REPORT ON MEDICAL ERRORS AND MEDCIAL INJURY COMPENSATION

EXECUTIVE SUMMARY
AND
ACTION STATEMENTS

1. The National Quality Forum (NQF) has created a national strategy for health care quality measurement and reporting through the development of the List of Serious Reportable Events. (Page 5) Adopting this list of designated events will make it possible for Wyoming to compare data and identify trends across systems, states, regions and the nation. Wyoming has taken this important step by passing W.S. §35-2-912(2005), utilizing the National Quality Forum's List of Serious Reportable Events. (Page 17)

- **ACTION STATEMENT:** Monitor on-going research in the area of patient safety to ensure Wyoming's reporting system tracks adverse events that are shown by research to significantly impact patient safety. Monitor revisions to the List of Serious Reportable Events to ensure Wyoming's reporting system reflects the most recent changes and information relevant to this system.

2. Defining what constitutes a reportable event requires detailed definitions to ensure uniformity. W.S. §35-2-912(2005), as it now stands, provides the reporter with too much discretion in interpreting terms. (Page 17) To eliminate the potential for varied construction, Wyoming should adopt, either by statute or rule, the NQF definitions associated with List of Serious Reportable Events. (See Appendix B)

- **ACTION STATEMENT:** Adopt the NQF definitions associated with the List of Serious Reportable Events.

3. W.S. §35-2-912 is designed as a method to gather data on frequency and type of errors in Wyoming healthcare facilities. The statute only requires the data to be reported in aggregate fashion and makes no provision to use the reported information to improve healthcare systems or share lessons learned with other healthcare facilities in order to prevent a similar occurrence at other locations. No root cause analysis of events is required, nor evidence that the facility took any action to improve the error prone system to prevent recurrence. A stronger system would include requirements for facilities to analyze events and take corrective action, as well as providing this information to other facilities to avoid similar errors. (Page 17-21)

- **ACTION STATEMENT:** Continually promote error analysis and corrective action within reporting institutions. Establish distribution of "lessons learned" from error reporting and corrective measures.

4. Certification as a patient safety organization under the Federal Patient Safety and

Quality Improvement Act of 2005 may enable Wyoming to participate in a national databank of error reporting information and may provide additional discovery protection for patient safety work product, including analysis of medical errors. If certified, Wyoming would be required to conform its reporting practices to any national standards that may be set. Wyoming should investigate certification under the Federal Patient Safety and Quality Improvement Act of 2005, including whether Wyoming's current safety reporting statute would permit Wyoming to be certified or would require further state legislation. (Page 21-22)

- **ACTION STATEMENT:** Determine the benefits and burdens encompassed by pursuing certification under the Federal Patient Safety and Quality Improvement Act of 2005.

5. W.S. §35-2-912 authorizes the Wyoming Department of Health to collect adverse event data from healthcare facilities. A better approach would be to empower an independent commission to perform this function, as well as act on the information received to improve patient safety in Wyoming's health care facilities. This independent commission should include front line practitioners, employers and health care consumers in the creation of the reporting system and identify content experts, within and outside the commission, to make correction and prevention recommendations to reporting facilities. An appointed independent commission which is authorized to require system changes and monitor results will allow prevention efforts to emerge from error tracking and address issues of accountability. The Pennsylvania Patient Safety Authority provides one example of an independent commission charged with being a knowledge broker of patient safety and prevention information, as well as determining the feasibility and cost to stakeholders of recommendations for change. Allowing practitioners, employers and health care consumers to participate in the important work of event reporting and patient safety will promote buy in from those most directly affected by these efforts. Specific duties should be identified for an independent commission engaged in the work of patient safety by reviewing states and countries with existing models to determine the potential make up of a Wyoming independent commission. (Page 17-21)

- **ACTION STATEMENT:** Determine preferred size, method of appointment and make up of an independent commission by reviewing commissions established in other states and countries. Engage stakeholder participation on an independent commission to collect data on adverse events and recommend practice improvements based on review and analysis of data.

6. W.S. §35-2-912 does not identify any individual involved in the error, which should encourage providers to report. Anonymous reporting and de-identified data offer protection against discovery but limit the ability of regulators to identify and analyze clusters of injuries at particular hospitals or healthcare facilities. (Page 13-16) With no provision for feedback to licensing boards or

agencies for either individuals or facilities involved, there is no accountability for prevention or error reduction. It appears no mix of mandatory/voluntary and public/confidential features can avoid trading off important interests of patients against those of providers. By enacting W.S. §5-2-912, the state has opted to forego disclosure in order to promote reporting. (Page 17) However, the state must realize that healthcare consumers believe error information should be available. Realizing this conflict exits, the Wyoming legislature or independent commission should at least strive to promote error prevention at every opportunity. Encouraging adoption of nationally recognized prevention campaigns, such as the Institute of Healthcare Improvement's 100,000 Lives Campaign, would begin to move prevention initiatives forward. (Page 23)

- **ACTION STATEMENT:** Encourage healthcare facilities to adopt prevention initiatives, such as the Institute of Healthcare Improvement's 100,000 Lives Campaign. Begin dialogue with licensing boards on error accountability.

7. Error reporting is not the same as peer review and provisions to protect peer review information from legal discovery may not protect those involved in error reporting. Error reporting will not occur, even if it is mandated, unless reporters know information will be safe from discovery. Statutes to specifically protect error reporting activities from discovery should be considered by the legislature. (Page 14-15) Encouraging reporting through legal protections should be balanced by sanctions for facilities that fail to report errors.

- **ACTION STATEMENT:** Review Wyoming statutes to determine discovery protections for error reporting and activities associated with reporting, such as error analysis or remediation measures. To assist in drafting legislation for discovery protection of Wyoming's reporting activities, review statutes and case law of established state adverse event reporting systems to determine court interpretation of discovery protections. Explore sanctions for facilities which fail to report errors under Wyoming's reporting statute, W.S. §35-2-912. Determine the applicability of protections under the Federal Patient Safety and Quality Improvement Act.

8. Technology applications, such as electronic medical record systems, may assist in reducing medical error. However, automating data will be of limited use if the information available from paper records is not first standardized. Only then will meaningful comparisons of electronic data be made within and across systems in the state as well as even regionally and nationally. Standardized record keeping should be mandated to facilitate accurate tracking of errors, keeping in mind state standards must eventually correspond with any national standards developed. (Page 8)

- **ACTION STATEMENT:** Support an independent commission of

stakeholders, such as the newly formed Wyoming Health Information Organization (WYHIO), to develop a standard medical record keeping system and require adoption by healthcare providers and facilities, being cognizant of national standards that may be developed in this area.

9. If medical error reporting is to become routine, it must have cultural acceptance in the health care community and reporters must feel safe to do so. Placing blame and shame on individuals instead of focusing on system issues for improvement will discourage reporting and may encourage cover-ups. It may also have the effect of elevating patient risk, if providers increase defensive medicine practices, thereby exposing patients to more procedures because it is legally, rather than medically, prudent to do so. Efforts should be supported for healthcare providers and healthcare facilities to make patient safety a priority, commit to replace systems that are not functional and institute interdisciplinary training to strengthen the healthcare team. Investigating techniques that have been successful in other industries, such as crew resource management, may determine potential application for Wyoming's healthcare community. (Page 24-25)

- **ACTION STATEMENT:** Make patient safety a priority of Wyoming's healthcare community through state support of education and training of administrators, providers and healthcare workers on patient safety issues.

10. The Wyoming Board of Medicine and hospital facilities should be encouraged to adopt regulations requiring physicians to participate in annual continuing medical education (CME) devoted to patient safety initiatives, design and application. (Page 26)

- **ACTION STATEMENT:** Require the Wyoming Board of Medicine and hospital facilities to mandate that providers acquire annual CME in patient safety initiatives, design, application and interdisciplinary training.

11. Patients injured by medical error or negligence want to know what happened, not because they want to blame the physician, but in order to understand their future treatment needs and to know the same mistake does not happen to others. Patients want to receive an apology from their physician and physicians would like to be able to offer an apology without fear of litigation. Wyoming's "I'm Sorry" legislation, W.S. §1-1-130 (2005), provides legal protection for providers who extend an expression of apology to a patient. Training for physicians and health care providers in use of tools provided in the "I'm Sorry" legislation, as well as training on the importance of open disclosure to patients should be authorized and supported. (Page 15-16)

- **ACTION STATEMENT:** Develop and support awareness campaigns on the elements and protections extended to Wyoming healthcare providers under W.S. §1-1-130(2005). Support the development of provider communication skills in the patient setting.

12. As consumer-directed healthcare programs grow, consumers will demand cost and quality data for potential sources of care in order to choose services that provide the most value for the resources expended, which is likely to increase demand for information on patient safety as well. Consumer access to information should be paired with patient education to help patients interpret what the data do and do not mean, and define the patient's role in reducing medical errors, ensuring safe care. (Page 26)

- **ACTION STATEMENT:** Empower an independent commission to support educational efforts to promote the patient's role in the safe delivery of medical care and understanding adverse event data.

13. At this time, not much is known about appropriate interventions to prevent medical errors. Avenues for intervention and prevention of medical errors need to be defined through on-going research that examines the epidemiology of error. Wyoming must stay abreast of these issues as they are identified in national research literature. Evidence-based patient safety interventions should be reviewed along with the cost-effectiveness of regulations promoting patient safety with the effects of pluralistic regulations on healthcare providers and facilities. Wyoming must work towards providing healthcare institutions with a variety of cost-effective interventions for implementation. (Page 28-29)

- **ACTION STATEMENT:** Empower an independent commission to continuously review evidence-based patient safety interventions to determine clinical effectiveness as well as cost-effectiveness in avoiding adverse events and following review, promote specific interventions for implementation.

14. Methods to motivate providers should be studied to encourage changes in their current practices to promote patient safety; determine constraints in implementing safety practices; identify where opportunities lie to implement patient safety practices; determine how best to inform the healthcare industry about safety issues; and how healthcare stakeholders can work together in consultation and collaboration on patient safety issues. (Page 27-28)

- **ACTION STATEMENT:** Conduct a survey of healthcare providers and facilities to determine current barriers to implementing patient safety practices. Convene a meeting of healthcare providers and stakeholders to identify methods to overcome barriers and create collaborations to promote patient safety.

15. Healthcare providers and facilities should be offered incentives and assistance to establish a business case for patient safety efforts by identifying and promoting evidence-based, cost-effective patient safety interventions. Employers, insurers and consumers valuing safety driven care will then be better able to support the

efforts of healthcare facilities and providers who can demonstrate a commitment to these shared values. (Page 27-28; 58-59)

- **ACTION STATEMENT:** Investigate healthcare facilities with established business case models promoting patient safety. Empower an independent commission to develop a model business case to assist healthcare facilities to establish this approach to supporting patient safety. Determine and provide the level and extent of assistance needed by Wyoming healthcare facilities to create a business case to support patient safety efforts. Empower an independent commission to work with employers, insurers and consumer groups to support healthcare facilities and providers who demonstrate a commitment to patient safety.

16. A system that compensates patients for avoidable injuries that can be readily defined and identified, known as accelerated compensation events, may provide a remedy for more individuals than those currently compensated through the tort litigation system. An administrative compensation system demonstration or pilot project should be supported with enabling legislation to permit organizations to experiment with these models on a limited basis. These efforts could follow Senator Enzi's proposed federal legislation. (Page 36-44)

- **ACTION STATEMENT:** Legislation enabling entities to develop demonstration or pilot projects to compensate patients for well defined and readily identifiable errors or adverse events should be passed by the Wyoming Legislature.

17. Certain medical specialties may experience greater frequency of malpractice claims, or involve procedures that permit errors to be more readily identified and categorized. These medical treatment areas offer potential for experimentation with administrative compensation systems (ACS). Data from the Wyoming Insurance Commissioner will assist in determining which specialty might benefit by using an administrative compensation system for claim determination and payment. Experts in the medical specialty area selected would be helpful in determining a discrete set of medical injuries for which an ACS could be designed. (Page 36-44)

- **ACTION STATEMENT:** Review and analyze claims data from the Wyoming Insurance Commissioner to identify medical practice areas experiencing high rates of malpractice claims. Identify and define a discrete set of medical injuries eligible for compensation through an administrative compensation system.

18. Enterprise liability makes the organizational unit ultimately responsible for efficient health care delivery, such as a hospital or physician group practice, should also share the financial risk for medical errors, in order to take appropriate steps when designing patient safety systems that eliminate error and establish

prevention measures. With a financial stake in patient safety, healthcare institutions will also become more cautious in designing and implementing cost-containment policies. The application of enterprise liability in Wyoming to facilitate medical error prevention and buy-in from healthcare institutions should be supported. (Page 57-58)

- **ACTION STATEMENT:** The Wyoming Legislature should support research to identify the potential costs and benefits of implementing enterprise liability in Wyoming, including direct effects on patient safety.