Paul Conlon. “The MHA PSO and Michigan hospitals are addressing these types of occurrences through statewide efforts to standardize a patient alert wristband that can identify patients at a risk for falls, and by providing extensive education and interventions on the causes and prevention of surgical errors.”

The MHA PSO is certified under the federal Patient Safety and Quality Improvement Act of 2005 and is a qualified hospital PSO under state law. PSOs perform two key functions:

- Allow health care providers to seek expert help in understanding patient safety events and preventing recurrence in a protected legal environment.
- Create a system of data collection to combine and analyze data so that hospitals might learn from each other.

By collecting data from hospitals throughout the state, the MHA PSO can identify issues and trends that individual hospitals, with their limited experience, may not detect. The ability of a PSO working with all hospitals in a given state to comprehensively aggregate data provides all hospitals tremendous value.

In addition to its own distinct work to enhance patient care, the MHA PSO has identified significant opportunities to complement the work of the MHA Keystone Center for Patient Safety & Quality, a nationally recognized leader in improving patient safety and health care quality. Early data trends regarding surgical errors have led the MHA PSO and MHA Keystone Center to examine how the data collection efforts benefit from the well-established MHA Keystone: Surgery collaborative, which seeks to make care safer for patients in the operating room.

Moving forward, the MHA PSO and member hospitals will continue their role as national leaders in patient care by educating hospital staff, enhancing data collection efforts, and identifying additional areas for patient safety and quality improvement. The report is available at www.mhapso.org.

The MHA PSO is a not-for-profit (501c3) corporation that seeks to improve patient safety and quality for all Michigan residents. The MHA PSO collaborates with providers to implement evidence-based best practices that will improve patient safety and quality of care. The MHA PSO is listed by the Agency for Healthcare Research and Quality (AHRQ) as a certified patient safety organization and is a component of the Michigan Health & Hospital Association Health Foundation. Visit AHRQ (http://pso.ahrq.gov/) for additional information on the federal PSO certification process.

###