Legislative Analysis

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

SAFE HEALTH CARE

House Bill 6683
Sponsor: Rep. David Farhat

House Bill 6684
Sponsor: Rep. Bruce Caswell

House Bill 6685
Sponsor: Rep. Carl Williams

House Bill 6686
Sponsor: Rep. Alma Wheeler Smith

Committee: Senior Health, Security, and Retirement
Complete to 12-4-06

A SUMMARY OF HOUSE BILLS 6683-6686 AS INTRODUCED 11-30-06

BRIEF SUMMARY:

House Bill 6683 would amend the Public Health Code to create a new Part 25a, to be known as the Michigan Adverse Health Care Events Reporting Act, to require the Department of Community Health, in cooperation with the Michigan Center for Safe Health Care, to establish an adverse health care event reporting program to facilitate quality improvement through communication and collaboration between the department, the center, health care professionals, and health care facilities. The reporting program could not be designed or used to punish errors or to investigate or take disciplinary action against health care facilities or health care professionals. The bill is tie-barred to House Bill 6684.

House Bill 6684 would create a new act to be known as the Michigan Center for Safe Health Care Act. Under the bill, the Michigan Center for Safe Health Care would be created and appointed by the Governor before May 31, 2007. (However, the governor could choose to designate an existing organization to act as the center.) The Center would be designed to provide statewide leadership, information, and training and advocacy for improving patient safety; to create a safer health care environment; and to reduce patient harm.

House Bill 6685 would amend the new Part 25a of the Public Health Code to require the DCH, in consultation with the Center for Safe Health Care, to develop standardized data collection tools and methods in regard to the reporting of patient safety performance data, in order to provide consistency in the reporting, utilization, and evaluation of data provided under the Adverse Health Care Reporting Program. The bill is tie-barred to House Bill 6683.

House Bill 6686 would amend the new part 25a of the Public Health Code on adverse event health care reporting to specify that patient safety work product and other records would be privileged and confidential and not available to the public; not discoverable or admissible in any civil, criminal, or administrative proceeding against a health care professional; and not subject to the Freedom of Information Act. No report or disclosure could contain information identifying a patient, employee, or health care professional. Patient safety activities would be considered health care operations and treated as such in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA). Under no

circumstances could the DCH or the Center disclose information obtained from a health care professional or facility that is confidential or protected under existing state or federal law.

FISCAL IMPACT:

House Bills 6683, 6684, and 6685 have fiscal implications for state government. House Bill 6686 does not have fiscal implications. Depending upon the success of the proposed programs, over the long term there may be state savings for health care costs of state employees and Medicaid participants as a result of the bills, due to a reduced number of preventable adverse health care events and related costs.

House Bill 6683 establishes the Adverse Health Care Event Reporting Program under the Department of Community Health (DCH). DCH will incur costs to setup and operate this program, including report receipt, collection, analysis, plan for correction, and distribution of information and findings to licensed or registered health professions and health facilities. The volume of participation will affect the cost of the program. The bill does not establish any new funding to support the costs of the program.

House Bill 6684 requires the Governor to establish a state Center for Safe Health Care, which shall not be a governmental entity. The bill states that the Center shall receive assistance from governmental entities necessary to properly carry out its powers, and requires the Center to submit a 5-year financial analysis of costs to the Governor and Legislature, although the bill does not establish any absolute state funding for the Center. The bill does require the creation and establishment of a new state fund, the Michigan Patient Safety Fund, and allows for the deposit of funds from any source into the Fund which may be expended by DCH to support certain activities of the Center for Safe Health Care. Treasury, DMB, and DCH will incur modest costs related to the administration of the Fund, including revenue receipt, investment, expenditures, and accounting. The bill does not otherwise establish a revenue source or appropriation for the Fund.

The requirements of House Bill 6685 to standardize certain program data collection may create additional costs for DCH.

DETAILED SUMMARY:

Following is a more detailed summary of House Bills 6683 and 6684.

House Bill 6683

House Bill 6683 would amend the Public Health Code to create a new act, the Michigan Adverse Health Care Events Reporting Act, to require the Department of Community Health, in cooperation with the Michigan Center for Safe Health Care, to establish an adverse health care event reporting program to facilitate quality improvement through communication and collaboration between the department, the Center, health care professionals, and health care facilities. The reporting program could not be designed or used to punish errors or to investigate or take disciplinary action against health care facilities or health care professionals. The department could not use the adverse health care event reports, near misses, findings or root causes analyses, and corrective action plans for any purpose not stated in the bill. The bill is tie-barred to House Bill 6684.

Under the bill, the reporting program would be voluntary and consist of the following:

- Reporting by participants of serious adverse health care events, near misses, root causes analysis of serious adverse health care events, corrective action plans established to prevent similar serious adverse health care events, and patient safety plans establishing procedures and protocols.

- Compiling, aggregating, and analyzing the reported information by the DCH, in cooperation with the Center, to determine patterns of systemic failure in the health care system and successful methods to correct these failures and to develop and disseminate information to improve the quality of care to patient safety.

- Providing technical assistance to participants, including recommendations and advice regarding methodology, communication, dissemination of information, data collection, security and confidentiality.

- Disseminating aggregated findings to participants and to the public in a timely and useful format in a manner that protects the confidentiality of the participants and identifies potential issues and appropriate solutions to achieve patient safety.
- Creating incentives to improve and reward participation in the reporting of adverse health care events.

Within three years after the effective date of the bill, the department, in cooperation with the Center, would be required to report to the legislature on the implementation and effectiveness of this reporting program.

Under the bill, the following terms would be defined as follows:

"Adverse Health Care Event": an objective and definable negative consequence of patient care, or the risk thereof, that is unanticipated, usually preventable, and results in, or presents a significant risk of, patient death or serious physical injury.

"Near Miss": a situation that could have resulted in an adverse health care event but did not either by chance or through timely intervention.

"Patient Safety Work Product": any data, reports, records, memoranda, analyses, or written or oral statements assembled or developed by a health care professional for reporting to the program. It would not include a patient's medical record, billing and discharge information, or any other original patient or health care professional record.

House Bill 6684

House Bill 6684 would create a new act to be known as the Michigan Center for Safe Health Care Act. Under the bill, the Michigan Center for Safe Health Care would be created and appointed by the Governor before May 31, 2007. However, the Governor could choose to designate an existing organization to act as the center.

Michigan Center for Safe Health Care. The center would be designed to provide statewide leadership, information, and training and advocacy for improving patient safety; to create a safer health care environment; and to reduce patient harm. If the Governor created a new

center, it would have to consist of seven members and be a nonprofit charitable 501 (c) (3) organization. Whether a new or existing organization, the Center would have to:

- Represent a wide variety of health care stakeholders, including but not limited to people with education, experience, and expertise in patient safety as well as health and human services. At a minimum, it would have to include health care consumers; the Michigan professional organizations for osteopathic and allopathic physicians, nurses, pharmacists, hospitals, and health plans; employers, labor groups, and other health care payers; the Michigan Department of Community Health; and any other individuals reflecting the center's scope of work.

- be capable of providing a balanced, unbiased, non-punitive environment in which to accomplish the center's mission.

- not be a governmental entity.

- be independent of any individual health care provider or professional organization, subsidiary, or collective.

Under the bill, the center would have to be certified as a patient safety organization under section 924 of the federal Patient Safety and Quality Improvement Act of 2005.

The Center's Duties. The bill specifies that the center must do all of the following:

- Perform patient safety activities.

- Coordinate the implementation of recommendations offered by the State Commission on Patient Safety that are included in the commission's final report to the Governor dated November 2005. This would have to include at a minimum each of the following: 1) cultivate collaborative relationships to solve complex patient safety problems; 2) promote active involvement of consumers, patients, and families in the structure and process of safe health care; 3) coordinate public educational efforts with programs targeting clinicians; 4) facilitate the systematic identification of practices and environments that result in patient harm; 5) collect and disseminate information and tools to accelerate improvement; 6) provide connections to expertise and technical assistance; 7) monitor the effects of patient safety improvement efforts and promote progress to the public; 8) shape public policy designed to encourage the adoption of patient safety practice by health care organizations and professionals; and 9) coordinate state level advocacy at the national level.

- Collect, coordinate, analyze, and maintain all patient safety work product received from the regional centers for safe health care in the state.

The bill specifies that governmental entities in Michigan must assist the Center with the data necessary to properly carry out its responsibilities.

The Center's Annual Report. The Center would be required to submit to the Governor and to the legislature an annual report on the center's work in the previous year, and a plan of work for the upcoming year. Every four years, the Governor would be required to conduct a

review of the Center's progress in meeting its duties, and then decide whether to reappoint or re-designate the current group or appoint a new one.

The Michigan Patient Safety Fund. Under the bill, a Michigan Patient Safety Fund would be created in the state treasury. The state treasurer could receive money or other assets from any source for deposit into the fund, excepting those that committed state funds or placed an obligation upon the state or Legislature to continue the purposes for which the money or assets were made available. (Nonetheless, a donor could stipulate the manner in which a donation would be expended, as long as the request was within the purposes described for the Center in this legislation.) The treasurer would direct the investment of the fund, crediting to it all interest and earnings from fund investments. Money in the fund at the close of the fiscal year would remain there and not lapse to the general fund. The Department of Community Health could expend money from the fund, upon appropriation, only for one or more of the following: 1) to provide support for the patient safety activities of the center, and 2) to implement the recommendations included in the commission's final report of the State Commission on Patient Safety dated November 2005.

Definitions. The bill defines "patient safety activities" to mean any of the following:

** Efforts to improve patient safety and the quality of health care delivery.
** The collection and analysis of patient safety work product.
** The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices.
** The utilization of patient safety work product for the purposes of encouraging a culture of safety and of providing feedback and assistance to effectively minimize patient risk.
** The maintenance of procedures to preserve confidentiality with respect to patient safety work product.
** The provision of appropriate security measures with respect to patient safety work product.
** The utilization of qualified staff.
** Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.

Legislative Analyst: E. Best
J. Hunault
Fiscal Analyst: Susan Frey