

State Commission on Patient Safety



Public Meeting
www.mihealthandsafety.org

April 28, 2005



Welcome and Introductions

Tom Simmer, MD

Chair, State Commission on Patient Safety
Chief Medical Officer and Senior Vice President,
Blue Cross Blue Shield of Michigan



Review of Meeting Agenda

- Meeting Purpose
- SCPS Background and Organization Structure
- Patient safety testimony solicitation process
- Review and Analysis of Testimony
- Recommendation Framework
- Project Timeline
- Question and Answer



Meeting Purpose

- Share information with the general public and healthcare stakeholders about the work of the State Commission on Patient Safety
 - April 28 meeting: Review process and timeline
 - June 30: Review preliminary recommendations

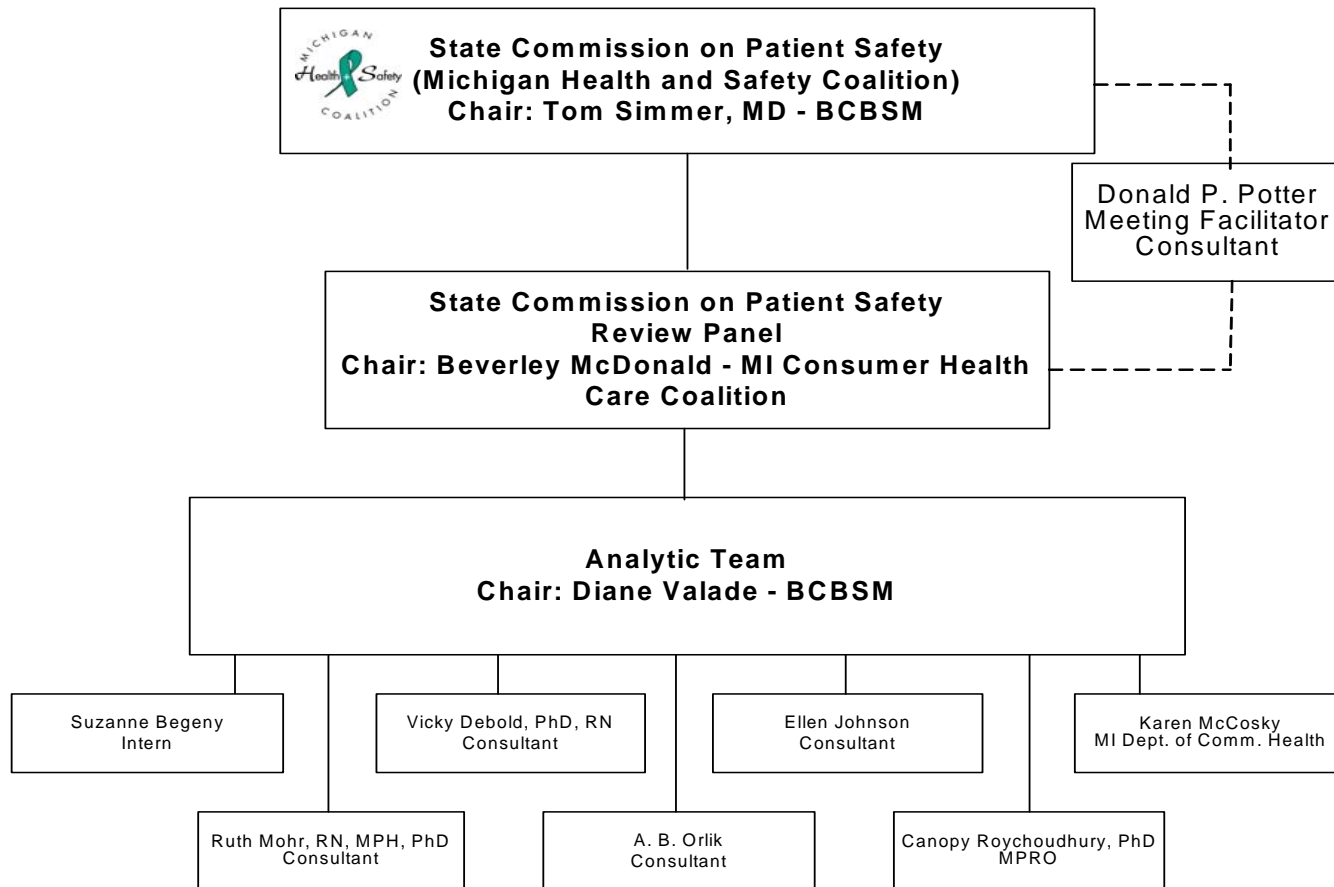


State Commission on Patient Safety: Background

- Legislation passed on May 27, 2004 creating a State Commission on Patient Safety (PA 119-04)
 - This section of the public health code is repealed on November 27, 2005
- Purpose: Examine ways to improve patient safety and reduce medical errors in Michigan
- MH&SC asked to assume this role in September, 2004. Required to:
 - Conduct at least 2 public hearings
 - Review patient safety initiatives and causes of medical errors
 - Provide a report with recommendations to the Governor by Fall, 2005



SCPS Organization Chart:





Patient Safety Testimony Solicitation Process

Beverley McDonald

Chair, State Commission on Patient Safety Review
Panel

Michigan Consumer Health Care Coalition



Testimony Solicitation Process

- Solicited testimony from 279 MI health care organizations and patient safety experts
 - Follow-up letter sent on 1/26/05 to organizations listed in PA 119 that did not initially respond
- Held three public hearings in November, 2004 (Southfield, Lansing and Traverse City)
 - Ads placed in local papers to inform consumers
- Responses received from 19 of 43 specifically invited organizations
 - 24 invited organizations did not respond
- Received 77 total testimony submissions (written and verbal) as of March 1, 2005



Summary of Testimony By Categories

TESTIMONY SUBMISSIONS		
100's Hospitals	6	7.8%
200's Providers	14	18.2%
300's Educators	5	6.5%
400's Consumers	17	22.1%
500's Employers	2	2.6%
600's Insurance	3	3.9%
800's Prof Org	25	32.5%
900's Other	5	6.5%
Totals	77	100%

Total recommendations from reviewed testimony: 353

On average, 4.6 Patient Safety related recommendations per submission



Review and Analysis of Testimony

Diane Valade
Chair, SCPS Analytic Team and
Director, Coalition Activities
Blue Cross Blue Shield of Michigan



Analytical Approach

- The Analytic Team reviewed all submitted testimony:
 - Written, verbal (transcribed), or both were reviewed by constituent
 - Gather the submitter’s original recommendations toward creating a safer health care environment
- Challenge was to make sense of a large amount of non-numeric data
 - Used a qualitative approach that was impartial and neutral on the part of the reviewers
 - Organized the recommendations to higher-level “clusters” of similar recommendations based on codes



Analytical Approach (cont'd.)

- Initial grouping of recommendation codes by:
 - Constituents: source of recommendations
 - Recommendation codes: range of different codes, fit of codes, consistency within grouped recommendation codes
 - Target codes: directed at State, health care institutions, professionals
 - Start initial clusters of recommendations within a defined recommendation code



Recommendation Codes: Example

Recommendation Code	Recommendation Abbreviation	Recommendation Description	Miscellaneous Notes to Coders
01	StateFocal	Identification and adoption of an institutional focal point for providing state-level leadership related to patient safety.	This code should be used to capture recommendations related to relatively high-level initiatives which could have far-reaching effects on patient safety. Functions of an institutional focal point could include establishing major centers, setting broad patient safety goals, tracking progress, and issuing annual progress reports.
07	ProfLic	Improvement of patient safety through licensing and/or certification of professionals working in the health care field, including the specific inclusion of content related to patient safety in these licensing and certification requirements.	Recommendations related to this area will be calling for state licensure of professionals working in the health care field who are not currently required to be licensed or certified in Michigan as a means of improving patient health and safety, and for state regulatory boards and professional associations and societies to more strenuously incorporate patient safety principles into licensure and certification standards.



Recommendation Framework



Recommendation Framework

- SCPS needs a framework to:
 - Organize the final report
 - Present groups of recommendations for review
 - Identify possible omissions in recommendation content

- Recommended framework:

Institute of Medicine (1999): To Err is Human

- A. Build Leadership and Knowledge
- B. Identify and Learn from Errors
- C. Set Performance Standards and Expectations for Safety
- D. Implement Safety Systems in Health Care Organizations



Recommendation Framework

Category A: Building leadership and knowledge to improve patient safety in the state

- Value of identifying a state focal point for patient safety to set goals for patient safety, track progress in meeting goals, and issue an annual report
- Alignment of state goals with national goals for patient safety
- Consumer Involvement
- Information Technology
- Funding requirements



Recommendation Framework (cont'd.)

Category B: Identifying and Learning from Errors

- Mandatory, public reporting for the collection of standardized information about preventable adverse events that result in death or serious harm
- Voluntary, confidential reporting of errors and preventable adverse events that do not result in death or serious harm
- Sharing of standardized information across health care organizations and/or between health care professionals to identify persistent safety issues that require more intensive analysis and/or a broader-based response
- Patient safety legislation to provide protection to encourage the voluntary reporting of errors and preventable adverse events that do not result in death or serious harm by health care professionals and organizations
- Consumer Involvement
- Information Technology
- Funding requirements



Recommendation Framework (cont'd.)

Category C: Setting Performance Standards and Expectations for Safety

- Purchaser and/or consumer demands for patient safety performance standards
- Incentives for patient safety improvement from public and private purchasers
- Regulatory and/or accreditation requirements for patient safety including licensing and certification
- Education and training curriculums
- Role of professional societies and groups in patient safety
- Standards for the safe use of drugs
- Role of the FDA in the safe use of drugs
- Consumer Involvement
- Information Technology
- Funding Requirements



Recommendation Framework (cont'd.)

Category D: Implementing Safety Systems in Health Care Organizations

- Safety as an explicit organizational goal (i.e., culture of safety in health care organizations)
- Leadership
- Meaningful patient safety programs
- Effective Team Functioning
- Medication safety practices
- Learning from other high risk industries such as aviation, chemical, manufacturing and defense
- Facility design
- Safety design concepts
- Staffing levels
- Consumer Involvement
- Information Technology
- Funding requirements



Project Timeline



SCPS Project Timeline

- April 2005
 - April 28: “Public” meeting – Discuss Review Process and Timeline
 - April 28: Review Panel Meeting - Discuss Category C. Setting Performance Standards and Expectations for Safety
- May 2005
 - May 12: Review Panel Meeting - Discuss Category A. Build Leadership and Knowledge to Improve Patient Safety
 - May 26: Review Panel Meeting - Discuss Category B. Identify and learn from Errors
- June 2005
 - June TBD: Review Panel Meeting - Discuss Category D. Implement Safety Systems in Health Care Organizations
 - June TBD: Second Review of all supported recommendations
 - June 30: “Public” meeting – Discuss Preliminary Recommendations
 - Present preliminary recommendations



SCPS Project Timeline (cont'd.)

- July 2005
 - July TBD: Finalize review of recommendations
 - End of July: Issue first draft SCPS Report
- August 2005
 - Issue second draft SCPS Report
- September 2005
 - Finalize MH&SC Patient Safety Report
 - Present Report to SCPS Review Panel and MH&SC for final approval
- October 2005
 - Publish report and prepare for distribution
- Before November 27, 2005
 - Submit report to Governor (when PA 119-04 is repealed)



NEXT PUBLIC MEETING:

JUNE 30

11:00 AM – NOON

BCBSM LYON MEADOWS

CONFERENCE CENTER



QUESTION AND ANSWER

Tom Simmer, MD



APPENDIX



Responding Organizations Listed in PA 119-04 (N= 19)

- Blue Cross Blue Shield of Michigan
- Economic Alliance of MI
- MI Academy of Physician Assistants*
- MI Association of Ambulance Services
- MI Association of Health Plans
- MI Council of Nurse Practitioners
- MI Dietetic Association (American Dietetics Association)
- MI Health & Hospital Association
- MI Home Health Association
- MI Nurses Association
- MI Occupational Therapy Association*
- MI Osteopathic Association
- MI Pharmacists Association
- MI Podiatric Medical Association
- MI Psychological Association
- MI Society of Anesthesiologists*
- MI Society for Clinical Laboratory Sciences
- MI State Medical Society
- Service Employees International Union

* Organizations that provided testimony in response to follow-up letter



Other Entities that Provided Testimony

- American Life Design
- Area Agency on Aging 1-B
- Association of Professionals in Infection Control and Epidemiology – Greater Detroit
- Association of Women’s Health, Obstetrics and Neonatal Nurses
- The Bergendahl Institute
- Citizens to Save Healthcare
- Consumers Advancing Patient Safety
- Detroit Medical Center
- Elder Law of Michigan
- HAP
- Health Care Passport
- General Motors
- Grand Valley State University
- Keystone Center for Patient Safety and Quality
- McClaren Health Care Corporation
- MI Association of Acupuncture and Oriental Medicine
- MI Association of School Nurses
- MI Campaign for Quality Care
- MI Consumer Health Care Coalition
- MI Critical Access Hospital Quality Network
- MI Post-Polio Network
- MI Society for Infection Control
- MI Society of Radiologic Technologists
- MPRO
- Munson Medical Center
- Risk Management and Patient Safety Institute (division of MHA)
- Teamsters Union Local 406
- Trinity Health
- U of M School of Nursing
- VHA National Center for Patient Safety
- Wayne State University
- William Beaumont Hospital



Non-Responding Organizations Listed in PA 119-04 (N=24)

- AARP
- American Society of Clinical Pathologists
- Emergency Nurses Association
- Health Care Association of MI
- Mental Health Association of MI
- MI Advocacy Project
- MI Association of Community Mental Health Boards
- MI Association of Emergency Medical Technicians
- MI Association of Home and Services for the Aging
- MI Association for Local Public Health
- MI Association of Nurse Anesthetists
- MI Chiropractic Association
- MI Chiropractic Society
- MI College of Emergency Physicians
- MI County Medical Care Facilities
- MI Dental Association
- MI Hospice and Palliative Care
- MI Physical Therapy Association
- MI Primary Care Association
- MI Radiological Society
- MI Society of Healthcare Risk Management
- MI Society for Respiratory Care
- MI Speech-Language-Hearing Association
- National Association of Social Workers