State of California

Department of Consumer Affairs

Medical Board of California

AGENDA ITEM 3

July 1, 2008

To: **Members,**
Task Force on Medical Errors

From: **Janie Cordray, Research Director**

Subject: **Who is addressing medical errors?**

At the January meeting, members voiced their interest in knowing about what types of medical error reduction initiatives were being conducted within California and in other states.

Laws of Interest:

Federal law:

In response to the Institute of Medicine report "To Err is Human," after several sessions and political wrangling, **The Patient Safety and Quality Improvement Act** was signed into law in 2005. The **Health & Human Services Agency for Healthcare Research and Quality,** however has been slow to promulgate regulations, which were not adopted until May of this year.

In summary, the law establishes a confidential reporting system that hospitals, physicians, and other healthcare practitioners may report errors to Patient Safety Organizations (PSOs) so that data may be collected and analyzed to develop system improvements and best practices for the prevention of future events. The system is entirely voluntary at this time. The data is confidential and protected from use in civil, criminal, or administrative proceedings. To become an effective source of information it is likely that incentives will need to be established in the future to encourage participation, such as requiring participation for reimbursement of services.

Now that there are regulations in place, the many organizations that have been working to create PSOs can start participating in the program by acting as a repository for error reports, and to begin analyzing and providing feedback to the providers.

A summary of S 544 is attached. The complete law can be downloaded at:

http://thomas.loc.gov/cgi-bin/query/D?c109:4:./temp/~c109UU35jr::

California law: SB 1301 (Alquist, Chap. 647, Stats. 2006) and
SB 1312 (Alquist, Chap. 894, Stats. 2006)

SB 1301 & SB 1312 increase the authority and responsibility of California's Department of Public Health (CDPH) relating to health care facilities and inspections and public disclosure.

A speaker from CDPH Licensing and Certification Branch is scheduled to make a short presentation at the July 24, 2008 Task Force meeting about these laws, and will provide a more complete explanation. In summary, SB 1301 requires hospitals, including general acute, psychiatric and special hospitals, to report adverse events within 5 days, or in cases involving urgent or emergent threats, within 24 hours. It requires CDPH to make an onsite inspection or initiate an investigation of the event within 48 hours or two business days if an event indicates an ongoing threat or imminent danger of death or harm. Information on the reports must also be posted on the CDPH Web site. (http://www.cdph.ca.gov)

SB 1312 contains similar requirements for long-term care facilities that are certified for Medicare and Medicaid programs. These facilities must meet the federal and state standards, and eliminated the exemption from periodic inspections. The law further authorized the assessing of administrative penalties for hospitals.

The Federation of State Medical Boards conducted a survey of what is being done in the states, including legislation. The results of the survey, along with their information on laws and bills related to medical error reduction are attached. (Their information is somewhat outdated, and does not include updated information on California, such as the Alquist legislation.)

Medical Error Reduction Programs and Initiatives:

The United States Department of Veterans Affairs established the National Center for Patient Safety in 1999 to address medical errors in their facilities. They established policy and protocols for their facilities, and their site offers summaries, toolkits, and other helpful materials. Their Web site is: http://www.patientsafety.gov/

The Institute for Healthcare Improvement has numerous programs, policies, and tools for quality improvement, including medical error reductions. One very useful paper is "Global Trigger Tool for Measuring Adverse Events." The full document (44 Pages), after registering, can be accessed on their Web site:

http://www.ihi.org/NR/rdonlyres/B277159C-60D4-4EFD-BF2A-B9FB62CAAA4A/0/IHIGlobalTriggerToolWhitePaper2007.pdf

The Institute for Healthcare Improvement has been involved in medical error reduction programs and initiatives for years. They have a Web site, including a manual that includes measures, changes, improvement stories, tools, resources and various articles and literature on the subject. The "Patient Safety" materials may be accessed at:

http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/

The Institute also initiated the "**100,000 Lives Campaign**" to reduce hospital deaths. The Campaign has now been renamed the "**5 Million Lives Campaign.**" Their stated purpose "is a voluntary initiative to protect patients from five million incidents of medical harm over the next two years." (December 2006 – 2008) The California Hospital Association and Lumetra are coordinating the California "node" of this campaign, as well as support from the **California Institute for Health Systems Performance (CIHSP)**. UCLA, UCSF, VA, Kaiser Permanente, Mercy and Sutter hospitals in California are participants, as well as a number of California healthcare systems. A complete hospital list is attached.

Their Web site is extensive, and includes a significant amount of information about their program, the participants, and tools to attack the problem of preventable errors. All of that information can be accessed at:

http://www.ihi.org/IHI/Programs/Campaign/

Joint Commission has published its 2008 Hospital National Patient Safety Goals, which is attached. They also have the **Joint Commission International Center for Patient Safety**, which includes a database of common errors, their causes and remedies. It can be viewed at:

http://www.jcipatientsafety.org/22782/

Institute for Safe Medication Practices is a nonprofit organization and a comprehensive source of information about various medication errors, as well as systems to prevent them. They also have a medication errors reporting program that is operated by **U.S. Pharmacopeia** in cooperation with the Institute. The reporting program information is attached. Their Web site is: www.ismp.org, where you can find numerous reports and publications.

National Quality Forum is a private, non-profit organization with a mission to develop and implement strategies for healthcare quality improvement and reporting. They have developed a number of consensus standards, performance measurement guidance, safe practices documents, etc. Their "National Voluntary Consensus Standards for the Reporting of Healthcare-Associated Infection Data" is on their site, and can be downloaded at:

http://www.qualityforum.org/pdf/reports/HAI%20Report.pdf

They also have published a list of 27 preventable adverse events, which is attached.

The Federal Drug Administration (FDA) has published a report on medication errors. They worked with the data gathered by the **Institute for Safe Medication Practices** program, explained above, as well as information and practices from the **American Hospital Association**. The report can be downloaded at:

http://www.fda.gov/cder/drug/MedErrors/default.htm

CalHospitalCompare.org is a tool for consumers to assess their choices of hospitals. The website is a result of work by the **California Health Care Foundation, UC San Francisco Institute for Health Policy Studies,** and the **California Hospital Assessment and Reporting Taskforce (CHART)**. The site allows consumers to enter a zip code, city or county, and obtain a list of hospitals on which they can check to compare ratings on things such as

critical care mortality rate, rate of infections from surgery, heart attack care, and so forth. Hospital participation is voluntary.

The SCR 49 Medication Errors Panel has completed their work in compliance with SCR 49, authored by Senator Jackie Speier in 2005. Lorie Rice, a former Medical Board member, was a member of the panel and has furnished a copy of their Executive Summary and full report, entitled "Prescription for Improving Patient Safety: Addressing Medication Errors." The Executive Summary is attached. Ms. Rice is scheduled to make a short presentation about their work at the July 24, 2008 Task Force meeting.

California Health & Human Services: Following the publication of the SCR 49 report, HHS Secretary Kim Belshe announced that the concepts contained in the report would become part of the Governor's health care proposal. (News release attached.)

California Department of Public Health requires that for hospitals to be eligible for Small Rural Hospital Improvement Program Grants, or SHIP Grants, they must implement quality improvement strategies to reduce medical errors.

California Department of Public Health, Licensing & Certification, published a "Patient Safety Manual," (81 Pages), which can be downloaded at:

http://www.dhs.ca.gov/lnc/download/PSPM/PatientSafetyProgramManual12-12-2005.pdf

As mentioned above, The CDPH, Licensing & Certification Program is in the process of implementing SB 1301 (Alquist, Chap. 647, Stats. 2006) and SB 1312 (Alquist, Chap. 894, Stats. 2006). Their Web site provides useful information for consumers, including:

- the Health Facilities Consumer Information System on certified long-term care facilities and hospitals in California: http://hfcis.cdph.ca.gov/default.aspx
- Hospital Administrative Penalties: http://www.cdph.ca.gov/certlic/facilities/Pages/Counties.aspx
- Nursing Home Citations: http://www.cdph.ca.gov/certlic/facilities/Pages/AACounties.aspx
- Nursing Home Compare: http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp?version=default&browser=IE%7C7%7CWinXP

&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True

- Hospital Compare: http://www.hospitalcompare.hhs.gov/Hospital/Search/Welcome.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home

SAFER: Strategic Alliance for Error Reduction has been operating out of UCLA, and was established to address safety issues for the UC system. SAFER will move forward to initiate PSOs to gather error data for analysis once the Federal regulations become effective. Their website is:

http://www.safer.healthcare.ucla.edu/default.htm

Sorry Works! is a nonprofit coalition founded on the belief that the medical malpractice crisis is "a customer service crisis – not a legal problem – that can be solved anytime by medical, insurance, and legal professionals." It provides teaching and training tools to help healthcare and insurance programs develop disclosure programs. Sorry Works! made a presentation to the Board in 2006. The Sorry Work! Coalition's Web site is:

www.sorryworks.net

Collaborative Practice California is "an organization of collaborative groups throughout the State of California" with the goal in assisting with dispute resolution using the collaborative process. (Web site: www.cpcal.com) One of their members, attorney Kathleen Anne Clark, has written the Board to offer to contribute to the members' dialogue on medical errors. Her letter is attached, as well as articles she has written, including, "The Use of Collaborative Law in Medical Error Situations."

California Medical Association: As Dr. James Hay mentioned at the February meeting of the task force, the CMA has developed a number of useful materials. Attached is "A Physician's Guide to Tracking and Communicating Test Results," "Taking an Active Role in Your Healthcare," and "Safe Medication Principles."

The California Patient Safety Action Coalition (CAPSAC), is an organization of members from the healthcare industry with the goal to address medical errors through reporting and analysis and instituting a change of culture within the medical community. Their organization is developing initiatives based on "Just Culture" to encourage a change of culture and behavior in medical settings to improve patient safety. Their Web site is

www.capsac.org. (Materials from their site are attached.) The Task Force may schedule a representative to speak at one of its future meetings. (Dr. Keats, president of CAPSAC, addressed the task force during "public comment" at the May meeting.)

Attachments*:

- Summary of S. 544
- FSMB Medical Error & Patient Safety Legislative Activity by State
- US Department of Veterans Affairs; National Center for Patient Safety – Culture Change: Prevention, Not Punishment
- Institute for Healthcare Improvement: IHI Global Trigger Tool for Measuring Adverse Events
- Journal on Quality and Patient Safety; *The 100,000 Lives Campaign: A Scientific and Policy Review*, by Drs. Robert M. Wachter and peter J. Pronovost (November 2006)
- IHI.org: Protecting 5 Million Lives from Harm
- Joint Commission: 2008 National patient Safety Goals for Hospitals
- Institute for Safe medication Practices: USP-ISMP Medication Errors Reporting Program
- The National Quality Forum; Serious Reportable Events in healthcare: 2005-2006 Update
- CalHospitalCompare.org
- Executive Summary: Prescription for Improving Patient Safety: Addressing medication Errors – The Medication Errors Panel Report pursuant to California Senate Concurrent Resolution 49
- Press Release: Office of the governor: Statement from Health & Human Services Secretary Kim Belshe Regarding Efforts to Reduce Medical Errors
- SorryWorks! Coalition
- Letter: To Cesar Aristeiguieta, M.D from attorney Kathleen Anne Clark, relating to Collaborative Practice California, including her article, "The Use of Collaborative Law in Medical Error Situations" published in *The Health Lawyer* (June 2007)
- California Patient Safety Action Coalition (CAPSAC) materials from www.capsac.org.

*To save paper, links to websites have been included rather than the entire documents (some are over 100 pages). Full documents are available upon request.

Also included:

- Article from **Duke University Medical Center & Health System** entitled *Who Are the Patient Safety Advocates in Your Unit?* part of their interdisciplinary, integrated patient safety and clinical quality program;
- Article from the **Hospital Association of Southern California**, *California Hospital Quality Initiative: Reducing Serious Events*, and;
- Article, *Bringing Hospital Infections Down to Zero*, about the **Maryland Health Care Commission** and their **Patient Safety Center** program to address hospital infections.

ADDITIONAL MATERIAL FOR AGENDA ITEM #3 WILL BE FORWARDED UNDER SEPARATE COVER