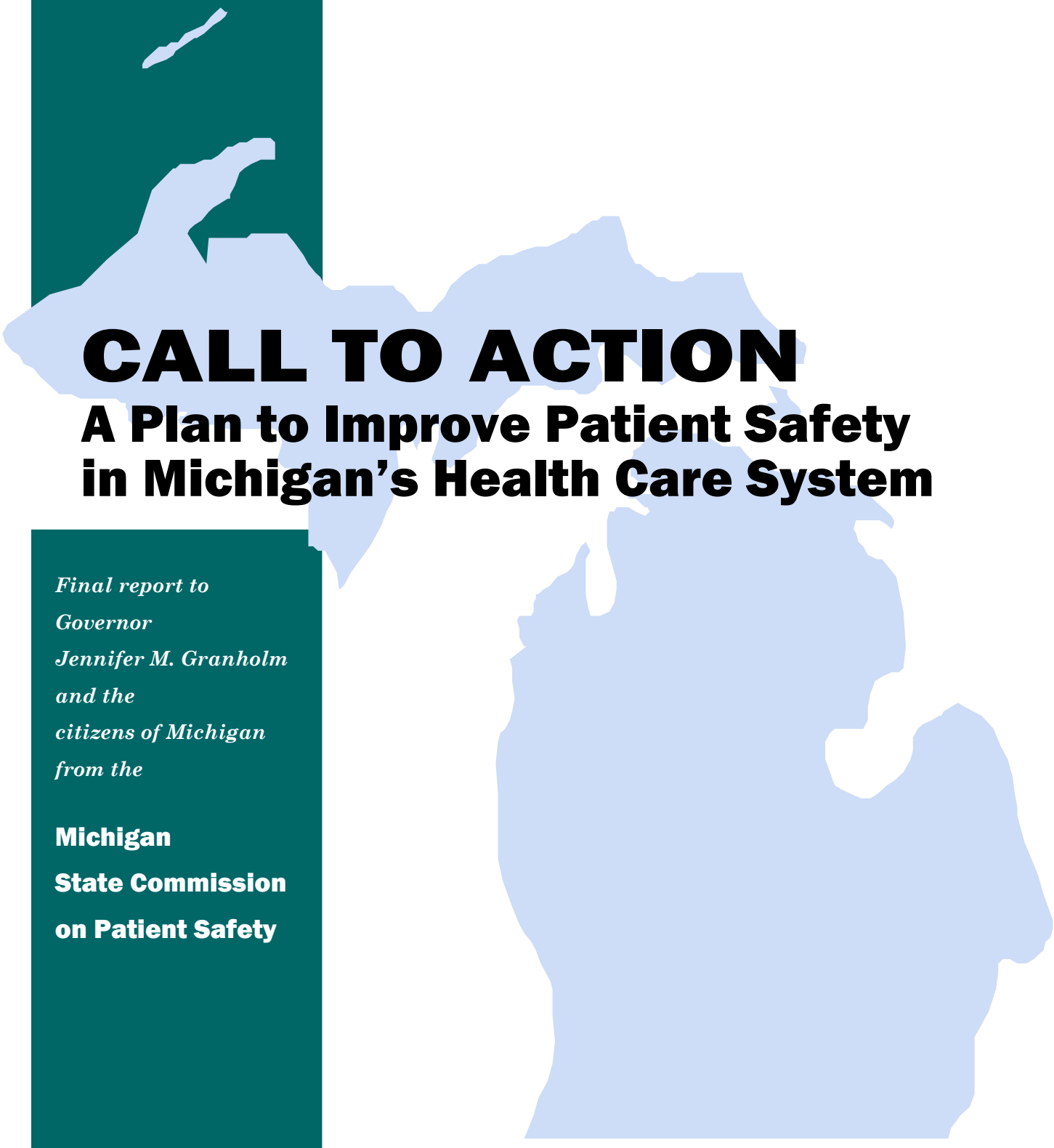
CALL TO ACTION

A Plan to Improve Patient Safety in Michigan's Health Care System

Final report to Governor Jennifer M. Granholm and the citizens of Michigan from the

Michigan State Commission on Patient Safety

November 2005



State Commission on Patient Safety

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Additional copies of this publication may be requested from the Michigan Health and Safety Coalition, B713, 27000 West 11 Mile Road, Southfield, Michigan 48034. The final report will be posted for a time at http://www.michigan.gov/mdch and the full report, including the technical appendix, will be available permanently at http://mihealthandsafety.org/statecommission/index.html.

Recommended citation

Michigan Health and Safety Coalition acting as the Michigan State Commission on Patient Safety (2005). *Call to action: A plan to improve patient safety in Michigan's health care system*. Southfield, Michigan: Michigan Health and Safety Coalition.

Financial and in-kind support

Although the Governor designated the Michigan Health and Safety Coalition to act as the Michigan State Commission on Patient Safety per Public Act 119-04, no state funds were appropriated for its work. We therefore gratefully acknowledge a grant from the Blue Cross Blue Shield of Michigan Foundation and additional funding from the Blue Cross Blue Shield of Michigan corporation and the Michigan Health and Safety Coalition. We also thank Blue Cross Blue Shield of Michigan, MPRO, and the Michigan Department of Community Health for considerable in-kind support through loaned staff and administrative services. Without their generous contributions, this effort would have failed.

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The Technical Appendix, which includes detailed analysis of the testimony and relevant literature, is available at http://mihealthandsafety.org/statecommission/index.html.

PREFACE

The Michigan State Commission on Patient Safety is proud to present this report to Governor Jennifer M. Granholm and the citizens of Michigan. The Michigan Health and Safety Coalition, which was designated to act as the Commission, thanks the Governor for this opportunity to serve the state.

We strongly believe that patient safety improvement requires a collaborative approach and that everyone with a stake in health care safety—whether providing care, paying for it, or depending on it—has the ability to influence the safety of our health care system.

As many of us do when planning a long trip, the Commission has set forth in this report a set of destinations—places that, if we reach them, will improve the safety of health care across the state. To the extent possible, we have also identified major landmarks—points along the way that will let us all know we are headed in the right direction.

This report represents the culmination of many months of individual and group effort. We have been fortunate to benefit from a rich variety of viewpoints during our work. While each organization may not agree with every detail of this final report, it does represent consensus among those who participated. We offer our thanks to everyone for their contributions and our apologies to anyone inadvertently omitted from the appendices. We are grateful, in particular, to those who shared their personal experiences in testimony. While we were not able to include here every detailed idea, we hope all who provided input throughout the process recognize their hands at work in this final document.

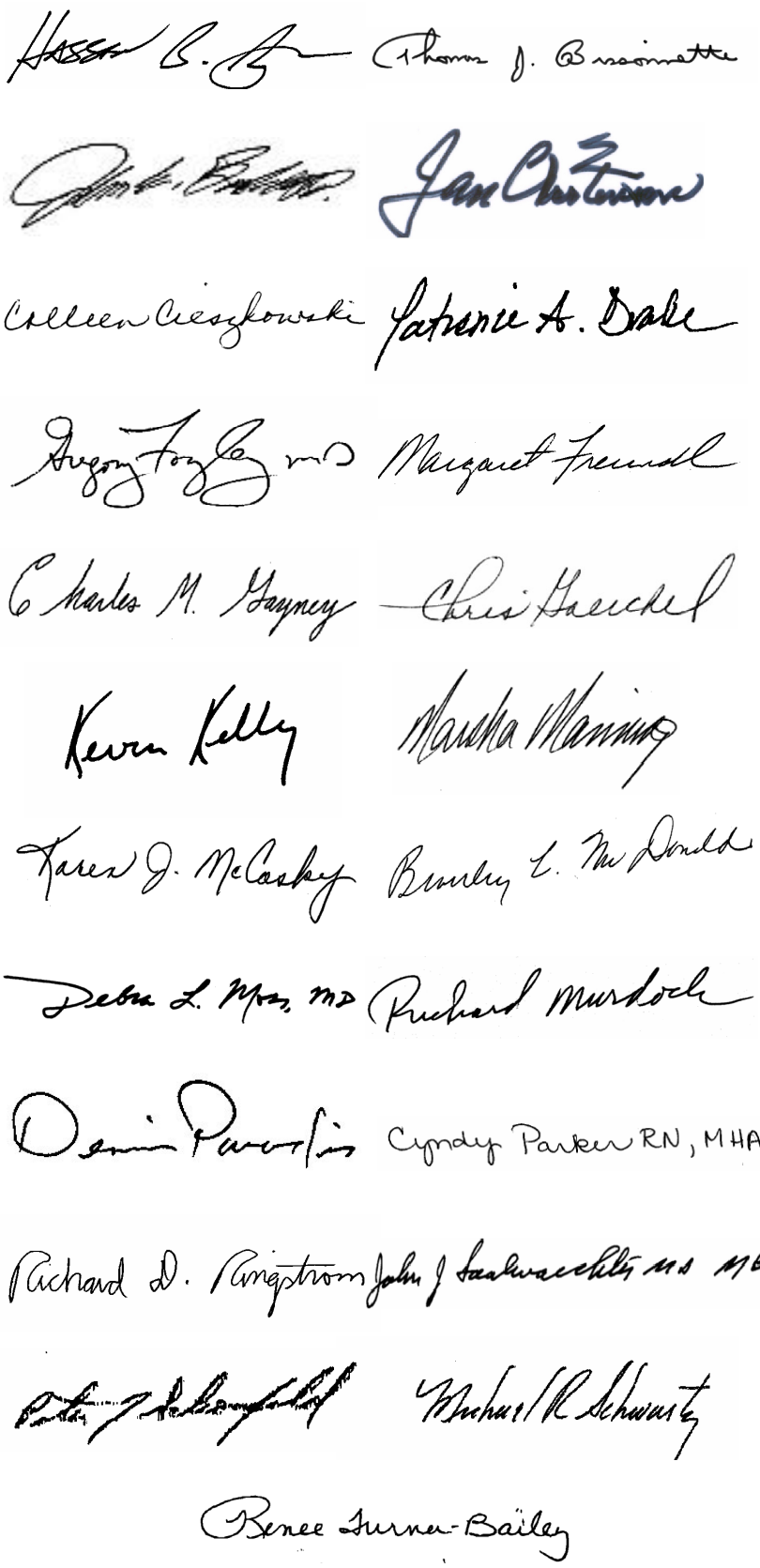
We expect this report to generate discussion, encourage each of us to identify opportunities for improvement in our "neighborhoods," and prompt the development of a statewide road map leading to safe care for every patient/consumer/resident every time. We look forward to working with the Governor, Legislature, and citizens of Michigan along the way.

Although the Commission's formal existence is at an end, our network of relationships will continue to enable us to move forward to improve the safety of health care for all who seek care in Michigan.

Thomas Simmer, MD, Chair

Larry Wagenknecht, RPh, Vice-Chair

Michigan State Commission on Patient Safety
Michigan Health and Safety Coalition
November 2005



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MI Health & Hospital Association
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General Motors Corporation

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MI Dept. of Community Health

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John J. Saalwaechter, MD
MI Association of Health Plans

Peter Schonfeld
MI Health & Hospital Association

Michael Schwartz
Blue Cross Blue Shield of Michigan

Renee Turner-Bailey
Ford Motor Company

EXECUTIVE SUMMARY

Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous.

—Sir Cyril Chantler (The Lancet, 1999)

Introduction

Nearly six years ago, the Institute of Medicine galvanized the public with estimates that errors in American hospitals cause as many as 98,000 deaths and more than 1 million patient injuries each year. The IOM noted that it would be "irresponsible to expect anything less than a 50 percent reduction in errors over five years." We are now a year beyond that point, and while much has been done, much work remains. The glass is still half empty—and half full.

We cannot ignore the continued human and economic costs of poor health care systems. Testimony submitted to the Commission demonstrates the continued urgency of this issue.

Yet the IOM report spurred unprecedented attention, research, activity, and funding opportunities focused on reducing harm caused by the processes of health care. Six years ago, those who viewed health care as a system of interdependent people, tools, and environments were in the minority. Only a few recognized the effects of fatigue, limited human memory, and information overload on health professionals and their ability to practice safely.

Today, as our health care culture continues to evolve, most of us involved with health care are less likely to seek a person to blame when something bad happens because we recognize these interdependencies. We also are less likely to ask individuals to do the impossible by trying to prevent errors on their own without control of all aspects of the situation.

This is progress.

In Michigan, key stakeholders responded to the IOM challenge by forming the Michigan Health and Safety Coalition, a diverse group of health care stakeholders developing system-level solutions to patient safety problems. Blue Cross Blue Shield of Michigan has chaired and staffed the MH&SC since its inception in 2000. Other MH&SC participants include the Michigan associations of physicians, nurses, pharmacists and hospitals; consumers; employer and union groups; MPRO; and the Michigan Department of Community Health.

This, too, is progress, as are the countless individual and collaborative patient safety improvement efforts under way across the state. The glass is, indeed, half full.

Michigan State Commission on Patient Safety

In September 2004, the Governor designated the Michigan Health and Safety Coalition to act as the State Commission on Patient Safety per Public Act 119-04. The MH&SC is honored to serve in this capacity. Per PA 119-04, the mission of the Commission is:

To examine means to improve patient safety and reduce medical errors in this state.

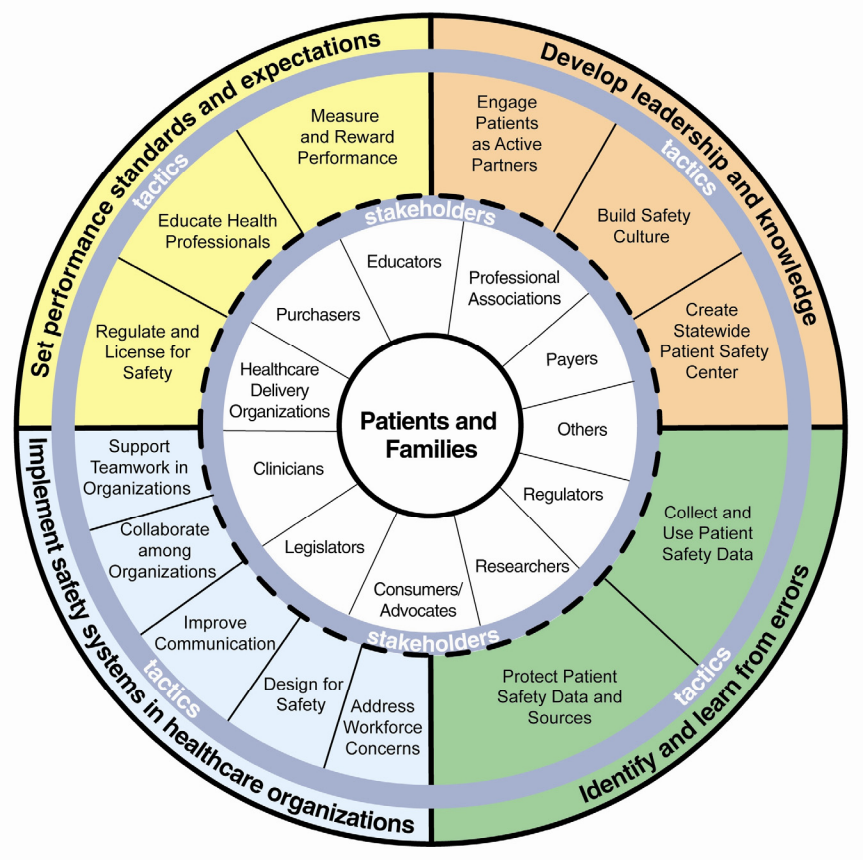
A focused vision keeps us moving forward, even against discouraging odds. We hope this vision is vivid and meaningful enough to motivate us all to bring it to realization.

Everyone in Michigan—whether providing, receiving or paying for health care—is focused on the prevention of patient harm, relentlessly questioning how we can do things better and safer.

Figure A. A model of safe care in Michigan

As its framework, the Commission adopted categories suggested by the Institute of Medicine report, *To Err is Human*. These categories, which had been listed in the invitation to provide testimony, appear in the outer ring of the model.

Within these broad categories, in the second ring, working inward, are areas in which the Commission developed recommendations. At the center of the model are patients and families, as they should always be at the center of our efforts to improve patient safety. Around them are arrayed the diverse stakeholders who must be united to realize our vision of a safer Michigan health care system.



From testimony to recommendations

The Commission's first task was to solicit input from a broad array of health care stakeholders and the general public. The Commission held three public hearings in November 2004 and invited written testimony from those who were unable to attend. A total of 77 informants (individuals and organizations) provided testimony to the Commission—verbally, in writing, or both. The Commission's job was to compile recommendations from the testimony into a meaningful report.

A group of researchers, the Analytic Team, was charged with making sense of the testimony consistently and impartially. Their qualitative approach condensed the information, identified important patterns, and communicated the essence of what the data revealed. In addition to the testimony, the Analytic Team was asked to review the literature and learn from other patient safety initiatives. Their synthesis of these sources informed development of the recommendations contained in this report.

The Review Panel, a subgroup of the Commission plus two Michigan patient safety experts, drafted recommendations for making Michigan's health care system safer for patients. The Review Panel conducted two rounds of deliberations, during which they discussed the Analytic Team's findings, brought additional information to light, and refined the recommendations. At the end of its second round of deliberations, the Review Panel was asked to prioritize the remaining recommendation categories. This process guided the order in which the recommendations appear in this report.

The Commission provided oversight and input throughout the process and refined this report after reviewing drafts in April and September 2005. The final report was approved by the Commission in November 2005.

Roles of patients/families and purchasers/payers

The Commission grappled with how best to articulate the role of patients and their families in this set of recommendations. It became clear that a simple "to-do" list for patients and families would not be enough. We do not, therefore, include action steps for patients and families in each chapter. Taking to heart the IOM's recommendation that patients be viewed as members of their health care team actively involved in their care, we have incorporated the patient/family voice in action steps throughout this document. In this way we remind health professionals, organizations, and policymakers to pay attention to patients and their families, actively solicit their input, and take action based on what this important group has to teach us.

The Commission also wrestled with how best to represent the important role of health care purchasers and payers, including health plans, insurers, employers, consumers, and state government in its role as purchaser for state employees and underserved populations. Addressing complex payment issues is beyond the scope of this report, yet it is clear that purchaser engagement is a critical component of patient safety improvement. We urge purchasers and payers to participate actively in working to realize all the recommendations laid out in this report by providing financial and nonfinancial incentives, research grants, subsidies, rewards, and public recognition.

Objectives and recommended action steps

The Commission received testimony from an impressive array of health care stakeholders, many of whom expressed a desire to continue working with a state-level entity to improve patient safety in a variety of health care settings. Our recommendations are intended to engage individuals and organizations across the entire continuum of care.

Much of the public testimony emphasized the importance of culture change in patient safety improvement. This thread of continuous culture change is woven throughout the Commission's recommendations. Changing health care culture and norms—"how things are done around here"—can lead to the age-old question of chickens and eggs. Our recommendations are designed both to accelerate culture change and to benefit from it.

Establishment of the Michigan Center for Safe Health Care, for instance, is intended to provide a focal point for leadership, to promote what is best in patient safety around the state, and to build energy and enthusiasm, all of which contribute to a willingness to change. In turn, recommendations to develop a voluntary statewide patient safety reporting system would benefit greatly from a health care culture characterized by a commitment to safety, learning, and collaboration.

The tables on the following pages summarize the Commission's objectives and provide a series of milestones against which to gauge progress. The substance of the Commission's recommendations, however, is contained in the detailed "Recommended Action Steps" in each section of the final report. These "to do" lists provide the road map to accomplishing the objective(s) set out in each section. Please refer to the full report for this detail.

Table A. Objectives of the Michigan State Commission on Patient Safety

The substance of the Commission's recommendations is contained in the detailed "Recommended Action Steps" in each section of the report. These "to do" lists—too long to reproduce here—provide the road map to accomplishing the objective(s) set out in each section. Please refer to the Commission's full report for this detail.

Report Section	Objectives
A. Build a safety culture	• Continue to transform Michigan's health care culture to one characterized by a commitment to safety, learning, collaboration, and systems thinking. • Reinforce a culture in which the state of Michigan, all clinical and administrative leaders who influence health care delivery, all persons involved in the caregiving process, and those who use health care services act consistently from a deep commitment to decreasing harm to patients.
B. Establish a statewide patient safety center	• Establish and fund the Michigan Center for Safe Health Care as a statewide center for leadership, information, and advocacy to reduce patient harm across a range of health care settings.
C. Collect and use data about errors and near misses	• Establish and fund a statewide voluntary, confidential, peer-protected, nonpunitive error reporting system. Ensure that important findings are disseminated regularly to improve health care safety. Complement, to the extent possible, emerging national data definitions and measurement criteria.
D. Protect patient safety data and sources	• Protect patient safety data and reporting activities under statute without denying patients and families access to information through normal channels when medical errors or unexpected events occur.
E. Measure and reward performance	• Establish or adopt standards for patient safety performance across the continuum of care; develop or adopt a common vocabulary and standardized data definitions; set dynamic benchmarks to measure progress; use the measured performance of Michigan's health care providers to inform ongoing improvement efforts; and reward excellence.
F. Address workforce shortages effectively	• Address health care workforce shortages without compromising patient safety while improving practice environments and the availability of qualified health professionals.
G. Design facilities and processes for safety	• Adapt tools and methods from human factors engineering, facility design, and industries with demonstrated error prevention records to improve patient safety in health care. Prevent or correct system defects in ways that respond to patient and staff needs rather than training staff or teaching patients to accommodate poor system design.
H. Improve communication of critical information	• Promote improved use of communication and technology to ensure that information critical to patient safety (e.g., health history, medication history, and critical lab values) is available to patients and health care providers within and across organizational boundaries.
I. Involve patients as active health care partners	• Empower consumers/patients/clients/residents and their families/caregivers/advocates to better assume their roles as partners in the health care encounter. • Promote open and clear communication between patients/families and health professionals about health issues, treatments, patient safety concerns, and adverse events. • Embed the consumer/patient voice in the structure and process of designing safe care.
J. Embrace safety in health professions education	• Weave the teaching and demonstration of patient safety principles, knowledge and skills into health professions education and continuing education requirements.
K. Emphasize collaboration among organizations	• Expedite the translation of patient safety-related evidence into practice, accelerate the spread of successful programs and processes for improving patient safety, and promote creative problem solving for patient safety challenges through cross-organization collaboration.
L. Support teamwork within organizations	• Improve teamwork across disciplines by providing training and support for cross-disciplinary teams.
M. Regulate and license with safety in mind	• Explore use of the state's licensing and regulation functions to improve the culture and processes of safety among health professionals and organizations.

Table B. Milestones toward objectives

The following milestones are designed to keep the process of patient safety improvement moving forward. The first step, of course, is for recommendations from the Michigan State Commission on Patient Safety to be adopted.

State of Michigan	2006 • The Legislature introduces and passes the Model Act to create the Michigan Center for Safe Health Care; the Governor designates or creates the Center; the Governor and Legislature help the Center secure start-up funding and reliable, sustainable long-term income (B, C). • The state invites patient safety stakeholders to participate in ongoing workforce and information technology activities (F, H). • The Certificate of Need Commission requires all health care facilities under its jurisdiction to conduct healthcare failure modes and effects analysis or equivalent as part of the CON application process (G). • The state invites consumer, patient, and family representatives to serve on state-level bodies and organizations related to patient safety (I). • The Michigan Department of Community Health and health professions licensing boards incorporate patient safety principles into the regulation/licensing function (J, M). 2007 and beyond • MDCH inventories health care education and continuing education programs and recommends changes (J). • MDCH annually evaluates progress toward professional education goals (J).
Michigan Center for Safe Health Care	2006 • Center presents a funding plan to the Governor and Legislature per enabling legislation (B, C). • Center establishes its infrastructure, including patient/family representatives (B, I). 2007 • Center begins to collect and promote patient safety improvement tools, resources, sources of expertise, and success stories to accelerate adoption of known safe practices (all). • Center coordinates Michigan stakeholders advocating at the federal level (all). • Center convenes work groups to: o Develop specifications for the voluntary reporting system and evaluate need for protections (C, D). o Develop or adopt common data definitions and statewide performance standards (E). o Discuss how to monitor and evaluate the effectiveness of staffing practices (F). o Develop a statewide education campaign for patients/families and health professionals (I). o Evaluate undergraduate, graduate and continuing education curricula with regard to patient safety (J). 2008 and beyond • Center launches voluntary reporting and shares lessons learned from the reporting system (C). • Center begins to collect performance measurement data and shares lessons learned (E). • Center connects patient/family representatives with health care organizations seeking their input (I). • Center evaluates the voluntary reporting system no later than three years after data collection begins and assesses the effectiveness of any state-level protections for data and sources (C, D).
All Other Stakeholders	2006-2007 • Health professionals and organizations begin to assess/measure and improve: o Organizational safety culture (A). o How quantity and qualifications of staff on duty are matched to patient needs (F). o Facilities, physical environments, and work processes (G). o Communication of critical information within and across organizations (H). o Policies, practices and programs supporting meaningful patient and family involvement (I). o Training and support for cross-disciplinary teams (L). • Health care organizations invite patients/families to serve on boards, committees, advisory councils (I). • Health professions educators incorporate the science of safety into training and education (J). • Purchasers and payers begin align incentives to support culture change and recommendations (all). 2008 and beyond • Health professionals and organizations collect and submit: o Data about errors and near misses to the statewide voluntary system (C). o Performance measurement data using common data definitions and standards (E). • Purchasers and payers provide incentives to health professionals and organizations: o Participating in the voluntary reporting system (C). o Collecting and submitting performance measurement data, meeting or exceeding performance targets, and conducting performance measurement demonstration projects (E).

Conclusion

In September 2004, the Governor designated the Michigan Health and Safety Coalition to act as the State Commission on Patient Safety per Public Act 119-04. Just over a year later, we submit this detailed roadmap and hope that its vision, values, and action steps motivate us all to bring them to realization. We believe we have demonstrated the value of open and accountable public debate about issues that require our best thinking. Those interested in the original testimony and interim reports generated during this process are referred to Volume II, the Technical Appendix, available at http://mihealthandsafety.org/statecommission/index.html.

We have been honored to undertake this important project. Great progress is being made, as demonstrated by myriad success stories presented in the testimony. Much is yet to be done, as we also learned. May this report serve as an organizing force so we all continue to work together to make Michigan health care safe.

INTRODUCTION

> *Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous.*
>
> —Sir Cyril Chantler (*The Lancet*, 1999)

Nearly six years ago, the Institute of Medicine galvanized the public with estimates that errors in American hospitals cause as many as 98,000 deaths and more than 1 million patient injuries each year. The IOM noted that it would be "irresponsible to expect anything less than a 50 percent reduction in errors over five years." We are now a year beyond that point, and while much has been done, much work remains. The glass is still half empty—and half full.

We cannot ignore the continued human and economic costs of poor health care systems. Selections from public testimony submitted to the Commission demonstrate the urgency of the problem.

> *Our nation spends more than one trillion dollars each year on health care, but … national studies demonstrate that patients receive recommended health care only 55% of the time and 30% of all health care costs are due to poor care.*
>
> —Health Alliance Plan (HAP)

> *A national survey of consumers this year identified that almost half are worried about the safety of care in health care facilities.*
>
> —Michigan Society for Infection Control

> *I think it's valid to say that there's a crisis in confidence in the consumer and purchaser community about this question of patient error.*
>
> —Economic Alliance for Michigan

> *For the most part when you get into the physician or the professional community, there really is very little activity or knowledge ... in terms of patient safety issues. ... I don't think that it's really been taken in by those individuals who are in small environments just trying to get through their individual day.*
>
> —Lawrence J. Abramson, DO, MPH

> *As a country, we haven't made the investments needed to learn what it means to be safer, to prioritize our efforts, and to help providers reinvent healthcare.*
>
> —Keystone Center for Patient Safety and Quality

> *If medical errors were a disease, we would call it an epidemic. If errors were a disease, we would attack it with the best research possible. … We would put resources in translating the research into practice.*
>
> —Leticia J. San Diego, EdD, PhD

> *Michigan must act with a sense of urgency to dramatically improve the safety, quality and efficiency of health care.*
>
> —General Motors Corporation

The IOM's first report on health care safety spurred unprecedented attention, research, activity, and funding opportunities focused on reducing harm caused by the processes of health care.

Six years ago, those who viewed health care as a system of interdependent people, tools, and environments were in the minority. Only a few recognized the effects of fatigue, limited human memory, and information overload on health professionals and their ability to practice safely.

Today, as our health care culture continues to evolve, most of us involved with health care are less likely to seek a person to blame when something bad happens because we recognize these interdependencies. We are also less likely to ask individuals to do the impossible by trying to prevent errors on their own without control of all aspects of the situation.

This is progress.

In Michigan, key stakeholders responded to the IOM challenge by forming the Michigan Health and Safety Coalition, a diverse group of health care stakeholders developing system-level solutions to patient safety problems. Blue Cross Blue Shield of Michigan has chaired and staffed the MH&SC since its inception in 2000. Other MH&SC participants include the Michigan associations of physicians, nurses, pharmacists and hospitals; consumers; employer and union groups; MPRO; and the Michigan Department of Community Health.

This, too, is progress, as are the countless individual and collaborative patient safety improvement efforts under way across the state, some of which are highlighted in this report.

Throughout our deliberations we sought to identify areas of knowledge and gaps in our current understanding to help focus future efforts. We ask all health care stakeholders to act with a sense of urgency and not to limit short-term application of the best available science and good judgment by focusing on what we do not yet know. We know a great deal, much of which is not yet applied consistently throughout the health care system.

We return to those who provided testimony to the Commission:

> *Michigan is … way ahead of other states … in the fact that we have demonstrated over the past 17 years that we can work effectively in evolving not only improvement to guidelines and improvement to care at the office space level but also, and most recently, in patient safety.*
>
> —Michigan Association of Health Plans

> *The Commission should be asking organizations … what solutions they have generated. What solutions are now present?*
>
> —Trinity Health (Novi)

> *All health care providers are united in the intent to create a safe environment of care.*
>
> —Michigan Home Health Association

> *Be bold and don't hold back. All patients deserve a safe environment.*
>
> —Munson Medical Center

Mission, vision, values

The Legislature established the mission of the Commission in Public Act 119 of 2004 as follows:

> *To examine means to improve patient safety and reduce medical errors in this state.*

A focused vision keeps us moving forward, even against discouraging odds. We hope this vision is vivid and meaningful enough to motivate us all to bring it to realization.

> *Everyone in Michigan—whether providing, receiving or paying for health care—is focused on the prevention of patient harm, relentlessly questioning how we can do things better and safer.*

Articulating shared values provides everyone with a consistent framework within which to establish priorities. Making our vision a reality will require individual and collective action across the continuum of care—including at home—consistent with the following values:

Mutual respect

- Acknowledge the complex, dynamic interdependence of people, organizations, processes, and structures.
- Welcome consumers/patients/clients/residents and their families as full partners.
- Communicate openly and honestly.

Innovation and continuous learning

- Design for safety.
- Explore high-tech and low-tech options.
- Spread success; share what works.

Collaboration and teamwork

- Strengthen teams within organizations.
- Learn collaboratively across organizations.
- Advocate at the national level.

Results and accountability

- Measure for improvement.
- Align payment systems with safety goals.
- Teach, regulate and license for safety.

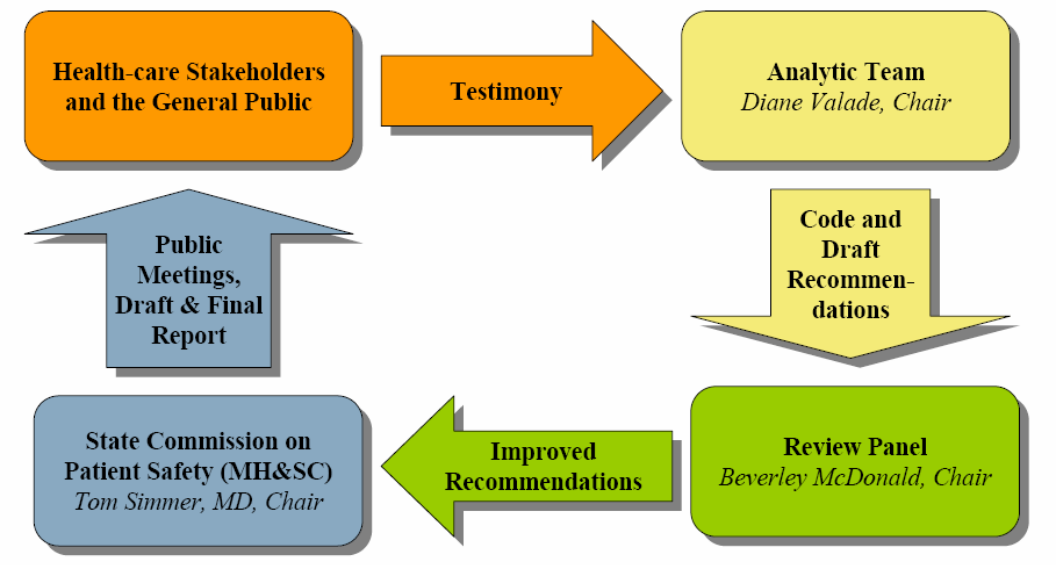
Long-term commitment

- Expect strong leadership.
- Commit to action.
- Measure success through improved patient outcomes.

PROCESS

In September 2004, the Governor designated the Michigan Health and Safety Coalition to act as the State Commission on Patient Safety. The process of translating public testimony into the recommendations contained in this report is illustrated in Figure 1 and described in this section. The individuals and organizations that made this work possible are recognized in Appendices A and B.

Figure 1. Process of the Michigan State Commission on Patient Safety



Public hearings

The Commission held three public hearings titled "Building a Safer Health Care System":

* In Lansing on November 15, 2004
* In Southfield on November 17, 2004
* In Traverse City on November 30, 2004

Informants

Entity Type	Number
Hospitals	7
Health professionals not representing an organization	12
Educators (faculty, schools)	5
Consumers and organizations representing consumers	17
Employer groups	2
Insurers	3
Health professional associations/organizations	26
Other (research institutes, for example)	5
TOTAL INFORMANTS	**77**

Public input

The Commission's first task was to solicit input from a broad array of health care stakeholders and the general public. In October 2004, the Commission extended a request for testimony to health care organizations, associations, professionals, consumers, researchers, and others with an interest in patient safety, some of which were identified in the authorizing legislation (Appendix D). The request for testimony was also advertised in newspapers around the state.

The Commission held three public hearings in November 2004, in Lansing, Southfield, and Traverse City.

A total of 77 informants (individuals or organizations) provided testimony to the Commission—verbally, in writing, or both. Many good suggestions for patient safety improvement were provided during these hearings. Several informants that did not participate in the public hearings submitted testimony in writing. The Commission's job was to compile recommendations from the testimony into a meaningful report.

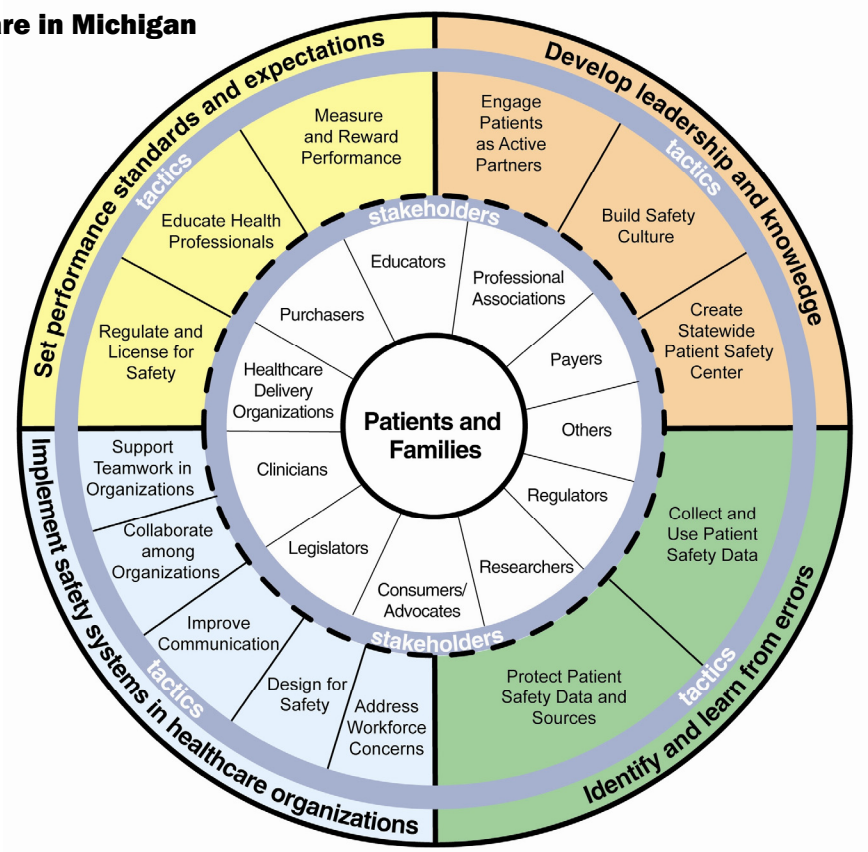
From testimony to recommendations

A group of researchers, the Analytic Team, was charged with making sense of the testimony consistently and impartially. Their qualitative approach condensed the information, identified important patterns, and communicated the essence of what the data revealed. The Analytic Team coded recommendations from the testimony using categories suggested by the Institute of Medicine report, *To Err is Human*. These categories, which had been listed in the invitation to provide testimony, serve as a framework for Commission recommendations.

Figure 2. A model of safe care in Michigan

As its framework, the Commission adopted categories suggested by the Institute of Medicine report, *To Err is Human*. These categories, which had been listed in the invitation to provide testimony, appear in the outer ring of the model.

Within these broad categories, in the second ring, working inward, are areas in which the Commission developed recommendations. At the center of the model are patients and families, as they should always be at the center of our efforts to improve patient safety. Around them are arrayed the diverse stakeholders who must be united to realize our vision of a safer Michigan health care system.



In addition to the testimony, the Analytic Team was asked to review the literature and learn from other patient safety initiatives. Their synthesis of these sources informed development of the recommendations contained in this report.

The Review Panel, a subgroup of the Commission plus two Michigan patient safety experts, drafted recommendations for making Michigan's health care system safer for patients. The Review Panel conducted two rounds of deliberations, during which they discussed the Analytic Team's findings, brought additional information to light, and refined the recommendations. At the end of its second round of deliberations, the Review Panel was asked to prioritize the remaining recommendation categories. This process guided the order in which the recommendations appear in this report.

The Commission provided oversight and input throughout the process. Commission members held two public meetings—on April 28 and June 30, 2005—to describe how public testimony was obtained and reviewed, discuss how the Commission was examining the compiled recommendations, and preview its report. These meetings were announced in the press and invitations were sent to all who provided testimony and to those who were originally invited to provide testimony but did not. The final report was approved by the Commission in November 2005.

Note about language

In this report, the term "informant" is used to refer to an individual or organization that provided testimony to the Commission. The words "patient" and "consumer" are used interchangeably to describe all types of people who might need health care services, now or in the future. And by "health professionals" we mean the vast array of individuals who provide health care services. From the context it should be clear when this term refers primarily to those offering clinical care and when it includes those who are involved in patient care less directly, such as housekeeping or facilities personnel.

Availability of Technical Appendix

A complete list of informants, details of the testimony by recommendation area, and more information from the literature are provided in Volume II of this report, the Technical Appendix, which is available online at http://mihealthandsafety.org/statecommission/index.html.

OBJECTIVES AND RECOMMENDED ACTION STEPS

The Commission received testimony from an impressive array of health care stakeholders, many of whom expressed a desire to continue working with a state-level entity to improve patient safety in a variety of health care settings. In addition to consumers, hospitals, physicians, nurses, pharmacists, employers, unions, and insurers, we heard from occupational therapists, anesthesiologists, radiologists, podiatrists, dieticians, and providers of ambulance, home health, mental health, long-term care, and school health services, just to name a few. Our recommendations are intended to engage individuals and organizations across the entire continuum of care.

From the testimony

The transformation of healthcare will only happen when the culture changes, and culture change is the most difficult thing in the world to accomplish. ... You change one small unit at a time, one heart, one mind, and it grows.

—Keystone Center for Patient Safety and Quality

Much of the public testimony emphasized the importance of culture change in patient safety improvement. While we address this complex issue explicitly in the first set of recommendations, the thread of continuous culture change is woven throughout this document. Changing health care culture and norms—"how things are done around here"—can lead to the age-old question of chickens and eggs. Our recommendations are designed both to accelerate culture change and to benefit from it. Establishment of the Michigan Center for Safe Health Care, for instance, is intended to provide a focal point for leadership, to promote what is best in patient safety around the state, to build energy and enthusiasm, all of which contribute to a willingness to change. In turn, recommendations to develop a voluntary statewide patient safety reporting system would benefit greatly from a health care culture characterized by a commitment to safety, learning, and collaboration.

Each recommendation section follows roughly the same format: An introduction to the topic; objective(s); and recommended action steps for relevant stakeholders. Variations on this format were made to accommodate different topic areas.

From the testimony

It is important to remember that patient safety relates to the safety of patients in all of their environments. From home, to work, to hospitals, to care facilities, and back home again, patient safety should be an ongoing educational process. ... It 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.

—Michigan Occupational Therapy Association

Role of patients and families

The Commission grappled with how best to articulate the role of patients and their families in this set of recommendations. It became clear that a simple "to-do" list for patients and families would not be enough. We do not, therefore, include action steps for patients and families in each chapter.

We believe the pathway to a sincere and secure role for patients and families is through change in health care organizations and processes. Health professionals and organizations, as well as policymakers, must make a permanent place for patients and families at the table and actively support them in that role. Taking to heart the IOM's recommendation that patients be viewed as members of their health care team actively involved in their care, we have incorporated the patient/family voice in action steps throughout this document. In this way we remind health professionals, organizations, and policymakers to pay attention to patients and their families,

actively solicit their input, and take action based on what this important group has to teach us.

From the testimony

Our experience demonstrates that when providers are sitting at the table with health care plans and purchasers, and are treated as equal partners, deeper change and safer health care can result.

—Blue Cross Blue Shield of Michigan and Blue Care Network

Involvement of purchasers and payers

The Commission also wrestled with how best to represent the important role of health care purchasers and payers, including health plans, insurers, employers, consumers, and state government in its role as purchaser for state employees and underserved populations. The current lack of long-term stability in health care reimbursement was identified as a barrier to more effective planning and capital investment by health care organizations to improve safety, productivity and efficiency. Addressing these complex payment issues is beyond the scope of this report, yet it is clear that purchaser engagement is a critical component of patient safety improvement.

We urge purchasers and payers to participate actively in working to realize all the recommendations laid out in this report by providing financial and nonfinancial incentives, research grants, subsidies, rewards, and public recognition. In particular, incentives might be used to encourage health professionals and organizations to:

- Measure and improve safety culture.
- Participate in the voluntary reporting system.
- Collect performance measurement data relevant to particular settings and patient populations using common data definitions.
- Meet or exceed safety performance targets.
- Conduct performance measurement demonstration projects.
- Monitor nurse-staffing effectiveness.
- Match the quantity and qualifications of staff on duty to patient needs, and achieve desirable patient outcomes.
- Maintain low vacancy and turnover rates among shortage health care workers.
- Achieve American Nurses Credentialing Center magnet status.
- Serve as clinical training sites.
- Design or redesign facilities and processes of care for improved patient safety.
- Work and learn together collaboratively.
- Strengthen cross-disciplinary teamwork.
- Engage in proactive and full disclosure of unanticipated patient outcomes and errors
- Report all sentinel and adverse events as required.
- Take appropriate corrective action as it relates to errors and near misses.

We encourage purchasers and payers to use their position in the health care system to promote positive change.

A note about costs

The Commission did not have the resources to estimate the private-sector costs of these recommendations. We did, however, attempt to balance the costs and benefits of the proposals and promote the alignment of payment policies to support these patient safety improvements.

Two areas of public-sector funding warrant attention. The Michigan Center for Safe Health Care will require both start-up funding and a reliable, sustainable source of long-term income, which could include membership fees, state general funds and budgetary carve-outs, additional fees on health professional and health care organization licensure renewal charges, user fees, and public and private grants. These funds would be used to support an office (space, equipment, and supplies), staff, and programs and services (meetings, printed materials, etc.). Annual costs to operate the Center have been estimated at roughly $2 million to $3 million.

Operating a statewide voluntary error and near-miss reporting system also will require substantial resources. Requests for funding should be bundled with budget requests for the Michigan Center for Safe Health Care. Federal grants should also be pursued. In 2001 the federal Agency for Healthcare Research and Quality (AHRQ) awarded $23 million to 16 three-year error reporting demonstration projects. The Center should watch for similar funding opportunities.

A. Build a safety culture

While most health care organizations are involved to some degree in improving patient safety and building cultures of safety, progress is slow. As Michigan's health care culture continues to evolve to one that acknowledges the dynamic, interdependent nature of health care, improvement likely will speed up. All of us involved with health care will experience greater freedom to explore creative ways to improve patient safety. We will no longer seek a person to blame when something bad happens. We will stop asking individuals to do the impossible by trying to prevent errors on their own without control of all aspects of the situation.

From the testimony

The patient safety culture is, I believe, fundamental to truly achieving the safe environment of care. There is a long tradition of punitive response to clinical errors and adverse outcomes in health care. 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.

—Beaumont Hospital (Royal Oak)

To begin, it is clear that what is needed first and foremost is leadership. The top leadership in the organization must recognize the importance of patient safety, make it a top priority and dedicate resources to it. ... Without this leadership patient safety efforts will surely fall flat on its face.

—Munson Medical Center

One key learning from our experiences is understanding that traditional physician culture honors autonomy and expert knowledge. ... Our approach is to involve physicians as leaders, to focus on defining and communicating the evidence that supports change, and to support our improvement efforts with ongoing measurement to demonstrate progress in process and outcome improvement.

—Henry Ford Health System

Culture change is hard work and requires long-term commitment, careful planning, and specific attention from top leadership. Because the recommended culture change challenges underlying assumptions about how the health care field should work, health care organizations and professionals, especially physicians, must be engaged. We can and should learn from successes in other industries—nuclear power and aviation, for instance—to speed our progress.

Informants at our fall 2004 hearings made a number of recommendations that, taken in total, support a health care culture that acknowledges the importance of interactions, interdependencies, and interrelated systems. Responses also conjured an environment characterized by an open and sincere commitment to safety, learning, collaboration, and systems thinking.

Objectives

- Continue to transform Michigan's health care culture to one characterized by a commitment to safety, learning, collaboration, and systems thinking.
- Reinforce a culture in which the state of Michigan, all clinical and administrative leaders who influence health care delivery, all persons involved in the caregiving process, and those who use health care services act consistently from a deep commitment to decreasing harm to patients.

Recommended action steps

State of Michigan

- Provide strong leadership for statewide change to improve patient safety across the continuum of care.
- Ensure that legislation and regulation support:
  - Collaborative approaches among health care organizations, professionals, employees, and health plans to stimulate and improve patient safety.
  - Open communication about patient safety by health professionals and organizations.

From the testimony

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.

—Sandra Jones, RN

As long as we stigmatize those people who make mistakes, we're not going to find out about very many of them because they're just going to be driven underground. … We've got to … figure out a way to allow those things to surface so we can understand them and then fix the system so the mistakes can't happen.

—Michigan Pharmacists Association

Michigan Center for Safe Health Care

For details, see "B: Establish a statewide patient safety center."

- Work collaboratively with patient safety stakeholders to gather or develop needed information and tools.
- Assist in culture transformation by making available information, tools, and technical assistance to help health care stakeholders achieve this vision.
- Encourage measurement of health care culture.

Health professionals and organizations

- Assess each organization's culture periodically to gauge progress and identify needed changes.
- Commit human and financial resources to support active patient safety programs in each institution.
- Communicate openly about patient safety at all levels.
- Proactively engage governing boards in establishing governance processes that support a culture of safety.
- Encourage active involvement of patients, families, and caregivers in patient care and in the assessment of safety issues and design of safer health care.
- Ensure that human needs and limitations are taken into account when designing facilities, physical environments, and work processes.
- Engage in and hold accountable for patient safety all persons involved in the caregiving process.

All health care stakeholders

- Recognize that patients are the cornerstone of the health care system.
- Design modifications to current work processes and structures as well as new programs and initiatives to take into account the complex, dynamic interdependence of people, organizations, processes, and structures within and beyond health care.
- Build environments that support communication, transparency, and full disclosure to patients.
- Build environments that support understanding what happened and why when medical errors and near misses occur, rather than assigning blame or finding fault.
- Align incentives to support desired culture change.
- Support and participate in collaborative approaches to learning, problem solving, and provision of care.
- Focus on specific, discrete improvements in quality and safety designed to yield the largest safety gains; clearly specify desired outcomes and build in timely evaluation of interventions to improve patient safety; and use principles known to support the adoption of innovations in other industries when designing and implementing patient safety initiatives and specific interventions.[1]

B. Establish a statewide patient safety center

Public hearing participants expressed strong interest in a state-level focal point for patient safety efforts. This Michigan Center for Safe Health Care would be in a unique position to coordinate and promote the work of patient safety programs around the state and across state agencies, between stakeholders at the state and national levels, and between public and private sectors. By establishing the Center, the state would demonstrate its commitment to patient safety, develop a mechanism for accountability among health care stakeholders, and respond to the needs of the public.

From the testimony

Opportunities for improvement have to get back out into the community with a way for them to get implemented; otherwise, it ends up being ... just another book on another shelf.

—Lawrence J. Abramson, DO, MPH

[We recommend] the identification of a state focal point for patient safety to set goals for patient safety, track progress in meeting goals, and [issue] an annual report.

—Henry Ford Health System

[We recommend] that a patient safety center ... 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.

—Michigan Consumer Health Care Coalition

In its coordinating role, the Center would foster a culture of patient safety around the state and:

- Cultivate collaborative relationships to solve complex patient safety problems.
- Promote active involvement of patients and families in the structure and process of safe health care.
- Coordinate public educational efforts with programs targeting clinicians.
- Facilitate the systematic identification of practices and environments that result in patient harm.
- Collect and disseminate information and tools to accelerate improvement.
- Provide connections to expertise and technical assistance.
- Monitor the effects of patient safety improvement efforts and promote progress to the public.
- Shape public policy to encourage the adoption of patient safety practices by health care organizations and professionals.
- Coordinate state-level advocacy at the national level.

Legislatures in six states—Florida, Maryland, Massachusetts, New York, Oregon, and Pennsylvania—have authorized or endorsed state centers for patient safety. Most statewide centers are still in their infancy, although several are further ahead.

All six intend to:

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

Five of the six centers also intend to:

- Foster creation of a culture of safety.
- Recommend statewide goals and track progress.
- Serve as clearinghouses for best practice information.
- Develop or sponsor patient safety research projects.
- Promote collaboration between federal and state initiatives.

Other state centers also create and/or disseminate self-assessment tools for medication errors, leadership practices, or safety culture and encourage their use.[2]

From the testimony

I would suggest an analogy—if each airline had to develop their own National Transportation Safety Board to study their close calls or accidents. That certainly is not the way we do it. … Perhaps … the State could assist to develop some expertise to help organizations study their events [and] truly come to appropriate conclusions and good solutions. 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.

—Beaumont Hospital (Royal Oak)

Congress recently acknowledged the important role of these centers. The Patient Safety and Quality Improvement Act of 2005 specifies that a patient safety center could be identified as a "patient safety organization" if:

- Its mission and primary activity are to conduct activities that are to improve patient safety and the quality of health care delivery.
- It has appropriately qualified staff (whether directly or through contract), including licensed or certified medical professionals.
- It is not, and is not a component of, a health insurance issuer.
- It collects patient safety work product from providers in a standardized manner that permits valid comparisons of similar cases among similar providers.
- It utilizes patient safety work product for the purpose of providing direct feedback and assistance to providers to effectively minimize patient risk.

As envisioned, the Michigan Center for Safe Health Care would meet all these criteria.

The Center would provide a central point of information about the wide variety of successful Michigan patient safety improvement projects—including those mentioned elsewhere in this report—that are expected to continue and flourish. The Center would also encourage new projects across the continuum of care, particularly among health care stakeholders not yet involved in collaborative efforts.

To accomplish these goals in a balanced, unbiased, nonpunitive learning environment, the Commission recommends that the Center:

- Involve a wide variety of stakeholders and remain open to partnerships with health care providers and others.
- Be independent of any individual health care provider or professional organization, subsidiary, or collective.
- Not be housed within or accountable to a state agency or other regulatory or licensing body.

Details of the Center's structure are provided in the Model Act in Appendix C. The responsibilities envisioned for the Center are detailed in Table 1 on the following page and in other recommendation areas.

Objective

Establish and fund the Michigan Center for Safe Health Care as a statewide center for leadership, information, and advocacy to reduce patient harm across a range of health care settings.

Recommended action steps

State of Michigan

- As detailed in the Model Act (Appendix C), establish the Center as a freestanding organization eligible to serve as a Patient Safety Organization pursuant to the requirements of the federal Patient Safety and Quality Improvement Act of 2005 (PA 109-41).

Michigan Center for Safe Health Care

- As required in the Model Act (Appendix C), submit to the Governor and Legislature a projected five-year financial analysis of the resources needed to support the activities and duties of the center.
- Include recommendations to the Governor and Legislature regarding potential sources of restricted, ongoing funding that might include membership fees, other restricted sources related to the promotion of patient safety, and federal sources.

Table 1. Michigan Center for Safe Health Care
Primary role: To coordinate and collaborate with stakeholder groups

Create Vision & Opportunity	Build Capacity & Transform Culture	Verify Progress & Improve Strategy
Work with Michigan stakeholders to: • Align state goals with national goals and link them to reporting/payment systems. • Align information and error reporting systems with national efforts. Support legislators and regulators to: • Secure peer protection. • Modify the regulatory environment to incorporate patient safety concepts and stimulate accountability. Work with federal agencies to: • Develop clear, standardized and measurable patient safety goals and information technology and error reporting system standards and structure. • Align federal health care payment policy with national goals. • Secure funding for patient safety research and education.	Work with Michigan stakeholders to improve patient safety. • Develop and coordinate a statewide voluntary, confidential, nonpunitive error and near-miss reporting system. • Create a learning environment for clinicians to learn from mistakes, share lessons, "safer practices," and solutions that improve patient safety. • Promote use of existing information to improve consumer knowledge and decision making. • Support knowledge development and dissemination through research and practitioner education. • Encourage use of communication and information technologies that improve the safety and coordination of health care. • Support efforts to provide incentives based on achieving patient safety goals.	Work with Michigan stakeholders to increase transparency and accountability. • Publish and disseminate periodic reports of the Center's progress toward goals. • Hold periodic open patient safety hearings to update the public on Center plans and progress and encourage the public to testify regarding patient safety issues. • Encourage public reporting of and provider accountability for provider performance relative to patient safety goals.

C. Collect and use data about errors and near misses

Reporting is not a new activity for health care organizations, although it often is associated with blame and fear of litigation. To make progress, this emphasis on punishment must change. The goal of the proposed reporting system is prevention—to learn from past errors, whether they reached the patient or not. Collecting and analyzing such data provides a clear picture of what is happening, so appropriate prevention measures can be taken. Committing state resources for patient safety improvement through data collection and analysis for prevention, not punishment, demonstrates the state's commitment to building a culture of safety and creating a learning environment.

From the testimony

Reporting is key. You need the data to give direction and to see how you're doing.

—Munson Medical Center

Reporting events does not improve patient safety unless it leads to action.

—VA National Center for Patient Safety

We need reporting of adverse events to make sure that whatever happened does not happen again. That's my biggest concern with what happened to my sister … to make sure that this doesn't happen to some else's sister, to someone else's daughter.

—Michigan Consumer Health Care Coalition

Few good measures of quality and safety exist. Measuring harm is challenging and the science of how to do it needs to advance. We will not be able to cross the quality and safety chasm until we understand that safe health care delivery requires just as much scientific rigor as conducting a clinical trial of a new drug or finding a new gene.

—Michigan Health & Hospital Association

The potential to learn from errors and near misses is greatly enhanced by collecting reports from many organizations, then compiling, aggregating and analyzing the data to detect trends, especially for rare events. Collecting and aggregating information across unaffiliated health care organizations requires a statewide system. Such a system would enhance learning opportunities for all participants by facilitating the sharing of de-identified data, lessons learned, and best practices so all organizations have an opportunity to develop, implement and evaluate their own error prevention programs.

A statewide reporting system also would facilitate communication with the public about which health care organizations are working to improve care by participating in error and near miss reporting and monitoring activities.

Both errors and near misses (or close calls) should be reported and analyzed. Near misses occur 100-300 times more often than actual errors; learning from near misses is critical.[3] It also will be essential that the reporting system return useful information to those who provide the data so systems of care can be changed to reduce the likelihood of future occurrences.

Twenty-seven informants (35 percent of the 77 testimonies) indicated support for an error reporting system. There was more support for a voluntary system than for a mandatory system. There was strong agreement that the primary purpose of analyzing data and conducting follow-up should be to share lessons learned. Almost all noted that "the state," "State of Michigan," or some aspect of the state (legislature, administration, or a state-level patient safety center) should be responsible for setting up and administering the system.

Informants tended to recommend that the reporting system be statewide and nonpunitive; that it protect the identity of reporters; that it use a standard format consistent with national standards, such as those being developed by the National Quality Forum; and that some public reporting of trends and facility/organization-specific reports be provided. All of these characteristics are reflected in our recommendations.

There was less agreement among informants regarding particular aspects of a reporting system such as its data

From the testimony

A voluntary system of reporting errors to a central repository that provides anonymity and peer/professional review protection for the reporter may permit broad sharing and learning to prevent errors.

—Risk Management and Patient Safety Institute

As you balance the fact that providers are incredibly frightened, distressed and anxious about reporting errors, near misses … I think the Commission has to balance that against what you are going to do to reassure the payers of health care and the consumers of health care that this problem is being meaningfully addressed.

—Economic Alliance for Michigan

It is appropriate that [State government] 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.

—Michigan Consumer Health Care Coalition

Using a standardized format across health care settings provides a mechanism to collect comparative data on the types and scope of health care errors, which can be used to implement improved safety practices. Only with standardization will data be available for aggregation, sharing and quality improvement.

—Blue Cross Blue Shield of Michigan and Blue Care Network

elements, reportable events, uses of the information, data collection methods, types of reporters, control and housing of the reporting system, contingencies and other issues. We recommend, therefore, that these details be studied further during development of the system's specifications.

Objective

Establish and fund a statewide voluntary, confidential, peer-protected, nonpunitive error reporting system. Ensure that important findings are disseminated regularly to improve health care safety. Complement, to the extent possible, emerging national data definitions and measurement criteria.

Recommended action steps

State of Michigan

- Provide restricted, dedicated, sufficient, reliable, ongoing funding for the reporting system from a combination of public and private sources as part of the funding package for the Michigan Center for Safe Health Care.
- Endorse application of the Michigan Center for Safe Health Care as a Patient Safety Organization under PA 109-41.
- Authorize the Center to design, implement, manage and maintain the reporting system. These responsibilities would include collecting and analyzing the data, and disseminating important findings to improve health care safety.
- Ensure that the reporting system's data, sources, and users are protected, as described under "D. Protect patient safety data and sources."
- Require an evaluation of the voluntary reporting system within three years of implementation and require that improvements identified during the evaluation be made.

Michigan Center for Safe Health Care

- Design the system's specifications in consultation with reporting system experts and a broad array of health care stakeholders, including consumers.
- Design the reporting system to:
  - Require use of standardized data collection tools and methods.
  - Collect adverse events and near miss reports.
  - Collect data from individuals and organizations across the continuum of care.
  - Accommodate information submitted by patients, families and consumers.
  - Complement, to the extent possible, existing reporting initiatives sponsored by Michigan health care organizations and emerging national data

definitions and measurement criteria, such as those being developed by the National Quality Forum.

- Design analysis of reported data to identify trends, system failures, and contributing human factors as well as persistent safety issues in need of intensive analysis or broad response.
- Return data to reporting organizations in a timely and useful format, provided the identity of the reporting individual is protected, should she or he request confidentiality.
- Disseminate aggregated findings to reporting organizations and to the public in a timely and useful format in a manner that protects the confidentiality of individual reporters and, in the case of publicly available data, protects the confidentiality of organizations.
- Communicate regularly with and convene stakeholders to facilitate sharing of error-based lessons learned and best practices.
- Develop or identify sources of expertise to help reporting organizations study error events and arrive at appropriate conclusions and good solutions.
- Disseminate solutions and successes of projects and patient safety initiatives to providers and the public.
- Consult with reporting system experts and a broad array of health care stakeholders, including consumers, to recommend incentives to encourage participation in the reporting system.
- Annually evaluate the types and numbers of participating organizations to ensure broad representation from across the health care spectrum. Use this analysis to focus recruitment of underrepresented types of organizations and to develop added value for participants submitting data to the system.

Success stories from the testimony

Health providers state that there continue to be significant barriers to reporting of [errors and near misses]. 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.

... The time has come for us to ... start understanding and identifying what are the root causes of medical errors and adverse events. ... We can only do that if we look at the data in a standardized manner, identify the opportunities for improvement, share information in a de-identified way, and focus on the improvement opportunities that are there.

... We've been able to implement an online anonymous-capable error and event reporting system that captures data on both near misses and actual events across our system. ... To date it is available in 28 of our facilities. ... In that system we have received almost 70,000 reports. The importance of that is that we are able to take disparate organizations, create a common nomenclature structure for gathering information on events and near misses, and then start analyzing that data to create information out of it.

—Trinity Health (Novi)

Like Trinity, we have implemented a Web-based voluntary, confidential reporting system for errors in our facility. ... We are getting over 14,000 reports now annually from our providers regarding near misses ... something we didn't have data collection on previously, and we're using those very vigorously ... to really improve care of our patients.

—Detroit Medical Center

D. Protect patient safety data and sources

Knowing about errors, adverse events and near misses is essential to preventing patient harm. To collect this data, however, everyone associated with health care delivery must be willing to provide this crucial information. Individuals will do so only if they feel safe from legal and professional repercussions within their own work settings and in the greater community. Organizations will participate in such reporting only if they will not be subject to a loss of business or damaged reputation. Commission recommendations articulate fundamental principles for protecting patient safety data and sources; further legal advice will be required during implementation to ensure that these principles become practice.

From the testimony

We have found that people want to tell us what is going on but they must have it safe. ... We had to make it safe for people to tell us what was going wrong.

—Trinity Health (Novi)

Initially, the most important step would be for the State of Michigan to promulgate regulatory protection for reporting medical errors for the purpose of improving patient safety on a statewide basis. Next, a plan should be developed for designing a state wide reporting system.

—Risk Management and Patient Safety Institute

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.

—Michigan Association of Health Plans

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.

—Michigan Society of Anesthesiologists

The wonderment of the FAA model is you're penalized for not reporting something. You're even penalized for not reporting a near miss. It's the near misses where the power is to make this a safer system.

—Lawrence J. Abramson, DO, MPH

To develop a robust database with the potential to point out system conditions that might lead to harm, patient safety data must be protected from unintended uses. Individuals that, in good faith, report conditions or events that jeopardize patient safety must also be protected from blame and disciplinary action. A comprehensive study of how states report medical errors to the public found that to be effective and reliable, protections should be:

- Comprehensive—to cover the many ways that confidentiality can be challenged.
- Statutory—to better withstand legal challenges.
- Specific to the reporting system—to make legislative intent clear.[4]

The Patient Safety and Quality Improvement Act of 2005 (PA 109-41) amended Title IX of the Public Health Service Act (42 U.S.C. 299 et seq) to provide specific federal statutory protection to patient safety work products and those who report patient safety data. Patient safety work products are designated as privileged and confidential, with limited exceptions. Those who report patient safety-related information and/or develop and maintain patient safety work products in good faith also are afforded protection against adverse employment action and adverse action by accrediting bodies.

There is some concern that the exceptions contained in the new federal law could result in unnecessary disclosure of patient safety information. The state of Michigan should review the federal legislation and related administrative rules to determine whether further state-level protections are needed to accomplish the goals set forth in this document.

Objective

Protect patient safety data and reporting activities under statute without denying patients and families access to information through normal channels when medical errors or unexpected events occur.

From the testimony

The confidentiality of reported information is critical to the success of a reporting system. Without assurance that this information could not be used in a punitive way against the reporter, there would not be a rational incentive to report patient safety information. … It is important to recognize that making patient safety information confidential does not deprive any of the pre-existing internal or external accountability systems of information that are required.

—VA National Center for Patient Safety

Recommended action steps

State of Michigan

- Align Michigan's protection strategies with emerging federal legislation and rules. Provide additional protection, if necessary, to support statewide patient safety improvement.
- Advocate at the federal level for an evaluation of the effectiveness of the new law to:
  - Protect patient safety data and sources.
  - Increase reporting of medical errors, adverse events and near misses after three years of implementation.
- If a federal evaluation is not planned, conduct a state-level assessment of the effectiveness of federal and state laws and rules in supporting Michigan's patient safety improvement efforts.

E. Measure and reward performance

Ongoing data measurement and meaningful incentives for change form the foundation of sustained quality improvement. Using a common set of goals and data definitions—what should be measured and how to measure it—would facilitate collaboration and comparison of progress while simplifying data collection and reducing the number of competing and conflicting standards. While it is critical that a full range of Michigan's perspectives on patient safety performance measures be communicated to those developing such standards at the national level, Michigan must not wait for a complete set of national standards to emerge before acting.

From the testimony

In order to change something, it's very helpful to be able to measure it, and our way of measuring [patient safety] at this point is somewhat lacking.

—University of Michigan Hospital

A statewide emphasis on key goals would help focus organizations on the few key performance indicators versus a broad and changing [list] resembling the "flavor of the month."

—The Bergendahl Institute, LLC

Our efforts now are like Brownian Motion, we're going in many directions. ... We need goals, very clear measurable goals ... [and] an explicit strategy for spreading what works.

—Keystone Center for Patient Safety and Quality

The hospital often feels overwhelmed as we attempt to respond to the multitude of payers and purchasers who do business with us. ... The result is an ongoing "scramble" to gather information and provide this information in the specific formats requested by the external entities.

—McLaren Health Care Corporation

The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. ... We should be able to benchmark our results on a multitude of measures. ... If we measure it, we can better understand it and then implement solutions to improve it.

—Munson Medical Center

A best practice is the continuous process of learning, feedback, reflection and analysis of what works and why. Best practices are the documentation of what works.

—American Ambulance Association

In an important 2004 report, Michigan scored above average in only 24 of 88 (27 percent) measures for which data were available. On 44 (50 percent) of the standards Michigan was considered average. Michigan scored below average on 20 (23 percent) of the measures and was unable to provide enough data for scoring on 90 more measures the report considered for other states.[5]

Michigan must do better. Once the common vocabulary, data collection/analysis guidelines, and solid feedback mechanisms are designed, health care organizations across the continuum of care must be held accountable for collecting data and acting effectively on the feedback they receive. Feedback to health care providers may include benchmarks, which allow organizations to compare themselves against the "best in class."

Payers can support change by providing incentives to health professionals and organizations that meet or exceed benchmarks and demonstrate improvement over time.

Objective

Establish or adopt standards for patient safety performance across the continuum of care; develop or adopt a common vocabulary and standardized data definitions; set dynamic benchmarks to measure progress; use the measured performance of Michigan's health care providers to inform ongoing improvement efforts; and reward excellence.

Recommended action steps

Michigan Center for Safe Health Care

- Convene and lead a group of stakeholders to:
  - Develop or adopt a common vocabulary around patient safety performance across the continuum of care that facilitates sharing, comparing, analyzing and evaluating data.
  - Recommend statewide standards for safety performance, benchmarks by which to measure progress, and expectations of excellence.
  - To the extent possible, ensure that Michigan's patient safety standards and goals are consistent

From the testimony

I remember the [J.D.] Powers report starting 35 years ago, and it was the most widely detested activity I every came across in the auto industry. I've been working in and around the auto industry for 50 years and ... did they hate that. But you know something, it had the most influential impact of anything I know of, crude as it may have been or anything else, in changing actual behavior within that major industry of ours, and it caused them to get better.

—Economic Alliance for Michigan

Our methods of paying for care must reward delivery of the right care at the right time in the right place.

—Health Alliance Plan (HAP)

Revise payment mechanisms to align incentives ... reward demonstrated implementation of safe practices and support investment in clinical information technology.

—General Motors Corporation

All levels of leadership have to be held accountable and have to ensure that the patient safety goals are met. One person, one department, cannot drive this through an organization.

—Munson Medical Center

[Recommended incentives include]:
* Means to support innovation, research and training—usually provided through research grants, contracts and funding for pilot programs.
* Legislation that promotes and stimulates change, while at the same time recognizing and partially compensating for the time and effort required to realize change.
* Alignment of incentives of all parties.
* Recognition of the magnitude of benefit that can be realized if an imperfect health care system is improved.
... Non-financial incentives are at least as important as financial incentives. The major non-financial incentive is enabling all key healthcare stakeholders to become part of the solution to critical patient safety issues. ...Participation in the development of systems and the ability to have shared goals and a shared commitment to success are key.

—Blue Cross Blue Shield of Michigan and Blue Care Network

with emerging national measures and standards such as those being developed by the National Quality Forum.
    - Standardize data definitions and specifications to facilitate comparison of progress across organizations.
- Collect and aggregate performance measurement data to inform the ongoing analysis of safe standards and provide feedback regarding performance progress.
- Support these activities through communication and education.

Health professionals and organizations

- Participate in development of a common vocabulary around patient safety performance across the continuum of care that facilitates sharing, comparing, analyzing and evaluating data.
- Collect and submit required performance measurement data relevant to particular settings and patient populations using common data definitions.

F. Address workforce shortages effectively

Ensuring the availability of qualified health professionals and the effectiveness of staffing to meet patient needs are crucial elements of a health care system that minimizes avoidable harm to patients. Health care organizations across the continuum of care are struggling to recruit and retain qualified staff. Without sufficient staff, patient health can suffer and staff dissatisfaction can rise, further impairing efforts to retain sufficient staff.

From the testimony

We have learned that good health care is not just procedures, medicine and new equipment: Motivated and experienced health care providers who have dignity, self respect and job security are perhaps the most important ingredient in the health care mix.

—Citizens to Save Healthcare

No nurse wants to go home at the end of the day and feel that she didn't get to things that needed to be done for a patient.

—Michigan Nurses Association

We know from our findings that fatigued nurses put themselves at risk, their patients at risk, and the public at risk.

—Linda Scott, RN

Some people … try to focus this whole issue and debate [about appropriate staffing] on just hospitals. It's an equally serious and relevant problem in our nursing homes. In nursing homes the turnover rate is even higher and workers are leaving due to these heavy workloads.

—Service Employees International Union

From the literature

After more than a decade in which the health care community anticipated a physician surplus, there is widespread recognition that this pattern may be reversing.

—Michigan State Medical Society

A public-private collaboration between the Michigan Departments of Community Health and Labor and Economic Growth and Public Policy Associates, Inc. has focused on the topic of developing the Michigan health care workforce. Their October 2004 report, *Health Care Workforce Development in Michigan*, provides valuable information about this complex issue.[6]

For example, the authors report that a number of health care disciplines are experiencing critical shortages of qualified staff and distribution problems (not enough staff in a particular city, town, or area of the state). In fact, within 10 years, substantial shortages of 25 health occupations are expected. Some shortages are worse in rural areas and some are considered to pose very serious threats to the health and safety of Michigan residents.

The workforce report also contains a list of strategies to reduce turnover and vacancies for all types of health occupations. A brief summary of the group's findings and recommendations follows.

- Health care workforce development in Michigan should be inclusive of a wide variety of occupations, not just nursing. While the nursing workforce crisis in Michigan is widely recognized, significant shortages in other health care occupations pose serious threats to Michigan's health care delivery system.
- Health care workforce development will be a long-term effort. While some occupations may be addressed through short-term recruitment and educational activities, the health care industry and the demand for health professionals and technicians will continue to grow for the next 20 years as the baby-boom generation enters retirement age.
- Model practice solutions to the health care workforce crisis in Michigan scan the entire range of age and career. Efforts to upgrade the skills of older, more-experienced incumbent health care workers and efforts to impart new skills and knowledge to displaced workers from other industries are as important as efforts to promote health careers among young people.
- An enormous variety of model practices have made an impact under varying circumstances, in different locations, and for a diversity of health professions and occupations.

From the testimony

Dedicated medical professionals and the care they provide is critical to patient safety and treatment. We need to create a culture that demonstrates respect for many of the frontline workers and encourage young people to seek careers in nursing and medical care.

—MPRO

The different schools 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. … For every nurse that gets into a nursing program, two are turned away, in the last data that I saw.

—Virginia Hosbach, RN

Another [suggestion] would be to educate healthcare workers that part of our job is … [to] educate and help train those new people in our profession.

—Jonathan Reed, RN

- The most successful programs have established high levels of collaboration among key stakeholders, especially educational organizations, professional associations, and health care employers.
- Successful models exhibit flexibility in education and training—e.g., flexibility in location, scheduling and administration.
- Health care workforce development also means health care education faculty development. Despite the recent upswing in nursing school enrollment, efforts to broaden nursing education, as well as education and training for other health professions and occupations, is being hindered by the shortage of qualified faculty to teach the next generation of health care workers.
- Health care workforce development also requires greater-than-average financial commitment. Health professional and technical education is very expensive, especially because of the need for laboratory and clinical education and the relatively low student-to-faculty ratios required by some accrediting bodies. Employers, educators, labor unions, and government will have to collaborate on acquiring additional funding from innovative sources.

The Commission recognizes that these problems are complex and the solutions require organized, multifaceted initiatives across a broad array of Michigan stakeholders, including the state. Although individual health care organizations and schools can do much, state-level intervention must be part of the solution. The state, in its various capacities as health care payer, purchaser, and employer, is needed to champion efforts to improve the health care workforce. We recommend that the report and recommendations cited above guide Michigan's efforts to improve the health care workforce.

Objective

Address health care workforce shortages without compromising patient safety while improving practice environments and the availability of qualified health professionals.

Recommended action steps

State of Michigan

- Implement recommendations from the final report of the Health Care Workforce Development in Michigan Advisory Roundtable.
- Advocate that schools receive support for training, hiring, and providing continuing education for the faculty critical to address health care workforce shortages.

Success story from the testimony

Locally we have a model of partnership between our community college ... and Munson Medical Center to increase the overall number of individuals choosing nursing as a profession and increasing the numbers of students in their nursing program. ... We have jointly promoted nursing as a positive career choice, strengthened the clinical experiences for students, created joint appointments for clinical instructors, provided new roles for nursing students and supported tuition needs.

—Munson Medical Center
(written testimony)

[Northwestern Michigan College has] looked on their end what they needed to do in the way of making sure that they've got the necessary classes that are staged appropriately so that the individuals considering nursing as a career option have easy access to those classes. At Munson, something that we have strengthened is improving the clinical experiences of the students there. Also for our staff that are qualified to be clinical nursing instructors, we have created joint appointments. ... We created a nurse tech program ... and expanded the nursing assistant position ... and put additional resources and energies into those folks so that we're building their skill and knowledge base so that when they do become nurses that they are off and running quicker.

—Munson Medical Center
(oral testimony)

Michigan Center for Safe Health Care

- Convene stakeholders to develop and implement novel solutions to reducing staff turnover and vacancy rates in clinical areas most affected by workforce shortages.
- Evaluate staffing effectiveness as it relates to harm at high levels of aggregation.

Health professionals and organizations

- Match the quantity and qualifications (appropriate training, experience and level of alertness) of staff on duty to patient needs as identified by staff working in the patient care unit and in accordance with recommendations made by national advisory bodies, regulatory and accreditation rules, and legislative and contractual mandates.
- Acknowledge human limitations and the serious potential for harm caused by fatigue-related performance and an aging workforce, and incorporate the findings of national advisory bodies related to overtime work precautions into staffing plans.
- Use national consensus standards and measures to monitor and evaluate the effectiveness of Michigan health care organizations' staffing practices on outcomes of patient safety, health, satisfaction, and access to care, as well as staff safety, satisfaction, and retention/turnover. As it relates to nursing, these standards may include those for nursing-sensitive care as defined by the National Quality Forum and as stipulated by the American Nurses Credentialing Center for hospital-based magnet status.

G. Design facilities and processes for safety

Health professionals are human, and human error plays a role in patient injury and death. Eliminating all error, however, is impossible and trying to do so only reinforces the mistaken belief that health care practice can be error free, resulting in more pressure to cover up mistakes than to admit them and learn from them.[7] When we think of health care as a system of complex moving parts—including humans—and work to identify and correct system errors, we are more likely to find root causes and reduce the probability of future error.

From the testimony

The lessons learned over the last 25 years indicate that the fundamental human behaviors and workplace conditions that cause errors are the same wherever there are humans involved in complex tasks.

—The Bergendahl Institute, LLC

It must be recognized that any system that involves humans is prone to error. The objective must be to develop systems that either make it impossible for human error to occur or allow mistakes to be caught early enough so accidents can be prevented.

—Michigan Pharmacists Association

You want to design your system so that when individual errors do occur they don't result in hurting a patient.

—VA National Center for Patient Safety

The environment should include adequate space, instrumentation, supplies, support staff, ergonomically sound design and personal protective equipment.

—Leticia J. San Diego, EdD, PhD

We know that performance and attention levels decrease with prolonged work periods. When individuals are fatigued, they experience inattentiveness to critical details, compromised problem-solving, and decreased reaction times.

—Linda Scott, RN

From the literature

Excessive reliance on memory, lack of standardization, inadequate availability of information, and poor work schedules all create situations in which individuals are more likely to make mistakes.

—Lucian L. Leape, MD
"Godfather" of patient safety

Experts recognize that most errors are the result of a poor fit between people, their environments and their tasks. What researchers label "human factors analysis" is simply the study of the relationships between humans, the tools they use, and the environments in which they live and work. Evidence suggests that when attention is paid to these human factors in facility and work design, safety and patient outcomes show measurable improvement, including:

- Reduced medication errors, patient falls, and hospital lengths of stay;
- Improved patient confidentiality and privacy; and
- Enhanced patient satisfaction and quality of care.[8]

What is needed is for health care organizations to focus their patient safety improvement efforts at the system level and use tools and methods from:

- Human factors engineering, which teaches how to build tasks around human limitations;
- Facility design, which teaches how to design buildings in which it is easier to deliver safe care; and
- Industries with far better error prevention records than health care, such as aviation and nuclear power.

While the costs of modifications to facilities and physical plants can be high, studies have demonstrated that facility design improves quality of care, attracts more patients, helps to recruit and train staff, helps to increase community and corporate support, and increases operational efficiency and productivity.[9] Investments in facility design can be recovered through improved staff performance; greater efficiency due to standardization; reductions in near misses, adverse events, and errors; and reduced expenses due to patient falls, patient transfers, infections, and medical errors.[10]

Objective

Adapt tools and methods from human factors engineering, facility design, and industries with demonstrated error prevention records to improve patient safety in health care. Prevent or correct system defects in ways that respond to patient and staff needs rather than training staff or teaching patients to accommodate poor system design.

Success story from the literature

In 2002, St. Joseph's Community Hospital of West Bend, Wisconsin, was in the unique position of building a new hospital rather than remodeling an existing facility. The hospital's approach to this opportunity has attracted national and even international attention.

Hospital leadership chose to design each aspect of the new hospital with safe patient care in mind. They knew that increasing standardization, lessening fatigue, limiting noise and providing quick access to information would help prevent errors, so they set out to design features that would do all that.

The new hospital's design features range from the simple, such as the type of lighting, to the complex, such as sophisticated computer systems designed to prevent medication errors. One result of this comprehensive approach is the standardized patient room.

* Standardization in room size and layout, including connection for gases, location of supplies, etc.
* Private room for personal privacy.
* In-room sink allowing physician/staff handwashing in patient view.
* Charting alcove with window increasing patient visibility for nurses, physicians, and staff.
* Close proximity between bed and bathroom reducing the potential for patient falls.
* Oversized window increasing natural light and providing a "healing" view.
* Sitting area and guest fold-out bed to encourage family support and involvement with care.
* Noise reduction using low-vibration steel, special noise-absorbing ceiling tiles, and no overhead paging.
* Improved technology including electronic medical records, computerized physician order entry, and an advanced nurse call system, including wireless phones.

The new 80-bed hospital opened in August 2005.

—Compiled from a variety of sources

Recommended action steps

State of Michigan—Certificate of Need Commission

- Require that all health facilities that fall under the jurisdiction of the Certificate of Need Commission conduct a healthcare failure modes and effects analysis or equivalent as part of all new CON applications, with special attention to infection control, safety features in building design and location, and environmental conditions. Cost savings through safer design are expected to moderate the incremental costs of this step.

Michigan Center for Safe Health Care

- Provide statewide leadership and direction in the area of designing safe care.
- Disseminate current knowledge and tools for error analysis and low-/no-cost approaches to work design and redesign, in collaboration with state and national centers of expertise on patient safety.
- Promote accelerated adoption of known safer practices and health care products designed for safety.
- In collaboration with appropriate state agencies, explore ways to incorporate the use of HFMEA or its equivalent for facilities not covered under the CON process.
- Collaborate with Michigan educational institutions with programs and expertise in human factors engineering and facility design to secure grants and funding to support adoption of these tools in health care settings.

Health professionals and organizations

- Design, redesign, or modify facilities, physical environments, and work processes to take into account human needs and limitations. Emphasize identifying and preventing or correcting system defects by responding to patient/staff needs, rather than expecting staff or patients to accommodate poor system design.
- Make use of current knowledge and tools in error analysis and human factors engineering, such as HFMEA, root cause analysis, and usability testing.
- Borrow strategies and tools that have proven successful in other industries, such as forcing functions, bar codes, simulators for learning, and others.
- Consider environmental factors—noise, light, distances, fatigue and limits to human memory—when designing or redesigning physical plants and care processes.
- Create environments that support safe care by taking into account other human limitations, understanding the sources of job-related hazards, and implementing harm reduction programs as recommended by the National Institute for Occupational Safety and Health.

H. Improve communication of critical information

Health professionals and patients rely on timely access to accurate, complete, and legible patient information such as health and medication histories, drug allergies, and lab results when choosing among treatment options. Making this information available to patients and health professionals across organizational boundaries continues to be a challenge. In the testimony, informants recommended everything from simple solutions such as a one-page paper summary carried by the patient, to complex systems such as electronic medical records and e-prescribing.

A daughter's story from the testimony

It would appear to me ... that the computer was down in the emergency room and that much of the information they obtained in the emergency room did not travel with him to the hospital room. So they were unaware in the hospital room he was functioning on just one lung. They did not know who his internist was. They did not know the seven oncologists that were taking care of him. ... The three-page emergency room report was typed and transcribed three days later. ... Basically, they weren't fully aware that he was a respiratory risk patient. ... This shows how important communication is and that this information travels with the patient.

—Alison Brown Heimsath

From the testimony

New and improved technologies absolutely have to be part of the patient safety solution. 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.

—Beaumont Hospital (Royal Oak)

For the most part, the present electronic documentation systems are cumbersome and time-consuming. ... There is a need for more standardization and computerized documentation systems.

—Mary B. Killeen, PhD, RN, CNAA, BC

The appropriate and important information necessary to provide safe patient care should be made available to the entire healthcare team.

—Michigan Home Health Association

Until health care information technology systems use common standards and are "interoperable"—can talk to each other securely—their potential to reduce harm and promote patient safety will be limited. Interoperable electronic health records, for example, could provide any number of health professionals access to a patient's information simultaneously, seven days a week, 24 hours a day.

The federal government is providing leadership for the development of an interoperable health information technology infrastructure. The American Health Information Community, a new public-private partnership, is helping with the nationwide implementation of electronic health records—including common standards and interoperability—while assuring that the privacy and security of those records are protected. According to the Community's Web site, widespread adoption of electronic health records and related health information technology improvements will result in fewer mistakes, lower costs, less hassle, and better care. They note, "The information needed to treat patients effectively will be a computer click away, no matter where the patient is receiving care."[11]

Activity in Michigan also is brisk. Among other efforts around the state:

- The Michigan Departments of Community Health and Information Technology have been meeting with interested stakeholders—including health care providers, labor unions, the auto industry, and other third-party payers—to advance state policy in this area.
- Blue Cross Blue Shield of Michigan, Michigan State Medical Society, Michigan Osteopathic Medical Society, and Michigan Health & Hospital Association have teamed up to conduct a comprehensive statewide inventory of current and planned health care IT.
- MPRO, under contract with the federal Centers for Medicare and Medicaid Services, is working with Michigan hospital CEOs to develop an implementation plan for computerized prescriber order entry, bar coding, and telehealth. MPRO is assisting Michigan's small to medium-sized physician offices to adopt electronic health records that enhance workflow efficiencies, care management and use of electronic data reports.

From the testimony

Pending [the availability of improved IT,] provide recommendations for practical manual systems to ensure follow-up and follow-through for results and interventions.

—Lawrence J. Abramson, DO, MPH

Every health care provider with hospital privileges should be required to maintain [an] up-to-date simple, universal, one-page data sheet on his or her patients, including diagnoses, medications, drug allergies and intolerances. Until computerized patient information via card chips or ethernet is a reality, this sheet could be quickly faxed and e-mailed to emergency rooms, medical specialists or regional hospital centers, if needed.

—Mary Johnson for Mary Pat Randall

We need to encourage people to have their own medical records. ... I just want to have patients have their own record, deliver it to their doctor so they can see what happened [in the hospital, for example], and you can get right to it.

—John Everett, MD

Maybe even most dispensing errors in pharmacy could be prevented if the pharmacist asked the patient three simple questions at the time the patient got the prescription filled: "What were you told this medication is for? How were you told to take it? What were you told to expect?" It's ten seconds worth of work and it could ... have a dramatic impact in reducing medication errors.

—Michigan Pharmacists Association

While IT system implementation requires significant resources, cost savings are also expected. The Wisconsin Health Information Network, which allows access to direct clinical and administrative data, was able to realize annual cost saving of between $17,000 and $68,000 for physician practices and between $398,000 and $1.1 million for hospitals. A study of 14 solo or small primary care practices that used electronic health records for one to three years found that while start-up costs averaged $44,000 per physician or nurse practitioner, small physician practices recouped the cost of investing in EHRs in 2.5 years.[12] Efficiency savings and gains from greater physician productivity, meanwhile, averaged $15,800 per physician or nurse practitioner per year. Another recent study estimates that implementation of health care IT likely will triple or quadruple in the next five years, with EHR functionality increasing from 9 percent to 25 percent in small practices, and from 15 percent to 38 percent in larger practices.[13]

In addition to information about a specific patient, the rapid development of medical information and technology—something new appears every day—makes it impossible for each health professional to retain the knowledge essential for evidence-based practice. In fact, health care technologies have developed more rapidly than the health professional's ability to deliver their use safely and efficiently. It is unreasonable to expect that health professionals be able to absorb ever-greater amounts of health care knowledge while making complicated decisions concerning patient care and safety. Electronic access to diagnostic and care guidelines, drug databases, and other decision-making tools can improve the professional's ability to provide safer care.

Imagine a health care system that supports:

- Electronic viewing of test results
- Electronic health records
- Computerized prescriber order entry (for medications) and electronic prescribing (where the prescription is transmitted to the pharmacy electronically)
- Electronic claims submission and eligibility verification
- Secure electronic patient communication

The following recommendation is intended to lead Michigan in this direction.

Objective

Promote improved use of communication and technology to ensure that information critical to patient safety (e.g., health history, medication history, and critical lab values) is available to patients and health care providers within and across organizational boundaries.

From the testimony

Pharmacists in community practice would be in a much better position to catch and correct prescribing errors if basic patient information such as diagnosis or treatment objectives were available to them, but typically that information is not available to the community pharmacist.

—Michigan Pharmacists Association

I go into a lot of private homes and I would much rather go into a private home where I kind of know what's going on. … I have a real hard time finding people accountable for medication administration and treatments such as wound care. … It's documented somewhere, but I don't know who is doing it or when.

—Terry Seaver, RN

We are especially concerned about standardized methods to provide imaging information obtained at one institution to a second institution when care for that patient is being undertaken at the second institution.

—Michigan Radiological Society

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.

—Henry Ford Health System

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 … to support an open, and efficient exchange of information while complying with all applicable rules to protect confidential information.

—General Motors Corporation

Recommended action steps

State of Michigan

- Continue collaboration among Michigan Department of Community Health, Michigan Department of Information Technology, and private sector stakeholders.

Michigan Center for Safe Health Care

- Learn from and work with existing efforts in this area. Encourage these groups to explore options for ensuring that critical information moves with the patient through and beyond each health system encounter (e.g., health "passport").
- Promote the information and tools generated by these collaborative efforts.
- Collect and disseminate successful practices using readily available technology (such as fax machines) to improve communication of critical information.
- Work to ensure that Michigan's interests, perspectives and concerns regarding health care IT are represented as national IT standards are developed.
- Advocate for national standards that are applicable and usable by all Michigan providers.

Health professionals and organizations

- Adopt information technology (IT) systems that are compliant with privacy and other provisions of HIPAA (the Health Insurance Portability and Accountability Act of 1996) and compatible with IT systems at the Michigan Center for Safe Health Care, to facilitate data exchange.
- Use IT systems to:
  - Ensure that health professionals across the continuum of care have timely access to the patient information required to provide safe care.
  - Capture data elements required for performance measurement at the aggregate level.
  - Record data to be reported and transmitted to the data warehouse in the Michigan Center for Safe Health Care.
- Use readily available technology (such as fax machines) to assure that critical information travels with the patient as she or he moves among different settings within the health care system. Such strategies should ensure access to the patient's chart by the patient and all health professionals involved in the patient's care.

I. Involve patients as active health care partners

The voices of patients and their families must become a legitimate and ongoing part of the structure and process of health care delivery at the state level and within individual organizations and settings of care. Many tools, strategies and examples of successful efforts that involve patients and families are available for Michigan health care organizations to build on. Many do not require extensive resources, only the willingness and resolve to carry through with implementation.

From the testimony

I think the bottom line is [that] an informed patient is an empowered patient.

—John Everett, MD

Michigan has close to a 50% low or no literacy rate for health information. This is a serious issue that underlies many patient safety concerns.

—Blue Cross Blue Shield of Michigan and Blue Care Network

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 a language that they understand.

—Lawrence J. Abramson, DO, MPH

We have talked a lot about patient education. … My challenge to you is to somehow … mandate that we assess learning … [to] verify patient and family understanding. … One must never assume that something taught is something learned.

—Virginia Hosbach, RN

Consumers basically see things that busy healthcare workers don't, and if we can capture that experience, integrate it into our learning systems and our reporting systems, we will have a safer system.

—Consumers Advancing Patient Safety

My fear is that many people being treated are either too sick or not educated enough to be aware of the serious mistakes being made.

—Jessica Kuttner

There is strong support among Michigan patient safety stakeholders and respected national organizations for bringing the concept of patient-centered care into the patient safety agenda,[14] where:

- The provider-patient relationship is reframed as a partnership with shared decision-making and open communication.
- Patients are encouraged to take an active role in the process of care as well as error prevention and safety design.

Educating patients about health care safety is recognized as central to reducing patient harm. A recent study noted that efforts to involve patients in safe care have focused to-date on distribution of safety advisories, which, the authors caution, may not be having the desired effect.[15] They recommend further research and rigorous debate around appropriate roles for patients in safety efforts, and how health care providers should facilitate patient contributions. They made several other important recommendations that we echo in this report:

- Efforts to increase patients' involvement to improve the safety of their care should include practical support for appropriate patient roles.
- Rather than rely on patients to remember to work around system deficiencies, systems should be designed to enable people to contribute appropriately by default.
- Attention also must be paid to how health professionals view patient safety and the patient's role in securing it. Work is required to ensure that efforts by patients to prevent errors and avert harms will be met by appropriate responses from their health care providers.

The role of effective communication in safe care cannot be overstated. Patients who know what they need, are able to make their preferences known, and take an active role in their care are more likely to have better health outcomes and be satisfied with the care they receive.[16] Yet one in five American adults reports having trouble communicating with their doctors, while one in ten reports being treated with disrespect during a health care visit.[17] When patients are unable to read, understand, or act on critical information, they are at greater risk for poor outcomes, inappropriate hospitalization, greater health care costs, and a higher incidence of medical errors.[18]

From the testimony

They were so afraid to tell me because they were so afraid I was going to sue them. … Don't be afraid that I'm going to sue you and take you for everything that you've got. I don't want your money. If you can fix me, put it back together.

—Theresa Lee

Harmed patients should be invited to tell their stories to hospital CEOs and board members so that a continuous quality improvement can be based on actual occurrences and have the highest priority.

—Mary Johnson for Mary Pat Randall

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.

—Sandra Jones, RN

To date most safety reform agendas have marginalized consumer input. Few real partnerships exist … with the result that the significant insights and perspectives of patients and their families are lost to the process.

—Michigan Consumer Health Care Coalition

Effective communication between patients and health professionals is a critical component of a fair, balanced and open health care system. Factors contributing to poor provider-patient communication include:

- The use of medical jargon or ineffective language.
- "Cross-cultural dyads," where providers' cultural backgrounds are significantly different than those of the patient.
- Patients unaware of their health status or who have trouble remembering and reporting details accurately and in a timely manner.

One very important part of the communication package is encouraging open and honest dialogue between clinicians and patients when errors occur. Patients want to know what happened and why, how to manage their care as a result, and how to prevent a similar incident from happening in the future. When health care results in unintended outcomes, families look to health professionals for comfort and support—and an apology. This level of openness is still the exception rather than the rule, although awareness that open communication can benefit the physician-patient relationship is growing.

Patient involvement strategies also must go beyond improved communication and shared decision-making during patient/provider encounters. Methods that have proven successful around the country include patient/family advisory councils, inviting patient representatives to serve on boards, and asking patients to be available to staff members in teaching/advisory positions.

Health professionals and organizations may be reluctant to share information and treat patients as partners; feel challenged, threatened, and fear lawsuits; or believe that involving patients will take more time. Yet patients cannot be partners if professionals and organizations are unwilling to listen. Successful patient-centered care relies on a culture of safety within health care settings. Both depend on strong support from leadership in adopting these philosophies, implementing tools at all levels of an organization, and staying the course over time.

Efforts to change consumer, patient, and family mindsets and habits also may be met with reluctance or discomfort. Cultural barriers and low levels of health literacy for certain population groups must be addressed. Despite wide acknowledgement of the important role of patients and families in error prevention and early detection, it is clear that they cannot carry out this role unless health care delivery organizations and providers help them understand it, invite them to join in designing safe care policies and programs, and work to create an environment that supports questions and provides specific mechanisms for soliciting reports and providing feedback. It will be important for organizations to include consumers and patients on their boards,

From the testimony

Through public service announcements and educating patients during visits to their family physician, awareness of issues such as safe medication practices, fall risk assessment and prevention, and home safety can begin. Education and awareness can then be continued throughout an individual's progression through a health care facility, home and community health services and with appropriate follow-up through their family physician.

—Michigan Occupational Therapy Association

More and more we are finding that our patients in the home care environment are computer literate or have family members who are, and it would be a great use of an open 'net to allow us to share accurate [and consistent] information with the patient.

—Michigan Home Health Association

We've forced patients to go through tremendous hoops to get access to their own medical records. It's wrong. They should have that record. They should be empowered by that information, and we should give them that case summary when they go home [from the hospital]. We should send the primary doctor a copy and the patient a copy.

—John Everett, MD

committees, and task forces and actively support consumers who accept these roles, as they learn how to be effective members.

Objectives

- Empower consumers/patients/clients/residents and their families/caregivers/advocates to better assume their roles as partners in the health care encounter.
- Promote open and clear communication between patients/families and health professionals about health issues, treatments, patient safety concerns, and adverse events.
- Embed the consumer/patient voice in the structure and process of designing safe care.

Recommended action steps

State of Michigan

- Include consumer/patient/family representatives in the membership of state-level bodies and organizations involved in developing policies or designing systems, facilities, and programs in patient safety.

Michigan Center for Safe Health Care

- Establish an ongoing statewide awareness and education campaign to improve health literacy and understanding of patient safety.
- Coordinate educational efforts to consumers/patients with programs targeting clinicians.
- Assess the impact of educational programs over time.
- Document consumer concerns and needs for information.
- Develop and/or disseminate information, tools, and resources for decision-making about health care and providers as well as guidelines on their use.
- Disseminate information about safe care initiatives in Michigan's health care delivery organizations.
- Consider collaborating with school health educators to develop consumer-targeted patient safety programs for primary and secondary school curricula.
- Appoint patients and representatives of community and employee groups to boards and committees.
- Connect health care organizations with consumers or patients willing and able to serve on their boards.
- Develop a range of alternative pathways to encourage open communication between health professionals and their organizations, and patients and their families, when problems or potential problems occur.
- Promote a balanced understanding of the legal environment to overcome objections of health professionals and organizations.

Success stories from the testimony

[Henry Ford Health System] embraces patients (and families) as partners in safe care. Patients and families are encouraged to "speak up." ... Family members have access 24 x 7 to a daily message from the health care team about their loved one's plan of care and progress. Open visitation is supported and encouraged since family involvement promotes better patient outcomes. Patient advisory committees have recently joined focus groups as tools to uncover patient needs and preferences.

—Henry Ford Health System

MPRO, along with our partners, the Michigan State Medical Society, and the Center for Rural Health, were awarded an American Medical Association Health Literacy Grant to become Centers for Health Literacy in Michigan. Through this grant we have provided health literacy training to physicians and medical residents throughout the state. This training is especially vital in Detroit, where the largest underserved population resides and 47% of all adults register in the two lowest literacy levels.

—MPRO

Success story from the literature

SorryWorks! is a voluntary program with incentives for healthcare organizations to adopt robust apology and compensation programs for patients who experience bad outcomes. It is an innovative idea consistent with the emerging research.

Under Sorry Works, physicians and hospital staff conduct root cause analyses after every bad outcome, and if a medical error caused the bad outcome, the physicians and hospital staff members apologize, provide solutions to fix the problem, and offer upfront compensation to the patient, family and their attorney(s). This approach removes anger and actually reduces the chances of litigation and costly defense litigation bills.

The program has worked successfully at the University of Michigan Hospital System, Stanford Medical Center, Children's Hospitals and Clinics of Minnesota, and the VA Hospital in Lexington, Kentucky.

—Adapted from a June 2, 2005, press release from the SorryWorks! Coalition

- Consider nonfinancial incentives, such as public recognition awards, to reward health care organizations that succeed in bringing the consumer/patient voice into their structure and process in meaningful ways.

Health professionals and organizations

- Develop or adopt policies, practices and programs that incorporate the values, needs and preferences of patients and their families in the health care process, and that promote open and clear communication between patients/families and health professionals about health issues, treatments, patient safety concerns, and adverse events.
- Facilitate teamwork and patient advocacy, where patients/families are active members of the team involved in decisions about health care.
- Offer programs/training to help providers, patients, and families learn effective communication skills.
- Offer staff training in cultural competency.
- Establish guidelines for disclosing adverse events and medical errors to patients/families and supporting both patients/families and providers in the aftermath.
- Support the patient/family role in error prevention by encouraging patients to communicate openly with health professionals and staff, and by providing tools and opportunities for patients to comment on safety issues.
- Incorporate patient safety training as part of annual staff competency programs.
- Adopt patient education materials and communication strategies tailored to varying levels of health literacy, with special attention paid to vulnerable populations, such as those with low literacy, limited English, or cognitive impairment.
- Establish guidelines to make available to patients information from the medical record about their health and health care.
- Appoint consumers/patients as well as representatives of community and employee groups to their boards.
- Develop consumer/patient advisory councils to provide input on all topics related to the delivery of safe, patient-centered care.

J. Embrace safety in health professions education

The challenges posed by a changing health care environment require a renewed focus on the training of tomorrow's health professionals. The time has come for leaders across the professions, local, state, and national governments to work together to effect reform in clinical education and related training environments. The cultural changes necessary to support such reform efforts should also be given careful consideration. Educational institutions and licensing boards must instill in each health professional a sense of being a lifelong learner. Employers must shape ongoing professional development to enhance patient safety.

From the testimony

Health care safety is in itself a discipline and has not as yet been widely incorporated into educational programs. In the short term, a patient safety continuing education requirement for all Michigan licensed healthcare professionals should be mandatory. ... The course content should be standardized by license type and approved by the licensing board. In the long term, the professional schools should have as a requirement patient safety courses and training as a basic curriculum requirement prior to graduation.

—Lawrence J. Abramson, DO, MPH

The state should ... promote standardization across education and training curriculums ... to enhance interdisciplinary education and collaboration; accelerate process improvements; share competencies; set common standards.

—Henry Ford Health System

I'd like to see some standardization and requirements for training for front-line [non-RN] mental health care workers.

—Carol Essenmacher, RN

The Health Professions Bureau in the Michigan Department of Community Health regulates 340,000 health professionals in 32 health care occupations.[19] Currently, courses in patient safety are not included in the educational requirements for initial licensure or license renewal for *any* of these professions, although enacting such requirements is within the Bureau's administrative rulemaking authority.[20] Because health professions curricula already must cover a great deal of material in limited time, we recommend that educators weave the teaching of patient safety principles, knowledge and skills into the entire process of professional and continuing education.

The current lack of coordinated oversight across the continuum of health care education results in fragmented responsibilities for undergraduate and graduate education, licensing, and certification. The variation in standards, expectations, and quality of education is an additional barrier to developing and maintaining a well-educated and appropriately trained workforce throughout the continuum of care.[21] Integrating a core set of competencies shared across all the professions would provide the most leverage in terms of reforming health professions education.[22]

A comprehensive overview of health professions educational standards, requirements and oversight, and perhaps changes to the existing structure, would provide the context needed to ensure such consistency.

Sufficient high-quality on-the-job training experiences and continuing education are vital to patient safety improvement in our state. In many areas, economic and staffing pressures have reduced on-the-job training opportunities and, while state requirements specify the number of continuing education hours a health professional must complete, they do not yet incorporate patient safety as an explicit content requirement. Appropriate content and a sufficient number of hours must be required under the state's licensing and relicensing guidelines to ensure that health professionals' basic understanding of safety concepts, depth of knowledge, and technical (implementation) skills support the broad goals of patient safety improvement.

From the testimony

There is a lesson to be learned from industry such as Ford Motor Company's training program for new engineers. Ford recognizes that a newly hire[d] engineer's knowledge will be ... 50 percent obsolete within the first year and [Ford] has programs in place to address those changes.

—Leticia J. San Diego, EdD, PhD

Objective

Weave the teaching and demonstration of patient safety principles, knowledge and skills into health professions education and continuing education requirements.

Recommended action steps

State of Michigan—Michigan Department of Community Health working with health professions licensing boards

- Promote through the professional licensing process the acquisition of knowledge and skills of patient safety from a systems perspective through discipline-specific patient safety curricula and continuing education programs grounded in research.
- Inventory existing education and continuing education programs, their oversight bodies, and related accreditation, licensing and regulatory requirements to gain a deeper understanding of their interrelated functions.
- Recommend evidence-based modifications to the structure and function of the health professions education system to meet the objective of competency in patient safety and outcome-based education programs.
- Evaluate on an annual basis whether significant progress has been made toward the goals identified in this section.

Michigan Center for Safe Health Care

- Convene a task force of undergraduate and graduate professional schools, continuing education providers, and health professions associations to:
  - Develop competency and outcome-based educational programs focused on providing safe care and creating systems focused on safety.
  - Review and develop multidisciplinary curricula, integrate "best practices," determine successful implementation strategies, and evaluate and test multiple collaboration based-approaches and outcomes in a variety of health care settings.
- Publish "success stories"—accomplishments and experiences with proven patient safety curricula and continuing education courses—on a prominent Web site.

Educators of health professionals

- Ensure that health professions education and continuing education curricula include training to:
  - Deliver patient-centered care.
  - Apply evidence-based practice.

- Understand patient safety from a systems perspective for all health care settings.
- Initiate collaboration, communication and integration of care in cross-disciplinary teams to safeguard continuity of care.
- Identify the potential for errors and hazards in care in a variety of health care settings.
- Design and implement interventions to improve the safety of systems and processes of care.
- Use a variety of patient safety and quality improvement methods and approaches, including basic safety design principles.
- Incorporate evidence-based practice into clinical care, utilizing a systems perspective.
- Use informatics—information technology that supports communication, manages knowledge, and supports decision making.

Professional societies and organizations

- Promote standardization across all education and training curricula for all health care settings so health professionals learn similarly about the types of processes and systems that impede safety and might lead to harm.
- Encourage use of cross-disciplinary teams by providing leadership, guidance and support to members to implement and evaluate such teams.
- Identify relevant evidence-based research and disseminate it for application in health care operations.

K. Emphasize collaboration among organizations

When groups of people and organizations work together collaboratively, their perspectives, resources, and skills are combined to create a whole that is greater than the sum of its parts. Successful collaboration generates creative, comprehensive, practical, and transformative thinking.[23] Collaborative learning also can accelerate the spread of successful programs and processes for improving patient safety.

From the testimony

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. ... Provide a learning environment and coordinated project techniques similar to the MHA Keystone ICU project for advancement of additional operational implementations.

—McLaren Health Care Corporation

Success stories from the testimony

The MHA Keystone Center [for Patient Safety and Quality] exists to bring health care providers together with information, resources, and collaborative opportunities to bridge the quality chasm. ... Since late 2002 through Keystone STROKE, Michigan hospitals have been working ... to improve stroke care throughout our state. ... Through Keystone ICU, 72 hospitals and 108 ICUs [intensive care units] are working together to improve ICU care using the best evidence that medicine has to offer.

—Michigan Hospital Association

The Michigan Society of Anesthesiologists ... [has] been integrally involved in developing and supporting the Anesthesia Patient Safety Foundation (APSF), which is the pioneer organization dedicated to assuring patient safety. Its mission is to ensure that no patient be harmed by anesthesia. ... The reason for the success of its efforts has been its attention to early identification of safety problems, promoting research, disseminating information, and promoting an emphasis on patient safety in clinical practice.

—Michigan Society of Anesthesiologists

While most health care organizations are involved in some form of collaboration, historical forces in the health care field continue to present barriers to working together. Competition for market share and other sources of revenue make it difficult for organizations (and sometimes professionals themselves) to work together. To be truly effective, cross-organizational collaboration requires participants to overcome competitiveness and lack of trust. Long-term, broad-based collaboratives focused on creative problem solving require nurturing and support. When participation is voluntary and the goals of participants' own institutions compete with participation in such a collaborative effort, it is likely that the collaborative will be unable to sustain its work over time without some mechanism for ongoing coordination and care of "housekeeping functions."

Patient safety centers are important vehicles for such collaboration. They offer participants the chance to test ideas and learn about unanticipated or harmful consequences of actions or policies being considered—an important benefit, given the lack of well-tested error management models in health care.[24]

Several opportunities for collaboration are identified in this report. Specific topics include:

- Accelerating adoption of health care information technology
- Facilitating participation of rural health professionals and organizations in patient safety initiatives
- Using models and initiatives for improving patient safety in small, primary care practice settings
- Addressing health care workforce shortages
- Reporting adverse events, medical errors, and near misses and learning from the data
- Encouraging use of patient safety tools such as root cause analysis and healthcare failure modes and effects analysis

Objective

Expedite the translation of patient safety-related evidence into practice, accelerate the spread of successful programs and processes for improving patient safety, and promote creative problem solving for patient safety challenges through cross-organization collaboration.

Success stories from the testimony

We have created something called the Patient Safety Institute within the society, that gives an opportunity for the membership to discuss issues of their collective expertise and wisdom about areas of knowledge that they have within their individual specialities. We have not created silos. We have created a forum where everyone can exchange these thoughts and ideas.

—Michigan State Medical Society

In 2000, our national association adopted a wrong site surgery position statement, and this has been disseminated to our members offering suggestions on how to avoid this medical error.

—Michigan Podiatric Medical Association

There may be as many as 10,000 medics, patients, and innocent citizens injured or killed each year in collisions involving ambulances. … Current studies focus on how to make ambulances structurally more crash worthy. … Safe driving techniques developed through the best practice demonstrate that … collisions can be reduced very significantly. Implementation of the best practice is the quickest and least expensive way to attack this national problem.

—American Ambulance Association

The *Guidelines Applied in Practice (GAP) Project* … led to the development of evidence-based guidelines … [that] assist in the diagnosis and management of patients with acute myocardial infarction or heart attack. Leaders of the GAP Project estimate that if these procedures were implemented nationwide, the mortality rate of acute heart attack could drop by as much as 25 percent; this translates into tens of thousands of lives saved.

—MPRO

In the community pharmacy setting, there are about 2,200 pharmacies in Michigan. Over 1,700 pharmacies completed the Institute for Safe Medication Practices survey [about safety processes]. … We've worked with key stakeholders in the pharmacy profession to create the Michigan Medication Safety Coalition to further efforts to promote best practices to improve patient safety in the community pharmacy setting using the results from the [ISMP] self-assessment.

—Blue Cross Blue Shield of Michigan and Blue Care Network

Recommended action steps

State of Michigan

- Support and participate in patient safety-related, cross-organization collaborative learning and problem solving.

Michigan Center for Safe Health Care

- Foster cross-organization collaborative efforts designed to develop creative solutions to patient safety challenges by leveraging Michigan's considerable knowledge, skills and resources.
- Build in timely evaluation of collaborative interventions focused on improving patient safety. Look both at collaborative processes and structures, and at the achievement of desired outcomes.

Health professionals and organizations

- Support and participate in patient safety-related cross-organization collaborative learning and problem solving.
- Build in timely evaluation of collaborative interventions focused on improving patient safety. Look both at collaborative processes and structures, and at the achievement of desired outcomes.

L. Support teamwork within organizations

Truly effective teamwork requires specific skills, processes and support. Experience in other industries, notably aviation, has shown that communication and coordination behaviors are identifiable, teachable, and applicable to high stakes environments. Health care's long-standing underlying culture of individual, professional autonomy can make it difficult to establish truly effective cross-disciplinary teams. While health care culture change may be a prerequisite for successful teamwork, successful teams also have the potential to accelerate culture change in support of patient safety. Team members who have trained together to achieve a specific outcome can provide the important day-to-day reinforcement and coaching needed to sustain new behaviors.

From the testimony

When all health care providers work together and have a comfort level with each other, can ask each other questions, can discuss patient care issues, that facilitates quality care.

—Jonathan Reed, RN

Respect for patients, families, nurses and all health care workers must be so fundamental that jobs and hospital privileges are at risk if standards are not met.

—Mary Johnson for Mary Pat Randall

Disseminate successful strategies for building patient safety teams within facilities designed to prevent infectious and noninfectious complications of care.

—Detroit Medical Center

In a 2003 report on health professions education, the Institute of Medicine identified the ability to work in cross-disciplinary teams—to cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable—as one of five core competencies for all health professionals.[25] In doing so, the IOM elevated teamwork to the same level of importance as employing evidence-based practice, applying quality improvement, utilizing informatics, and providing patient-centered care, the other four designated core competency areas. Effective cross-disciplinary teams can:

- Improve communication among treatment team members—including patients and their families—resulting in fewer medical errors caused by miscommunication and dropped hand-offs.
- Lead to greater valuing of the role of the patient in the provision of safe, quality health care.
- Reach conclusions more rapidly by breaking down communication barriers and exposing group blind spots.[26]
- Help spread evidence-based best practices within and throughout an organization.

Effective cross-disciplinary teams demand a different mode of communication than is found in many health care environments. Communication must flow freely, without regard for the authority gradient.[27] In other words, every member of the health care team should be empowered to speak up to prevent patient harm. Because members of cross-disciplinary treatment teams are trained in separate disciplines, they may need assistance appreciating each other's strengths and recognizing potential weaknesses.[28]

Objective

Improve teamwork across disciplines by providing training and support for cross-disciplinary teams.

From the testimony

Communication between professions does not flow as it should. ... For example, in one 6 bed ICU, verbal miscommunication between nurses and physicians was responsible for 37% of all errors. ... In another ICU study, communication between nurses and physicians was the single factor most significantly associated with excess hospital mortality.

—Milisa Manojlovich, RN, CCRN, PhD

From the literature

Clinical effectiveness of team interventions is supported in the literature. For example:

- Rapid response teams were associated with a 15 percent decrease in cardiac arrests.
- Team training in labor and delivery resulted in a 50 percent reduction in adverse outcomes in pre-term deliveries.
- Reduced emergency department clinical errors were experienced after teamwork training based on crew resource management.
- Introduction of a medical emergency team resulted in a decrease in unanticipated intensive care unit admissions without increased mortality.

—Compiled from a variety of sources

Recommended action steps

Michigan Center for Safe Health Care

- Serve as a clearinghouse to identify and disseminate "best practices" for building teams to improve patient safety.

Health professionals and organizations

- Assure that health professionals and all health care personnel have the skills necessary for effective cross-disciplinary team functioning.
- Incorporate proven methods of team management into cross-disciplinary team training programs.
- Provide the support necessary for teams to fulfill their charge.
- Consciously recruit team members with a broad mix of skills and knowledge, including patients and family members or other consumers, as appropriate.
- Pay particular attention to improving communication among all members of treatment teams with a special focus on social dynamics that may adversely affect the transfer of information between treatment team members.
- Build in timely evaluation of team-based interventions focused on improving patient safety. Look both at the teamwork processes and structures and at the achievement of desired outcomes.

Educators of health professionals

- Include cross-disciplinary teamwork skill development as a competency in all health professions education curricula and in continuing education courses.

M. Regulate and license with safety in mind

Licensing and regulation are principal mechanisms available to state government to increase patient safety awareness among health professionals and organizations. The state clearly has a legitimate and compelling interest in this area because of its exclusive right to regulate, license, monitor and control the activities of health professionals and organizations to protect the health and well-being of its citizens. In Michigan, each health professions licensing board is an independent entity. Testimony indicated that coordination among these bodies and communication between the boards and the Michigan Department of Community Health could be improved. Our recommendations aim to accomplish this important goal and incorporate principles of a "culture of safety" into the structure and practice of health professions licensing boards and the bodies that regulate health care organizations.

From the testimony

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.

—Sandra Jones, RN

There will always be a need to identify negligent healthcare professionals and remove them from practice. But most errors involve systems defects, and the emphasis should be on identifying and correcting those defects rather than on punishing the practitioner.

—Michigan Pharmacists Association

Children are coming to school with increasingly complex health conditions that require treatment during the school day. ... The Michigan Department of Education (MDE) recommends, but does not require, training [in medication administration]. Many school employees have not been trained at all. This leaves serious potential for error.

—Michigan Association of School Nurses

In Michigan your plumber is licensed. Of course physicians and nurses are licensed. But hair dressers are licensed and registered dieticians, who are part of the health care team, need to be licensed also.

—Michigan Dietetic Association

A recent study argues that significant changes in the way licensing boards address issues related to errors and near misses is needed if they are to function as a means for improving safety. The study found considerable fear that punitive action would result from disclosing a medication error, even if the error was a near miss and did not reach the patient. Expectation of punitive action varied by discipline, but was highest among professionals who had served on a licensing board.[29] Failure to change these conditions impedes adoption of a culture of safety throughout the entire health care industry.

In Michigan, unlike several other states, licensing boards do not have the statutory authority to use nondisciplinary approaches such as "alternative mediation" to deal with professionals involved in system-driven patient safety issues. It will be important that licensing boards, while they incorporate culture-of-safety principles into their operations, continue to meet their obligation to protect the public from unsafe and incompetent professionals and bar professionals with certain criminal histories from working with vulnerable patients.

The recommendations also aim to reduce harm by requiring all health care organizations across the continuum of care to comply with patient safety-related requirements. Almost all accrediting and federal regulatory bodies have adopted or are adopting voluntary and/or mandatory patient safety requirements. The requirements vary greatly, however.

A minimum set of safety program requirements should apply to all health care organizations operating in Michigan, rather than just to some (e.g., hospitals but not outpatient surgery centers). Moreover, high levels of compliance with safety program requirements should be expected. The Bureau of Health Systems, Division of Healthcare Facilities and Services in the Michigan Department of Community Health issues licenses to health care organizations across the continuum of care. Modifying these requirements is within the Bureau's administrative rulemaking authority.

The public testimony included several requests to license new groups of health professionals, including registered dieticians who provide medical nutritional therapy and technologists who operate ionizing radiation equipment. The Commission recommends that such determinations be made by the state following existing procedures.

Objective

Explore use of the state's licensing and regulation functions to improve the culture and processes of safety among health professionals and organizations.

Recommended action steps

State of Michigan—Department of Community Health, Bureau of Health Professions

- Review the structure and functions of Michigan's health professions licensing boards to strengthen their ability to address patient safety issues, report system-related patient safety concerns, and discharge their responsibilities effectively. Work with licensing boards to effect change.
- Educate licensing board members about the science of safety so they can identify system-related errors and include such findings in their reports, communicate identified system issues to the applicable health care organizations and professional associations, collect and trend individual-level data related to system issues and communicate trends to applicable health care organizations and professional associations.
- Encourage licensing boards to use nondisciplinary approaches such as alternative mediation when dealing with health professionals involved in errors attributable to health care systems rather than individuals or to slips and other unintentional acts.
- Actively engage licensing boards in drafting model administrative rules that support a culture of safety. Encourage licensing boards to review and comment on proposed rules to ensure that these boards drive the policy and substance of rules.
- Develop systems that more quickly and effectively identify and remove from practice unsafe professionals until competence to practice or operate is proven.
- Require criminal background checks on all new health professional license applicants.
- Evaluate the state's health care facility licensing/regulatory requirements to promote the following behaviors among health care organizations:
    - Proactive and full disclosure to patients of unanticipated patient outcomes and errors

- Reporting of all sentinel and adverse events
- Appropriate corrective action related to sentinel events, adverse events, errors and near misses
- Investigation of patient safety issues or error trends as identified and reported by a licensing board and implement appropriate system changes
- Performing criminal background checks on new employees and on all employees working in facilities across the continuum of care

MILESTONES

Table 2. Milestones toward objectives

The following milestones are designed to keep the process of patient safety improvement moving forward. The first step, of course, is for recommendations from the Michigan State Commission on Patient Safety to be adopted.

State of Michigan	**2006** • The Legislature introduces and passes the Model Act to create the Michigan Center for Safe Health Care; the Governor designates or creates the Center; the Governor and Legislature help the Center secure start-up funding and reliable, sustainable long-term income (B, C). • The state invites patient safety stakeholders to participate in ongoing workforce and information technology activities (F, H). • The Certificate of Need Commission requires all health care facilities under its jurisdiction to conduct healthcare failure modes and effects analysis or equivalent as part of the CON application process (G). • The state invites consumer, patient, and family representatives to serve on state-level bodies and organizations related to patient safety (I). • The Michigan Department of Community Health and health professions licensing boards incorporate patient safety principles into the regulation/licensing function (J, M). **2007 and beyond** • MDCH inventories health care education and continuing education programs and recommends changes (J). • MDCH annually evaluates progress toward professional education goals (J).
Michigan Center for Safe Health Care	**2006** • Center presents a funding plan to the Governor and Legislature per enabling legislation (B, C). • Center establishes its infrastructure, including patient/family representatives (B, I). **2007** • Center begins to collect and promote patient safety improvement tools, resources, sources of expertise, and success stories to accelerate adoption of known safe practices (all). • Center coordinates Michigan stakeholders advocating at the federal level (all). • Center convenes work groups to: o Develop specifications for the voluntary reporting system and evaluate need for protections (C, D). o Develop or adopt common data definitions and statewide performance standards (E). o Discuss how to monitor and evaluate the effectiveness of staffing practices (F). o Develop a statewide education campaign for patients/families and health professionals (I). o Evaluate undergraduate, graduate and continuing education curricula with regard to patient safety (J). **2008 and beyond** • Center launches voluntary reporting and shares lessons learned from the reporting system (C). • Center begins to collect performance measurement data and shares lessons learned (E). • Center connects patient/family representatives with health care organizations seeking their input (I). • Center evaluates the voluntary reporting system no later than three years after data collection begins and assesses the effectiveness of any state-level protections for data and sources (C, D).
All Other Stakeholders	**2006-2007** • Health professionals and organizations begin to assess/measure and improve: o Organizational safety culture (A). o How quantity and qualifications of staff on duty are matched to patient needs (F). o Facilities, physical environments, and work processes (G). o Communication of critical information within and across organizations (H). o Policies, practices and programs supporting meaningful patient and family involvement (I). o Training and support for cross-disciplinary teams (L). • Health care organizations invite patients/families to serve on boards, committees, advisory councils (I). • Health professions educators incorporate the science of safety into training and education (J). • Purchasers and payers begin align incentives to support culture change and recommendations (all). **2008 and beyond** • Health professionals and organizations collect and submit: o Data about errors and near misses to the statewide voluntary system (C). o Performance measurement data using common data definitions and standards (E). • Purchasers and payers provide incentives to health professionals and organizations: o Participating in the voluntary reporting system (C). o Collecting and submitting performance measurement data, meeting or exceeding performance targets, and conducting performance measurement demonstration projects (E).

RECOMMENDATIONS FOR FURTHER RESEARCH

> *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.*
>
> —Testimony: Keystone Center for Patient Safety and Quality

Suggestions for additional research were collected throughout the process of analyzing the public testimony and reviewing the literature. Continued funding and resource assistance are necessary to expand research efforts. We present this list to focus the attention of researchers and funders. Recommended topics for further research include:

- Virtually every aspect of reporting:
  - Technologies and when they are most effective
  - Validation of definitions and measurement criteria
  - Best methods to aggregate data and provide feedback to reporters
  - Efficiency and effectiveness, especially as it relates to harm reduction
  - Relationship between underreporting and the strength of legal protections
- Patient safety performance measures that are feasible for health care organizations to report in the long run
- Mechanisms by which regulated health professionals should be required to demonstrate competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers
- Educational approaches that support current expectations for collaborative and cooperative cross-disciplinary relationships
- Approaches to integrating safety topics in professional education to improve outcomes
- Ways to incorporate the "culture of safety" in training and apprenticeship, and maintaining the "culture of safety" in a practice environment
- Effective mechanisms which unsafe professionals are identified and removed from practice until competence to practice or operate is proven
- Translating research into practice—how to implement strategies that are known to improve safety and change culture to ensure safety and quality of care
- Medical errors in primary care
- Process and effects of patient-centered care on patient outcomes and safety in all health care settings—ambulatory, acute, and long-term care as well as home care
- The relationship between health disparities and patient safety
- Ways to reduce the onus of documentation and paperwork (even 'electronic' paperwork)—"streamlining the documentation and care planning processes in organizations"
- Patient safety within the home care environment; home care research has guided the development of patient safety standards in other countries, while the American health care industry uses a one-size-fits-all-patients model
- The impact of nursing models, human factors, and processes of care on patient outcomes
- The effect of staffing practices on patient safety, health, satisfaction, and access to care outcomes, as well as staff safety, satisfaction, and retention/turnover
- Minimum nurse-to-patient ratios in all patient care areas
- Interventions to improve communication between nurses and doctors, an important aspect of team building
- The association between strategies such as team building and collaborative initiatives and a decrease in patient harm

CONCLUSION

Everyone in Michigan—whether providing, receiving or paying for health care—is focused on the prevention of patient harm, relentlessly questioning how we can do things better and safer.

In September 2004, the Governor designated the Michigan Health and Safety Coalition to act as the State Commission on Patient Safety per Public Act 119-04. Just over a year later, we submit this detailed roadmap and hope that its vision, values, and action steps motivate us all to bring them to realization. We believe we have demonstrated the value of open and accountable public debate about issues that require our best thinking. Those interested in the original testimony and interim reports generated during this process are referred to Volume II, the Technical Appendix, available at http://mihealthandsafety.org/statecommission/index.html.

We have been honored to undertake this important project. Great progress is being made, as demonstrated by myriad success stories presented in the testimony. Much is yet to be done, as we also learned. May this report serve as an organizing force so we all continue to work together to make Michigan health care safe.

ENDNOTES

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APPENDIX A: Commission Members

Members, October 2005

Chair: Thomas Simmer, MD	Blue Cross Blue Shield of Michigan
Vice-Chair: Larry Wagenknecht, RPh	Michigan Pharmacists Association
Hassan B. Azar	Ford Motor Company
Tom Bissonnette, MS, RN	Michigan Nurses Association
John Bodell, DO	Michigan Osteopathic Association
Jan Christensen	Michigan Department of Community Health
Colleen Cieszkowski, RN, MA, CPHQ	MPRO
Patience Drake	Michigan Consumer Health Care Coalition
Gregory J. Forzley, MD	Michigan State Medical Society
Margaret Freundl, MSN, RN	Michigan Nurses Association
Charles M. Gayney	Social Security Dept. International Union, UAW
Chris Goeschel, RN, MPA, MPS	Michigan Health & Hospital Association
	Keystone Center for Patient Safety & Quality
Kevin A. Kelly	Michigan State Medical Society
Marsha Manning	General Motors Corporation
Karen J. McCosky	Michigan Department of Community Health
Beverley McDonald	Michigan Consumer Health Care Coalition
Debra L. Moss, MD, MBA	MPRO
Richard Murdock	Michigan Association of Health Plans
Dennis Paradis	Michigan Osteopathic Association
Cyndy Parker	DaimlerChrysler Corporation
Dick Ringstrom	Michigan Education Special Services Association
John J. Saalwaechter, MD	Michigan Association of Health Plans
Peter Schonfeld	Michigan Health & Hospital Association
Michael Schwartz	Blue Cross Blue Shield of Michigan
Renee Turner-Bailey	Ford Motor Company

Past members

Ralph Cerny	Michigan Health & Hospital Association
Sue Hamel	Michigan Education Special Services Association
Janice Whitehouse	General Motors Corporation

Meeting facilitator

Donald Potter	Consultant to the Commission

APPENDIX B: Acknowledgements

Review Panel

Chair: Beverley McDonald	Michigan Consumer Health Care Coalition
Vice-Chair: Patience Drake	Michigan Consumer Health Care Coalition
James P. Bagian, MD, PE	VA National Center for Patient Safety
Tom Bissonnette, MS, RN	Michigan Nurses Association
Jan Christensen	Michigan Department of Community Health
Colleen Cieszkowski, RN, MA, CPHQ	MPRO
Sarah Fink	Michigan Health & Hospital Association
Margaret Freundl, MSN, RN	Michigan Nurses Association
Chris Goeschel, RN, MPA, MPS	Michigan Health & Hospital Association Keystone Center for Patient Safety & Quality
Barbara A. Lucas, MD	Michigan State Medical Society
Marsha Manning	General Motors Corporation
Karen J. McCosky	Michigan Department of Community Health
Donald B. Muenk, MD	Michigan State Medical Society
Dennis Paradis	Michigan Osteopathic Association
Michael Schwartz	Blue Cross Blue Shield of Michigan
Larry Wagenknecht, RPh	Michigan Pharmacists Association
Gail Warden	Henry Ford Health System

Analytic Team

Chair: Diane K. Valade	Blue Cross Blue Shield of Michigan
Suzanne Begeny, MS, RN, BSN	Intern with BCBSM
Vicky Pebsworth Debold, PhD, RN	Consultant to the Commission
Ellen Johnson, MSc	Consultant to the Commission
Milisa Manojlovich, PhD, RN, CCRN	Consultant to the Commission
Karen J. McCosky	Michigan Department of Community Health
Ruth A. Mohr, RN, MPH, PhD	Consultant to the Commission
A.B. Orlik	Consultant to the Commission
Canopy Roychoudhury, PhD	MPRO
AkkeNeel Talsma, PhD, RN	Consultant to BCBSM

Students of Professor W.B. Allen, Michigan State University

Sarah Abraham, Jessie Brooks, Jeff Espineli, Elena Palombo, Amanda Satlowski, Valencia Short, Dan Vacanti, Amber Van Amburg, Steven Zack

Additional support

Virginia Hosbach, RN, MSN	Blue Cross Blue Shield of Michigan
Mary Ann Ingraham	Blue Cross Blue Shield of Michigan
Mary Ellen Mohn	Blue Cross Blue Shield of Michigan
Pooja Naik	Michigan State Medical Society
Julie L. Novak	Michigan State Medical Society
Jon Ogar	Blue Cross Blue Shield of Michigan

APPENDIX C: Model Act— Michigan Center for Safe Health Care

Introduction: Findings and Purpose

The state commission on patient safety, designated by the governor pursuant to Public Act 119, 2004, finds that most Michigan health professionals and organizations are involved in efforts to reduce patient harm. Progress could be greatly accelerated, however, with a statewide center for patient safety leadership, information and advocacy. Specifically, Michigan citizens would benefit through a center's coordination and promotion of the work of patient safety programs around the state and across state agencies, between stakeholders at the state and national levels, and between public and private sectors.

The purpose of the following "Model Act" is to ensure that these functions are addressed in legislation. By establishing and funding the Michigan center for safe health care, the state demonstrates its commitment to patient safety, develops a mechanism for accountability among health care stakeholders around the state, and responds to the needs of the public.

Sec. 1 Short Title

This act shall be known and may be cited as the *Michigan Center for Safe Health Care Act*.

Sec. 2 Definitions

Words used in this act shall have the following meanings:

(a) "Center" means the Michigan center for safe health care created and appointed by the governor pursuant to this act or the organization designated to act as the center by the governor pursuant to this act.

(b) "Commission" means the State Commission on Patient Safety designated by the governor pursuant to Public Act 119, 2004 and repealed November 27, 2005.

(c) "Patient safety fund" means a dedicated and restricted fund established in the department of treasury to support the activities of the center.

Sec. 3 Michigan Center for Safe Health Care; creation.

To provide statewide leadership, information, training and advocacy for improving patient safety, creating a safer health care environment and reducing patient harm, the governor shall no later than May 31, 2006, create and appoint a Michigan center for safe health care or designate an existing organization to act as the Michigan center for safe health care.

(a) If the governor chooses to designate an existing organization or patient safety initiative to act as the center, the organization shall represent a wide variety of health care stakeholders and:

(1) Be a charitable organization certified by the Internal Revenue Service as meeting the requirements for exemption under IRC Section 501(c)(3).

(2) Include, but not be limited to, individuals with education, experience, and expertise in patient safety as well as health and human services more generally, including individuals representing each of the following:

(i) Health care consumers.

(ii) The Michigan professional organizations for osteopathic physicians, allopathic physicians, nurses, pharmacists, hospitals, and health plans.

(iii) Employers, labor groups, and other health care payers.

(iv) The Michigan department of community health.

(v) Other individuals reflecting the Center's scope of work.

(3) Provide a balanced, unbiased, nonpunitive environment in which to accomplish the Center's mission.

(4) Not be a governmental department, division, board, bureau, commission or agency.

(5) Be independent of any individual health care provider or professional organization, subsidiary, or collective.

(b) If the governor chooses to create a center, the center shall consist of no fewer than 7 members appointed by the governor to represent a wide variety of health care stakeholders and:

(1) Include, but not be limited to, individuals with education, experience, and expertise in patient safety as well as health and human services more generally, including individuals representing each of the following:

(i) Health care consumers.

(ii) Health professionals and health care organizations.

(iii) Employers, labor groups, and other health care payers.

(iv) The Michigan department of community health.

(v) Other individuals reflecting the Center's scope of work.

(2) Provide a balanced, unbiased, nonpunitive environment in which to accomplish the Center's mission.

(3) Not be a governmental department, division, board, bureau, commission or agency.

(4) Be independent of any individual health care provider or professional organization, subsidiary, or collective.

Sec. 4 Center; duties.

The center shall:

(a) Coordinate implementation of the recommendations of the commission's November 2005 final report to the governor.

(1) Cultivate collaborative relationships to solve complex patient safety problems.

(2) Promote active involvement of consumers/patients and families in the structure and process of safe health care. Coordinate public educational efforts with programs targeting clinicians.

(3) Facilitate the systematic identification of practices and environments that result in patient harm.

(4) Collect and disseminate information and tools to accelerate improvement. Provide connections to expertise and technical assistance.

(5) Monitor the effects of patient safety improvement efforts and promote progress to the public.

(6) Shape public policy designed to encourage the adoption of patient safety practices by health care organizations and professionals. Coordinate state-level advocacy at the national level.

(b) Develop its structure and processes to be eligible to serve as a patient safety organization pursuant to the requirements of 42 U.S.C. 299 et seq. as amended by the Patient Safety and Quality Improvement Act of 2005 (PA 109-41).

(1) Conduct activities to improve patient safety and the quality of health care delivery.

(2) Maintain appropriately qualified staff (whether directly or through contract), including licensed or certified medical professionals.

(3) Collect patient safety work product from health care providers in a standardized manner that permits valid comparisons of similar cases among similar providers.

(4) Utilize patient safety work product for the purpose of providing direct feedback and assistance to providers to effectively minimize patient risk.

(c) Submit to the governor and legislature a projected five-year financial analysis of the resources needed to support the activities and duties of the center. Include recommendations to the governor and legislature regarding potential sources of restricted, ongoing funding that might include membership fees, other restricted sources related to the promotion of patient safety, and federal sources. Submit this report not later than:

(1) 90 days after designation by the governor, if an organization is designated to act as the Michigan center for safe health care under Section 3(a).

(2) 90 days after all members are appointed, if the governor creates and appoints a Michigan center for safe health care under Section 3(b).

(d) Receive from any department, division, board, bureau, commission or agency of the state such assistance and data as to enable it properly to carry out its powers and duties hereunder.

(e) Maintain its status as a charitable organization certified by the Internal Revenue Service as meeting the requirements for exemption under IRC Section 501(c)(3).

Sec. 5 Center; executive director appointment, duties.

The center shall appoint an executive director whose duties and responsibilities shall be prescribed by the center. The center shall evaluate the performance of the executive director annually.

Sec. 6 Center; annual report to governor, four-year review.

Annually the center shall submit to the governor and legislature a report of the center's work in the previous year and plan for work in the coming year. Every fourth year the governor shall conduct a review of the center's progress in meeting its duties as described in this act. At that time the governor shall determine whether to re-appoint or re-designate the then-current body serving as the Michigan center for safe health care or create and appoint or designate a new body. Any change to the then-current appointment or designation shall conform to Section 1 of this act.

Sec. 7 Michigan Patient Safety Fund; creation, supplementation.

(a) There is created in the department of treasury the Michigan patient safety fund.

(1) The fund may accept restricted revenues dedicated to patient safety.

(2) Use of money deposited into the fund shall be restricted to providing support for the activities of the Michigan center for safe health care and the implementation of the recommendations of the final report to the governor of the state commission on patient safety created under Public Act 119, 2004.

(3) Funds not appropriated or expended in any fiscal year shall carry forward to the next fiscal year unless prohibited by law or the expressed intention of the donor.

(b) In addition to funds from the Michigan patient safety fund, the center may accept federal funds granted by congress or executive order for all or any of the purposes of this act, provided that the acceptance and use of federal funds commits no state funds and places no obligation upon the legislature to continue the purposes for which the funds are made available. The center may accept grants, contributions or gifts in cash or otherwise from individuals, private organizations, associations, corporations or foundations. Contributions and gifts shall be expended as provided by law, in the same manner as moneys appropriated for implementing the purposes of this act. The donor of the gift may stipulate the manner in which the gift shall be expended within the guidelines of this act.

APPENDIX D: Authorizing Statute (PA 119-04)

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

***** 333.20188 THIS SECTION IS REPEALED BY ACT 119 OF 2004 EFFECTIVE NOVEMBER 27, 2005 *****

333.20188 Commission on patient safety; creation; designation of existing organization; membership; chairperson; public hearing; report; conduct of business; availability of writings;

Sec. 20188. (1) To examine means to improve patient safety and reduce medical errors in this state, the governor shall create and appoint a commission on patient safety within the department of community health or designate an existing organization or patient safety initiative to act as the state commission on patient safety. If the governor chooses to designate an existing organization or patient safety initiative to act as the state commission, the organization or initiative designated shall include, but is not limited to, individuals with education, experience, and expertise in health and human services and individuals representing health care consumers, providers, and payers. If the governor chooses to create a commission, the commission shall consist of 7 members appointed by the governor as follows:

(a) Two individuals from the general public.

(b) One individual representing hospitals.

(c) Three licensed health care professionals.

(d) One individual representing the health care insurance industry.

(2) The commission on patient safety shall conduct public hearings to seek input from the public and from all of the following organizations that have an interest in patient safety:

(a) The Michigan health and hospital association or its successor organization.

(b) The Michigan state medical society or its successor organization.

(c) The Michigan osteopathic association or its successor organization.

(d) The Michigan college of emergency physicians or its successor organization.

(e) The Michigan nurses association or its successor organization.

(f) The emergency nurses association or its successor organization.

(g) The Michigan association of emergency medical technicians or its successor organization.

(h) The Michigan pharmacists association or its successor organization.

(i) The Michigan society for clinical laboratory sciences or its successor organization.

(j) The Michigan academy of physician assistants or its successor organization.

(k) The Michigan society of healthcare risk management or its successor organization.

(*l*) The Michigan association of health plans or its successor organization.

(m) The American society of clinical pathologists or its successor organization.

(n) The Michigan physical therapy association or its successor organization.

(o) The Michigan speech-language-hearing association or its successor organization.

(p) The American dietetics association or its successor organization.

(q) The national association of social workers, Michigan chapter or its successor organization.

(r) The mental health association of Michigan or its successor organization.

(s) The Michigan occupational therapy association or its successor organization.

(t) Health care association of Michigan or its successor organization.

(u) Michigan association for local public health or its successor organization.

(v) Michigan hospice and palliative care organization or its successor organization.

(w) Michigan society of anesthesiologists or its successor organization.

(x) The Michigan home health association or its successor organization.

(y) The Michigan dental association or its successor organization.

(z) The Michigan association of community mental health boards or its successor organization.

(aa) The Michigan chiropractic society or its successor organization.

(bb) The Michigan association of nurse anesthetists or its successor organization.

(cc) The Michigan association of homes and services for the aging or its successor organization.

(dd) The Michigan radiological society or its successor organization.

(ee) Blue cross/blue shield of Michigan or its successor organization.

(ff) The service employees international union or its successor organization.

(gg) The AARP or its successor organization.

(hh) The Michigan council of nurse practitioners or its successor organization.

(ii) The Michigan advocacy project or its successor organization.

(jj) The Michigan primary care association or its successor organization.

(kk) The Michigan association of ambulance services or its successor organization.

(*ll*) The economic alliance of Michigan or its successor organization.

(mm) The Michigan society for respiratory care or its successor organization.

(nn) The Michigan psychological association or its successor organization.

(oo) The Michigan podiatric medical association or its successor organization.

(pp) The Michigan chiropractic association or its successor organization.

(qq) The Michigan county medical care facilities council or its successor organization.

(rr) Any other organization that the commission determines has an interest in patient safety.

(3) If the governor creates and appoints a commission on patient safety under subsection (1), the commission shall meet and appoint a chairperson within 30 days after all members are appointed by the governor. The commission shall conduct its first public hearing within 60 days after all members are appointed by the governor. If an organization or patient safety initiative is designated to act as the state commission on patient safety under subsection (1), the commission shall conduct its first public hearing as the commission within 60 days after designated by the governor.

(4) The commission shall consider all information received from its public hearings, review information from other patient safety initiatives, and study the causes of medical errors occurring

in the continuum of care, including in health facilities and in private practices. Within 1 year after the commission is appointed or designated by the governor, the commission shall issue a written report. The report shall contain recommendations for improvements in medical practice and a system for reducing medical errors, both in health facilities and in private practice.

(5) The commission shall conduct its business as the commission at a public meeting of the commission held in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. The commission shall give public notice of the time, date, and place of the meeting in the manner required by the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

(6) The commission shall make available a writing prepared, owned, used, in the possession of, or retained by the patient safety commission in the performance of an official function as the commission to the public in compliance with the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(7) As used in this section, "commission" means the commission created and appointed by the governor under subsection (1) or the organization or patient safety initiative designated to act as the commission by the governor under subsection (1).

History: Add. 2004, Act 119, Imd. Eff. May 27, 2004.