

The Milwaukee Patient Safety Collaborative: When safety trumps competition

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For the past few years, health care organizations have been striving to identify and implement patient safety strategies that will transform our health care system.¹ The literature is rich with recommendations for patient safety, but limited in evidence-based strategies that demonstrate true success in reducing errors and improving outcomes. Often working in isolation from one another, organizations struggle to identify effective solutions to the safety problems inherent in our current systems of care.

One strategy that has been recommended for improving patient care is collaboration.¹ A collaborative project in Walworth County, Wis that involves patients, providers, and the community to improve medication safety is described in this issue of the *Journal* (Partners in safety: implementing a community-based patient safety advisory council. *WMJ*. 2006;105(8):54.). Using

a collaborative approach among health care systems and their affiliated physicians to confront patient safety challenges allows for the open exchange of information and coordination of care across organizations. In 2002, a group of physicians in Milwaukee and Waukesha Counties decided to put aside their competitive concerns and address their common patient safety challenges as a collaborative. Eight health care systems in these counties established the Milwaukee Patient Safety Collaborative (MPSC). Its mission was defined as providing “a structure for area health care providers to work together to develop, share, and implement patient safety solutions within the community.” Members of the Collaborative include Advanced Healthcare, Aurora Health Care, Children’s Hospital of Wisconsin, Columbia St. Mary’s Health Care System, Froedtert Memorial Lutheran Hospital, Wheaton Franciscan Healthcare, Clement J. Zablocki Medical Center, and Waukesha Memorial Hospital. In addition to health care systems, over 10 pharmacies including Walgreens, Aurora, and Advanced Healthcare have participated in the safety projects conducted through the Collaborative. To broaden its impact, the MPSC partnered with the business community, receiving financial assistance and participation from members of the Greater Milwaukee Business Foundation

on Health, Inc.² The MPSC was founded and remains a subcommittee of the Medical Society of Milwaukee County.

The first project of the MPSC was to eliminate the use of high-risk abbreviations written by physicians. (Results of this initial project were recently published.³) Strategies for reducing the use of abbreviations and changing physicians prescribing patterns were developed and discussed among the MPSC members. Through the exchange of information, the MPSC members were able to identify those interventions that were successful, and take these ‘lessons learned’ back to their respective organizations. The combined effort of the MPSC members successfully achieved their goals. The overall rate of preferred documentation (no abbreviations used in medication orders) improved in the 13 participating hospitals from 61.6% to 81.4%, a 32.1% improvement. In the outpatient setting, the improvement was not statistically significant, but did show a 5.6% improvement as measured in 9 retail pharmacies (from 69.1% to 72.9%). However, the only MPSC site that demonstrated a complete elimination of abbreviations from its physician prescriptions implemented a computerized order entry system as its primary intervention. Only through the use of computer technology could the goal of 100%

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elimination of abbreviations be achieved.

The second project of the MPSC has focused on engaging patients to maintain their own personal medication list. Initiated in 2005, the “Know Your Medicines” campaign focused on the creation and distribution of a medication profile pamphlet for patients to document all their medications. Baseline data collected at 35 sites, including emergency departments, clinics, and retail pharmacies, identified that only 33% of the 2455 patients surveyed carried any type of medication list. However, as patients get older and are on more medications, they are more likely to have a medication list. Over 50% of patients >65 years old carried a medication list, while 66.9% of patients who took 11 or more medications had their own list. Using a community health approach to reach patients, an outreach worker attended over 30 events. From fairs and festivals, senior programs, clinics, hospitals, and public libraries, MPSC reached out to the community to distribute personal medication lists and provide education. As of October 2006, 264,000 personal medication lists have been distributed throughout Milwaukee and Waukesha Counties. Evaluation of the impact of this project is underway, with post-intervention data being collected at the MPSC sites.

The Milwaukee Patient Safety Collaborative has demonstrated the effectiveness and sustainability of a collaborative approach to patient safety. The greatest lesson learned through the process was the power of collaboration—the benefits of breaking down the competitive barriers between organizations and uniting as a team to tackle patient safety initiatives together. By pooling their experiential knowledge, lessons that were previously isolated within a single organiza-

tion were disseminated effectively throughout the larger community. The collective level of knowledge from the combined group was ‘greater than the sum of the parts.’ The consistent message endorsed by all MPSC members was more effective than individual attempts to influence physician and patient behaviors. Collaboration offered a method both efficient and effective for moving safety forward.

The most significant barrier recognized in the MPSC projects was the challenge of changing physician behavior. As is frequently noted in the literature, the greatest barrier to implementing patient safety interventions is physician engagement. During the abbreviation project, most physicians balked at policies requiring them to change their writing habits, until they were forced to comply. Though the abbreviation project did improve overall outcomes, the only MPSC site that completely eliminated abbreviations relied not on changing physicians’ practice patterns but on electronic systems. In our current health system, physician autonomy is defended at the expense of standardization, coordination, and using a system approach. Integration and alignment of delivery systems across the continuum of care are necessary to truly achieve a safe health care system. This can only be done through collaboration.

Patients remind us of the discordant systems that not only frustrate them but lead to dangerous mistakes and errors. The inability to share data between health care professionals seems archaic in this day and age of electronic connectivity. We need to break down these barriers that grow from competitive forces, inadequate health care information systems, and prioritization of physician autonomy over standardization. These seem enormous goals, but the Milwaukee Patient Safety Collaborative has demonstrated what can be achieved together. When we agree that ‘safety trumps competition,’ perhaps our priorities will be realigned and solutions achieved. Working together—with our patients—patient safety can be approached as the critical community health issue it is, for us all.

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Wisconsin Medical Journal

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The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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