State Health Watch

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THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

Retrospective look at landmark report: Are patients safer now?

[Editor's note: Five years ago, the Institute of Medicine (IOM) caused a stir with a landmark report, To Err is Human, *which said the number of people who die in the United States as a result of medical errors is equivalent to a jumbo jet crashing each day. The report cited evidence that as many as 98,000 Americans die in any given year from medical errors — more than from motor vehicle accidents, breast cancer, or AIDS. This past fall, many organizations and individuals recognized the fifth anniversary of that report with assessments of how far we've come in addressing the problem from the perspective of providers, the general public, and the health care system. While providers and health system analysts are cautiously optimistic about the progress that has been made, consumers say they don't feel safer, perhaps because they're not aware of some of the changes that have taken place. Also in the discussion is an initial report on patient safety centers in several states — one attempt to take bold steps to improve patient safety.]*

A provider assessment, supported by the Commonwealth Fund and published as a *Health Affairs* web exclusive, said the United States has made

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Governors ask Congress for Medicaid reform, but don't want cost shifted to state budgets

Saying that reform of the Medicaid program is their highest priority, the nation's governors asked Congress for changes that will result in cost savings and efficiencies for both the federal and state governments.

Fiscal Fitness: How States Cope

However, they said reform should not be part of a FY 2006 budget reduction and reconciliation process, especially if it does nothing more than shift additional costs to states.

In a Dec. 22, 2004, letter to House and Senate leaders of both parties, National Governors Association (NGA) chairman Mark Warner, governor of Virginia, and vice chairman Mike Huckabee, governor of Arkansas, said the nation's governors are "committed to administering the Medicaid program in a very cost-effective way, and as equal partners in the program have a tremendous incentive to continue doing so."

They said commitment is reflected in the fact that the annual

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Landmark report

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insufficient progress to improve the safety of patients in hospitals, giving an overall grade of C+. Though the report noted some improvement, it also acknowledged considerable deficiencies in key areas.

The report was written by Robert Wachter, associate chairman of the Department of Medicine at the University of California at San Francisco, who said a lack of funding, training, organizational structure, and culture have created barriers to meeting the goals laid out in the IOM 1999 report, which called for reducing medical errors by half by 2004.

In his analysis, Mr. Wachter gives high marks to the effects of strong regulation and broader use of information technology, but said error reporting systems have had little impact on fostering patient safety and there has been virtually no progress on making clinicians or health care systems more accountable for their actions over the past five years.

Wachter looked back at history to discover how health care has become so unsafe. "When the tools of medicine were the doctor's intellect and the nurse's empathy, and a few simple surgical procedures and potions, there was little price to be paid for absent safety systems and lack of coordination. As medicine's tools became more powerful and technologically sophisticated, highly specialized teams were needed to deliver care. The modern intensive care unit [ICU], an invention of the 1960s and 1970s, vividly illustrates the problem," he writes.

"Patients there are supported by an extraordinary array of breathtaking technologies and pharmaceuticals, each accompanied by an armada of skilled professionals to manage their use. A critically ill patient might be seen by a half-dozen different physician specialists and scores of nurses, respiratory therapists, pharmacists, social workers, clergy, and others and receive hundreds of medications and tests. It should come as no surprise, then, that without a culture, procedures, and technology focused on flawless execution, errors would become commonplace. One study found that the average ICU patient experiences 17 errors per day, nearly one-third of which are potentially life-threatening. Most involve communication problems," he adds.

According to Mr. Wachter, as care became potentially more dangerous, several main forces limited ability of those working in the system to answer the challenge:

1. a flawed mental model and collective inattention that before 1999 saw medical errors in terms of individual culpability rather than as a system problem;
2. a reimbursement system that pays hospitals and physicians the same regardless of the safety of the care they deliver and thus creates no incentive to invest in safety, and an organizational structure that separates physicians from the rest of the hospital enterprise, creating divergent bottom lines and incentive structures;
3. a milieu in which patient safety was quite naturally ignored, with a focus, as in most industries, on production or progress rather than safety.

His report card assesses progress in several broad areas seen as necessary to meet a goal of significantly reducing medical errors: regulation, error reporting systems, information technology (IT), the malpractice system and other vehicles for accountability,

and work force and training issues.

Mr. Wachter gives regulation an A-, noting the work done by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A survey of hospitalists (physicians specializing in inpatient care) indicated JCAHO was the second most important force for change, while hospital leaders said it was the most important driver of progress in patient safety. He cites two examples: First, before JCAHO's safety goal requiring read-backs of patients' names and oral orders, virtually no U.S. hospital had a strict policy mandating what Mr. Wachter calls a commonsensical redundancy, despite the fact that many restaurants have long performed read backs to avoid errors in processing takeout orders.

Second, he says, during the preregulatory days of "sign your site," some surgeons placed an "X" on the site to be operated on, while others put an "X" on the wrong site, as in "don't cut here," another argument for standardization.

"JCAHO's revamping of its methods to use more clinically realistic assessment tools (following patients through the course of their care, a process known as the tracer methodology) instead of its traditional focus on policies and procedures, has helped as well," Mr. Wachter writes.

Most grades not high

Error-reporting systems were assigned a grade of C, in part, because of the flawed notion that reporting has any intrinsic value in and of itself. "Error reporting systems can be powerful tools when the reports are used to improve systems or educate providers," he adds, "and they are particularly valuable when those who submit reports subsequently learn that their submissions made a difference. There are certainly examples of successes; one is hospitals where incident reports do lead to meaningful actions instead of pie charts. Another is the federally supported web-based journal that I am privileged to edit . . . in which interesting reports of errors, submitted anonymously by readers, are accompanied by expert commentaries. But, unlike in aviation, in which reports of near misses help illustrate human factor problems that catalyze action, in health care, errors are so frequent, the number of man-machine interfaces are so voluminous, and we have so much catching up to do that the average patient safety officer would have a full plate for the next five years without a single new report. Reporting is an area in which new models, and far greater resources devoted to translating submissions into action, will be needed."

IT also got one of the higher grades, a B-. Mr. Wachter notes we may finally be nearing a time when institutions and providers will not be seen as credible providers of safe, high-quality care if they lack a strong IT backbone. He also credits the 2004 appointment of David Brailer as a national health information technology coordinator, the recent awarding of $139 million in IT grants by the U.S. Department of Health and Human Services, and the efforts to develop uniform data sharing standards as clear evidence that the federal government is taking the IT issue seriously. A caution he reports from the hospitalist survey is that patient safety and clinical IT are not synonymous, and the greatest danger from IT is that institutions that have invested heavily in it may feel that they have spent all they can on safety.

The lowest grade, D, went to the malpractice system and other vehicles for accountability. Research has demonstrated, he writes, that the nation's medical malpractice system is terribly broken, doing a poor job of compensating patients, punishing the negligent, and protecting the innocent. The system also demoralizes physicians and is beginning to lead to major access problems in some locations and among some specialists.

Mr. Wachter says he believes the malpractice system's impact — both positive and negative — on patient safety tends to be overemphasized. Also, the debate over tort reform has centered on caps on pain and suffering awards, which would not fundamentally alter the dynamics of the malpractice system in terms of its influence on patient safety. Switching to a no-fault system for compensating victims of medical errors would alter the dynamics, he says, but has not generated much political support. More promising, he adds, is the notion of "enterprise liability," in which malpractice suits are directed at organizations such as hospitals rather than at individual providers, creating an incentive for system change.

In contrast to malpractice, Mr. Wachter says, the lack of accountability for poor performance does harm patient safety, but also presents some of the most complex issues in patient safety — how to promote a no-blame culture for providers who make innocent slips or mistakes, while holding persistent rule violators or incompetent providers accountable; how to compensate patients for harm without necessarily invoking the heavy hand of tort law; how to hold institutions accountable for allowing unsafe conditions to persist without hammering them in the newspapers or courts when they acknowledge their flaws.

"I believe that we have made virtually no progress in tackling these exceptionally thorny questions in

the past five years," Mr. Wachter concludes.

Work force and training issues are given a B in the report, a grade that he says represented a growing appreciation of the importance of work force issues and a few examples of action.

He cites the emergence of hospitalists as a specialty as the most positive development for inpatient care, while the situation is less hopeful on the ambulatory side.

Time an issue for PCPs

"Although, ideally, primary care physicians would assume leadership roles in ambulatory safety," Mr. Wachter writes, "few have the time to do so. Moreover, the perceived unattractiveness of primary care careers has led to a marked drop-off in applicants for these positions, and is likely to result in a major shortage in coming years. Finally, few small practices have had the resources to invest in office-based IT, although larger ambulatory systems are proving that progress is possible."

He also is critical of medical education in terms of duty-hour requirements and also the neglect of teamwork and simulation training. "Despite the fact that patient outcomes are increasingly determined by how well teams function under pressure (for example, promptly facilitating emergency coronary angioplasty and stenting in patients with acute myocardial infarction), no teamwork training is yet required of providers, and few medical and nursing schools include it in their curricula," Mr. Wachter explains.

"Even when institutions have invested in such training, it is usually offered in small organizational units [the neonatal ICU, for example], not institutionwide. Simulator training, because it is more resource intensive, is even less well developed," he notes.

Mr. Wachter tells *State Health Watch* that it is easy to become demoralized over the level of progress in reducing medical errors in the last five years, and it's important to remember that many of the things that have been accomplished are quite important and will be the building blocks for the next five years.

The next steps, he notes, involving moving from procedural and regulatory safety to the three biggest items that can't be regulated: educating providers in very different ways, starting in medical schools, change the culture to increase and improve communication; and expanding use of information technology.

Have to get past regulations

"The regulatory part is the low-hanging fruit," he continues. "If the Joint Commission remains the most important thing between 2004 and 2009, we won't have done the job. We need a different level of effort and a different kind of commitment. There are no simple answers. We have to attack the problem from 15 different directions."

At the level of individual institutions, Mr. Wachter says, the CEO and board must say that safety is the top item in their strategic plan and actually mean it. Then they have to ask their staff what it means to make safety the top priority.

While there are no cookie-cutter approaches that will work for all, he points out, there are general themes that will emerge, including:

1. a recognition that it's hard to believe an institution can be as safe as possible without computerizing key processes;
2. training for health care workers;
3. reasonable numbers of doctors and nurses;
4. new training methods.

Incentives for institutions to change — which Mr. Wachter describes as too wimpy — need to be beefed up.

He says pressures from patients, the news media, and providers can't be ignored and will lead to change. Investing safety has to be seen has a rational business decision.

Mr. Wachter sees a difference between safety and the quality movement's ability to provide incentives through pay for performance because there is no easy way to measure safety.

"Until there are equivalent safety measures, it will be hard to develop an incentive system," he points out. "But I would have said the same thing about quality five years ago, and that landscape has changed."

According to Mr. Wachter, in the last five years, a momentum has developed that is very impressive because safety is an issue that resonates with providers as well as patients.

"There's a lot of energy and passion being applied to tackle this," he adds.

"The momentum on computerization will only grow. I hope there will be increased federal support for IT development. The biggest question we'll have to face over the next five years is the extent to which we can really change the culture and change training. A lot depends on the incentives. It may be that we'll make slow — but not breathtaking — progress," Mr. Wachter continues. "Five years after *To Err is Human,* we have reached the end of the beginning. Our patients clearly do not think that our work is done. Do we?" he poses.

[To read Mr. Wachter's article, go to www.healthaffairs.org. Contact Mr. Wachter at (415) 476-5632. E-mail: bobw@medicine.ucsf.edu.] ■

State Budget Forecasts

Number of States with…	FY 2003 (11/02)	FY 2004 (11/03)	FY 2005 (11/04)
Budget gaps	31	10	3
Revenues above forecast	8	21	36
Revenues on target	8	13	10
Revenues below forecast	23	16	3
Stable or optimistic revenue outlook	10	32	48
Cumulative budget gap	$17.5 billion	$2.8 billion	$568.1 million

Source: National Conference of State Legislatures, Washington, DC.

Fiscal Fitness

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growth in Medicaid per capita spending has not exceeded approximately 4.5% per year, substantially lower than the growth rate of private health insurance premiums, which the governors say averaged 12.5% per year in the last three years.

But total Medicaid costs, Warner and Huckabee said, are growing at a rate of 12% per year and note total Medicaid expenditures exceed those for Medicare, primarily, the governors claim, due to two factors beyond the control of states — large caseload increases of some 33% in the last four years and the impact of long-term care and the dual-eligible population.

According to the letter, Medicaid accounts for 50% of all long-term care dollars and finances the care for 70% of all people in nursing homes.

Also, 42% of all Medicaid expenditures are spent on Medicare beneficiaries, despite the fact that they comprise a small percentage of the Medicaid caseload and already are fully insured by Medicare. The governors say benefits for the dual-eligible population should be financed 100% by Medicare.

Things must change

"We agree that maintaining the status quo in Medicaid is not acceptable," Mr. Warner and Mr. Huckabee wrote. "However, it is equally unacceptable in any deficit reduction strategy to simply shift federal costs to states, as Medicaid continues to impose severe strains on state budgets. Our most recent survey of states shows Medicaid now averages 22% of state budgets.

"This commitment has caused a strain on funding for other crucial state responsibilities. These funding challenges will become more acute as states absorb new costs to help implement the Medicare Modernization Act for the millions of dual-eligible beneficiaries," they pointed out.

The NGA survey of states referenced in the letter was conducted along with the National Association of State Budget Officers and also released at the end of 2004.

The report said that for proposed FY 2005 state budgets, states estimated Medicaid growth rates of 12.1% in state funds and 3.9% in federal funds.

The large variance in rates of growth for federal and state shares is attributable to the temporary increase of 2.95% in the Federal Medical Assistance Percentage that was in effect from April 2003 through June 2004 as part of state fiscal relief.

"Even with extensive cost containment and fiscal relief, Medicaid expenditures have exceeded the amount that had been originally budgeted for the program," the report said.

Some 23 states experienced Medicaid shortfalls in FY 2003 and 18 states anticipated shortfalls in FY 2004.

All states have cut costs

States have been able to maintain a growth rate below private insurance levels due to the cost containment efforts used by all 50 states, the governors said.

Every state implemented at least one new Medicaid cost containment strategy in FY 2004. But states continue to feel pressure in funding Medicaid and long-range projections of Medicaid spending growth by both the Congressional Budget Office and the White House's Office of Management and Budget range from 8% to 9%.

"Even after state budgets begin to recover fully," the report concluded, "Medicaid cost increases will far outstrip the growth in state revenues into the future."

Meanwhile, a November 2004 report from the National Conference of State Legislatures (NCSL) echoes the concerns expressed by the governors and budget officers, saying that although more money is coming into state coffers, it's not expected to be enough to relieve health and education funding pressures for FY 2006 in many states.

The NCSL report shows that revenues for the first few months of FY 2005 (starting July 1, 2004) are at or above projections in almost every state.

Budget overruns are less severe than in recent years, and budget gaps are practically nonexistent. (**See chart, p. 5.**)

But at the same time, officials in 22 states said budget problems will occupy much of legislators' attention in the upcoming session as they develop spending plans for the next fiscal year, beginning July 1, 2005.

Looking for revenue streams

Lawmakers will be looking for ways to replace one-time revenues they used to balance FY 2005 budgets and also will contend with rising health care costs, a reduction in the federal Medicaid match, and funding needs in elementary and secondary education.

Personal income and sales tax collections — an estimated two-thirds of state tax collections — are above targets in almost every state, NCSL said.

Corporate income taxes — a comparatively small state revenue source, also is running higher than expected.

"The 2005 sessions will pose challenges for legislators across America," said Bill Pound, NCSL executive director.

"There will be challenges in preparing the FY 2006 budgets, including changes in Medicaid funds distribution and the continued fiscal strain of No Child Left Behind. State legislators look forward to the continued improvement of the national economy and are grateful for the direction it's headed," he added.

(For more information from the NGA, go to www.nga.org, and for information from the NCSL, go to www.ncsl.org.) ■

This issue of *State Health Watch* brings you news from these states:

Six states serve as models for those establishing patient safety centers

States wanting to follow the lead of the six that have enacted legislation supporting creation of state patient safety centers to help address the problem of medical errors should be sure there is clear legislative authority, coordinate center activities with other state activities, and begin by focusing on creating a safety culture.

That conclusion is from a report from the National Academy for State Health Policy that examined the models in use in the six states.

IOM report spurred effort

Report author Jill Rosenthal tells *State Health Watch* the effort grew out of the 1999 Institute of Medicine (IOM) report that documented 98,000 deaths per year in the United States due to medical errors.

"The IOM recommended two types of reporting systems: state mandatory reporting for serious adverse events and a voluntary system for near misses. The safety centers are a way of implementing the voluntary reporting," she notes.

The report says that all six patient safety centers studied — Florida, Maryland, Massachusetts, New York, Oregon, and Pennsylvania — are legislatively authorized or endorsed in some manner. That authorization distinguishes them from other state or public/private patient safety programs or coalitions.

Four of the centers are housed within their state governments, while two are outside of but still have legislatively authorized affiliations with the state governments. But Ms. Rosenthal says that whether a center is housed within or outside of state government does not alone dictate how a center interfaces with that government.

More important is the authorizing legislation and how it describes the working relationship between the center and the government.

Mission statements are similar

Although patient safety centers may have different governing structures, operations, and activities, they are similar in their mission statements — all six have statements on improving, ensuring, or promoting patient safety.

Ms. Rosenthal says the most universal function, common to all six centers surveyed, is to educate providers about best practices to improve patient safety.

Other common roles include identifying causes of patient safety problems, fostering a culture of safety, developing collaborative relationships among patient safety stakeholders, and educating consumers about patient safety.

Five of the six states with centers have separate mandatory reporting systems for serious adverse events, and those systems are housed in state regulatory agencies.

Several centers have access to the data in those systems and will assist with their analysis. Three of the states chose to develop within their patient safety centers a voluntary reporting system for less serious errors, intended to complement the mandatory systems already in place.

According to Ms. Rosenthal, center officials face a number of challenges, including the level and reliability of funding and staffing levels.

Also, despite efforts to carefully separate patient safety center activities from regulatory processes in many states, providers may be hesitant to participate in some patient safety center activities, especially reporting, due to fear of publicity or negative repercussions, even though the patient safety center data systems offer strong protections.

The report says the state patient safety centers are charged with promoting patient safety through a variety of activities that vary by state but may include:

- educating health care providers and patients on processes that may reduce future occurrences of adverse events;
- developing systems of near miss and/or adverse-event data reporting, collection, analysis, and dissemination to improve the quality of health care;
- fostering creation of safety cultures to identify and determine causes of adverse events and near misses;
- informing consumers about patient safety issues;
- serving as a clearinghouse for development, evaluation, and dissemination of best practices;
- promoting ongoing collaboration between the public and private sectors;
- coordinating state agency initiatives.

Most patient safety centers are governed by a board of directors (Florida, Massachusetts, Oregon, and Pennsylvania), but membership on the boards is quite distinct, Ms. Rosenthal says.

Boards can include representatives of various stakeholder groups including providers (Oregon and Pennsylvania) or their associations (Florida), consumer groups and purchasers (Florida and Oregon), and medical insurers (Florida and Oregon), among others.

Boards in Oregon and Pennsylvania are appointed by the governor and legislature.

Florida's law specifies which stakeholder groups may appoint board members, including the state hospital association, practitioner associations, and payers.

Because the Massachusetts center is a state government agency, its board contains three secretary-level state officials. Centers in Maryland and New York are overseen by their center executive officials. Four of the five centers with boards include state government representatives. Several states also have advisory committees or councils that support the work of the centers.

Various ways to fund centers

Financial support for patient safety centers comes primarily from fees, grants, and appropriations. Florida and New York are supported through legislative appropriations, while Oregon and Pennsylvania rely on fees.

Pennsylvania has a dedicated Patient Safety Trust Fund supported by an annual surcharge on licensing fees for facilities subject to the enabling legislation's reporting requirements. Oregon's center may levy fees on eligible participants. Maryland's center will be funded for its first three years through contributions from the Maryland Hospital Association and the Delmarva Foundation.

Future funding may come from grants. Massachusetts is relying on a combination of state monies and a grant from the federal Agency for Healthcare Research and Quality.

While all six centers plan to focus on hospitals, other commonly mentioned facilities include ambulatory surgery centers (Florida, Massachusetts, Oregon, and Pennsylvania), long-term care facilities (Florida, Maryland, Massachusetts, and Oregon), and birthing centers (Oregon and Pennsylvania).

New York and Oregon specifically mention serving health care professionals. Some center activities may focus on a particular type of provider. Thus, educational activities, reporting systems, and legal protections may be designed to address the needs and concerns of specific providers. New York, for example, prepared a toolkit to help reduce overprescribing of antibiotics and distributed it to pediatricians, family practitioners, and other appropriate primary care providers.

As the six patient safety centers ramp up, staffing levels are modest, the survey shows, with much of the work conducted through contracts.

The most universal functions, common to all six centers, are to educate providers about best practices to improve patient safety, promote collaboration between the public and private sectors, and inform consumers on patient safety issues.

Ms. Rosenthal says other activities that the majority of centers propose to do include recommending statewide goals and tracking progress, fostering creation of a culture of safety and learning, reviewing and promoting patient safety research, promoting collaboration between state and federal initiatives, and implementing a reporting system.

Unique data collection tactics

The types of data and methods of collection and analysis used by the centers vary. Ms. Rosenthal says some interesting and unique activities of patient safety centers include:

- Florida will examine ways to reward providers who implement evidence-based medical practices and will recommend core competencies in patient safety for health professional curricula.
- Massachusetts has developed a patient safety ombudsman program to work with patients, families, and consumers on patient safety-related problems and also plans to address health system and individual practitioner accountability.
- New York administers an award program to recognize patient safety leaders of various types of health care facilities and also will recommend statewide medical safety goals and will track the progress of health care providers in meeting those goals.
- Pennsylvania's statute includes a provision for a discount in medical malpractice liability insurance premiums for facilities that can demonstrate a reduction in serious events following adoption of center recommendations.

Ms. Rosenthal says the IOM report envisioned mandatory reporting systems housed within state regulatory agencies for serious adverse events and nonregulatory voluntary reporting systems for near misses, with the two systems intended to complement each other.

The first would provide data to assist government in holding facilities accountable, while the voluntary system would be a more collaborative mechanism to learn from mistakes.

Separate reporting systems

Five of the six states with centers have separate mandatory reporting systems — Florida, Maryland, Massachusetts, New York, and Pennsylvania — housed within state regulatory agencies for serious adverse events.

Florida, Maryland, and Pennsylvania embraced the IOM's vision by also developing a reporting system within their patient safety centers for less serious errors.

Florida collects near miss data, while Maryland and Pennsylvania collect near misses and adverse events up to a specified threshold.

Only Oregon has no mandatory reporting system; the Oregon Patient Safety Commission will be creating a voluntary reporting system for serious adverse events as part of its mission.

Centers in Massachusetts and New York have authority to implement a voluntary reporting system but have chosen to focus on other activities. Massachusetts is considering developing a system in the future.

Public reporting

All of the patient safety centers plan to make some information available to the public. If the centers have reporting systems, they will publicly report only data patterns using aggregate de-identified data that do not name facilities. Maryland and Oregon also will provide information on which facilities are participating in the reporting systems.

Only New York provides facility- and provider-specific outcome information (which is contained within its physician profiling system) and outcome measure reports.

The accessibility of data from New York's center may be attributed to its mission, which has a unique focus on improving public access to health care information and to the great consumer demand for information.

Patient safety centers will identify evaluation strategies and indicators, Ms. Rosenthal says, to measure their progress and submit their required reports.

"Despite the difficulty of evaluating success, the centers have already made progress," she reports. "In all six states, the legislatures have recognized the serious issue of patient safety and made commitments to supporting patient safety centers. In some states, the legislature has committed resources. Stakeholders have collaborated to create governing and advisory bodies that represent diverse groups brought together to achieve common goals.

Legislative authorization key

Participants involved in the National Academy of State Health Policy survey recommended that states considering developing a patient safety center do it legislatively to create a public mandate for the center's mission.

Participants also acknowledged the importance of clear and consistent legislation, noting that inconsistencies and lack of clarity in some of the centers' authorizing legislation delayed progress.

Patient safety centers are more likely to be successful, those surveyed said, if sponsors share a common vision.

However, in creating a center governing structure, one meeting participant suggested balancing the desire to create an all-inclusive board with the need to create an efficient and effective board process.

Participants said patient safety center activities need to be coordinated with other state activities, rather than operating as standalone entities.

States recommended clarifying how the patient safety center differs from any existing patient safety coalition and then clearly examining and clarifying the relationship between the two entities.

Center officials recommended allocating sufficient time during center development to consider operational issues before starting on activities. Depending on the patient safety center's anticipated role in collecting, analyzing, and disseminating data, centers may have complex infrastructure issues to consider. Ms. Rosenthal says data-flow processes can be more complex than expected.

Developing and putting into operation clear definitions of reportable events is a challenge for any reporting system, and may influence decisions regarding access to data.

Participants noted a need to educate the news media about reporting systems, especially conveying the message that an increase in reporting should be viewed as a success, as an indication of growing support for a coalition of safety. Increased reporting also provides data that will be useful for identifying root causes and potential solutions. Participants also recommended that centers reach out to the media before crises occur in hopes of ensuring enlightened reporting.

Competing priorities

"With all of the potential areas of focus for state patient safety centers, it may be difficult for emerging centers to set priorities," Ms. Rosenthal writes.

"Several participants suggest that centers begin by focusing on creating a patient safety culture. According to some participants, newly created centers should be cautious about focusing on data collection. Unless the data will add a particularly unique value, [they] may only contribute to the vast amount of data already available. Some questioned the need for additional reporting systems and whether centers should instead focus on implementation of best practices. However, according to one state, a reporting system can be useful in providing facility-specific and peer-specific feedback to help facilities target their quality improvement interventions," she continues.

Ms. Rosenthal notes that whether other states should create a patient safety center is an individual decision based on what else is going on in the state, what a center

would do, and whether funding is available.

Questions raised by the survey, she says, include:

1. What role can/should the state play in a patient safety center? Is government responsible for quality improvement initiatives? Should government be involved?
2. What role can/should patient safety centers assume in data collection, analysis, and evaluation? Does it differ depending on whether the state already has a regulatory reporting system? Does every state need to develop its own voluntary system to track problems and identify best practices, or can states learn from other databases? Should centers focus on collecting data or implementing already identified best practices?
3. How can the centers address patient safety systems problems in addition to clinical processes of care? If most errors are the result of systems of care, how can provider education lead to improvement? Can centers provide training in leadership, culture of safety, and human factors in addition to clinical improvement? How can patient safety centers help states move from focusing only on avoiding mistakes to improving quality outcomes?

"The impact of state patient safety centers remains to be seen," Ms. Rosenthal says.

"Despite the lack of rigorous indicators, patient safety centers ultimately will have to demonstrate gains in patient safety. If they are unable to do this, pressure will no doubt build from regulators, purchasers, and the public for more draconian measures," she adds.

[Contact Ms. Rosenthal at (207) 874-6524.] ■

Consumers still worry about health care safety

While providers are willing to give high marks for at least some of the steps taken to address the Institute of Medicine's 1999 report on the high number of medical errors in this country (**see related story, p. 6**), consumers surveyed as part of the five-year anniversary of the report don't believe the nation's quality of care has improved.

The consumer survey, conducted by the Kaiser Family Foundation, U.S. Agency for Healthcare Research and Quality, and Harvard School of Public Health, found that 40% of respondents believe the quality of health care has gotten worse in the past five years, while 17% say it has gotten better and 38% think it has stayed the same.

Nearly half of U.S. residents (48%) said they are concerned about the safety of the medical care that they and their families receive, and 55% said they are dissatisfied with the quality of U.S. health care, up from 44% who gave that opinion in a survey conducted four years ago.

The latest survey found that people with chronic health conditions are considerably more likely than other consumers to express concerns about their quality of care and report having personal experiences with medical errors.

"This survey shows that the challenge is not just to improve patient safety, but to convince the public that real progress is being made," said Kaiser Family Foundation president Drew Altman.

Medical errors

After being read a common definition of a medical error, 34% of those interviewed said that they or a family member had experienced a medical error at some point in their lives, including 21% of all Americans who said that a medical error caused serious health consequences such as death (8%), long-term disability (11%), or severe pain (16%).

Some 14% of those who said the error caused serious health consequences (3% of all Americans) said that they or their family filed a malpractice lawsuit as a result of the error.

Of those who were involved in a medical error, 28% (9% of all Americans) said the doctor or other health professional involved told them about the medical error.

Half of all people with chronic conditions reported they have experienced a medical error in their own

care or the care of a family member, far more than those without chronic illnesses (30%).

Some 92% of Americans said that reporting of serious medical errors should be required, and 63% want the information released publicly.

Almost nine in 10 (88%) said doctors should be required to tell a patient if a preventable medical error resulted in serious harm in the patient's own care.

Consumers' views on errors

Consumers are most likely to cite workload, inadequate staffing, and poor communication among health care providers as causes of medical errors, with 74% saying workload, stress, or fatigue of health professionals is a very important cause of medical errors.

Nearly as many said that doctors not having enough time with patients (70%), too few nurses in hospitals (69%), and health professionals not working together or not communicating as a team (68%) are very important causes of medical errors.

When asked about a variety of potential solutions, 79% said that giving doctors more time to spend with patients would be "very effective" in reducing preventable medical errors, while nearly as many said that requiring hospitals to develop systems to avoid medical errors (72%) and better training of health professionals (72%) would be "very effective." Slightly more than half (51%) said that more use of computerized medical records instead of paper records for ordering drugs and medical tests would be very effective.

"Many steps have been taken to improve patient safety, and the greater use of health information technology is one of the most promising developments in this area," said Agency for Healthcare Research and Quality director Carolyn Clancy.

"However, these are largely system-related improvements that aren't always apparent, even though consumers may recognize their importance. Our challenge is to show the connection between these kinds of changes and improving the care patients receive, while at the same time expanding and accelerating these efforts," she added.

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Carolyn Clancy
Director
Agency for Healthcare Research and Quality
Rockville, MD

The survey found that 35% of people said they have seen information comparing the quality of health plans, hospitals, or doctors in the past year, up from 27% in 2000.

Some 19% of all Americans said they have used comparative quality information about health plans, hospitals, or other providers to make decisions about their care, up from 12% in 2000.

More specifically, 14% of consumers said they have used quality information to choose health plans, 8% to choose hospitals, and 6% to choose doctors.

Consumers generally said that data about medical errors, numbers of malpractice cases, and professional experience are most likely to be useful at assessing quality of care.

For example, 70% said that information about medical errors or mistakes would tell them "a lot" about a hospital's quality of care.

Consumers are nearly as likely to say that information on how many times a hospital has performed a particular test or surgery (65%) and information on how many patients die after having surgery (57%) tells them "a lot."

Fewer, but still approximately half, said that how patients rate a hospital's quality of care (52%) or the number of patients who don't get standard recommended treatments (47%) tells them "a lot" about quality.

Steps to reduce errors

The survey also found that a significant number of Americans said they have taken precautions to reduce the risk of experiencing a medical error when seeking treatment, including:

- checking medication that a pharmacist gave them with the prescription their doctor wrote (69%) and bringing a list of all medications taken to a doctor's appointment (48%);
- calling to check on results of a medical test (69%);
- talking to a surgeon about details of a proposed surgery, such as exactly what the surgeon will do, how long it will take, and the recovery process (66%);

- taking a friend or relative with them to ask questions and help them understand what their doctor was telling them (43%);
- consulting their doctor about the hospital they use (37%).

The Agency for Healthcare Research and Quality says it recommends use of such precautions to enable patients and their families to reduce their risk of experiencing medical errors.

Patients' perceptions

University of California at San Francisco physician Robert Wachter, who wrote an analysis of progress made in the five years since the IOM report (**see cover story**), says the difference in perceptions of progress between providers and patients is not unexpected.

"Patients' perceptions are related to what they can see," Mr. Wachter tells *State Health Watch*. "The system still appears chaotic to patients. It doesn't appear well thought out, and that often is the case."

Patients also deal with recollections rather than current experience, according to Mr. Wachter. And he says that, in some ways, the IOM report engendered a higher level of public distrust, even as it helped galvanize energy and resources to be used to address the problem. "We can't fix the problem of medical errors unless people appropriately understand the need for it to be fixed," he says.

While some have called for a massive public relations effort to convince people they are safer, Mr. Wachter tells us he's not sure that's the most important thing to do at this point, especially since he is convinced that patients are not yet safe enough and more work needs to be done.

(Download the survey report from www.kff.org.) ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Maryland unveils malpractice bill

ANNAPOLIS, MD—The Ehrlich administration released in December an executive summary of its bill aimed at averting Maryland's medical-malpractice insurance crisis.

The bill was the focus of a special legislative session on the issue. It called for disciplining lawyers who file frivolous cases under a new three strikes law and for allowing health care providers the right to apologize without it being considered an admission of guilt in a malpractice case.

A key provision in the bill would create a stop-loss fund that would cover a 33% increase in doctors' malpractice-insurance premiums for three years.

The stop-loss fund has been a point of contention between Gov. Robert L. Ehrlich Jr., who is a Republican, and Democratic legislative leaders.

Senate President Thomas V. Mike Miller Jr. and House Speaker Michael E. Busch, both Democrats, favored lifting a tax credit for HMOs, which they estimated would generate up to $70 million to cover the higher insurance premiums.

—*Washington Post,* Dec. 23, 2004