

**State Commission on Patient Safety
Demographic Information**

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I am providing testimony on behalf of the organization listed above.

Short bio-sketch of the person or organization's experience in patient safety:

For 11 years, the Michigan Consumer Health Care Coalition has focused extensive activity and information dissemination on consumer education in the area of patient safety, health care quality issues and consumer protection. For two years the coalition has been an active member of the Michigan Health & Safety Coalition representing the perspective of patients, families and consumers in general. The coalition serves as one of the Founding Advisors of the national Consumers Advancing Patient Safety (CAPS) organization.

Signature

Statement and Recommendations
for the State Commission on Patient Safety
presented by the
Michigan Consumer Health Care Coalition
December 2004

Executive Summary

In the spirit of improving quality, accountability and consumer protection, the consumer coalition presents the following recommendations for state government activities to increase patient safety in Michigan. The urging of consumer involvement flows from the unique role the coalition plays in Michigan health care when it attempts to bridge the gap between grass roots organizations, their members, state legislators, and the executive branch. The following recommendations assume a preferred role for consumers—one of active partnering to reach desired safety outcomes.

Recommendations and discussion

1. Creation of a repository of serious adverse events within a state regulatory agency

-- That legislation be enacted or executive order issued to initiate a function/agency within state government with specific responsibility for the collection and analysis of adverse events in the state's health care system.

Since state government in Michigan has a singular responsibility for the public health and safety of its citizens, it is appropriate that it play a primary role in improving patient safety through the creation of a clearinghouse for the data collection, analysis and reporting which could serve to assist in the development of responsive and well focused corrective actions.

2. Development of a state level patient safety center

--That a patient safety center within the public or private sector be established by state action which has as its primary functions the fostering of a culture of patient safety; the education of providers, consumers and purchasers; and the promotion of collaborative initiatives between the public and private sectors.

The experience of other states could inform the development of a patient safety center in Michigan. Centers in Florida, Maryland, Massachusetts, New York, Oregon and Pennsylvania have been legislatively authorized or endorsed in some way, many incorporated into broader schemes to address affordable health care, quality improvement and consumer education, or malpractice reform.

3. Fostering of local consumer/patient advisory groups

--That, by every means available, the state encourage the development of consumer advisory groups to hospitals and long term care facilities to strengthen patient safety.

To date most safety reform agendas have marginalized consumer input. Few real partnerships exist in which quality and safety initiatives are not simply relayed to a few consumers after they are formalized, with the result that the significant insights and perspective of patients and their families are lost to the process.

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Coalition mission and background

In the fall of 1993, in anticipation of the introduction of a universal health care proposal at the national level, several of Michigan's prominent consumer groups foresaw a need to develop a single, clear voice for consumers' needs in the reorganization of the health care system. Despite the defeat of the 1994 national reform initiative, these early discussions led to the creation of the Michigan Consumer Health Care Coalition (MCHCC) to address proposals for incremental reforms to the system, and help forge a viable, affordable, sustainable, and quality delivery system. To this end, MCHCC and its member organizations strive to

- ♦ be a voice for consumers' needs in health care at the state level;
- ♦ represent the broad spectrum of insured and uninsured consumers; and
- ♦ advocate for improved quality, access, accountability, cost efficiency, information dissemination and consumer protection within the Michigan system.

It is in the spirit of improving quality, accountability and consumer protection that the following recommendations for state government activities to increase patient safety in Michigan are presented.ⁱ The urging of consumer involvement flows from the unique role the coalition plays in Michigan health care when it attempts to bridge the gap between grass roots organizations, their members, state legislators, and the executive branch.

Consumer involvement in patient safety initiatives

At the policymaking, regulatory and health care management levels, most stakeholders in health care have been actively discussing and engaged in advancing patient safety and systems-based improvement strategies since at least late 1999, when the Institute of Medicine's (IOM) *To Err is Human* reportⁱⁱ was released. This and subsequent reports by the IOM established patient safety as a public health priority and generated a nationwide discussion about developing health care that is safe, patient-centered and evidence-based.

Consumers are not customarily a part of these discussions and, hence, their perspective is not incorporated into the thinking on systems change to enhance patient safety. When consumers are included in patient safety or quality care improvement discussions, it usually is in a marginal advisory role to providers or policymakers. The following recommendations assume a preferred role for consumers—one of active partnering to reach desired safety outcomes.

Recommendations and discussion

1. Creation of a repository of serious adverse events within a state regulatory agency

Recommendation

That legislation be enacted or executive order issued to initiate a function/agency within state government with specific responsibility for the collection and analysis of adverse eventsⁱⁱⁱ in the state's health care system.

Discussion

Since state government in Michigan has a singular responsibility for the public health and safety of its citizens, it is appropriate that it play a primary role in improving patient safety through the creation of a clearinghouse for the data collection, analysis and reporting which could serve to assist in the development of responsive and well focused corrective actions.

In a recent study of twelve communities to determine whether professionalism (a self-governance system), regulation or market forces provided the most stimulus for hospitals to reduce medical errors, it was found that regulation had the biggest impact—when the government establishes a set of standards to which all parties must adhere. In this case study the primary driver of hospitals' patient safety initiatives was a quasi-regulatory agency, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).^{iv}

The Consumer Coalition's recommendation is for information on adverse events, collected and analyzed by a state regulatory agency, to be used to encourage the widest possible participation by health care providers, and not for punitive measures. Reports of the aggregate data would be widely disseminated, with individual providers' experience available to a select number of agencies/organizations involved in the development of proposals to create systems solutions to improve safety.

Legislative language is available from the National Academy of State Health Policy for the enabling statutes of the five states that have undertaken different agency models for administration of mandatory reporting systems for serious adverse events.^v

Many other models exist for the development of a safety tracking and communication system--in everything from automobile dependability to airline traffic, from nuclear plants to baby strollers, all of which have a public or quasi-public agency monitoring consumer safety and risks.

Patient safety in the health care system deserves no less from state and federal governments.

2. Development of a state level patient safety center

Recommendation

That a patient safety center within the public or private sector be established by state action which has as its primary functions the fostering of a culture of patient safety; the education of providers, consumers and purchasers; and the promotion of collaborative initiatives between the public and private sectors.

Discussion

The experience of other states could inform the development of a patient safety center in Michigan. Six states have created or are in the process of developing patient safety centers-- Florida, Maryland, Massachusetts, New York, Oregon and Pennsylvania.^{vi} All were legislatively authorized or endorsed in some way, many incorporated into broader schemes to address affordable health care, quality improvement and consumer education, or malpractice reform.

While centers vary in terms of their governance structures and other major features, most have as a part of their focus the development of a patient safety culture in the health care system, education about patient safety, and a potential role as a data repository, particularly for less serious errors, or near misses, not collected by the state's regulatory agency. Four have access to adverse event data collected through their states' mandatory reporting system. All include consumers on advisory boards or committees.

Coordination could be a strong focus of a Michigan center: between public and private safety programs and between federal and state initiatives. The recommended state center would be well positioned to be designated as a patient safety organization (PSO) if the *Patient Safety and Quality Improvement Act* is enacted at the federal level, with the role of collection and analysis of patient safety data and feedback on patient safety improvement strategies.^{vii}

4. Fostering of local consumer/patient advisory groups

Recommendation

That, by every means available, the state encourage the development of consumer advisory groups to hospitals and long term care facilities to strengthen patient safety.

Discussion

To date most safety reform agendas have marginalized consumer input. Few real partnerships exist in which quality and safety initiatives are not simply relayed to a few consumers after they are formalized, with the result that the significant insights and perspective of patients and their families are lost to the process.

This approach fails to recognize that consumers are intelligent, functioning adults who understand that health care is delivered in an increasingly complex and risky world. As patients and lay caregivers they understand risk management, quality improvement and communication issues.

When significant partnering between health care facility quality and safety committees and consumers is discussed, the specter of malpractice litigation immediately surfaces. Ultimately an alternative dispute resolution will have to be created to answer the rationale that adverse events cannot be discussed openly with patients and their families for fear of litigation. This issue too will be best resolved through open and direct communication between providers and consumers.

The existence of a "market-driven" health care system also is raised as an impediment to facility/consumer partnering at the local level. It should be noted, however, that in a competitive system the way to a patient's heart may not be through the opportunity for Internet access or a special-order gourmet meal, but rather through word of mouth that a health care facility is focused on providing safe care and, in determining how to do that, patients and their families are intimately involved.

¹ A list of coalition members is provided as Attachment A. As with all coalitions, every member does not necessarily support each recommendation made by the coalition; all members do subscribe to the focus of advocacy activities.

¹ Kohn LT, Corrigan JM, Donaldson M, eds. *To Err is Human: Building a Safer Health Health System*, Washington, DC, National Academy of Sciences, 2000.

¹ The definitions used by the Institute of Medicine are intended in this statement: an “adverse event” is an injury caused by medical management rather than the underlying condition of the patient; a “near miss” is an error that does not result in harm.

¹ “What Is Driving Hospitals’ Patient-Safety Efforts” *Health Affairs* March/April 2004

¹ See the October 2004 report of the Flood Tide Forum, “State Patient Safety Centers: A new approach to promote patient safety,” Table 1, Page 5, compiled by the National Academy for State Health Policy <www.nashp.org>

¹ Ibid; see Appendix A for characteristics of the various state-level centers

¹ The proposed legislation would create a national, confidential, voluntary reporting system in which providers could report error information to patient safety organizations.

ATTACHMENT A

Michigan Consumer Health Care Coalition

Founding Members

American Association of Retired Persons*
American Association of University Women in Michigan
Citizens for Better Care
International Union, United Auto Workers, Social Security Department
League of Women Voters of Michigan
Michigan Consumer Federation
Michigan League for Human Services
Michigan Peer Review Organization
Michigan Primary Care Association
Older Women's League, Michigan Chapter
Service Employees International Union

Other Members

Community Choice Michigan
Michigan Council for Maternal and Child Health
Michigan Parkinson's Foundation
National Association of Social Workers, Michigan Chapter
National Association for the Physically Handicapped, Michigan Chapter
National Council on Alcoholism and Drug Dependence of Michigan

* No longer active

ⁱ A list of coalition members is provided as Attachment A. As with all coalitions, every member does not necessarily support each recommendation made by the coalition; all members do subscribe to the focus of advocacy activities.

ⁱⁱ Kohn LT, Corrigan JM, Donaldson M, eds. *To Err is Human: Building a Safer Health Health System*, Washington, DC, National Academy of Sciences, 2000.

ⁱⁱⁱ The definitions used by the Institute of Medicine are intended in this statement: an "adverse event" is an injury caused by medical management rather than the underlying condition of the patient; a "near miss" is an error that does not result in harm.

^{iv} "What Is Driving Hospitals' Patient-Safety Efforts" *Health Affairs* March/April 2004

^v See the October 2004 report of the Flood Tide Forum, "State Patient Safety Centers: A new approach to promote patient safety," Table 1, Page 5, compiled by the National Academy for State Health Policy <www.nashp.org>

^{vi} Ibid; see Appendix A for characteristics of the various state-level centers

^{vii} The proposed legislation would create a national, confidential, voluntary reporting system in which providers could report error information to patient safety organizations.
