The Flood Tide Forum

State Patient Safety Centers:
A new approach to promote patient safety

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ACKNOWLEDGMENTS

EXECUTIVE SUMMARY

Medical errors are a leading cause of death in the United States. Research indicates that serious safety issues cut across settings of care. As the evidence grows, so, too, do attempts to address the problem. In the past five years, six states have enacted legislation supporting the creation of a state patient safety center to help address the problem. Most centers are still in their infancy; nonetheless, several have already forged ahead with projects.

This report examines the various models that states have adopted in designing their centers and includes discussions of how the centers operate and monitor performance. It also summarizes recommendations from center staff to other states that may follow in their footsteps. The information was gathered during a Flood Tide Forum, a small invitational discussion, that NASHP convened in July 2004 to discuss patient safety centers. Center administrators, board members, and state regulatory agencies participated from each of the six states that have moved forward to create a patient safety center.

All six patient safety centers are legislatively authorized or endorsed in some manner. This authorization distinguishes them from other state public or public/private patient safety programs or coalitions. Most patient safety centers are governed by a board of directors. Several states also have advisory committees that support the work of the centers.

Four of the centers are housed within state government, and two others are located outside of, but have legislatively authorized affiliations with, state government. However, whether the center is housed within or outside state government does not alone dictate how a center interfaces with that government. Authorizing legislation is pivotal in describing working relationships and/or the autonomy that the center will exercise in the conduct of its work.

Patient safety centers may have different governing structures, operations, and activities, but they share similarities in their mission statements. All six centers include a statement about improving, ensuring, or promoting patient safety. The most universal function, common to all six patient safety centers, is to educate providers about best practices to improve patient safety. Other common roles include identifying the causes of patient safety problems, fostering a culture of safety, developing collaborative relationships among patient safety stakeholders, and educating consumers about patient safety. As these roles suggest, centers plan to emphasize a collaborative model of working with providers to improve safety, whether the centers are public or private entities.

Five of the six states with centers have separate mandatory reporting systems for serious adverse events, and these systems are housed within state regulatory agencies. Several centers have access to that data and will assist with its analysis. Three of these states chose to develop within their patient safety centers a voluntary reporting system for less serious errors. These systems are intended to complement the mandatory system already in existence in their states.

Center officials face a number of challenges. The level and reliability of funding is an issue in most states. Fees, grants, and appropriations are the primary means of support for the patient safety centers. Staffing levels are modest. Despite efforts to carefully separate patient safety

center activities from state regulatory processes in many states, providers may be hesitant to participate in some patient safety center activities, especially reporting, due to fear of publicity or negative repercussions, even though the center data systems offer strong data protections.

All six states are required to submit periodic progress reports to their legislative and/or executive branch. However, measuring progress may be a challenge, given a lack of clear indicators for measuring whether health care systems are safer. Despite the desire to focus on creating safer health care systems, many of the center activities and measurements focus on clinical process improvements, since measures are more readily obtainable for these activities.

Forum participants had a number of recommendations for states that are interested in following their lead. Legislative authority should be clear, center activities should be coordinated with other state activities, and centers should begin by focusing on creating a culture of safety. Other decisions, such as whether to house the center within state government and whether to create a reporting system, may depend on state-specific factors.

INTRODUCTION

Medical Errors and the State Role

In 1999, the Institute of Medicine released *To Err is Human*, which estimated that medical errors in hospitals alone cause as many as 98,000 patient deaths and more than one million patient injuries, at a cost of up to $29 billion each year.[1] As the report detailed, medical errors are a leading cause of death in the United States; more people die as a direct result of medical errors in a given year than die from motor vehicle accidents, breast cancer, or AIDS. Since the 1999 report, the nation's understanding of the magnitude of the problem has grown. Additional studies have focused on ambulatory and nursing-home care settings and suggest that medical errors in these and other settings also result in a significant number of deaths and injuries.

Stakeholder groups have attempted to address the problem through various avenues. The federal government, provider organizations, purchasers, and consumers have all focused on the issue. States, which have a responsibility to protect public health and safety, have addressed the issue in a variety of ways as well. The most focused area of state activity has been in the development and refinement of state mandatory reporting systems. The National Academy for State Health Policy (NASHP) has tracked state activity and progress in this area and provided technical assistance to states.[2] Although mandatory reporting systems have dominated the states' agendas, other more collaborative and proactive approaches have begun to emerge. States recognize that in order to improve the safety of the health care system, they must collaborate with providers, consumers, and purchasers; provide leadership to establish clear goals; develop useful benchmarks to measure progress; and coordinate across all agencies of state government to achieve their desired outcomes.

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[1] Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999).

[2] Jill Rosenthal, Maureen Booth, *Defining Adverse Events: A Guide for States Tracking Medical Errors* (Portland, ME: National Academy for State Health Policy, 2003); Jill Rosenthal, Maureen Booth, *How Safe Is Your Health Care? A Workbook for States Seeking to Build Accountability and Quality Improvement Through Mandatory Reporting Systems* (Portland, ME: National Academy for State Health Policy, 2001); Lynda Flowers and Trish Riley, *State-Based Mandatory Reporting of Medical Errors: An Analysis of the Legal and Policy Issues* (Portland, ME: National Academy for State Health Policy, 2001); Jill Rosenthal, Maureen Booth, and Anne Barry, *Cost Implications of State Medical Error Reporting Programs: A Briefing Paper* (Portland, ME: National Academy for State Health Policy, 2001); Lynda Flowers and Trish Riley, *How States Are Responding to Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, 2000); Trish Riley, *Improving Patient Safety: What States Can Do About Medical Errors* (Portland, ME: National Academy for State Health Policy, 2000); Jill Rosenthal et al., *Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives*, (Portland, ME: National Academy for State Health Policy, 2001); Jill Rosenthal, Trish Riley, and Maureen Booth, *State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey* (Portland, ME: National Academy for State Health Policy, 2000).

Patient Safety Centers: A New Approach

Since 2000, six states have enacted legislation supporting the creation of a state patient safety center. These entities include:

- the Florida Patient Safety Corporation,
- the Maryland Patient Safety Center,
- the Betsy Lehman Center for Patient Safety and Medical Error Reduction (Massachusetts),
- the New York Center for Patient Safety,
- the Oregon Patient Safety Commission, and
- the Pennsylvania Patient Safety Authority.

These centers may be designated as commissions, authorities, or corporations, but they share some characteristics. All six centers are designed to house and coordinate statewide patient safety activities. Specifically, patient safety centers are charged with promoting patient safety through a variety of activities, which vary by state but may include:

- educating health care providers and patients regarding processes that may reduce future occurrences of adverse events;
- developing systems of near miss[3] and/or adverse event data reporting, collection, analysis, and dissemination to improve the quality of health care;
- fostering the creation of safety cultures to identify and determine the causes of adverse events and near misses;
- informing consumers about patient safety issues;
- serving as a clearinghouse for the development, evaluation, and dissemination of best practices;
- promoting ongoing collaboration between the public and private sectors and
- coordinating state agency initiatives.

Most of the six centers are still in their infancy; nonetheless, many have forged ahead with projects. These early adopter states, as well as others that are following in their footsteps, have expressed an interest in understanding the similarities and differences in center goals, activities, and operations. They are also interested in learning from one another about the challenges they have faced and the successes they have accomplished during the early stages of implementation.

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[3] According to the Institute of Medicine, an adverse event is an injury caused by medical management rather than the underlying condition of the patient. A near miss is an error that does not result in harm. Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999), 28.

Purpose and Overview of the Project

NASHP convened a Flood Tide Forum on patient safety centers in July 2004. Flood Tide Forums are small, invitational discussions convened and facilitated by NASHP to provide state health policy leaders with an opportunity to meet informally and explore emerging issues. Each Forum provides participants with an opportunity to assess the successes and challenges of initiatives, to learn from their colleagues about promising new policies and programs, and to craft new ideas for future action in state health policy.

In tracking state efforts to address concerns about patient safety, NASHP noted a growing trend among states to establish patient safety centers. Hoping to provide states that had established such centers with an opportunity to share insights with one another and a means to share lessons learned with additional states, NASHP organized a Flood Tide Forum on the topic. The Forum was intended to clarify and define the various patient safety center models, examine their operations, and identify perceived indicators of success. A profile of patient safety center characteristics was prepared to facilitate discussion and is included as Appendix A.

Meeting participants included representatives of the six states with patient safety centers as well as several additional states that are considering developing centers. Center board members, center directors, and state regulatory agency officials were invited to participate. Representatives from states without centers were asked to raise issues of interest to states that may be considering the establishment of a center.

Information gathered prior to and during the meeting is provided in the following sections which are organized to mirror the agenda of the meeting:

1. Patient safety center models,
2. Patient safety center operations,
3. Performance monitoring, and
4. Recommendations to other states.

Each section provides information on the six centers and analyzes similarities and differences among them.

PATIENT SAFETY CENTER MODELS

Enabling Legislation

All six patient safety centers are legislatively authorized or endorsed in some manner. This authorization distinguishes them from other state public or public/private patient safety programs or coalitions.

In many cases, the legislative impetus for patient safety centers originated from interest in a broader issue. For instance,

- Patient safety center authorization is included within broader legislation in Florida, New York, and Pennsylvania. In these states, the legislation focused more broadly on affordable health care (Florida), consumer information and quality improvement (New York), and malpractice reform (Pennsylvania).
- The impetus behind the creation of the Massachusetts center was the death of Boston Globe reporter Betsy Lehman (as the result of a chemotherapy overdose) and the consumer interest and public pressure that followed her death.
- New York's legislation was consumer driven. It mandated publication of outcome measures and physician profiles in addition to creation of a patient safety center.
- Florida, Oregon, and Pennsylvania capitalized on the convergence of patient safety and medical malpractice insurance issues.
- Oregon chose to create a center with a voluntary reporting system, in part to give a collaborative model a fair chance to succeed. If it does not, the state legislature is obligated to consider a mandatory approach in 2007.
- The motives in Massachusetts and Maryland also included recognizing and strengthening existing patient safety coalitions.

The motive for the establishment of a patient safety center may influence the activities of the center, as discussed later in this report.

Maryland's center is unique in that the legislation provides medical review committee status (sometimes referred to as peer review) to a center designated by the Maryland Health Care Commission, which is a state agency. Although Maryland differs from the other centers in that the legislature did not enact specific legislation to create a center, the legislature nonetheless endorsed the creation of the center by giving it legislatively-authorized privileges.

Table 1 provides information on the enabling legislation for the six patient safety centers.

Table 1   Enabling legislation

Florida	Established in the 2004 Affordable Health Care for Floridians Act (HB 1629). Section 18, Section 381.0271, Florida Statute (http://election.dos.state.fl.us/laws/04laws/ch_2004-297.pdf, section 18, pp. 24-30)
Maryland	Legislature required a study of feasibility in Patients' Safety Act of 2001 (HB 1274), Section 19-139 of the Health General Article (http://mlis.state.md.us/2001rs/bills/hb/hb1274f.rtf). In 2003, the legislature provided medical review committee status to a center designated by the Maryland Health Care Commission (MHCC) as the Maryland Patient Safety Center (HB164), Section 1-401 of the Health Occupations Article (http://mlis.state.md.us/PDF-Documents/2002rs/bills/hb/hb1259f.pdf)
Massachusetts	Established as an outside section (not a line-item) without funding in Fiscal Year 2002 Budget (Chapter 177 Section 6 of the Acts of 2001). General Laws of MA. Part 1, Title II, Chapter 6A, Section 16E (http://www.mass.gov/legis/laws/seslaw01/sl010177.htm)
New York	Established in Patient Health Information and Quality Improvement Act of 2000. Article 29D Title 2 S2998 PHL7 (http://ssl.csg.org/dockets/22cycle/2002A/2002Abills/2122a05ny.html)
Oregon	Established in Chapter 686 Oregon Laws 2003 (HB2349) (http://www.leg.state.or.us/orlaws/sess0600.dir/0686ses.htm) and in Oregon Revised Statutes 442.820 - 442.990 (http://www.leg.state.or.us/ors/442.html
Pennsylvania	Established in Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act, P.S. 40, § 1303 (http://www.mcare.state.pa.us/mclf/lib/mclf/hb1802.pdf)

Mission

Although patient safety centers may have different governing structures, operations, and activities, they share similarities in their mission statements. All six centers include a statement about improving, ensuring, or promoting patient safety. Other common features of many of the centers include:

- fostering a culture of safety,
- educating about patient safety, and
- potentially serving as a data repository.

Massachusetts' mission statement is unique in its emphasis on coordinating functions. The mission includes coordinating patient safety programs across state agencies, between the state and federal level, and between the private and public sectors. A previous NASHP report found that in most cases state responsibility for patient safety is spread across an array of state agencies leading to a fragmented approach.[4] Massachusetts' approach may address that concern.

Table 2 provides mission statements for the six patient safety centers.

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[4] Jill Rosenthal, Maureen Booth, Lynda Flowers, Trish Riley, *Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives*, (Portland, ME: National Academy for State Health Policy, 2001); 86.

Table 2   Mission

Florida	To serve as a learning organization dedicated to assisting health care providers in this state to improve the quality and safety of health care rendered and to reduce harm to patients. The corporation shall promote a culture of patient safety in the health care system in this state. The corporation shall not regulate health care providers in this state.
Maryland	To serve as a data repository for a voluntary adverse event and near miss reporting system for all health care facilities statewide, and as the primary coordinator for educational activities focused around patient safety issues.
Massachusetts	To serve as a clearinghouse for development, evaluation and dissemination, including but not limited to, sponsoring training and education programs, best practices, coordinating state agency initiatives, promoting ongoing collaboration between the public and private sectors, coordinating state and federal patient safety programs, and promoting patient safety through educating both health care providers and patients
New York	To maximize patient safety; reduce medical errors; improve the quality of health care by improving systems of data reporting, collection, analysis, and dissemination; improve public access to health care information
Oregon	To improve patient safety by reducing the risk of serious adverse events occurring in Oregon's health care system and by encouraging a culture of patient safety in Oregon
Pennsylvania	To reduce and eliminate medical errors by identifying problems and recommending solutions that promote and ensure patient safety

Table 3 illustrates the various patient safety centers' roles. All six centers plan to focus on educating providers about best practices, promoting collaboration between the public and private sectors, and informing consumers about patient safety issues. Other common roles are: identifying the causes of patient safety problems, fostering a culture of safety, and recommending statewide goals. As these roles suggest, centers plan to emphasize a collaborative model of working with providers to improve safety, whether the centers are public or private entities. Cross-agency coordination and addressing accountability, which are both features of Massachusetts' state system, are less common. Purchasing and regulatory functions are not common.

Table 3   Patient safety center roles

Role	FL	MD	MA	NY	OR	PA
Educate providers about best practices to improve patient safety	✔	✔	✔	✔	✔	✔
Promote collaboration and/or build consensus between public and private sectors	✔	✔	✔	✔	✔	✔
Inform consumers about patient safety issues	✔	✔	✔	✔	✔	✔
Foster creation of a culture of safety	✔	✔		✔	✔	✔
Recommend statewide goals and track progress	✔	✔		✔	✔	✔
Serve as a clearinghouse for best practice information	✔	✔	✔	✔	✔	
Promote collaboration between federal and state initiatives	✔		✔	✔	✔	✔
Review and promote patient safety research	✔	✔		✔		✔
Evaluate and/or promote health information technology to improve patient safety	✔	✔	✔	✔		
Implement a reporting system to collect, analyze, and evaluate patient safety data to identify causes of patient safety problems	✔	✔			✔	✔
Coordinate state agency initiatives	✔		✔	✔		
Analyze existing data sources for their potential to provide patient safety information (malpractice data, Medicaid data, etc.)	✔	✔		✔		
Recommend health professional curricula to address patient safety	✔	✔		✔		
Address provider and system accountability	✔		✔			
Propose state regulations and rules that address patient safety	✔		✔			

Governance Structure

Most patient safety centers are governed by a board of directors. This is true in Florida, Massachusetts, Oregon, and Pennsylvania. However, the memberships of these boards are quite distinct. In three of the states, the boards include representatives of various stakeholders groups, including health care providers (OR, PA) or their associations (FL); consumer groups and purchasers (FL, OR); and medical insurers (FL, OR,) among others. Oregon's and Pennsylvania's boards are appointed by the governor and legislature. Florida's statute specifies which stakeholder groups may appoint directors to the board. They include the state hospital association, practitioner associations, and payers. Because Massachusetts' center is an entity within state government, its board is comprised of three secretary-level state officials. The other two centers, in Maryland and New York, are overseen by their center directors.

Several states also have advisory committees or councils that support the work of the centers. The state coalition in Massachusetts functions as an advisory committee to the board. Maryland has a leadership council that is responsible for day-to-day activities and an advisory board, composed of representatives from various stakeholder groups, that is responsible for guiding overall center activities. Maryland's advisory board is unique in including members who do not reside in the state but who have national expertise to contribute. New York forms advisory committees for assistance on particular projects and is unique in that no board or advisory group is required by legislation.

Four of the five centers with boards include state government representatives (MA, MD, OR, PA). Massachusetts' board includes only state officials. Pennsylvania's legislation specifies that the board is chaired by the state Physician General. However, if there is no Physician General, the Governor can appoint any physician to serve as board chair. In that case, there would not be any government official on the center board. Government officials serve in *ex-officio* roles in Maryland. In contrast, Florida specifically excludes state agencies from its board in an effort to ensure that the center is entirely separate from state regulatory functions. However, the board anticipates working with state universities to provide analytic and technical expertise.

Table 4 details the governance structure in each of the six states.

Table 4   Governance structure

Florida	*Board of directors* including chair of the Florida Council of Medical School Deans, health insurer, health maintenance organization, medical malpractice insurer, Central Florida Health Care Coalition president, two hospital representatives, and representatives of medical, osteopathic, podiatric, chiropractic, dental, and nurses associations, institutional pharmacist, AARP representative. Advisory committees will include: scientific research, technology, health care provider, health care consumer, state agency, litigation alternatives, and education. No state agencies are represented on the board.
Maryland	*Leadership Council* to be chaired by the director of the center and comprised of equal representation from the Maryland Hospital Association and Delmarva Foundation for Medical Care (Delmarva Foundation). *Advisory Board* will be co-chaired by MHA and Delmarva Foundation and consist of representatives of Maryland hospitals and nursing homes, state nursing home associations, health care provider associations, Maryland Health Care Commission (*ex-officio*), The Health Services Cost Review Commission (*ex-officio*), and consumers, as well as several prominent national patient safety experts.
Massachusetts	Three members of the *Patient Safety and Medical Errors Reduction Board*-- Secretary of Health and Human Services, Director of Consumer Affairs and Business Regulations, and Attorney General. The Commissioner of Public Health serves in the place of the Secretary of Health and Human Services. The Massachusetts Coalition for the Prevention of Medical Errors, a non-profit corporation, serves as advisory committee to the board. Coalition members include representatives of state and federal agencies; JCAHO; professional associations for hospitals, physicians, nurses, nurse-executives and long term care facilities; individual hospitals; the Quality Improvement Organization ; consumer organizations; health plans; employers; state policymakers; malpractice insurers; researchers; and educational institutions.
New York	No advisory board or board of directors. There are advisory groups for particular projects.
Oregon	*Board of directors* consisting of 17 members, including the Public Health Officer and 16 directors appointed by the Governor and confirmed by the Senate: one faculty member who is not involved in direct delivery of care from the Oregon University System or a private Oregon university; two group purchasers, one representing the state; two health care consumers; two health insurers; one statewide or national labor union; two physicians licensed in Oregon in active practice; two hospital administrators; one pharmacist; one ambulatory surgical center or outpatient renal dialysis facility; one nurse licensed in active practice; one nursing home administrator or one nursing home director of nursing services. Four-year terms, up to two terms, staggered.
Pennsylvania	Eleven member *board*, including seven persons appointed by the Governor (the Physician General, who serves as chair; a physician; a nurse; a pharmacist; a health care worker employed by a hospital; and two other Pennsylvania residents, one a health care worker and one who is not a health care worker) and four Pennsylvania residents appointed by the legislature.

Relationship to State Government

The project examined three aspects of how patient safety centers relate to their state governments: the locus of operations, requirement for conducting meetings in public (known as "sunshine laws"), and level of autonomy.

Locus of operations

Four of the centers (MA, NY, OR, and PA) are housed within state government. Massachusetts and New York are housed within their respective Departments of Health. Oregon and Pennsylvania were created as "semi-independent" and "independent" state agencies, respectively. These types of agencies are defined differently in Oregon and Pennsylvania but generally have public missions with less government oversight than traditional state agencies.

Two of the centers (FL, MD) are located outside of, but have legislatively authorized affiliations with, state government. Florida is a not-for-profit corporation which is assisted by a state agency on matters relating to organizational start-up activities (e.g., appointment of board of directors, drafting of bylaws, meeting arrangements). As a result of a competitive proposal solicitation, the Maryland Patient Safety Center is a joint enterprise of the Maryland Hospital Association and the Delmarva Foundation for Medical Care (Delmarva Foundation).

Sunshine laws

The four centers with boards of directors (FL, MA, OR, and PA) must conduct those meetings in public, except for some exceptions for reviewing confidential patient safety data. New York has no board of directors. Maryland, as a private, not-for-profit corporation, is exempt from the state's "sunshine laws."

Degree of autonomy

The Centers fall along a continuum, with the Florida Patient Safety Corporation having the most autonomy from state government and the New York Center for Patient Safety the least:

- Florida's center, a not-for-profit entity, is assisted by the Agency for Health Care Administration during the first year of the center's operation on matters relating to organizational start-up activities (e.g., recruitment of board of directors, drafting of bylaws, meeting arrangements). A State Agency Advisory Committee is established in statute as one of seven advisory committees that will assist the center, primarily after its first year of operation.

- The Oregon and Pennsylvania centers, although partially or fully independent state agencies, have public missions but are exempt from a good deal of state administrative oversight. The Pennsylvania center, although technically an independent agency (called a "body corporate and politic" in the enabling legislation) operates under a memorandum of understanding with another state agency that provides the center with administrative support to minimize the center's staffing and operating budget. As a result, the center adheres to some state government administrative rules, particularly for procurement and personnel matters.

- The Massachusetts center, the Betsy Lehman Center, is organizationally located within, but not under the supervision of, the Executive Office of the Department of Health. Its director wears two hats: one as assistant commissioner of the Department of Public Health, the other as the director for the center.

- The Maryland center, a not-for-profit organization, must submit semi-annual reports to the Maryland Health Care Commission.

- The New York Patient Safety Center is both housed within and operates as a creature of state government with all associated reporting relationships and administrative functions.

Table 5 summarizes the relationship of the centers to state government.

Table 5   Relationship to state government

	Locus of operation	Subject to state sunshine laws	Degree of autonomy
Florida	Outside state government	yes	Assistance from a state agency with start-up activities during its first year of operation. There is a State Agency Advisory Committee that will assist the center on an ongoing basis. The center was designed to be independent of state health care regulatory departments.
Maryland	Outside state government	no	Must submit semi-annual reports to the Maryland Health Care Commission and may have access to reports submitted under the state's mandatory reporting system.
Massachusetts	Within Executive Office of Department of Health	yes	Board is not under the control of any state agency. Center director wears two hats: one as assistant commissioner of the Department of Public Health, the other as the executive director for the Betsy Lehman Center.
New York	State agency within Department of Health	yes	Operates as a state agency subject to all reporting and administrative requirements.
Oregon	Semi-independent state agency	yes	No regulatory functions, free of much administrative oversight. No data sharing with other state agencies.
Pennsylvania	Independent state agency	yes	No regulatory functions, administrative responsibilities or data sharing but the center does adhere to many executive agency rules. The center must submit an annual report to the General Assembly and the Secretary of Health and interact with state regulatory agency to comply with certain reporting requirements.

As Table 5 indicates, whether the center is housed within or outside state government does not necessarily dictate how it interfaces with that government. Authorizing legislation is pivotal in describing working relationships and/or the autonomy that the center will exercise in the conduct of its work.

PATIENT SAFETY CENTER OPERATIONS

Funding

Fees, grants, and appropriations are the primary means of support for the patient safety centers. Florida and New York are supported through legislative appropriations. Florida's legislature approved $350,000 for FY 2004-2005 with an additional $300,000 to establish a near-miss reporting system. The activities of New York's Center for Patient Safety are supported by special revenue funds of the Office of Professional Medical Conduct.

Oregon and Pennsylvania rely on fees to support their patient safety center activities. Pennsylvania has a dedicated Patient Safety Trust Fund supported by an annual surcharge on licensing fees for those facilities subject to the Act's reporting requirements, up to a maximum of $5 million per year. Unspent funds roll over and earned interest is deposited into the fund. The center is authorized to procure additional funds from other sources. Oregon's Commission may levy fees on eligible participants.

The Maryland Hospital Association and the Delmarva Foundation, sponsors of the Maryland Patient Safety Center, will each contribute $200,000 a year to fund the first three years of operation. Maryland hospitals will contribute another $200,000. The Health Services Cost Review Commission, the state's hospital rate setting system, has approved $765,000 per year for three years to be included in hospital rates and then passed on to the Maryland Patient Safety Center. Future funding may come from grants.

Massachusetts relies on a combination of state monies and a grant from the Agency for Healthcare Research and Quality to fund the work of the Betsy Lehman Center. The Center anticipates future funding through federal and foundation support.

Many states expressed concern about the level and reliability of future funding. Without dedicated funding, states cautioned that it was more difficult to build the capacity necessary to fulfill the expectations set forth in legislation. Pennsylvania is unique in creating an independent funding stream that has enabled its center to develop, implement, and maintain a sophisticated data collection and analysis system.

Table 6   Funding

Florida	Received a $350K appropriation for operations in FY2004-2005, as well as $300K to establish a near-miss reporting system. The legislation is silent on future state funding. The corporation is directed to seek private and grant funding.
Maryland	The Request for Proposals to administer the center required applicants to indicate level and source of funding. Funding in the first three years will be provided by the approved applicants, the Delmarva Foundation, and the Maryland Hospital Association, along with contributions from hospitals for a total of $600K. An additional $765K per year for three years has been approved by the state hospital rate setting commission. Grant funding will be sought for subsequent years.
Massachusetts	Currently, no dedicated funding. Funding and resources provided through a Department of Public Health (DPH) trust fund and DPH administrative accounts. The center shall seek federal and foundation support to supplement state resources. DPH and the center have applied for AHRQ Health Information Technology (HIT) grant funding.
New York	Special revenue funds support the implementation of the New York physician profiles, development of the hospital performance measures, and activities relating to patient safety.
Oregon	The Commission may assess fees on eligible participating entities. The legislative intent was to require mandatory assessment of fees for all eligible facilities regardless of participation in the program. In addition, the Commission may seek federal and private funding.
Pennsylvania	A dedicated funding stream, the Patient Safety Trust Fund, is independent of the General Fund. Moneys in the Trust Fund come from an annual surcharge on licensing fees charged to facilities required to report. Total annual assessment for those surcharges cannot exceed $5M, plus the current consumer price index for subsequent years after the first year. The Department of Health uses recommendations from the center, based on its fiscal needs, to set and collect the surcharge.

Type of Facilities and Professionals Served

The Institute of Medicine report *To Err is Human* noted that errors may occur in a variety of care settings; however, it recommended that efforts to improve patient safety initially focus on hospitals, and, to date, state approaches to patient safety have primarily focused on hospital settings. State patient safety centers provide an opportunity to expand the focus to other settings of care and to focus on health care professionals in addition to institutions.

While all centers plan to focus on hospitals, other commonly mentioned facilities include ambulatory surgery centers (FL, MA, OR, PA), long term care or nursing facilities (FL, MD, MA, OR), and birthing centers (OR, PA). Two states (NY, OR) specifically mention serving health care professionals. Some center activities may focus on a particular type of provider; for instance, educational activities, reporting systems, and legal protections may be designed to address the needs and concerns of particular types of providers. New York, for example, prepared a toolkit to help reduce over-prescribing of antibiotics. The center distributed the toolkit to pediatricians, family practitioners, and other appropriate primary care providers.

Table 7   Type of facilities and professionals served

Florida	Unspecified. There is a breadth of representation on the board. The target will likely include hospitals, ambulatory surgical centers, nursing homes, other facilities, and office-based surgery.
Maryland	Ultimately all health care facilities/providers but will focus on hospitals and nursing homes during the first three years.
Massachusetts	Coordination of state agency patient safety programs and promotion of best practices for all health care settings.
New York	Health care professionals, hospitals, and long term care facilities.
Oregon	Hospitals, long term care facilities, pharmacies, ambulatory surgical centers, freestanding birthing centers, outpatient renal dialysis facilities, independent professional health care societies or associations.
Pennsylvania	Hospitals, birthing centers, and ambulatory surgery centers.

Consumer Involvement

All patient safety centers include consumers on advisory boards or committees. Legislation in two states, Florida and Oregon, also provides for the appointment of consumer sub-committees.

Legislation calling for consumer members on boards varies in its level of specificity. In Florida, the consumer is a representative of the AARP; in Massachusetts it is the state director of Consumer Affairs and Business Regulations; Maryland includes the director of the Josie King Pediatric Patient Safety Foundation, who lost a child to a medical error, and several legislators; in Pennsylvania the board must include a resident who is not a health care worker. The current non-health care worker is a health insurer.

Massachusetts and New York have been particularly active in developing initiatives to more fully engage consumers in patient safety. Massachusetts' initiatives include:

- A dedicated ombudsman to facilitate consumer access to assistance on patient safety related matters.
- Tools for consumer use in health care decision-making based on evidence based science.
- Support to patients, families, and caregivers following an adverse event or medical error.
- Active engagement of consumers in patient safety initiatives, such as medication safety.

The New York Center for Patient Safety is working on a public outreach campaign regarding the appropriate use of antibiotics. The center is also working with the U.S. Food and Drug Administration (FDA) to better educate the public regarding the use of over-the-counter medications. The center has convened an expert panel of pharmacists, geriatricians, and others to develop information, both for practitioners and consumers, relating to the management of medications as a risk factor in falls among the elderly.

Four of the states with patient safety centers also have coalitions representing a broader array of consumer and stakeholder interests (MA, MD, OR, PA), although the level of activity among these coalitions varies. In states such as Maryland, the coalition tends to focus on building

consumer awareness about patient safety, whereas the center tends to focus on provider education and improvement strategies.

Table 8   Consumer involvement

Florida	A consumer is on the board. There will also be a Health Care Consumer Advisory Committee.
Maryland	Consumers are represented on the advisory board.
Massachusetts	The state director of Consumer Affairs and Business Regulations is a board member. Consumers are represented on the coalition, which serves in an advisory capacity to the center. Work of the ombudsman gives assistance to consumers as do other planned activities. (See "Current and Planned Activities.")
New York	Consumers participate on advisory committees.
Oregon	Two consumer representatives are on the board of directors. The board may appoint one or more consumer advisory groups.
Pennsylvania	One board member must be a non-health care worker.

Staffing and Resources

Staffing levels for patient safety centers are modest. Four of the six centers have hired or plan to hire their own director/administrator and support staff (MD, NY, OR, PA). In addition to an executive director, the New York Center for Patient Safety has a medical director and pharmacist on staff. Pennsylvania has a dedicated team on contract including a physician who serves as program clinical director, pharmacists, nurses, and other medical professionals.

The assistant commissioner of the Department of Public Health in Massachusetts also serves as the director for the Betsy Lehman Center. The Department's full-time patient safety ombudsman is also assigned to the center.

Much of the work of the centers is conducted through contracts. Pennsylvania has a significant five-year contract with ECRI and its subcontractors, the Institute for Safe Medication Practices (ISMP) and EDS, for clinical, analytic, and information technology expertise. Florida anticipates contracting with state-based universities to provide analytic and technical expertise. The Maryland Patient Safety Center uses the resources of its co-sponsors, the Maryland Hospital Association and the Delmarva Foundation, a nationally designated Quality Improvement Organization, to provide analytic and administrative resources for its patient safety activities.

Table 9   Staffing and resources

Florida	The center is responsible for securing staff for proper administration and is assisted by a state agency for start-up activities in the first year. The center anticipates contracts with state-based universities for analytic and technical expertise in order to limit the bureaucracy of the center.
Maryland	Director and one support staff in addition to in-kind support provided through the Maryland Hospital Association and the Delmarva Foundation.
Massachusetts	The director of the Betsy Lehman Patient Safety Center is also the assistant commissioner of the Department of Public Health (DPH). The patient safety ombudsman is a full-time employee of DPH assigned to the center.
New York	Director, medical director, and pharmacist.
Oregon	The board of directors shall appoint an administrator.
Pennsylvania	The board employs staff as necessary. An administrator, program manager, communications director, and support staff have been employed to date. A multi-year contract has been negotiated with ECRI and its subcontractors, ISMP and EDS, with full-time program staff for the center's analytical, technical, and clinical support.

Current and Planned Activities

As described in the section on mission, all six centers strive to improve, ensure, or promote patient safety. They plan to accomplish this mission through a variety of activities. The most universal functions, common to all six patient safety centers, are to educate providers about best practices to improve patient safety, to promote collaboration between the public and private sectors, and to inform consumers about patient safety issues. Other activities that the majority of centers propose to do include:

- recommending statewide goals and tracking progress,
- fostering the creation of a culture of safety and learning,
- reviewing and promoting patient safety research,
- promoting collaboration between state and federal initiatives, and
- implementing a reporting system.

Provider education

Centers must consider various approaches to provider education. Maryland plans to educate providers through the development of learning collaboratives, which will focus on specific process improvements as well as more general training through workshops and conferences, including a program for nurse managers and clinical managers. Maryland also plans training in root cause analysis and failure mode and effects analysis (a web-based program for hospital and nursing home employees) and will also offer a special program for physician leaders. Massachusetts plans to offer programs directly, including an annual patient safety symposium, and to support many other educational activities organized by the Massachusetts Coalition for the Prevention of Medical Errors. Pennsylvania issues quarterly newsletters with in-depth clinical analysis from its reporting system and will facilitate conferences and training programs

that build on the reporting system's internal analytical tools. New York is working with medical colleges to incorporate patient safety training into residency programs. The center is also conducting an annual training program on antibiotic prescribing and will issue a newsletter on the topic. Some centers are exploring partnerships with Quality Improvement Organizations for provider education.

Center staff note that additional issues need to be considered when determining the focus of provider education. The costs and sources of revenue available for provider education may influence program design. Center officials acknowledge that, despite their emphasis on provider education, this function alone will not address many patient safety problems. Provider education tends to focus primarily on clinical process improvements rather than creating safety cultures. However, they stress that provider education can create leadership to stimulate environmental change.

Data collection and analysis

The types of data and methods of collection and analysis used by the centers vary. For example, Florida plans to include analysis of medical malpractice closed claims, state mandatory reporting data (from two separate systems, one focusing on facilities and one on office-based surgery), voluntarily reported near miss data, hospital discharge data, and vital statistics data. Oregon will focus exclusively on data reported to its voluntary system. Reporting systems are described in more detail in the following section.

Some interesting and unique activities of patient safety centers include:

- Florida will examine ways to reward providers who implement evidence-based medical practices and will recommend core competencies in patient safety for health professional curricula.
- Massachusetts has developed a patient safety ombudsman program to work with patients, families, and consumers on patient safety related problems and also plans to address health system and individual practitioner accountability.
- New York administers an award program to recognize patient safety leaders of various types of health care facilities and will also recommend statewide medical safety goals and will track the progress of health care providers in meeting those goals.
- Pennsylvania's statute includes a provision for a discount in medical malpractice liability insurance premiums for those facilities that can demonstrate a reduction in serious events following the adoption of recommendations made by the center. There is a detailed protocol for this initiative which involves two state regulatory agencies (Departments of Health and Insurance).

Appendix A provides details on center activities and categorizes them according to whether they are current or planned activities. New York's and Pennsylvania's centers have been in existence for a longer period of time and therefore have the most experience to date.

Reporting system within the center

The IoM report envisioned mandatory reporting systems housed within state regulatory agencies for serious adverse events and non-regulatory voluntary reporting systems for near misses. These systems were intended to complement each other. The first would be designed to provide data that would assist government in holding facilities accountable. The other would be a more collaborative mechanism to learn from mistakes.

Five of the six states with centers have separate mandatory reporting systems (FL, MD, MA, NY, and PA) housed within state regulatory agencies for serious adverse events. Three of these states (FL, MD, and PA) embraced the IoM's vision by also developing a reporting system within their patient safety centers for less serious errors. Florida collects near miss data. Maryland and Pennsylvania collect near misses and adverse events up to a specified threshold. The Maryland Patient Safety Center reviews adverse events that do not cause harm; otherwise, they are directed to the Department of Health and Mental Hygiene. The Pennsylvania Patient Safety Authority receives both near miss and adverse event data with the exception of incidents relating to infrastructure failures (e.g., fires) which are directed to the Department of Health.

Of the six states, only Oregon has no mandatory reporting system. The Oregon Patient Safety Commission will be creating a voluntary reporting system for serious adverse events as part of its mission.

Centers within Massachusetts and New York have authority to implement a voluntary reporting system but have chosen to focus on other activities. Massachusetts is considering developing a system in the future.

Table 10   Reporting system within the center

Florida	Confidential, voluntary reporting system for near misses.
Maryland	Confidential, voluntary reporting system for near misses and adverse events that do not cause harm.
Massachusetts	Is pursing the possibility of a voluntary, confidential reporting system for near misses and complications in order to provide hospitals information to help in establishing best practices.
New York	Has legislative authority to implement a confidential, voluntary system but has not done so yet. Plans are under development for a *Hospital Report Card* .
Oregon	Confidential, voluntary system for serious adverse events.
Pennsylvania	Mandatory, confidential web-based system for serious events, near misses, and infrastructure failures, with no identifiable patient or provider information. All licensed hospitals, birthing centers, and ambulatory surgical facilities are required to submit reports through a single portal. There is a statutory provision for submission of "anonymous reports" by health care workers who can demonstrate a facility's failure to submit a required report. The reporting system automatically directs reports of serious events and incidents to the Patient Safety Authority and reports of serious events and infrastructure failures to the Department of Health. The system contains integral, facility-specific analytical and statistical tools for use by facilities to promote internal quality improvement and patient safety activities.

Public access to information

All of the patient safety centers plan to make some information available to the public. If the centers have reporting systems, they will publicly report only data patterns using aggregate de-identified data that do not identify facilities. Maryland and Oregon will also provide information on which facilities are participating in the reporting systems. Only New York provides facility and provider specific outcome information (which is contained within its physician profiling system) and outcome measures reports. The accessibility of data from New York's center may be attributed to its mission, which has a unique focus on improving public access to health care information, and to the great demand for information from consumers.

Center officials differ in the extent to which they believe their state legislation prioritizes public access to information. According to several states, providers are the initial audiences of the centers. However, all of the centers include consumer education as one of their current or planned activities. (See Table 3.)

At this initial stage, states have not yet fully considered how public information might be used. However, several states mentioned at the forum that public release of information can provide incentives for facilities to improve their patient safety practices. Florida referenced a state study that found that even if consumers believe they cannot use the information to make decisions about their care, they want others to have access to the information to use on their behalf.

What mechanisms should exist to allow the public to access information remains an unanswered question: should reports be published in hard copy or available on websites? What kinds of distribution plans should exist and what should they look like? How should findings be publicized? A previous NASHP report concluded that information that is available to the public from reporting systems is often difficult for the public to access.[5] The Pennsylvania statute requires that certain information be made publicly accessible and posted on the web. Maryland, New York, and Pennsylvania's centers have developed websites. Massachusetts' website is under development. The website addresses are available in Appendix A.

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[5] Mimi Marchev, Jill Rosenthal, and Maureen Booth, *How States Report Medical Errors to the Public: Issues and Barriers* (Portland, ME: National Academy for State Health Policy, October 2003).

Table 11   Public Access to Information

Florida	Aggregated data from reporting system will be made available publicly.
Maryland	Reports to the MHCC on the progress of the center will be publicly available. These reports will include trends in facility participation, an aggregate evaluation of the number and types of reported adverse events and near misses, and the educational strategies provided by the center.
Massachusetts	Information reported to Massachusetts' center is confidential. Patients will have access to aggregate data through the ombudsman's office.
New York	One goal of the New York center is to improve public access to health care information through mechanisms such as the New York State Physician Profile website.
Oregon	Will maintain a website to facilitate public access to aggregate, de-identified data.
Pennsylvania	An annual report, with certain aggregate data and fiscal information, must be publicly accessible. Patient safety advisories are publicly distributed and available on the website. Information received and generated by the authority is protected.

Relationship between center's reporting system and state regulatory agency system

Three of the centers (FL, NY, and PA) have access to adverse event data collected through their states' mandatory reporting systems. The statute in Florida requires that the Patient Safety Corporation analyze adverse events submitted under the mandatory reporting system. The New York Center for Patient Safety uses aggregate data obtained through the state's mandatory reporting to identify quality improvement opportunities. In Pennsylvania, the Patient Safety Authority is responsible for developing and administering the state's mandatory reporting system, replacing a previous system administered by the regulatory agency. Both the Authority and the Department of Health review adverse events.

Maryland also envisions that the reports on serious adverse events that cause death or serious disability that are submitted under the state's mandatory reporting system will be supplied to the Maryland Patient Safety Center so the center will have a complete picture of errors in Maryland. There are also efforts in Maryland to coordinate educational activities between the center and the state agency responsible for the mandatory reporting system.

Massachusetts' center does not have access to data collected through the state's mandatory reporting system, except to the extent that information is otherwise publicly available. Massachusetts shares it data with the state coalition, an advisory group of the center, to determine approaches for alerting and informing facilities about the risk of errors and practices for addressing identified problems.

Table 12 on the following page summarizes the relationship between a center's reporting system and its state regulatory agency system.

Table 12   Relationship with state facility regulatory reporting systems

Florida	State regulatory department has a separate mandatory reporting system created by statute. Adverse incidents reported to the state will be analyzed by the Patient Safety Corporation.
Maryland	State regulatory agency has a separate mandatory reporting system created by regulation. Data sharing with the Maryland Patient Safety Center of serious adverse events that cause death or serious disability collected by the Department of Health and Mental Hygiene is under consideration; however, the data collected by the MPSC will not be shared with the department. Some coordination of educational activities.
Massachusetts	State regulatory agency has a separate mandatory reporting system created by regulation. No sharing of information between the systems except to the extent that information is otherwise public.
New York	The NYPORTS is a mandatory reporting system created by both statute and regulation. The Center uses NYPORTS aggregate information to identify areas in need of quality improvement.
Oregon	No state mandatory or regulatory reporting system exists. No information from the center's voluntary reporting system will be shared with any state regulatory agency.
Pennsylvania	To reduce the reporting burden on facilities, the Patient Safety Authority's web-based system uses a single portal for the submission of all reports so that a facility enters a report only once. In turn, the system directs reports of serious events and incidents to the authority and reports of serious events and infrastructure failures to the regulatory agency. The authority also developed an interface for the regulatory agency so some data elements are forwarded in real-time to an existing electronic system within the regulatory agency to simplify its administrative responsibilities. In addition, the authority meets and consults regularly with the regulatory agency to discuss patient safety issues, including the development of protocols that can ultimately result in a reduction in medical malpractice liability insurance premiums for facilities that implement patient safety improvements as recommended by the authority.

Accountability

Given the statutory authority granted to state patient safety centers, it is likely that state legislatures will be interested in monitoring the progress of the centers, and, if they receive state funding, they may be held accountable for results. Five states are required to submit periodic progress reports to the legislature and, in some cases, to the executive branch (FL, MA, NY, OR, PA). Because Maryland's center is not legislatively authorized, the legislature does not require progress reports. Instead, the center must report to the Maryland Health Care Commission, the state agency that is legislatively authorized to designate the center. The commission has the authority to rescind its designation if the center does not fulfill its requirements.

Table 13 on the following page provides information on accountability for each of the centers.

Table 13   Accountability

Florida	Three state agencies are responsible for developing performance standards to measure the success of the Patient Safety Corporation. There will be an audit using these standards in 2006. A report will be submitted to the governor and legislature by 2007.
Maryland	The Maryland Patient Safety Center must report semi-annually to the Maryland Health Care Commission. A report describing and evaluating the activities of the MPSC must be provided to the commission six months prior to the completion of the base contract period. If the commission does not receive the reports or the contractor does not demonstrate completion of the specified requirements on a timely basis, the commission may rescind the designation of the MPSC from the contractor.
Massachusetts	The center will report annually to the general court (legislature) regarding progress made in improving patient safety and medical error reduction.
New York	The center will provide a report to the governor and the legislature and make the report available to the public at regular intervals.
Oregon	The commission will make annual reports to the legislature noting progress against defined milestones. The public health officer is charged with certifying the completeness, credibility, and acceptability of participant reports, root cause analyses, and action plans. The commission is mandated by legislation to make public disclosure of aggregate information. The commission is audited by the secretary of state. There will be public disclosure of which entities participate and which do not, as well as any participants that have been terminated from the reporting program. Participating organizations may be terminated from the program for incomplete reporting, failure to tell patient or family that an error occurred, or failure to adequately implement an action plan. Purchasers can make contracting decisions based on whether facilities participate in the program. Possible transition to mandatory system in 2007 if performance goals are not met.
Pennsylvania	The authority will report annually to the Department of Health and the General Assembly on the authority's activities, including schedule of meetings, list of contracts, summary of the fund receipts and expenditures, number of serious events and incidents reported by medical facilities on a geographical basis, information derived from the data including trends, number of anonymous reports filed and reviews conducted, number of referrals to licensure boards for failure to report, and recommendations for statutory or regulatory changes to help improve patient safety. The authority is also required to post the Annual Report on a publicly accessible website.

Indicators of Success

Patient safety centers will identify evaluation strategies and indicators in order to measure their progress and submit their required reports. Other states and patient safety stakeholders will be watching their progress.

Some center officials acknowledge that it may be difficult to identify indicators of improved patient safety. They are cautious about relying on reporting system data, since the number of reports received may be unrelated to the actual number of events occurring or to facility safety improvements. Nevertheless, they note that an increase in the number of reports over time would be an accomplishment, in that it would demonstrate enhanced use of internal facility systems and a willingness to share data for analysis. Some participants also noted that the number of facilities that report and the uniformity of types of reporting would be indicators of success. A decrease in reports of a particular type of event after an educational program could also indicate effectiveness of that educational program.

Center officials note a lack of clear indicators for systems change. Despite the desire to focus on creating safer health care systems, many of the activities and measurements adopted by the centers focus on improvement of clinical processes, since measures are more readily obtainable for these activities. In addition, participants acknowledge that shifting the health care culture to a culture of safety will be a gradual process, making measurement all the more difficult. Pennsylvania does offer facilities a statutory mechanism to reduce their medical liability malpractice insurance premiums if they can document a reduction in serious events as a result of having implemented procedures recommended by the center. Two state regulatory agencies (Departments of Health and Insurance) are part of this process.

Successes and Challenges to Date

Despite the difficulty of evaluating success, the centers have already made progress. In all six states, the legislatures have recognized the serious issue of patient safety and made commitments to supporting patient safety centers. In some states the legislature has committed resources. Stakeholders have collaborated to create governing and advisory bodies that represent diverse groups brought together to achieve common goals.

Operationally, some centers have already hired staff and created websites. Activities are already underway in the more mature centers, e.g. the patient safety ombudsman program in Massachusetts, the guidelines and reports that have been developed in New York, and the creation of a comprehensive reporting and analytical system in Pennsylvania.

Center officials face a number of challenges. The level and reliability of funding is an issue in most states. Governance may be a challenge in states with diverse boards whose members may have conflicting agendas. Despite efforts to carefully separate patient safety center activities from state regulatory processes in many states, some providers may be hesitant to participate in patient safety center activities, especially reporting systems, due to the mistaken concern that reporting may result in regulatory sanctions.

RECOMMENDATIONS

Patient Safety Center Models

Meeting participants recommend that states considering developing a patient safety center do so through the legislative process in order to create a public mandate for their mission. Participants also acknowledged the importance of clear and consistent legislation, noting that inconsistencies and lack of clarity in some of the existing centers' authorizing legislation has delayed progress. For example, Pennsylvania's statute created its Patient Safety Authority as an independent state agency, without clearly specifying the meaning of this term, and with required, but undefined, relationships with other state agencies. Participants also recommended that the legislature establish a funding stream. Pennsylvania stands out as an example in this regard.

There are various issues to consider in deciding whether to house a patient safety center within state government. Some states, such as Massachusetts, emphasize the benefits of a public center that can coordinate various state agency approaches to patient safety and potentially help the state become a more effective partner with the private sector. Others, such as Florida, hope to build trust among providers by beginning their efforts in the private sector and considering state involvement in the future if needed. This decision may influence not only the governing structure of the center but also the activities of the center and relationships with stakeholders.

Meeting participants acknowledge that patient safety centers are more likely to be successful if sponsors share a common vision. However, in creating a center governing structure, one meeting participant suggested balancing the desire to create an all-inclusive board with the need to create an efficient and effective board process.

Meeting participants also note that patient safety center activities should be coordinated with other state activities, as opposed to operating as stand-alone entities. States recommend clarifying how the patient safety center differs from any existing patient safety coalition and then clearly examining and clarifying the relationship between the two entities. In Massachusetts, the Coalition for the Prevention of Medical Errors serves as an advisory committee to the board of the Betsy Lehman Center for Patient Safety and Medical Error Reduction. This symbiotic relationship enables the center to take advantage of the vast expertise, diversity, and experience of the coalition while enabling greater promotion of the coalition's work. In Maryland, the roles of the two entities are perceived by staff as distinct, with the center focusing primarily on provider issues and the coalition focusing on consumer issues.

Patient Safety Center Operations

Meeting participants recommend allocating sufficient time during center development to consider operational issues before rushing into activities. Depending on the anticipated role of the patient safety center in collecting, analyzing, and disseminating data, centers may have complex infrastructure issues to consider. Data flow processes can be more complex than

expected. For example, the Pennsylvania electronic reporting system must interface with the state regulatory agency so that the regulatory agency can access appropriate data. In Florida, the patient safety center may need to consider mechanisms to access medical malpractice data.

Developing and putting into operation clear definitions of reportable events is a challenge for any reporting system, and may influence decisions regarding access to data. For instance, Pennsylvania's statute included definitions unique to that state, requiring a steep learning curve for staff in both the center and the regulatory agency as well as in the health care facilities. In addition, the statute required the center to develop a system in which the Patient Safety Authority has access to both serious events (events that result in harm) and incidents (events that do not result in harm), while the regulatory agency can only access information related to serious events. Although the distinction between these types of events may appear obvious, the state had to go through a process of defining "harm" to alleviate fears of inappropriate agency access to data.

Participants note a need to educate the media about reporting systems. In particular, they note the importance of conveying the message that an increase in reporting should be viewed as a success, as an indication of growing support for a culture of safety. Increased reporting also provides data that will be useful for identifying root causes and potential solutions. Participants also recommended that centers reach out to the media before crises occur in order to ensure enlightened reporting.

With all of the potential areas of focus for state patient safety centers, it may be difficult for emerging centers to set priorities. Several meeting participants suggest that centers begin by focusing on creating a patient safety culture. According to some participants, newly created centers should be cautious about focusing on data collection. Unless the data will add a particularly unique value, it may only contribute to the vast amount of data already available. Some questioned the need for additional reporting systems and whether centers should instead focus on the implementation of existing best practices. However, according to one state, a reporting system can be useful in providing facility-specific and peer-specific feedback to help facilities target their quality improvement interventions.

CONCLUSION

Given the relatively recent creation of state patient safety centers, it is not yet possible to assess their impact. However, analysis of their missions, governing structures, and operations could prove useful to states that may follow this trend.

The six state patient safety centers analyzed for this report are all legislatively authorized or endorsed. All aim to improve, ensure, or promote patient safety. All plan to educate providers about best practices. Most plan to identify causes of patient safety problems, foster the creation of a culture of safety, promote research and collaboration around patient safety issues, and educate consumers. However, they vary in many ways.

State patient safety centers differ in terms of state government involvement (from their governing structures to their locus of operations), adherence to sunshine laws, degree of autonomy from the state, and interface with state government agencies. One center plans to propose state regulations and rules, while another specifically excludes state government regulation from its mission. Working relationships between centers and state government are critical issues to work out in that they can affect successful collaborations between the public and private sectors.

Potential Impact of Patient Safety Centers

State patient safety centers provide new opportunities for improving patient safety. Although many states have already been organizing stakeholders and attempting to address some of the goals of the centers, the establishment of state patient safety centers can add legitimacy and resources to these efforts.

State patient safety centers often have mandates, funding, and staff. As a result, they may garner more attention than voluntary efforts. Some of the centers are authorized to assess fees. They may also have statutory protections for data, and they will be held accountable for their progress.

In the future, patient safety centers may have the opportunity to be designated as patient safety organizations (PSOs) if *The Patient Safety and Quality Improvement Act* is enacted at the federal level. This legislation would create a national, confidential, voluntary reporting system in which physicians, hospitals, and other health care providers could report information on errors to patient safety organizations. PSOs would collect and analyze patient safety data and provide feedback on patient safety improvement strategies. State patient safety centers would be logical models to serve as PSOs.

According to the Institute of Medicine, the development of a safer health care system requires a commitment by all stakeholders to a culture of safety and improved information systems.[6] Given the focus of patient safety centers as described in this report, they may be a step in that direction.

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[6] Institute of Medicine. *Patient Safety: Achieving a New Standard for Care*, (Washington, D.C.: National Academy Press, 2004), 1.

Questions that Remain

Several questions were raised by this project. First, what role can/should the state play in a patient safety center? Is government responsible for quality improvement initiatives? Should government be involved?

Second, what role can/should a patient safety center assume in data collection, analysis, and evaluation? Does it differ depending on whether a state already has a regulatory reporting system? Does every state need to develop its own voluntary system to track problems and identify best practices, or can states learn from other databases? Should centers focus on collecting data or implementing already identified best practices?

Third, how can the centers address patient safety systems problems in addition to clinical processes of care? If most errors are indeed the result of systems of care, how can provider education lead to improvements? Can centers provide training in leadership, culture of safety, and human factors in addition to clinical improvement? How can patient safety centers help states move from focusing only on avoiding mistakes to improving quality outcomes?

The impact of state patient safety centers remains to be seen. Despite the lack of rigorous indicators, patient safety centers ultimately will have to demonstrate gains in patient safety. If they are unable to do this, pressure will no doubt build from regulators, purchasers, and the public for more draconian measures.

Appendix A

A profile of patient safety center characteristics

Profile of State Patient Safety Centers

	Florida	Maryland	Massachusetts	New York	Oregon	Pennsylvania
Name of center	Florida Patient Safety Corporation	Maryland Patient Safety Center	Betsy Lehman Center for Patient Safety and Medical Error Reduction	New York Center for Patient Safety	Oregon Patient Safety Commission	Pennsylvania Patient Safety Authority
Enabling legislation	Established in the 2004 Affordable Health Care for Floridians Act (HB 1629). Section 18, Section 381.0271, Florida Statute (http://election.dos.state.fl.us/laws/04laws/ch_2004-297.pdf section 18, pp. 24-30).	Legislature required a study of feasibility in Patients' Safety Act of 2001 (HB 1274), Section 19-139 of the Health General Article (http://mlis.state.md.us/2001rs/bills/hb/hb1274f.rtf). In 2003, the legislature provided medical review committee status to a center designated by the Maryland Health Care Commission (MHCC) as the Maryland Patient Safety Center (HB164), Section 1-401 of the Health Occupations Article (http://mlis.state.md.us/PDF-Documents/2002rs/bills/hb/hb1259f.pdf)	Established as an outside section (not a line-item) without funding in FY 2002 budget (Chapter 177 Section 6 of the Acts of 2001). General Laws of Massachusetts. Part 1, Title II, Chapter 6A, Section 16E (http://www.mass.gov/legis/laws/seslaw01/sl010177.htm).	Established in Patient Health Information and Quality Improvement Act of 2000. Article 29D Title 2 S2998 section 2998 of the PHL (http://ssl.csg.org/dockets/22cycle/2002A/2002Abills/2122a05ny.html).	Established in Chapter 686 Oregon Laws 2003 (HB2349) (http://www.leg.state.or.us/orlaws/sess0600.dir/0686ses.htm) and in Oregon Revised Statutes 442.820 - 442.990 (http://www.leg.state.or.us/ors/442.html).	Established in Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act, P.S. 40, § 1303 (http://www.mcare.state.pa.us/mclf/lib/mclf/hb1802.pdf).

	Florida	Maryland	Massachusetts	New York	Oregon	Pennsylvania
Mission	To serve as a learning organization dedicated to assisting health care providers in this state to improve the quality and safety of health care rendered and to reduce harm to patients. The corporation shall promote a culture of patient safety in the health care system in this state. The corporation shall not regulate health care providers in this state.	To serve as a data repository for a voluntary adverse event and near miss reporting system for all health care facilities statewide, and as the primary coordinator for educational activities focused around patient safety issues.	To serve as a clearinghouse for development, evaluation, and dissemination, including but not limited to, sponsoring training and education programs, best practices, coordinating state agency initiatives, promoting ongoing collaboration between the public and private sectors, coordinating state and federal patient safety programs, and promoting patient safety through educating both health care providers and patients.	To maximize patient safety; reduce medical errors; improve the quality of health care by improving systems of data reporting, collection, analysis, and dissemination; improve public access to health care information.	To improve patient safety by reducing the risk of serious adverse events occurring in Oregon's health care system and by encouraging a culture of patient safety in Oregon.	To reduce and eliminate medical errors by identifying problems and recommending solutions that promote and ensure patient safety.

	Florida	Maryland	Massachusetts	New York	Oregon	Pennsylvania
Governance structure	Board of directors including chair of the Florida Council of Medical School Deans; health insurer; health maintenance organization; medical malpractice insurer; Central Florida Health Care Coalition president; 2 hospital representatives; representatives of medical, osteopathic, podiatric, chiropractic, dental, and nurses associations; institutional pharmacist; and AARP representative. Advisory committees will include: scientific research, technology, health care provider, health care consumer, state agency, litigation alternatives, and education. No state agencies are represented on the board.	Leadership Council to be chaired by the director of the center and comprised of equal representation from MHA and Delmarva Foundation for Medical Care (Delmarva Foundation). Advisory board will be co-chaired by MHA and Delmarva Foundation and consist of representatives of Maryland hospitals and nursing homes, state nursing home associations, health care provider associations, Maryland Health Care Commission (*ex-officio*), The Health Services Cost Review Commission (*ex-officio*), and consumers, as well as several prominent national patient safety experts.	Three members of the Patient Safety and Medical Errors Reduction Board-- Secretary of Health and Human Services, Director of Consumer Affairs and Business Regulations, and Attorney General. The Commissioner of Public Health serves in the place of the Secretary of Health and Human Services. The Massachusetts Coalition for the Prevention of Medical Errors, a non-profit corporation, serves as advisory committee to the board. Coalition members include state and federal agencies; JCAHO; professional associations for hospitals, physicians, nurses, nurse-executives, and long term care facilities; individual hospitals; the QIO; consumer organizations; health plans; employers; state policymakers; malpractice insurers; researchers; and educational institutions.	No advisory board or board of directors. There are advisory groups for particular projects.	Board of directors consisting of 17 members, including the Public Health Officer and 16 directors appointed by the Governor and confirmed by the Senate: one faculty member who is not involved in direct delivery of care from the Oregon University System or a private Oregon university; two group purchasers, one representing the state; two health care consumers; two health insurers; one statewide or national labor union; two physicians licensed in Oregon in active practice; two hospital administrators; one pharmacist; one ambulatory surgical center or outpatient renal dialysis facility; one nurse licensed in active practice; one nursing home administrator or one nursing home director of nursing services. Four-year terms up to two terms, staggered.	Eleven member board, including seven persons appointed by the Governor (the Physician General, who serves as chair; a physician; a nurse; a pharmacist; a health care worker employed by a hospital; and two other Pennsylvania residents, one a health care worker and one who is not a health care worker) and four Pennsylvania residents appointed by the legislature.

	Florida	Maryland	Massachusetts	New York	Oregon	Pennsylvania
Relationship to state government	Locus of operation: outside state government Subject to state sunshine laws: yes Degree of autonomy: Assistance from a state agency with start-up activities during its first year of operation. There is a State Agency Advisory Committee that will assist the center on an ongoing basis. The center was designed to be independent of state health care regulatory departments.	Locus of operation: outside state government Subject to state sunshine laws: no Degree of autonomy: Must submit semi-annual reports to the Maryland Health Care Commission and may have access to reports submitted under the state's mandatory reporting system.	Locus of operation: within Executive Office of Department of Health Subject to state sunshine laws: yes Degree of autonomy: Board is not under the control of any state agency. Center director wears two hats: one as assistant commissioner of the Department of Public Health, the other as the executive director for the Betsy Lehman Center.	Locus of operation: state agency within Department of Health Subject to state sunshine laws: yes Degree of autonomy: Operates as a state agency subject to all reporting and administrative requirements.	Locus of operation: semi-independent state agency Subject to state sunshine laws: yes Degree of autonomy: No regulatory functions, free of much administrative oversight. No data sharing with other state agencies.	Locus of operation: independent state agency Subject to state sunshine laws: yes Degree of autonomy: No regulatory functions. Theoretically, no administrative responsibilities but, in fact, adheres to many executive agency rules. Must submit an annual report to the General Assembly and the Secretary of Health. Must interact with state regulatory agency to comply with certain reporting requirements.

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Funding	Received a $350K appropriation for operations in FY 2004-2005, as well as $300K to establish a near-miss reporting system. The legislation is silent on future state funding. The corporation is directed to seek private and grant funding.	The Request for Proposals to administer the center required applicants to indicate level and source of funding. Funding in the first three years will be provided by the approved applicants, the Delmarva Foundation and the Maryland Hospital Association, along with contributions from hospitals for a total of $600K. An additional $765K per year for three years has been approved by the state hospital rate setting commission. Grant funding will be sought for subsequent years.	Currently, no dedicated funding. Funding and resources provided through a Department of Public Health (DPH) trust fund and DPH administrative accounts. The center shall seek federal and foundation support to supplement state resources. DPH and the center have applied for AHRQ Health Information Technology (HIT) grant funding.	Special Revenue Funds support the implementation of the New York physician profiles, development of the hospital performance measures, and activities relating to patient safety.	The commission may assess fees on eligible participating entities. The legislative intent was to require mandatory assessment of fees for all eligible facilities regardless of participation in the program. In addition, the commission may seek federal and private funding.	A dedicated funding stream, the Patient Safety Trust Fund, is independent of the General Fund. Moneys in the Trust Fund come from an annual surcharge on licensing fees charged to facilities required to report. Total annual assessment for those surcharges cannot exceed $5M, plus the current consumer price index for subsequent years after the first year. The Department of Health uses recommendations from the center, based on its fiscal needs, to set and collect the surcharge.

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Type of facilities and professionals served	Unspecified. There is a breadth of representation on the board. The target will likely include hospitals, ambulatory surgical centers, nursing homes, other facilities, and office-based surgery.	Ultimately all health care facilities/providers but will focus on hospitals and nursing homes during the first 3 years.	Coordination of state agency patient safety programs and promotion of best practices for all health care settings.	Health care professionals, hospitals, and long term care facilities.	Hospitals, long term care facilities, pharmacies, ambulatory surgical centers, freestanding birthing centers, outpatient renal dialysis facilities, independent professional health care societies or associations.	Hospitals, birthing centers, and ambulatory surgery centers.
Consumer involvement	A consumer is on the board. There will also be a Health Care Consumer Advisory Committee.	Consumers are represented on the advisory board.	The state director of consumer affairs and business regulations is a board member. Consumers are represented on the coalition, which serves in an advisory capacity to the center. Work of the Ombudsman gives assistance to consumers as do other planned activities.	Consumers participate in advisory groups.	Two consumers representatives are on the board of directors. The board may appoint one or more consumer advisory groups.	One board member must be a non-health care worker and four other members do not have to fulfill any occupational or professional requirements.
Staffing and resources	The center is responsible for securing staff for proper administration. The center is assisted by a state agency for start-up activities in the first year. The center anticipates contracts with state-based universities for analytic and technical expertise in order to limit the bureaucracy of the center.	Director and one support staff in addition to in-kind support provided through the Maryland Hospital Association and the Delmarva Foundation.	The director of the Betsy Lehman Patient Safety Center is also the assistant commissioner of the Department of Public Health (DPH). The patient safety ombudsman is a full-time employee of the DPH, assigned to the center.	Director, medical director and pharmacist.	The board of directors shall appoint an administrator.	The board employs staff as necessary. An administrator, program manager, communications director and support staff are on board. A multi-year contract is in place with ECRI and its subcontractors, ISMP and EDS, with full-time PA-PSRS program staff for analytical, technical, and clinical support.

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Current or past activities	Corporation is not yet operational.	The center became operational in June 2004 and has hired a director, begun Leadership Council meetings, and created a website.	Created a patient safety ombudsman office to work with patients, families, and consumers on patient safety related problems; – developing best practices in areas such as prevention of medication errors in nursing homes; and – supporting implementation of best practice initiatives developed by the Coalition for the Prevention of Medical Errors and the Patient Safety Improvement Corps.	Held patient safety conference targeted to hospital CEOs, board members, risk managers, quality assurance and environmental senior staff in conjunction with AHRQ; –administering New York State Hospital Patient Safety Award Program to recognize hospital, nursing home, FQHC, and adult home leaders; –maintaining DOH public website; –issued report on clinical guidelines for office-based surgery, preoperative protocols panel; – issuing cardiac surgery reports; – developing hospital quality indicators; and – evaluating Health Information Technologies.	Commission is in early stages of development.	Maintain and continue system development of PA-PSRS, the mandatory statewide electronic reporting and data analysis system; -manage a 5-year, $9.5 million contract with ECRI in partnership with EDS (Electronic Data Systems) and ISMP (Institute for Safe Medication Practices) that forms the PA-PSRS program and staff; -issue quarterly and supplementary Patient Safety Advisories based on submitted reports; -manage the Patient Safety Trust Fund; -receive and investigate "anonymous" reports from health care workers; -maintain the public website; and -conduct ongoing training on the application and use of PA-PSRS for newly licensed facilities, including the facility-based analytical tools.

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Planned activities	Establish a near-miss patient safety reporting system; – collect, analyze, and evaluate patient safety data and quality and patient safety indicators, medical malpractice closed claims, and adverse incidents reported to the Agency for Health Care Administration and the Department of Health to recommend changes to improve health care quality and prevent future adverse events; – work collaboratively with state agencies in developing electronic health records; – provide access to a library of evidence-based medicine and patient safety practices; – recommend core competencies in patient safety for health professional curricula; – recommend ways to educate the public; – recommend opportunities for interagency coordination; and	Collect, analyze, and share appropriate information about adverse events and near misses; – develop a grassroots model for building consensus to improve patient safety in Maryland health care settings, with maximum participation from hospitals and nursing homes; – promote a "culture of safety" that encourages system improvements instead of faulting individuals; – develop and provide education for health care professionals and hospital and nursing home staff, including activities related to root cause analysis and sharing "better practices;" – sponsor patient safety collaboratives to bring together providers and national experts to focus on specific process improvements (beginning with a focus on Leadership and Culture); – lead applied research to find and implement safer processes and practices in Maryland;	Address health system and individual practitioner accountability; – involve consumers in patient safety issues through nursing home family satisfaction survey; – participate in AHRQ Patient Safety Indicators efforts; – respond to Expert Panel Recommendations on weight loss surgery best practices; – develop best practices on hospital disclosure of adverse events to patients and families; – improve medication safety through promotion of e-prescribing; and -convene experts for participation in annual patient safety symposium.	Identify available information useful for maximizing patient safety, including information from federal, state, and local agencies; – promote the coordination of activities with federal and other programs for improving patient safety or health care quality including programs of the National Quality Forum; – promote efforts by health care organizations, health plans, and health care providers to participate in voluntary, cooperative efforts to improve patient safety; – utilize information from the Statewide Health Information System and the Statewide Planning and Research Cooperative System (SPARCS) to recommend statewide medical safety goals and track progress of health care providers in meeting these goals;	Establish a confidential, voluntary, serious adverse event reporting system; – establish quality improvement techniques to reduce system' errors; – disseminate evidence-based prevention practices to improve patient outcomes; – adopt rules for selecting list of reportable events with an initial focus on those that cause death and serious physical injury; – develop a method to determine participant fees; – establish oversight and auditing procedures; and – develop criteria for terminating a participant.	Maintain mandatory statewide reporting and data analysis system (PA-PSRS); -continue publication of quarterly and supplementary Patient Safety Advisories based on submitted reports; -solicit and share feedback and best practices among reporting facilities; -enhance PA-PSRS analytical capacities for use by facilities; -issue recommendations to facilities, with the required approval of the Department of Health, regarding changes, trends, and improvements in health care practices and procedures; -work with the Department of Health to develop protocols that allow facilities to obtain discounts on their medical liability malpractice insurance premiums for reducing serious events by implementing recommendations made by the Authority;

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Planned activities (continued)	– 2005 report to the Governor on: ability to join or support efforts to use evidence-based medicine already underway; means to promote research using Medicaid and other data collected by the state to identify and quantify most cost-effective treatment and interventions; means to reward providers who implement evidence-based medical practices; regulatory barriers that interfere with sharing clinical information among providers.	– plan kickoff meetings and collaboratives for the fall of 2004; and – plan the data system for mid-2005.		– review and promote research to assist health care providers and health plans in identifying and resolving systemic problems in health care leading to medical error or impairing patient safety; and – serve as a clearinghouse for quality improvement strategies and best practices.		-facilitate conferences and seminars to educate facility boards, management, and clinical staff on patient safety issues, including safety culture, root cause analysis and best practices; -strengthen existing partnerships with statewide professional provider and health system organizations; -continue to meet with the Department of Health and other state agencies on patient safety issues; and -issue periodic press releases and media advisories/interviews.
Reporting system within center	Confidential, voluntary reporting system for near misses.	Confidential, voluntary reporting system for near misses and adverse events that do not cause harm.	Is pursing the possibility of a voluntary, confidential reporting system for near misses and complications in order to provide hospitals information to help in establishing best practices.	Has legislative authority to implement a confidential, voluntary system but has not done so yet. Plans are under development for a Hospital Report Card. The New York State Physician Profile System provides profiles of all doctors licensed to practice medicine in New York.	Confidential, voluntary system for serious adverse events.	Mandatory, confidential web-based system for serious events, near misses, and infrastructure failures. The reporting system automatically directs reports of serious events and incidents to the Patient Safety Authority and reports of serious events and infrastructure failures to the Department of Health.

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Public access to information	Aggregated data from reporting system will be made available publicly.	Reports to the MHCC on the progress of the center will be publicly available. These reports will include trends in facility participation, an aggregate evaluation of the number and types of adverse events and near misses reported, and the educational strategies provided by the center.	Information reported to center is confidential. Patients will have access to aggregate data through the ombudsman's office.	One goal of the center is to improve public access to health care information through mechanisms such as the New York State Physician Profile website.	Will maintain a website to facilitate public access to aggregate, de-identified data.	An annual report, with certain statewide aggregate and/or regional data and fiscal information, must be publicly accessible and posted to the website. Patient Safety Advisories, based on data submitted through mandatory reports, are issued quarterly and on a supplementary basis. Although directed to providers and facilities, they are publicly distributed and accessible on the web. Information received and generated by the authority is protected.

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Relationship with state facility regulatory reporting system	State regulatory department has a separate mandatory reporting system created by statute. Adverse incidents reported to the state will be analyzed by the corporation.	State regulatory agency has a separate mandatory reporting system created by regulation. Data sharing with the Maryland Patient Safety Center of serious adverse events that cause death or serious disability collected by the Department of Health and Mental Hygiene is under consideration; however, the data collected by the MPSC will not be shared with the department. Some coordination of educational activities.	State regulatory agency has a separate mandatory reporting system created by regulation. No sharing of information between the systems except to the extent that information is otherwise public.	The NYPORTS is a mandatory reporting system created by both statute and regulation. The center utilizes NYPORTS aggregate information to identify areas in need of quality improvement.	No state mandatory or regulatory reporting system exists. No information from the center's voluntary reporting system will be shared with any state regulatory agency.	To reduce the reporting burden on facilities, the authority's web-based system uses a single portal for the submission of all reports so that a facility enters a report only once. In turn, the system directs reports of serious events and incidents to the authority and reports of serious events and infrastructure failures to the regulatory agency. The authority also developed an interface for the regulatory agency so some data elements are forwarded in real-time to an existing electronic system within the regulatory agency to simplify its administrative responsibilities.

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Accountability	Three state agencies are responsible for developing performance standards to measure the success of the corporation. There will be an audit using these standards in 2006. A report will be submitted to the governor and legislature by 2007.	The Maryland Patient Safety Center must report semi-annually to the Maryland Health Care Commission. A report describing and evaluating the activities of the MPSC must be provided to the commission six months prior to the completion of the base contract period. If the commission does not receive the reports or the contractor does not demonstrate completion of the specified requirements on a timely basis, the commission may rescind the designation of the MPSC from the contractor.	The center will report annually to the general court regarding progress made in improving patient safety and medical error reduction.	The center will provide a report to the governor and the legislature and make the report available to the public at regular intervals.	The commission will make annual reports to the legislature noting progress against defined milestones. - The public health officer is charged with certifying the completeness, credibility, and acceptability of participant reports, root cause analyses, and action plans; - The commission is mandated by legislation to make public disclosure of aggregate information; - The commission is audited by the secretary of state; - There will be public disclosure of which entities participate and which do not, as well as any participants that have been terminated from the reporting program; - Participating organizations may be terminated from the program for incomplete reporting, failure to tell patient or family that an error occurred, or failure to adequately implement an action plan;	The authority will report annually to the Department of Health and the General Assembly on the authority's activities, including schedule of meetings, list of contracts, summary of the fund receipts and expenditures, number of serious events and incidents reported by medical facilities on a geographical basis, information derived from the data including trends, number of anonymous reports filed and reviews conducted, number of referrals to licensure boards for failure to report, and recommendations for statutory or regulatory changes to help improve patient safety.

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Accountability (continued)					- purchasers can make contracting decisions based on whether facilities participate in the program; and - possible transition to mandatory system in 2007 if performance goals are not met.	
Website	None available	www.marylandpatientsafety.org	Currently being developed	www.health.state.ny.us/nysdoh/healthinfo/patientsafety.htm	None available	www.psa.state.pa.us