Legislative Analysis

Mitchell Bean, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

QUALIFIED HOSPITAL
PATIENT SAFETY ORGANIZATION

House Bill 6456 (Substitute H-1)
Sponsor: Rep. Kathy Angerer
Committee: Health Policy

First Analysis (9-23-08)

BRIEF SUMMARY: The bill would designate a qualified hospital patient safety organization (PSO) that met specified criteria as a "review entity," require hospitals in the state to report serious adverse events to the qualified hospital PSO, and require the PSO to annually develop and distribute a public report.

FISCAL IMPACT: The bill will have no fiscal impact on the state or local government.

THE APPARENT PROBLEM:

In 1999, the Institute of Medicine released a report entitled "To Err is Human" that cited studies revealing that at least 44,000 and as many as 98,000 people died each year in hospitals from preventable medical errors. Most of these adverse events were found not to have been caused by the error of a single, reckless individual or by a particular group, but were the result of faulty systems, processes, and conditions that led health care workers to make mistakes or fail to prevent an adverse event. Since the release of the report, many initiatives at the state and federal level, as well as by individual hospitals and healthcare systems, have been studied and policies implemented in an attempt to reduce hospital-related errors.

In 2005, Congress passed the Patient Safety and Quality Improvement Act. Among other things, the act allowed for the creation of independent, federally-certified Patient Safety Organizations (PSO). Doctors, hospitals, and other health care providers can, under the act, voluntarily report information on a confidential basis to a PSO for analysis of patient safety events. Analysis of large volumes of information is expected to identify patterns and commonalities associated with adverse events, and also to reveal practices that could increase the risk of adverse events.

In June of this year, hospitals and health systems in Michigan established a PSO through the Michigan Health and Hospital Association. It is hoped that the data collected and analyzed regarding medical errors and near misses will, according to a press release issued by the Michigan Health & Hospital Association, "aid health care providers in better understanding why some errors occur" and enable the PSO to "develop and implement best practices at the bedside to prevent errors before they happen to ensure the best patient outcomes possible."

Some believe that all hospitals in the state should be required to report certain types of adverse events and near misses to this new PSO in order to ensure that patients receiving services in Michigan hospitals experience the best possible outcomes. Legislation has been offered to address this concern.

THE CONTENT OF THE BILL:

Among other things, the bill would designate a qualified hospital patient safety organization (PSO) that met specified criteria as a "review entity" and require hospitals in the state to report serious adverse events to the qualified hospital PSO.

Qualified Hospital Patient Safety Organization

Under Public Act 270 of 1967, a person, organization, or entity is allowed to provide certain types of confidential information on patients and health care providers to review entities listed in the act. House Bill 6456 would amend the act to include in the definition of "review entity" a qualified hospital patient safety organization that collects data on serious adverse events as prescribed by the bill.

"Qualified hospital patient safety organization" would mean a patient safety organization that had been incorporated under state law before January 1, 2009 by an organization with a membership of at least 75 percent of all hospitals in this state and was organized to carry out activities of a PSO as described in the federal Patient Safety and Quality Improvement Act of 2005 (42 USC 299b-24).

"Serious adverse events" would include, but not be limited to, events listed by the National Quality Forum in its publication entitled, "Serious Reportable Events in Healthcare 2006 Update." (Among the 28 events currently listed are surgery performed on the wrong body part or on the wrong person, a patient death or serious disability associated with a medication error, and a physical assault on a patient or staff member resulting in death or significant injury.)

Reporting by Hospitals

Beginning January 1, 2009, each hospital would have to report to a qualified hospital patient safety organization (PSO) all serious adverse events that occurred in the hospital within 45 days of the event being identified. The qualified hospital PSO would have to create a nonpunitive, confidential reporting system to collect data for the purpose of improving patient safety and to facilitate the safe delivery of health care in hospitals in Michigan. All hospitals would have to use the system designated by the qualified hospital PSO to report a serious adverse event.

A qualified hospital PSO would have to annually develop and distribute a public report for the purpose of improving patient safety and facilitating the safe delivery of health care in hospitals in Michigan.

"Hospital" would mean that term as defined in Section 20106 of the Public Health Code. (Under Section 20106, “hospital” means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. Hospital does not include a mental health hospital licensed or operated by the Department of Community Health or a hospital operated by the Department of Corrections.)

MCL 331.531

ARGUMENTS:

For:

Reportedly, Patient Safety Organizations are based on the Federal Aviation Administration model that encourages a non-punitive system of reporting near-misses so that problems that potentially lead to collisions can be identified and addressed before a tragedy occurs. The 2005 federal legislation set the stage by establishing a framework by which independent PSOs can be created to collect and analyze data regarding medical errors and near misses in hospitals. The bill would require all hospitals in the state to report certain information to the PSO established through the Michigan Health and Hospital Association.

The information required to be reported was developed by the National Quality Forum, which, according to its website, is "a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting." Currently, the NQF identifies 28 events as "serious reportable events in healthcare" grouped into six categories: surgical, product or device, patient protection, care management, environmental, and criminal events. They include events such as operating on the wrong patient or performing the wrong surgery on a patient; a death or disability from giving the wrong type of blood in a transfusion; a maternal death or disability associated with labor or delivery in a low-risk pregnancy; injuries resulting in death or disability to patients while in a hospital such as from a fall, burn, or due to the use of restraints; and physical or sexual assaults on a patient. However, the bill would allow the PSO to add other reportable events; for instance, the PSO could require a hospital to report deaths from hospital-acquired or post-surgery infections, or require information on nurse staffing ratios to identify if there is a link between staffing ratios and adverse events.

Currently, there is no standardized, state-wide reporting of adverse events in hospitals. Also, some healthcare providers fear that disclosure could result in license sanctions or other punitive measures. The non-punitive nature of the PSO should eliminate this existing reluctance. Further, it is expected that by collecting statewide data, patterns of problems and potential problems would emerge and facilitate policy making to address those problems. The bill therefore has the potential to save lives and minimize injuries from hospital medical errors. Moreover, the 1999 Institute of Medicine report estimated that the annual total national costs of preventable adverse events, such as lost income, lost

household productivity, permanent and temporary disability, and health care costs for the injured patient are between $17 billion and $29 billion, of which health care costs represent one half. Thus, identification of those practices contributing to medical errors and development of best practices to eliminate those errors should significantly impact health care costs in the state in a positive way.

For:

The annual public report required to be distributed by the PSO would not compromise the confidentiality of individual patients. The federal act and rules promulgated under it require strict confidentiality and compliance with HIPPA rules. According to committee testimony, though the data collection and reporting process is still being developed, the intent of the PSO is to focus on aggregate data in such a way as to not identify a particular hospital or region of the state if in so doing, a patient's confidentiality would be compromised (for example, if there was only one adverse event of a particular type in the state or in a region of the state, then making that public could inadvertently identify the patient involved).

POSITIONS:

The Department of Community Health supports the bill. (9-18-08)

The Michigan Health and Hospital Association and MHA Service Corporation support the bill. (9-18-08)

The Michigan State Medical Society supports the bill. (9-18-08)

The Economic Alliance of Michigan supports the bill. (9-18-08)

The Michigan Society of Anesthesiologists supports the bill. (9-18-09)

Legislative Analyst: Susan Stutzky
Fiscal Analyst: Margaret Alston

■ 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.