Final Report

“Building Consensus Among States on Patient Safety Reporting”

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Executive Summary

Building Consensus Among States on Patient Safety Reporting

Many coalitions at the state level are attempting to develop and implement patient safety reporting systems. Because designing patient safety systems is a new endeavor, these groups need more information and guidance on how to facilitate patient safety at the state level. Thus, the Arkansas Foundation for Medical Care and the Agency for Healthcare Research and Quality held a patient safety conference, titled "Building Consensus Among States on Patient Safety Reporting." The general purpose of the conference was to facilitate the sharing of ideas and information between patient safety coalitions. The following conference objectives were met.

1. To foster communication between leaders of regional consortia on patient safety to develop consensus on patient safety reporting systems
2. To identify preferred priorities for implementation of patient safety reporting systems
3. To identify promising strategies for how to disseminate patient safety information to provider communities in an effort to foster local change

Conference Framework

The Conference was held on October 10 and 11, 2002, at the Capitol Hotel in Little Rock, Arkansas. The Conference was funded by the Agency for Healthcare Research and Quality and the Arkansas Foundation for Medical Care (AFMC). AFMC organized the conference.All invited participants brought experience with patient safety reporting systems that could be shared with others. Participants included representatives from quality improvement organizations, healthcare providers, healthcare payers, and regulators.

The Conference objectives were accomplished by having plenary speakers address the technical and methodological issues revolving around patient safety reporting followed by state patient safety coalition leaders reporting on their current abilities and past experiences with patient safety reporting. Then, in break-out sessions, participants were asked to develop a consensus on how a patient safety reporting system should work and how the data can be utilized and communicated. The main topics of discussion were recreating the culture, reviewing existing initiatives to track medical errors, data collection and data analysis, and data sharing and dissemination.

Conference Findings

Open discussions gave participants a chance to share ideas and experiences. The group discussed error reporting systems, the kinds of errors that should be reported, and how the information should be used. Opinions varied, but most agreed that:

- Healthcare providers and facilities should be required to report serious and harmful errors.
- Reported data should be used to build a body of knowledge about the kinds of errors that commonly occur and the circumstances surrounding those errors.
- State government should be involved in the collecting and managing of patient safety data, but this activity need not be solely a state function.
- The focus of state and institutional efforts should be on prevention rather than punishment, except in cases of reckless conduct.

- Stories of "sentinel events" -- errors that carried serious or life-threatening consequences -- should be combined carefully with patient safety data to educate healthcare providers and administrators. Personal accounts and anecdotes can illustrate the consequences of errors and encourage active participation in patient safety efforts.
- Funding is limited in many states for statewide coalition activities.

A Summary Booklet and White Paper based on the conference have been developed. These publications have been made available to each attendee, each quality improvement organization, national health organizations, and state health departments.

Conference Evaluation
Overall, the evaluations were positive. On a five-point Likert-type scale (5=excellent and 1=poor), the participants rated the overall quality of the program a 4.67. The main strengths of the program were open discussion and breakout sessions, networking, and the small size of the conference with quality speakers. The main weakness was limited time to cover such a variety of topics.

One-Page Summary

Building Consensus Among States on Patient Safety Reporting

The Conference was held on October 10 & 11, 2002, at the Capitol Hotel in Little Rock, Arkansas. It was funded by the Agency for Healthcare Research and Quality and the Arkansas Foundation for Medical Care. Representatives from various state consortia and national organizations participated in the Conference.

Findings

Open discussions gave participants a chance to share ideas and experiences. The group discussed error reporting systems, the kinds of errors that should be reported, and how the information should be used. Opinions varied, but most agreed that:

- Healthcare providers and facilities should be required to report serious and harmful errors.
- Reported data should be used to build a body of knowledge about the kinds of errors that commonly occur and the circumstances surrounding those errors.
- State government should be involved in the collecting and managing of patient safety data, but this activity need not be solely a state function.
- The focus of state and institutional efforts should be on prevention rather than punishment, except in cases of reckless conduct.
- Stories of "sentinel events" -- errors that carried serious or life-threatening consequences -- should be carefully combined with patient safety data to educate healthcare providers and administrators. Personal accounts and anecdotes can illustrate the consequences of errors and encourage active participation in patient safety efforts.
- Funding is limited in many states for statewide coalition activities.

A White Paper and Summary Booklet have been developed and made available to quality improvement organizations, state health departments, and other interested organizations.

Other Highlights

Keynote speaker David Marx kicked off the conference with an address on "Patient Safety and the Just Culture." Marx defined a just culture as one that recognizes that even professionals make mistakes and develop unhealthy habits that can lead to errors. He pointed out that we often lose sight of the inherent risks in our daily activities, such as driving a car, and may develop unhealthy or risky behaviors as a result. A just culture, he said, realizes that human error is a manageable aspect of any organization, yet has a fierce intolerance for reckless conduct.

Mr. Fred Heigel from the New York State Department of Health described the robust reporting system and current activities of NYPORTS. Sharon Conrow Comden then provided an overview of patient safety coalition activities based on the report, "Statewide Patient Safety Coalitions: A Status Report," provided by the National Academy for State Health Policy. A panel of state coalition leaders followed her report with further descriptions of state initiatives. Dr. Robert S. Muscalus, Physician General of Pennsylvania, spoke on medical liability and the patient safety connection. Thomas Jackson from Operations HealthInsight discussed intervention strategies for translating research into practice.

Building Consensus Among States on Patient Safety Reporting

Conference Objectives

In 1999, the Institute of Medicine (IOM) reported that as many as 98,000 people die each year as a result of avoidable errors that occur in the healthcare system.[1] The IOM report recommended that states develop patient safety reporting systems to provide for the collection of standardized information. The Agency for Healthcare Research and Quality has also placed high priority on patient safety reporting systems, according to the *Preliminary Research Agenda: Medical Errors and Patient Safety*.[2] The reporting of adverse events, near misses, or observed hazards, with the purpose of identifying lessons learned, is needed to efficiently and effectively improve healthcare processes. Many groups at the national, regional, and state levels are beginning to develop and implement patient safety reporting systems.

States in different regions of the country are taking different approaches, as the reporting system needs to reflect the local culture, politics, and environment. However, because designing these systems is a new endeavor, states could benefit from more information and guidance. These consortia could learn from each other, creating a need for an information sharing conference. The Arkansas Foundation for Medical Care (AFMC) and the Agency for Healthcare Research and Quality held a patient safety conference with participants from 16 states. The purpose of the conference, titled *Building Consensus Among States on Patient Safety Reporting,* was to provide a forum for the sharing of ideas between patient safety consortia and to develop consensus on how a medical error reporting system should operate and how to foster local change in response to patient safety data.

The conference enabled key stakeholders to discuss and develop consensus about the development of patient safety reporting systems and how to use patient safety data to facilitate quality improvement. Conference objectives were:

- To foster communication between leaders of regional consortia on patient safety to develop consensus on reporting systems.
- To identify preferred priorities for implementation of reporting systems.
- To identify promising strategies for disseminating patient safety information to provider communities in an effort to foster local change.

Conference Framework

The Arkansas Foundation for Medical Care (AFMC) organized the conference. AFMC, a nonprofit corporation, was founded in 1972 as a peer review organization for Medicare and is now Arkansas' quality improvement organization (QIO). Since 1992, AFMC has conducted more than 50 healthcare quality improvement projects for Medicare and Medicaid. The Patient Safety Conference was funded by the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research). AHRQ research provides evidence-based information on healthcare outcomes; quality; and cost, use, and access. Information from AHRQ's research helps people make more informed decisions and improve the quality of healthcare services.

Participant organizations were selected based on their current involvement in patient safety issues at the state level. A small number of national organizations were included because of their interest and expertise in patient safety reporting. All invited representatives brought experience with patient safety reporting systems and a willingness to share that experience with others. The participants included representatives of quality improvement organizations, healthcare providers, healthcare payers, and regulators, as shown in Appendix A.

The conference was held October 10 and 11, 2002, at the Capitol Hotel in Little Rock, Arkansas. Plenary speakers addressed the technical and methodological issues surrounding patient safety reporting. Representatives from state patient safety consortia presented their current approaches. In breakout sessions, participants were asked to develop a consensus on what a patient safety reporting system should look like and how the data can be utilized and communicated. Following breakout discussions, participants reconvened to discuss their conclusions. See Appendix B for the agenda and speaker bios.

Conference Discussion

Invited Speakers

Keynote speaker David Marx kicked off the conference with an address on "Patient Safety and the Just Culture." Marx, a former Boeing aircraft design analyst, has developed a human error investigation process used by air carriers around the world. He now has his own research and consulting practice focusing on human error management and serves as an advisor on patient safety to the Agency for Healthcare Quality and Research.

Marx defined a just culture as one that recognizes that even professionals make mistakes and develop unhealthy habits that can lead to errors. He pointed out that we often lose sight of the inherent risks in our daily activities, such as driving a car, and may develop unhealthy or risky behaviors as a result. A just culture, he said, realizes that human error is a manageable aspect of any organization, yet has a fierce intolerance for reckless conduct.

Marx explained how the United States' aviation industry has designed systems that allow for some human error and minimize risk. For instance, airplanes are designed so that the chance of one failed component actually preventing a safe flight and landing is extremely improbable. If an improper part or improperly performed maintenance task could endanger the flight of the aircraft, the task must be a required inspection item. The payoff is that flying is statistically quite safe, with only one accident per one billion flight hours.

Mr. Fred Heigel from the New York State Department of Health described the robust reporting system and current activities of NYPORTS. Sharon Conrow Comden then provided an overview of patient safety coalition activities based on the report, "Statewide Patient Safety Coalitions: A Status Report," provided by the National Academy for State Health Policy. A panel of state coalition leaders followed her report with further descriptions of state initiatives.

Dr. Robert S. Muscalus, physician general of Pennsylvania, spoke on medical liability and the patient safety connection. Muscalus explained that malpractice insurance had become so expensive in parts of Pennsylvania that some areas were experiencing a shortage of physicians, particularly in certain specialties such as obstetrics/gynecology. The state took emergency steps,

such as providing some financial relief, and an act eventually was passed. Among other things, the act called for increased patient safety measures as well as tort reform to discourage inappropriate litigation against healthcare providers.

Thomas Jackson from Operations HealthInsight discussed intervention strategies for translating research into practice. He described the successes and challenges of introducing new patient safety ideas to organizations in Nevada and Utah. Other speakers discussed the benefits of patient safety coalitions -- partnerships formed by healthcare organizations, providers, and government representatives to find ways to improve safety in healthcare.

Break-Out Session: Role of Regulation to Promote Patient Safety: Preferences for Reporting Systems

Meeting participants broke into three discussion groups to examine experiences with structural aspects of patient safety initiatives and reporting in their states. Emphasis was placed on lessons learned and attributes of an effective system to effect meaningful change in local clinical environments. Participants agreed that some mechanism for reporting sentinel events would be of value to identify high-risk situations and assign priorities for process redesign and education of clinical staff. However, reporting should not necessarily lead to public disclosure. All participants were concerned about achieving balance between creating a learning environment versus the demands for accountability. Too much emphasis on accountability could foster a punitive culture antithetical to the goals of encouraging patient safety.

There was concern about what types of information should be collected for statewide safety reporting. Participants seemed to agree that reporting of major events in which patient injury occurred should be mandatory. However, participants expressed considerable concern that taxonomy of near misses and minor errors could become unwieldy. Several participants expressed that, in most cases, near misses and minor errors could be addressed more effectively at the facility level; aggregate reports could be forwarded to a statewide database.

There was general agreement that involving state government was important for the evolution of patient safety initiatives; however, this concept did not necessarily imply that governmental agencies should own databases or be the central coordinating leadership of patient safety programs or coalitions. State governmental agencies have an obligation to promote and protect public safety and, therefore, have an agenda that can be different from statewide coalition partners. This regulatory and protective role is important for creating some tension in the system that can provide stimulus for change in the private sector.

Considerable discussion ensued about data sharing and the different attributes of mandated versus voluntary data collection. Many participants expressed that both mandatory and voluntary data can be used effectively by coalitions. There was disagreement over whether hard data is necessary for development of effective interventions to enhance patient safety. Appropriate models, concepts, and national research can draw much local support for patient safety efforts. Nevertheless, pre- and post-initiative data can document successes and challenges in reducing patient risk, which can be critical to sustain reform and to reinforce the value of ongoing discussions and projects.

Another important role for patient safety coalitions is that of information clearinghouse for the public and media as well as for healthcare providers. A patient safety coalition could highlight emerging trends and information that could then be translated into local action and reduction of patient risk. Patient safety coalitions could help to merge state regulatory activity with provider-focused educational activities to create a synergistic environment for fostering learning and innovation.

A statewide coalition can also function as an umbrella organization, bringing together partners from different disciplines, assisting with their independent activities, and allowing their successes to be shared across groups. Another role of coalitions is providing an educational framework for quality improvement. Many smaller- and middle-size institutions have yet to begin to incorporate patient safety activities into their programs. They may need some modeling and training in order for clinical staff to participate and be effective in designing and launching new processes and systems.

There was a general sense that the public has some degree of skepticism regarding the healthcare sector's commitment to addressing patient safety issues. Statewide initiatives could play a vital role in demonstrating progress in reducing patient risk and in informing the public about ongoing initiatives that address public concerns and the patient safety issues reported in the mainstream media and by the Institute of Medicine. Many participants pointed out the need for educating the public on the feasibility of system change and the time needed to launch effective reforms and new ways of delivering healthcare.

Funding statewide patient safety initiatives remains a challenge. A few states have reasonable funding for patient safety activities. Many coalitions are limited in their ability to take on projects because of a lack of funding. In many jurisdictions, this situation is not likely to change in the near future.

Interactive Plenary Session: Strategies for Disseminating and Sharing Patient Safety Information to Foster Local Change

The final session of the conference was held as an interactive plenary session and focused on the quality and need for data to promote and facilitate patient safety regionally. Considerable time was spent reviewing the strengths and limitations of collecting detailed event data as opposed to "stories" — anecdotes associated with near misses and sentinel events. The participants believed that such stories have a definite role in patient safety activities. Stories may be valuable to different audiences and for different purposes. At the policy-making level, stories can give context to patient safety activities and make ongoing activities meaningful to nonclinical decision makers. Stories can also be of use to healthcare professionals who can perform assessments of their own institutions in the context of the risks embodied in a near miss or sentinel event that has occurred at another facility. Stories can be reflective of self-assessment and improvement – the documentation of a successful analysis, reinvention, and implementation of an improved process.

On the other hand, stories can overdramatize rare events and distract from dealing with less exciting medical errors that are more prevalent and potentially more expensive and dangerous to a larger number of patients and institutions. Mainstream media could ignore significant successes in patient safety if not associated with dramatic, "newsworthy" stories.

There is a clear need for the collection of data documenting the frequency of common events. This data could be used for policy making and analyzing the impact of patient safety activities.

Conference Findings

Overall, the conference evaluations were positive. On a five-point Likert-type scale (5=excellent and 1=poor), the participants rated the overall quality of the program a 4.67. The main strengths of the program were open discussion and breakout sessions, networking, and the small size of the conference with quality speakers. The main weakness was limited time to cover such a variety of topics. See Appendix C for a summary of the conference evaluations.

A Summary Booklet and White Paper based on the conference have been developed. These publications have been made available to each attendee, each quality improvement organization, national health organizations, and state health departments. A copy of the comprehensive White Paper was made available in PDF format at http://www.afmc.org.

Many viewpoints were represented, but the majority of participants agreed on some major points:

- Healthcare providers and facilities should be required to report serious and harmful errors.
- Reported data should be used to build a body of knowledge about the kinds of errors that commonly occur and the circumstances surrounding those errors.
- State government should be involved in the collecting and managing of patient safety data, but this activity need not be solely a state function.
- The focus of state and institutional efforts should be on prevention rather than punishment, except in cases of reckless conduct.
- Stories of "sentinel events" — errors that carried serious or life-threatening consequences — should be combined carefully with patient safety data to educate healthcare providers and administrators. Personal accounts and anecdotes can illustrate the consequences of errors and encourage active participation in patient safety efforts.
- Funding is limited in many states for statewide coalition activities.

This invitational meeting of state-based patient safety coalitions resonated among attendees. Many perceived a need for just such a forum to compare experiences and perceptions of opportunities in their environments. These groups clearly have a shared understanding of the challenges and opportunities facing their regional patient safety efforts. Discourse was lively but not confrontational, and several themes emerged:

- Many patient safety coalitions serve multiple constituencies that can diffuse focus and tax limited resources.
- There remains an unresolved tension between public accountability and a "just" culture. A just culture supports open discussion of medical error to improve care delivery systems.
- State government's commitment to protect the public serves as a useful stimulus to put patient safety initiatives into context.
- State government is an important stakeholder but not necessarily the architect of statewide activity.

The meeting's participants felt that this experience marked the start of future communication and collaboration between regional groups. Participants expressed the need for similar gatherings and discussion in the future. Patient safety coalitions should channel the energies of professional, consumer, and purchaser communities proactively to influence public policy and institutional behavior. Much work needs to be done. Research and demonstration projects such as those funded by AHRQ will yield increasing opportunities to model successful programs throughout the United States. Statewide patient safety coalitions are in a unique position to ease such translation and promote active adoption of new techniques to reduce patient risk and reduce medical error.

References

1. Institute of Medicine. To Err is Human: Building a Safer Health System. Washington: National Academy Press; 1999.
2. Preliminary Research Agenda: Medical Errors and Patient Safety. National Summit on Medical Errors and Patient Safety Research. October 2000. http://www.quic.gov/summit/resagenda.htm.

Appendix A

Building Consensus Among States on Patient Safety Reporting

List of Participants

Carl Armstrong, M.D.
Virginia Hospital and Healthcare Association
Virginians Improving Patient Care and Safety
Richmond,Virginia

John Combes, M.D.
Healthcare Alliance of Pennsylvania
Pennsylvania Patient Safety Collaborative
Harrisburg, Pennsylvania

Sharon Conrow Comden, Dr.P.H.
Comden and Associates
Bandon, Oregon

Judy Eads
Tennessee Department of Health
Tennessee Improving Patient Safety
Nashville, Tennessee

Gregory Forzley, M.D.
Advantage Health
Michigan Health and Safety Coalition Grand Rapids, Michigan

Nancy Foster
American Hospital Association
Chicago, Illinois

William Golden, M.D.
Arkansas Foundation for Medical Care
Arkansas Patient Safety Initiative
Little Rock, Arkansas

Zenobia Harris
Arkansas Department of Health
Little Rock, Arkansas

Fred Heigel
New York State Department of Health Troy, New York

Eileen Hogan
Agency for Healthcare Research and Quality
Rockville, Maryland

John Holcomb, M.D.
Texas Patient Safety Alliance
San Antonio, Texas

Beth Ingram
Arkansas Hospital Association
Arkansas Patient Safety Initiative
Little Rock, Arkansas

Thomas R. Jackson, M.B.A.
HealthInsight
Salt Lake City, Utah

Tania Krueger
Minnesota Hospital and Healthcare Partnership
Minnesota Alliance for Patient Safety St. Paul, Minnesota

David Marx, J.D.
Outcome Engineering, LLC
Chanhassen, Minnesota

Rob Muscalus,D.O.
Physician General of Pennsylvania
Harrisburg, Pennsylvania

Bruce Naylor, M.D., F.A.C.P.
VHA Oklahoma/Arkansas
Oklahoma City, Oklahoma

Vi Naylor
Georgia Hospital Association
Georgia's Partnership for Health and Accountability
Marietta, Georgia

Marsha Nelson, M.B.A., R.N.
California Institute for Health Systems Performance
Sacramento, California

A.B.Orlik
Wisconsin Patient Safety Institute
Madison, Wisconsin

Deborah Queenan
Agency for Healthcare Research and Quality Rockville, Maryland

Denise Remus, Ph.D., R.N.
Agency for Healthcare Research and Quality
Rockville, Maryland

Nancy Ridley
Massachusetts Department of Public Health
Massachusetts Coalition for the Prevention of Medical Errors
Boston, Massachusetts

Jill Rosenthal, M.P.H.
National Academy of State Health Policy
Portland, Maine

Jeanne D. Scinto, Ph.D., M.P.H.
Qualidigm
Middletown, Connecticut

H.Michael Tripple
Minnesota Department of Health
Minnesota Alliance for Patient Safety

Donna West, Ph.D.
Arkansas Foundation for Medical Care
Arkansas Patient Safety Initiative
Little Rock, Arkansas

Jon Wolfe, Ph.D.
University of Arkansas College of Pharmacy
Arkansas Patient Safety Initiative
Little Rock, Arkansas

David Wroten, M.B.A.
Arkansas Medical Society
Arkansas Patient Safety Initiative
Little Rock, Arkansas

Appendix B

Building Consensus Among States on Patient Safety Reporting

Agenda and Speaker Bios

Agenda

October 10		
TIME	**TOPIC**	**SPEAKER**
11:30-12:30 PM	Registration	
12:30-1:30 PM	Lunch Buffet Welcoming Remarks Introductions Overview of Conference	William E. Golden, MD Arkansas Foundation for Medical Care
1:30-2:30 PM	**Keynote Address**: Patient Safety and the Just Culture	David Marx, JD Outcome Engineering, LLC
2:30-3:30 PM	Data Collection and Analysis: The New York State Experience	Fred Heigel, New York Department of Health
3:30-3:45 PM	Break	
3:45-5:00 PM	Patient Safety Coalitions: Lessons Learned and New Directions Massachusetts Experience Georgia Experience	Sharon Conrow Comden, DrPH Comden and Associates REACTION PANEL: Nancy Ridley, Massachusetts Department of Public Health Vi Naylor, Georgia Hospital Association
5:45-7:30 PM	Working Dinner Regional Perspectives on Patient Safety	William E. Golden, MD Arkansas Foundation for Medical Care
October 11		
TIME	**TOPIC**	**SPEAKER**
Breakfast buffet is provided complimentary with your hotel room		
8:00-9:00 AM	Medical Liability and the Patient Safety Connection	Robert S. Muscalus, DO Physician General of Pennsylvania
9:00-10:15 AM	**Break-Out Session I**: The Role of Regulation to Promote Safety: Preferences for Reporting Systems	
10:15-10:30 AM	Networking Break	
10:30-11:45 AM	Sharing of Group Findings and Developing Consensus	Moderator: Jill Rosenthal, MPH National Academy for State Health Policy
11:45-1:00 PM	Working Lunch Intervention Strategies for Translating Human Factors Research into Practice	Thomas R. Jackson, MBA Operations HealthInsight
1:00-2:15 PM	**Break-Out Session II:** Strategies for Disseminating and Sharing Patient Safety Information to Foster Local Change	
2:15-2:20 PM	Networking Break	
2:20-3:30 PM	Sharing of Group Findings and Developing Consensus	Moderator: Nancy Foster American Hospital Association
3:30-4:00 PM	Summary of Conference	William E. Golden, MD Arkansas Foundation for Medical Care

Questions for Breakout Sessions

Morning Session:
Role of Regulation to Promote Patient Safety: Preferences for Reporting Systems

Please discuss in terms of local experience and lessons learned from successes and failures.

- **What are the objectives of a statewide initiative? (e.g., create change, collect data, regulate, increase accountability)**
  - Is reporting the highest priority a state should have?
  - Are some objectives potential barriers to others?
  - What is the nature of the partnership of stakeholders?
    - Independent activity vs Common undertaking
    - Does funding affect mission, effectiveness?

- **How does a statewide initiative balance accountability and learning?**
  - What type of system should it be?
    - Purpose of collecting data (e.g., regulatory, QI)
    - Mandatory versus voluntary reporting
    - Who reports, how do you protect confidentiality?
    - Is there a master database? Who controls the data?

Afternoon Session:
Strategies for Disseminating and Sharing Patient Safety Information to Foster Local Change

- **What is the role of aggregate data vs sentinel "stories"?**
- **What are effective uses of experience, data?**
  - How does a statewide effort effect change? How does it use the data?
  - Is there a need for a national clearinghouse of case histories, implementation strategies? What about a web-based system that everyone could use/help build economies of scale?

Speaker Bios

William E.Golden, M.D., F.A.C.P.
Dr. William E. Golden is the director of general internal medicine and professor of medicine at the University of Arkansas for Medical Sciences. He is vice president of quality improvement at the Arkansas Foundation for Medical Care and served as principal clinical coordinator for 10 years. He serves on the Board of Directors of the National Quality Forum and is immediate past president of the American Health Quality Association. He has served on three committees of the Institute of Medicine as well as two study sections for the Agency for Healthcare Research and Quality.

David Marx, J.D.
David Marx is an advisor on patient safety to the Agency for Healthcare Research and Quality. He began his career as a Boeing aircraft design analyst. In his final years at Boeing, he organized the maintenance human factors and safety group, where he developed a human error investigation process used by air carriers around the world. In 1997, he started his own research and consulting practice focusing on the management of human error through the integration of systems engineering, human factors and the law. For Columbia University's MERS-TM project, he authored the document, "Patient Safety and the 'Just Culture: A Primer for Healthcare Executives." His current work is focusing on application of sociotechnical risk management techniques in the aerospace and healthcare industries. He holds a degree in mechanical systems engineering and a juris doctor.

Frederick J. Heigel
Frederick J. Heigel is the director of the Bureau of Hospital and Primary Care Services in the New York State Department of Health. The Bureau investigates complaints and adverse events and manages the adverse event reporting process (NYPORTS), among many other functions. Heigel has been employed by the New York State Department of Health for more than 28 years. He has been the director of the Bureau since 1991 and was assistant director for 10 years.

Robert S. Muscalus, D.O.
Dr. Robert S. Muscalus has been the Pennsylvania Physician General since March 1999. He is the principle advisor to the Governor and the Secretary of Health on public health and policy issues. He is a member of the State Board of Medicine, State Board of Osteopathic Medicine, and the State Board of Physical Therapy. Dr. Muscalus served as a medical director in managed care programs and as the medical director for Pennsylvania's Medicare program. He has also served on the faculties of the Penn State University College of Medicine and the Harrisburg Hospital Family practice residency program. Dr. Muscalus holds a bachelor's degree in economics from the College of William and Mary, and he is a graduate of the Philadelphia College of Osteopathic Medicine. He is board certified in family medicine and is a fellow of the American Academy of Family Physicians.

Sharon Conrow Comden, Dr.P.H.
Dr. Sharon Conrow Comden is a healthcare consultant with leadership experience in progressive, nonprofit hospital, managed care, and academic organizations. Dr. Comden has directed both regional and national programs in quality/outcomes improvement, risk

management, medical and allied health education, clinical and health services research, new service development, clinical policy development, health education, and physician personnel management. She has 10 years of experience designing, implementing, and evaluating a wide range of quality and patient safety programs in a variety of settings. Dr. Comden received her Dr.P.H. and M.P.H. from the University of California, Los Angeles.

Nancy Ridley, M.S.
Nancy Ridley is the Massachusetts Department of Public Health's assistant commissioner for the Bureau of Health Quality Management. For the past 20 years, she has managed a variety of state public health programs in healthcare and environmental health quality management and has specialized in risk management. She is also a US Food and Drug Administration Commissioned Officer and an active member of the Steering Committee for the Massachusetts Coalition for the Prevention of Medical Errors.

Vi Naylor
As Georgia Hospital Association's Executive Vice President, Vi Naylor assists in overall policymaking and strategic planning. She also advocates for hospitals in a variety of areas including nursing, professional issues, licensing, accreditation, peer review, other regulatory areas, health information and accountability, and community health planning. She led the development of the CARE Performance Measurement system, the Orion-Georgia/JCAHO Continuous Survey Readiness Program and the Association's safety initiative, the Partnership for Health and Accountability. She has more than 34 years of experience in healthcare.

Thomas R. Jackson
Thomas Jackson is the vice president of operations for HealthInsight, the quality improvement organization (QIO) for Utah and Nevada. He has been with the company since 1993, having served as the senior analyst and director of Utah Operations. Jackson is the current president of the Utah Association for Healthcare Quality, and participates on many other state coalitions and committees. During his tenure at HealthInsight, he has concentrated on statewide health system redesign. He initiated the organization's first community collaborative on patient safety in 1997.

Appendix C

Building Consensus Among States on Patient Safety Reporting

Conference Evaluations

Arkansas Foundation for Medical Care
PROGRAM EVALUATION

Activity Title: Consensus Among States on Patient Safety Reporting
Capital Hotel
111 West Markham Street
Little Rock, Arkansas

Date(s): October 10 & 11, 2002

Sponsor: AFMC

To assist us in planning future courses, we need your comments, criticisms, and suggestions on this program.
Please return this form at the conclusion of this program.

Please rate the questions according to the scale below:

5 – Excellent	4 – Good	3 – Average	2 – Fair	1 – Poor	N/A – Not Applicable

		5	4	3	2	1	N/A	Mean	%
1.	The organization of the program was	7	2	0	0	0	0	4.78	95.56%
2.	The relevance of the information presented was	5	3	1	0	0	0	4.44	88.89%
3.	The objectives of the program were met to what extent	5	4	0	0	0	0	4.56	91.11%
4.	The facilities were	8	1	0	0	0	0	4.89	97.78%
5.	The selection of topics was	7	1	1	0	0	0	4.67	93.33%
6.	The Audio-visual technology was	7	1	1	0	0	0	4.67	93.33%
7.	The pace of the program was	4	5	0	0	0	0	4.44	88.89%
8.	The overall quality of this activity was	6	3	0	0	0	0	4.67	93.33%

9. What were the greatest STRENGTHS of the program?

- Open discussion and breakouts
- Networking and learning what other are doing
- Good topics, good discussion & solution of everyone's input; Dr. Golden did a good job modifying the schedule to keep us on track
- Size – there was a good mix of perspectives but still had opportunity to focus on issues
- Collaborative thought sharing and open networking in the conference (not just at breaks)
- Small size; top speakers
- Ability to dialogue with peers
- Small groups; presenters
- Time to network share information
- Overview of NYPORTs was excellent. Some of the plenary section (Mass Dott) were quite long. Interactive work group sessions great!

10. What were the greatest WEAKNESSES of the program?
11. Too much in the way of presentations the first day
12. Burn-out by 3:30 PM Friday; I'd maxed my ability to absorb
13. No breathing time – 15 minutes (e.g. during lunch and dinner)
14. Summary of each states' status of patient safety – i.e., mandatory/voluntary, coalition active/none, etc.

- Somewhat unclear goals related to reporting and group discussion
- Not enough time for breakout sessions

11. What was the most IMPORTANT thing you learned?
12. David Marx and PRA
13. Everyone is facing similar barriers, asking similar questions, and that I can learn from others who have found solutions/answers
14. Reporting successes & barriers among states
15. Issues are similar in many venues - contacts to provide further follow up
16. Coalition importance
17. How to take "lessons learned" to policy process
18. Not enough time
19. Support development of coalitions
20. David Marx – aviation is not a blame free system; blame free isn't the goal
21. State reporting/confidentiality laws, discussion of how information is received

12. What was the most CONFUSING thing you heard ?
13. Purpose of storytelling; focus
14. Why would we have NPSF takeover/lead our efforts? We would lose individuality/director/& it would cost! We should be able to convene, conf calls, e-mails on our own as a start!
15. How to do it and who the player should be

13. What are you going to do as a result of what you have heard?
- Try to obtain additional financing for our collaborative
- Speak with my Board Chair about how to incorporate what I've learned into our plan for the coming year
- How to incorporate what I've learned into our plan for the coming year
- Share leanings with my organization coalition; Hopefully keep in touch with other coalition fully
- Continue to push for clarification* of roles – begin to develop project
- Not certain
- Take information to our group within state
- Keep track of state activities
- Share information with individuals in my state; on project that I direct regarding reporting and patient safety

14. Suggestions for future program topics:
15. Sharing resources we've developed what tools have worked to translate research into practice
16. Continue on this… Part II – how about meeting at Annenberg V in Wash, DC; March full day at corporate
17. Actual analysis of data – annual reports
18. A forum on developing consensus about patient safety measures, Educating consumers and report formats

15. Additional comments or suggestions:
16. Great information on other states, gave balance of presentation, information sharing, and networking opportunities
17. Thanks for the invitation