Congress Negotiating Error-Reporting Measure

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WASHINGTON — The House and Senate are negotiating legislation that would establish a voluntary medical error reporting system with the goal of passing a consensus measure by the August recess, lawmakers and staffers say.

Following a June 9 hearing of the House Energy and Commerce subcommittee on Health, Nathan Deal (R-Ga.), chairman of the subcommittee on Health, told reporters that the measure is likely to have some variations from last year's versions of the bill, but said the scope of the proposed legislation is the same. "Hopefully, if we can get a consensus worked out, it would be a bill that I think would move rather quickly" to gain approval, he said.

The House and Senate each passed similar patient safety bills last year—the House on a 418-6 vote and the Senate by voice vote. But the bills got bogged down in conference and died in the waning days of the 108th Congress.

The lawmakers are trying to establish a voluntary system where providers could confidentially report errors to official patient safety organizations. The previously proposed bills differed in the degree to which information was legally protected and in approaches to health information technology interoperability.

Now, as lawmakers negotiate a new measure, Agency for Healthcare Research and Quality (AHRQ) Director Carolyn Clancy, M.D., is calling for increased training of data analysts.

She recently testified that her agency continues its patient safety efforts. "While an increasing number of hospitals are developing the capacity to analyze the causes of medical errors, we need to recognize that the ability to conduct these analyses is uneven both in terms of experience and skill level," Dr. Clancy said. Moving to a system where the errors are routinely analyzed will require "significant skill development and technical assistance."

Dr. Clancy also warned that as the environment for patient safety improves, the number of reported errors is likely to rise as "previously hidden errors are disclosed." An initial increase in the number of reported errors, therefore, "is a sign of success, not failure."

She also called for increased information on care improvement in outpatient settings. "There is a significant amount of information on how to improve the safety of hospital care, but the evidence base is less robust for other settings of care."

The day before the hearing, AHRQ announced it will award more than $8 million for 15 projects designed to help clinicians, facilities, and patients implement evidence-based safety practices. More than half of the projects focus on reducing medication errors. Another area of interest is improved communications among health care teams.

Despite efforts in the public and private sectors to improve patient safety, Joint Commission on Accreditation of Healthcare Organizations President Dennis O'Leary, M.D., told the House panel that "we may actually be falling further behind as new drugs, procedures, and technologies are introduced every day."

Each new intervention carries its own risks that have not been identified, Dr. O'Leary said, and "they will be introduced into care delivery systems where patient safety and systems thinking … are not constantly top of mind."

Dr. O'Leary also said more should be done to ensure adherence to clinical guidelines, which he said can reduce legal risk for providers. He suggested providing incentives to focus on improvements in patient safety and health care quality as one way to increase guideline adherence.

Dr. O'Leary also recommended finding a private sector alternative for the National Provider Data Bank, which he said "has probably never met its full expectations." He said the data bank tends not to record information about whether a standard of care was violated, making the information "relatively unhelpful" for patient safety analysis. He suggested an approach that may include a network of databases.

Health subcommittee members asked about patient safety as part of medical education. William Bornstein, M.D., of the Medical Association of Georgia, testified that training in systems thinking for patient safety should occur at the level of residents and interns.

But, he said, one downside of the effort to limit the number of hours worked by medical students is limitations on the time available for additional training. ■