STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
JUNE 8, 2005

Category A: Leadership and Knowledge

Codes:

State Focal (01) – identification and adoption of an institutional focal point for providing state-level leadership related to patient safety.

Recommendation: A3 State Focal. A Michigan Center for Patient Safety (Center) should be established.[1, 2] The Center should provide strong leadership and a clear commitment to promoting collaboration[3, 4, 5] among healthcare and public stakeholders[6, 7, 8] and use comprehensive, uniform and centralized approaches for engaging in broad-ranging patient safety activities.[9] The Center should engage in three distinct but inter-related areas of work including: 1) creating vision and opportunity, 2) building capacity and transforming culture, and 3) verifying progress and improving strategies. (See Figure 1.)

- Create Vision and Opportunity
  - Work with federal agencies to represent Michigan stakeholders and to promote policies that incorporate:
    a. clear, standardized and measurable patient safety goals[10, 11, 12] and information technology[13] and error reporting system[14, 15, 16] standards and structures;
    b. federal healthcare payment policy that is aligned with national goals;[17] and
    c. funding for patient safety research[18] and healthcare practitioner and public education[19].
  - Work collaboratively with Michigan stakeholder groups to establish state-level:
    a. patient safety goals[20, 21, 22, 23] that are aligned with national goals and linked to reporting and payment systems;[24, 25, 26] and
    b. information and error reporting systems that are aligned with national initiatives.[27]
  - Support state and federal legislators[28] and regulators to:
    a. secure peer protection for providers and practitioners engaged in patient safety activities;[29] and
    b. modify the regulatory environment for providers and practitioners to incorporate patient safety concepts[30, 31, 32, 33] and stimulate accountability among providers.[34, 35]

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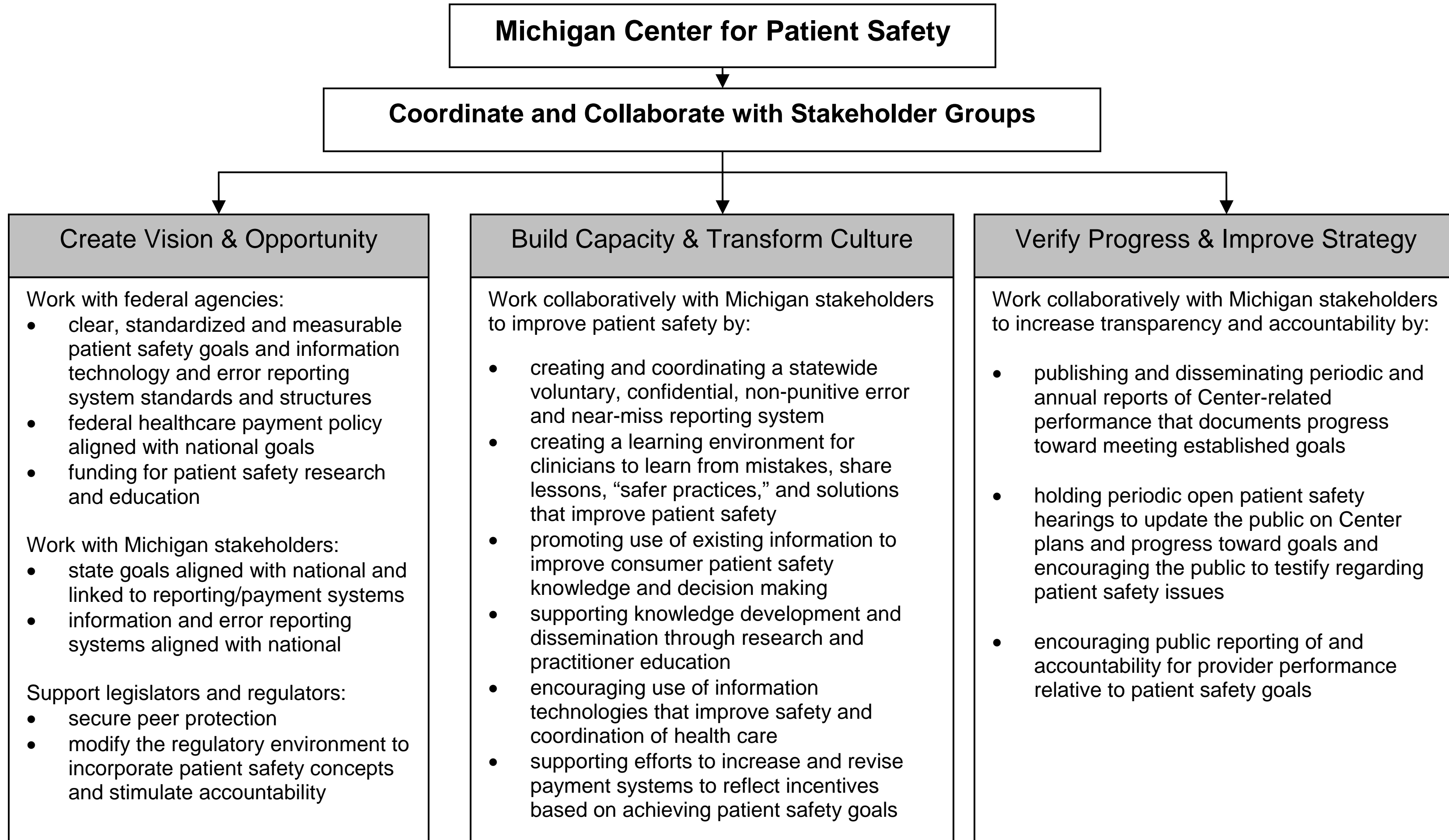
- Build Capacity and Transform Culture[36]
  - Work collaboratively with Michigan stakeholder groups to improve the safety of patient care in Michigan by:
    a. creating and coordinating a statewide voluntary, confidential, non-punitive error and near-miss reporting system;[37, 38, 39, 40, 41]
    b. creating a learning environment for clinicians to learn from mistakes, share lessons, "safer practices," and solutions that improve patient safety;[42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53]
    c. promoting use of existing information to improve consumer patient safety knowledge and decision making;[54, 55, 56, 57]
    d. supporting knowledge development and dissemination through research and practitioner education;[58, 59, 60, 61, 62, 63]
    e. encouraging use of information technologies that improve safety and coordination of health care;[64, 65, 66, 67, 68] and
    f. supporting efforts to increase and revise payment systems to reflect incentives based on achieving patient safety goals[69, 70, 71, 72]

- Verify Progress and Improve Strategy
  - Work collaboratively with Michigan stakeholder groups to increase transparency and accountability related to patient safety by:
    a. publishing and disseminating periodic and annual reports[73] of Center-related performance that documents progress toward meeting established goals;[74]
    b. strengthening ties to the community by holding periodic open patient safety hearings where the Center can update the public on it's plans and progress toward meeting established goals [75, 76, 77, 78] and the public can testify regarding patient safety issues;[79] and
    c. encouraging public reporting of and accountability for provider performance [80, 81, 82, 83, 84] relative to patient safety goals.[85]

Figure 1. Draft Conceptual Model for Michigan Center for Patient Safety



Testimony Summary:
The testimony and literature reviewed in this section addressed the topic of state-level activities that could be employed to improve the safety of patient care in Michigan. Data were derived from the testimony of 20 informants representing all stakeholder groups. Additionally, data were used from all other recommendation areas where there was a recommendation that targeted state-level organizations or agencies.

It should be noted that this document addresses some – but not all – of the areas that need to be specified to fully develop a recommendation for a Center. This document primarily deals with whether a Center is needed, and if so, what activities and functions it should undertake. It also addresses some aspects of its accountability. Yet to be developed are recommendations related to Center funding, staffing, governance structure, and its relationship to state government and regulatory agencies. Presumably, recommendations related to funding, staffing and governance structure depend on what activities the Center is charged with performing. Background material on the other aspects of Center structure as enacted by other state patient safety centers are provided later in the document.

Rationale:
The State of Michigan has a compelling interest in protecting its citizens from avoidable harm. It should be noted that discussions about a Center assume that it will be a state-level organization which may or may not be a part of Michigan state government. In fact, the text in the recommendations is written from the perspective that the Center is not a state agency and does not have regulatory authority and instead, works in a voluntary and collaborative manner with all stakeholders.

The testimony reviewed revealed a high level of interest in having some type of state-level entity serve as a focal point for a coordinated patient safety program. Two informants explicitly recommended developing a state-level center for patient safety.[86] Although not explicitly recommending establishment of a Center per se, six other informants recommended use of state-level leadership related to various patient safety initiatives without indicating that an existing state-level organization or agency assume the responsibilities. In particular, one informant[87] made a compelling case that "leadership is needed first and foremost to create environments where patient safety is a top priority" and that the "State of Michigan should be assuming a lead role in creating a safer environment for patients." The informant urged that the State Commission on Patient Safety to, "be bold and don't hold back [because] [a]ll patients deserve a safe environment." Other informants made similar recommendations.[88] Two informants mentioned

that the Michigan Health and Safety Coalition provided “a good place to start.”[89, 90]

Several informants noted the unique opportunity in Michigan to make an important contribution to patient safety. In particular, one informant stated, “This Commission is faced with a historic opportunity – and I want to underline the opportunity as being historic – to do something unique, different, provocative, and challenging.”[91] One informant, however, cautioned that the Center “be devoted to research inquiry and education only and that it not become involved in the politics of regulating or financing health care.”[92] Another informant stated that “[I]t is highly recommended that patient safety centers be separate and distinct from state regulatory processes.”[93]

Additionally, throughout the review of testimony in various topic areas, recommendations were developed that made reference to some aspect of “the state” or “an appropriate state-level organization” as the entity to fulfill various needs. The information from all the other recommendation areas has been incorporated into this document.

Michigan does not have a Center for Patient Safety. Without a state-level Center, it will not be possible for Michigan to establish state-level programs to enhance patient safety which involve comprehensive, uniform and centralized approaches. Nor will it be possible to use the power of the state to work with the federal government to improve access to and integration with patient safety information, technologies and funding. Without a Center, Michigan will not be able to systematically identify clinical and other practices that result in health care errors or even understand the extent to which errors affect the public; monitor the effects of improvements; or convene various groups of stakeholders to solve complex problems that require the cooperation of groups that usually do not engage in collaborative projects. Moreover, without a Center, it will be difficult to hold any particular organization accountable for improving aggregate safety. The state needs to be accountable to the public on this matter and creation of a Center is one method to instill accountability and respond to the needs of the public.

Evidence and/or information on comparable initiatives in other states:
The information in this section is drawn from a document prepared in 2004 by staff at the National Academy for State Health Policy. This report reviewed the existing State Patient Safety Centers.[94]

Early state efforts to improve patient safety focused on implementing mandatory reporting systems, with varying degrees of success. Lately, a more collaborative approach has emerged, as states have realized that, to effectively improve the

safety of the healthcare system, they need to collaborate with providers, consumers and purchasers; provide leadership to establish clear goals; develop useful benchmarks to measure progress; and coordinate across all agencies of state government to achieve their desired outcomes.

Six states have legislatively authorized or endorsed a state center for patient safety. The states include Florida, Maryland, Massachusetts, New York, Oregon, and Pennsylvania. Efforts in Florida and Oregon are in the early stages of setting up their safety centers. Apparently, Minnesota is working on plans to develop a state patient safety center.

The six states that implemented patient safety centers had varying motives. In Florida, New York and Pennsylvania, the legislation focused on broader issues (affordable health care, consumer information and quality improvement (including the publication of outcome measures and physician profiles), and malpractice reform, respectively). Florida, Oregon and Pennsylvania capitalized on the convergence of patient safety and medical malpractice insurance issues. In Massachusetts and Maryland, motives included recognizing and strengthening existing patient safety coalitions. (In Massachusetts, the impetus behind the creation of the Massachusetts center was the death of Boston Globe reported, Betsy Lehman and the consumer interest and public pressure that followed.)

Four of the six centers are housed within state government and two others are located outside of, but have legislatively authorized affiliations with state government. The degree of autonomy from state government varies considerably. The center in New York is a state agency within the Department of Health and it is subject to all reporting and administrative requirements. Others have no regulatory functions, do not share data with state agencies and are free of most administrative oversight requirements. Similarly, the governance structure among centers is variable. In New York, there is no advisory board or board of directors. For the others, there are different configurations of board of directors, advisory committees, and leadership counsels. The constituencies of the governance and oversight structures vary as does the method by which membership is selected. All centers have consumer representation in one or more governance structures.

The scope of work for the centers also varies but all address patient safety issues in hospital settings. Most address nursing home facilities and others address ambulatory surgery centers. The Massachusetts center is mandated to address care in “all health care settings.” Similarly, Oregon is mandated to address care in six types of facilities. Only one center, New York, stated that it also addressed safety concerns related to healthcare professionals.

Staffing levels within the centers is unclear. All centers have directors or administrators. Two centers – Pennsylvania and Florida – are working with outside contractors to provide analytical and technical support. Florida plans to contract with state-based universities. Pennsylvania has a multi-year contract in place with ECRI, ISMP and EDS to provide technical services.

Most centers are still in their infancy, although several have moved ahead with projects. All six centers intend to: 1) educate providers about best practices to improve patient safety, 2) promote collaboration and/or build consensus between public and private sectors, and 3) inform consumers about patient safety issues. Five of the six centers also intend to: 1) foster creation of a culture of safety, 2) recommend statewide goals and track progress, 3) serve as a clearinghouse for best practice information, and 4) promote collaboration between federal and state initiatives.

With respect to error reporting systems, four states – Florida, Maryland, Oregon and Pennsylvania – have in place or are planning to implement a reporting system to collect, analyze, and evaluate patient safety data to identify causes of patient safety problems. The other two states – Massachusetts and New York – either have the legislative authority to implement a system or are developing plans to do so in the future. Three states – Florida, Maryland and New York – analyze existing data sources for their potential to provide patient safety information (malpractice data, Medicaid data, etc.). Pennsylvania has a mandatory, confidential reporting system for serious events, near misses and infrastructure failures. The remainder of systems either have in place or are planning voluntary and confidential reporting systems for near misses (Florida, Maryland, and Massachusetts), complications (Massachusetts), adverse events that do not cause harm (Maryland), serious adverse events (Oregon) or are unspecified (New York). Oregon chose to create a center with a voluntary reporting system, in part to give the collaboration model a chance to succeed. If it does not, the state legislature is obligated to consider a mandatory approach in 2007.

In all six states, aggregated data are (or will) be available to the public. In Massachusetts, aggregated data will be available through an ombudsman's office and Oregon will publish de-identified aggregated data on its website. Pennsylvania publishes on its website aggregated statewide and regional data and fiscal information. Additionally, Pennsylvania publishes advisories for providers and facilities that are available on the web. Through its center's progress report, Maryland will make publicly available trends in facility participation, an aggregate evaluation of the number and types of adverse events and near misses reported.

All of the centers are required to produce one or more reports documenting progress related to improving patient safety and reducing medical errors. Two states – Florida and Oregon – are subject to audits of their reports and their progress is measured against defined milestones. The report required of Pennsylvania is very detailed. Most of the reports are submitted to both the governor and legislature.

Existing state centers of patient safety have a variety of funding mechanisms. Pennsylvania, the most well-funded, created an independent funding stream from an annual surcharge on licensing fees for those facilities subject to the PA Act's reporting requirements, up to $5 million a year. Unspent funds rollover and earned interest is placed in a Patient Safety Trust Fund. The center is also authorized to procure additional funds from other sources.

In Maryland, the Maryland Hospital Association and the Delmarva Foundation, sponsors of the Patient Safety Center, each contribute $200,000 a year for the first three years of operation. An additional $200,000 a year is contributed by hospitals. These funds are supplemented by $765,000 per year for three years from the states' hospital rate setting system. The funds are included in hospital rates and then passed on to the Patient Safety Center.

Massachusetts relies on state monies and a grant from the Agency for Healthcare Research and Quality. New York's Center is funded by special revenue funds from the Office of Professional Misconduct. Florida's legislature approved $350,000 for the first year with an additional $300,000 to establish a near-miss reporting system. Oregon can assess fees on "all eligible facilities regardless of participation in the program."

Pros:

- this appears to be the direction other states are taking
- the State is in a position to coordinate the work of patient safety programs across state agencies, between the state and federal level, and between the public and private sector
- in a coordinating role, the state could:
    - educate providers about best practices to improve patient safety
    - help develop public policy recommendations designed to encourage the adoption of patient safety practices by healthcare organizations and professionals
    - educate consumers about patient safety
    - help to foster a culture of patient safety in the State
    - develop collaborative relationships among patient safety stakeholders, including providers, consumers and purchasers

  - help develop statewide systems to report and analyze adverse events and/or near misses
  - develop useful statewide patient safety benchmarks to monitor healthcare system improvements and/or clinical process improvements
  - evaluate and promote health information technology to improve patient safety
  - recommend health professional curricula to address patient safety

Barriers:

- Level and reliability of funding is an issue; especially when the State is cutting rather than expanding government functions due to budget constraints. If under-funded, the Center may not be staffed sufficiently to perform duties contained in (potential) legislation.
- Potential to become too focused on seeking regulatory solutions rather than voluntary, private sector solutions to patient safety issues.
- Providers may be hesitant to submit data to a Center too closely tied to a state governmental agency, due to concern that sanctions may result.

Additional Comment/Concerns: In Michigan, there are existing private sector non-profit organizations which could perform some or all of the recommended activities. For example, the Michigan Health and Safety Coalition could be legislatively authorized to provide this function, assuming sufficient funds were available through fees, grants or appropriations.

Implementation Steps:

- Requires legislation authorizing the creation of a new state agency or the designation of an existing organization
- Further clarification of various aspects of the proposed organization including the governance structure, relationship with state government, funding, and staffing are needed.

Cost: TBD, depending on mandate.

Reference List:

[1] Testimony 826W:134-138
[2] Testimony 605B:P2, L16-17
[3] Recommendation D5a – Collaboration - An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a "place" to work together to:

- Increase everyone's awareness of patient safety as an important health care concern
- Develop and prioritize Michigan-specific patient safety goals
- Share expertise and best practices around patient safety strategies
- Develop creative strategies to improve patient safety in Michigan, and

Report progress in improving patient safety. Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives, shortage of nurses for staffing hospitals, implementation of electronic health records or other information technology solutions.
[4] Recommendation C 13 – Education of Practitioners - The State of Michigan, Michigan health care organizations, Michigan professional associations, and Michigan health care educational institutions should develop collaborative relationships with each other and with non-health care disciplines that can bring relevant knowledge to patient safety issues to develop and implement interventions to improve the patient safety knowledge and skills of all levels of health care providers in all health care service delivery situations in the State.
[5] Recommendation C14 – Education of Consumers - The State of Michigan, in collaboration with health care organizations, insurers, employers and professional associations should establish an ongoing statewide education effort on patient safety for consumers. This effort should serve broadly to increase the health literacy of consumers in Michigan, especially with respect to patient safety, and to empower consumers to assume their part in the health care encounter. Specifically, this effort should aim to:
Document consumer concerns and needs for information

- Educate consumers on their role in patient safety and preventing medical errors
- Educate patients on their role in illness, disease and medication management
- Help patients to be better health care consumers by
  - defining quality care
  - developing and/or disseminating information, tools, and resources for decision-making about health care and provider choices
  - educating patients on the use of these tools, resources and information
- Build community support for strategies that reward and promote quality care, such as public reporting of performance measures; pay-for-performance; and investments in technology
- Promote system-based approaches to patient safety
- Provide consumers with information about existing and forthcoming patient safety initiatives in Michigan's health care facilities and organizations

[6] Testimony 906W:230-241, 211-213
[7] Testimony 403O:32-33
[8] Recommendation D3 – Information Technology - An appropriate state level entity should identify and convene stakeholders that can potentially (a) gain from investment in clinical information technology and (b) provide some means of financial support to healthcare delivery organizations to purchase, install, train and implement improved technology that is applicable and usable by all providers in Michigan. These improved technologies should be compatible within and across providers to support an efficient exchange of information, while complying with all the applicable rules of confidentiality.

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[9] Testimony 605B:P2, L16-17
[10] Testimony 906W:74-76, 94, 106-107, 166-168
[11] Testimony 828W:116-117
[12] Recommendation C28 – Safety Standards - Patient Safety recommendations call for establishment, adoption and implementation of safety standards following clinical and structural guidelines across care settings that includes long-term care facilities, inpatient and outpatient health care providers, and by the State of Michigan.
[13] Testimony 906W:174-178
[14] Testimony 906W:117-121, 162-163
[15] Testimony 828W:116-117
[16] Recommendation B3 – Voluntary Reporting - As it relates to reporting of health care errors and near-misses, the State of Michigan (legislature, administration and/or an appropriate state-level organization) should establish, manage and maintain a statewide voluntary error and near miss reporting system. The exact specifications of the system should be determined by an appropriate state-level organization in conjunction with all affected parties including healthcare providers, consumers and regulators. To the extent that it is possible, the reporting system should compliment existing voluntary reporting initiatives sponsored by various Michigan organizations. The appropriate state-level organization should ensure that the reporting system has the following characteristics:

- data on actual and potential adverse events and near misses are housed in a central repository and are collected in ways that are consistent with national standards related to error definitions and measurement criteria,
- findings are reported in ways that are timely, accessible and useful to consumers as it relates to selection of providers and reporting personal experiences with healthcare errors,
- findings are reported in ways that are timely, accessible and useful to healthcare delivery organizations so that they can learn from errors and widely share lessons learned, and
- the identity of reporters is protected and safeguards are in places that ensure that the act of reporting is non-punitive.

[17] Testimony 906W:166-172
[18] Testimony 906W:25-28, 46-49, 88-89, 161-162
[19] Testimony 906W:159-164, 199-201
[20] Testimony 212W:68-70
[21] Testimony 102B:W 103-105
[22] Recommendation D5a – Collaboration - An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a “place” to work together to:

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- Share expertise and best practices around patient safety strategies
- Develop creative strategies to improve patient safety in Michigan, and

Report progress in improving patient safety. Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives, shortage of nurses for staffing hospitals, implementation of electronic health records or other information technology solutions.
[23] Recommendation C28 – Safety Standards - Patient Safety recommendations call for establishment, adoption and implementation of safety standards following clinical and structural guidelines across care settings that includes long-term care facilities, inpatient and outpatient health care providers, and by the State of Michigan.

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[24] Recommendation D2 – Performance Benchmarks - The State of Michigan should have benchmarking information available for a variety of measures for HCOs. The methodology used to calculate benchmarks should be available to the public and follow an established methodology, including peer-group defined benchmarking. Incentives that are based on meeting the benchmarks should be supported by all payors, using 'centers of excellence', including longitudinal compliance and performance as part of the incentive.
[25] Recommendation 04 – Measurement Criteria - The submitted testimony recommends standardization of all measures of patient safety including near misses and adverse events by an appropriate state level organization. These measurements should be finalized following national standards by the state level organization along with purchasers and payers.
[26] Testimony 906W:166-172
[27] Testimony 819B:O107-113, O115-117, O114-115
[28] Testimony 605B:P2, L21-22.
[29] Recommendation B1 – Peer Protection - The State of Michigan should provide statutory protection for patient safety activities to encourage healthcare organizations and professionals to report information and to facilitate the development of a state-wide medico-legal environment that supports a learning versus a punitive approach to health care errors, adverse events, and near misses.
[30] Testimony 906W:37-38, 166-172, 199-201, 97-101
[31] Testimony 302B:W399-400, O112-114, W421-422
[32] Recommendation C06 – Regulation of Organizations - In particular, the appropriate state-level organization should work with national and state regulatory, licensing and accreditation organizations to develop and implement mechanisms which hold healthcare organizations accountable to: 1) comply with existing licensure and accreditation requirements related to full disclosure of unanticipated patient outcomes and errors, and 2) take appropriate corrective action as it relates to reported errors.
[33] Recommendation C.07 - Licensure of Professionals - The Michigan state legislature, administrative regulatory agencies and licensure boards should enhance the safety of patient care by appropriately educating, licensing and disciplining individuals providing health care services. In particular, the Michigan state legislature, administrative regulatory agencies and licensure boards should: 1) require all healthcare practitioners to undertake approved and appropriate discipline-specific patient safety education which shall include radiation safety training for physicians overseeing use of ionizing radiation as a condition of licensure/re-licensure; and 2) review and revise the structure and functions of licensure boards so that they may more effectively discharge their responsibilities by encouraging special consideration of situations where individual practitioners voluntarily disclose errors which are "errors of the system" rather than "errors of the individual."
[34] Testimony 105B:O 209-213; W 117-118
[35] Testimony 403O:28, 28-29
[36] Testimony 106B:W 28-31].
[37] Testimony 906W:117-121, 162-163
[38] Testimony 106B:W 31-34, O 46-56
[39] Recommendation D5a – Collaboration - An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a "place" to work together to:

- Increase everyone's awareness of patient safety as an important health care concern
- Develop and prioritize Michigan-specific patient safety goals
- Share expertise and best practices around patient safety strategies

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- Develop creative strategies to improve patient safety in Michigan, and

Report progress in improving patient safety. Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives, shortage of nurses for staffing hospitals, implementation of electronic health records or other information technology solutions.

[40] Recommendation B2 – Sharing Information - In regards to data on adverse events and near misses collected from error reporting systems in the state of Michigan, an appropriate state-level organization should receive these data, analyze them and conduct follow-up action as needed, with the primary goal of sharing lessons learned. Specific tasks of this organization would include:

- aggregating and de-identifying reported data
- developing standardized data collection tools
- conducting analyses for to identify both system failures and human factors contributing to the problem
- developing or identifying sources of expertise to help organizations study adverse events and arrive at appropriate conclusions and good solutions
- identifying trends and opportunities to improve patient safety
- identifying persistent safety issues in need of intensive analysis or broad response
- disseminating solutions and successes of projects and patient safety initiatives to providers and the public

[41]Recommendation B3 – Voluntary Reporting - As it relates to reporting of health care errors and near-misses, the State of Michigan (legislature, administration and/or an appropriate state-level organization) should establish, manage and maintain a statewide voluntary error and near miss reporting system. The exact specifications of the system should be determined by an appropriate state-level organization in conjunction with all affected parties including healthcare providers, consumers and regulators. To the extent that it is possible, the reporting system should compliment existing voluntary reporting initiatives sponsored by various Michigan organizations. The appropriate state-level organization should ensure that the reporting system has the following characteristics:

- data on actual and potential adverse events and near misses are housed in a central repository and are collected in ways that are consistent with national standards related to error definitions and measurement criteria,
- findings are reported in ways that are timely, accessible and useful to consumers as it relates to selection of providers and reporting personal experiences with healthcare errors,
- findings are reported in ways that are timely, accessible and useful to healthcare delivery organizations so that they can learn from errors and widely share lessons learned, and
- the identity of reporters is protected and safeguards are in place that ensure that the act of reporting is non-punitive.

[42] Testimony 103O:94-97, 101-103, 98-101
[43] Testimony 106B:O 69, W 70-75
[44] Testimony 901W:212, 214-215, 82-85
[45] Testimony 906W:133-136, 128-131, 148-151
[46] Draft recommendations from other testimony areas contained references to creating learning environments. Specifically, with respect to collaboration – “to share expertise and best practices around patient safety strategies” and “develop creative strategies to improve patient safety in Michigan.” Regarding development of a voluntary reporting system, the recommendation was made that “findings are reported in ways that are timely accessible and useful to healthcare delivery organizations so that they can learn from errors and widely share lessons learned.”
[47] Testimony 821B:W26-30
[48] Testimony 829W:W35-38

[49] Testimony 830W:23-25, 106-110

[50] Recommendation D6a – Team Development - To assist HCOs in establishing effective patient safety focused interdisciplinary teams, an appropriate state-level agency should serve as a clearinghouse to identify and disseminate best practices for building patient safety teams within facilities e.g., reflect clearly defined organization performance goals in the defined purpose and goals of individual teams, use simulator training.

[51] Recommendation D5a – Collaboration - An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a “place” to work together to:

- Increase everyone’s awareness of patient safety as an important health care concern
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Report progress in improving patient safety. Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives, shortage of nurses for staffing hospitals, implementation of electronic health records or other information technology solutions.

[52] Recommendation D5b – Collaboration - All organizations and practitioners concerned with the delivery of health care services including the State of Michigan should expedite the translation of patient safety relevant evidence into practice through supporting and participating in collaborative learning opportunities.

[53] Recommendation C 13 – Education of Practitioners - The State of Michigan, Michigan health care organizations, Michigan professional associations, and Michigan health care educational institutions should develop collaborative relationships with each other and with non-health care disciplines that can bring relevant knowledge to patient safety issues to develop and implement interventions to improve the patient safety knowledge and skills of all levels of health care providers in all health care service delivery situations in the State.

[54] Testimony 403O:32-33

[55] Testimony 501W:160-175

[56] Recommendation D5a – Collaboration - An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a “place” to work together to:

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Report progress in improving patient safety. Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives, shortage of nurses for staffing hospitals, implementation of electronic health records or other information technology solutions.

[57] Recommendation C14 – Education of Consumers - The State of Michigan, in collaboration with health care organizations, insurers, employers and professional associations should establish an ongoing statewide education effort on patient safety for consumers. This effort should serve broadly to increase the health literacy of consumers in Michigan, especially with respect to patient safety, and to empower consumers to assume their part in the health care encounter. Specifically, this effort should aim to:

Document consumer concerns and needs for information

- Educate consumers on their role in patient safety and preventing medical errors
- Educate patients on their role in illness, disease and medication management
- Help patients to be better health care consumers by
  - defining quality care
  - developing and/or disseminating information, tools, and resources for decision-making about health care and provider choices
  - educating patients on the use of these tools, resources and information
- Build community support for strategies that reward and promote quality care, such as public reporting of performance measures; pay-for-performance; and investments in technology
- Promote system-based approaches to patient safety
- Provide consumers with information about existing and forthcoming patient safety initiatives in Michigan's health care facilities and organizations

[58] Testimony 605B:P2, L21-22
[59] Testimony 826W:134-138
[60] Testimony 906W:159-164, 199-201, 25-28, 46-49, 88-89, 161-162
[61] Recommendation C13.1 – Education of Practitioners - an appropriate state-level organization should work collaboratively with and provide a forum for all MI organizations involved in the education of health care practitioners and/or the delivery of health care services (e.g., academic institutions, health care service organizations of all types, professional associations, and employee unions), safety and other experts in areas relevant to safety interventions, frontline practitioners, accrediting agencies, and consumers to develop:

a) Consensus regarding patient safety core competencies required for practitioner licensure or certification and for those who serve on health care facility boards or are employed in a state regulatory capacity;
b) Standardization as appropriate across curricula; and
c) Education modules for both academic and continuing education programs that emphasize a science-based approach to preventing health care errors and assure core competencies for all levels of care providers.

[62] Testimony 212W:180-181
[63] Recommendation D6a – Team Development - To assist HCOs in establishing effective patient safety focused interdisciplinary teams, *an appropriate state-level agency* should serve as a clearinghouse to identify and disseminate best practices for building patient safety teams within facilities e.g., reflect clearly defined organization performance goals in the defined purpose and goals of individual teams, use simulator training.
[64] Testimony 906W:174-178
[65] Testimony 501W:158-160
[66] Testimony 818B: W55-57, O114-115
[67] Recommendation D3 – Information Technology - An appropriate state level entity should identify and convene stakeholders that can potentially (a) gain from investment in clinical information technology and (b) provide some means of financial support to healthcare delivery organizations to purchase, install, train and implement improved technology that is applicable and usable by all providers in Michigan. These improved technologies should be compatible within and across providers to support an efficient exchange of information, while complying with all the applicable rules of confidentiality.
[68] Recommendation D5a – Collaboration - An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a "place" to work together to:

- Increase everyone's awareness of patient safety as an important health care concern

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- Develop and prioritize Michigan-specific patient safety goals
- Share expertise and best practices around patient safety strategies
- Develop creative strategies to improve patient safety in Michigan, and

Report progress in improving patient safety. Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives, shortage of nurses for staffing hospitals, implementation of electronic health records or other information technology solutions.

[69] Testimony 906W:166-172, 148-151

[70] Testimony 501W:158-160

[71] Recommendation D3 – Information Technology - An appropriate state level entity should identify and convene stakeholders that can potentially (a) gain from investment in clinical information technology and (b) provide some means of financial support to healthcare delivery organizations to purchase, install, train and implement improved technology that is applicable and usable by all providers in Michigan. These improved technologies should be compatible within and across providers to support an efficient exchange of information, while complying with all the applicable rules of confidentiality.

[72] Recommendation D2 – Performance Benchmarks - The State of Michigan should have benchmarking information available for a variety of measures for HCOs. The methodology used to calculate benchmarks should be available to the public and follow an established methodology, including peer-group defined benchmarking. Incentives that are based on meeting the benchmarks should be supported by all payors, using 'centers of excellence', including longitudinal compliance and performance as part of the incentive.

[73] Testimony 212W:68-70

[74] Testimony 212W:68-70

[75] Testimony 501W:158-160

[76] Testimony 501W:160-175

[77] Testimony 605B:P2, L21-22

[78] Recommendation C14 – Education of Consumers - The State of Michigan, in collaboration with health care organizations, insurers, employers and professional associations should establish an ongoing statewide education effort on patient safety for consumers. This effort should serve broadly to increase the health literacy of consumers in Michigan, especially with respect to patient safety, and to empower consumers to assume their part in the health care encounter. Specifically, this effort should aim to:

- Document consumer concerns and needs for information
- Educate consumers on their role in patient safety and preventing medical errors
- Educate patients on their role in illness, disease and medication management
- Help patients to be better health care consumers by: defining quality care, developing and/or disseminating information, tools, and resources for decision-making about health care and provider choices, and educating patients on the use of these tools, resources and information
- Build community support for strategies that reward and promote quality care, such as public reporting of performance measures; pay-for-performance; and investments in technology
- Promote system-based approaches to patient safety
- Provide consumers with information about existing and forthcoming patient safety initiatives in Michigan's health care facilities and organizations

[79] Testimony 416W:7-8, 23

[80] Testimony 105B:O 209-213; W 117-118

[81] Testimony 403O:28, 28-29

[82] Testimony 830W:23-25, 106-110

[83] Recommendation C06 – Regulation of Organizations - In particular, the appropriate state-level organization should work with national and state regulatory, licensing and accreditation

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organizations to develop and implement mechanisms which hold healthcare organizations accountable to: 1) comply with existing licensure and accreditation requirements related to full disclosure of unanticipated patient outcomes and errors, and 2) take appropriate corrective action as it relates to reported errors.

[84] Recommendation C.07 - Licensure of Professionals - The Michigan state legislature, administrative regulatory agencies and licensure boards should enhance the safety of patient care by appropriately educating, licensing and disciplining individuals providing health care services. In particular, the Michigan state legislature, administrative regulatory agencies and licensure boards should: 1) require all healthcare practitioners to undertake approved and appropriate discipline-specific patient safety education which shall include radiation safety training for physicians overseeing use of ionizing radiation as a condition of licensure/re-licensure; and 2) review and revise the structure and functions of licensure boards so that they may more effectively discharge their responsibilities by encouraging special consideration of situations where individual practitioners voluntarily disclose errors which are "errors of the system" rather than "errors of the individual."

[85] Testimony 906W:166-172

[86] Testimony 826W:134-138. Testimony 605B:P2, L16-17

[87] Testimony 105B:O 209-213; W 117-118, O 215-219; W119-121, W157-158, W 182-184

[88] Testimony 403O:28-29. Testimony 405O:167-169. Testimony 901W:212, 214-215. Testimony 906W:133-136.

[89] Testimony 105B:O 213-215; W 118-119

[90] Testimony 605B:P2, L39-40

[91] Testimony 106B:O46-56

[92] Testimony 826W:134-138

[93] Testimony 605B:P2, L34-36

[94] Rosenthal J & Booth M. (2004). *State Patient Safety Centers: A new approach to promote patient safety.* Portland, OR: National Academy for State Health Policy.