

**The Pennsylvania Learning Exchange:
Helping States Improve and Integrate
Patient Safety Initiatives**

Summary Report

*Carrie Hanlon
Jill Rosenthal*

December 2007

Funded by
The Commonwealth Fund

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Publication No. 2007-204 -- Available on the Web at: www.nashp.org/Files/Learning_Exchange_Summary

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ACKNOWLEDGEMENTS

The authors wish to thank the Commonwealth Fund, whose support made the Pennsylvania Patient Safety Learning Exchange possible. We appreciate the feedback of the advisory group, which helped guide the development of the event and selection process (see Appendix C for a list of members). We thank the individuals who served as speakers; they contributed their invaluable time and expertise to the planning and execution of the event. We are similarly grateful to the visiting state officials for sharing their experiences with us and each other. Their ideas formed the basis for this report. A list of participants is included in Appendix B. Any errors or omissions are those of the authors.

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EXECUTIVE SUMMARY

According to the Institute of Medicine (IOM), preventable medical errors are a leading cause of death in the United States. Yet, state officials who focus on patient safety have few venues to meet, share innovative strategies, and problem solve with each other because patient safety initiatives originate in a variety of state agencies.

This report summarizes the Pennsylvania Learning Exchange, an event that brought state officials to Pennsylvania in September 2007 to learn about the state's successes, challenges, and key elements of its patient safety initiatives. The event was supported by the Commonwealth Fund.

Pennsylvania's initiative is a model for developing a comprehensive, interagency approach to address patient safety within a broader context of state health policy and as a critical component of health reform. The Prescription for Pennsylvania coordinates patient safety efforts under an umbrella entity (the Governor's Office of Health Care Reform) and involves multiple agencies. The learning exchange event focused on Pennsylvania's innovative strategies, including its successful efforts to call statewide attention to the issue of patient safety; build a case for change; translate data into practice and policy; and create a state infrastructure to address the issue. It also provided an opportunity for visiting state officials to share their own innovations.

The purpose of the learning exchange was to enable state officials to explore policy and operational issues, identify emerging issues, develop policy solutions, and improve state health policy and practice.

Ten Pennsylvania patient safety officials from key state agencies (Governor's Office of Health Care Reform, Pennsylvania Health Care Cost Containment Council, Pennsylvania Patient Safety Authority, Pennsylvania Department of Health, and Pennsylvania Department of Public Welfare) were host officials. Participants included 24 state officials representing eleven states (Illinois, Kansas, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Utah, Washington, and Wisconsin), plus the District of Columbia.

All visiting officials provided short written summaries of what they gained from the learning exchange and how they planned to apply this new knowledge to their state's work to improve patient safety. Participants' lessons learned at the event include:

- By converting preventable errors and hospitalizations into avoidable costs, states can make a business case for patient safety.
- State officials can elevate patient safety on state agendas by integrating it into other policy initiatives.
- Demonstrating the impact of patient safety initiatives continues to pose a challenge.
- Patient safety initiatives need to be tailored to reflect the unique circumstances of each state.

Visiting state officials developed new ideas for improving state patient safety policy and processes, including those related to data use and stakeholder relations. Officials made contacts

for future collaboration on patient safety initiatives, and they are eager to sustain relationships fostered by the site visit and continue to learn from others' approaches. While offering ideas and alternatives, the event also underscored challenges states face in implementing patient safety initiatives within their diverse environments and individual constraints. The overwhelmingly positive reaction from learning exchange participants speaks to the value of providing state officials with the opportunity to convene with their peers and exchange ideas about patient safety.

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INTRODUCTION

Preventable medical errors are a leading cause of death in the United States, with as many as 98,000 hospitalized patients dying as a result of errors each year.¹ In many cases, existing evidence-based methods can prevent these deaths from occurring.

States have many opportunities to improve patient safety and safeguard the public. State agencies can work independently, coordinate with other state entities, and partner with the private sector. However, state officials who focus on patient safety have few venues to meet, share innovative strategies, and problem solve with each other because patient safety initiatives originate in a variety of state agencies. State officials often request additional opportunities to meet with and learn from their peers, particularly innovators.

This report summarizes the Pennsylvania Learning Exchange, an event coordinated by the National Academy for State Health Policy (NASHP) and which brought together state officials to discuss approaches to improving patient safety. The Learning Exchange focused on Pennsylvania's innovative strategies, including its successful efforts to call statewide attention to the issue of patient safety; build a case for change; translate data into practice and policy; and begin to create a state infrastructure to address the issue. The sections that follow will outline:

- the genesis and structure of the Pennsylvania Learning Exchange,
- Pennsylvania's innovative approach to patient safety, including key agency activity and involvement, and
- themes and take-home lessons that emerged from the event and resonated most with participating state officials.

About the Pennsylvania Learning Exchange

With support from the Commonwealth Fund, the National Academy for State Health Policy convened a 1-1/2 day "on-site learning exchange," bringing state officials to Pennsylvania to learn about the state's successes, challenges, and key elements of its patient safety initiatives. The Commonwealth of Pennsylvania's initiatives are a model for developing a comprehensive interagency approach to address patient safety within a broader context of state health policy and as a critical component of health reform. The learning exchange provided state officials with the opportunity to learn first hand about innovative strategies for addressing patient safety in Pennsylvania and in other states and to consider and share how these state experiences apply to their own efforts

The purpose of the learning exchange was to enable state officials to explore policy and operational issues, identify emerging issues, develop policy solutions, and improve state health policy and practice. The agenda included discussion of driving change through leadership; creating a statewide patient safety mandate; building a case for change; translating data into practice and policy; stakeholder partnerships and perspectives; and creating a state infrastructure (see Appendix A for the event's agenda).

Participants

NASHP used a competitive process to select participants for the learning exchange. States at varying stages of patient safety activity implementation and progress were chosen to maximize the potential for exchange and education. Participants included 24 state officials representing eleven states (Illinois, Kansas, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Utah, Washington, and Wisconsin), plus the District of Columbia. Nine of these officials agreed to serve as a “state reactor” by sharing their states’ experiences and posing discussion questions.

Ten Pennsylvania patient safety officials from key state agencies (Governor’s Office of Health Care Reform, Pennsylvania Health Care Cost Containment Council, Pennsylvania Patient Safety Authority, Pennsylvania Department of Health, and Pennsylvania Department of Public Welfare) were host officials. Based on state interest, NASHP also invited three individuals from non-government entities in Pennsylvania (Pittsburgh Regional Health Initiative, Hospital & Healthsystem Association of Pennsylvania, and Pennsylvania Public Interest Research Group) to represent private stakeholder perspectives in the state (see Appendix B for a complete list of participants).

This report synthesizes participants’ summaries of their experiences and lessons learned during the visit, which will help other states explore opportunities to advance patient safety.

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PENNSYLVANIA'S APPROACH TO PATIENT SAFETY

The Commonwealth of Pennsylvania's approach to patient safety is unique in many respects, including its breadth of patient safety activities, national recognition for innovation, attempts to develop a comprehensive interagency approach, and consideration of patient safety's impact on a broad health care agenda of access, cost, and quality. Some of the innovations discussed during the meeting are described in this section of the report.

Patient Safety and the Prescription for Pennsylvania

In January 2007, Governor Edward Rendell presented his health care reform plan, the Prescription for Pennsylvania, a collection of strategies to improve health care and reduce costs by addressing issues of health care affordability, accessibility, and quality. Leading up to the unveiling of the proposal, in 2005, the Governor convened an advisory panel that worked with the Governor's Office of Health Care Reform (GOHCR) on ideas to increase access to affordable, quality health care. After an exploration of the status of the critical issues of access, quality, and cost in Pennsylvania, the advisory panel realized that the costs associated with patient safety issues (and broader quality issues), such as readmissions and errors, avoidable hospitalizations due to inadequate care for people with chronic conditions, and hospital acquired infections (HAIs), were impossible to ignore in any attempts to improve access and affordability of care. As a result, the Governor's reform plan incorporated many quality improvement and patient safety initiatives, including:

- mandatory reporting of HAIs to the Centers for Disease Control, sharing of the data with the Pennsylvania Patient Safety Authority and Pennsylvania Health Care Cost Containment Council (described below), and uniform electronic surveillance by 2008;
- mandatory filing of infection control plans by hospitals, nursing facilities, and ambulatory surgical centers for approval by the Pennsylvania Department of Health;
- event reporting by nursing homes with an assessment to fund analysis of the data;
- hospital patient safety and quality improvement annual reports;
- establishment of the Office of Health Equity to eliminate health disparities;
- hospital and provider patient safety training licensure requirements;
- pay for performance focused on avoidable hospitalizations;
- creation of a Chronic Care Commission to address chronic health conditions;
- hospital payment restructuring to eliminate perverse incentives (e.g. ending state-funded program payment for never events); and
- expanded powers of the Insurance Commissioner to review rate increases and deny requests if the insurance company has not made progress through its healthcare providers to reduce costs associated with patient safety events and avoidable hospitalizations.

Patient safety initiatives were underway within a few agencies prior to 2007; now, however, the Prescription for Pennsylvania coordinates efforts under an umbrella entity, the Governor's Office of Health Care Reform, and involves additional agencies. GOHCR, created by executive order, provides statewide leadership on patient safety, coordinating the above initiatives across multiple

state agencies (see Appendix D), including the Pennsylvania Patient Safety Authority, the Pennsylvania Health Care Cost Containment Council, and the Pennsylvania Departments of Health and Public Welfare.

Patient Safety Authority

The Pennsylvania Patient Safety Authority (PSA) is an independent, non-regulatory agency charged with identifying patient safety problems and implementing solutions to improve safety and reduce harm from medical errors. The Authority received the John M. Eisenberg Award in 2006 for innovation in improving patient safety.

The PSA's Patient Safety Reporting System (PA-PRS) is a safety education and learning resource that analyzes a large number of reported events (approximately 200,000 in 2006), and provides feedback to providers via safety advisories and an annual report. An outside contractor identifies trends in the adverse event and near-miss data submitted electronically to PSA by hospitals, ambulatory surgical facilities, birthing centers, and certain abortion facilities. For the PSA, narratives are critically important to initiating change in systems and provider behavior.

The Pennsylvania Health Care Cost Containment Council

Established in 1986, the Pennsylvania Health Care Cost Containment Council (PHC4) provides comparative information about health care providers to consumers and purchasers in an effort to contain costs and improve health care quality by stimulating competition in the health care market. Hospitals and ambulatory surgery centers are mandated to provide PHC4 with charge and treatment information.

PHC4 collects myriad types of information: diagnosis and procedure data; hospital financial data; Medicare, Medicaid, and commercial insurance payment data; as well as clinical information about patient illness level at hospital admission. The Council is nationally recognized as the first state agency to analyze and release data on the human and financial impact of HAIs.

Using the Centers for Disease Control and Prevention's definitions, identification criteria, and major site categories, Pennsylvania hospitals identify specific HAIs and report them to PHC4. In addition to its HAI reports, PHC4 releases Patient Safety Reports to hospitals, as well as public reports about cardiac surgery, diabetes, and hospital performance. PHC4 provides data that are vital to GOHCR's health care reform efforts. The \$1 billion in hospital charges in Pennsylvania for additional care for HAIs, the number of hospital HAIs (19,154), and patients with HAIs who died in hospitals (2,478) in 2005 made the case for change.² These data supported the notion that too much of the cost of health care is due to inferior care that threatens patient safety. This quantification of cost is unique; no other state has done this. In collaboration with the Pittsburgh Regional Health Initiative, PHC4 participated in a demonstration project that reduced HAIs and quantified HAI costs in five Pennsylvania hospitals.

Department of Health

The Department of Health (DOH) is Pennsylvania's health care licensing agency. It conducts periodic inspections and receives serious event data reported to the PSA. DOH can enforce regulations via corrective action plan requirements, fines, admissions bans, and licensure action. DOH will approve the state's new mandatory infection control plans and develop and calculate benchmarks and infection rates. DOH will also share information among facilities, connecting them with peer leaders in HAI prevention.

Department of Public Welfare's Office of Medical Assistance Programs

The Commonwealth of Pennsylvania, as a very large purchaser of health care (i.e. Medicaid, adultBasic, SCHIP, employee benefits program) uses its purchasing leverage to improve patient safety. Pennsylvania's Office of Medical Assistance Programs (OMAP) within the Department of Public Welfare administers the state's Medicaid program and operates pay for performance programs for primary care providers (Access Plus), managed care plans (HealthChoices®), and hospitals (Hospital Care Incentive Program). The Hospital Quality Care Incentive Program uses data hospitals report to PHC4 and CMS, among other sources, to reward hospitals for improvement in patient safety (e.g. better drug therapy management, investment in pharmacy error reduction). In the first year, OMAP provided \$1 million in hospital incentives. In 2008, OMAP will adjust payment to hospitals based on costs attributable to never events.

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LESSONS LEARNED

All visiting officials provided short written summaries of what they gained from the learning exchange and how they planned to apply this new knowledge to their state's work to improve patient safety. This section encapsulates the lessons participants reported from the learning exchange, including:

- making the case for patient safety by converting preventable errors and hospitalizations into avoidable costs,
- elevating patient safety on state agendas by integrating it into other policy initiatives,
- improving and influencing state patient safety policy and processes,
- making contacts for future collaboration on patient safety initiatives,
- demonstrating the impact of patient safety initiatives, and
- tailoring initiatives to reflect the unique circumstances of each state.

The Business Case: Quantifying the Cost-quality Connection

At the learning exchange, host officials explained how Pennsylvania made the business case for investing in patient safety initiatives by tying errors and hospital acquired infections to excessive and avoidable costs in health care. Pennsylvania officials quantified the costs associated with failing to address patient safety as a proportion of all health care costs, and the numbers were too powerful to ignore. Governor Rendell's health care reform proposal calls for improvements in patient safety and quality to reduce overall costs, saying: "charges for uncompensated care for the uninsured, additional days of hospital care due to potentially avoidable hospital acquired infections, certain medical errors, readmissions for complications and infections and avoidable hospitalizations due to inadequate care for patients with chronic diseases total \$7.6 billion per year."³

"Money is an effective communicator. Converting poor, inadequate care into dollars lost packs a big punch and will speak to most people...."
~ Visiting state official

Concrete examples of how Pennsylvania quantified the costs associated with poor care proved to be motivational for many states. Kansas, Illinois, and Washington officials plan to explore opportunities to strengthen data systems in order to

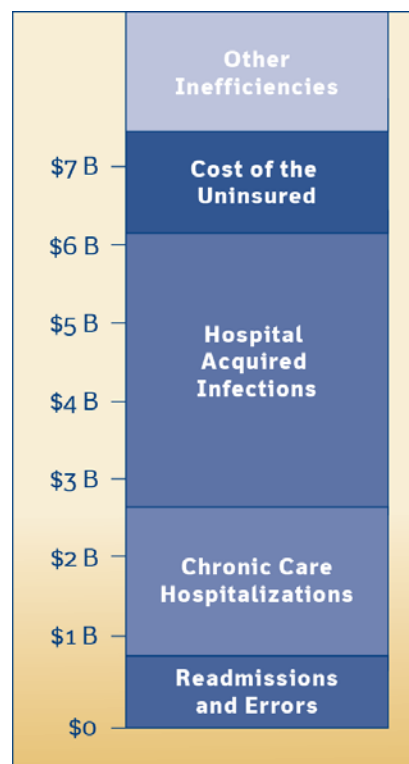


Figure 1: Pennsylvania's Depiction of Avoidable Health Care Costs

(Source: "A Message from Governor Edward G. Rendell" Prescription for Pennsylvania, January 2007)

identify the cost of errors and/or avoidable hospitalizations in their own states. Maryland and Minnesota officials are eager to pursue new opportunities for making the business case for addressing patient safety. Utah has already incorporated the type of “cost of patient safety” graphic presented by Pennsylvania officials (see Figure 1) in an appropriations request and has similar plans for its annual report. Similarly, the District of Columbia presented the information in its testimony before the District Council. Indeed, as Minnesota and New Jersey officials reported, one of the challenges states face in addressing patient safety is the dearth of funding available and allocated to it.

Limited budgets, myriad programs, and competing interests make it imperative that states be able to demonstrate the rationale for investing in patient safety. Pennsylvania officials gave visiting officials additional tools to justify this investment to stakeholders. In fact, many participants reported that seeing how Pennsylvania calculated the cost of avoidable events such as infections was the most significant lesson of the learning exchange.

Elevating Patient Safety on States’ Agendas by Developing a Cohesive Approach

The cornerstone of the Prescription for Pennsylvania is the interdependency of quality, cost, and access. Patient safety is one of several integral pieces of Pennsylvania’s health reform plan, thus health reform discussions provide an opportunity for states to elevate the profile of patient safety. Savings offset by improved patient safety can be invested in other health care initiatives, such as increased access and coverage. In states such as Oregon, Minnesota, and Illinois, patient safety also is, or has the potential to be, part of a larger health care reform initiative. Both Massachusetts’ Health Care Quality and Cost Council, which was created as part of health reform legislation, and Washington State’s recent Blue Ribbon Commission legislation, link cost and quality. Learning more about Pennsylvania’s plan helped reinforce these states’ efforts and provided encouragement to link patient safety to larger state health care system transformation.

“State government needs to be the framework and platform to support and promote collaborative projects. Leadership needs to develop a comprehensive vision to address competing priorities that exist among programs...”
~Visiting state official

Policy and Process Changes

Visiting state officials walked away from the learning exchange with additional ideas for state policy and processes, including those related to data use and stakeholder relations. Several states described how the learning exchange will influence their use of patient safety data moving forward. As mentioned, states plan to use data to connect improved patient safety with savings potential. Additionally, Maryland plans to look for new ways to utilize its discharge data to promote patient safety issues, particularly hospital-acquired infections. Utah is working to redefine data definitions to facilitate the identification of events and collection of data.

State policies will be directly affected at the legislative level as well. Information shared at the learning exchange will impact how Kansas revises its patient safety regulations. Similarly, lessons learned will help inform an executive order related to quality improvement that is in development in Illinois.

The site visit will also affect officials' processes for engaging stakeholders.

After participating in the learning exchange, Kansas reported feeling better equipped to empower risk management personnel and plans to incorporate new information into risk management training. New Jersey plans to channel more energy into fostering local cooperative relationships with libraries, employers, and providers to help use and disseminate patient safety information. Massachusetts intends to involve additional state agencies in its patient safety initiatives, while Wisconsin will focus on collaborating with university personnel in its patient safety efforts.

“The conversations I was able to have with people during breaks were as valuable as the sessions, in some ways, as we could pick each others’ brains about what works and doesn’t work, and find opportunities to take what others have done and make it our own.”
~ *Visiting state official*

Opportunities for New Inter-state and Intra-state Collaboration

At the learning exchange, visiting state officials gained not only greater insight into Pennsylvania's and other states' patient safety activities, but also key contacts for those activities. Officials who found parallels between their own work and that of other states, or who were simply inspired by other states, reported taking the first important step of creating a solid foundation for future collaboration on mutually significant issues. Visiting state officials plan to turn to host officials for their expertise because patient safety initiatives are coordinated and successful in Pennsylvania. At the same time, visiting officials anticipate relying on each other for guidance, given their similar constraints (e.g. limited resources, decentralization) and stages of activity, as well as the successful strategies of participating states. Some examples include:

- Massachusetts plans to contact Pennsylvania officials for future guidance on implementation of its healthcare associated infection project, including risk adjustment issues.
- Similarly, Illinois hopes to garner feedback on its adverse event act from Pennsylvania and Minnesota.
- After discovering state interest in and activity related to wrong-site surgery in other states at the learning exchange, Minnesota has contacted other states about working together in the future.
- Visiting officials from Utah, Maryland, and Washington discovered a mutual interest in perinatal safety issues and will continue to discuss the topic with each other.
- New York found dialogue with New Jersey and Pennsylvania to be useful in its efforts to create a regional, multi-state coalition on the use of color-coded wristbands.⁴

With or without one specific patient safety issue or project linking them together, visiting state officials found value in establishing state contacts that they can turn to for advice and assistance in the months and years to come. Oregon and Minnesota saw parallels between their approaches to patient safety. Neighboring states, such as Washington and Oregon, found the site visit to be helpful in paving the way for future interaction facilitated by their proximity. Even visiting officials from within the same state noted the importance of having this opportunity to connect with their colleagues from other agencies. Officials in several states reported plans to identify and discuss collaboration with state agencies and other entities that are not always present in the safety and quality arena in order to align initiatives and develop a more cohesive state approach to patient safety.

State Approaches to Patient Safety: One Size Does Not Fit All

The learning exchange served to point out that not every state expects to replicate Pennsylvania's approach to patient safety. First, every state environment is distinct. Political climate, state government structure, budget, competing priorities, and state leadership and commitment to patient safety all vary. For this reason, it may not be feasible for states to seek to replicate Pennsylvania's success. Second, visiting officials who are testing alternative models shared their own successful patient safety strategies that they have implemented in their states. Some of their approaches are similar to Pennsylvania, while others are not:

**“We all have the same goal
but are moving along
different paths to get there.”**
~ *Visiting state official*

- Oregon and Massachusetts, like Pennsylvania, have strategic plans for patient safety and quality. The recently passed *Healthy Oregon Act*, creates the framework for a statewide, comprehensive health care reform plan, asks a state agency to develop “recommendations for a model quality institute.”
- New Jersey encourages hospital investment in patient safety via rewards programs with the Leapfrog Group and a large insurance plan that provides financial and public recognition to hospitals.
- Wisconsin is tackling patient safety with an eHealth Action Plan that outlines the path to statewide electronic health record adoption and information exchange.
- Alternative patient safety data strategies include Utah's utilization of data originally designed for other purposes, such as Medical Examiner data about prescription-based overdoses; and New York's use of potentially preventable complication rates derived from administrative data.
- States have developed unique reporting systems, such as Washington's Patient Safety Adverse Event Reporting Program, and New York's NYPORTS system for serious events and a new complementary, near miss hospital event reporting system in which source identification is removed.
- States disseminate patient safety data by educating providers in different ways: Maryland issues clinical alerts, and Minnesota offers provider training, quarterly newsletters, and facility-specific information in its annual reports.

In short, states have adapted successful approaches and carried out innovative strategies to improve patient safety. One size does not necessarily fit all.

Demonstrating Improvement

One challenge with which visiting and host state officials continue to grapple is demonstrating the impact of their patient safety initiatives. States are able to collect and track patient safety data and indicators, but they struggle to produce measures of patient safety *outcomes* because they have difficulty quantifying the effect of events that fail to occur: How does one substantiate the number of errors or infections a provider training or safety advisory helped *prevent*? Does a lack of improvement on a specific patient safety measure necessarily indicate that a state initiative is ineffective or that patient safety is worsening (and vice versa)? How many errors prevented or lives saved does it take to show substantive change and improvement in patient safety? (Some argue that a single life saved or error averted justifies the investment).

“Continuing the conversation with the other states will help those states that are in the early stages of implementing reporting to overcome barriers and continue to draw from the more mature states.”
~Visiting state official

These are unresolved questions that the entire patient safety community will continue to work through together to find meaningful responses. One way the Patient Safety Authority (PSA) demonstrates improvement is via a survey of patient safety officers. For instance, 77% of patient safety officers surveyed in 2006 reported that a PSA Patient Safety Advisory caused them to make a change in their facility’s practices.⁵ For Pennsylvania officials, first-hand accounts from the perspective of providers and others that enumerate the positive impact of patient safety initiatives are a compelling alternative and supplement to statistics.

Continuing Support

Several themes emerged among states’ ideas and requests for continuing support.

First, states are eager to learn more from each other and see value in working across state lines to improve patient safety, for example via regional exchanges or multi-state projects.

Second, participants see a need for insight from and exchange with federal and national entities, including the Centers for Medicaid & Medicare Services, National Quality Forum, and Institute for Healthcare Improvement. States are interested in streamlining measures across these organizations to reduce hospital and provider burden across states. Also, there is state interest in creating a standardized reference for sentinel events, which would aid in decreasing variation in interpretation across states.

Third, visiting officials believe issue-specific meetings would be beneficial. Topics of interest include: approaches to HAI reporting, perinatal safety issues, discontinuing payment for never

events/ HAIs, health information technology, and the effect of pay-for-performance on patient safety.

Last, in addition to uncertainty regarding measuring impact of patient safety, states face other challenges. A few examples of existing challenges are:

- aligning initiatives to develop a cohesive state approach to patient safety,
- successfully collaborating with stakeholders who have differing priorities and agendas,
- determining how to make information meaningful to consumers,
- monitoring provider understanding and use of patient safety information, and
- obtaining an adequate source of funding to make gains in patient safety and quality.

“Many states are collecting data related to patient safety but translating that data into improvements and measuring that improvement remain significant challenges.”

~Visiting state official

States would benefit from additional opportunities to discuss these challenges as they strive to improve patient safety.

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CONCLUSION

State officials are eager to sustain relationships fostered by the site visit and continue to learn from others' approaches. Participants reported that the event re-energized them, validating their patient safety efforts and providing take-away information. The event showed that one size does not fit all in the realm of patient safety initiatives; states must implement customized approaches that fit their states' needs and circumstances. While offering ideas and alternatives, the event also underscored challenges states face in implementing patient safety initiatives within their diverse environments and individual constraints.

The overwhelmingly positive reaction from learning exchange participants speaks to the value of providing states with the opportunity to convene and exchange ideas about patient safety with their peers.

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Notes

¹ Institute of Medicine. *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 2000), 26.

² PHC4. *Hospital-acquired infections in Pennsylvania* (November 2006), 1. Available online at <http://www.phc4.org/reports/hai/05/docs/hai2005report.pdf>

³ <http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Rx-for-Pennsylvania.pdf>

⁴ New Jersey published its protocol for color coded wristbands in October of 2007. Information is available online at <http://www.njha.com/qualityinstitute/colorcodes.aspx>.

⁵ Patient Safety Authority. *2006 Annual Report*. April 30, 2007, page 5. Available online at http://www.psa.state.pa.us/psa/lib/psa/annual_reports/annual_report_2006.pdf

APPENDIX A: AGENDA, PENNSYLVANIA LEARNING EXCHANGE

Wednesday, September 19, 2007	
2:00-2:30 pm	<p>Welcome and introductions</p> <p><u>Speaker</u> Jill Rosenthal, M.P.H., Program Director, National Academy for State Health Policy (NASHP)</p>
2:30-4:00 pm	<p>Driving change with effective leadership: Building a statewide mandate for patient safety and quality reform</p> <p>This session will review the patient safety components of Governor Rendell's Prescription for Pennsylvania and the efforts to create coherent state policy. It will include an introduction of the key PA state agencies and their various distinct roles in addressing patient safety.</p> <ul style="list-style-type: none"> • Who are your vital partners/leaders and how did you gain their support? • How do you plan to build the necessary infrastructure and ensure coordination among various state agencies involved? • How did you set priorities for change? • What are past and present roadblocks and strategies to move them? • How do states, which may not have designated funding for patient safety, make gains in patient safety and quality? <p>Other approaches: two states will comment on the PA approach and share their patient safety & quality strategic plans.</p> <p><u>Speaker</u> Ann Torregrossa, J.D., Deputy Director & Director of Policy, Governor's Office of Health Care Reform (Pennsylvania)</p> <p><u>State reactors</u> Jim Dameron, M.A., M.F.A., Administrator, Oregon Patient Safety Commission Eileen McHale, R.N., B.S.N., Patient Safety Ombudsman, Betsy Lehman Center for Patient Safety and Medical Error Reduction (Massachusetts)</p>
4:00-4:15 pm	Break
4:15-5:30 pm	<p>Building a case for change: The power of meaningful data</p> <p>Good policy needs to be based on good data. This session will explore how two Pennsylvania agencies have created their data systems for patient safety information, the types of information considered critical, and their strategies for collection and de-identification.</p> <ul style="list-style-type: none"> • What kinds of data are being collected? • Can existing state data systems be used? What are the pros/cons of creating separate systems versus using existing systems, including surveillance? • What are past/present barriers and strategies to overcome them? • Reflection: if you had to do it over again, what would you do differently? <p>Other approaches: two states will comment on the PA approach and share their data collection strategies.</p> <p><u>Speakers</u> Flossie Wolf, M.S., Director, Health Policy Research, Pennsylvania Health Care Cost Containment Council (PHC4) Michael C. Doering, M.B.A., Executive Director, Pennsylvania Patient Safety Authority (PSA) John R. Clarke, M.D., Clinical Director, Pennsylvania Patient Safety Reporting System (PA-PSRS)</p> <p><u>State reactors</u> Iona M. Thraen, M.S.W., Patient Safety Director, Utah Department of Health Ellen Flink, M.B.A., Director of Research in Patient Safety and Quality Initiatives, New York State Department of Health</p>
6:30 pm	Dinner

Thursday, September 20, 2007	
7:30-8:00 am	Breakfast
8:00-9:30 am	<p>Translating data into practice: Creating meaningful change</p> <p>Once data is collected, state agencies need to determine how to analyze and disseminate it so that stakeholders can use it to create improvements. This session will explore Pennsylvania's approaches, including issuing safety advisories for providers, patient safety training for providers and board members, and consumer reports.</p> <ul style="list-style-type: none"> • What are the goals of the two state agencies in data dissemination, and how do they intersect? • How do you balance the need for transparency with the need to create or maintain a culture of safety among the professional community? • How have you determined what information is meaningful to consumers/providers/other stakeholders? • How do you share lessons across facilities without overwhelming them, and monitor/assess their understanding/use of information? • What is your strategic plan? • How do you measure your impact? <p>Other approaches: two states comment on the PA approach and share their strategies for using data.</p> <p>Speakers <i>Joe Martin</i>, Director of Communications and Education, PHC4 <i>Michael C. Doering, M.B.A.</i>, Pennsylvania PSA <i>John R. Clarke, M.D.</i>, PA-PSRS</p> <p>State reactors <i>Anne Jones, R.N., B.S.N., M.A.</i>, Nurse Surveyor II, Maryland Office of Health Care Quality <i>Diane Rydrych, M.A.</i>, Assistant Director, Division of Health Policy, Minnesota Department of Health</p>
9:30-9:45 am	Break
9:45-11:15 am	<p>Translating data into state policy: Compliance and enforcement approaches to improvement</p> <p>Compliance with best practices is not always easy, and incentives can help make sure change is uniform/fair across the state. This session will include a discussion of Medicaid's value-based purchasing and plans to discontinue payments for never events, DOH enforcement of facility licensure requirements including ensuring that hospitals and nursing homes implement required proven, effective infection control procedures, patient notification requirements, and other policies.</p> <ul style="list-style-type: none"> • How have state policy makers used data to drive policy decisions and sought to develop an evidenced-based approach? • How do state policy makers balance incentives and disincentives to change? Learning and accountability? • How can state policy makers increase standardization of best practices when the medical culture strives for autonomy? • How do you measure your impact? <p>Other approaches: two states will comment on the PA approach and share their strategies for creating change.</p> <p>Speakers <i>Ann Torregrossa, J.D.</i>, Governor's Office of Health Care Reform (Pennsylvania) <i>Stacy Mitchell, M.P.H.</i>, Acting Deputy Secretary for Quality Assurance, Pennsylvania Department of Health (DOH) <i>Michael Nardone</i>, Deputy Secretary, Pennsylvania Department of Public Welfare (DPW) <i>David K. Kelley, M.D., M.P.A.</i>, Chief Medical Officer, Pennsylvania DPW</p> <p>State reactors <i>Leonard Leto, M.S.</i>, Manager, Policy and Planning, New Jersey State Health Benefits Program <i>Douglas Englebert, R.Ph.</i>, Pharmacy Practice Consultant, Wisconsin Division of Quality Assurance</p>
11:15-11:30 am	Break

<p>11:30 am-1:00 pm</p>	<p>Internal forces and external drivers: Purchaser, provider, and consumer perspectives on private and state initiatives</p> <p>States need to work in partnership with private stakeholders to advance patient safety. This session will explore perspectives of Pennsylvania stakeholders including their role in state initiatives, private sector efforts, and synergy or tension between the two.</p> <ul style="list-style-type: none"> • What is/should be the role of the private sector in Pennsylvania's patient safety plans—as purchasers, providers, and consumers? • What do consumers want/need to know? • What have been the greatest obstacles to working with the state and what strategies have you used to overcome them? • How have state initiatives helped/hindered private efforts to improve safety? • What are best or preferred strategies for states to engage purchasers, providers, board members, and consumers? <p>Other approaches: two states will comment on the PA approach and share their strategies for working with private sector stakeholders.</p> <p>Speakers Karen Wolk Feinstein, Ph.D., President and Chief Executive Officer, Jewish Healthcare Foundation and Pittsburgh Regional Health Initiative Paula A. Bussard, Senior Vice President, Policy and Regulatory Services, The Hospital & Healthsystem Association of Pennsylvania James Browning, M.A., Director, Pennsylvania Public Interest Research Group</p> <p>State reactors Eileen McHale, R.N., B.S.N., Betsy Lehman Center for Patient Safety and Medical Error Reduction (Massachusetts) Linda Furkay, Ph.D., R.N., Patient Safety Adverse Event Officer, Washington Department of Health</p>
<p>1:00-1:45 pm</p>	<p>Lunch</p>
<p>1:45-3:15 pm</p>	<p>Creating the state infrastructure: Strategies for success</p> <p>This session will review the major issues that states face in efforts to move the state patient safety agenda forward in a strategic way. These issues include: leadership, communicating and coordinating across state agencies and avoiding silos, resource allocation and prioritization, creating and balancing a vision with the everyday work, partnering with the private sector, measuring impact, and financing. Other approaches: two states will comment on the PA approach and share their strategies for overcoming challenges faced in their state systems.</p> <p>Moderator Jill Rosenthal, M.P.H., NASHP</p> <p>Panelists Michael C. Doering, M.B.A., Pennsylvania PSA David K. Kelley, M.D., M.P.A., Pennsylvania DPW Joe Martin, PHC4 Stacy Mitchell, M.P.H., Pennsylvania DOH Michael Nardone, Pennsylvania DPW Ann Torregrossa, J.D., Governor's Office of Health Care Reform (Pennsylvania)</p> <p>State reactors Jim Dameron, M.A., M.F.A., Oregon Patient Safety Commission Ellen Flink, M.B.A., New York State Department of Health</p>
<p>3:15-3:30 pm</p>	<p>Next steps and adjourn</p> <p>This session will describe the next steps in the project.</p> <p>Speaker Jill Rosenthal, M.P.H., NASHP</p>

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APPENDIX D: PRESENTATION, PRESCRIPTION FOR PENNSYLVANIA



Driving change with effective leadership:
Building a statewide mandate for patient
safety and quality reform
Ann S. Torregrossa, Esq.
Deputy Director & Director of Policy
GOHCR

GOHCR | Edward G. Rendell, Governor, Commonwealth of Pennsylvania | www.RxforPa.com

Vital State Partners

- Pennsylvania Health Care Cost Containment Council (PHC4)
- Patient Safety Authority (PSA)
- Department of Health
- State-funded health coverage programs
 - Department of Public Welfare (DPW)
 - PA Employee Trust Benefit Fund (PEBTF)
 - adultBasic & CHIP Programs
- Department of Insurance

2



Rx for Affordability

Pennsylvania Health Care Cost Containment Council (PHC4)

- PHC4 is an independent entity created by state law.
- The Council is made up of labor and business representatives and health care providers.
- The Council seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparative information about the most efficient and effective health care providers to consumers and purchasers of health services.
- Hospitals and ambulatory surgery centers are mandated to provide PHC4 with charge and treatment information, which represents 3.8 patient encounters a year. PHC4 collects data from HMOs on a voluntary basis.
- The Council produces free public reports by procedure and provides a great deal of data to GOHCR that has been critical to our health care reform efforts.
- Funded through the Pennsylvania state budget.

3



Patient Safety Authority (PSA)

- An independent entity created by state law.
- 400 healthcare facilities are required to report serious patient safety events (actual occurrences and incidents (patient safety near-misses) to PSA through the confidential web-based report system.
- PSA analyzes and evaluates the reports and makes recommendations for change in health care practices and procedures to reduce the number and severity of patient safety issues.
- PSA's role is non-regulatory and non-punitive, although serious events reported to PSA are forwarded to the Department of Health, the health care licensing agency.
- PSA has a dedicated funding stream from an annual surcharge on licensing fees, which goes into a trust fund for PSA.

4



Pennsylvania Department of Health

- Responsible for licensing health care facilities.
- Periodic inspections to ensure compliance with laws and regulations.
- Regulatory enforcement for facilities that are not meeting requirements through requiring plans of correction, imposing fines, banning admissions, and licensure action.
- Publishes information on the web on inspection reports of nursing facilities, etc.

5

State Agencies that Fund Health Care Coverage

- Department of Public Welfare administers the Medicaid Program, which covers about 1.8 million individuals.
- The Pennsylvania Department of Insurance administers the adultBasic Program with about 54,000 enrollees and the Children's CHIP Program with 164,146 children.
- The Pennsylvania Employees Benefit Trust Fund provides coverage for 84,000 state employees and dependents and 60,000 retirees and their dependents.
- Pennsylvania is a very large purchaser of health care and can use its purchasing leverage to impact patient safety not only for those for whom we pay for care, but others.

6

Pennsylvania Department of Insurance

- Seeking legislation to give the Insurance Commissioner expanded powers to review rate increases and deny requests if the insurance company has not made progress through its healthcare providers to reduce costs associated with:
 - Additional care associated with hospital-acquired infections.
 - Certain readmissions
 - Avoidable hospitalizations due to inadequate community-based chronic care.
 - Medical misadventures

- PHC4 data has helped us make the case that far too much of the cost of health care is due to inferior care that threatens patient safety and will be used by the Commissioner for rate increase reviews.

7

Setting Priorities for Change

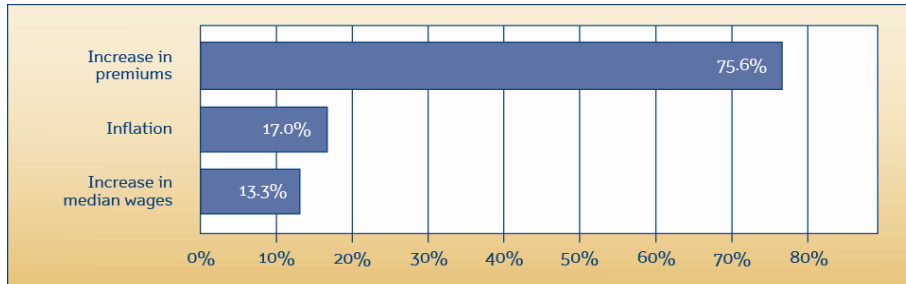
- PA was one of the last states to receive a HRSA state planning grant to provide greater access to affordable health care coverage.
- Convinced HRSA that we could not look at access in isolation, we also had to look at reforms that would impact cost, quality and patient safety.
- The Governor appointed 101 Pennsylvanians to serve on an Advisory Board.
- We used the grant funds to hire consultants who had worked with other states, including Maine and Vermont.
- We asked the consultants to first give us an overview of the state of our state on the critical issues of access, quality and cost.

8

State of the State

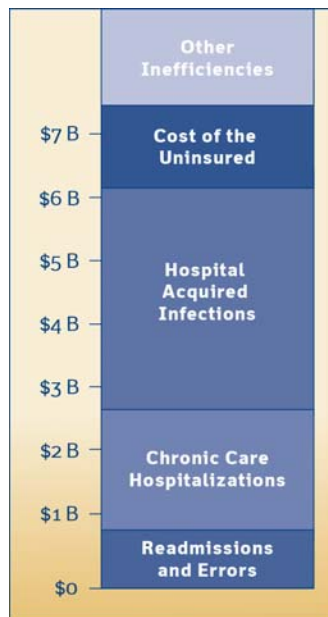
Pennsylvania's Employees and Pennsylvania's Businesses Cannot Keep Up with Health Care Inflation

% Increase in Family Health Insurance Premiums vs. Inflation and Increase in Median Wages in PA Between 2000 and 2006



9

Prescription for Pennsylvania



The cost of inaction is far too great.

10

Prescription for Pennsylvania

Prescription for Pennsylvania is a set of integrated practical strategies for improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost.



Right State | Right Plan | Right Now

11



Rx for Pennsylvania Initiatives

Making Quality Health Care Accessible, Affordable and Cost Effective

Rx for Affordability	Rx for Access	Rx for Quality
Cover All Pennsylvanians	Health Care Workforce	Hospital-Acquired Infections
Coverage for College Students and Young Adults	Removing Practice Barriers	Quality Outcomes
Community Benefit Requirements	Cost-Effective Sites	Pay for Performance
Uniform Admission Criteria	Co-Occurring Disorders	Chronic Care
Fair Billing and Collection Practices		Health Disparities
Capital Expenditures		Child Wellness
Small Group Insurance Reform		Adult Wellness
Transparency of Cost and Quality Data		Long Term Living
		End of Life and Palliative Care

12



Progress to Date

- Health-Care Acquired Infection bill passed that requires mandatory reporting of HAIs to CDC and sharing of this data by PSA and PHC4.
 - Mandatory filing of Infection Control Plans by hospitals, nursing facilities, and ambulatory surgical centers with DOH for approval.
 - Electronic surveillance using lab data by hospitals unless good cause shown to DOH by December 31, 2008.
 - Insurers must pay for infection screenings.
- The billion dollars in hospital charges for additional care for HAIs and the ability to quantify the hospital HAIs (34,369 infections) and the related deaths (4,221) in 2006 made the case with the legislature and the hospitals that change was needed.
- Scope of practice bills to facilitate team care and improve access.
- Creation of a Chronic Care Commission to recommend the infrastructure needed to widely disseminate the Chronic Care Model throughout the State.
- Creation of an Office of Health Equity for health disparities.

13



Coming Soon

- Executive Order to Create a Pay for Performance group so that other payers can join with the state in having common pay for performance efforts, measures and desired outcomes.
- Not paying for Never Events in our state-funded programs, ultimately not paying for extra care due to HAIs.
- New comprehensive hospital regulations.
- Expanding urgent care, wellness mobile vans, FOHCs and nurse managed health care.

14



Coming Soon--We hope

- Cover All Pennsylvanians: subsidized health care coverage for individuals up to 300% FPL and for small low-wage businesses that have not offered health care coverage to their employees in the last 6 months. (We have Cover All Kids with subsidies up to 300% FPL).

- Insurance reform
 - One of only 3 states that does not limit how insurance companies can rate small group and individual coverage.
 - Adjusted community rating.
 - Minimum loss ratio of 85%.
 - Allowing Commissioner to deny rate requests that exceed a certain level if there has not been progress in reducing HAIs, avoidable hospitalizations and avoidable readmissions.

15

Roadblocks Past and Present

- The power of special interests, especially the Hospital Association.
- Lack of campaign finance reform and need of legislators to obtain funding from special interests to finance their campaigns.
- Partisan politics
 - Only got the HAI bill because it was lead by a Democrat in the House and a Republican in the Senate.
- President Bush's hard line on income levels for subsidized coverage. At what income level will CMS approve an 1115 waiver?
- No new tax pledges taken by many legislators they felt necessary to get elected. How can we fund this without new revenue?
- Eliminating state agency silos and getting everyone working in a complimentary direction.

16

How to get started without funding?

- It is critical to make the case that the state cannot afford to not get started.
- Determine the cost of HAIs, avoidable hospitalizations, readmissions, uncompensated care past on to payers.
- Appoint an Advisory Group to ratify and legitimize your recommendations--not the usual characters.
- Look at mechanisms that do not cost the state anything:
 - Require hospitals to report to CDC and allow state agency access to HAI data.
 - Increase licensure fee to pay for patient safety efforts, as was done with our Patient Safety Authority. Get business and labor to push for patient safety efforts that will reduce the cost of health care.

17

Prescription for Pennsylvania

Prescription for Pennsylvania is a set of integrated practical strategies for improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost.



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