http://www.seattlepi.com/local/427528_medicalerror29.html

Lawmaker: State's medical-error reporting needs upgrade

Seattlepi.com story detailed flaws in system

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HEARST NEWSPAPERS

Legislation to upgrade Washington's medical-error reporting program will be introduced in January in response to a seattlepi.com story that showed problems with the current system, a prominent state lawmaker says.

Included in the bill will be the imposition of a nominal fee on medical facilities to pay for a program that works, said State Sen. Karen Keiser, D-Des Moines, chair of the Senate Health & Long-Term Care Committee.

"We are certainly willing to explore the idea but we need to see the details," said Cassie Sauer, spokeswoman for the Washington State Hospital Association, a non-profit trade group. "We would want to see what the fee level is, exactly how the money would be used, and how patient safety would improve as a result."

The money from the fee would go to a research effort - an analysis of medical-error reports - so that hospitals and other facilities statewide can learn from each other's deadly mistakes, Keiser said. The goal is to produce a system equivalent to Pennsylvania's, thought by many experts to be among the best in the country. Sauer and others at the hospital association have long criticized Washington's program for its lack of research money and feedback to hospitals.

Keiser said she was "dismayed" by the findings in the seattlepi.com reporting, but added, "I'm sad to say I wasn't surprised."

Though Washington is one of 27 states that require hospitals to report medical errors, research shows the state is hearing about only a fraction of them. Studies by a major Utah hospital chain show that there should be at least 2,200 reports submitted annually in Washington. That's based on the requirements in Washington's reporting law.

Last year, only 198 reports were turned in statewide (Click here for a database).

Moreover, the rules laying out which incidents must be reported make it easy for hospitals to determine that an event isn't a "reportable error." There are numerous loopholes in the definitions the state uses for the 28 types of "adverse events" that must be reported. Also, there is no enforcement of the reporting requirements. And Washington's program is among the worst funded in the country.

More money needed

Without proper financing, the state Department of Health does little or nothing to perform any research on the medical-error reports that are submitted by hospitals.

In states like Pennsylvania and Minnesota -- where there is a fee on hospitals to pay for it -- the incoming reports are analyzed and hospitals get feedback that assists them in correcting the problems that killed or injured patients. Those states also hire consultants to do the research and work with local hospital associations to spread the lessons learned.

Pennsylvania spends $5 million a year on a program that casts a far wider net than Washington does in capturing reports of medical errors. Minnesota spends $410,000 a year on a well-respected program that has reporting requirements similar to Washington's. Washington spends $127,000 a year, and is considering cuts.

In 2006, Washington's reporting law required the department to hire a contractor to analyze medical error data with money from the state general fund. But when bids were sought, the lowest proffer was far higher than the money the Legislature authorized; a contractor was never hired.

Keiser noted the state faces huge deficits, which is why a fee on medical facilities would be necessary. In other states, fees are based on the number of beds in a hospital or the number of procedures performed at ambulatory surgery centers. The facilities that are required to report adverse events in Washington include 93 hospitals, three psychiatric hospitals, six state Department of Corrections medical facilities, 12 birthing centers and, starting last January, 162 ambulatory surgery facilities.

Medical error deaths exceed automobile deaths every year. More Americans die each month because of preventable medical injuries than died in the terrorist attacks of Sept. 11, 2001, according to federal research. Nationally, harm occurs 15 million times a year, according to estimates by the Institute for Healthcare Improvement, including about 200,000 deaths caused by avoidable mistakes and hospital-acquired infections.

The goal of a redesigned Washington State medical-error reporting system would be "to not have them happen again," said Keiser.

State Sen. Cheryl Pflug, R-Maple Valley and the ranking Republican on Keiser's committee, said she is willing to consider the legislation Keiser is proposing and she is interested in the approaches taken in other states. Pflug said the Legislature must first redesign the state's program, and then provide it with money. A fee might be necessary, she said, but the Legislature might also consider "repurposing" money already in the Department of Health budget. The health department is currently targeted for further budget cuts.

Pflug said something must be done to compel hospitals to submit reports. Perhaps the definitions of reportable events need to be broadened to eliminate loopholes, she said.

The current law has ambiguities that seem to encourage non-reporting.

In a story published on Monday, seattlepi.com used as an example the death of a patient, Gary William Clezie, after routine arthroscopic shoulder surgery at Yakima Regional Medical & Cardiac Center in February 2009.

Though state investigators found Clezie died because of a failure by nurses to follow physician orders and to monitor his pain medication, Clezie's death was not reported to the health department's medical-

errors reporting program. Hospital officials decided his death didn't fit any of the state's definitions of an "adverse event", including a category called "medication error", according to the health department

State hospital licensing officials went along with the hospital's decision not to report it, according to a DOH spokesman. As a result, Yakima Regional has a clean record on the state's new public website that displays statistics on medical-error reporting. It has filed no reports since the program began in June 2006, according to the state's reporting website.

Pflug criticized both the hospital and the state for the handling of Clezie's case when it came to adverse-event reporting.

"To say that wasn't a medication error doesn't even pass the straight-face test," said Pflug, who is a registered nurse as well as a legislator. "Ask his doctor if he thinks it isn't a medical error. I am really disappointed that the health department went along with it."

Yakima Regional has declined to comment on Clezie's case, as has an attorney representing his family.

Yakima Regional CEO Rich Robinson made a statement by e-mail on Tuesday, in response to this week's story and Pflug's comment: "We support an atmosphere that fosters full transparency and maintains compliance with all laws and industry regulations, including reporting requirements, because ultimately we know that's in the best interest of our patients and caring for them is why we're here."

More reporting leads to fixes

Research shows public reporting of medical errors causes hospitals to take greater steps to fix problems, than if their mistakes are kept secret. But hospitals also experience downsides.

Seattle Children's Hospital recently told the state of the death of a "profoundly fragile" infant due to a medication error. A nurse gave the child 10 times the intended dose of a medication. The hospital also sent an e-mail to its staff about the incident last Wednesday, and posted it on an internal website on Thursday, describing the steps it has taken to prevent another accident. Hospital CEO Tom Hansen said in the email that the hospital had apologized to the family.

The law doesn't require some of the steps taken by Children's, including the apology to family members and the communications to hospital staff, but patient safety experts strongly endorse each one.

Health Department records show that hospitals around the state report medical-errors at very different rates. Prominent patient safety experts like Utah's Dr. Brent James and Pennsylvania's Dr. John Clarke say consumers should consider the possibility that the better hospitals are the ones that submit more adverse-event reports than others of a similar size, since they are probably doing more to prevent future errors.

"Those facilities that work hard to prevent recurrences are penalized by the current reporting system," Pflug said.

Keiser said hospitals need more incentives to do the right thing.

"I think we really do have to give them encouragement. If they are forthright and honest in their reporting, they need to know they are not going to get punished in an unfair, bashing sort of way," she said.

Keiser said she is not inclined at this point to change the state's definitions of medical errors. The National Quality Forum -- the organization that wrote the definitions of adverse events used by Washington State -- is planning to rewrite them, a process that will take until next year.

"I'm more interested in having an effective program with the current definition," Keiser said.

Keiser said requirements in Initiative 1053 might scuttle any attempts to impose a new fee on hospitals for an upgraded reporting program. The initiative would require a two-thirds vote in the legislature to create any new taxes or fees, meaning that a minority can block any proposals.

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