American Hospital Association™
Advancing Health in America

Member Advisory

October 23, 2019

20th Anniversary of *To Err Is Human* Brings Opportunity for Hospitals and Health Systems to Highlight Safety and Quality Strides Made

Background:

In November 1999, the Institute of Medicine (IOM), which is now the National Academy of Medicine (NAM), released its landmark report, *To Err Is Human: Building a Safer Health System.* The report, which estimated that as many as 98,000 people died each year in U.S. hospitals because of preventable medical harm, captured the attention of the public, policymakers and the media and was a call to action for hospitals, health systems and other providers of care.

In anticipation of the 20th anniversary of the report's release, media outlets will be revisiting the report and commenting on the progress the field has made on the important issues of quality and patient safety. With this renewed interest, it is critical that your hospital or health system be prepared to respond to questions from the public and the media about what has been done to improve patient safety over the past two decades.

The anniversary is also an opportunity for you to proactively share through your various communications channels and methods, and with the AHA, the many strides your organization has taken to improve safety and the quality of care for patients.

This advisory includes talking points and messages to consider when crafting communications and responding to questions. It also includes various other resources, like an action plan, helpful national statistics and a digital toolkit.

Further Information and Questions:

Please do not hesitate to contact us with any questions regarding this advisory. You can contact Nancy Foster, vice president of quality and patient safety policy, at nfoster@aha.org or (202) 626-2337; Akin Demehin, director of quality policy, at ademehin@aha.org or (202) 626-2365; or Colin Milligan, senior associate director of media relations, at cmilligan@aha.org or (202) 638-5491.

Action Plan

- ✓ **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 your 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.

- ✓ **Compile stories of progress and review your hospital's or health system's performance on key patient safety measures and statistics over the past several years.** This compilation could include the data that are on the Centers for Medicare & Medicaid Services *Hospital Compare* website, like healthcare-associated infections (HAIs), but also other positive data that you feel comfortable speaking to publicly.

- ✓ **Choose a spokesperson for your organization**. A good choice may be a physician or nurse leader, or your director of quality – a person who 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.

- ✓ **Prepare the spokesperson to discuss the steps your organization has taken to improve patient safety and quality.**

- ✓ **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 messages on social and digital media, as an op-ed to submit to a local news publication, or as an overview posted on your website for the public, the media and your employees and volunteers.

Talking Points

About the Report:

- Today – 20 years after the Institute of Medicine's landmark report, *To Err Is Human*, was released – **hospitals and health systems are more dedicated than ever to patient safety and delivering the highest quality of care**.

    - While even one incident of preventable harm is one too many, hospitals and health systems continuously seek to achieve the best possible outcomes for all of their patients, which means avoiding medical errors and reliably delivering the most appropriate, highest quality care.

    - Hospitals and health systems have also helped lead the way in developing transparent reporting of quality and patient safety data and helped create

Hospital Compare, a website where consumers can find information about hospital quality. Physicians, nurses and other clinicians also use the data to improve care for patients.

- *To Err is Human* was an **important call to action to which the hospital field readily responded.**

    - Hospitals and health systems have taken numerous steps to develop a culture of safety within their organization and have increased their efforts to communicate effectively with clinicians, patients and their families, and the communities they serve.

    - Hospitals have also 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; and

        - bedrails and monitors to alert the nursing staff, who can prevent falls, and a variety of other improvements in care.

National Statistics on the Progress Made:

- Our field has **made bold changes to improve care quality and safety** over the past decade, and patients are reporting more and more favorable hospital experiences.

    - Federal data show that hospitals have made care safer by:

        - **Reducing hospital-acquired conditions (e.g., safety events like falls, pressure ulcers and adverse drug events) by 13%** from 2014-2017. This trend is consistent with previous data showing a 17% decline from 2010 through 2014.

        - **Significantly reducing healthcare-associated infections**, including:

            - A 40% reduction in central line-associated bloodstream infections (CLABSI) between 2009 and 2014. These declines have continued, with a 19% decline from 2015 to 2017.

            - Surgical site infections (SSI) decreased 16% between 2009 and 2014. These declines also have continued, with declines

of 9% and 11% for abdominal hysterectomies and colon surgeries, respectively, between 2015 and 2017.

- Clostridium difficile (C. difficile) infections declined by 20% between 2015 and 2017.

➢ **Making a 77% reduction in the occurrence of medically unnecessary early elective deliveries** between 2012 and 2016.

➢ **Having more than 70,000 fewer avoidable readmissions** between 2010 and 2015.

- Between 2014 and 2018, **hospitals directly engaged in the AHA Hospital Improvement Innovation Network (HIIN) program saved $1.2 billion in healthcare costs, prevented 141,000 harms and saved 14,000 lives**. Every dollar invested in the program resulted in a $12 return on investment.

- See the AHA report from October of 2018 with additional information about how hospitals and health systems are improving outcomes.

However, More Work Needs to be Done:

- **While we have made considerable progress, more work needs to be done**. That's why hospitals and health systems are working hard to:

  - further reduce infections, including sepsis;

  - improve communication among providers and between the patient and caregivers;

  - reduce the use of opioids to protect patients from potential addiction;

  - reduce the use of antibiotics to preserve their effectiveness against deadly diseases;

  - engage clinicians even further in performance improvement and reducing variation; and

  - help the field connect quality and safety efforts to equity of care.

- In addition, the AHA and the hospital field are redoubling efforts to make sure women have safe pregnancies, from the first days of pregnancy through the postpartum period.

- As part of that commitment, AHA has long partnered with other national organizations as an active member in the Alliance for Innovation on Maternal Health (AIM).

- The hospital field is also partnering with others in the health field on the Better Health for Mothers and Babies initiative, which is focused on improving maternal health outcomes.

- The Preventing Maternal Deaths Act (H.R. 1318), legislation that the AHA supported, was signed into law last year and will provide funding for states to develop maternal mortality review committees to better understand maternal complications and identify solutions.

- AHA currently supports legislation, including provisions of H.R. 1897/S. 916, the Mothers and Offspring Mortality and Morbidity Awareness Act, as well as provisions in S. 1895, the Lower Health Care Costs Act, that would fund programs to: improve data collection and dissemination of best practices; educate health care professionals on implicit bias in order to reduce and prevent discrimination; and support state perinatal quality collaboratives.

- The AHA continues to actively work with the field and other stakeholders to disseminate best practices and share strategies through a variety of AHA platforms and initiatives, many of which can be found on the AHA's Advancing Clinical Care webpage HERE.

- As the health care system continues to transform, one thing remains constant for America's hospitals and health systems: We are **committed to providing patients with high-quality, safe and person-centered care**.

Additional Important Messages:

- Patient safety is a priority throughout the continuum of care and across settings and care teams – from the moment a patient walks in the door, through the course of their care or treatment, throughout their recovery process and as they return to their families and communities.

- We believe that one of the most important steps in preventing errors is to involve the patients and help them become full partners in decisions about their care and treatment. Better communication among patients, nurses and physicians is an important ingredient to improve overall care.

- Over the past 20 years, hospitals and health systems have worked to create a culture of safety and move away from an environment of blame. This encourages nurses, physicians and other caregivers to come forward when mistakes are made so we can learn from and prevent them from happening again.

- When an error does occur, hospitals work to identify and understand the series of events so they can update patient safety systems and further prevent errors. We encourage hospitals and physicians to talk with patients and their families whenever something unexpected in their care occurs.

- With all that we do, can the possibility of human error ever be totally eliminated? Since hospitals are human organizations – people caring for people – the answer is probably no. But we can and do work hard each day to improve the quality of care provided.

Digital Toolkit

Twitter Messages

- This year marks the 20th anniversary of the To Err is Human report -- see what @ahahospitals is doing to improve quality & patient safety https://www.aha.org/advancing-clinical-care

- Hospitals & health systems have made bold changes to improve care quality & safety over the last decade, with data showing hospitals reduced hospital-acquired conditions by 13% between 2014 & 2017 www.aha.org/advocacy/quality-and-patient-safety

- Hospitals & health systems are advancing quality & safety & have seen a significant decline in avoidable readmissions since 2010 www.aha.org/advocacy/quality-and-patient-safety

- Hospitals & health systems are advancing maternal health, reducing medically unnecessary early elective deliveries between 2012 & 2016 by 77% www.aha.org/advocacy/quality-and-patient-safety

Facebook/LinkedIn Messages

- On the 20th anniversary of the To Err is Human report, hospitals and health systems remain committed to advancing patient safety and quality. While we have made considerable progress, we continue to work hard each day to enhance the quality of patient care www.aha.org/advocacy/quality-and-patient-safety.

- The AHA has taken a leadership role in supplying information to hospitals and health systems to help further the important efforts to improve patient quality of care and safety. For more resources, visit our Advancing Clinical Care webpage https://www.aha.org/advancing-clinical-care.

Graphics


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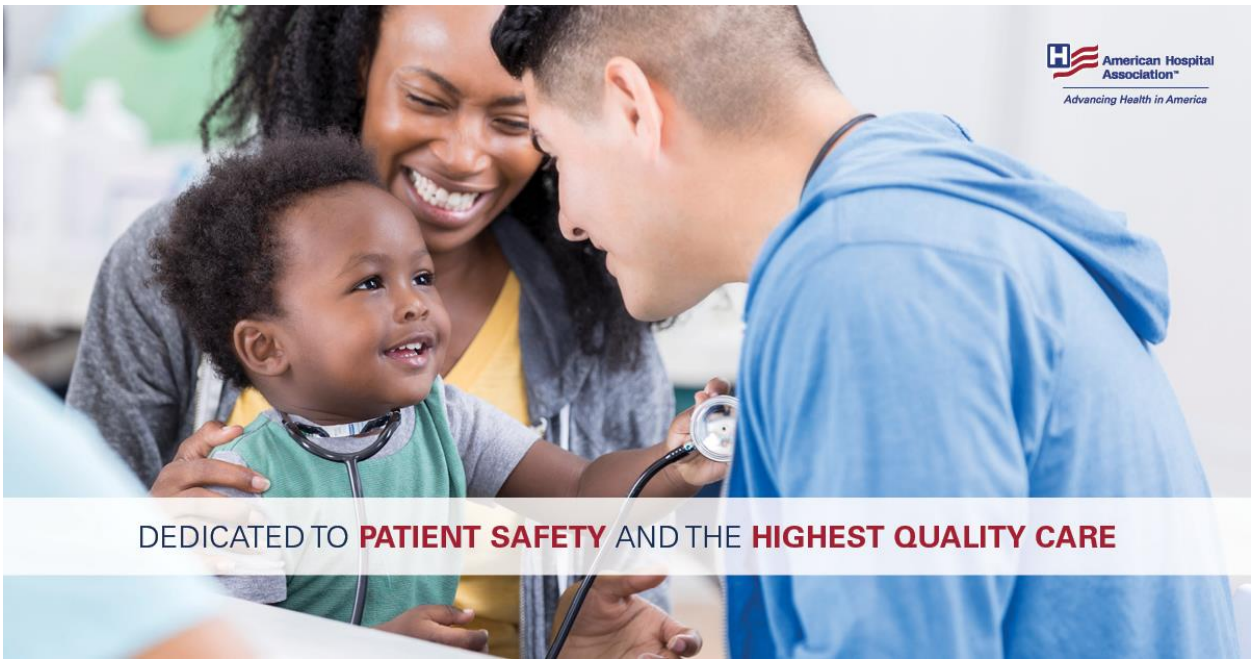

Additional Resources

- In November, the AHA will release a series of podcasts on patient safety and quality. Please visit the AHA's *Advancing Health Podcast* webpage for more information at https://www.aha.org/advancing-health-podcast.

- Please see the 2018 AHA *TrendWatch* report, executive summary and infographic on quality advances by hospitals and health systems over the past decade.

- For additional quality and patient safety resources, visit https://www.aha.org/advocacy/quality-and-patient-safety and https://www.aha.org/advancing-clinical-care.