

Recommendations

These recommendations take into consideration testimony originally coded to 01 (State Focal)¹, portions of 27 (Advocacy)², 21 (DrgStand),³ and 22 (MedPrac)⁴ as well as other sources, as noted.

- P1. Establish and fund the Michigan Partnership for Safe Health Care as a statewide center for leadership, information and advocacy to reduce patient harm.
 - o P1a. Establish the Partnership as a free-standing, quasi-public organization existing as an autonomous unit in the Department of Community Health, except for budgeting, procurement and related management functions.
 - o P1b. Provide the Partnership with restricted, dedicated, sufficient, reliable, ongoing funding.
 - o P1c. Ensure that the Partnership's data and reporting systems are protected from the State's public disclosure requirements and that State agencies do not have access to the Partnership's data and reporting systems.
 - o P1d. Expect the partnership to develop appropriate staffing and governance structures; set annual goals and submit an annual progress report to the Governor; and perform the tasks required to meet annual goals.⁵

Rationale

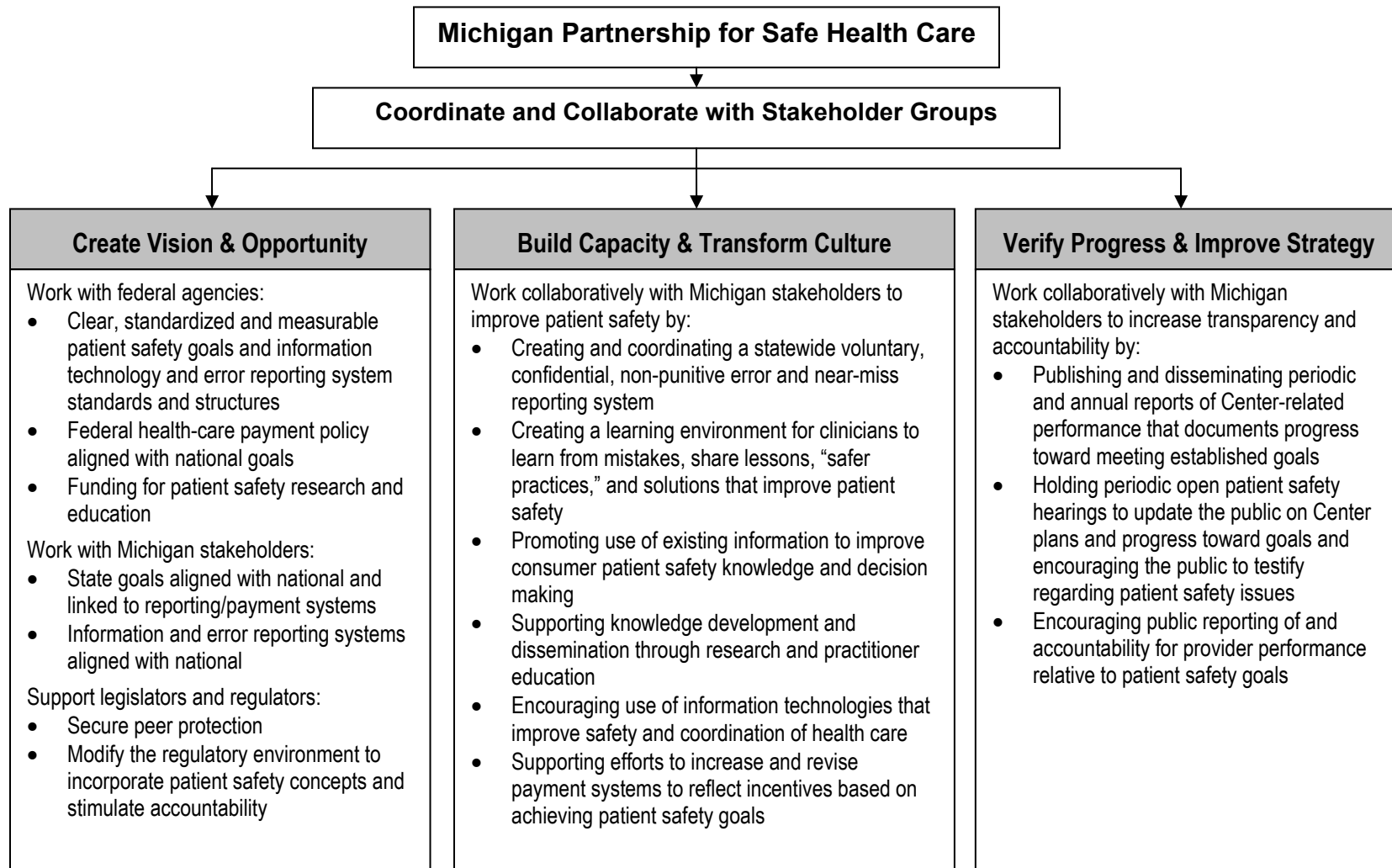
Without a state-level patient safety center, which we have chosen to call the Michigan Partnership for Safe Health Care, the following important activities are very unlikely:

- Systematic identification of clinical and other practices that result in health-care errors.
- Understanding of the extent to which errors affect the public.
- Monitoring the effects of improvements.
- Convening various groups of stakeholders to solve complex problems that require the cooperation of groups that usually do not engage in collaborative projects.
- Leadership of patient safety improvement programs that require comprehensive, uniform and centralized approaches across the state.
- Coordinated Michigan advocacy at the national level to improve access to and integration with patient safety information, technologies and funding.

Moreover, without the Partnership, it will be difficult to hold any particular organization accountable for improving aggregate safety. The State must be accountable to the public on this matter and creation of the Partnership demonstrates commitment, develops a mechanism for accountability, and responds to the needs of the public.

While the Partnership's specific responsibilities to meet currently unmet needs related to reducing avoidable harm to patients are outlined in other recommendation areas, generally speaking it should engage in three distinct but inter-related areas of work: creating vision and opportunity, building capacity and transforming culture, and verifying progress and improving strategies. The Partnership's strategic plan should specify the order in which the areas of work in Figure 1 should be implemented.

Figure 1. Draft Conceptual Model for Michigan Partnership for Safe Health Care



Evidence for harm reduction

The impact of patient safety centers on reducing patient harm has not been rigorously evaluated, in part because existing centers are relatively new. Research in this area is likely to be difficult; there are few centers and each is structured and operates in a slightly different way, hindering efforts to compare structures, processes and outcomes.

Assessment

Advantages

- Other progressive states are developing such state-level patient safety centers.
- The Partnership would be in a unique position to coordinate the work of patient safety programs around the state and across state agencies, between stakeholders at the state and national levels, and between public and private sectors.
- In a coordinating role, the Partnership could:
 - Foster a culture of patient safety in the state.
 - Develop collaborative relationships among patient safety stakeholders, including providers, consumers and purchasers.
 - Educate consumers about patient safety.
 - Educate providers about best practices to improve patient safety.
 - Recommend health professionals curricula to address patient safety.
 - Shape public policy designed to encourage the adoption of patient safety practices by health-care organizations and professionals.
 - Develop statewide systems to report and analyze adverse events and/or near misses.
 - Develop useful statewide patient safety benchmarks to monitor health-care system improvements and/or clinical process improvements.
 - Evaluate and promote health information technology to improve patient safety.

Barriers

- The Center, whatever its scope of work, will require restricted, dedicated, sufficient, reliable, and ongoing funding.
- The scope of work proposed in Figure 1 may be too broad for the level of staffing suggested in the Resources section.
- There are few, if any, models from other states that encompass the broad range of functions envisioned for the Partnership.

Implementation

Further research

No further research needs were identified.

Legislation and/or administrative rules

- Establish and fund the Michigan Partnership for Safe Health Care as specified in this document.

Resources

The following cost areas were identified:

- “Housing” and operations—Office space, equipment, supplies, etc.
- Staffing—Estimated needs include a Director/Administrator, a Medical Director, an Engineer, two Data Analysts, two Registered Nurses, and clerical support.
- Programs and services—Convening work groups, printing materials, developing a patient safety reporting system, etc.

Annual costs to operate the Partnership have been roughly estimated at \$2 million. The Partnership will need start-up funding and a reliable and sustainable source of income, which could be secured from a variety of mechanisms including state general funds and budgetary carve-outs, additional fees on health professional and health-care organization licensure renewal charges, user fees, and public and private grants.

Incentives

No need for incentives was identified.

Specific steps and target dates

- Within 6 months, the Governor and Legislature will establish and fund the Michigan Partnership for Safe Health Care.
- Within 15 months, the Partnership’s governance and staff structures will be in place, its first set of operational goals will be established, and a strategic plan for achieving those goals will be under development.

Testimony overview

Summary

Data regarding development of a state-level patient safety center 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.

Key findings

The testimony reviewed revealed a high level of interest in some type of state-level entity as a focal point for a coordinated patient safety program. Two informants explicitly recommended developing a state-level center for patient safety.⁶ 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 informant⁷ 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 the State Commission on Patient Safety to, “be bold and don’t hold back

[because] all patients deserve a safe environment.” Other informants made similar recommendations.⁸ Two informants mentioned that the Michigan Health and Safety Coalition provided “a good place to start.”^{9 10}

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.¹¹

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.”¹² Another informant stated, “It is highly recommended that patient safety centers be separate and distinct from state regulatory processes.”¹³

Research overview

The information in this section is drawn primarily from a document prepared in 2004 by researchers with the National Academy for State Health Policy who reviewed existing state patient safety centers.¹⁴

The Academy found that 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 effectively improving health-care safety necessitates:

- Collaboration with providers, consumers and purchasers.
- Leadership to establish clear goals.
- Useful benchmarks to measure progress.
- Coordination across all agencies of state government to achieve their desired outcomes.

Legislatures in six states—Florida, Maryland, Massachusetts, New York, Oregon, and Pennsylvania—have authorized or endorsed state centers for patient safety. Efforts in Florida and Oregon are in the early stages. According to new information, Minnesota is working on plans to develop a center.

Motivation

Motives for implementing a center vary. 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. The creation of the Massachusetts center was prompted in part by the death of Boston Globe reporter, Betsy Lehman and the consumer interest and public pressure that followed.

Relationship to State government

The degree of autonomy from state government varies considerably. Four of the six centers are housed within state government and the remaining two are located outside of but have legislatively authorized affiliations with state government. The center in New York is a state agency within the Department of Health and 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.

Governance structures and staff

Similarly, the centers' governance structures differ. The New York center has no advisory board or board of directors. The others use different configurations of boards of directors, advisory committees, and leadership councils. 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.

Center staffing levels are unclear. All centers have directors or administrators. Two centers—in 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.

Scopes of work

The centers' scopes of work also vary 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 health-care professionals.

Most centers are still in their infancy, although several have moved ahead with projects. All six centers intend to:

- Educate providers about best practices to improve patient safety.
- Promote collaboration and/or build consensus between public and private sectors.
- Inform consumers about patient safety issues.

Five of the six centers also intend to:

- Foster creation of a culture of safety.
- Recommend statewide goals and track progress.
- Serve as a clearinghouse for best practice information.
- Promote collaboration between federal and state initiatives.

Relationship with reporting systems

Four states—Florida, Maryland, Oregon and Pennsylvania—have in place or are planning to implement as part of their state center's function, reporting systems 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 (malpractice or Medicaid data, for example) to glean important insights regarding patient safety. For a more detailed discussion of state patient safety reporting efforts, see recommendations to Collect & Use Data (code K).

Deliverables

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.

Funding strategies

Existing state centers employ a variety of funding mechanisms. Pennsylvania's center, the best funded, was granted an independent funding stream from an annual surcharge on licensing fees for those facilities subject to the Pennsylvania Act's reporting requirements, up to \$5 million a year. Unspent funds roll over 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 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 State's 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."

Review Panel Round One

Scoring summary

In Round One, the Review Panel was asked to score each recommendation area on a scale of 1 to 5, where 5=extremely viable, 4=very viable, 3=somewhat viable, 2=potentially viable with changes, and 1=not viable for this project. Average scores for relevant recommendations considered in Round One:

- State Focal: 3.6 (range 2 to 5)
- Medication Practices and Drug Standards (presented together): 3.2 (range 2 to 5); score includes material not included in this set of recommendations
- Advocacy: Was not evaluated by the review committee

Notes

Overall, there was strong support for this set of recommendations, but support was contingent upon the center (now referred to as the Partnership) being adequately funded and not being part of any state regulatory agency. The scores assigned to this recommendation reflected uncertainty about further specifications for the Partnership.

- We have to have this in some form.
- The key question of funding drives the viability of this recommendation.
- Big funding issue.
- The patient safety center must be a quasi-public entity funded by a nominal fee added to the release of patient records charge that now exists.
- Free standing entity is critical (not part of state government). Funding will be the big issue.

There was strong support for the Partnership fulfilling the role of convener of experts and providing educational opportunities.

- The Center should be the convener of experts, not become “the” expert.
- How do we include the patient safety experts? Many groups/people are doing work in this area how do we include all the research/work out of these groups? Role of state center should be convening the experts not becoming the experts.
- Highlight education function of such a center.

There was disagreement between two panelists as to whether the Partnership should be should be involved with the voluntary error reporting system. This issue may have been resolved as a result of additional work on this set of recommendations and those concerning a voluntary reporting system.

- The center should coordinate voluntary reporting of medical errors.
- Reporting should not be included in the function of this center – it “may” be involved, but it will depend on how the Center is formed and what it’s specific functions will be.

All issues raised by the review committee have been integrated into this report.

Additional comments or concerns

- Five recommendations from Code 27 (Advocacy) were incorporated into this report. These suggestions addressed the need for a Center to “move” state and federal safety legislation, coordinate leaders from stakeholder groups, convene open forums for discussion of safety issues, and advocate for federal funding changes, a federally-funded safety research agenda, and a national error reporting system.
- The Analytic Team chose to incorporate one recommendation from Code 22 (MedPrac) into the current category—A state registry to support the transfer/exchange of medication information across all health-care organization and pharmacies, including mail order pharmacies.¹⁵ There was not strong support for this particular recommendation from the Review Panel, however. Instead, they felt it should be part of a larger electronic medical record recommendation. This recommendation was not, therefore, incorporated into the current recommendations.
- The Analytic Team chose to incorporate one recommendation from Code 21 (DrgStand) into the current category—Mail order pharmacies doing business in Michigan should be required to network with local community pharmacies to help decrease fragmentation of care, to help meet patients’ acute care needs, and to help assure patients have access to a local pharmacist when they need to address problems or concerns regarding any of their prescription or nonprescription medications. In addition, to decrease the risk of error, a patient’s community pharmacist in Michigan should have access to the records for that patient which are maintained by the pharmacy benefits manager (PBM) and/or the mail order company shipping drugs by mail.¹⁶ Although this recommendation is not included verbatim in the list of Partnership tasks, the Partnership could convene a forum to address medication-related safety concerns.

Endnotes

¹ Code 01 (State Focal) was used to identify testimony recommending identification and adoption of an institutional focal point for providing state-level leadership related to health-care safety.

² Code 27 (Advocacy) was used to identify testimony that recommended undertaking acts in a formal manner (e.g. lobbying) to influence public opinion and societal attitudes or to bring about changes in legislation, administrative rules and regulations, and/or policy at all levels (governmental, community, or institutional).

³ Code 21 (DrugStand) was used to identify testimony that recommended development of standards to guide the design of processes and procedures related to the safe use of drugs.

⁴ Code 22 (MedPrac) was used to identify testimony that recommended adoption and implementation of medication safety practices.

⁵ See also other recommendation sets, where tasks/goals for the Michigan Partnership for Safe Care are detailed. A complete list of these activities will be developed for the final report to the Governor.

⁶ Testimony 826W:134-138; Testimony 605B:P2 L16-17.

⁷ Testimony 105O: 209-213,215-219; Testimony 105W: 117-118,119-121,157-158, 182-184

⁸ Testimony 403O:28-29, 167-169; Testimony 901W: 212, 214-215; Testimony 906W:133-136.

⁹ Testimony 105O:213-215; Testimony 105W:118-119.

¹⁰ Testimony 605B:P2, L39-40.

¹¹ Testimony 106B:O46-56.

¹² Testimony 826W:134-138.

¹³ Testimony 605B:P2, L34-36.

¹⁴ Rosenthal J & Booth M. (2004). *State Patient Safety Centers: A new approach to promote patient safety*. Portland, OR: National Academy for State Health Policy.

¹⁵ Round One recommendation C22.1.3.

¹⁶ Testimony 302W:469-476.