

Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
Code 01: State Focal		
102B	01.00 State Focal	Apply a “framework for prevention” that draws on national patient safety goals outlined by the CDC, National Quality Forum, and Centers for Medicare & Medicaid Services (CMS), etc., to assist the Commission’s advocacy efforts. [W 103-104]: ... draws on national patient safety goals outlined by the CDC, National Quality Forum, and Centers for Medicare & Medicaid Services (CMS), etc. ... [W 103-105]
1030	01.15 State Focal / Collab	Similarly, so that each institution doesn't have to reinvent the wheel, I think it's important to develop a means where institutions can share their solutions, share best practices. ... And anything that can be done through statewide efforts to encourage the sharing of those practices I think would be very helpful. [O 94-97, 101-103]
105B	01.00 State Focal	Leadership. The state of Michigan must assign leadership to the body aimed at improving patient safety and reducing medical errors. [O 209-213; W 117-118] This leadership [assigned by the state of Michigan] needs to stress accountability to hospitals and healthcare providers for implementing systems to make it safer for our patients. Be bold and don't hold back. All patients deserve a safe environment. [O 215-219; W119-121] Leadership is needed first and foremost to create environments where patient safety is a top priority. [W157-158] Recommendations [from Executive Summary]: The State of Michigan should be assuming a lead role in creating a safer environment for patients [W 182-184]
106B	01.00 State Focal	The State of Michigan Commission on Patient Safety has an important opportunity to improve patient safety and reduce medical errors. To be successful in executing this opportunity it is critical that Michigan take bold steps to create a culture across Michigan that sustains the improvement climate and results in substantive improvements. [W 28-31]
106B	01.00 State Focal	Just as providers have learned that a culture that is supportive if [assume “of”] identifying errors and near misses is the foundation of any patient safety improvement program, the State must also appreciate that the discovery of errors and near misses is fundamental to patient safety improvement efforts. [W 31-34] 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. The time has come for us to get out of the blaming and shaming game and start understanding and identifying what are the root causes of medical errors and adverse events. We cannot do that if the environment is one of shame and blame. [O 46-56]
106B	01.00 State Focal	A focus should be on that [what type of solutions are being effective and utilized]. [O 69] The time has come to focus on what is going to be done to prevent events in the future from occurring. Enough has been said about the problem and far less has been learned about what to do about the problem. Michigan has a historic opportunity to do something different. To create great learning and implement safer systems of care should be our greatest responsibility. It can be done. It can be done now. We have to be bold and not confine our thinking to past models of intervention. Let’s build a health care system that is safer and learns from its defects. [W 70-75]
2060	01.08 StateFocal / PerfBench	...but my challenge to you is to somehow mandate, ask you to mandate that we assess learning, because if we don't assess learning and document it, how will we verify patient and family understanding so that there can be follow-up at home, whether it be on medication, administration, wound care, injections, whatever, because one must never assume that something taught is something learned (O79-86).
212W	01.00 State Focal	The identification of a state focal point for patient safety to set goals for patient safety, track progress in meeting goals, and the issuance of an annual report is supported by Henry Ford Health System. [W68-70]
212W	01.00 State Focal	The <u>state should serve as the forum to align the various professional societies and organizations</u> to promote standardization across education and training curriculums. [W180-181]
302B	01.00 State Focal	The structure [of licensure boards] should be reviewed and modified to assure boards can effectively discharge their responsibilities (W421-422).
302B	01.11 State Focal / Guid Prin	We must change the culture surrounding healthcare regulation in Michigan to recognize that “to err is human.” At the present time, our system is punitive (W399-400). First, as you've heard from others, we have to change the culture to recognize the fact that to err is human.(O 112-114)
302B	01.22 State Focal / Med Prac	Michigan needs to recruit and retain an adequate number of qualified pharmacists to conduct regular and routine inspections of all licensed pharmacies in the state (W494-495).

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4030	01.30 State Focal / Cons Adv	To the issue of systematic change and accountability is what I address today. [028]First, we need a system in each state that will be responsible for patient safety. [028-29]It is critical that these bodies that involve health care consumers include families and health care professionals. Families need to be involved at every step of the way. [032-33]
4050	01.00 State Focal	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [056-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [0164-167] The first is to establish an authority, preferably a national authority, to really coordinate the work that's being done on safety. [0167-169]
416W	01.00 State Focal	...I have some suggestions that may promote patient safety in community health settings. [W7-8] 5. Hold patient safety testimony hearings on a monthly basis. [W23]
501W	01.00 State Focal	Inform and Engage Key Stakeholders[:] The state should undertake efforts to inform the public and key stakeholders about its focus on advancing the key strategies [i.e., define and publicly report comprehensive set of performance measures, revise payment mechanisms to align incentives, promote investments in clinical information technology as presented in testimony 501 (Bradley)] we are proposing. [W 158-160]
605B	01.00 State Focal	The State of Michigan should create a Patient Safety Center to provide a comprehensive, centralized approach to patient safety (P2 L16-17).
605B	01.10 State Focal / Resources	A challenge is ensuring the level and reliability of funding for the Centers. P2 L36-37
819B	01.02 State Focal / Meas Crit	Records of Medication Errors are currently mandated by accrediting bodies for health care providers. Statewide analysis of trends and root causes would benefit from common language and coding of types [of medication errors] (W55-57). And we encourage the Commission to look at this common language, common coding (O114-115).
821B	01.00 State Focal	MH&SC has placed recent emphasis on designing implementation plans for guidelines created at the national level. This will use state resources to best advantage and put the emphasis on action where there is already national consensus. MSMS would like to see these newest efforts of the MH&SC continue under the Commission (W26-30).
826W	01.00 State Focal	We applaud the call for the establishment of a national Center for Patient Safety and urge 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. We would ask the MH&SC to consider a similar state Center for Patient Safety to look out for the health and safety of Michigan residents.(W 134-138)
828W	01.02 State Focal / Meas Crit	State governments should, in every case, support patient safety and work to bring national consensus on the targets and reporting methods (W116-117).
828W	01.11 State Focal / Guid Prin	State governments should, in every case, support patient safety and work to bring national consensus on the targets and reporting methods (W 116-117).
828W	01.29 State Focal / Reporting	State governments should, in every case, support patient safety and work to bring national consensus on the targets and reporting methods (W 116-117).
829W	01.28 State Focal / Safety Stand	We are similarly interested in patient safety involved with magnetic resonance imaging and spectroscopy. Increasingly powerful magnets are being used for diagnosis and to guide therapy. The lack of effective safety policies may result in inadvertent injury to patients or members of the health care team (W35-38).

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830W	01.11 State Focal / Guid Prin	We urge the State Commission on Patient Safety to give significant attention to the multitude of patient safety concerns faced by the state's approximately 40,000 nursing home residents (W23-25). We therefore urge the Commission to pay careful attention to the plethora of urgent patient safety issues facing the state's vulnerable nursing home residents and to make recommendations for addressing these shameful and unnecessary conditions (W106-110).
901W	01.00 State Focal	The Commission is encouraged to; [...] to lead Michigan on this important journey of continuous improvement in patient safety. [W 212, 214-215] The State Commission on Patient Safety can provide the leadership to ensure proven methods from Industries such as Nuclear Power are adopted in Michigan and applied consistently across the State to permit rapid Technology Transfer without a long trial and error period associated with each institution learning on their own. [W 82-85]
906W	01.11 State Focal / Guid Prin	The science of safety can be summarized in four points: (1) We will make mistakes. (2) We need to create a culture where mistakes are identified. (3) To maximize learning we must focus on systems rather than people. (4) Leaders control the potential to change systems. State leadership is needed to create an environment where clinicians can learn from mistakes. [W 133-136] There are two goals for safety education. One is to have caregivers become comfortable saying "I'm fallible. I'm going to make mistakes. That's just part of the human condition." Having acknowledged that, we need to strive to make our care harm-free rather error-free. The second is to get them to understand the idea of systems. [W 138-141]
Code 02: Measurement Criteria		
1040	02.00 MeasCrit	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O 9-13] The patient safety goals that give direction for the leaders need to be measurable to be able to hold the leadership group accountable. [O 21-23] We need to report near misses. Employees need to know what a near miss is, and not only do we need to know what the near miss is but we need to give it a severity level. If we could have harmed a patient with a near miss, we need to do a root cause analysis just as if it were occurrence. We can then truly look at the processes that need to be improved ... [O 86-92]
105B	02.03 MeasCrit / MandRpt	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Secondly, mandatory nonpunitive reporting systems. This should be instituted for errors and near misses occurring in healthcare. We must create a learning environment so that care providers are not operating in a vacuum, unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, I would suggest these results be made public by organization [written "should be publicly made available"] so that informed decisions can be made as to where people choose [want replaces choose in written] to receive their healthcare. We should be able to benchmark our results on a multitude of measures, including [oral "patient" added] falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates and other patient satisfaction measures [last phrase in written "and general patient satisfaction with pain control to name a few"
106B	02.00 MeasCrit	Michigan also should not go off on its own and establish its own unique taxonomy for how this reporting is to be done. It should look towards national reporting organizations ... and piggyback upon that so we can maximize the utilization of the data that we collect. [O 107-114]
110W	02.00 MeasCrit	There are several improvement goals the purchasers of care could focus on to assist the hospitals:[W 55-56] Do not self create measurements of patient safety in an isolated fashion. [W 57] Rely on validated evidenced based patient outcome measures that have been proven through research to improve the safety of patients. [W 58-59] Coordinate efforts within the public/private sectors to move towards a more consistent approach and process [for patient safety measurement and reporting] for the hospitals to respond to. [W 63-64]
110W	02.00 MeasCrit	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Allow the hospitals to define the process and procedures (for addressing patient safety problems) within their organization (the "how") and hold the hospital accountable to measurable patient outcomes. Avoid mandating the "how" since many of these solutions are often no cost effective and/or cannot be implemented in a "cookie-cutter" fashion. [W 65-68] Avoid mandating the "how" since many of these solutions are often no cost effective and/or cannot be implemented in a "cookie-cutter" fashion. [W 65-68]
211B/ 113B	02.00 MeasCrit	Our findings question the validity of the patient safety indicators as they now exists. As the State Commission on Patient Safety looks to examine the state of patient safety in Michigan, a temptation will be to use the AHRQ Patient Safety Indicators to compare hospital performance. According to our investigation and testimony, such an approach would be ill advised as these indicators do not have sufficient reliability to identify important issues in the area of patient safety. [W61-66]
212W	02.00 MeasCrit	Health care institutions would also benefit from a coordinated reporting system to document issues with equipment, medications, etc. [W125-127]

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302B	02.25 MeasCrit / Legis	We also need legislative changes to permit creation of a peer review process designed to collect and analyze reports on medication errors that occur outside the institutional setting (W453-457, O167-171).
501W	02.00 MeasCrit	Michigan should take immediate action to: [W 49-50] Define and publicly report a comprehensive set of performance measures [bolded in original text]: Support and participate in the work of the Michigan Health and Safety Coalition safety initiatives [as it defines a comprehensive set of performance measures], particularly hospital reporting in cooperation with the Leapfrog Group. Public and private stakeholders are collaborating in Southeastern Michigan to define and implement a comprehensive set of publicly reported performance measures for hospitals, physicians and physician groups, integrated delivery systems and treatments to assess their relative safety, timeliness of care, efficiency, equity, effectiveness and patient-centeredness of care. [W 51-57] ... the Michigan Health and Safety Coalition is collecting and publicly reporting hospital performance for a number of additional measures. These efforts should be expanded to include additional measures for hospitals, including additional conditions such as cancer treatment, orthopedic surgery, and obstetrics. Hospital measures should also be added to assess and report the relative efficiency of Michigan's hospitals, as well as patient perceptions of care following hospital stays. A similar set of publicly reported measure
5020	02.03 MeasCrit / MandRpt	I would think that you should recommend that State Government take an active and proactive role in doing something on an ongoing basis and not just have you submit the report, like the Institute of Medicine, but that out of your work come an ongoing instrumentality that will ... set up some kind of structure for both the voluntary reporting and the ultimate mandatory reporting and publicly available information that I think we're going to really need if we're going to achieve the actual outcomes we want and deal with the question of confidence. [O 258-271] You need some method of ultimately assuring that [reduction of deaths related to medical errors] has really happened. [O 240-241] ... it would be useful for this Commission to not get sucked into the issue that it's all one or all the other [type of reporting system]. [O 149-151] [U]nless you have some kind of mandatory system with standards, criteria, and some degree of spot check auditing, you don't really know that you're getting all the information. That doesn't mean it's necessarily going to be put on the Web the next morning after the entity receives it. I think there's a distinction between whether you initially make it mandatory and whether you immediately put it out. [O 165-173] ... at some point I think you're going to have to require some elements of this process to be publicly available if you're going to address the concern of the patients and the payers and, yeah, even random sample juries. [O 186-190] ... this Commission should ... look at the Institute of Medicine report, see what is the mix of required mandatory versus voluntary. [O203-206] [From Q and A period:] [T]here is a benefit of having some kind of governmentally sponsored – not necessarily a State agency, ... but some kind of standardized method so that we could have a common arrangement by which we look at these things [patient outcomes]. [O 337-342]
5020	02.03 MeasCrit / VolRpt	I would think that you should recommend that State Government take an active and proactive role in doing something on an ongoing basis and not just have you submit the report, like the Institute of Medicine, but that out of your work come an ongoing instrumentality that will and set up some kind of structure for both the voluntary reporting and the ultimate mandatory reporting and publicly available information that I think we're going to really need if we're going to achieve the actual outcomes we want and deal with the question of confidence. [O 258-271] ... it would be useful for this Commission to not get sucked into the issue that it's all one or all the other. [O 149-151] ... this Commission should ... look at the Institute of Medicine report, see what is the mix of required mandatory versus voluntary. [O203-206] [From Q and A period:] [T]here is a benefit of having some kind of governmentally sponsored – not necessarily a State agency, ... but some kind of standardized method so that we could have a common arrangement by which we look at these things. [O 337-342]
804B	02.00 MeasCrit	We are aware that Michigan policy makers also struggle with the issue and related questions have arisen among Michigan legislators. MSIC members believe they can assist the Commission as the issue develops in the near future. The ultimate goal being to identify measures that provide meaningful information for consumers on a voluntary rather than mandatory basis.(W267-271)
806B	02.28 MeasCrit / SafeStand	Update and comply with Part 9101, of the Michigan Public Act 368 of 1978 Public Health Code, which mandates that the department (MDCH) shall establish a plan for health services for pupils in elementary and secondary schools of this state.(W207-209). Implement guidelines and standards of care for school health related services, such as, minimum standards for school health services, medications, management of chronic illnesses, confidentiality, delegation, health promotion, communicable diseases, school based health clinics, first aid/disaster response.(W225-227). Develop and implement criteria for: reporting type, provider classification, accountability, evaluation of health services provided in schools to both the Michigan Department of Community Health and the Michigan Department of Education (W235-241).

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808B	02.03 MeasCrit / MandRpt	A mandatory reporting system that can be implemented in our state to be regulated and to be standardized that provide a standardized documentation of adverse or sentinel events that could be a link to accountability and made available to public.(0162-167).
8100	02.00 MeasCrit	Measuring harm is challenging and the science of how to do it needs to advance.(O 142-143)
817W	02.00 MeasCrit	A better national database is needed with standard definitions for what constitutes a reportable crash or collision and common definitions for types of injuries (W111-112).
819B	02.01 MeasCrit / StateFocal	Records of Medication Errors are currently mandated by accrediting bodies for health care providers. Statewide analysis of trends and root causes would benefit from common language and coding of types [of medication errors] (W55-57). And we encourage the Commission to look at this common language, common coding (O114-115).
828W	02.01 MeasCrit / StateFocal	State governments should, in every case, support patient safety and work to bring national consensus on the targets and reporting methods (W116-117).
Code 03: Mandatory Reporting		
105B	03.00 MandRpt	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Secondly, mandatory nonpunitive reporting systems. This should be instituted for errors (and near misses [not in written]) occurring in healthcare. We must create a learning environment so that care providers are not operating in a vacuum, unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, I would suggest these results be made public by organization [written: "should be publicly made available"] so that informed decisions can be made as to where people choose ["want" replaces "choose" in written] to receive their healthcare. We should be able to benchmark our results on a multitude of measures, including ["patient" added in oral] falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates and other patient satisfaction measures [last phrase in written "and general patient satisfaction with pain control to name a few"]. If we measure it, we can [written: "better"] understand it and then improve – create [written: "implement" replaces "improve – create"] solutions to improve it. [O 220-240; W 123-132] Creating a culture of patient safety is needed. This involves: Non-punitive error reporting[;] Follow-up on errors when they happen[;] Making system changes so errors are not repeated [W 160-163] Recommendations [from Executive Summary]: We must create a mandatory, non-punitive reporting system for errors [W 182, 185]
105B	03.02 MandRpt / Meas Crit	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Secondly, mandatory nonpunitive reporting systems. This should be instituted for errors and near misses occurring in healthcare. We must create a learning environment so that care providers are not operating in a vacuum, unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, I would suggest these results be made public by organization [written "should be publicly made available"] so that informed decisions can be made as to where people choose [want replaces choose in written] to receive their healthcare. We should be able to benchmark our results on a multitude of measures, including [oral "patient" added] falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates and other patient satisfaction measures [last phrase in written "and general patient satisfaction with pain control to name a few"]. If we measure it, we can [written "better"] understand it and then improve – create (written "implement" replaces "improve – create") solutions to improve it. [O 220-240; W 123-132]
105B	03.08 MandRpt / PerfBench	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Secondly, mandatory nonpunitive reporting systems. This should be instituted for errors and near misses occurring in healthcare. We must create a learning environment so that care providers are not operating in a vacuum, unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, I would suggest these results be made public by organization [written: "should be publicly made available"] so that informed decisions can be made as to where people choose [want replaces choose in written] to receive their healthcare. We should be able to benchmark our results on a multitude of measures, including [oral: "patient" added] falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates and other patient satisfaction measures [last phrase in written "and general patient satisfaction with pain control to name a few"]. If we measure it, we can [written: "better"] understand it and then improve – create (written: "implement" replaces "improve – create") solutions to improve it. [O 220-240; W 123-132]

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212W	03.26 MandRpt / Peer Prot	Mandatory, public reporting for the collection of standardized information about preventable adverse events is supported if legal protection is provided both to the organization and the provider(s). [W119-121]
4030	03.00 MandRpt	We need reporting of adverse events to make sure that whatever happened does not happen again. [O38-39] Mr. Wagenknecht: Jean, back when you were talking about the reporting of errors, are you advocating mandatory reporting or voluntary reporting. The Witness: No, I think there should be mandatory reporting. [O72-74]
404B	03.25 MandRpt / Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] <u>Require that health care employees have an obligation to disclose patient safety issues.</u> [W55-56; W390-391]
404B	03.25 MandRpt / Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] <u>Require the health care institution to make timely disclosure of patient consumer information like infection, incident and medical error rates.</u> [W58-59; W393-394]
404B	03.25 MandRpt / Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] ! <u>Require the health care institution to make timely disclosure of financial reports</u> that will reveal the financial status of institution [W62-63; W397-398]
4100	03.00 MandRpt	In the body of our written report – and I've supplied five copies that can be seen at the back table – we have included several areas that we feel would create opportunity for bettering the hospital's ability to serve the public interest. And, briefly, these would include: [O54-59] Number two, hospitals should publish infection rates on a quarterly basis. [O67-68]
4100	03.00 MandRpt	In the body of our written report – and I've supplied five copies that can be seen at the back table – we have included several areas that we feel would create opportunity for bettering the hospital's ability to serve the public interest. And, briefly, these would include: [O54-59] Number three, require detailed financial disclosure from nonprofit hospitals. [O71-72]

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5020	03.02 MandRpt / Meas Crit	I would think that you should recommend that State Government take an active and proactive role in doing something on an ongoing basis and not just have you submit the report, like the Institute of Medicine, but that out of your work come an ongoing instrumentality that will ... set up some kind of structure for both the voluntary reporting and the ultimate mandatory reporting and publicly available information that I think we're going to really need if we're going to achieve the actual outcomes we want and deal with the question of confidence. [O 258-271] You need some method of ultimately assuring that [reduction of deaths related to medical errors] has really happened. [O 240-241] it would be useful for this Commission to not get sucked into the issue that it's all one or all the other [type of reporting system]. [O 149-151] [U]nless you have some kind of mandatory system with standards, criteria, and some degree of spot check auditing, you don't really know that you're getting all the information. That doesn't mean it's necessarily going to be put on the Web the next morning after the entity receives it. I think there's a distinction between whether you initially make it mandatory and whether you immediately put it out. [O 165-173] at some point I think you're going to have to require some elements of this process to be publicly available if you're going to address the concern of the patients and the payers and, yeah, even random sample juries. [O 186-190] ... this Commission should ... look at the Institute of Medicine report, see what is the mix of required mandatory versus voluntary. [O203-206] [From Q and A period:] [T]here is a benefit of having some kind of governmentally sponsored – not necessarily a State agency, ... but some kind of standardized method so that we could have a common arrangement by which we look at these things [patient outcomes]. [O 337-342]
808B	03.02 MandRpt / Meas Crit	A mandatory reporting system that can be implemented in our state to be regulated and to be standardized that provide a standardized documentation of adverse or sentinel events that could be a link to accountability and made available to public.(O162-167).
826W	03.24 MandRpt / Research	We do have serious concerns about the practicality, advisability and utility of the type of mandatory reporting of serious events recommended in the IOM report. Believing this recommendation to be premature and too specific, we suggest instead further study of existing mandatory systems to determine whether any form of mandatory reporting is desirable, and if so, what form it should take. (W 140-144)
Code 04: Voluntary Reporting		
1020	04.00 VolRpt	... I'd like to recommend that the Commission strongly considers a confidential voluntary de-identified patient safety reporting system modeled after the CDC NNIS system that promotes adoption of evidence-based practice and feeds back comparison data to participating hospitals [O 116-121]
204B	04.23 VolRpt / InfoTech	Seventh, develop and implement a statewide anonymous, non-punitive voluntary reporting system, preferably web-based or other electronic system, for actual or potential adverse medical outcomes or events using a simple format that collects only essential information concerning the event (W88-91).
205B	04.00 VolRpt	Encourage the development of voluntary, confidential reporting of adverse events and close calls within individual health systems [W159-162, 166-167]; Establish a state voluntary reporting system of de-identified reports from Michigan health care facilities that could be aggregated at the state level, and lessons learned would be shared with all Michigan health care institutions [W173175]. You need an addition of a voluntary one [reporting system] where people can report things, share this information with others in their own institution and elsewhere so people can learn from them how to make their own system safer [V653-661].
302B	04.00 VolRpt	A similar system of “incentivised, voluntary reporting” should be developed in healthcare (W413-414). A healthcare provider who voluntarily reports a mishap should not automatically be subjected to a disciplinary process that becomes a permanent part of his/her licensure file and a matter of public record (W414-416).
416W	04.26 VolRpt / Peer Prot	... I have some suggestions that may promote patient safety in community health settings. [W7-8] 6. Establish an 800# for anonymous tips re: patient safety/problems. [W24]
5020	04.02 VolRpt / Meas Crit.	I would think that you should recommend that State Government take an active and proactive role in doing something on an ongoing basis and not just have you submit the report, like the Institute of Medicine, but that out of your work come an ongoing instrumentality that will and set up some kind of structure for both the voluntary reporting and the ultimate mandatory reporting and publicly available information that I think we're going to really need if we're going to achieve the actual outcomes we want and deal with the question of confidence. [O 258-271] ... it would be useful for this Commission to not get sucked into the issue that it's all one or all the other. [O 149-151] ... this Commission should ... look at the Institute of Medicine report, see what is the mix of required mandatory versus voluntary. [O203-206] [cont] [Recommendation cont] [From Q and A period:] [T]here is a benefit of having some kind of governmentally sponsored – not necessarily a State agency, ... but some kind of standardized method so that we could have a common arrangement by which we look at these things. [O 337-342]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
608W	04.00 VolRpt	The State of Michigan should develop a reporting system to collect and use medical errors and near misses data for the purpose of cultivating and sharing contributing factors to prevent and reduce future patient harm. This repository of data would become central to decision making for future patient safety initiatives. The data would identify areas where system changes need to occur and where human behavior may need modification. [W124-129] A <u>voluntary system of reporting errors</u> to a central repository that provides anonymity and peer/professional review protection for the reporter may permit broad sharing and learning to prevent repeat errors. [W40-42]
608W	04.30 VolRpt / Cons Adv	Consumers (patients) need to be involved in this reporting process [to develop a voluntary system of reporting errors to a central repository [W40]]---they need a mechanism to report errors and near misses that reach/impact them, and they need methods to learn from the lessons as they are central to preventing harm and errors. [W159-163]
608W	04.23 VolRpt / InfoTech	The technology that would be required for this type of voluntary reporting system [that reports errors to a central repository [W40]] is a web based data reporting system as well as an anonymous phone reporting process. The technology or process that is utilized needs to meet the various mechanisms of the users and their various technological capabilities. [W165-170]
608W	04.10 VolRpt / Resources	The initial funding [to develop a voluntary system of reporting errors to a central repository [W40]] should support the development of a white paper that outlines the necessary aspects and issues that must be considered to create a statewide mechanism for identifying medical errors and using this information for the purpose of improving patient safety. [W172-177]
804B	04.00 VolRpt	We are aware that Michigan policy makers also struggle with the issue and related questions have arisen among Michigan legislators. MSIC members believe they can assist the Commission as the issue develops in the near future. <u>The ultimate goal being to identify measures that provide meaningful information for consumers on a voluntary rather than mandatory basis.</u> [W267-271]. MSIC would be pleased to offer the Commission a number of areas that we can support this activity, including advocacy, public reporting of health care associated infections is certainly on the horizon and we would be happy to help the Commission with that [V3262-3270]. [Coder's note - this is not strongly worded as recommendations go - and this, may not, truly be a recommendation]
806B	04.00 VolRpt	Voluntary reporting of medical treatment and medication errors made when health services are provided to students in schools to the Michigan Department of Community Health and the Michigan Department of Education.(W243-245).
807B	04.00 VolRpt	Michigan ICPs hope our support for public, voluntary disclosure of HALs will obviate the need for mandatory reporting in Michigan.(W500-501). We hope that our support for public voluntary disclosure would obviate the need for mandatory reporting (O119-121).
808B	04.26 VolRpt / Peer Prot	And a voluntary reporting system also that would complement the mandatory reporting system to identify errors. The information from the voluntary reporting system must be obtained by an independent entity and used to identify patterns of errors. The data collected related to patient and patient safety must be protected (O 175-184). A clinical scientist and health services expert and experienced individual should be seated on the voluntary – on this reporting committee. (O 189-191). Further recommendation to extend peer review protection to data related to patient safety and quality improvement gathered through voluntary reporting system.(W 336-338).
826W	04.00 VolRpt	We strongly endorse the recommendations for a voluntary reporting system (W 144-145). The MSA also endorses the ASA's support of national legislation, which would establish the basis for a national voluntary medical error reporting system (W34-36).
826W	04.25 VolRpt / Legis	On the legislative front, there were two bills introduced at the federal level last year, S. 720 (The Patient Safety and Quality Improvement Act) and a companion bill HR 663 that would improve patient safety and reduce medical errors. 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. A key feature of the bills is the inclusion of provisions designed to assure that reported data could not be discovered while, at the same time, not limiting the availability of information under other laws.(W 170-179). In the State of Michigan, a similar endeavor was discussed at the Michigan State Medical Society's State Legislative & Regulations Committee meeting. (W 181-182). The MSA encourages the MH&SC to support the adoption of these laws, since they would offer a new dimension to the ASA's existing closed-claims study program.(W 187-188).

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906W	04.27 VolRpt / Advocacy	A voluntary, non-punitive reporting environment has been a critical component of the aviation industry success story, and we need similar environmental protections in healthcare. We suggest that the role of state governments ought to be supportive of a national agenda for voluntary healthcare reporting systems, aligned at a federal level, so that care providers throughout the country can learn from each other, much as the aviation industry does. [W 117-121] The first dimension [to the work that lies ahead] could be described as building capacity for quality and patient safety [underlining in original]. That includes training health care providers and further training the research community who could lead these efforts. We must also build a body of evidence to support the wholesale transformation of the industry. [cont][Recommendation cont col] Building capacity includes development of a non-punitive reporting system so we can learn where mistakes are happening, where patients are at greatest risk of harm. That knowledge will provide a platform for the second dimension of progress [development of clear national patient safety goals and implementation of related measures]. [W 159-164]
Code 05: Share Info		
1030	05.10 ShareInfo / Resources	Just to study the events [i.e., very detailed root cause analysis, O 73-74] and come to appropriate conclusions requires significant resources, as well. [O 68-70] And perhaps something that the State could assist with to develop some expertise, expertise to help organizations study their events truly come to appropriate conclusions and good solutions. [O 90-93]
106B	05.17 ShareInfo / HuDesign	In order to improve patient safety we must learn from errors and near misses. The knowledge that is generated from errors requires that the <u>errors and near misses must be analyzed</u> for system defects, and <u>human factors that contribute to the occurrence of the events</u> . [W 36-38] The State of Michigan has an historic opportunity to make good out of bad, to learn from mistakes, to design safety into care processes and to continue its' tradition of progressive innovative care improvement opportunities. The State could create an event reporting system based upon the experience of reporting systems like NASA's Aviation Safety Reporting System, Trinity Health's event reporting system, and The Veteran Administration reporting system for all hospitals to contribute to and learn from. The system could capture de-identified data that could be analyzed for system related failures. The identification of root causes of problems with the systems of care could provide the basis for identification of and implementation of solutions to avert similar future adverse events. The public should be informed as providers implement the solutions. As solutions are implemented and fewer events occur patients benefit, providers benefit and the State benefits. [W 59-68] I think it's a great opportunity for us to create a warehouse of data at a state level to learn and from all ... 136 hospitals across the state. What a great learning lab. But you have to make it safe environment for people to report. [O 283-292] ... I think there's a great opportunity to create even at a state level by some state organization that is not tied to the regulation an opportunity to learn about these events. [O 271-274]
106B	05.19 ShareInfo / FacDesign	In order to improve patient safety we must learn from errors and near misses. The knowledge that is generated from errors requires that the <u>errors and near misses must be analyzed for system defects</u> , and <u>human factors that contribute to the occurrence of the events</u> . [W 36-38] The State of Michigan has an historic opportunity to make good out of bad, to learn from mistakes, to design safety into care processes and to continue its' tradition of progressive innovative care improvement opportunities. The State could create an event reporting system based upon the experience of reporting systems like NASA's Aviation Safety Reporting System, Trinity Health's event reporting system, and The Veteran Administration reporting system for all hospitals to contribute to and learn from. The system could capture de-identified data that could be analyzed for system related failures. The identification of root causes of problems with the systems of care could provide the basis for identification of and implementation of solutions to avert similar future adverse events. The public should be informed as providers implement the solutions. As solutions are implemented and fewer events occur patients benefit, providers benefit and the State benefits. [W 59-68] I think it's a great opportunity for us to create a warehouse of data at a state level to learn and from all ... 136 hospitals across the state. What a great learning lab. But you have to make it safe environment for people to report. [O 283-292] ... I think there's a great opportunity to create even at a state level by some state organization that is not tied to the regulation an opportunity to learn about these events. [O 271-274]
204B	05.11 ShareInfo / GuidePrin	Seventh, identify trends or other significant opportunities to make care safer and share that information in a meaningful way with potentially similar impacted practitioners or institutions (W91-94).
204B	5.00 ShareInfo	Disseminate successes [of patient safety demonstration projects] to others in the provider community (W136-137).

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205B	05.00 ShareInfo	<u>Establish a state voluntary reporting system of de-identified reports from Michigan health care facilities</u> that could be aggregated at the state level, <u>and lessons learned would be shared with all Michigan health care institutions</u> [W173-175]. Mandatory systems don't really get you where you want to go, and accountability systems don't. <u>You need an addition of a voluntary one where people can report things, share this information with others in their own institution and elsewhere so people can learn from them how to make their own system safer</u> [V653-661].
212W	05.00 ShareInfo	Additionally, transparency across organizations is critical to identify persistent safety issues that require more intensive analysis and/or a broader-based response. [W124-125]
Code 06: Regulation of Organizations		
106B	06.11 OrgReg / GuidePrin	We would echo Dr. Bagian's comments that all reporting is voluntary, and we have to make it safe for people to do that type of reporting [voluntary reporting], to tell the stories. The Commission should be holding healthcare organizations accountable to take action upon the stories [told through voluntary reporting]. [O 149-151] The Commission should be asking organizations not what problems that they have had but what solutions they have generated. What solutions are now present? [O 61-64] A focus should be on that [what type of solutions are being effective and utilized]. [O 69]
213W	06.26 OrgReg / PeerProtect	I will argue in my testimony that developing a "culture of safety" in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 6. St. John Health is implementing a training program for physicians about disclosure of unanticipated outcomes. We believe that full disclosure is the right thing. Partnering with our patients by fully disclosing errors, apologizing, offering fair compensation when appropriate, and sharing ways to improve processes so that the error will not occur again, should decrease the litigious environment in Michigan. The State Commission on Patient Safety should support changes to facilitate the changes in our legal and licensing systems. [W 175-183] [I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to "near misses," where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why and an error occurred, and take steps to avoid the error in the future. [W 128-133]
Code 07: Professional Licensure		
204B	07.13 ProfLic / EdP	In the short term, a patient safety continuing education requirement for all Michigan licensed healthcare professionals should be mandatory as part of the continuing medical education requirement for licensure as has become practice for some other states (e.g. Florida) (W100-103). ...one of the thoughts that comes to mind, whether it would be talking about physicians, pharmacists, or any other type of licensed individual in the state of Michigan providing healthcare services. I would think that in terms of granting those licenses, there should be some type of required safety education, at least on an annual basis. This is something which is present in a number of other states that I'm aware of, and I think this would be something that would be of benefit (O55-65). While I opined that healthcare students providers should all have some continuing educational requirement for patient safety (including systems theory), in my opinion, this should expand to include individuals who serve on healthcare facility boards and to individuals employed by the state in healthcare regulatory capacities (O177-181). The courses could be either stand-alone, in conjunction with other scientific educational sessions conducted by the relevant professional state association, or through an on-line tutorial course. The course content should be standardized by license type and approved by the licensing board (W103-106).
213W	07.26 ProfLic / PeerProtect	I will argue in my testimony that developing a "culture of safety" in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] . 7. St. John Health is implementing a training program for physicians about disclosure of unanticipated outcomes. We believe that full disclosure is the right thing. Partnering with our patients by fully disclosing errors, apologizing, offering fair compensation when appropriate, and sharing ways to improve processes so that the error will not occur again, should decrease the litigious environment in Michigan. The State Commission on Patient Safety should support changes to facilitate the changes in our legal and licensing systems. [W 175-183] [I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to "near misses," where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why and an error occurred, and take steps to avoid the error in the future. [W 128-133]
302B	07.25 ProfLic / Legis	The licensing boards in Michigan should be given the flexibility to use non-disciplinary approaches to deal with practitioners involved in medication errors (W404-406,O130-133). The structure should be reviewed and modified as necessary and appropriate to ensure boards can effectively discharge their responsibilities (O141-143).

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812B	07.25 ProfLic / Legis	Registered dietitians seek to improve the health and safety of Michigan residents by providing Medical Nutrition Therapy.(W135-136) Licensing registered dietitians can be an important step in protecting patients in Michigan.(W217-218).
829W	07.00 ProfLic	As the Michigan Chapter of the American College of Radiology, we are very concerned with the use of ionizing radiation and believe that those operating the equipment should be licensed technologists and that the physicians overseeing the use of ionizing radiation must have documented training in radiation safety (W30-33).
Code 08: Performance Benchmarks		
105B	08.03 PerfBench / MandRpt	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Secondly, mandatory nonpunitive reporting systems. This should be instituted for errors and near misses occurring in healthcare. We must create a learning environment so that care providers are not operating in a vacuum, unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, I would suggest these results be made public by organization [written: "should be publicly made available"] so that informed decisions can be made as to where people choose [want replaces choose in written] to receive their healthcare. We should be able to benchmark our results on a multitude of measures, including [oral: "patient" added] falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates and other patient satisfaction measures [last phrase in written "and general patient satisfaction with pain control to name a few"]. If we measure it, we can [written: "better"] understand it and then improve – create (written: "implement" replaces "improve – create") solutions to improve it. [O 220-240; W 123-132]
110W	08.00 PerfBench	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W55-56] Assist to bring other commercial industry techniques to healthcare processes for benchmarking purposes. [W76-77]
204B	08.09 PerfBench / Incent	Align incentives for practicing evidence-based clinical guidelines through all payors – creating "centers of excellence" in disease management or recommended preventive care with financial incentives for performance. These incentives must represent longitudinal performance, not annual, with demonstrated compliance over time (W129-132).
2060	08.01 PerfBench / StateFocal	...but my challenge to you is to somehow mandate, ask you to mandate that we assess learning, because if we don't assess learning and document it, how will we verify patient and family understanding so that there can be follow-up at home, whether it be on medication, administration, wound care, injections, whatever, because one must never assume that something taught is something learned (079-86).
2060	08.18 PerfBench / Staffing	From a safety perspective, I believe patients in emergency room holding should not have their care on hold, that the staffing should not compromise their well-being because an ICU bed or a step-down bed or a regular medical bed is not available. I think that from a perspective of ER holding that the staff should see these patients as high acuity and render the appropriate care. And once again, because a patient is in holding doesn't mean their care should be in holding (066-75).
218W	08.00 PerfBench	My goal in providing this written testimony is to encourage other Michigan clinical leaders to develop patient safety programs at their own hospitals by providing one approach for such an endeavor.(W 78-80).
819B	08.16 PerfBench / Team	MHHA recommends that the Commission give consideration to methods to improve communication along the full continuum of care from patient entry into the system through return to the community, particularly as related to specific medication orders and patient history of such conditions as MRSA (Methotrexate Resistance Staphylococcus Aureus) (W31-35).
Code 09: Incentives		
1030	09.23 Incent / InfoTech	New and improved technologies absolutely have to be part of the patient safety solution. My – some of the things that I'm most enthusiastic about in terms of potential to reduce clinical errors would be the electronic medical record and physician computerized order entry for medications. [O 47-52] Any incentives or assistance that can be provided to both healthcare organizations and individual practitioners to implement these technologies I think would be very valuable. [O 64-67]
105B	09.18 Incent / Staffing	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Recommendations [from Executive Summary]: Incentives should be created for hospitals to achieve Magnet recognition. [W 182, 187] And lastly, nurse staffing and nursing vacancy rates. In addition, expecting and supporting hospitals to create positive working environments consistent with magnet standards will go a long way in both attracting and keeping smart bright nurses at the bedside as well as improving patient outcomes and decreasing harm and mortalities. [O 251-264; W 142-145]

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110W	09.00 Incent	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Provide incentives to the <i>physicians</i> for achievement of the patient outcomes. [W 69]
204B	09.08 Incent / PerfBench	Align incentives for practicing evidence-based clinical guidelines through all payors – creating “centers of excellence” in disease management or recommended preventive care with financial incentives for performance. These incentives must represent longitudinal performance, not annual, with demonstrated compliance over time (W129-132).
204B	09.23 Incent / InfoTech	Communication with other practitioners. The investment in clinical information systems must increase with incentives for small and medium sized practices to invest in this technology. [W120-122]
212W	09.15 Incent / Collab	<u>The state could provide financial incentives to organizations who design “safe” facilities and who implement meaningful patient safety programs and support “evidence-based” collaboratives.</u> [W259-261]
212W	09.17 Incent / Human Design	<u>The state could provide financial incentives to organizations who design “safe” facilities and who implement meaningful patient safety programs and support “evidence-based” collaboratives.</u> [W259-261]
212W	09.19 Incent / Facility Design	<u>The state could provide financial incentives to organizations who design “safe” facilities and who implement meaningful patient safety programs and support “evidence-based” collaboratives.</u> [W259-261]
212W	09.22 Incent / MedPrac	With regard to safe medication practices, we (HFH) support the following National Quality Forum practices: - Active participation by Pharmacists in the medication-use process; - Dispensing medication in unit-dose or unit-of-use form [W270-275] <u>The state could offer incentives/funding for organizations to utilize more Pharmacists on patient care units.</u> [W276-278]
305W	09.25 Incent / Legis	Therefore, the second recommendation to the Commission is to suggest to the Governor that legislation be enacted to offer a financial incentive to hospitals that seek and retain ANCC magnet recognition. (W161-163).
416W	09.18 Incent / Staffing	... I have some suggestions that may promote patient safety in community health settings. [W7-8] 2. Allow more flexibility with nursing staff schedules, including shorter shifts, and bonus/incentive programs to obtain their own coverage among staff. [W14-15]
501W	09.00 Incent	Michigan should take immediate action to: [W 49-50] Revise payment mechanisms to align incentives [Bolded in text]: Private and publicly financed health plans and reimbursement arrangements should be revised to reward high performing providers and encourage the citizens of Michigan to use the best care givers and treatments. [W 59-61] Public and private purchasers and health plans should revise their provider payment and benefit designs to promote improvement and reward providers who document that they are doing the best job based on publicly reported performance measures. [W 131-133] In addition to direct financial incentives, Michigan should develop a public recognition program for high performing providers. Beneficiaries in public and private programs should also be engaged by crafting appropriate incentives for them to use the best providers and treatments. [W 140-142]
605B	09.23 Incent / InfoTech	<u>We encourage the State of Michigan to consider providing public incentives</u> to promote adoption of electronic prescribing, to supplement incentives provided by third-party payers (i.e., reimbursement for utilization of electronic prescribing or for the information processed (Relative Value Units - RVUs), pay for performance programs, defrayed costs, per-Rx fees). P4/5 L43-6
606W	09.00 Incent	CALL TO ACTION HAP has pledged to implement programs of this type – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Employ incentives.</u> Reward delivery systems that make substantial performance improvements in quality and safety. [W273-274]
828W	09.25 Incent / Legis	Any regulation or legislation considered must be developed in the spirit of reward for improvement and not punishment.(W 116-119).

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906W	09.28 Incent / SafeStand	States such as Michigan need to use their voice to help raise the volume on the urgency of a national, goal-directed, funded agenda for quality and patient safety. [W 106-107] A second dimension [to the work that lies ahead] is to develop ... clear national patient safety goals and implement measures for those goals [highlighted words underlined in original]. As an industry, both at a national level and at an institutional level, we don't have a really clear idea of what it means to be safer, and we need to. Included broadly in this second dimension is <u>alignment of payment for care</u> [underlined in original]. If we establish goals for quality and safety, that is what we should pay for. <u>When the goals and national priorities are clear, and payment is aligned with performance measured against those goals, institution and provider specific, public reporting of performance in relation to the goals should be a requirement of licensure</u> [words "institution" through "licensure" underlined in original]. [W 166-172]
Code 10: Resources		
1030	10.05 Resources / ShareInfo	Just to study the events [i.e., very detailed root cause analysis, O 73-74] and come to appropriate conclusions requires significant resources, as well. [O 68-70] And perhaps something that the State could assist with to develop some expertise, expertise to help organizations study their events truly come to appropriate conclusions and good solutions. [O 90-93]
1030	10.23 Resources / InfoTech	New and improved technologies absolutely have to be part of the patient safety solution. My -- some of the things that I'm most enthusiastic about in terms of potential to reduce clinical errors would be the electronic medical record and physician computerized order entry for medications. [O 47-52] Any incentives or assistance that can be provided to both healthcare organizations and individual practitioners to implement these technologies I think would be very valuable. [O 64-67]
1040	10.23 Resources / InfoTech	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O 9-13] The biggest improvement that's going to be made in patient safety is through technology. Bar coding, electronic medical records, computer order entry are currently out there and organizations need to somehow find the dollars to adopt them. [O 113-117]
105B	10.18 Resources / Staffing	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] And lastly, nurse staffing and nursing vacancy rates. We need to create partnerships between hospitals, colleges and universities to increase the numbers of young women and men entering the nursing profession. This will require increased funding for schools and scholarships. [O 251-258; W 140-142] Having an appropriate number of new registered nurses graduating from nursing programs is critical to providing a safe environment for patients. [O 205-208; W 110-112] The college has increased the number of positions in their nursing program, which, by the way they lose money on every nursing student that they take in. And so something the State can do is help the community colleges with these financial losses that they do. [O 328-336]
105B	10.23 Resources / InfoTech	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Funding. We need support in funding the electronic medical record. It cannot be understated that it takes [added oral: "literally"] millions of dollars to move forward with these systems. Let's call a spade a spade. Medicare [probably means Medicaid based on next sentence and written] funding is woefully inadequate in the state of Michigan. [Written states "Medicaid funding is pitiful."] Munson and other hospitals across the state lose millions of dollars every year caring for the Medicaid population. It is the state of Michigan's moral responsibility to adequately fund the care needed by this population. [O 241-250; W 134-138] The electronic medical record holds great promise and hospitals need help in funding those efforts. [CLICK ON BOX FOR FULL CONTENT] [O 127-129; W 71-72] Recommendations [from Executive Summary]: Increased funding is needed to support development of the electronic medical record [W 182, 186]
110W	10.00 Resources	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Help to subsidize the hospital data gathering efforts through reimbursement or subsidies. [W 70-71]
110W	10.24 Resources / ResEval	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Provide research grants and funding to continue to explore the impact of human factors theory on medical errors. [W 74-75]
110W	10.24 Resources / ResEval	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] <u>Advance research resources</u> , opportunities, and <u>funds</u> related to care models, nurse patient ratios, and human factors theory. [W 122-123] Professional societies and groups can help to reduce patient medical errors by assisting as advocates for healthcare patient safety efforts. These advocacy efforts include ongoing research to continue and provide correlations of acute care processes to patient outcomes, .. [W 79-80] Continued funding and resource assistance are necessary to expand research efforts. [W 90]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
204B	10.23 Resources / InfoTech	Communication with other practitioners. The investment in clinical information systems must increase with incentives for small and medium sized practices to invest in this technology (W 120-122).
204B	10.24 Resources / ResEval	Fund patient safety/risk reduction demonstration projects involving small to medium size practices or a collaborative of small to medium size practices (W134-135).
205B	10.11 Resources / GuidePrin	Encourage Chief Executive Officers of Michigan health systems to invest in patient safety organizational structure by committing human and fiscal resources to operationalize a robust patient safety program in their respective institutions (eg. patient safety manager/officer, medical director of safety, patient safety line item budget) [W168-172].
212W	10.00 Resources	Additionally, it is recommended that resources and funding be available at the state level to assist organizations with the implementation of safety programs. [W73-75]
212W	10.22 Resources / MedPrac	With regard to safe medication practices, we (HFH) support the following National Quality Forum practices: - Active participation by Pharmacists in the medication-use process; - Dispensing medication in unit-dose or unit-of-use form [W270-275] <u>The state could offer incentives/funding for organizations to utilize more Pharmacists on patient care units.</u> [W276-278]
213W	10.23 ResReq / InfoTech	I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term. ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 3. We implemented an on-line occurrence reporting system to help us more accurately track these trends. We are looking at instituting an Electronic Medical Record, and other technology to assist in reducing errors. This will be very expensive. Increased use of technology needs to be encouraged, and <u>some means of financial support needs to be provided, to encourage and assist healthcare organizations to implement this technology.</u> [W 154-160]
406B	10.27 Resources / Advocacy	It is through my testimony today that I request the Commission continue to advocate and identify funding, that allows older adults to remain safe and independent in their own homes for as long as possible [W123-125]
411W	10.25 Resources / Legis	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] 2.) Funding: In the past the legislature, mindful of the needs to maintain a stable work force has provided for a wage pass through to nursing home care givers. That pass through legislation must continue to be increased. [W129-131]
501W	10.29 Resources / PSRpt	FROM CONCERN/COMMENT COLUMN 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. [W 114-115] While we need to be sensitive to the added burden of reporting results, we cannot let that concern prevail over the need to measure quality to support informed choices of providers and promote dramatic improvements in care. [W 124-126]
605B	10.01 Resources / StateFocal	A challenge is ensuring the level and reliability of funding for the Centers. P2 L36-37
605B	10.23 Resources / InfoTech	In the experience of BCBSM and BCN, as health plans, we have developed several different approaches to improving patient safety in hospitals, physician offices, and community pharmacies, and other settings, and one of the biggest barriers to implementation of high technology tools is <u>cost</u> . And it goes beyond just the economic <u>cost</u> of implementing these tools P26-29. There is also a required need for a change in the culture of safety in these settings, as well as substantial training and re-engineering of clinical processes, which represent additional <u>costs</u> for providers P3, L30-31.
605B	10.23 Resources / InfoTech	<u>We encourage the State of Michigan to consider providing public incentives to promote adoption of electronic prescribing, to supplement incentives provided by third-party payers (i.e., reimbursement for utilization of electronic prescribing or for the information processed (Relative Value Units - RVUs), pay for performance programs, defrayed costs, per-Rx fees).</u> P4/5 L43-6
608W	10.04 Resources / VolRpt	The initial funding [to develop a voluntary system of reporting errors to a central repository [W40]] should support the development of a white paper that outlines the necessary aspects and issues that must be considered to create a statewide mechanism for identifying medical errors and using this information for the purpose of improving patient safety. [W172-177]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
806B	10.25 Resources / Legis	Encourage congress to establish a budget item for a health services consultant at the state level to develop and implement the plan.(W231-232).
8090	10.13 Resources / EdP	I would encourage the Commission to recommend promotion of the funding for education of nurses and nursing educators (O 86-88).
8110	10.00 Resources	FROM CONCERN/COMMENT COLUMN Our main concern, however, is any enactment of mandates that could have financial implications to our members.(O57-61). Our members are committed to protect the health and safety of the public we serve but we implore you when you make any decisions that you respect and try not to make it a financial burden to our practices.(O89-93).
815W	10.00 Resources	Insurance companies need to allow Physical Therapy for a longer period of time when patients have delirium when PT is first initiated.(W29-31).
821B	10.23 Resources / InfoTech	And unless the people who understand health care environments know that it costs money to provide bar codes, that's one of the significant issues that we are going to try to overcome (O46-48). I think those individuals who are not here today would have to provide that for the system because of their awareness of the importance of this, and that we are moving to a new system where it's not only qualitative in terms of new techniques, broader scope of service, but also quantitative (O56-59). We have to identify those individuals, and I think the system itself has to provide that (O64).
9030	10.23 Resources / InfoTech	[From Q and A period:] And I think consumers will want this [healthcare passport] if we make it available to them, but I think we need a boost from the State, we need a boost from the insurance companies. But we want to get us off the bottom. [O 711-714]
906W	10.00 Resources	FROM CONCERN/COMMENT COLUMN In the face of a rapidly aging population, a shrinking healthcare workforce, increasing complexity of care delivery and wholly inadequate healthcare financing, the need for a rapid, significant and sustained investment in learning what works, sharing what is learned, and aligning incentives for high quality, safe care has never been greater. [W 148-151]
906W	10.27 Resources / Advocacy	One of the important patient safety roles of state governments should be to be relentless in advocating for funding changes at the federal level, so that health systems and care providers can learn the most efficient and effective ways to improve quality and safety. These are complicated challenges. Expecting individual providers or individual states to achieve best care through local or regional trial and error is neither efficient nor effective. [W 25-30]
Code 11: Guiding Principles		
1030	11.00 GuidePrin	The patient safety culture is I believe fundamental to truly achieving the safe environment of care. And there is a long tradition of punitive response to clinical errors and adverse outcomes in healthcare. I think these issues have to be overcome by leadership, by education, and by an infrastructure of organizational policies that support a nonpunitive reporting of errors. Organizations absolutely must learn from these events. These events are inevitable. Human error is inevitable. And no system is going to be absolutely perfect and eliminate entirely errors and adverse events. It's absolutely essential that when these events occur people are comfortable to report them openly, to participate in very detailed in-depth root cause analysis of the underlying reasons for the event. I would like to suggest as one part of this that the medical-legal climate is a barrier to this open reporting and would urge that to be one focus of many. [O 22-46]
1040	11.00 GuidePrin	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O 9-13] I'd like to start first with the patient safety needs to be an organizational goal. [O 12-15] Organizations need to develop a culture of safety. [O 52-55] Part of this culture is a nonpunitive culture. That means that employees can report without having any penalties. They don't have to be fearful for their jobs, for themselves, or for their peers. It promotes reporting, and we usually find in our organization that this has truly increased those occurrence reporting and those near misses. This allows us to put our emphasis on systems and on processes and not on people. [O 67-75] We need to make - we need to say that the national patient safety goals makes sense. They're not just requirements out there. They make sense. We need to implement (the national patient safety goals) and we need to measure them to make sure that we keep 100 percent on all goals, that they're not just something because a regulatory agent has said we need to apply them. [O 167-173] We need to tell our stories. We use story-telling. We talk about "It Happens Here." [O 174-175] Finally, I'd like to close with three comments. Nothing changes until we change it. Safety is everyone's responsibility. And as clinicians and people working with patients, the first thing we learn is do no harm. [O 183-187]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
105B	11.03 GuidePrin / MandRpt	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Secondly, mandatory nonpunitive reporting systems. This should be instituted for errors and near misses occurring in healthcare. We must create a learning environment so that care providers are not operating in a vacuum, unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, I would suggest these results be made public by organization [written "should be publicly made available"] so that informed decisions can be made as to where people choose [want replaces choose in written] to receive their healthcare. We should be able to benchmark our results on a multitude of measures, including [oral: "patient" added] falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates and other patient satisfaction measures [last phrase in written: "and general patient satisfaction with pain control to name a few"]. If we measure it, we can [written: "better"] understand it and then improve – create (written: "implement" replaces "improve – create") solutions to improve it. [O 220-240; W 123-132] Creating a culture of patient safety is needed. This involves: Non-punitive error reporting[;] Follow-up on errors when they happen[;] Making system changes so errors are not repeated [W 160-163]
106B	11.00 GuidePrin	We would echo Dr. Bagian's comments that all reporting is voluntary, and we have to make it safe for people to do that type of reporting [voluntary reporting], to tell the stories. [O 146-149] We have found that people want to tell us what is going on but they must have it safe. [O 117-118] It's [error reporting is] more about the culture than the economic cost. [O 164-165] It's the culture. It's how do you create an environment where the people that work in it day in, day out, are willing to say I think this went wrong. Here's another interesting fact. Most of our reports are self-identified reports. In other words, it's Paul talking about what Paul's experience of what he did or almost did in his role and participation in an error. What we are finding is that this whole system that we have had in the past of human vigilance of watching for mistakes doesn't work and we have to develop systems in place to make that obsolete, and that's what we're talking about. We want to create an environment where it's safer – we want to create an environment where people feel safe to report but they also see the benefit of that reporting. Benefit is we are implementing systems that make it safer for them to do their job. [O 172-191] And here's the other important point: We are celebrating the fact that our reports are going up. That's a cultural issue and sometimes it's hard for people to understand. But if you don't celebrate that you've got an open environment to hear more about the events, and this what I'm deeply concerned about mandatory reporting, if we're going to go out there and say look at all these bad things that occurred at St. Elsewhere Hospital, if we do that we're going to drive our reporting underground. [O 243-253]
106B	11.06 GuidePrin / OrgReg	We would echo Dr. Bagian's comments that all reporting is voluntary, and we have to make it safe for people to do that type of reporting [voluntary reporting], to tell the stories. The Commission should be holding healthcare organizations accountable to take action upon the stories [told through voluntary reporting]. [O 149-151] The Commission should be asking organizations not what problems that they have had but what solutions they have generated. What solutions are now present? [O 61-64] A focus should be on that [what type of solutions are being effective and utilized]. [O 69]
204B	11.00 GuidePrin	Create a statewide culture of safety (W70).
204B	11.00 GuidePrin	First, the Commission should establish a definition of patient safety that health care practitioners willingly embrace (W70-71).
204B	11.05 GuidePrin / ShareInfo	Seventh, identify trends or other significant opportunities to make care safer and share that information in a meaningful way with potentially similar impacted practitioners or institutions (W91-94).
204B	11.00 GuidePrin	Eighth, publicly celebrate identified safety improvement ideas generated.
204B	11.13 GuidePrin / EdP Used in EdP	Second, in conjunction with safety experts, healthcare leaders, and frontline practitioners, identify patient safety issues and develop a priority index relevant to each aspect of care in the clinical continuum: hospital, ambulatory clinic or office, nursing home, pharmacy, etc. Third, identify the practitioner type involved in the priority index. Fourth, develop and implement a communications plan to make practitioners aware of the index and the rationale behind it. Fifth, develop effective education curricula or modules addressing each element in the priority index. (W76-83).

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Verbatim Recommendations from Testimony with Original Coding

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204B	11.26 GuidePrin / PeerProtect Used in PeerProtect	Sixth, re-design the professional peer review process to make it safe to conduct substantive review without casting aspersions (W83-84).
205B	11.00 GuidePrin	<u>Encourage Chief Executive Officers of Michigan health systems to invest in patient safety organizational structure by committing human and fiscal resources to operationalize a robust patient safety program in their respective institutions</u> (eg. patient safety manager/officer, medical director of safety, patient safety line item budget) [W168-172].
205B	11.10 GuidePrin / Resources	Encourage Chief Executive Officers of Michigan health systems to invest in patient safety organizational structure by committing human and fiscal resources to operationalize a robust patient safety program in their respective institutions (eg. patient safety manager/officer, medical director of safety, patient safety line item budget) [W168-172].
213W	11.00 GuidePrin	I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 1. As in most hospitals, Providence has a process in place, where all serious errors are reviewed. The focus of this team is not to place blame, but to look at all factors to discover the “root causes” of the error. The leader of this team begins by explaining this to the involved individuals, to encourage their participation and honest sharing of information. This attitude needs to be adopted across the state. [W 138-144] We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future. [W 131-133]
213W	11.00 GuidePrin	I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 2. We have various multidisciplinary patient safety committees that I facilitate, or participate in. During these meetings, we review all errors, and near misses related to medication [assume medication] use, and patient identification. We identify trends, and develop action plans to deal with them, and the information is filtered up to our governing board. <u>All healthcare organizations need to share this kind of information with their governing boards.</u> Additionally, the fact that these processes exist needs to be shared with the public. [W 145-153] 4. <u>Healthcare organizations need to continue to focus on developing “just” cultures,</u> and do a better job of communicating and educating the public. [W 165-167] You may have heard the term “blame-free” culture used. This is not an appropriate phrase to use, since it implies that there is no accountability. The overwhelming majority of healthcare workers do not come to work to harm or injure a patient. In rare instances, an individual may cause harm to a patient due to gross negligence, or criminal actions. In these cases, blame is appropriate and necessary. However, in the majority of cases, medical errors are not totally due to an individual’s error. There is frequently a system or process component that contributes to the error. The better term to use would be “just” culture ... [W 116-123] Effective change is never easy, and in order to continue to provide safer care to the patients we serve, we need to cultivate a “just” culture across our state. [W 201-202] [I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to “near misses,” where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future. [W 128-133] 7. Performance improvement (PI) processes such as Six Sigma, LEAN, Failure Mode Effects Analysis (FMEA), and traditional PI tools are being integrated throughout the organization. We are seeing positive results from the use of these processes, and are beginning to see a change in our culture. Encourage healthcare organizations to integrate business improvement strategies that have proven successful in other businesses. [W 184-190] 8. Encourage all healthcare organizations to assess their baseline culture to identify what changes are necessary. [W 197-199]
302B	11.01 GuidePrin / StateFocal	We must change the culture surrounding healthcare regulation in Michigan to recognize that “to err is human.” At the present time, our system is punitive (W399-400). First, as you’ve heard from others, we have to change the culture to recognize the fact that to err is human.(O 112-114)
3030	11.00 GuidePrin	...respect for patients, families, nurses and all healthcare workers must be so fundamental that jobs and hospital privileges are at risk if standards are not met (O171-174).

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
605B	11.00 GuidePrin	[For] (implementation of high technology tools) There is also <u>a required need for a change in the culture of safety in these settings</u> (hospitals, physician offices, and community pharmacies, and other settings), as well as substantial training and re-engineering of clinical processes, which represent additional costs for providers P3, L30-31
606W	11.00 GuidePrin	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type [that support and promote bedrock principles of patient safety; W27] – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Refocus on specific quality “leaps.”</u> ... Therefore, HAP urges a renewed focus on specific, discrete improvements in quality and safety designed to yield the largest safety gains. These include:... [W249-252] b. Evidence-based hospital referral, in which elective treatment is guided by referrals to hospitals and clinical teams with superior outcomes and/or procedures linked with minimum patient volumes [W257-259]
606W	11.00 GuidePrin	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Leverage purchasing power.</u> [W279]
606W	11.18 GuidePrin / Staffing	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type [that support and promote bedrock principles of patient safety; W27] – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Refocus on specific quality “leaps.”</u> ... Therefore, HAP urges a renewed focus on specific, discrete improvements in quality and safety designed to yield the largest safety gains. These include:... [W249-252] c. ICU physician staffing, in which hospital intensive care units are managed by physicians certified in critical care medicine [W260-261]
606W	11.22 GuidePrin / MedPrac	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type [that support and promote bedrock principles of patient safety; W27] – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Refocus on specific quality “leaps.”</u> ... Therefore, HAP urges a renewed focus on specific, discrete improvements in quality and safety designed to yield the largest safety gains. These include: [W249-252] a. CPOE implementation, in which physicians enter prescriptions and treatments into a computer rather than manual transcription. An alignment of government, health plans, coalitions and purchasers to implement CPOE by 2007-2008 in high-volume hospitals would have a huge impact on quality care and patient safety. [W253-256]
608W	11.00 GuidePrin	To that end, [to prevent future harm [W32]] we need to develop a process that would not only encourage reporting of medical errors but would enhance the reporters comfort in reporting. A process that creates further fear of retribution is useless. An environment that encourages reporting of medical errors, whether facility specific, state wide or national basis should be created in the spirit of a <u>“just culture”</u> . (A just culture is a shared understanding of how the acceptability of individual behavior is to be determined and how accountability/culpability is evaluated. Ultimately a just culture is shared accountability.) [W32-39]
807B	11.00 GuidePrin	I am submitting in written testimony today with references to illustrate that the promotion of a safety culture in healthcare facilities, regular feedback of our findings from the surveillance, education of direct care providers on practices to prevent infection, and organizational leadership support all can be brought to bear in enhancing patient safety. (O 60-69).
816W	11.00 GuidePrin	A culture of safety must be developed in which mental health providers can provide data about psychiatric/psychological medical errors (W 72-74).

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
827W	11.00 GuidePrin	Patient safety should be a multi-faceted concept, including participation with patients, their families, health care providers, third party payers, government agencies, employers, and consumer groups, that is embraced before an individual enters the health care system and then followed throughout the system with them (W70-73). Creating a culture of safety goes beyond implementing an organizational concept. It should entail prevention before entry into the health care system and follow-up after hospitalization. Organizations should develop meaningful patient safety programs that actively involve patients, their families, and staff before, during, and after the need for hospitalization (W80-84). Patient safety training should be required as part of an organizations annual staff competency program. This will foster an environment that emphasizes the importance of patient safety. Part of this type of program should provide an opportunity for patients to comment on safety issues. This information can be used to improve the patient safety program as needed (W101-105).
828W	11.01 GuidePrin / StateFocal Considered with StateFocal	State governments should, in every case, support patient safety and work to bring national consensus on the targets and reporting methods (W 116-117).
828W	11.25 GuidePrin / Legis	Regulation and legislation must support collaborative approaches among hospitals, physicians, hospital employees, and health plans to stimulate and improve patient safety and must be non-punitive(W 96-98).
830W	11.01 GuidePrin / StateFocal	We urge the State Commission on Patient Safety to give significant attention to the multitude of patient safety concerns faced by the state's approximately 40,000 nursing home residents (W23-25). We therefore urge the Commission to pay careful attention to the plethora of urgent patient safety issues facing the state's vulnerable nursing home residents and to make recommendations for addressing these shameful and unnecessary conditions (W106-110).
901W	11.00 GuidePrin	The Commission is encouraged to; [...] ignore the nay-sayers who claim Healthcare improvements can not be successful because of legal or insurance issues ... [W 212-214]
906W	11.01 GuidePrin / StateFocal	The science of safety can be summarized in four points: (1) We will make mistakes. (2) We need to create a culture where mistakes are identified. (3) To maximize learning we must focus on systems rather than people. (4) Leaders control the potential to change systems. State leadership is needed to create an environment where clinicians can learn from mistakes. [W 133-136] There are two goals for safety education. One is to have caregivers become comfortable saying "I'm fallible. I'm going to make mistakes. That's just part of the human condition." Having acknowledged that, we need to strive to make our care harm-free rather error-free. The second is to get them to understand the idea of systems. [W 138-141]
906W	11.23 GuidePrin / InfoTech	By far the most cost-effective opportunity to improve care in this country is not from discovering new therapies but in learning how to deliver those therapies that we know work safely and cost-effectively. We need a more balanced health care research portfolio, to help with those efforts. We know, through research on organizational behaviors, that we need to focus on "systems" to truly impact change. [W 46-50] The third dimension [to the work that lies ahead] is improving communication, which is at the core of culture change. IT infrastructure including an electronic medical record is part of that because it is not a tool to just help link us better, but a tool that has to be coupled with culture change and enhancing our ability to work together as human beings. The transparency needed to create a seamless system of care cannot be accomplished without standardizationof IT [W 174-178] [Targets indicated in strategy: e.g.,] why we went into the healing profession to begin with [W 62-63]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
906W	11.24 GuidePrin / ResEval	<p>By far the most cost-effective opportunity to improve care in this country is not from discovering new therapies but in learning how to deliver those therapies that we know work safely and cost-effectively. We need a more balanced health care research portfolio, to help with those efforts. We know, through research on organizational behaviors, that we need to focus on “systems” to truly impact change. [W 46-50]</p> <p>And to get leverage for changing that [culture of health care], to get stickiness for changing our systems of work and relationships, we’re going to need to begin to understand how we can possibly create the culture that we need to ensure, to the maximum extent possible, safety and quality of care. [W 56-69]</p> <p>[T]here are three bold dimensions to the work that lies ahead. The first dimension could be described as <u>building capacity for quality and patient safety</u> [underline in original]. That includes training health care providers and further training the research community who could lead these efforts.</p> <p>We must also build a body of evidence to support the wholesale transformation of the industry. Building capacity includes development of a non-punitive reporting system so we can learn where mistakes are happening, where patients are at greatest risk of harm. That knowledge will provide a platform for the second dimension of progress [development of clear national patient safety goals and implementation of related measures]. [W 159-164]</p> <p>[Targets indicated in strategy: e.g.,] why we went into the healing profession to begin with [W 62-63]</p>
Code 12: Leadership		
1030	12.00 Ldrship	<p>The patient safety culture is I believe fundamental to truly achieving the safe environment of care. And there is a long tradition of punitive response to clinical errors and adverse outcomes in healthcare. I think these issues [patient safety culture and tradition of punitive response to clinical errors and adverse outcomes] have to be overcome by leadership, by education, and by an infrastructure of organizational policies that support a nonpunitive reporting of errors. Organizations absolutely must learn from these events. These events are inevitable. Human error is inevitable. And no system is going to be absolutely perfect and eliminate entirely errors and adverse events. [O 22-37]</p>
1040	12.00 Ldrship	<p>I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O 9-13] Leadership is the key for the organization to move towards a culture of safety. The direction for the patient safety begins with the board and begins with the president, the CEO, the COO, and the top leadership group. [O 32-36]</p> <p>The president needs to be the leader of the Patient Safety Committee. This gives the organization the message that patient safety is the number one priority. [O 48-51]</p> <p>An active Patient Safety Committee can be the pulse for the organization for patient safety success. We have employees and managers at all levels in the organization as part of our Patient Safety Committee, which is led by the president. Data and measurement drive the agenda. They have reviewed the occurrences, they look at near misses, they look at the actions, and they make recommendations. They give the direction to the organization, the people down in the ranks who know what's going on about what needs to be done and what resources need to be provided to the organization. [O 99-112]</p>
807B	12.00 Ldrship	<p>I am submitting in written testimony today with references to illustrate that the promotion of a safety culture in healthcare facilities, regular feedback of our findings from the surveillance, education of direct care providers on practices to prevent infection, and organizational leadership support all can be brought to bear in enhancing patient safety. (O 60-69).</p>
906W	12.27 Ldrship / Advocacy	<p>Michigan has a strong tradition of voluntary hospital reporting, a leadership track record for collaboration ... , an enviable assembly of healthcare stakeholders that are members of the Michigan Health and Safety Coalition, and a major insurer (Blue Cross Blue Shield of Michigan) with a progressive vision of how to support quality and safety improvements. That combination of forces with a shared vision could position the state to aggressively innovate and add to the body of knowledge necessary to demonstrate definitively, year after year, that healthcare is indeed safer. ... We encourage the patient safety commission to recommend this level of state leadership. [W 230-241]</p> <p>An overarching opportunity is for states like Michigan to call for and support coordinated leadership from all of these different major stakeholders [Fed, State (incl licensing), health professional ed, health care delivery systems, practitioners – see W 198-203] rather than developing one more unique, state specific set of expectations for healthcare quality and safety. [W 211-213]</p> <p>Leadership for reform, then, really needs to come from several different sources. In Crossing the Quality Chasm the IOM called for fundamental change at many different levels. We need to see change at the Federal level and we also need change at the state level. We need change in the health profession education, training and licensure. We also need change in the healthcare delivery system at the community level and the local level and in the micro-systems of care: individual care units in hospitals, physician’s offices, clinics etc. [W 198-203]</p>
419W	12.00 Ldrship	<p>Another critical factor to improving patient safety is to allow for health care workers to have a stronger voice and more involvement in decision-making in health care facilities. [W300-302]</p>

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
4100	12.30 Ldrship / CPAdvocacy Used in CPAdvocacy	In the body of our written report – and I've supplied five copies that can be seen at the back table – we have included several areas that we feel would create opportunity for bettering the hospital's ability to serve the public interest. And, briefly, these would include: [054-59] Number one, nonprofit hospital boards should have appointments from community and employee organizations. [060-62]
Code 13: Education of Professionals		
102B	15.13 Collab / EdP	Collaborate with key groups to develop education modules and assuring core competencies for direct care providers that emphasize a science-based approach to preventing healthcare errors. [W 115-117]
1030	13.00 EdP	The patient safety culture is I believe fundamental to truly achieving the safe environment of care. And there is a long tradition of punitive response to clinical errors and adverse outcomes in healthcare. I think these issues have to be overcome by leadership, by education, and by an infrastructure of organizational policies that support a nonpunitive reporting of errors. Organizations absolutely must learn from these events. These events are inevitable. Human error is inevitable. And no system is going to be absolutely perfect and eliminate entirely errors and adverse events. [O 22-37]
110W	13.00 EdP	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Provide physician and resident training regarding human factors theory and communication techniques. [W 72-73]
110W	13.00 EdP	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Assist hospitals to identify current relevant research and applicability to healthcare operations. [W 124-125] Professional societies and groups can help to reduce patient medical errors by assisting as advocates for healthcare patient safety efforts. These advocacy efforts include ... education and dissemination of best practices within hospitals as well as other industry applications and lobby efforts to continue and promote a culture of safety. [W 79-83]
2010	13.00 EdP	I'd like to see some standardization and requirements for training for front line mental health care workers. [V2288-2292].
2020	13.00 EdP	My suggestion to you is that there be some consistent education of the nursing staff and physician staff about the peer review process (046-48).
204B	13.07 EdP / ProfLic	In the short term, a patient safety continuing education requirement for all Michigan licensed healthcare professionals should be mandatory as part of the continuing medical education requirement for licensure as has become practice for some other states (e.g. Florida) (W100-103). ...one of the thoughts that comes to mind, whether it would be talking about physicians, pharmacists, or any other type of licensed individual in the state of Michigan providing healthcare services. I would think that in terms of granting those licenses, there should be some type of required safety education, at least on an annual basis. This is something which is present in a number of other states that I'm aware of, and I think this would be something that would be of benefit (055-65). While I opined that healthcare students providers should all have some continuing educational requirement for patient safety (including systems theory), in my opinion, this should expand to include individuals who serve on healthcare facility boards and to individuals employed by the state in healthcare regulatory capacities (O177-181).
204B	13.11 EdP / GuidePrin	Second, in conjunction with safety experts, healthcare leaders, and frontline practitioners, identify patient safety issues and develop a priority index relevant to each aspect of care in the clinical continuum: hospital, ambulatory clinic or office, nursing home, pharmacy, etc. Third, identify the practitioner type involved in the priority index. Fourth, develop and implement a communications plan to make practitioners aware of the index and the rationale behind it. Fifth, develop effective education curricula or modules addressing each element in the priority index. (W76-83).
204B	13.20 EdP / PtInclude	Education and training for communicating at the patient's level will help mitigate this risk. Involving patients or their care givers increases the responsibility and ability to participate in the care process and to act as a final checkpoint to avoid a potential misadventure (W115-118). And one of the other areas that I see an opportunity for improving patient safety is learning how to communicate with our patients. Learning how to talk to them in language they understand so that when we get done giving them instruction, whether it's about their medication or how to change a lifestyle, that it's in language that they understand (088-97).
2080	13.00 EdP	Another part would be to educate healthcare workers that part of our job is peer education [V63-64]. So I believe that should be incorporated in our education for nurses and doctors and other healthcare team members that part of what we do is educate and help train those new people in our profession and in the healthcare industry so that we can be supportive of new people and help retain those new people when they come in and keep them there [V69-75].

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Verbatim Recommendations from Testimony with Original Coding

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212W	13.00 EdP	<u>The state should serve as the forum to align the various professional societies and organizations to promote standardization across education and training curriculums.</u> [W180-181]
402B	13.00 EdP	We know we need to see Schools of Nursing graduate more RN's, many of us want to retire soon and we need to have nurses at the bedside to replace us. [W94-96]
4050	13.14 EdP / EdC	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [O56-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167] Next is to establish a national education effort for patient safety for both providers and consumers really finding ways to reach both the public and the providers about systems-based approaches to safety. [O201-205]
4050	13.14 EdP / EdC	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [O56-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167] Fifth is develop awareness that healthcare systems really are intrinsically dangerous [O207-208]
411W	13.00 EdP	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] 1.) Training: We [the union] should begin to build a partnership with the state's teaching facilities to provide training for Certified Nurse Assistants. [W123-124]
411W	13.00 EdP	Patient safety training should be required as part of an organizations annual staff competency program. (W101-102).
605B	13.00 EdP	[For] (implementation of high technology tools) <u>There is also a required need for a</u> change in the culture of safety in these settings (hospitals, physician offices, and community pharmacies, and other settings), as well <u>as substantial training</u> and re-engineering of clinical processes, which represent additional costs for providers P3, L31-32.
606W	13.00 EdP	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type - recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations - and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Mandate patient safety training</u> as part of physician and nursing education. [W284]
807B	13.00 EdP	I am submitting in written testimony today with references to illustrate that the promotion of a safety culture in healthcare facilities, regular feedback of our findings from the surveillance, education of direct care providers on practices to prevent infection, and organizational leadership support all can be brought to bear in enhancing patient safety. (O 60-69).
808B	13.00 EdP	Physicians must have continuing education and exams, as new medications are continually developed before dispensing.(O 195-197). Develop programs introducing healthcare professionals to error analysis and the challenges of practicing technically complex environment (W 377-378).
8090	13.00 EdP	I would recommend enhanced and increased clinical education [for nursing students - see concern] (O 95-96).
8090	13.10 EdP / Resources	I would encourage the Commission to recommend promotion of the funding for education of nurses and nursing educators (O 86-88).
8110	13.15 EdP / Collab	We hope this Commission will ultimately help develop additional educational programs to assist our members to be better equipped to protect the safety of our patients (O40-43). We also welcome the opportunity to work with you in developing these programs and presenting these programs (O44-46). Our association stands willing to collaborate with other organizations to address patient safety (O55-56).
819B	13.00 EdP	MRSA is a growing concern for the elderly and those patients living in communal facilities. Education about its management and control to providers, patients, day care centers and adult living facilities is another recommendation for consideration (W 60-62).

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8230	13.22 EdP / MedPrac	The specific recommendation I want to make here and now is that information and warnings about post polio reactions to pharmaceuticals be included in all pharmaceutical databases, the kind that I believe are now under development to make things safer so that drugs don't conflict and that kind of thing, and in training. (O 8-11). But I do think that as computer-based systems aimed at the safety of drug prescriptions, this is the kind of information, for polio and probably some other conditions, needs to get in there if only to flag. You must go outside for this information before you prescribe this drug at all. I think that would be the number one safety measure that occurs to me. And you can try to get it into training. (O 59-64)
826W	13.17 EdP / HuDesign	The MSA supports continuing and expanding the use of simulators as a means to improve patient safety and reduce medical errors in Michigan. (W 114-116).
827W	13.00 EdP	Occupational therapy and physical therapy should also play an active part in training staff on safe patient transfer techniques to limit both patient and staff injuries (W94-96).
827W	13.14 EdP / EdC	From the home, to work, to hospitals, to care facilities, and back home again, patient safety should be an ongoing educational process (W118-119)
827W	13.0 EdP	In the long term, the professional schools should have as requirement patient safety courses and training as a basic curriculum requirement prior to graduation (W106-108). But as I thought about this in terms of a regulation or a licensing requirement, it also dawned on me that I'm not sure that this is really being provided in our professional schools (O68-71). So I would think that it would be advantageous, listening to folks from the pharmacy before. It needs to be part of that curriculum (O76-79).
829W	13.00 EdP	As the Michigan Chapter of the American College of Radiology, we are very concerned with the use of ionizing radiation and believe that those operating the equipment should be licensed technologists and that the physicians overseeing the use of ionizing radiation must have documented training in radiation safety (W30-33).
904B	13.20 EdP / PtInclude	MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [W 61-62] Combating the problems associated with health literacy and cultural competency [W 68-69] Rationale for the incorporation of cultural competence into organizational policy is numerous. The National Center for Cultural Competence has identified six salient reasons for review: 1. To respond to current and projected demographic changes in the United States. 2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds. 3. To improve the quality of services and health outcomes. 4. To meet legislative, regulatory and accreditation mandates. 5. To gain a competitive edge in the marketplace. 6. To decrease the likelihood of liability/malpractice claims. 7 [Recommendation cont] National Center for Cultural Competence: Georgetown University Center for Child and Human Development. Available at http://www.georgetown.edu/research/guccd/nccc/cultural5.html . Accessed online November 27, 2002. [304-316] [This seems to indicate the target group for this recommendation:] The programming opportunities that MPRO provides to health and community service agencies throughout the country are designed to address health disparities at the level of the patient-provider relationship. [W 241-143]
Code 14: Education of Consumers		
213W	14.00 EdC	I will argue in my testimony that developing a "culture of safety" in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 2. We have various multidisciplinary patient safety committees that I facilitate, or participate in. During these meetings, we review all errors, and near misses related to medication [assume medication] use, and patient identification. We identify trends, and develop action plans to deal with them, and the information is filtered up to our governing board. All healthcare organizations need to share this kind of information with their governing boards. Additionally, <u>the fact that these processes exist needs to be shared with the public.</u> [W 145-153] 5. We are in the process of further integrating the concept of a "just" culture in all we do at Providence. Within the entire St. John Health System, training on the concept of a "just" culture is being developed to assist managers to appropriately address errors on their units. <u>Healthcare organizations need to continue to focus on developing "just" cultures, and do a better job of communicating and educating the public.</u> [W 161-167]

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4050	14.13 EdC / EdP	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [056-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [0164-167] Next is to establish a national education effort for patient safety for both providers and consumers really finding ways to reach both the public and the providers about systems-based approaches to safety. [0201-205]
4050	14.13 EdC / EdP	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [056-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [0164-167] Fifth is develop awareness that healthcare systems really are intrinsically dangerous [0207-208]
501W	14.00 EdC	Michigan should take immediate action to: [W 49-50] Inform and engage key stakeholders [Bolded in original text]: Public and private sector interests should develop a comprehensive public education campaign to build community support for these strategies [i.e., define and publicly report comprehensive set of performance measures, revise payment mechanisms to align incentives, promote investments in clinical information technology as presented in testimony 501 (Bradley)]. [W 70-71]
606W	14.00 EdC	CALL TO ACTION HAP has pledged to implement programs of this type – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] <u>Inform and educate employees.</u> [W269]]
819B	14.20 EdC / PtInclude	Education of patients and caregivers about their own safety responsibilities related to medication and disease management is also essential to patient compliance and accurate reporting of problems (W51-53). MRSA is a growing concern for the elderly and those patients living in communal facilities. Education about its management and control to providers, patients, day care centers and adult living facilities is another recommendation for consideration (W 61).
827W	14.13 EdC / EdP	From the home, to work, to hospitals, to care facilities, and back home again, patient safety should be an ongoing educational process (W118-119)
827W	14.00 EdC	Employers can provide many prevention programs for patient/employee safety (W113).
Code 15: Collaboration		
102B	15.13 Collab / EdP Used in EdP	Collaborate with key groups to develop education modules and assuring core competencies for direct care providers that emphasize a science-based approach to preventing healthcare errors. [W 115-117]
1030	15.01 Collab / StateFocal	Similarly, so that each institution doesn't have to reinvent the wheel, I think it's important to develop a means where institutions can share their solutions, share best practices. ... And anything that can be done through statewide efforts to encourage the sharing of those practices I think would be very helpful. [O 94-97, 101-103]
1040	15.00 Collab	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [09-13] We need to join and learn with others. Lots of organizations have a lot of good information. [0156-157]
105B	15.18 Collab / Staffing	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] And lastly, nurse staffing and nursing vacancy ["rates" added in oral]. We need to create partnerships between hospitals, colleges and universities to increase the numbers of young women and men entering the nursing profession. This will require increased funding for schools and scholarships. [O 251-258; W 140-142] Having an appropriate number of new registered nurses graduating from nursing programs is critical to providing a safe environment for patients. [O 205-208; W 110-112] Recommendations [from Executive Summary]: Partnerships must be promoted between hospitals and schools of nursing to increase the number of young women and men choosing nursing as a profession [W 182, 188-189]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
110W	15.00 Collab	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Provide a learning environment and coordinated project techniques similar to the MHA Keystone ICU project (uses collaboration and support) [W 100-101] for advancement of additional operational implementations. [W 126-128] Continued efforts to help healthcare organizations to engage with each other will lessen the steep learning curve and the ability to build on each other's experiences. [W 94-96]
2020	15.00 Collab Used with PeerProtect	And also I think that the – that the peer review process should be removed from the hospital where it occurs at.(057-59). ...hospitals of similar size and of similar activity look at other hospitals of similar size and similar activity, peer review material, and judge them dispassionately and in an uninvolved fashion.(060-63).
204B	10.24 Resources / ResEval	Fund patient safety/risk reduction demonstration projects involving small to medium size practices or a collaborative of small to medium size practices (W134-135).
212W	15.09 Collab / Incent	<u>The state could provide financial incentives to organizations who design “safe” facilities and who implement meaningful patient safety programs and support “evidence-based” collaboratives.</u> [W259-261]
305W	15.24 Team / ResEval Addressed in ResEval	Therefore, the first recommendation to the Commission is to fund research into interventions to improve communication between nurses and physicians. (W98-99)
4050	15.30 Collab / CPAdvocate	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [056-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [0164-167] The second goal is to create consumer-led advisory councils, preferably at the community level, to really be sort of a standing focus group for healthcare providers in the community to go to consumers for their input on everything from patient education materials to facility design to any of the other issues you've heard today. [0178-185]
606W	15.00 Collab	At Health Alliance Plan (HAP), we believe that a <u>true partnership among insurers, providers and purchasers</u> will make it possible to improve patient safety. [W80-82]
807B	15.00 Collab	Having said that, we would like to provide some practical evidence that our efforts are successful and hope as a result, that the Commission ensure a continued role for ICP input when designing future, safer healthcare systems in Michigan (W365-367). This is clear demonstration of the activities that are ongoing in Michigan and APIC-GD and MSIC are interested using these and others as examples to assist the Commission with its goals of collating safety initiatives and developing recommendations to share with providers, purchasers, and the citizens of Michigan. We plan to build on this collaboration and approach in future educational events and would welcome opportunities to formally participate in Michigan Health & Safety Coalition educational events as well (W422-427). We believe we can assist the commission as the issue develops in the near future (W481-482). APIC-GD along with MSIC, by utilizing its' extensive network of members in almost every setting along the continuum of care is pleased to offer the Commission its support and expertise for the following improvement interventions (W505-506). The items above are only a few of the ways APIC-GD, MSIC and all Michigan ICPs, can assist the Commission with its assigned responsibilities (W531-532).
808B	15.00 Collab	There must be collaboration with healthcare professionals to develop strategies and raise awareness (O 203-205).
8100	15.00 Collab	Michigan hospitals accept responsibility for improving care and safety and are aggressively forging new methods of bringing the best evidence-based care to all Michigan citizens. We know, however, that the journey has only begun (O133-137). On behalf of the 144 acute care hospitals in Michigan, I invite you to hold us accountable and work with us to make healthcare safer (O158-160).
8110	15.13 Collab / EdP	We hope this Commission will ultimately help develop additional educational programs to assist our members to be better equipped to protect the safety of our patients (O40-43). We also welcome the opportunity to work with you in developing these programs and presenting these programs (O44-46). Our association stands willing to collaborate with other organizations to address patient safety (O55-56).

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
822B	15.00 Collab	<p>... collectively they (MICAH hospitals) are providing a significant volume of patient care to their share of Michigan communities. In addition, most of the facilities serve as a hub of rural healthcare activity that forms the nucleus for noncompetitive networking with a variety of providers in their local communities. The roots of integrated healthcare and continuum of care development have already begun and are essential in any discussion concerning rural healthcare performance improvement. Coordination of EMS and first responder activities and support of the development and recruitment of primary care providers round out this significant and diverse set of responsibilities for the rural CEO and Governing Board. For these reasons it is believed that the Commission will be well served to include MICAH and other similar groups in the process of defining methods to improve patient safety. [W 36-47]</p> <p>As plans develop to look at the vast array of continuum providers it is believed that the Michigan Center for Rural Health and MICAH can be excellent partners in your efforts. [W 122-123]</p> <p>Recommendation cont. Any effort to improve the performance of overall healthcare systems and impact safe and quality care must include critical access hospitals. [O 36-38] In closing, I would like to say that the quality network supports the efforts to provide safer care throughout Michigan. We share your commitment to serve and look forward to working with you to identify plans to achieve improved patient safety and reducing medical errors. [O 80-85]</p>
828W	15.25 Collab / Legis	Regulation and legislation must support collaborative approaches among hospitals, physicians, hospital employees, and health plans to stimulate and improve patient safety and must be non-punitive. (W 96-98)
904B	15.00 Collab	MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [written: "Stakeholder"] collaborations to create systematic change [W 61-64; O 19-21] Collaboration is Key to Creating Systematic Change [bolded in original] [W 71]
904B	15.23 Collab / InfoTech	<p>MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [W 61-62; O 19-20]</p> <p>The implementation of electronic health records [W 65; O 21]</p> <p>A key area where patient safety can be improved and produce positive results involves the adoption of interoperable electronic health records (EHR). [W 180-181]</p> <p>A key area where partnering can produce results involves the adoption of electronic health records. One day in the not too distant future physicians will be able to share patient records across the information highway. [O 39-41]</p> <p>In April of this year, President Bush called for widespread adoption of electronic health records within 10 years. [W 189-190; O 46-47]</p> <p>[Targets indicated in strategy where talks about MI health care providers and systems.] [W 184-187]</p>
Code 16: Teamwork		
102B	16.00 Team	... I'd like to recommend that the Commission [O 116-117] strongly considers disseminating successful strategies for building patient safety teams within facilities. [O 121-123]... designed to prevent infectious and noninfectious complications of care. [W 118-119]
2080	16.00 Team	So I believe that the solution to this problem should involve taking steps to offer mentorship for new grad nurses, something that's often being done right now with other nurses, but maybe start involving physicians and other healthcare team members in that process to mentor to those new grads and help establish more of a peer relationship and help these new grads feel comfortable talking to physicians, which can often be an intimidating experience when you're a new nurse [O53-62].
212W	16.00 Team	Additionally, <u>ongoing, state-funded, state sponsored safety education programs that focus on innovative approaches</u> to teaching patient safety and <u>effective team functioning</u> including Crew Resource Management, especially in the ER, ICU, and OR settings; simulation training; and medication safety practices would further advance the cause [of improving patient safety]. [W261-265]
3030	16.20 Team / PtInclude	Teamwork and patient advocacy must be encouraged in order to ensure patient safety (O98-99).
305W	16.24 Team / ResEval	Therefore, the first recommendation to the Commission is to fund research into interventions to improve communication between nurses and physicians. (W98-99)
4030	16.20 Team / PtInclude	Third, local consumers should be nurtured and used as partners to help local families solve the system's problem. [O58-59]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
819B	16.08 Team / PerfBench	MHHA recommends that the Commission give consideration to methods to improve communication along the full continuum of care from patient entry into the system through return to the community, particularly as related to specific medication orders and patient history of such conditions as MRSA (Methotrexate Resistance Staphylococcus Aureus) (W31-35).
819B	16.22 Team / MedPrac	MHHA recommends that the Commission give consideration to methods to improve communication along the full continuum of care from patient entry into the system through return to the community, particularly as related to specific medication orders and patient history of such conditions as MRSA (Methotrexate Resistance Staphylococcus Aureus) (W31-35).
825W	16.00 Team	The Michigan Academy of Physician Assistants supports and promotes the utilization of physician assistants in the health care team. The Physician/PA team is a strong means to supplying quality, safe and accessible health care to the citizens of Michigan.(W 112-114).
827W	16.00 Team	Social work should be involved regarding social supports and resources to assist with safe care and follow-up after discharge. A discharge planner should be available to coordinate a patient's discharge care including follow-up physician appointments, occupational therapy and physical therapy care, durable medical equipment, home medical equipment and supplies (W96-100). It [patient safety] should include many disciplines including physicians, nurses, occupational therapists, pharmacists, physical therapists, nursing aides, social workers, discharge planners, employers, third party payers, government agencies, and consumer groups (W121-124).
Code 17: Human Factors		
1040	17.00 HuDesign	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [09-13] Forcing functions, we need to learn about it in healthcare. The free-flow infusion pumps, we need to know that they're going to make it safe for giving IVs to patients. [O 137-140] We can only rely on an employee for lots of things but bar coding puts that forcing function in there that we all need to start adopting from other industries. [O 123-126]
106B	17.05 HuDesign / ShareInfo	In order to improve patient safety we must learn from errors and near misses. The knowledge that is generated from errors requires that <u>the errors and near misses must be analyzed for</u> system defects, and <u>human factors that contribute to the occurrence of the events</u> . [W 36-38] The State of Michigan has an historic opportunity to make good out of bad, to learn from mistakes, to design safety into care processes and to continue its' tradition of progressive innovative care improvement opportunities. The State could create an event reporting system based upon the experience of reporting systems like NASA's Aviation Safety Reporting System, Trinity Health's event reporting system, and The Veteran Administration reporting system for all hospitals to contribute to and learn from. The system could capture de-identified data that could be analyzed for system related failures. The identification of root causes of problems with the systems of care could provide the basis for identification of and implementation of solutions to avert similar future adverse events. The public should be informed as providers implement the solutions. As solutions are implemented and fewer events occur patients benefit, providers benefit and the State benefits. [W 59-68] I think it's a great opportunity for us to create a warehouse of data at a state level to learn and from all ... 136 hospitals across the state. What a great learning lab. But you have to make it safe environment for people to report. [O 283-292] ... I think there's a great opportunity to create even at a state level by some state organization that is not tied to the regulation an opportunity to learn about these events. [O 271-274]
212W	17.09 HuDesign / Incent	<u>The state could provide financial incentives to organizations who design "safe" facilities and who implement meaningful patient safety programs and support "evidence-based" collaboratives.</u> [W259-261]
416W	17.00 HuDesign	...I have some suggestions that may promote patient safety in community health settings. [W7-8] 3. Establish uniform documentation forms for therapists (checklist format), reducing the amount of handwritten notes and labor intensive forms required by insurance companies. [W16-17] 4. Establish ONE UNIFORM AUTHORIZATION PROCESS FOR ALL INSURANCE COMPANIES, WITH A MINIMUM OF WRITTEN DATA. [W21-22]
605B	17.00 HuDesign	[For] (implementation of high technology tools) <u>There is also a required need for</u> a change in the culture of safety in these settings (hospitals, physician offices, and community pharmacies, and other settings), as well as substantial training and <u>re-engineering of clinical processes</u> , which represent additional costs for providers P3, L31-32.

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
808B	17.00 HuDesign Should have been coded to 07 ProfLic	Licensure of laboratory personnel, as well as all health care practitioners should be a number one priority in our state to reduce medical errors. (W 379-380).
826W	17.13 HuDesign / EdP	The MSA supports continuing and expanding the use of simulators as a means to improve patient safety and reduce medical errors in Michigan. [W114-116]
901W	17.00 HuDesign	The Commission is encouraged to; use the tools which have already been proven effective [in optimizing organizational and human performance (W 105)] ... [W 212-213] With the leadership of the State Commission in overcoming myths which prevent progress, advances using the lessons learned from the past 25 years in the Nuclear power Industry can be applied to Healthcare organizations and begin to immediately improve error management and human performance. [W 175-178] Regardless of the initiatives chosen, an emphasis on using methods that have been proven effective is critical. For example, in hospitals there has been recent interest in “walk around” and “handoff” protocol improvements. Many of these improvement initiatives however, have been launched without utilizing the thousands of person-years of experience nuclear power has in optimizing the use of these tools. Therefore the result will likely be; multiple iterations as lessons are learned, multiple versions of the tool used across the State at different Institutions, and a lot of wasted time. [W 202-208] [...] I'd like to just recommend that this committee save time, learn from other industries like nuclear power, be proactive, use the experience, use what has been proven to work. [O 108-111]
Code 18: Staffing		
105B	18.00 Staffing	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] And lastly, nurse staffing and nursing vacancy rates. In addition, expecting and supporting hospitals to create positive working environments consistent with magnet standards will go a long way in both attracting and keeping smart bright nurses at the bedside as well as improving patient outcomes and decreasing harm and mortalities. [O 251-264; W 142-145] Recommendations [from Executive Summary]: Incentives should be created for hospitals to achieve Magnet recognition. [W 182, 187]
105B	18.09 Staffing / Incentives	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Recommendations [from Executive Summary]: Incentives should be created for hospitals to achieve Magnet recognition. [W 182, 187] And lastly, nurse staffing and nursing vacancy rates. In addition, expecting and supporting hospitals to create positive working environments consistent with magnet standards will go a long way in both attracting and keeping smart bright nurses at the bedside as well as improving patient outcomes and decreasing harm and mortalities. [O 251-264; W 142-145]
105B	18.10 Staffing / Resources	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] And lastly, nurse staffing and nursing vacancy rates. We need to create partnerships between hospitals, colleges and universities to increase the numbers of young women and men entering the nursing profession. This will require increased funding for schools and scholarships. [O 251-258; W 140-142] Having an appropriate number of new registered nurses graduating from nursing programs is critical to providing a safe environment for patients. [O 205-208; W 110-112] [cont] [Recommendation cont] The college has increased the number of positions in their nursing program, which, by the way they lose money on every nursing student that they take in. And so something the State can do is help the community colleges with these financial losses that they do. [O 328-336]
105B	18.15 Staffing / Collaboration	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] And lastly, nurse staffing and nursing vacancy [“rates” added in oral]. We need to create partnerships between hospitals, colleges and universities to increase the numbers of young women and men entering the nursing profession. This will require increased funding for schools and scholarships. [O 251-258; W 140-142] Having an appropriate number of new registered nurses graduating from nursing programs is critical to providing a safe environment for patients. [O 205-208; W 110-112] Recommendations [from Executive Summary]: Partnerships must be promoted between hospitals and schools of nursing to increase the number of young women and men choosing nursing as a profession [W 182, 188-189]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
2030	18.00 Staffing	I really think you can keep your nurses and bring some of the – some back into patient, direct patient care by lightening the patient load (0124-126)
2030	18.00 Staffing	FROM CONCERN/COMMENT COLUMN The other issue I really wanted to speak on was the use of mandatory overtime [047-48]. But one of the stories that I have about mandatory overtime is the nurse that precepted me...(052-76). Well, I think it may be a little different at individual institutions, but at this particular one it was kind of in their contract that – I mean, you can't abandon the unit and they would try to get people who would volunteer first, but on that particular night, that happens, you know, in a trauma center, you know, a big burn came through the door (083-92). Unfortunately, on that particular unit the need to mandate or to request the use of overtime became a staffing tool (0101-103). Testimony submitter wanted to raise the issue of mandatory overtime as an improper staffing solution to inadequate staffing levels but did not make a specific recommendation.
204B	18.00 Staffing	FROM CONCERN/COMMENT COLUMN Analogous to the situation that now exists in hospitals involving shortages of registered nurses and ancillary personnel, many practitioners' offices have been unable to locate and hire sufficient appropriately educated and trained individuals to meet the demand. As in hospitals, a downward delegation to less qualified personnel continues despite the increasing complexity of medical therapy (W35-40). Coder Comment: Although the testimony submitter noted a concern/problem related to staffing, no recommendation was made.
2060	18.00 Staffing	FROM CONCERN/COMMENT COLUMN I would like you to be on notice that we are, in the different school of nursing in Michigan, are turning away hundreds of qualified applicants that could be and would be very, very good nurses if they could get into a school, but because of the faculty shortages, because of the clinical arena shortages, because we're not looking outside of the box in terms of doing things such as they're using at the Community College up here with affiliations with active clinical faculty – or clinical nurses, we are going to continue to have a shortage (092-100). But truly I would say for every nurse that gets into a nursing program, two are turned away, in the last data that I saw (0101-103). It's been said that recruitment in middle school is a really great time to encourage young folks to consider being healthcare professionals. Anything that we can do to promote our healthcare professionals to that population would be beneficial, but, again, we have many, many people who would make excellent nurses based on their grade point averages but they can't get into nursing programs (0110-119).
2060	18.08 Staffing / Performance Benchmarks	From a safety perspective, I believe patients in emergency room holding should not have their care on hold, that the staffing should not compromise their well-being because an ICU bed or a step-down bed or a regular medical bed is not available. I think that from a perspective of ER holding that the staff should see these patients as high acuity and render the appropriate care. And once again, because a patient is in holding doesn't mean their care should be in holding (066-75).
2090	18.00 Staffing	My recommendations are while the nursing staffing is under this constant review that we just need to increase the staffing of licensed registered nurses (034-37).
2100	18.00 Staffing	[Regarding minimum nurse to patient staffing levels] And I'm not unreasonable asking for, you know, maybe three or four, like some of the units, but I think five would be the maximum that would be safe, approximately five to one (083-87).
3010	18.00 Staffing	I would like to recommend that you establish a standard regarding the number of hours that hospital staff nurses work, which is no more than 12 consecutive hours during a 24-hour period and no more than 60-hours during a seven-day period [01233-1241]. We believe that the establishment of these work hour recommendations as a standard of practice for both health care institutions and nurses will improve patient safety [01328-1334]. ...which is no more than 12 consecutive hours during a 24-hour period and no more than 60-hours during a seven-day period. This standard or practice should be voluntarily adopted by both health care institutions and registered nurses [01237-1247].
3030	18.00 Staffing	There is a cadre of retired RNs, many of whom are willing to volunteer in healthcare if only they can do actual nursing care (0126-128). Volunteer RN corps .. (0132)
3030	18.00 Staffing	If these supervisors can now be freed up for this clinical detective role, maybe trained RNs can be designated on each shift to serve in that capacity (0150-153).
3030	18.00 Staffing	...every hospital in the state should be challenged to immediately and voluntarily establish unit staffing committees with the authority to determine and deliver safe nurse/patient ratios as described in Senate Bill 1190 (0182-186).
402B	18.25 Staffing / Legislation	We believe we need guidelines, either agreed upon with the employer, or by legislation, to limit the number of patients each RN is responsible for. [W92-94]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
404B	18.25 Staffing / Legislation	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] Staffing levels should be monitored and a patient/nursing ratio should be established at a level that provides an environment for the provision of quality and affordable health care. The patient/nursing staff ratio should also clearly limit the number of nursing staff that are provided by traveling nursing firms. [W47-50]
4080	18.00 Staffing	Some of the IOM and National Quality Foundation, National Quality Form work references nursing homes but it's more cursory. Some of their recommendations have the potential to be applied in the nursing home industry. And the one I would particularly like to address is the staffing and the staff turnover in the nursing homes today. [O31-37] The one recommendation I would make, I'm very pleased to see MPRO and CMS take on an initiative to address staff turnover in the scope of work. [O69-71]
4100	18.00 Staffing	In the body of our written report – and I've supplied five copies that can be seen at the back table – we have included several areas that we feel would create opportunity for bettering the hospital's ability to serve the public interest. And, briefly, these would include: [O54-59] Minimum nurse/patient ratios should be established. And this is number four. Minimum staffing standards need to be set. [O81-83]
411W	18.00 Staffing	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] 3.) Staffing: there must be adequate staffing in these facilities. [W135]
411W	18.00 Staffing	In Michigan, we cannot wait for federal standards for patient safety and quality care that needs to establish minimum nurse-to-patient ratios and other staffing levels for all hospitals and other health care facilities. [W5-8] Minimum nurse-to-patient ratios will reduce the risk of medical errors and complications by ensuring that nurses have enough time to properly carry out treatments prescribed by physicians, continually assess and monitor patients – and modify interventions accordingly, as well as provide education to help speed recovery and prevent relapses. [W12-16] Establishing minimum staffing ratios by unit in all hospitals will guarantee a safe level of care for patients, who are not always able to choose their hospital or transfer to another if they are not satisfied with their care. [W27-30] The State of Michigan and the health care industry need to redefine what Nursing Care Personnel means. [W17-18]
416W	18.00 Staffing	...I have some suggestions that may promote patient safety in community health settings. [W7-8] 1. Establish minimum nursing staffing guidelines to appropriately cover patient caseloads in hospital and rehab. settings. [W12-13]
416W	18.09 Staffing / Incent	... I have some suggestions that may promote patient safety in community health settings. [W7-8] 2. Allow more flexibility with nursing staff schedules, including shorter shifts, and bonus/incentive programs to obtain their own coverage among staff. [W14-15]
419W	18.25 Staffing / Legislation	In an effort to remedy these problems on a national level, the SEIU Nurse Alliance is calling upon Congress to enact federal legislation for safe staffing and restrictions on mandatory overtime that provides as follows: [W122-124] Minimum Bedside Patient/Nurse Staffing Standards. 1. Establish safe staffing standards covering all acute care and psychiatric hospitals, emergency room facilities, and ambulatory and outpatient facilities that receive Medicare funds.2. Require each health care facility to develop a staffing plan that: o Establishes minimum staffing requirements based on number of patients, level of acuity, and intensity of care needed to ensure good patient outcomes. o Establishes the specific nursing staff and skill mix needed to carry out the requirements. The skill mix must assure that all elements of the nursing process - assessment, nursing diagnosis, planning, intervention, evaluation, and patient advocacy - are performed in the planning and delivery of care for each patient. o Is developed in consultation with the direct-care nursing staff. 3. Require public disclosure of staffing plans, including both mandated and actual staffing levels. [W125-142]
419W	18.25 Staffing / Legislation	In an effort to remedy these problems on a national level, the SEIU Nurse Alliance is calling upon Congress to enact federal legislation for safe staffing and restrictions on mandatory overtime that provides as follows:(W122-124) Ban Mandatory Overtime- 1. Set maximum hour limits for nurses, as is done in the transportation industry where public safety is at risk. 2. Except where a formally declared state of emergency has been declared, employers are prohibited from requiring mandatory overtime of nurses that would exceed: o A daily limit of previously determined work schedules or 12 hours in a 24-hour period. o 80 hours in a 14 consecutive day period. 3. Licensed nurses providing direct care may voluntarily work overtime as long as their hours do not exceed: o More than 16 hours in a 24 hour period without an intervening 8 hour non-work period; or o More than 7 consecutive days without at least one consecutive 24-hour off duty period within that time. 4. Negotiated provisions in union contracts that exceed these protections will prevail. [W143-159]

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ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
606W	18.11 Staffing / GuidPrin	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type [that support and promote bedrock principles of patient safety; W27] – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] Refocus on specific quality "leaps." ... Therefore, HAP urges a renewed focus on specific, discrete improvements in quality and safety designed to yield the largest safety gains. These include:... [W249-252] c. ICU physician staffing, in which hospital intensive care units are managed by physicians certified in critical care medicine [W260-261]
803B	18.00 Staffing	The MNA-proposed solution, as codified in Senate Bill 1190, requires (establish) minimum patient-to-registered nurse ratios in hospitals, staffing plan requirements for each hospital, and the use of acuity systems to increase the RN staffing capacity as necessary for the provision of appropriate patient care within each hospital unit (P1,L30-33). MNA proposes that to best ensure safe patient care in hospitals, a sea change must occur regarding inpatient staffing levels and hours of work for nurses (P3,L37-8). The bottom line is that the research examined, and included in the appendix of our testimony packet, is that establishing minimum registered nurse-to-patient staffing ratios, combined with a prohibition of the use of mandatory overtime outside of natural disaster and emergency situations, is sound public policy (P3,L38, P4,L4-6). MNA strongly stands by its recommendation that Michigan must work to eliminate mandatory overtime for nurses, and establish minimum registered nurse-to-patient staffing ratios, in order to fix a broken system in too many of Michigan's hospitals (P5,L38-41). So that when we're advocating for a minimum ratio, what we're advocating for is what's been — was research supported, in fact, that I can keep you as a patient or your family member safer if I have a right number of patients that I can care for, that I can get to, that I can see, prevent problems [V2144-2154].
830W	18.00 Staffing	The key element to improved resident health and safety is better staffing (W34).
830W	18.00 Staffing	FROM CONCERN/COMMENT COLUMN Another factor contributing to the poor care residents too often receive is the infrequent attention by physicians. Generally, residents have little or no real choice of physician and are simply assigned an attending physician. These physicians often visit numerous residents at facilities on the same day, provide only cursory examinations of the residents, fail to provide appropriate and individualized orders, and are unavailable to residents or their families who seek to discuss the resident's health status and care needs. Indeed, while our members are in nursing homes every day, they rarely see, and are even more infrequently able to talk to, the physicians responsible for their loved ones' care (W47-59). Coder Assessment: Although this concern deals with physician staffing, no recommendation was made.
904B	18.00 Staffing	[Seems to indicate target group] An area of concern for the medical community as a whole continues to be workforce retention. MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [W 61-62; O 19-20] Development of workforce retention initiatives [W 67; O 22-23]
Code 19: Facility Design		
106B	19.05 FacDesign / ShareInfo	In order to improve patient safety we must learn from errors and near misses. The knowledge that is generated from errors requires that the errors and near misses must be analyzed for system defects, and human factors that contribute to the occurrence of the events. [W 36-38] The State of Michigan has an historic opportunity to make good out of bad, to learn from mistakes, to design safety into care processes and to continue its' tradition of progressive innovative care improvement opportunities. The State could create an event reporting system based upon the experience of reporting systems like NASA's Aviation Safety Reporting System, Trinity Health's event reporting system, and The Veteran Administration reporting system for all hospitals to contribute to and learn from. The system could capture de-identified data that could be analyzed for system related failures. The identification of root causes of problems with the systems of care could provide the basis for identification of and implementation of solutions to avert similar future adverse events. The public should be informed as providers implement the solutions. As solutions are implemented and fewer events occur patients benefit, providers benefit and the State benefits. [W 59-68] I think it's a great opportunity for us to create a warehouse of data at a state level to learn and from all ... 136 hospitals across the state. What a great learning lab. But you have to make it safe environment for people to report. [O 283-292] ... I think there's a great opportunity to create even at a state level by some state organization that is not tied to the regulation an opportunity to learn about these events. [O 271-274]
212W	19.09 FacDesign / Incent	The state could provide financial incentives to organizations who design "safe" facilities and who implement meaningful patient safety programs and support "evidence-based" collaboratives. [W259-261]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
808B	19.00 FacDesign	Healthcare institutions must provide an environment that is safe for all patients and workers, as well. (O 205-209).
Code 20: Patient Inclusion		
1040	20.00 PtInclude	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O 9-13] Patients want to be involved. Use them as a resource. [O 141-142]
204B	20.13 PtInclude / EdP	Education and training for communicating at the patient's level will help mitigate this risk. Involving patients or their care givers increases the responsibility and ability to participate in the care process and to act as a final checkpoint to avoid a potential misadventure (W115-118). And one of the other areas that I see an opportunity for improving patient safety is learning how to communicate with our patients. Learning how to talk to them in language they understand so that when we get done giving them instruction, whether it's about their medication or how to change a lifestyle, that it's in language that they understand (O88-97).
303B	20.16 PtInclude / Team	Teamwork and patient advocacy must be encouraged in order to ensure patient safety (O98-99).
4030	20.16 PtInclude / Team	Third, local consumers should be nurtured and used as partners to help local families solve the system's problem. [O58-59]
404B	20.25 PtInclude / Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] In conjunction with the inspection scheme, the State should develop a framework to allow patients to be interviewed to assess the level of care being provided. [W43-44; W376-377]
4070	20.00 PtInclude	And I think that if doctors were to just listen, listen, they could really do wonders for people. [O95-97] ...if they would sit down and look at you right in your eye and pay attention to what you are saying, they could avoid a lot of these mistakes, ... [O160-163] So I think that really the doctors need to listen. They need to really just listen and quit being afraid of us. [O181-183] So I really do think that the doctors need to sit down and listen and quit running people through so quickly as they do. [O189-191]
807B	20.00 PtInclude	...we support the consumer's (any of our families) right to know and understand the risks that accompany the benefits of using medical devices, and the environment in which procedures occur (W348-350, O38-42).
819B	20.14 PtInclude / EdC	Education of patients and caregivers about their own safety responsibilities related to medication and disease management is also essential to patient compliance and accurate reporting of problems (W51-53). MRSA is a growing concern for the elderly and those patients living in communal facilities. Education about its management and control to providers, patients, day care centers and adult living facilities is another recommendation for consideration (W 61).
827W	20.00 PtInclude	Organizations should develop meaningful patient safety programs that actively involve patients, their families, and staff before, during, and after the need for hospitalization (W82-84). Patients and families should be educated by physicians and nursing staff on medication safety as well as fall risk assessments and prevention [W85-86] Patient safety training should be required as part of an organizations annual staff competency program. This will foster an environment that emphasizes the importance of patient safety. Part of this type of program should provide an opportunity for patients to comment on safety issues. This information can be used to improve the patient safety program as needed (W101-105)
827W	20.22 PtInclude / MedPrac	Patients and families should be educated by physicians and nursing staff on medication safety as well as fall risk assessments and prevention [W85-86]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
831B	20.23 PtInclude / InfoTech	I think we need to make that clear and then we need to encourage people to have their own medical record. I mean, it really goes hand in hand with this other thing. It's educating patients (0264-268). And I just want to have patients have their own record, deliver it to their doctor so they can see what happened, and you can get right to it (0272-275).
9030	20.23 PtInclude / InfoTech	So our recommendation is that we encourage people to have [healthcare] passports. We encourage the primary care providers to do these out of their offices. [O 313-315] [W]e would like to recommend that the insurance companies and the State encourage primary care doctors to have a [healthcare] passport. [O 335-337] What it is is it's a passport. It's a healthcare record that a patient has, they own it, it's theirs, and it gives pertinent data. [O 47-49] The patient has full access to this information. They can't change it, but they can bring it up on a computer and they can review it with their family. ... You can have a hard copy print for the patient and they can carry it right inside their passport so family members as well as themselves can access the information for the patient's healthcare. [O 143-146] ... a patient can follow along at home and know when they're going downhill and communicate this information to their doctor. [O 279-282] ... this portion of the chart, the patient can access and add information to. Any of it can be printed out hard copy for them to follow along and, of course, bring to their physician's office. [O 291-294] the bottom line is an informed patient is an empowered patient, and we think that this is the way the whole government is going in 2010 EMR. They want to have things like this. [O 296-299] ... an infectious disease log. It basically tracks the patient's infectious illnesses and what they were treated with. And so this can be accessed by your physicians for epidemiology purposes. [O 267-270] ... the way we feel that we get around that [information going to people who shouldn't have it] is we give this to the patient so it is theirs. They get to read it. They get to know about their disease. They get to be educated. They come in and ask intelligent questions. They go to the next doctor, they give them a history better than you would get getting a referral form or anything else. This is much more complete, and so this is theirs. [O 304-311] [From Q and A period:] ... the patient is part of their own healthcare. They participate as opposed to this passive player. [O 818-820] It can be used in conjunction with that [electronic medical record system]. One of our updates that we're planning, the passport will contain its own electronic medical records system that the physician can utilize. Obviously, they need the computer and the hardware there, but the software will be self-contained on the passport and they can utilize that for their system. [O 232-239] [From Q and A period:] ... they can go right to the problem as opposed to spending tremendous amount of time just trying to get an accurate history and accurate information. ... I would rather my doctor spend it on the problem that I'm there for as opposed to trying to gather this information. [O 1059-1084]
904B	20.13 PtInclude / EdP	MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [W 61-62] Combating the problems associated with health literacy and cultural competency [W 68-69] Rationale for the incorporation of cultural competence into organizational policy is numerous. The National Center for Cultural Competence has identified six salient reasons for review: 1. To respond to current and projected demographic changes in the United States. 2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds. 3. To improve the quality of services and health outcomes. 4. To meet legislative, regulatory and accreditation mandates. 5. To gain a competitive edge in the marketplace. 6. To decrease the likelihood of liability/malpractice claims. 7. National Center for Cultural Competence: Georgetown University Center for Child and Human Development. Available at http://www.georgetown.edu/research/gucdc/ncc/cultural5.html . Accessed online November 27, 2002. [304-316] [This seems to indicate the target group for this recommendation:] The programming opportunities that MPRO provides to health and community service agencies throughout the country are designed to address health disparities at the level of the patient-provider relationship. [W 241-143]
9050	20.24 PtInclude / ResEval	We would like to recommend a closer examination of the relationship of health disparity and patient safety. [O 13-25]
Code 21: Drug Standards		
212W	21.00 DrgStand	Part of FDA approval for the safe use of drugs must include the implementation of a process to address the problem of look alike and sound alike drugs and appropriate labeling of medication. [W188-190]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
302B	21.23 DrgStand / InfoTech	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.(W 469-476)
Code 22: Medication Practices		
212W	22.00 MedPrac	Ideally, the state should support some sort of state registry to support the transfer/exchange of medication information across all health care organizations and pharmacies. Patients, in many cases, do not exclusively receive care at one organization. Any means to provide medication information and potentially medical history information across organizations (in an easily retrievable format but well protected) can only enhance patient safety efforts. [W286-292]
212W	22.09 MedPrac / Incent	With regard to safe medication practices, we (HFH) support the following National Quality Forum practices: - Active participation by Pharmacists in the medication-use process; - Dispensing medication in unit-dose or unit-of-use form [W270-275] The state could offer incentives/funding for organizations to utilize more Pharmacists on patient care units. [W276-278]
212W	22.10 MedPrac / Resources	With regard to safe medication practices, we (HFH) support the following National Quality Forum practices: - Active participation by Pharmacists in the medication-use process; - Dispensing medication in unit-dose or unit-of-use form [W270-275] The state could offer incentives/funding for organizations to utilize more Pharmacists on patient care units. [W276-278]
212W	22.23 MedPrac / InfoTech	Additionally, all organizations should be required to maintain ongoing lists of patients' medications. Such lists should be maintained in an electronic registry and printed for patients to carry to facilitate their movement throughout the delivery system and ensure safe medication practices amongst multiple providers and settings. This integrated medication list should be reconciled at each patient admission and discharge. [W282-286]
302B	22.00 MedPrac	And we think we need to find a way in Michigan to do that same kind of thing [mandatory patient consultation with the pharmacists] (O 209-213).
302B	22.01 MedPrac / StateFocal	Michigan needs to recruit and retain an adequate number of qualified pharmacists to conduct regular and routine inspections of all licensed pharmacies in the state (W494-495).
606W	22.11 MedPrac / GuidPrin	CALL TO ACTION HAP has pledged to implement programs of this type [that support and promote bedrock principles of patient safety; W27] – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] Refocus on specific quality “leaps.” ... Therefore, HAP urges a renewed focus on specific, discrete improvements in quality and safety designed to yield the largest safety gains. These include: [W249-252] a. CPOE implementation, in which physicians enter prescriptions and treatments into a computer rather than manual transcription. An alignment of government, health plans, coalitions and purchasers to implement CPOE by 2007-2008 in high-volume hospitals would have a huge impact on quality care and patient safety. [W253-256]
816W	22.00 MedPrac	...recommendations for safer mental health treatment must focus on three major areas: medication, seclusion and restraint, and reduction of suicide (W 33-34).
819B	22.00 MedPrac	We further recommend that all current medications (herbal and OTC included) be listed on discharge instructions from facilities to patients (W67-68).
819B	22.16 MedPrac / Team	MHHA recommends that the Commission give consideration to methods to improve communication along the full continuum of care from patient entry into the system through return to the community, particularly as related to specific medication orders and patient history of such conditions as MRSA (Methotrexate Resistance Staphylococcus Aureus) (W31-35).
8230	22.13 MedPrac / EdP	The specific recommendation I want to make here and now is that information and warnings about post polio reactions to pharmaceuticals be included in all pharmaceutical databases, the kind that I believe are now under development to make things safer so that drugs don't conflict and that kind of thing, and in training (O 8-11). But I do think that as computer-based systems aimed at the safety of drug prescriptions, this is the kind of information, for polio and probably some other conditions, needs to get in there if only to flag. You must go outside for this information before you prescribe this drug at all. I think that would be the number one safety measure that occurs to me. (O59-62)

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8230	22.23 MedPrac / InfoTech	The specific recommendation I want to make here and now is that information and warnings about post polio reactions to pharmaceuticals be included in all pharmaceutical databases, the kind that I believe are now under development to make things safer so that drugs don't conflict and that kind of thing, and in training (O 8-11). But I do think that as computer-based systems aimed at the safety of drug prescriptions, this is the kind of information, for polio and probably some other conditions, needs to get in there if only to flag. You must go outside for this information before you prescribe this drug at all. I think that would be the number one safety measure that occurs to me. (O59-62)
826W	22.00 MedPrac	Finally, the Michigan Society of Anesthesiologists sees the practice of more complex surgery and invasive procedures in physician offices, particularly those in which anesthesia is administered, as a threat to safety. The lack of training of personnel, the absence of adequate monitoring and anesthesia delivery equipment, poorly constructed facilities, and the overall lack of accreditation, credentialing, regulation and oversight of activities must be addressed by this commission.(W 161-166).
827W	22.20 MedPrac / PtInclude	Patients and families should be educated by physicians and nursing staff on medication safety as well as fall risk assessments and prevention (W85-86).
9030	22.23 MedPrac / InfoTech	So our recommendation is that we encourage people to have [healthcare] passports. We encourage the primary care providers to do these out of their offices. [O 313-315] [W]e would like to recommend that the insurance companies and the State encourage primary care doctors to have a [healthcare] passport. [O 335-337] [I]t's a perfect record of what they're allergic to. It also has a record of what medicines they were on that didn't work. [O 67-69] Medication allergies, not just the medication but what actually happens to the person when they take that medication; do they have nausea and vomiting or do they go into anaphylactic shock. Again, all of this information accessed through a standard desktop computer, one that you find in my clinic or any other clinic around the country. [O 160-166] A complete medication log, which has the medication, the dosing schedule, the start date of the medication; and then of course, most important for the patient, the reason why we're taking this medication, the purpose. There is a separate section for discontinued medications and the reasons they were discontinued. [O 208-215] [From Q and A period:] It can be used in conjunction with that [electronic medical record system]. One of our updates that we're planning, the passport will contain its own electronic medical records system that the physician can utilize. [O 234-236] With an electronic medical record system, you would hit pharmacy and electronically that information is sent to the pharmacist, and the patient just goes and picks up their prescription ... and there is no prescription involved. We also have a safety feature in this if narcotics are to be distributed to the patient. Again, that goes on a section of a passport that the patient cannot change. [O 525-535]
Code 23: Information Technology		
102B	23.17 InfoTech / HuDesign	Evaluate and assist with application of emerging information technology tools, such as data mining, that can enhance surveillance of healthcare-associated errors and investigate feasibility of real-time decision support applications designed to optimize use of evidence-based practices for patient care. [W 106-109]
102B	23.24 InfoTech / ResEval	Evaluate and assist with application of emerging information technology tools, such as data mining, that can enhance surveillance of healthcare-associated errors and investigate feasibility of real-time decision support applications designed to optimize use of evidence-based practices for patient care. [W 106-109]
102B	17.23 HuDesign / InfoTech	Evaluate and assist with application of emerging information technology tools, such as data mining, that can enhance surveillance of healthcare-associated errors and investigate feasibility of real-time decision support applications designed to optimize use of evidence-based practices for patient care. [W 106-109]
1030	23.00 InfoTech	New and improved technologies absolutely have to be part of the patient safety solution. My – some of the things that I'm most enthusiastic about in terms of potential to reduce clinical errors would be the electronic medical record and physician computerized order entry for medications. [O 47-52]
1030	23.09 InfoTech / Incent	New and improved technologies absolutely have to be part of the patient safety solution. My – some of the things that I'm most enthusiastic about in terms of potential to reduce clinical errors would be the electronic medical record and physician computerized order entry for medications. [O 47-52] Any incentives or assistance that can be provided to both healthcare organizations and individual practitioners to implement these technologies I think would be very valuable. [O 64-67]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
1030	23.10 InfoTech / Resources	New and improved technologies absolutely have to be part of the patient safety solution. My – some of the things that I'm most enthusiastic about in terms of potential to reduce clinical errors would be the electronic medical record and physician computerized order entry for medications. [O 47-52] Any incentives or assistance that can be provided to both healthcare organizations and individual practitioners to implement these technologies I think would be very valuable. [O 64-67]
1040	23.10 InfoTech / Resources	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O 9-13] The biggest improvement that's going to be made in patient safety is through technology. Bar coding, electronic medical records, computer order entry are currently out there and organizations need to somehow find the dollars to adopt them. [O 113-117]
105B	23.10 InfoTech / Resources	I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29] Funding. We need support in funding the electronic medical record. It cannot be understated that it takes [added oral: "literally"] millions of dollars to move forward with these systems. Let's call a spade a spade. Medicare [probably means Medicaid based on next sentence and written] funding is woefully inadequate in the state of Michigan. [Written states "Medicaid funding is pitiful."] Munson and other hospitals across the state lose millions of dollars every year caring for the Medicaid population. It is the state of Michigan's moral responsibility to adequately fund the care needed by this population. [O 241-250; W 134-138] The electronic medical record holds great promise and hospitals need help in funding those efforts. [O 127-129; W 71-72] Recommendations [from Executive Summary]: Increased funding is needed to support development of the electronic medical record [W 182, 186]
204B	23.04 InfoTech / VolRpt	Seventh, develop and implement a statewide anonymous, non-punitive voluntary reporting system, preferably web-based or other electronic system, for actual or potential adverse medical outcomes or events using a simple format that collects only essential information concerning the event (W88-91).
204B	23.09 InfoTech / Incent	Communication with other practitioners. The investment in clinical information systems must increase with incentives for small and medium sized practices to invest in this technology.
204B	23.10 InfoTech / Resources	Communication with other practitioners. The investment in clinical information systems must increase with incentives for small and medium sized practices to invest in this technology.
204B	23.00 InfoTech	Open architecture software support systems within the confines of HIPAA and other aspects of protected information to make information available across the continuum would contribute to reduction[of patient safety problems]. Similarly medical decision support software incentives would further reduce risk. Pending such availability provide recommendations for practical manual systems to ensure follow-up and follow-through for results and interventions for facilities and practitioners (W122-127).
212W	23.22 InfoTech / MedPrac	Additionally, all organizations should be required to maintain ongoing lists of patients' medications. Such lists should be maintained in an electronic registry and printed for patients to carry to facilitate their movement throughout the delivery system and ensure safe medication practices amongst multiple providers and settings. This integrated medication list should be reconciled at each patient admission and discharge. [W282-286]
213W	23.10 InfoTech / Resources	I will argue in my testimony that developing a "culture of safety" in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 3. We implemented an on-line occurrence reporting system to help us more accurately track these trends. We are looking at instituting an Electronic Medical Record, and other technology to assist in reducing errors. This will be very expensive. Increased use of technology needs to be encouraged, and some means of financial support needs to be provided, to encourage and assist healthcare organizations to implement this technology. [W 154-160]
302B	23.21 InfoTech / DrgStand	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.(W 469-476)
302B	23.00 InfoTech	We must work to identify and remove legal and other barriers to the implementation of this type of technology [electronic prescribing]. We must also anticipate and work to avoid the many problems that otherwise will occur as the technology is fully implemented (W378-380).

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3030	23.00 InfoTech	Priority should be given for a thorough assessment of patients by RNs to ensure accurate databases (O155-157).
306B	23.25 InfoTech / Legis	Therefore, I am making the following recommendations to improve patient safety and reduce information errors in health care organizations (W68-69). Monies be appropriated by the legislature to support the development and implementation of computerized information systems to streamline documentation of patient care (W76-78).
306B	23.00 InfoTech	Therefore, I am making the following recommendations to improve patient safety and reduce information errors in health care organizations (W68-69). ANA recognized, standardized nursing terminologies be used for information entry and retrieval in manual and computerized documentation systems in all clinical settings (W73-75).
501W	23.29 InfoTech / PSRpt	Michigan should take immediate action to: [W 49-50] Promote investments in clinical information technology [Bolded in original text]: Efforts should be undertaken to accelerate the adoption of improved clinical information technology to support improved coordination of care, practice of evidence-based medicine, and public reporting of safety, quality and efficiency. [W66-69] Purchasers, health plans, government entities, and providers should work together to advance rapid adoption of clinical information technology. This technology should be based on common national standards to assure that compatible information technology systems are adopted by key stakeholders such as plans and providers to support an open, and efficient exchange of information while complying with all applicable rules to protect confidential information. [W 146-152]
605B	23.00 InfoTech	BCBSM and BCN recommend that the state and other key stakeholders, including health plans, physicians and other providers of care, consumers and employer groups, focus on the following seven strategies to improve patient safety in Michigan, keeping in mind that there are no magic bullets for improving patient safety (P3 L6-10) Implement Information Technology Tools (P3 L12).
605B	23.09 InfoTech / Incent	We encourage the State of Michigan to consider providing public incentives to promote adoption of electronic prescribing, to supplement incentives provided by third-party payers (i.e., reimbursement for utilization of electronic prescribing or for the information processed (Relative Value Units - RVUs), pay for performance programs, defrayed costs, per-Rx fees). P4/5 L43-6
605B	23.10 InfoTech / Resources	We encourage the State of Michigan to consider providing public incentives to promote adoption of electronic prescribing, to supplement incentives provided by third-party payers (i.e., reimbursement for utilization of electronic prescribing or for the information processed (Relative Value Units - RVUs), pay for performance programs, defrayed costs, per-Rx fees). P4/5 L43-6
605B	23.10 InfoTech / Resources	In the experience of BCBSM and BCN, as health plans, we have developed several different approaches to improving patient safety in hospitals, physician offices, and community pharmacies, and other settings, and one of the biggest barriers to implementation of high technology tools is cost. And it goes beyond just the economic cost of implementing these tools P26-29. There is also a required need for a change in the culture of safety in these settings, as well as substantial training and re-engineering of clinical processes, which represent additional costs for providers P3, L30-31.
608W	23.04 InfoTech / VolRpt	Information Technology: The technology that would be required for this type of voluntary reporting system [that reports errors to a central repository [W40]] is a web based data reporting system as well as an anonymous phone reporting process. The technology or process that is utilized needs to meet the various mechanisms of the users and their various technological capabilities. [W165-170]
808B	23.00 InfoTech	And technology in the form of bar codes that would identify medication in which a patient is allergic to by matching a bar code on the hospital identifications for the patient.(O 197-200).
8090	23.25 InfoTech / Legis	I would promote legislation to enhance the use of technology in healthcare facilities (O 96-98).
819B	23.00 InfoTech	Now that HIPAA regulations have been put into place affecting most, if not all, health care providers, the appropriate and important information necessary to provide safe patient care should be made available to the entire healthcare team (W37-39). Use of internet dissemination of patient safety information to all health providers is also recommended (W64-65).

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Verbatim Recommendations from Testimony with Original Coding

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821B	23.10 InfoTech / Resources	And unless the people who understand health care environments know that it costs money to provide bar codes, that's one of the significant issues that we are going to try to overcome (O46-48). I think those individuals who are not here today would have to provide that for the system because of their awareness of the importance of this, and that we are moving to a new system where it's not only qualitative in terms of new techniques, broader scope of service, but also quantitative (O56-59). We have to identify those individuals, and I think the system itself has to provide that (O64).
821B	23.00 InfoTech	But unless we have info systems (O45). We have to simplify the system for us. We have to really make it very patient-focused (O63-64).
8230	23.22 InfoTech / MedPrac	The specific recommendation I want to make here and now is that information and warnings about post polio reactions to pharmaceuticals be included in all pharmaceutical databases, the kind that I believe are now under development to make things safer so that drugs don't conflict and that kind of thing, and in training (O 8-11). But I do think that as computer-based systems aimed at the safety of drug prescriptions, this is the kind of information, for polio and probably some other conditions, needs to get in there if only to flag. You must go outside for this information before you prescribe this drug at all. I think that would be the number one safety measure that occurs to me. (O59-62)
829W	23.28 InfoTech / SafeStand	Systems for electronic transfer of data must be robust yet provide for confidentiality and be HIPAA compliant (W58-59). Information Technology is of critical importance to the medical field and especially to Radiology. We are especially concerned about standardized methods to provide imaging information obtained at one institution to a second institution when the care for that patient is being undertaken at the second institution (W 54-56).
831B	23.25 InfoTech / Legis	I propose that we legislate that on the day of discharge, the patient be given a discharge disk (to be run on Window 98 or above), to include the history and physical, consults, medicines, allergies, operative reports, labs, EKGs, and radiologic services (W - lines unavailable). ...unless people like yourselves, running the Health and Safety Coalition and possibly our legislators get involved and help the patient get access to their own medical information, as well as getting that information to the primary care providers (W - lines unavailable). One very simple solution that would 1) educate patients, 2) given much needed and accurate information to the primary care physician, as well as the patient and 3) save thousands of dollars in time and decreasing the ordering of tests already done, is to give a "hospitalization summary" (W - lines unavailable). What I am recommending is that the electronic records that we get in the hospital, anything that's dictated, anything that's read out, for example, their medication list is all electronic, their history and physical is electronic, their EKGs are read out electronically, their echocardiogram, their heart cath (O89-95). That stuff is all there. All we do is download it on a little disk (O104-105).
831B	23.20 InfoTech / PtlInclude	I think we need to make that clear and then we need to encourage people to have their own medical record. I mean, it really goes hand in hand with this other thing. It's educating patients (O264-268). And I just want to have patients have their own record, deliver it to their doctor so they can see what happened, and you can get right to it (O272-275). None noted.
9030	23.20 InfoTech / PtlInclude	So our recommendation is that we encourage people to have [healthcare] passports. We encourage the primary care providers to do these out of their offices. [O 313-315] [W]e would like to recommend that the insurance companies and the State encourage primary care doctors to have a [healthcare] passport. [O 335-337] What it is is it's a passport. It's a healthcare record that a patient has, they own it, it's theirs, and it gives pertinent data. [O 47-49] The patient has full access to this information. They can't change it, but they can bring it up on a computer and they can review it with their family. ... You can have a hard copy print for the patient and they can carry it right inside their passport so family members as well as themselves can access the information for the patient's healthcare. [O 143-146] ... a patient can follow along at home and know when they're going downhill and communicate this information to their doctor. [O 279-282] ... this portion of the chart, the patient can access and add information to. [cont] [Recommendation cont] Any of it can be printed out hard copy for them to follow along and, of course, bring to their physician's office. [O 291-204] the bottom line is an informed patient is an empowered patient, and we think that this is the way the whole government is going in 2010 EMR. They want to have things like this. [O 296-299] ... an infectious disease log. It basically tracks the patient's infectious illnesses and what they were treated with. And so this can be accessed by your physicians for epidemiology purposes. [O 267-270] ... the way we feel that we get around that [information going to people who shouldn't have it] is we give this to the patient so it is theirs. They get to read it. They get to know about their disease. They get to be educated. They come in and ask intelligent questions. They go to the next doctor, they give them a history better than you would get getting a referral form or anything else. This is much more complete, and so this is theirs. [O 304-311] [cont] [Recommendation cont] [From Q and A period:] ... the patient is part of their own healthcare. They participate as opposed to this passive player. [O 818-820] It can be used in conjunction with that [electronic medical record system]. One of our updates tha

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Verbatim Recommendations from Testimony with Original Coding

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9030	23.22 InfoTech / MedPrac	So our recommendation is that we encourage people to have [healthcare] passports. We encourage the primary care providers to do these out of their offices. [O 313-315] [W]e would like to recommend that the insurance companies and the State encourage primary care doctors to have a [healthcare] passport. [O 335-337] [I]t's a perfect record of what they're allergic to. It also has a record of what medicines they were on that didn't work. [O 67-69] Medication allergies, not just the medication but what actually happens to the person when they take that medication; do they have nausea and vomiting or do they go into anaphylactic shock. Again, all of this information accessed through a standard desktop computer, one that you find in my clinic or any other clinic around the country. [O 160-166] A complete medication log, which has the medication, the dosing schedule, the start date of the medication; and then of course, most important for the patient, the reason why we're taking this medication, the purpose. There is a separate section for discontinued medications and the reasons they were discontinued. [O 208-215] [cont] [Recommendation cont] [From Q and A period:] It can be used in conjunction with that [electronic medical record system]. One of our updates that we're planning, the passport will contain its own electronic medical records system that the physician can utilize. [O 234-236] With an electronic medical record system, you would hit pharmacy and electronically that information is sent to the pharmacist, and the patient just goes and picks up their prescription ... and there is no prescription involved. We also have a safety feature in this if narcotics are to be distributed to the patient. Again, that goes on a section of a passport that the patient cannot change. [O 525-535]
9030	23.10 InfoTech / Resources	[From Q and A period:] And I think consumers will want this [healthcare passport] if we make it available to them, but I think we need a boost from the State, we need a boost from the insurance companies. But we want to get us off the bottom. [O 711-714]
904B	23.15 InfoTech / Collab	MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [W 61-62; O 19-20] The implementation of electronic health records [W 65; O 21] A key area where patient safety can be improved and produce positive results involves the adoption of interoperable electronic health records (EHR). [W 180-181] A key area where partnering can produce results involves the adoption of electronic health records. One day in the not too distant future physicians will be able to share patient records across the information highway. [O 39-41] In April of this year, President Bush called for widespread adoption of electronic health records within 10 years. [W 189-190; O 46-47] [Targets indicated in strategy where talks about MI health care providers and systems.] [W 184-187]
906W	23.11 InfoTech / GuidePrin	By far the most cost-effective opportunity to improve care in this country is not from discovering new therapies but in learning how to deliver those therapies that we know work safely and cost-effectively. We need a more balanced health care research portfolio, to help with those efforts. We know, through research on organizational behaviors, that we need to focus on "systems" to truly impact change. [W 46-50] The third dimension [to the work that lies ahead] is improving communication, which is at the core of culture change. IT infrastructure including an electronic medical record is part of that because it is not a tool to just help link us better, but a tool that has to be coupled with culture change and enhancing our ability to work together as human beings. The transparency needed to create a seamless system of care cannot be accomplished without standardizationof IT [W 174-178] [Targets indicated in strategy: e.g.,] why we went into the healing profession to begin with [W 62-63]
Code 24: Research and Evaluation		
110W	24.00 ResEval	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Advance research resources, opportunities, and funds related to care models, nurse patient ratios, and human factors theory. [W 122-123] Professional societies and groups can help to reduce patient medical errors by assisting as advocates for healthcare patient safety efforts. These advocacy efforts include ongoing research to continue and provide correlations of acute care processes to patient outcomes, .. [W 79-80] Continued funding and resource assistance are necessary to expand research efforts. [W 90]
110W	24.10 ResEval / Resources	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Provide research grants and funding to continue to explore the impact of human factors theory on medical errors. [W 74-75]
110W	24.10 ResEval / Resources	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Advance research resources, opportunities, and funds related to care models, nurse patient ratios, and human factors theory. [W 122-123] Professional societies and groups can help to reduce patient medical errors by assisting as advocates for healthcare patient safety efforts. These advocacy efforts include ongoing research to continue and provide correlations of acute care processes to patient outcomes, .. [W 79-80] Continued funding and resource assistance are necessary to expand research efforts. [W 90]

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204B	24.10 ResEval / Resources	Fund patient safety/risk reduction demonstration projects involving small to medium size practices or a collaborative of small to medium size practices (W134-135).
305W	24.15 ResEval / Team	Therefore, the first recommendation to the Commission is to fund research into interventions to improve communication between nurses and physicians. (W98-99)
306B	24.00 ResEval	Therefore, I am making the following recommendations to improve patient safety and reduce information errors in health care organizations (W68-69). Research monies be sought for demonstration studies focused on streamlining the documentation and care planning processes in organizations with the specific aim that documentation becomes a realistic component of the nurse workload (W70-72).
824W	24.28 ResEval / SafeStand	While in the United States, technical advancements has produced longer life spans, and shorter hospital stays the health care industry have yet to recognize the need to research home care safety issue associated with all patient populations (W72-75). In the United States the health care industry lacks the understanding of how patients and caregivers work within the home care environment and this leads some patients to search for answers in countries like Canada or Sweden (W36-39).
826W	24.03 ResEval / MandRpt	We do have serious concerns about the practicality, advisability and utility of the type of mandatory reporting of serious events recommended in the IOM report. Believing this recommendation to be premature and too specific, we suggest instead further study of existing mandatory systems to determine whether any form of mandatory reporting is desirable, and if so, what form it should take. (W 140-144)
826W	24.26 ResEval / PeerProtect	The MSA and the APSF also have serious concerns about the call to develop methods to identify and take action against "unsafe providers." While we agree that methods should be investigated for assessing the performance ability and competence of health care providers, this is not a simple matter and will require considerable research. (149-152)
9050	24.20 ResEval / PtInclude	We would like to recommend a closer examination of the relationship of health disparity and patient safety. [O 13-25]
906W	24.11 ResEval / GuidePrin	By far the most cost-effective opportunity to improve care in this country is not from discovering new therapies but in learning how to deliver those therapies that we know work safely and cost-effectively. We need a more balanced health care research portfolio, to help with those efforts. We know, through research on organizational behaviors, that we need to focus on "systems" to truly impact change. [W 46-50] And to get leverage for changing that [culture of health care], to get stickiness for changing our systems of work and relationships, we're going to need to begin to understand how we can possibly create the culture that we need to ensure, to the maximum extent possible, safety and quality of care. [W 56-69] [T]here are three bold dimensions to the work that lies ahead. The first dimension could be described as building capacity for quality and patient safety [underline in original]. That includes training health care providers and further training the research community who could lead these efforts. We must also build a body of evidence to support the wholesale transformation of the industry. Building capacity includes development of a non-punitive reporting system so we can learn where mistakes are happening, where patients are at greatest risk of harm. That knowledge will provide a platform for the second dimension of progress [development of clear national patient safety goals and implementation of related measures]. [W 159-164]
Code 25: Legislation		
205B	25.26 Legis / PeerProtect	Recommend that the state legislature pass legislation that will establish a privilege of confidentiality for all reported patient safety information (eg. Oregon) [W163-165. To achieve that goal [to prevent harm to patients and not to prevent human error], there must be uniform, unambiguous, and assured confidentiality of patient safety information [W179-180].
302B	25.00 Legis	In the interest of public safety, Executive Order 1996-2 should be rescinded and Boards should once again be given full responsibility and authority to promulgate rules needed to assure safe practice in all the licensed health professions in our state (W441-443). Executive Order 962 removed [licensure] boards ability to promulgate rules, and that Executive Order should be rescinded (O 144-146).
302B	25.02 Legis / MeasCrit	We also need legislative changes to permit creation of a peer review process designed to collect and analyze reports on medication errors that occur outside the institutional setting (W453-457, O167-171).
302B	25.07 Legis / ProfLic	The licensing boards in Michigan should be given the flexibility to use non-disciplinary approaches to deal with practitioners involved in medication errors (W404-406,O130-133).

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302B	25.26 Legis / PeerProtect	We need to change the Public Health Code to assure that quality assurance (QA) activities undertaken in community pharmacy practice have the same protection from discovery as those done in hospitals. We also need legislative changes to permit creation of a peer review process designed to collect and analyze reports on medication errors that occur outside the institutional setting (W453-457, O167-182). Under our current Public Health Code, those exist for medicine only, not for the other health professions, and we think pharmacy needs to be included in that (O182-185).
305W	25.09 Legis / Incent	Therefore, the second recommendation to the Commission is to suggest to the Governor that legislation be enacted to offer a financial incentive to hospitals that seek and retain ANCC magnet recognition. (W161-163).
305W	25.18 Legis / Staffing	Therefore, aspects of nursing other than staffing levels need to be addressed to adequately assure that hospitalized patients are safely cared for, and this researcher is NOT recommending that Michigan follow the example set by other states and mandate minimum staffing levels [W44-48].
306B	25.23 Legis / InfoTech	Therefore, I am making the following recommendations to improve patient safety and reduce information errors in health care organizations (W68-69). Monies be appropriated by the legislature to support the development and implementation of computerized information systems to streamline documentation of patient care (W76-78).
4010	25.27 Legis / Advocacy	And so I think the best thing for my point of view that this Commission could do would be to set up a Michigan Hospital Grievance Commission, patterned after the Attorneys Grievance Commission. [O41-43].
402B	25.18 Legis / Staffing	We believe we need guidelines, either agreed upon with the employer, or by legislation, to limit the number of patients each RN is responsible for. [W92-94]
402B	25.18 Legis / Staffing	My colleagues at [name of hospital] believe we need legislation banning mandatory overtime. [W91-92]
404B	25.00 Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] a. Recommendations for State actions in a pre-strike environment. Prior to the commencement of a strike the following recommendations would mandate dialogue and communication for the purpose of informing the public of the issues in dispute. [W23-25] The State should also create a framework to enable parties to a labor dispute in a health care setting to engage in a fact finding or binding arbitration hearing. [W28-29; W354-355]
404B	25.00 Legis	The State should enact legislation or develop a regulatory scheme to provide that even during labor disputes, a hospital is obligated to remain fiscally responsible to assure that it is able to continue to operate for the benefit of the public. [W247-249; O184-188]
404B	25.00 Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] ! Exhibit greater oversight of a health care institution's requests for loans, bond issuance, certificate of need filings, etc. during strike periods. [W64-65; W403-404]
404B	25.00 Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] a. Recommendations for State actions in a pre-strike environment. Prior to the commencement of a strike the following recommendations would mandate dialogue and communication for the purpose of informing the public of the issues in dispute. [W23-25; W345-347] ! The State should mandate that a health care institution publish a plan of action to address issues related to public safety. [W26-27; W350-351]
404B	25.03 Legis / MandRpt	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] Require that health care employees have an obligation to disclose patient safety issues. [W55-56; W390-391]

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404B	25.03 Legis / MandRpt	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] ! Require the health care institution to make timely disclosure of financial reports that will reveal the financial status of institution [W62-63; W397-398]
404B	25.18 Legis / Staffing	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] Staffing levels should be monitored and a patient/nursing ratio should be established at a level that provides an environment for the provision of quality and affordable health care. The patient/nursing staff ratio should also clearly limit the number of nursing staff that are provided by traveling nursing firms. [W47-50]
404B	25.20 Legis / PtlInclude	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] In conjunction with the inspection scheme, the State should develop a framework to allow patients to be interviewed to assess the level of care being provided. [W43-44; W376-377]
404B	25.26 Legis / PeerProtect	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] Enact specific whistle blower type to protect health care employees who report problems with the provision of medical services. [W51-52; W384-385]
404B	25.29 Legis / PSRpt	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36; W365-369] ! A system of frequent and random inspections should be mandated to monitor the level of care being provided at the institution. [W37-38; W370-371]
411W	25.10 Legis / Resources	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] 2.) Funding: In the past the legislature, mindful of the needs to maintain a stable work force has provided for a wage pass through to nursing home care givers. That pass through legislation must continue to be increased. [W129-131]
411W	25.26 Legis / PeerProtect	2.) Expanded Whistleblower Protection for Hospital Workers [W45] PA 731 of 2002, (HB 5829) Vander Veen This bill provides a hospital worker immunity from civil or criminal liability and protects them from being discharged, threatened, or otherwise discriminated against by the hospital regarding his or her compensation or the terms, conditions, location, or privileges of his or her employment, if he or she reports to CIS (verbally or in writing) an unsafe practice or condition, that is not currently protected under Article 17 of the Public Health Code. [W46-53]
411W	25.26 Legis / PeerProtect	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] 4.) Patient Abuse: [W140] ..The current legislation dealing with patient abuse needs to provide that findings against a care giver not trump the just cause provisions in a collective bargaining agreement. [W141-143] Collectively bargained procedures should be protected by state law and regulation. [W145-146]
413W	25.27 Legis / Advocacy	We seek your support to pass the original version of HB 5537. [W55] The frail and elderly certainly deserve a day-to-day living environment that meets contemporary standards for safety and comfort. Michigan needs to adopt this standard for all of its nursing homes. [W138-141]

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419W	25.18 Legis / Staffing	In an effort to remedy these problems on a national level, the SEIU Nurse Alliance is calling upon Congress to enact federal legislation for safe staffing and restrictions on mandatory overtime that provides as follows: [W122-124]
419W	25.27 Legis / Advocacy	And I strongly encourage you to please do whatever you can do to encourage the State or the Feds to move some of this legislation [legislation introduced in Michigan and at Fed level on issues of mandatory overtime and staffing levels] and really have an open forum of discussion on these issues of staffing and mandatory overtime. [095-99]
608W	25.26 Legis / PeerProt	Patient Safety Legislation: The first step [to develop a voluntary system of reporting errors to a central repository [W40]] is for the State of Michigan to establish regulatory protection for reporting of medical errors for the purpose of improving patient safety on a statewide basis. This legislation should embrace all types of reporting, regardless of the cause or outcome. [W149-53]
8020	25.28 Legis / SafeStand	It is imperative that Michigan join the other 41 states in this country to consider the National Council of Acupuncture's standards for eligibility as the minimum standards for safe practice in our profession.(O63-65).
806B	25.10 Legis / Resources	Encourage congress to establish a budget item for a health services consultant at the state level to develop and implement the plan.(W231-232).
8090	25.00 Legis	I would promote legislation to regard nursing -- this is sort of revolutionary -- as a revenue center rather than a cost center which would obviate the ability of people to look at the largest single part of the hospital work force and diminish it as an inappropriate way of saving money (O 89-94).
8090	25.23 Legis / InfoTech	I would promote legislation to enhance the use of technology in healthcare facilities (O 96-98).
812B	25.07 Legis / ProfLic	Registered dietitians seek to improve the health and safety of Michigan residents by providing Medical Nutrition Therapy.(W135-136) Licensing registered dietitians can be an important step in protecting patients in Michigan.(W217-218).
818B	25.00 Legis	The specifics of this action by the State of Michigan are spelt out well by the House of Representatives in a House Bill (4898) introduced by Rep Larry Julian. This Bill passed the House without any opposition and came out of committee by unanimous support. This Bill, sat in the office of the Chair of the Senate Health Committee, and never brought to the committee for discussion or public testimony. The Executive Office might benefit from reviewing this proposed legislation. (W62-68).
826W	25.04 Legis / VolRpt	On the legislative front, there were two bills introduced at the federal level last year, S. 720 (The Patient Safety and Quality Improvement Act) and a companion bill HR 663 that would improve patient safety and reduce medical errors. 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. A key feature of the bills is the inclusion of provisions designed to assure that reported data could not be discovered while, at the same time, not limiting the availability of information under other laws.(W 170-179)- In the State of Michigan, a similar endeavor was discussed at the Michigan State Medical Society's State Legislative & Regulations Committee meeting. (W 181-182). The MSA encourages the MH&SC to support the adoption of these laws, since they would offer a new dimension to the ASA's existing closed-claims study program.(W 187-188).
826W	25.26 Legis / PeerProtect	We strongly endorse the recommendations for a voluntary reporting system and for enacting legislation, both nationally and at the state level, to extend peer review protection to data related to patient safety. The two must go hand in hand.(W 144-147).
828W	25.09 Legis / Incent	Any regulation or legislation considered must be developed in the spirit of reward for improvement and not punishment.(W 116-119).
828W	25.11 Legis / GuidePrin	Regulation and legislation must support collaborative approaches among hospitals, physicians, hospital employees, and health plans to stimulate and improve patient safety and must be non-punitive(W 96-98).
828W	25.15 Legis / Collab	Regulation and legislation must support collaborative approaches among hospitals, physicians, hospital employees, and health plans to stimulate and improve patient safety and must be non-punitive.(W 96-98)

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
828W	25.26 Legis / PeerProtect	To foster continuous improvement in patient safety, legislation or public policy must create a “safe haven” for hospitals and hospital employees working toward improvement and protection against the use of information in legal proceedings.(W 98-101).
831B	25.23 Legis / InfoTech	I propose that we legislate that on the day of discharge, the patient be given a discharge disk (to be run on Window 98 or above), to include the history and physical, consults, medicines, allergies, operative reports, labs, EKGs, and radiologic services (W - lines unavailable). ...unless people like yourselves, running the Health and Safety Coalition and possibly our legislators get involved and help the patient get access to their own medical information, as well as getting that information to the primary care providers (W - lines unavailable). One very simple solution that would 1) educate patients, 2) given much needed and accurate information to the primary care physician, as well as the patient and 3) save thousands of dollars in time and decreasing the ordering of tests already done, is to give a "hospitalization summary" (W - lines unavailable). What I am recommending is that the electronic records that we get in the hospital, anything that's dictated, anything that's read out, for example, their medication list is all electronic, their history and physical is electronic, their EKGs are read out electronically, their echocardiogram, their heart cath (089-95). That stuff is all there. All we do is download it on a little disk (0104-105).
Code 26: Peer Protection		
1030	26.00 PeerProtect	It's absolutely essential that when these events [clinical errors] occur people are comfortable to report them openly, to participate in very detailed in-depth root cause analysis of the underlying reasons for the event. I would like to suggest as one part of this that the medical-legal climate is a barrier to this open reporting and would urge that [medical-legal climate] to be one focus of many. [O 38-46]
110W	26.27 PeerProtect / Advocacy	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Provide lobby efforts and advocacy for tort reform and liability protection within the healthcare industry to participate with the private/ public sector in patient safety efforts. [W 129-131] Professional groups need to play a strong role in tort reform and the application of peer protection for hospital participation within the current environment. [W 103-104]
110W	26.00 PeerProtect	There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Provide a peer protection environment and process for disclosure requests of internal processes related to patient outcomes. (Much like the JCAHO process for sentinel events.) [W 60-62] We strongly encourage and believe in the promotion of a nonpunitive culture. The private sector can assist with this by promoting methods to peer protect disclosure of information that may be necessary for their use. [W 45-48]
2020	15.00 Collab Considered under PeerProtect after further review	And also I think that the – that the peer review process should be removed from the hospital where it occurs at.(057-59). ...hospitals of similar size and of similar activity look at other hospitals of similar size and similar activity, peer review material, and judge them dispassionately and in an uninvolved fashion.(060-63).
204B	26.11 PeerProtect / GuidPrin	Sixth, re-design the professional peer review process to make it safe to conduct substantive review without casting aspersions (W83-84).
205B	26.25 PeerProtect / Legis	Recommend that the state legislature pass legislation that will establish a privilege of confidentiality for all reported patient safety information (eg. Oregon) [W163-165. To achieve that goal [to prevent harm to patients and not to prevent human error], there must be uniform, unambiguous, and assured confidentiality of patient safety information [W179-180].
212W	26.03 PeerProtect / MandRpt	Mandatory, public reporting for the collection of standardized information about preventable adverse events is supported if legal protection is provided both to the organization and the provider(s). [W119-121]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
213W	26.25 PeerProtect / Legis	I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 5. In the near future, we will be implementing a recognition program to encourage reporting of errors. Only if people feel safe to report, can we identify issues that may be occurring system-wide, and approach it from that standpoint. Changes need to be made in our legal and licensing systems, so that healthcare providers are held accountable, but not punished unless there is criminal activity or gross negligence. [W 168-174] [I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to “near misses,” where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future. [W128-133]
213W	26.06 PeerProtect / OrgReg	I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 6. St. John Health is implementing a training program for physicians about disclosure of unanticipated outcomes. We believe that full disclosure is the right thing. Partnering with our patients by fully disclosing errors, apologizing, offering fair compensation when appropriate, and sharing ways to improve processes so that the error will not occur again, should decrease the litigious environment in Michigan. The State Commission on Patient Safety should support changes to facilitate the changes in our legal and licensing systems. [W 175-183] [I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to “near misses,” where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future. [W 128-133]
302B	26.25 PeerProtect / Legis	We need to change the Public Health Code to assure that quality assurance (QA) activities undertaken in community pharmacy practice have the same protection from discovery as those done in hospitals. We also need legislative changes to permit creation of a peer review process designed to collect and analyze reports on medication errors that occur outside the institutional setting (W453-457, O167-182). Under our current Public Health Code, those exist for medicine only, not for the other health professions, and we think pharmacy needs to be included in that (O182-185).
404B	26.25 PeerProtect / Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36] Enact specific whistleblower type to protect health care employees who report problems with the provision of medical services. [W51-52; W384-385]
411W	26.25 PeerProtect / Legis Not a recommendation	2.) Expanded Whistleblower Protection for Hospital Workers [W45] PA 731 of 2002, (HB 5829) Vander Veen This bill provides a hospital worker immunity from civil or criminal liability and protects them from being discharged, threatened, or otherwise discriminated against by the hospital regarding his or her compensation or the terms, conditions, location, or privileges of his or her employment, if he or she reports to CIS (verbally or in writing) an unsafe practice or condition, that is not currently protected under Article 17 of the Public Health Code. [W46-53]
411W	26.25 PeerProtect / Legis Not focused on patient safety	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] 4.) Patient Abuse: [W140] ...The current legislation dealing with patient abuse needs to provide that findings against a care giver not trump the just cause provisions in a collective bargaining agreement. [W141-143] Collectively bargained procedures should be protected by state law and regulation. [W145-146]
416W	26.04 PeerProtect / VolRpt Handled under VolRpt	... I have some suggestions that may promote patient safety in community health settings. [W7-8] 6. Establish an 800# for anonymous tips re: patient safety/problems. [W24]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
608W	26.25 PeerProtect / Legis	Patient Safety Legislation: The first step [to develop a voluntary system of reporting errors to a central repository [W40]] is for the State of Michigan to establish regulatory protection for reporting of medical errors for the purpose of improving patient safety on a statewide basis. This legislation should embrace all types of reporting, regardless of the cause or outcome. [W149-53]
808B	26.04 PeerProtect / VolRpt	And a voluntary reporting system also that would complement the mandatory reporting system to identify errors. The information from the voluntary reporting system must be obtained by an independent entity and used to identify patterns of errors. The data collected related to patient and patient safety must be protected (O 175-184). A clinical scientist and health services expert and experienced individual should be seated on the voluntary – on this reporting committee. (O 189-191). Further recommendation to extend peer review protection to data related to patient safety and quality improvement gathered through voluntary reporting system.(W 336-338).
826W	26.24 PeerProtect / ResEval	The MSA and the APSF also have serious concerns about the call to develop methods to identify and take action against “unsafe providers.” While we agree that methods should be investigated for assessing the performance ability and competence of health care providers, this is not a simple matter and will require considerable research.
826W	26.25 PeerProtect / Legis	We strongly endorse the recommendations for a voluntary reporting system and for enacting legislation, both nationally and at the state level, to extend peer review protection to data related to patient safety. The two must go hand in hand.(W 144-147).
828W	26.25 PeerProtect / Legis	To foster continuous improvement in patient safety, legislation or public policy must create a “safe haven” for hospitals and hospital employees working toward improvement and protection against the use of information in legal proceedings.(W 98-101).
Code 27: Advocacy		
110W	27.26 Advocacy / PeerProt Handled under PeerProt	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Provide lobby efforts and advocacy for tort reform and liability protection within the healthcare industry to participate with the private/ public sector in patient safety efforts. [W 129-131] Professional groups need to play a strong role in tort reform and the application of peer protection for hospital participation within the current environment. [W 103-104]
4010	27.25 Advocacy / Legis Recorded to 30.25 CPAdvocate / Legis	And so I think the best thing for my point of view that this Commission could do would be to set up a Michigan Hospital Grievance Commission, patterned after the Attorneys Grievance Commission. [O41-43].
4050	27.00 Advocacy Recorded to 30.00 CPAdvocate	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [O56-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167] Finally, this is the recommendation that probably surprised me the most of all that emerged, consumers really want a healthcare system that provides them different kinds of pathways to resolving disputes when something happens. [O216-218]
406B	27.10 Advocacy / Resources Handled under Resources	It is through my testimony today that I request the Commission continue to advocate and identify funding, that allows older adults to remain safe and independent in their own homes for as long as possible [W123-125]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
413W	27.25 Advocacy / Legis Handled under Legis	We seek your support to pass the original version of HB 5537. [W55] The frail and elderly certainly deserve a day-to-day living environment that meets contemporary standards for safety and comfort. Michigan needs to adopt this standard for all of its nursing homes. [W138-141]
419W	27.25 Advocacy / Legis Handled under StateFocal and Staffing	And I strongly encourage you to please do whatever you can do to encourage the State or the Feds to move some of this legislation [legislation introduced in Michigan and at Fed level on issues of mandatory overtime and staffing levels] and really have an open forum of discussion on these issues of staffing and mandatory overtime. [095-99]
906W	27.10 Advocacy / Resources Handled under StateFocal and Resources	One of the important patient safety roles of state governments should be to be relentless in advocating for funding changes at the federal level, so that health systems and care providers can learn the most efficient and effective ways to improve quality and safety. These are complicated challenges. Expecting individual providers or individual states to achieve best care through local or regional trial and error is neither efficient nor effective. [W 25-30]
906W	27.28 Advocacy / SafeStand Handled under SafeStand	States such as Michigan need to use their voice to help raise the volume on the urgency of a national, goal-directed, funded agenda for quality and patient safety. [W 106-107] A second dimension [to the work that lies ahead] is to develop ... clear national patient safety goals and implement measures for those goals. As an industry, both at a national level and at an institutional level, we don't have a really clear idea of what it means to be safer, and we need to. Included broadly in this second dimension is alignment of payment for care [words highlighted here were underlined in original]. If we establish goals for quality and safety, that is what we should pay for. When the goals and national priorities are clear, and payment is aligned with performance measured against those goals, institution and provider specific, public reporting of performance in relation to the goals should be a requirement of licensure [words "institution" through "licensure" underlined in original]. [W 166-172]
906W	27.04 Advocacy / VolRpt Handled under VolRpt	A voluntary, non-punitive reporting environment has been a critical component of the aviation industry success story, and we need similar environmental protections in healthcare. We suggest that the role of state governments ought to be supportive of a national agenda for voluntary healthcare reporting systems, aligned at a federal level, so that care providers throughout the country can learn from each other, much as the aviation industry does. [W 117-121] The first dimension [to the work that lies ahead] could be described as building capacity for quality and patient safety [underlining in original]. That includes training health care providers and further training the research community who could lead these efforts. We must also build a body of evidence to support the wholesale transformation of the industry. Building capacity includes development of a non-punitive reporting system so we can learn where mistakes are happening, where patients are at greatest risk of harm. That knowledge will provide a platform for the second dimension of progress [development of clear national patient safety goals and implementation of related measures]. [W 159-164]
906W	27.12 Advocacy / Ldrship Handled under StateFocal and Ldrship	Michigan has a strong tradition of voluntary hospital reporting, a leadership track record for collaboration ... , an enviable assembly of healthcare stakeholders that are members of the Michigan Health and Safety Coalition, and a major insurer (Blue Cross Blue Shield of Michigan) with a progressive vision of how to support quality and safety improvements. That combination of forces with a shared vision could position the state to aggressively innovate and add to the body of knowledge necessary to demonstrate definitively, year after year, that healthcare is indeed safer. ... We encourage the patient safety commission to recommend this level of state leadership. [W 230-241] An overarching opportunity is for states like Michigan to call for and support coordinated leadership from all of these different major stakeholders [Fed, State (incl licensing), health professional ed, health care delivery systems, practitioners – see W 198-203] rather than developing one more unique, state specific set of expectations for healthcare quality and safety. [W 211-213] [cont] [Recommendation cont] Leadership for reform, then, really needs to come from several different sources. In Crossing the Quality Chasm the IOM called for fundamental change at many different levels. We need to see change at the Federal level and we also need change at the state level. We need change in the health profession education, training and licensure. We also need change in the healthcare delivery system at the community level and the local level and in the micro-systems of care: individual care units in hospitals, physician's offices, clinics etc. [W 198-203]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
Code 28: Safety Standards		
3030	28.00 SafeStand	Every healthcare provider with hospital privileges should be required to maintain up-to-date simple, universal, one-page data sheet on his or her patients, including diagnoses, medications, drug allergies and intolerances (O161-165).
411W	28.00 SafeStand	Patient safety cannot be effective unless the State of Michigan address the Health crisis in Nursing Homes. [W91-92] The establishment of physical and financial standards for the operation of these homes should start at the front end. Homes should not be allowed to open unless they are determined to be able to provide a measure of stability, are adequately funded and provide reasonable physical surroundings [W99-102]
8020	28.25 SafeStand / Legis	It is imperative that Michigan join the other 41 states in this country to consider the National Council of Acupuncture's standards for eligibility as the minimum standards for safe practice in our profession.(O63-65).
806B	28.02 SafeStand / MeasCrit	Update and comply with Part 9101, of the Michigan Public Act 368 of 1978 Public Health Code, which mandates that the department (MDCH) shall establish a plan for health services for pupils in elementary and secondary schools of this state.(W207-209). Implement guidelines and standards of care for school health related services, such as, minimum standards for school health services, medications, management of chronic illnesses, confidentiality, delegation, health promotion, communicable diseases, school based health clinics, first aid/disaster response.(W225-227). Develop and implement criteria for: reporting type, provider classification, accountability, evaluation of health services provided in schools to both the Michigan Department of Community Health and the Michigan Department of Education (W235-241).
815W	28.00 SafeStand	Fracture prevention and fall prevention guidelines should be instituted in nursing home settings.(W 20).
815W	28.00 SafeStand	Some guidelines need to be put into place regarding care for the patient with delirium in a long-term setting.(W 37-38).
816W	28.00 SafeStand	Patient safety would be improved by developing and disseminating best practice models for assessment and diagnosis, particularly regarding suicidality (W 57-59).
824W	28.00 SafeStand	There are successful programs that can be duplicated here in the United States like the Enable-Age Project (W45-46).
824W	28.24 SafeStand / ResEval	While in the United States, technical advancements has produced longer life spans, and shorter hospital stays the health care industry have yet to recognize the need to research home care safety issue associated with all patient populations (W72-75). In the United States the health care industry lacks the understanding of how patients and caregivers work within the home care environment and this leads some patients to search for answers in countries like Canada or Sweden (W36-39).
829W	28.01 SafeStand / StateFocal	We are similarly interested in patient safety involved with magnetic resonance imaging and spectroscopy. Increasingly powerful magnets are being used for diagnosis and to guide therapy. The lack of effective safety policies may result in inadvertent injury to patients or members of the health care team (W35-38).
829W	28.23 SafeStand / InfoTech	Systems for electronic transfer of data must be robust yet provide for confidentiality and be HIPAA compliant (W58-59). Information Technology is of critical importance to the medical field and especially to Radiology. We are especially concerned about standardized methods to provide imaging information obtained at one institution to a second institution when the care for that patient is being undertaken at the second institution (W 54-56).
906W	28.09 SafeStand / Incent	States such as Michigan need to use their voice to help raise the volume on the urgency of a national, goal-directed, funded agenda for quality and patient safety. [W 106-107] A second dimension [to the work that lies ahead] is to develop ... clear national patient safety goals and implement measures for those goals [highlighted words underlined in original]. As an industry, both at a national level and at an institutional level, we don't have a really clear idea of what it means to be safer, and we need to. Included broadly in this second dimension is alignment of payment for care [underlined in original]. If we establish goals for quality and safety, that is what we should pay for. When the goals and national priorities are clear, and payment is aligned with performance measured against those goals, institution and provider specific, public reporting of performance in relation to the goals should be a requirement of licensure [words "institution" through "licensure" underlined in original]. [W 166-172]

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906W	28.27 SafeStand / Advocacy	States such as Michigan need to use their voice to help raise the volume on the urgency of a national, goal-directed, funded agenda for quality and patient safety. [W 106-107] A second dimension [to the work that lies ahead] is to develop ... clear national patient safety goals and implement measures for those goals. As an industry, both at a national level and at an institutional level, we don't have a really clear idea of what it means to be safer, and we need to. Included broadly in this second dimension is alignment of payment for care [words highlighted here were underlined in original]. If we establish goals for quality and safety, that is what we should pay for. When the goals and national priorities are clear, and payment is aligned with performance measured against those goals, institution and provider specific, public reporting of performance in relation to the goals should be a requirement of licensure [words "institution" through "licensure" underlined in original]. [W 166-172]
Code 29: Patient Safety Reporting (not specified whether mandatory or voluntary)		
102B	29.30 PSRpt / CPAdvocate	Engage additional professional societies and providers in Michigan on the value of public release of facility-specific data on medical errors and seek suggestions for indicators that may be helpful to consumers when selecting providers in Michigan. [W 110-112]
1040	29.00 PSRpt	I'd like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O9-13] Reporting is key. You need the data to give direction to see how you're doing. [O 76-77] We need to report near misses. Employees need to know what a near miss is, and not only do we need to know what the near miss is but we need to give it a severity level. If we could have harmed a patient with a near miss, we need to do a root cause analysis just as if it were occurrence. We can then truly look at the processes that need to be improved ... [O 86-92]
110W	29.00 PSRpt	Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Continue focus on public patient outcome reporting and de-emphasize commercial marketing use of data that victimizes hospitals or rewards only those that pay. [W 132-134] A continued focus on public reporting and a comprehensive government web site should slowly help the industry to move away from this type of activity. [W 118-119]
404B	29.25 PSRpt / Legis	This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344] b. Recommendations for State actions during a strike at a health care institution. Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care: [W32-36; W365-369] ! A system of frequent and random inspections should be mandated to monitor the level of care being provided at the institution. [W37-38; W370-371]
4050	29.30 PSRpt / CPAdvocate	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [O56-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167] The third is to institute a nonpunitive national patient safety reporting and learning system [O190-191]
501W	29.00 PSRpt	Michigan should take immediate action to: [W 49-50] Define and publicly report a comprehensive set of performance measures [bolded in original text]: Support and participate in the work of the Michigan Health and Safety Coalition safety initiatives, particularly hospital reporting in cooperation with the Leapfrog Group. Public and private stakeholders are collaborating in Southeastern Michigan to define and implement a comprehensive set of publicly reported performance measures for hospitals, physicians and physician groups, integrated delivery systems and treatments to assess their relative safety, timeliness of care, efficiency, equity, effectiveness and patient-centeredness of care. [W 51-57]
501W	29.10 PSRpt / Resources	FROM CONCERN/COMMENT COLUMN 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. [W 114-115] While we need to be sensitive to the added burden of reporting results, we cannot let that concern prevail over the need to measure quality to support informed choices of providers and promote dramatic improvements in care. [W 124-126]
501W	29.23 PSRpt / InfoTech	Michigan should take immediate action to: [W 49-50] Promote investments in clinical information technology [Bolded in original text]: Efforts should be undertaken to accelerate the adoption of improved clinical information technology to support improved coordination of care, practice of evidence-based medicine, and public reporting of safety, quality and efficiency. [W66-69] Purchasers, health plans, government entities, and providers should work together to advance rapid adoption of clinical information technology. This technology should be based on common national standards to assure that compatible information technology systems are adopted by key stakeholders such as plans and providers to support an open, and efficient exchange of information while complying with all applicable rules to protect confidential information. [W 146-152]

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Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
5020	29.00 PSRpt	I think you need to have some method of this [a provider's reporting status relative to complete, audited and verified data presented in the standardized proper manner] ultimately being available to the community. [O 228-230]
606W	29.00 PSRpt	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] Publicize comparative ratings, or hospital “report cards.” [W263]
606W	29.00 PSRpt	[CODER NOTE: Two sets of targets in this testimony: General, as in "other Michigan organizations", and those specific to program named in the recommendation. Specific targets in BOLD at left] CALL TO ACTION HAP has pledged to implement programs of this type – recommended by The Leapfrog Group, the Institute for Healthcare Improvement and other patient safety organizations – and we urge other Michigan organizations to adopt them as well. [W37-40; also W245-248] Increase public reporting of health care errors/quality events, ... [W282]
828W	29.01 PSRpt / StateFocal	State governments should, in every case, support patient safety and work to bring national consensus on the targets and reporting methods (W 116-117).
901W	29.00 PSRpt	[Commissioner]: I actually have two questions for you. The first, you referenced reporting of some data. Do you have any recommendation as far as whether that be voluntary confidential reporting versus mandatory, or is it just, in fact, having data to review? [Informant]: I think reporting is important to measure the progress. I agree with the consensus, there appears to be a movement towards mandatory reporting of the more significant events and voluntary reporting of minor events. I believe in those minor events are where you'll have the opportunity to take action and prevent the larger events. Reporting systems are beneficial. The reporting systems will validate, again, what we already know, that it's the communication breakdowns and distractions that are going to cause the events. [O 119-137]
904B	29.00 PSRpt	MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [W 61-62; O 19-20] Publicly reporting quality measures to consumers and providers [W 66; O 21-22] The availability of this information opens the lines of communication between patients, their caregivers, and providers. People can now take a more active role in their treatment and care decisions. Publicly-reported data can motivate providers to improve quality of care, and MPRO is available to provide free tools/training/resources to assist them. In 2005, hospitals will begin reporting quality of care information to the public as well. [W 205-210; O 66-72]
Code 30: Consumer Protection and Advocacy		
102B	30.00 CPAdvocate	And, lastly, I would urge the Commission to (oral: further) engage consumer groups as well as providers in its mission as patients should be first and foremost (oral: in patient safety efforts in Michigan). [O 124-129; W 120-121]
4030	30.01 CPAdvocate / StateFocal	To the issue of systematic change and accountability is what I address today. [O28] First, we need a system in each state that will be responsible for patient safety. [O28-29] It is critical that these bodies that involve health care consumers include families and health care professionals. Families need to be involved at every step of the way. [O32-33]
4050	30.15 CPAdvocate / Collab	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [O56-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167] The second goal is to create consumer-led advisory councils, preferably at the community level, to really be sort of a standing focus group for healthcare providers in the community to go to consumers for their input on everything from patient education materials to facility design to any of the other issues you've heard today. [O178-185]
4050	30.29 CPAdvocate / PSRpt	Today I'm going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan. [O56-60] To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167] The third is to institute a nonpunitive national patient safety reporting and learning system [O190-191]

^a Each entity providing testimony was assigned a three-digit testimony ID number. “W” after the ID number indicates that the quotation came from written testimony; “O” refers to oral testimony; “B” indicates that the testimony was submitted both orally and in written form.

^b The two-digits before the decimal point identify the main code. The two digits after the decimal point indicate a secondary code or, if “00” appears after the decimal point, no second code was selected. For a complete description of the coding process, please refer to the Reviewer’s Guide elsewhere in this Technical Appendix.

Verbatim Recommendations from Testimony with Original Coding

ID ^a	Coding ^b	Verbatim Recommendation from Public Testimony
4100	30.12 CPAdvocate / Ldrship	In the body of our written report – and I've supplied five copies that can be seen at the back table – we have included several areas that we feel would create opportunity for bettering the hospital's ability to serve the public interest. And, briefly, these would include: [054-59] Number one, nonprofit hospital boards should have appointments from community and employee organizations. [060-62]
608W	30.04 CPAdvocate / VolRpt	Consumer Involvement: Consumers (patients) need to be involved in this reporting process [to develop a voluntary system of reporting errors to a central repository [W40]]---they need a mechanism to report errors and near misses that reach/impact them, and they need methods to learn from the lessons as they are central to preventing harm and errors. [W159-163]

^a Each entity providing testimony was assigned a three-digit testimony ID number. “W” after the ID number indicates that the quotation came from written testimony; “O” refers to oral testimony; “B” indicates that the testimony was submitted both orally and in written form.

^b The two-digits before the decimal point identify the main code. The two digits after the decimal point indicate a secondary code or, if “00” appears after the decimal point, no second code was selected. For a complete description of the coding process, please refer to the Reviewer’s Guide elsewhere in this Technical Appendix.