House
Legislative
Analysis
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COMMISSION ON PATIENT SAFETY

House Bill 4272 (Substitute H-4)
First Analysis (5-14-03)

Sponsor: Rep. Stephen Ehardt
Committee: Health Policy

THE APPARENT PROBLEM:

In December 1999, the National Academy of Science's Institute of Medicine released a report on patient safety as part of its ongoing special initiative on health care quality. Extrapolating from two regional studies of hospitalizations—one conducted in Colorado and Utah and one in New York—the report suggests that "deaths due to medical errors exceed the number attributable to the 8th-leading cause of death. More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516)." The report advises that the actual number of medical errors may be significantly higher for two reasons. First, the studies cited only involved hospitalized patients and thus do not tally the medical errors that occur in other health care facilities. Second, generally speaking only those errors that lead to adverse events, such as injury or death, are noticed; the numbers above do not reflect the (likely) significant number of "near misses" that occur each year.

No one would disagree with the report's judgment that "[w]hether a person is sick or just trying to stay healthy, they should not have to worry about being harmed by the health system itself." The possibility of death or serious harm due to improper treatment, rather than the patient's underlying condition, is a fairly significant reason to take the issue of patient safety seriously. It is far easier, however, to overlook the less obvious costs of medical errors. Remedying conditions brought on by medical errors often requires additional, emergency care, which is often extremely expensive. Also, the time and resources spent on the victim of a medical error reduce the amount of time and resources that health care professionals have to spend on other patients. Further, much of the harm associated with medical errors defies easy measurement; for instance, it is very difficult to factor the public's loss of trust in and patients' diminished satisfaction with the health care system into a cost-benefit analysis.

The report's title "To Err is Human: Building a Safer Health System," articulates two operating premises of the institute's work. First, although humans—including medical professionals—inevitably make some mistakes, individual mistakes are frequently identifiable and preventable. In the report's own terms, "[i]t may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives and meet the challenges ahead." In general, the report advocates various efforts to learn more about medical errors. Specifically, the report recommends that "[a]ll adverse events resulting in serious injury or death . . . be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events in the future." Despite the difficulty of detecting errors that do not result in serious harm, the report suggests that the analysis of such "minor" errors can vastly improve the quality of health care.

Second, while it may seem tempting to reduce the problem of medical errors to the acts of individual health care providers who are careless or incompetent and to solve the problem by identifying those providers and punishing them for their mistakes, any effective solution to the problem must begin with an acknowledgement of the role of the health care *system*—or "nonsystem" as the report refers to it—in perpetuating, or at least creating the climate for, errors. While individual health care professionals who commit errors frequently or commit serious errors should be held responsible for their mistakes, many of the problems derive from the complex interaction of health care providers, insurers, regulatory officials, and others who collectively constitute the health care delivery system. For instance, a nurse who works in an understaffed hospital may regularly have to work double shifts and care for more patients than a nurse in a fully-staffed hospital. While it may be tempting to blame hospital administrators for low staffing levels, there is a well-documented nursing shortage in the state (and nation). It is not clear who is responsible when a medical error occurs under such imperfect conditions. Committee testimony on the bill and its predecessor, House Bill 4537 of the 2001-2002 legislative session,

corroborated this need to emphasize the role of the health care system.

Legislation has been introduced to allow the governor either to create a commission on patient safety or to designate an existing organization or initiative as the state's commission on patient safety.

THE CONTENT OF THE BILL:

The bill would add a new section to the Public Health Code (MCL 333.20188) to allow the governor either to create 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's commission. The commission would be directed to consult with various groups with an interest in patient safety and to examine means to improve patient safety and reduce medical errors in the state.

Composition. If the governor chose to create a commission, the commission would have to consist of seven members appointed by the governor as follows: two individuals from the general public; one individual representing hospitals; three licensed health care professionals; and one individual representing the health care insurance industry.

If the governor chose to designate an existing organization or patient safety initiative to act as the state commission, the organization or initiative would have to include (but would not be limited to) individuals with education, experience, and expertise in health and human services and individuals representing health care consumers, providers, and payers.

Consultation and input. The commission would be required to conduct public hearings to seek input from the public and from all of the following organizations (or their successor organizations):

- the Michigan Health and Hospital Association;
- the Michigan State Medical Society;
- the Michigan Osteopathic Association;
- the Emergency Physicians Association;
- the Michigan Nurses Association;
- the Emergency Nurses Association;
- the Michigan Association of Emergency Medical Technicians;
- the Michigan Pharmacists Association;
- the Michigan Society for Clinical Laboratory Science;
- the Michigan Academy of Physician Assistants;
- the Michigan Society of Healthcare Risk Management;
- the Michigan Association of Health Plans;
- the American Society of Clinical Pathologists;
- the Michigan Physical Therapy Association;
- the Michigan Speech-Hearing-Language Association;
- the American Dietetics Association;
- the National Association of Social Workers, Michigan Chapter;
- the Mental Health Association of Michigan;
- the Michigan Occupational Therapy Association;
- the Health Care Association of Michigan;
- the Michigan Association for Local Public Health;
- the Michigan Hospice and Palliative Care Organization;
- the Michigan Society of Anesthesiologists;
- the Michigan Home Health Association;
- the Michigan Association of Community Mental Health Boards;
- the Michigan Chiropractic Society;
- the Michigan Association of Nurse Anesthetists;
- the Michigan Association of Homes and Services for the Aging;
- the Michigan Radiological Society;
- Blue Cross/Blue Shield of Michigan;
- the Service Employees International Union;

- the American Association of Retired Persons;
- the Michigan Council of Nurse Practitioners;
- the Michigan Advocacy Project;
- the Michigan Primary Care Association;
- the Michigan Association of Ambulance Services;
- the Economic Alliance of Michigan;
- the Michigan Society for Respiratory Care;
- the Michigan Psychological Association;
- the Michigan Podiatric Medical Association; and
- any other organization that the commission determined had an interest in patient safety.

First public hearing. If the governor created and appointed a commission on patient safety, the commission would have to meet and appoint a chairperson within 30 days after all members were appointed by the governor. The commission would have to conduct its first public hearing within 60 days after all members were appointed by the governor.

If an organization or initiative was designated to act as the state commission on patient safety, the commission would have to conduct its first public hearing as the commission within 60 days after being designated by the governor.

Commission's operations. The commission would have to 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 one year after being appointed or designated by the governor, the commission would have to issue a written report containing both recommendations for improvements in medical practice and a system for reducing medical errors in health facilities and private practice.

Commission business would have to be conducted in public (and public notice of the time, date, and place of commission meetings would have to be given) in compliance with the Open Meetings Act. Writings prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function would have to be made available to the public under the Freedom of Information Act.

Repeal. This new section of the Public Health Code would be repealed 18 months after the (proposed) act took effect.

BACKGROUND INFORMATION:

Institute of Medicine report. Among other things, the IOM report provides a useful set of definitions of terms used (sometimes incorrectly) in discussions of patient safety. *Safety* is defined as freedom from accidental injury. The report distinguishes between two general types of errors: errors of planning and errors of execution. An *error of planning* is "the use of a wrong plan to achieve an aim", whereas an *error of execution* is the "failure of a planned action to be completed as intended". An *adverse event* is an "injury resulting from a medical intervention, or in other words, it is not due to the underlying condition of the patient". The report further explains that "[w]hile all adverse events result from medical management, not all are preventable (i.e., not all are attributable to errors). For example, if a patient has surgery and dies from pneumonia he or she got postoperatively, it is an adverse event. If analysis of the case reveals that the patient got pneumonia because of poor hand washing or instrument cleaning techniques by staff, the adverse event was preventable (attributable to an error of execution). But the analysis may conclude that no error occurred and the patient would be presumed to have had a difficult surgery and recovery (not a preventable adverse event)".

The full report is available online at: www.nap.edu/books/0309068371/html.

Michigan Health and Safety Coalition. The Michigan Health and Safety Coalition was formed "to help improve health care quality in Michigan through cost-effective improvements in patient safety, including medical errors, across all health care settings". Coalition members include: Blue Cross Blue Shield, Daimler Chrysler, Ford, General Motors, the UAW, the Michigan Association of Health Plans, the Michigan Department of Community Health, the Michigan Education Special Services Association, the Michigan Health and Hospital Association, the Michigan Nurses Association, the Michigan Osteopathic Association, the Michigan Peer Review Organization, the Michigan Pharmacists Association, and the Michigan State Medical Society. To read about the coalition's activities, visit its web site at: www.mihealthandsafety.org.

Other state legislation. According to a May 2002 report by the National Academy for State Health Policy, entitled *Statewide Patient Safety Coalitions: A Status Report*, 17 statewide patient safety organizations had either formed or were developing as of last May. The report categorizes the organizations into four types: public-private partnerships or coalitions (12, including Michigan Health and Safety Coalition), advisory committees (1), research-focused groups (3), and provider-driven groups (2). Of these organizations, the Maryland Patient Safety Coalition, the only (then active) "advisory committee", is perhaps the closest in concept to the commission proposed by House Bill 4272. As described by the report, advisory committees are "created to collect, analyze, and interpret information to make patient safety recommendations to state policy makers within a particular time span, often one year." Florida, Illinois, Massachusetts, and Virginia have created advisory committees over the past few years but have finished their work and issued their reports, (as has Maryland since the report was issued), though in some cases they have continued to work on patient safety issues as public-private coalitions.

Florida's report may be found on line at: www.floridahealthstat.com/publications/fcehc.pdf

Illinois' report may be found on line at: www.idph.state.il.us/mederrors/recommendations.htm

Massachusetts' report may be found at: www.sihp.brandeis.edu/mhpf/Medical%20Errors%20Issue%20Brief.pdf

Links to work done by Virginians Improving Patient Care and Safety and an extensive set of links to other work on patient safety can be found at: www.vipcs.org/all_resources.htm

Links to Maryland's final report, including the executive summary and appendices, can be found at: www.mhcc.state.md.us/legislative/_legislative.htm

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, there will be costs associated with the establishment, operation, and reporting of a 12-18 month commission. Costs to the Department of Community Health will depend upon the availability of existing resources. Utilizing an existing organization or initiative may be less costly than establishing a new commission as some initial costs would be bypassed. For previous legislation, DCH estimated a cost of $265,000 to establish and support a commission for this purpose. As a comparison, a Long-Term Care Work Group coordinated by the department in 1998-2000 used existing department staff and resources and existing funds of about $147,000 for contractual support services. (HFA fiscal analysis dated 5-14-03)

ARGUMENTS:

For:

To Err is Human, the Institute of Medicine's report on medical errors in hospitals, shed much light on a problem that few people know much about. While some people have suggested that the report overstates the problem, medical professionals and others who work within the health care system want to provide the highest level of care possible to their patients. A patient's last concern when entering a hospital or a doctor's office should be whether something that a doctor or nurse will do to her will make her sicker than she was when she left home. Everyone agrees that one medical error is one too many.

The report was not meant to be a terminal project. It was intended to encourage individual states to evaluate how well or how poorly the medical system is operating within their boundaries. Since no formal study of the issue has been performed in Michigan, it is important to conduct such a study now. Proponents' commitment to a comprehensive examination of the problem of medical errors is evident in the long list of organizations with which the commission would be required to consult in studying the issue. Successive drafts of the bill have included more groups than their predecessors, and in its current form, the bill would require the commission to seek comment from interested groups, regardless of whether they are listed in the bill.

In its current form the bill wisely allows the governor to create a patient safety commission or designate an existing organization or initiative, such as the Michigan Health and Safety Coalition (see "Background Information" above) as the state's patient safety commission. Either way, the bill ensures that the commission would include members who have education, experience, and expertise in health care as well as members representing health care consumers, providers, and payers. Designating an existing organization or initiative could save the state money, but allowing the governor to decide whether to create a new commission or designate an existing one would help ensure that the study is conducted properly.

Response:

Some people believe that patient safety is important enough to merit ongoing attention rather than a one-year study. However insightful the commission's report may be, newly developed medical technologies and evolving relationships within the health care system will continue to raise the potential for new types of medical errors. Perhaps a permanent commission should be established or the DCH should be directed to study the issue and formulate policies on an ongoing basis.

Also, perhaps the bill should guarantee various health care organizations representation on the commission. The bill would simply require the commission to "consult with or seek input from" these organizations. Without knowing the exact composition of the commission, it is difficult to know how seriously any individual organization's input will be considered.

Reply:

With respect to the first consideration, if the commission determined in the course of its investigation and consultations that ongoing attention to the problem of medical errors was necessary, it could recommend a strategy for long-term oversight. Patient safety initiatives in other states have successfully brought interested parties together and have developed into enduring coalitions, which continue to study ways to improve patient safety regardless of state mandates. Again, the various members of the health care system passionately care about this issue and are unlikely to simply drop it once the commission has submitted its report.

While it is certainly understandable that individual organizations want a seat at the table, there might not be a big enough table or enough chairs. The bill represents a sound compromise, ensuring that interested groups will have the opportunity to contribute to discussions but keeping the commission from growing too large and unwieldy. As successive drafts of the bill and successive drafts of its predecessor, House Bill 4537 from the 2001-2002 legislative session, will reveal, every attempt has been made to include organizations who have an interest in reducing medical errors and improving patient safety. Groups who have been left off the bill's list should remind legislators--or the commission itself once it has been created or designated--of their potential contributions in assessing the problem and developing a solution.

POSITIONS:

The Michigan Department of Community Health supports the bill. (5-13-03)

The Michigan Health and Hospital Association supports the bill. (5-13-03)

The William Beaumont Hospital supports the bill. (5-13-03)

The Michigan Osteopathic Association supports the bill. (5-13-03)

The Michigan Association of Ambulance Services supports the bill. (5-13-03)

The Michigan Community Health Boards support the bill. (5-13-03)

The Michigan Primary Care Association supports the bill. (5-13-03)

The Michigan Psychological Association supports the bill. (5-13-03)

The Michigan Psychological Association supports the bill. (5-13-03)

The Michigan Home Health Association supports the bill. (5-13-03)

Analyst: J. Caver

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.