

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
MAY 12, 2005**

Category: B. Identifying and Learning from Errors

Code 05 (ShareInfo) – Share Information: The submitted testimony recommends the development of programs where standardized data elements are shared across health care organizations and/or between health care professionals for the purpose of joint problem-solving.

Recommendation #B2

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*

(Compiled from 7/7 recommendations submitted under this code)

Rationale:

Taken together, this set of testimonies expressed a sentiment echoed in the literature as well: that there is a need to move from reporting through analysis to policy changes and practice improvements. Without some means to analyze collected data and share the results, little learning can occur and reporting systems cannot realize their full potential.^{1 2 3 4} In its 2000 report, the Institute of Medicine (IOM) made it clear that “the goal of reporting programs is not to count the number of reports....Analyzing and using the information they provide and attaching the right tools, expertise and resources to the information contained in the reports helps to correct errors.”⁵ Five years later, in his assessment of the progress made since the IOM report, Wachter reiterated the need to pay attention to what happens to data from reporting systems once it is collected. He calls this “the Achilles heel of error-reporting systems: the flawed notion that reporting has any intrinsic value in and of itself.”⁶ Though error-reporting systems are one of the five major areas of activity in patient safety over the past

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five years, Wachter grades these efforts a 'C', because not enough has been done with data from these systems. Wachter calls for new reporting models and "far greater resources devoted to translating submissions into action."⁷

Translating submissions into policy change and practice improvements needs to be viewed not only as a necessary outcome of reporting, but one of the benefits to reporters. Without these feedback loops, reporting systems may become counterproductive, where participation is viewed as a waste of time and resources, a burden with no purpose or reward.^{8 9 10}

Submitted testimony cited a number of concerns and barriers to reporting adverse events: a lack of organized data collection methods, the lack of an organized approach to analyze root causes, failure in the past to focus on system defects, and the absence of a way to share lessons learned.^{11 12} These in turn become elements that need to be in place to enable both reporting *and* analysis. They also lend support to the notion of an entity at the state level (or a state-wide body) that would assume these tasks.

While hospitals and health care facilities may conduct their own investigations and follow-up when adverse events or near misses occur, there are good arguments for establishing a state-level organization to complement or even supplant what individual organizations do. One of the leading reasons is to be able to muster the knowledge and resources needed to thoroughly assess a situation. As one respondent put it:

...it [doing something after an adverse event], requires a very sound understanding, a very detailed root cause analysis of the true underlying causes of any particular event, not only to involve clinicians and people with a system mind, particularly, but importantly to involve people with formal training in biomedical engineering, human factors analysis, sometimes even behavioral psychology. It's very unlikely, at least in my view, that every organization could do this on their own. And I would suggest as an analogy if each airline had to develop their own National Transportation Safety Board to study their close calls or accidents. That certainly is not the way we do it. We have the National Transportation Safety Board to primarily study these events.¹³

Other reasons for large-scale or state-wide analyses include the ability to identify trends and emerging problems and to detect rare events or system failures that occur infrequently.¹⁴

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Evidence and information on comparable initiatives:

Federal level. While the need for a learning component in error reporting systems is clearly recognized by the IOM, the Joint Commission and others at the federal level, regardless of whether the reporting system is mandatory or voluntary, work by the National Academy for State Health Policy (NASHP) indicates that there has been little or no corresponding support from the federal government to help states carry out this task.¹⁵ Important elements of support are funding and technical assistance, for designing reporting systems and supporting the analysis and solution-dissemination roles, and legal protection for error data or analyses reported to a third party. The question of legal protection may change in the near future if Congress passes proposed patient safety legislation that includes such protection.¹⁶ Federal sources of support for funding and technical assistance, however, remain major obstacles.

State level. Based on the studies by the NASHP,¹⁷ there is growing number of states with error reporting systems and, as part of these systems, there is some effort to process the information and make reports publicly available. To date, aggregating data to identify trends appears to be the most common use of reported error information from states with mandatory reporting systems. Overall, however, the degree to which submissions are effectively translated into action and initiatives to improve patient safety remains unclear.

In 2003, the NASHP documented 21 states with mandatory reporting systems, 9 of which publicly release aggregate data in periodic reports.¹⁸ In these reports, most states include some description of the reporting system, definitions of reportable events, and various statistics on the frequencies and rates of incidents. Half or less, however, include any recommendations or plans to improve the system, examples of how data has led to patient safety improvements, or interpretive information. None provided analysis or discussed implications. In its conclusions, the NASHP noted that “patient safety event data require careful analysis and interpretation before they are useful to the public,”¹⁹ but highlighted the lack of funding and resources to support the development of reporting systems that incorporate both collection and learning components.

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Pros:

- Ability to pool knowledge and resources across organizations and professions to analyze problems and develop solutions
- Improved analytic power to detect rare events, trends
- Putting resources towards the use of reported data for patient safety improvements demonstrates the State's commitment to building a culture of safety and creating a learning environment
- Availability of viable models: NASA's ASRS and the PSRS used by Veteran's Administration; Trinity's on-line system

Barriers:

- Insufficient funding and resources: Analysis and follow-up is seen as expensive and difficult. Many states currently having difficulty securing necessary resources for analysis and dissemination of lessons learned
- Underreporting is a major issue – leads to concerns about accuracy and validity of data that is available for analysis
- Concern that poor or inadequate information will get out to the public without interpretation or context
- All of the other barriers that go with reporting and disclosure, particularly fear of malpractice litigation
- Limitations of data: inadequate, incomplete, too much variability, non-standardized data elements

Implementation steps:

Submitted testimonies offered two strategies to implement this recommendation. One was to enact legislation that would provide legal protection to individuals and organizations involved in reporting adverse events or near misses.²⁰ The second was to use NASA's ASRS, which is also being rolled out in VA medical facilities, or Trinity's on-line reporting system as a starting point. Further work is needed to assess the broad-scale applicability of each of these systems, as well as how any systems will mesh with efforts that unfold at the federal level.

Of utmost important is that both of these strategies along with any action on this recommendation be linked with recommendations on reporting systems and legal protection. Many aspects of the information sharing role addressed here hinge on the type of reporting system that the Commission will support as well as the form and degree of peer protection.

Cost: TBD

Implementation Target Date: TBD

Grade:

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Endnotes

¹ Testimony 106B

² Wachter RM (2004). The end of the beginning: Patient safety five years after 'To err is human'. *Health Affairs – Web Exclusive*, W4-534—W4-545.

³ Kohn LT, Corrigan JM & Donaldson M (eds). (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press, p.100.

⁴ Joint Commission on Accreditation of Health Care Organizations (2005). *Health care at the crossroads: Strategies for improving the medical liability system and preventing patient injury. Executive Summary*. Washington, DC: JCAHO, pp 10-11. Retrieved 4.18.05 from http://www.jcaho.org/about+us/public+policy+initiatives/medical_liability.pdf .

⁵ Kohn, Corrigan & Donaldson, op.cit., p.100.

⁶ Wachter, op.cit., p.538.

⁷ Wachter, op.cit., p.539.

⁸ Kohn, Corrigan & Donaldson, op.cit., p.100.

⁹ Wachter, op.cit., p.538.

¹⁰ JCAHO, op.cit.

¹¹ Testimony 106W:38-43.

¹² Testimony 205W:173-175.

¹³ Testimony 103O:70-89.

¹⁴ Kohn, Corrigan & Donaldson, op.cit., p. 98.

¹⁵ Marchev M, Rosenthal J, Booth M (2003). *How states report medical errors to the public: Issues and barriers*. Portland: National Academy for State Health Policy. Retrieved 5.1.05 from http://www.nashp.org/files/GNL52_medical_errors_reporting_for_the_web.pdf.

¹⁶ JCAHO, op.cit., p.11.

¹⁷ In addition to the report by Marchev, Rosenthal, and Booth, two others were of relevance here: Riley T (September 2000). *Improving patient safety: What states can do about medical errors: A report from the Flood Tide Forum. Executive Summary*. Portland: National Academy for State Health Policy; and Rosenthal J, Riley T, Booth M (April 2000). *State reporting of medical errors and adverse events: Results of a 50-State survey. Executive summary*. Portland: National Academy for State Health Policy. Both retrieved 5.3.05 from <http://www.nashp.org/store/prodpage.cfm?CategoryID=2> .

¹⁸ Marchev, Rosenthal, & Booth, op.cit.

¹⁹ Marchev, Rosenthal, & Booth, op.cit., p.32.

²⁰ Testimony 212W:121-123