Capital Blue Cross Member Safety Efforts Benefit All Patients

By Jeff McGaw (Capital)

Medical errors contribute to an estimated 250,000 deaths per year. Systemic problems involved with poorly coordinated care and underuse of safety protocols are primarily to blame. Capital Blue Cross' Member Safety Committee is working to reduce risks to patient safety.

Researchers from Johns Hopkins believe medical errors – including improper transfusions, medication errors, misdiagnosis, wrong-site surgery, patient falls, inpatient suicides, and more – contribute to more than 250,000 deaths per year in the U.S.

Most, they say, are not due to bad doctors, but to preventable systemic problems such as poorly coordinated care, underuse of safety protocols, and other factors.

Such concerns led Capital Blue Cross to create its own Member Safety Program and a cross-functional Member Safety Committee led by Senior Medical Director Dr. Denise Harr. The preventable suicide of a psychiatric facility inpatient in early 2021 hastened the program's creation last December.

The key question is always the same, Harr said: "Are our members safe?"

The Member Safety Program provides a framework that allows the committee to respond to potential member safety concerns – everything from non-medical complaints about bad service to serious reportable events that contribute to a patient's death.

While the committee's focus is on members, the net effect of its work to reduce the risk of medical errors benefits all patients.

The committee works to ensure members receive quality care and service in a safe and effective manner, and to identify opportunities for improving care. By understanding the root cause of an issue, it can then determine how to respond.

Such was the case when a Capital Blue Cross case manager learned that a hospitalized Capital member mistakenly received treatment for conditions diagnosed in another patient with the same name. The safety committee's investigation prompted the facility to revise its policies and procedures to reduce the risk of a reoccurrence, Harr said.

That patient survived, but medication errors can have deadly consequences. In extreme cases, the committee can remove a facility or provider from the network.

The committee's work requires close attention to detail. Sometimes, the only hint of a potential member safety issue might be a vague reference to "complications" or "surgical misadventure" on a medical record, according to Harr. Capital trains staff who handle claims and other records to spot and report such clues.

"Facilities and providers have always had to report certain types of events to organizations, like the Joint Commission (an independent, nonprofit organization that seeks to improve healthcare and accredits and certifies more than 22,000 healthcare organizations), but not necessarily to us," Harr said.

That has changed. Now, Harr said, "we expect (providers) will report these things to us just like they do the other regulatory bodies.

"The ultimate goal," she added, "is to not only identify medical errors, but find ways to ensure they never happen in the first place."