



Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: [LINK](#)

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The State of Pennsylvania released this report in July 2005: "In 2004, hospitals reported 11,668 hospital-acquired infections, that is, 7.5 hospital-acquired infections per 1,000 patients admitted to Pennsylvania's general acute care hospitals. 15.4 percent or 1,793 of these patients died. \$2 billion in additional hospital charges and 205,000 additional hospital days were associated with the hospital admissions in which these devastating infections occurred. However, until all Pennsylvania hospitals have met the current PHC4 reporting requirements for hospital-acquired infection data, the full impact of these infections remains unknown." www.phc4.org

Toward Evidence-Based Health Care Reform

Vol. 1, No. 5

How other states are improving quality and safety

While Vermont lawmakers discuss whether we should be the first state in the US with a single payer, other states have implemented government programs to improve quality and safety for patients, reducing costs for their citizens over the long term by eliminating errors and unnecessary utilization.

Over twenty states now require hospitals to disclose serious errors and hospital-acquired infections to state authorities. Many states have created patient safety institutes that require hospitals to collaborate on re-engineering their processes of care to prevent errors. Many states require hospitals to develop a corrective action plan for the error, and the state monitors for compliance and improvement. Some states – CO and MN - publish hospital specific reports each year, and some – CT, FL, ME, NY, RI, TN, TX, UT - publish aggregate information combining all hospitals and showing trends from year to year. Maine has developed an award program that publicizes hospitals that fully implement and comply with 28 nationally recognized safety practices.

These state-legislated programs have several fundamental principles in common:

- **Patient safety is in the public interest** – as important as restaurant safety and worksite safety, and government has a proper role providing oversight and ensuring accountability from institutions granted state hospital licenses.
- **Concern that an explosion of litigation will follow public disclosure has a chilling effect on hospitals' willingness to cooperate with reporting systems.** This is why most states have chosen not to publicly report hospital-specific error rates. However, all states have designed processes that hold hospitals accountable for fixing their errors, generally by involving state agency staff participating in confidential, non-discoverable reviews of reported errors and other adverse events. Within these confidential safety programs, state agencies still have the authority to impose sanctions or penalties, or seek court orders to enforce safety standards and require compliance.

- **All systems or processes will produce the outcomes that they are designed to produce.** This even applies to systems/processes that produce errors – that is, a system or process that is error prone *is designed in a way that allows errors*. To eliminate errors, systems --- include the hospitals that deliver health care, and the processes and treatment protocols to deliver that care --- must be redesigned so that errors can't and won't happen. It takes vision, leadership, good data and information, participation of "front line" staff and accountability to the customer to successfully redesign a system or process for error-free outcomes. "Slapping the hands" of a hospital or practitioner that errs will not prevent future errors. Making it imperative that the hospital reengineers its systems to be error-free *all the time* is the principle that state policy must enforce.
- **Adequate and robust state oversight requires adequate state funding.** State safety institutes and data gathering and reporting programs described above have been provided funding for staff and resources by their legislatures.

Not only is Vermont falling behind other states on overseeing patient safety, but numerous initiatives we have recently undertaken in Vermont – Managed Care Consumer Protection, Health Resource Planning, Certificate of Need reform, Hospital Budget Review Reform and Hospital Community Report Cards – passed the legislature without the additional staffing and resources truly needed by the agencies assigned responsibility (BISHCA, Dept of Health).

"Oversight" and "reform" are only window-dressing without adequate staffing, and using those words misleads consumers who believe they are being protected.