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BILL ANALYSIS

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House Bill 4272 (Substitute H-4 as reported without amendment)
Sponsor: Representative Stephen Ehardt
House Committee: Health Policy
Senate Committee: Health Policy

Date Completed: 5-7-04

RATIONALE

According to a report by the National Academy of Science's Institute of Medicine entitled, "To Err is Human: Building a Safer Health System", at least 44,000 people, and possibly as many as 98,000, die in hospitals every year due to preventable medical errors. Medical error is said to be the eighth-leading cause of death in the United States, resulting in more deaths than car accidents, breast cancer, and AIDS. It has been suggested that a Commission on Patient Safety should be established to study the causes of medical errors and methods to reduce the error rate.

CONTENT

The bill would add Section 20188 to the Public Health Code to require that the Governor create and appoint a Commission on Patient Safety to examine means to improve patient safety and reduce medical errors in this State. Section 20188 would be repealed 18 months after the bill's effective date.

The Governor would have to create and appoint the Commission within the Department of Community Health, or designate an existing organization or patient safety initiative to act as the Commission. If the Governor designated an existing organization or initiative, it would have to include individuals with education, experience, and expertise in health and human services and individuals representing health care consumers, providers, and payers.

If the Governor chose to create a Commission, it 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.
-- One individual representing the health care insurance industry.

If the Governor created and appointed a Commission, it would have to meet and appoint a chairperson within 30 days after all members were appointed. The Commission would have to conduct its first public hearing within 60 days after all members were appointed, whether the Governor created the Commission or designated an existing organization or initiative. The Commission would be subject to the Open Meetings Act and the Freedom of Information Act.

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 the Commission was appointed or designated, it would have to issue a written report containing recommendations for improvements in medical practice and a system for reducing medical errors, both in health facilities and in private practice.

The Commission would have to conduct public hearings to seek input from the public and from all of the following organizations that had an interest in patient safety, or their successor organizations:

-- The Michigan Health and Hospital Association.
-- The Michigan State Medical Society.
-- The Michigan Osteopathic Association.
-- The Michigan College of Emergency Physicians.
-- 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 Sciences.
-- 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-Language-Hearing 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 Association.
-- The Michigan Society of Anesthesiologists.
-- The Michigan Home Health Association.
-- The Michigan Dental 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 and Blue Shield of Michigan.
-- The Service Employees International Union.
-- The AARP.
-- 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.
-- The Michigan Chiropractic Association.
-- The Michigan County Medical Care Facilities Council.
-- Any other organization that the Commission determined had an interest in patient safety.

Proposed MCL 333.20188

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

In its November 199 report, the Institute of Medicine asserted "[I]t is not acceptable for patients to be harmed by the health care system that is supposed to offer healing and comfort—a system that promises, 'First, do no harm.'" Furthermore, the Institute concluded, "[T]he majority of medical errors do not result from individual recklessness or the actions of a particular group—this is not a 'bad apple' problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them." The proposed Commission would conduct a comprehensive examination to pinpoint these systemic weaknesses, which exact significant tolls on patients, health care workers, and society as a whole.

In addition to thousands of deaths every year, medical errors nationwide have been estimated to result in costs of between $17 billion and $29 billion per year in additional care necessitated by the errors, lost income and household productivity, and disability. Patients may require longer hospital stays, experience further physical and psychological pain, or become disabled. Patients might lose trust in the health care system and health care workers might experience a frustration at not being able to provide the best possible care. On a larger scale, the implications of medical errors include lost worker productivity, reduced

school attendance by children, and an overall lower health status for the general population.

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. This combination of individuals would ensure that all aspects of the health care system were examined to identify ways to avoid preventable medical errors.

Legislative Analyst: Julie Koval

FISCAL IMPACT

The bill would have an indeterminate impact on State government. The Department of Community Health would incur costs for the establishment and operation of the Commission. Costs could be reduced if the Governor chose to designate an existing organization to act as the Commission.

Fiscal Analyst: Dana Patterson

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