

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
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Category B: Identifying and Learning From Errors

Codes:

MandRpt (03) – use of a mandatory reporting system related to preventable adverse health events.

VolRpt (04) - use of a voluntary reporting system related to preventable adverse health events.

PSRpt (29) – use of reporting system related to patient safety data but does not specify mandatory or voluntary.

Recommendations: B3 – Reporting.

B3a. Voluntary Reporting System. As it relates to reporting of health care errors, the State of Michigan (legislature, administration and/or an appropriate state-level organization) should establish, manage and maintain a statewide voluntary error 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 are protected and safeguards are in place that ensure that the act of reporting is non-punitive.

B3b. Mandatory Reporting System. As it relates to reporting of health care errors, the State of Michigan (legislature, administration and/or an appropriate state-level organization) should evaluate existing mandatory systems to determine whether a statewide mandatory reporting system is needed to improve the safety of patient care and if so, define, establish, manage and maintain such a system.

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Testimony Summary:

A total of 47 recommendations related to reporting were received by the State Commission on Patient Safety (SCPS). The recommendations were submitted by 27 entities representing hospitals (4), practitioners (4), educators (1), consumers (5), employers (2), insurers (2), professional societies (6), and others (3). The recommendations related to reporting also addressed the following recommendation areas: State Focal (1), Measurement Criteria (5), Performance Benchmarks (1), Resources (3), Guiding Principles (1), Information Technology (3), Research and Evaluation (1), Legislation (5), Peer Protection (3), Advocacy (1) and Consumer Advocate (2).

Recommendations were submitted by the 27 entities and all indicated support for an error reporting system. There was more support for a voluntary reporting system than for a mandatory system. Of the 27 submissions, 11 requested creation of an exclusive voluntary system, 5 requested creation of an exclusive mandatory reporting system, 2 requested a mixed voluntary/mandatory system, and 9 requested reporting systems but did not specify whether it should be mandatory and/or voluntary in nature. As shown in Appendix A, there was less agreement among submitters as it relates to the following aspects of such a reporting system: 1) characteristics of the error reporting system and its data elements, 2) reportable events, 3) uses of the information, 4) data collection methods, 5) types of reporters, 6) control and housing of the reporting system, 7) contingencies and other issues (See Appendix A).

Almost all of the recommendations indicated that “the state” or “State of Michigan” or some aspect of the state (legislature, administration, or a state-level patient safety center) be responsible for setting up and administering a reporting system.

Reporting System Characteristics. Testimony submitters, whether recommending creation of a voluntary or mandatory error reporting system, supported protecting the identity of the reporter with requests for “confidential, anonymous, de-identified, and protected” being mentioned in 7 testimonies. Additionally, there was strong support for public reporting in that 11 out of 27 testimonies specifically mentioned that reporting should be public. Similarly, 10 testimony submitters supported use of a standardized format that is consistent with various national standards. Other support was noted for reports that are facility/organization-specific, non-punitive, and state-wide. As shown in Table 1, a number of other characteristics of a reporting system were identified. (Please note that data are sorted by error reporting system and the column heading numbers are defined in Appendix A.)

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Table 1. Characteristics of Error Reporting Systems and Reported Data Elements by Type of Error Reporting System

ID		11	26	1	4	5	7	16	17	6	21	25	2	9	15	22	3	8	10	12	13	14	18	19	20	23	24	27
105BE	M	•								•					•	•		•		•						•		
212W	M	•														•								•				
403O	M	•																										•
404B	M	•																										
410O	M	•																										
102B	V		•		•					•								•					•					
204B	V		•	•							•									•							•	
205B E	V		•		•	•														•							•	
302B	V		•																•							•		
416W	V		•	•																								
608WE	V		•	•				•				•															•	
804BE	V		•															•					•					
806BE	V		•																									
807BE	V		•																					•				
826W	V		•											•														
906W	V		•											•						•								
502OE	X	•	•													•	•					•	•					
808BT	X	•	•		•			•	•	•		•				•	•					•	•		•			•
104O	U																									•		
110W	U																							•				
213W	U																											
405O	U													•							•							
501WE	U				•									•		•							•					
606WE	U															•							•					
828W	U													•										•				
901W	U	•	•											•														
904B	U																							•				

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Reporting Events and Uses of Reported Information. Testimony submitters, whether recommending creation of a voluntary or mandatory error reporting system, recommended that the systems capture a wide range of events as shown in Table 2. The specific types of events captured by an error reporting system should be consistent with national standards and specified by an appropriate state-level organization as noted in Recommendation 3a. There was no discernable pattern related to type of event and support for a particular type of error reporting system. (Please note that data are sorted by error reporting system and the column heading numbers are defined in Appendix A.)

Table. 2 Reportable Events by Error Reporting System Type

ID		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
105BE	M																								
212W	M		•																						
403O	M		•																						
404B	M							•	•	•	•	•						•							
410O	M							•		•															
102B	V											•													
204B	V	•																	•						
205B E	V		•	•																					
302B	V																								
416W	V																		•						
608WE	V				•							•	•		•										
804BE	V								•																
806BE	V											•	•												
807BE	V								•																
826W	V																								
906W	V																								
502OE	X											•						•						•	
808BT	X		•										•					•			•	•			
104O	U														•										
110W	U																	•							
213W	U																								
405O	U															•									
501WE	U				•																				
606WE	U											•										•			•
828W	U																								
901W	U														•								•		
904B	U																					•			

Similarly, testimony submitters identified at least two dozen unique uses to which reported information should be applied. Support for various uses is shown in Table 3 and the data are sorted by support for mandatory, voluntary, mixed or unspecified error reporting systems. Again, there was no discernable pattern related to uses of error reporting information and support for a particular type of error reporting system. (Please note that data are sorted by error reporting system and the column heading numbers are defined in Appendix A.)

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Table 3. Uses of Reported Information by System Type

ID		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
105BE	M			•			•				•	•						•			•							
212W	M																											
403O	M										•																	
404B	M			•																								
410O	M		•																									
102B	V			•													•					•						
204B	V																											
205B E	V										•	•		•						•	•							
302B	V																											
416W	V																											
608WE	V	•									•				•						•		•					
804BE	V		•																									
806BE	V																											
807BE	V																					•						
826W	V																											
906W	V						•				•										•						•	
502OE	X																										•	
808BT	X		•				•	•	•		•	•										•				•		
104O	U							•									•											
110W	U																											
213W	U									•																		
405O	U		•				•			•																		
501WE	U																•			•								
606WE	U		•																									
828W	U																											
901W	U																											
904B	U														•													

Rationale:

Aside from creating mechanisms to prevent errors from occurring, there is a need to identify errors that have occurred and learn how to prevent them from occurring in the future. This can only be accomplished if errors are identified and analyzed, and responses to them, evaluated. To do so, requires reporting and compiling errors for analysis. To that end, error reporting systems are discussed in this section of the report.

Evaluation of errors, particularly those that occur rarely, need to be compiled across healthcare organizations and shared with a broad group of healthcare providers so that error prevention programs can be developed, implemented and evaluated. An additional reason for developing error reporting systems is to inform the public regarding which healthcare providers are participating in error monitoring systems and are successful at reducing preventable errors and then, permit the public to choose healthcare providers accordingly.

Reporting of various types of information by hospitals and other healthcare organizations is, and has been, occurring in Michigan for a very long time. Data on reporting requirements for hospitals and other healthcare organizations is being collected by the analytic team so that the current reporting environment can be better understood and used as a platform for recommendations related to

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error reporting systems. New endeavors as it relates to creation of statewide error reporting systems are more likely to be viable if they build on current efforts and strengths.

Reporting of some types of errors and other events are activities already performed in Michigan hospitals and other healthcare organizations. The Michigan Health & Hospital Association (MHA) has indicated that Michigan hospitals report various “events” to the Centers for Medicare and Medicaid Services (CMS), the Department of Community Health, the Hospital Quality Alliance (HQA), the Food and Drug Administration (FDA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Michigan Health and Safety Coalition (MHSC) and Leapfrog Group.¹ In particular, hospitals, as a condition or participation, report to CMS; provide mortalities, communicable and occupational disease statistics to the Department of Community Health; provide data for the National Quality Measures program within the Hospital Quality Alliance; medical device failures to the FDA, data related to “core measures” to JCAHO; and procedure and practice volumes and other data for the annual survey fielded by the MHSC and Leapfrog Group. Some aspects of data reported to HQA, JCAHO, MHSC and the Leapfrog Groups are reported and released to the public.

In addition to the reporting efforts noted above, since 1996, Michigan hospitals have voluntarily provided the public with hospital-specific information on important quality of care indicators, including length of stay, morbidity and mortality for more than 20 important medical procedures, including select medical and surgical cases, heart cases and hip and knee replacements. The MHA Keystone Center has numerous initiatives currently underway to improve patient safety and quality by offering health care providers information, resources and collaborative opportunities to implement proven interventions in Michigan hospitals.

- **MHA Keystone Stroke:** Michigan hospitals have worked with the Michigan Department of Community Health and state stroke experts to improve stroke care.
- **MHA Keystone Intensive Care Unit project:** A partnership with Johns Hopkins that started just one year ago – has already reduced blood stream infections and decreased respirator-associated pneumonias. Through Keystone ICU hospitals throughout the state have focused on implementing evidence based ICU care, including reducing catheter related bloodstream infections and ventilator associated pneumonias. Teams have demonstrated dramatic improvements in their infection rates.

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- **Medication Errors:** The MHA has been recognized nationally for its efforts to deal with the most frequently cited problem in the IOM study – medication errors. In 2001, Michigan’s hospitals were recognized by the Institute for Safe Medication Practices for their participation in a national initiative to improve medication safety awareness and enhance safe medication practices.
- **Keystone Hospital Acquired Infections:** Most recently MHA has gotten approval from the cooperate board to initiate a voluntary Keystone Center initiative to address public reporting of hospital acquired infection data. On February 28 the Healthcare Infection Control Practices Advisory Committee (HICPAC) released a consensus document outlining a framework and recommendations regarding the design and implementation of public reporting systems for hospital associated infections. The HICPAC recommendations are consistent with what was recommended to the MHA Board and will be utilized in this new MHA Keystone initiative. The HICPAC recommendations have also been endorsed by the Association for Professionals in Infection Control and Epidemiology, the Council of State and Territorial Epidemiologists, and the Society for Healthcare Epidemiology of America. HICPAC is a federal advisory committee established in 1991 to provide advice and guidance to the department of Health and Human Services and CDC regarding surveillance, prevention and control of HAIs and related events in healthcare settings.
- **Participating Hospital Agreement (PHA) Incentive Program:** This is a program that Michigan hospitals contracting with Blue Cross Blue shield of Michigan (BCBSM) can chose to participate in. The program provides incentive payments from BCBSM to hospitals that meet the current goals of the program to improve patient care, patient safety as well as improvement of the health of the community. Currently, the quality improvement measures include: heart failure, pneumonia and surgical infection prevention. The patient safety elements include involvement in the Keystone ICU project and safe medication practices.

As the above information details, hospital-based voluntary reporting of various clinical events is already occurring in Michigan. It needs to be determined how many other healthcare organizations are reporting similar information and whether the information is sufficient and of the type that can be used broadly by a range of providers to decrease preventable adverse events across the continuum of care. Analytic staff are working to collect such information.

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Evidence and Other State Initiatives:

As evidenced by the work of the Institute of Medicine (IOM) and a number of state-based patient safety coalitions, there is support for error reporting systems. Specifically, the IOM (1999) recommended creating reporting systems that would allow for the identification and prevention of errors. They suggested two types of systems to serve the purpose of identifying errors. First, mandatory reporting systems were cited as a way to hold providers accountable.² They are run by the state in order to allow the public to be aware of unsafe conditions. Second, voluntary reporting systems were identified as a way of detecting weakness before serious harm occurred.¹ Voluntary systems were viewed as confidential and not necessarily run by the state. Their purpose is to improve patient safety and quality.

To date, 21 states have adopted mandatory reporting systems as is shown in Table 4.² Colorado, for example, implemented a system to improve the access to information concerning the safety of the health care environment.¹ Utah developed the system to help healthcare providers know system failures and to make improvements towards patient injuries. However, as Marchev, Rosenthal and Booth (2003) state, these systems are not supplying the public with consistent information about the release of adverse events and medical errors.¹ Marchev et al (2003) believe that the question remains how to best present the data. States that do adopt mandatory reporting systems give their data to the regulatory branch that license the healthcare facilities.¹ The information they share however varies, yet all 21 states offer some level of information to the public regarding complaints they receive and poor decisions made.¹

Most of the information collected from mandatory reporting systems are in regards to serious injury.³ Although, some states with mandatory reporting will include near misses in their disclosure information. Table 4 illustrates the varying types of information and ways in which states with mandatory reporting systems report their data.

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Table 4. Selected Characteristics of State Reporting Systems

Data at the Incident Level	Periodic Reports with Aggregate Information	Facility-Specific Aggregate Information	Information Available only on Request	Information Available on Website	Information Available in a Publicly Distributed Report
California Colorado Connecticut Massachusetts New Jersey South Carolina Washington	Colorado Connecticut Florida Kansas Maine Massachusetts Minnesota New York Ohio Pennsylvania Road Island Tennessee Texas Utah	Colorado Minnesota New York Ohio	California Connecticut Massachusetts New Jersey Ohio South Carolina Washington	Colorado Connecticut Florida New York Rode Island Tennessee Utah Washington	Connecticut Kansas New York Rode Island Tennessee Utah

Note: Information obtained from Marchev, M., Rosenthal, J., & Booth, M. (2003). *How states report medical errors to the public: Issues and barriers*. National Academy for State Health Policy: ME.

The type of information that would be released includes:

- Background information
- Description of the system
- Authority for reporting system
- Definition of reportable events
- Analysis of incidents
- Number of incidents reported
- Number of incidents reported by category
- Number of incidents reported by region
- Trends in reporting over time, total and by category
- Number and types of incidents by facility
- Category percentage of total incidents reported
- Incidents compared to total discharges
- Number of incidents by facility per 10,000 discharges for lowest reporting hospitals
- Information on malpractice claims and comparison to adverse incident reports
- Implications

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- Under-reporting identified as a problem
- Comparison to other databases
- Interpretative information: larger numbers do not necessarily equate with poorer quality of care
- Recommendations/plans by state to improve the system
- Examples of how the data have led to quality improvements/best practices¹

While the information that is reported varies, some information is deemed by the state to be protected. States may choose to keep individual incidents or facility-specific information protected. There are 15 states with mandatory systems, that currently keep some information protected. Eleven of the 21 states have protected confidential information, meaning they do not offer the facility's name.⁴ Ten states do disclose the name of the facility and of these 10 only 7 release incident specific information.⁴

In addition to adopting mandatory reporting systems, six states have enacted state patient safety centers, which include:

- The Florida Patient Safety Corporation,
- The Maryland Patient Safety Center,
- The Betsy Lehman Center for Patient Safety and Medical Error Reduction (Massachusetts),
- The New York Center for Patient Safety,
- The Oregon Patient Safety Commission, and
- The Pennsylvania Patient Safety Authority.³

However, only five have mandatory reporting systems. (FL, MD, MA, NY, and PA).⁴ Oregon is a voluntary reporting system.

There remains a good deal of analysis to be done to compare and contrast various state-level reporting systems particularly as it relates to pending federal legislation and existing evidence of the effectiveness of voluntary and mandatory reporting systems to improve the safety of patient care. This work is ongoing and will be provided to the review committee.

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Pros and Barriers by Recommendation:

Pros:

Should a state choose a mandatory reporting system and publicly release their information, the benefits include: “(1) accountability for health care safety, (2) providing information to the consumer about health care facility safety, (3) improving trust, and (4) creating pressure to drive change and enhance patient safety.”(p. 9).¹

Barriers:

Mandatory systems do have downfalls. For instance, states may choose a system that was designed for the regulatory agencies to guarantee a minimum level of health care delivery performance as opposed to tailor the system to the consumer. In this instance, informing the public may not be a priority.

Another barrier is seen with regards to disclosing information to the public. One concern is that under-reporting would cause the data to be inaccurate and misleading. A second concern is seen with the facility fearing malpractice litigation. Additionally, some states feel that requiring the facilities to report will be seen as punitive. This would hinder the establishment of a working relationship between the state and healthcare facility.¹

Another barrier involves the disclosure of information to the public. While the recommendation was put forth in the IOM (1999) *To Err is Human* report for states to develop mandatory systems, there has not been an effort to support states in taking on this role. There are no federal mandates or federal resources for this state endeavor. Therefore, issues of resources, and clear definitions are of particular concern.¹

Additional Comment/Concerns:

Implementation Steps: TBD, depends on recommendation(s) supported.

Cost: TBD, depends on recommendation(s) supported.

Implementation Target Date: TBD, depends on recommendation(s) supported.

Grade: TBD

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**Appendix A
I. Reporting System Characteristics Summary Chart**

ID	System type	Target	Rec Code	Characteristics of Reporting Systems and Reported Data Elements	Reportable Events	Collection Methods	Types of Reporters	Uses of Reported Information	Control and Housing of Reporting System Data	Sources of Input Related to Design of Reporting System	Contingencies and Other Issues	Miscellaneous
105B	M	1b	03.00	11, 12, 6, 15, 18, 8, 12, 23				6, 3, 17, 10, 20, 11				
105B	M	1b	03.02	11, 12, 6, 15, 18, 8, 12				6, 3, 17, 10				
105B	M	1b	03.08	11, 12, 6, 15, 18, 8, 12				6, 3, 17, 10				
105B E	M	1b 3a 4a 8b	03.11	11, 12, 6, 15, 18, 8, 12				6, 3, 17, 10				
212W	M	1b 8b 9a	03.26	11, 18, 22,	2						2, 3	
403O	M	1b 3a 4a	03.00	11	2			10				
404B	M	1b	03.25	11	17		5					5b
404B	M	1b	03.25	24	9, 8, 11		4	3				
404B	M	1b	03.25	24	7		4					
404B	M	1b	29.25		10						4?	
410O	M	3a	03.00	11	9		6					
410O	M	3a	03.00	11	7		6	2				
104O E	U	3a	29.00	20	14			7, 16				
110W	U	2b	29.00	18,	16				2		1	
213W	U	Not specified	29.23		15	5		9				
405O	U	1b	29.30	12, 9			2	2, 6		3		

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501W	U	NA	29.10									8, 9
501W	U	1b 3a 4a 2a 5a 6b 9a	29.23	18, 9, 22, 4		3		16, 18				6, 10
501WE	U	3a 4a 2a 5a 6b 8b	29.00	18	4		6, 12, 4,	18				6, 7
606WE	U	1b 2a 3a 4a 5a 6a 8a	29.00	18, 22,	24		4	2				
606WE	U	1b 2a 3a 4a 5a 6a 8a	29.00	18	11, 20	7						
828W	U	1b	29.01	9					27			
901W	U	3a 4a 2a	29.00	11, 26	13, 22							
904B	U	3a 4a 2a	29.00	18	20			15				
102B	V	1a 2a 3a 4a	29.30	18, 8	11			3				
102O E	V	1a	04.00	4, 5, 26				16, 21				5a
204B T	V	1a	04.23	23, 1, 12, 26, 21	1, 18	4, 6						
205B E	V	1c	04.00	26, 4, 23, 5,	2, 3			19, 13, 20, 11, 10				

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302B	V	1b	04.00	10, 26							5	
416W	V	1a	04.26	1, 26	17	1						
608W	V	1b	04.10	26, 23	11		10	1				1
608W	V	1b	04.23	26, 25	11	6, 2		1				
608W	V	1b 6a 7a	04.30	26	5, 11, 14		2	1	1			
608WE	V	1b	04.00	26, 1, 16	12, 14,			22, 14, 10, 20	1			11
804BE	V	1a	04.00	26, 18, 8	9			2				
806BE	V	1a	04.00	26	11, 12		8, 11					
807BE	V	1a	04.00	26, 18	9			20				
826W	V	1b	03.24									2
826W	V	1a	04.00	26, 9								
826W	V	1a	04.25									3
906W	V	1b	04.27	26, 12, 9				19, 10, 6, 27				
502O	X	1a	04.02	14, 26, 11, 18, 3, 22	11, 23, 16			26	3		4	5d
502OE	X	1a	03.02	14, 26, 11, 18, 3, 22	11, 23, 16			26	3		4	5d
502OE	X	1a	03.02	14, 26, 11, 18, 3, 22	11, 23, 16			26	3		4	5d
502OE	X	1a	29.00	18							4	
808BT	X	1a	03.02	11, 19, 22, 18, 4, 27, 6, 25,	2, 21	6		6, 10, 25, 2, 21, 7, 11,				
808BT	X	1a	04.26	26, 17, 16	12, 17, 20		1, 3	8				

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II. Recommendations Summary Codes

<p>Characteristics of Reporting Systems and Reported Data Elements</p> <ol style="list-style-type: none"> 1. Anonymous 2. Based on national standards 3. Combination/flexible system (not an all one or all the other type of reporting system) 4. Confidential 5. De-identified 6. Easily understood data elements 7. Extended peer protection 8. Facility and /or organization-specific 9. Federal and/or national(dovetails with) 10. Incentivized 11. Mandatory disclosure/reporting 12. Non-punitive 13. Ongoing basis (rather than one time report) 14. Ongoing instrumentality that will set up some kind of structure for both the voluntary reporting and the ultimate mandatory reporting 15. Operationalized consistently 16. Peer professional review protection for the reporter 17. Protected 18. Publicly available information (including data collection process) 19. Regulated reporting system 20. Severity-"level" (of reported incident) 21. Simple format that only collects essential information 22. Standardized method and information 23. State-wide 24. Timeliness (disclosure and availability of reports) 25. User-friendly (for all types of users) 26. Voluntary disclosure/reporting 27. Punitive sanctions for failure to report 	<p>Reportable Events</p> <ol style="list-style-type: none"> 1. Actual adverse medical events/outcomes 2. Adverse events (preventable and unspecified) 3. Close calls 4. Comprehensive set of performance measures 5. Consumer identified errors and near misses that reach/impact them 6. Efficiency measures 7. Financial data 8. Incident rates 9. Infection rates (hospital and healthcare acquired/associated) 10. Level of care 11. Medical (treatment) errors 12. Medication errors 13. Minor events 14. Near misses 15. Occurrences 16. Patient outcomes 17. Patient safety issues/problems/measures 18. Potential adverse medical events/outcomes 19. Preventable events 20. Quality (improvement) measures 21. Sentinel events 22. Significant events 23. Deaths 24. "Report cards"
<p>Collection Methods</p> <ol style="list-style-type: none"> 1. 800-number 2. Anonymous phone reporting 3. Clinical information technologies 4. Electronic 5. On-line 6. Web-based (data reporting system) 7. State hot line 	<p>Types of Reporters</p> <ol style="list-style-type: none"> 1. An independent entity 2. Consumers 3. Health services and clinical experts/scientists 4. Health systems/institutions 5. Healthcare employees 6. Hospitals 7. Michigan Dept. of Community Health 8. Michigan Dept. of Education 9. Michigan health care facilities 10. Patients 11. Schools 12. Physicians and physician groups

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Uses of Reported Information	Miscellaneous
<p><u>Consumers</u></p> <ol style="list-style-type: none"> 1. Consumer oriented methods to learn from the lessons as they are central to preventing harm and errors 2. Providing information that is meaningful to consumers; meaningful measures and ease of getting information 3. Help consumers to make informed choices about where to get healthcare and what provider to choose <p><u>Healthcare Organizations</u></p> <p>Identify and appropriately address patient safety problems within the individual delivery systems</p> <ol style="list-style-type: none"> 4. Learn where mistakes are happening and where patients are at greatest risk of harm 5. Do root cause analysis on near misses / risk management review of errors 6. Identify patterns of errors 7. Track these trends in "occurrences" and errors 8. Identify ways to make individual systems safer, areas where human behavior may need modification and where system changes need to occur so errors are not repeated 9. Disseminate information within own healthcare institution 10. Follow-up on errors when they happen 11. Derive lessons learned 12. Inform administrative decision making regarding future patient safety initiatives <p>Strengthen general quality improvement programs</p> <ol style="list-style-type: none"> 13. Motivate providers to improve quality of care 14. Promote adoption of evidence-based practice and improve processes of care 15. Implement improvement measures and benchmark multiple measures(get examples – 105) 16. Assess the relative safety, timeliness of care, efficiency, equity, effectiveness and patient-centeredness of care <p>Share information and lessons learned</p> <ol style="list-style-type: none"> 17. Aggregate data at state and/or national level 18. Share comparison data with all Michigan healthcare institutions 19. Share and best practices with participating hospitals 20. Identify contributing factors to prevent and reduce future errors and patient harm <p>Fulfill Public Accountability Responsibilities</p> <ol style="list-style-type: none"> 21. Increase public reporting of health care errors/quality events 22. Publicize comparative ratings or hospital "report cards" 23. Link events to accountability 24. Ultimately assuring that reduction of death relate to medical errors has really happened <p>Contribute to Refinement of National Standards and Goals</p> <ol style="list-style-type: none"> 25. Contribute to clear national safety goals 	<ol style="list-style-type: none"> 1. Develop a white paper that outlines the necessary aspects of issues 2. Further study of existing mandatory systems to determine whether any form of mandatory reporting is desirable, and if so, what form it should take 3. S. 720 (The Patient Safety and Quality Improvement Act) and a companion bill HR 663 that would improve patient safety and reduce medical errors <ol style="list-style-type: none"> a. These bills would create a new voluntary medical error reporting system under which "patient safety organizations" would receive and analyze, on a confidential and privileged basis, information on reported errors; they would then be expected to develop and disseminate evidence-based information to help providers implement changes in practice patterns that help to prevent future medical errors 4. The State of Michigan should contract with a vendor who can respond to the limitations listed above as to factors why organizations do not share errors today and that can demonstrate the following capabilities: <ol style="list-style-type: none"> a. An established and proven tracking system (software program for patient safety events/incidents) to recognize risk issues and to track and trend the data b. Analytical capability to turn the data into meaningful information to share the lessons for improvement c. Quarterly reporting to all users regarding trends and areas of opportunity for system, human and process improvement d. Real time reporting by the repository to all users of urgent issues that need to be shared (concurrently) to prevent harm e. Clinically qualified repository staff interpreting data and reporting information f. Mechanisms to involve consumers/ patients in the reporting and learning process g. Information technology systems to support a statewide initiative h. Industry leaders with the ability to educate healthcare facilities and staff on the utility and value of error reporting, methods to implement a just culture and the design and use of accountability models for action determinations [608W - W127-147] 5. Examples of Reporting Systems to Consider <ol style="list-style-type: none"> a. CDC National Nosocomial Infection Surveillance system b. Mandatory reporting system used by school employees to report suspected child abuse c. PEERS system d. IOM's recommended blend of mandatory and voluntary reporting systems 6. Develop a comprehensive public education campaign to build community support for these strategies (public reporting) 7. Do not let concerns over provider reporting burden trump the need to measure and publicly report their performance. 8. We must be sensitive to the burden on providers that reporting entails and thus must support strategies to minimize the burden as much as possible. 9. The Disclosure Group "Ground Rules" would [reduce provider reporting burden and] assure consistency and non-duplication of measurement and reporting, reducing the number of measures multiple organizations would be asking for [through use of an interoperable electronic clinical information system]. 10. Michigan should closely monitor ongoing efforts at the federal level to develop health information technology standards to assure that Michigan adopts specifications that are consistent with national standards. 11. Specification of software vendor criteria for reporting system and essential aspects of IT system

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<p>Control and Housing of Reporting System Data</p> <ol style="list-style-type: none">1. Central repository2. Comprehensive government web site3. Governmentally sponsored – not necessarily a state agency4. Independent entity5. Reporting committee <p>Sources of Input Related to Design of System</p> <ol style="list-style-type: none">1. Professional societies2. Providers3. Consumers	<p>Contingencies and Other Issues</p> <ol style="list-style-type: none">1. De-emphasize commercial uses of data that victimizes some hospitals and rewards other hospitals that pay (Health Grades concern)2. Legal protection needs to be provided to the organization3. Legal protection needs to be provided to the provider4. Reports must be audited and verified as to completeness and results of audits be made available to community presented in standardized format5. Reports should not be used to discipline providers who report (shouldn't go into licensure file and be made public)
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Reference List:

¹ Personal communication, Sarah Fink, Michigan Health & Hospital Association, 5.5.05.

² Marchev M, Rosenthal J, & Booth M. (2003). *How states report medical errors to the public: Issues and barriers*. National Academy for State Health Policy: ME.

² Colorado, Florida, Kansas, New York, California, Ohio, Massachusetts, New Jersey, Rhode Island, South Carolina, South Dakota, Washington, Connecticut, Georgia, Maine, Minnesota, Nevada, Pennsylvania, Tennessee, Texas, Utah.

³ Weissman J, Annas C, Epstein A, Schneider E, Clarridge B, Kirle L, Gatsonis C, Feibelmann S, & Ridley N (2005). Error reporting and disclosure systems: views from hospital leaders. *JAMA*, 293, 1359-1366

⁴ Rosenthal J, & Booth M. (2004). State patient safety centers: A new approach to promote patient safety. National Academy for State Health Policy: ME.