

27870 Cabot Drive
Novi, MI 48377-2920
ph 248.489.5004

34605 Twelve Mile Road
Farmington Hills, MI 48331-3221
ph 248.489.6000

www.trinity-health.org

November 30, 2004

Michigan Health and Safety Coalition
Att: Diane Valade
27000 W. 11 Mile Road – B713
Southfield, MI 48034

Re: State Commission on Patient Safety
Trinity Health Written Testimony

Dear Ms. Valade,

State Commission on Patient Safety
Trinity Health Written Testimony

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. Just as providers have learned that a culture that is supportive 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.

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. Analysis of errors and near misses is predicated upon the identification and reporting events. Health care providers have been very cautious to report errors and near misses. Health providers state that there continue to be significant barriers to reporting of events. Barriers include fear of retribution and lawsuits, cultures of blame, lack of organized data collection methods, lack of an organized approach to analyze the root causes of the events and a historical failure to focus on the systems of care that facilitated the occurrence of an event.

Trinity Health has been very successful in improving the reporting these events from over 25 hospitals across the country with over 30,000 events reports annually. The success of this program is based upon the following principles:



2004 Award Winner

1. Reporting may be anonymous (but the reporters may identify themselves)
2. Reporting is non-punitive
3. Reporting is fast
4. Reporting follows a logical script with filed descriptors selected from menus
5. Reporting automatically populates a data base for analysis
6. Risk management is immediately notified of all reports
7. Focus of analysis is on identifying the systems that failed to support safe care.

Last year Trinity Health documented over 700 practice and policy changes that were a direct result of the information obtained from the on-line reporting system.

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.

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.

Sincerely,

Paul F. Conlon, Pharm D., J.D.
Sr. Vice President, Clinical Quality and Patient Safety

PFC: kp



2004 Award Winner