

## MEASURING SERIOUS, AVOIDABLE ADVERSE EVENTS IN HOSPITAL CARE

### PURPOSE

This project will identify and develop consensus on a core set of patient safety measurements related to avoidable, serious adverse events in hospital care. The core measure set, in turn, will enable standardized data collection and reporting of these events within and across states.

### BACKGROUND

In December 1999, the Institute of Medicine's report *To Err is Human* brought national attention to the frequency of healthcare errors. Although the report's recommendation for a national, state-based mandatory reporting system for serious errors continues to be controversial, a number of states have implemented, or are contemplating, reporting systems. The federal government has also indicated its intent to support pilot tests of reporting systems.

Accurate assessment of such information both within and across states, however, requires that concepts be clearly defined and measures of these events be applied consistently. Currently, standardized definitions and measures of avoidable, serious adverse events do not exist. Nor is there clear agreement on appropriate ways to apply these measures within a state-based reporting system.

### SCOPE

This project will:

- ? Develop a definition of "serious, avoidable adverse events," or an analogous term, and apply this and other criteria to identify a core set of appropriate measures. The measures will be defined with enough clarity that states can apply them, either independently or as part of a demonstration program to test feasibility.
- ? Apply the NQF consensus process to these measures to yield an NQF-approved core measure set for reporting such events in hospital and other healthcare settings.
- ? Identify potential candidate measures not included in the initial core measure set, describe needed research areas, and recommend a process for future updating of the list.
- ? Discuss issues relating to the implementation of the initial measure set, including use of these measures within reporting systems, and appropriate and effective ways to summarize and report data to the public.
- ? Develop a plan for disseminating the core measure set to states, hospitals, and other critical stakeholders.

### THE NQF PROCESS

This project, like all NQF activities, involves the active participation of representatives from across the spectrum of stakeholders. The project is guided by a Steering Committee, with additional expertise provided by several technical advisory panels. Agreement around the recommendations will be developed through NQF's detailed formal consensus process. The final core set of serious, avoidable adverse events will be then disseminated and implemented through interested states and through the member organizations of the NQF.

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