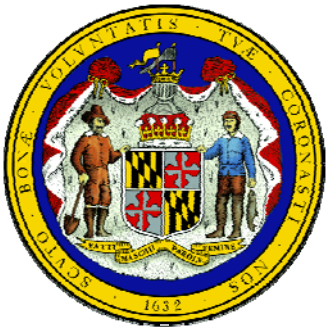
MARYLAND HEALTH CARE COMMISSION

REQUIRED UNDER HB 2 of the 2004 SPECIAL SESSION

"Maryland's Patient Access to Quality Health Care Act of 2004"



October 1, 2005

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Developing patient safety initiatives that extend beyond hospitals and into health care practitioner offices: A status report from the Maryland Health Care Commission

Reporting requirement

HB 2 of the 2004 Special Session contains the following provision in Chapter 5, Section 10a:

> "That the Maryland Health Care Commission shall work with the Health Services Cost Review Commission, the Department of Health and Mental Hygiene, the Maryland Patient Safety Center, the Maryland Board of Physicians, and third-party payers to develop systemic patient safety initiatives that extend beyond hospitals and into health care practitioner offices. The agencies shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly, on their efforts on or before October 1, 2005."

Background

During the 2001 session, the Maryland General Assembly passed the "Patients' Safety Act of 2001" charging the Maryland Health Care Commission (MHCC or Commission) with studying the feasibility of developing a system for reducing the incidence of preventable adverse medical events in Maryland including a system for reporting such events. The Commission issued an Interim Report on the Study of Patient Safety in Maryland in January 2002 and a Final Report on the Study of Patient Safety in Maryland in January 2003. These reports placed particular emphasis on patient safety in institutions, the creation of the Maryland Patient Safety Center, and regulatory changes in certificate of need, licensing, data reporting, and rate setting that would help create a culture of patient safety. Technological advances with implications for patient safety including e-prescribing, bar coding, and electronic medical records were discussed.

Legislation was passed in 2003 enabling the creation of the Maryland Patient Safety Center (MPSC). The Maryland Patient Safety Center, a collaboration between the Maryland Hospital Association and the Delmarva Foundation, was created by the Maryland Health Care Commission in 2004, following the passage of legislation in 2003 enabling the Center's creation and providing essential protections for safety data gathered by the Center. The Center is funded by the Maryland Hospital Association, the Delmarva Foundation, and Maryland hospitals, with additional financial assistance from the Maryland Health Services Cost Review Commission and various private sources.

By law, the primary focus of the MPSC during the first three years of its existence is patient safety in hospitals and nursing homes. This focus reflects not only the primary funding sources, but also a careful judgment about where initial efforts would yield the best results. Institutions provide an established infrastructure for patient safety improvement efforts; in contrast, solo and small group practices and other ambulatory care settings pose substantial challenges to mounting the kind of effort-intensive quality-improvement programs necessary to produce change, given the current health care system and its fragmented information infrastructure.

This carefully focused effort has yielded impressive results in a short period of time. More than 2,000 individuals, representing every hospital in the state as well as other health care providers, have received training from the Center on the causes of unsafe practices and ways to design safer systems. The activities of the Center are offered at no charge to Maryland health care providers.

The Center's first collaborative effort to improve safety in the intensive care units (ICUs) of Maryland hospitals is already showing evidence of success. Working with national experts and over 35 teams from Maryland hospital ICUs, these teams have reduced ventilator-associated pneumonia by 19 percent in just eight months. Teams working on reducing blood stream infections have seen a 36 percent reduction over this time period.

The Center has designed a voluntary reporting system for health care providers to report "close calls" and errors that do not result in permanent harm to the patient. This information will supplement the mandatory reporting of serious adverse events already being collected by the state that will help health providers improve their systems and reduce mistakes.

The remarkable first year of effort was recently awarded national recognition when the federal Agency for Healthcare Research and Quality awarded the 2005 John M. Eisenberg Patient Safety and Quality Award for national/regional innovation in patient safety to the Center.

Extending patient safety efforts into healthcare practitioner offices: The central role of health information technology

Because of its mandate and its chosen focus for its first three years, Maryland Patient Safety Center activities that extend beyond hospitals and into healthcare practitioners offices have been limited. Dr. William Minogue, Director of the Maryland Patient Safety Center has made presentations to the Baltimore County Medical Society and the Quality Committee of MedChi. Drs. Joshi and Minogue made presentations and participated on a plenary panel at MedChi's annual Convention on October 15, 2005 in Cambridge, MD. The Center also had an exhibit at the Convention in order to further engage members of the medical

profession. The Commission believes that maintaining the Center's focus on hospitals and nursing homes is appropriate for its first three years.

However, there are key efforts underway in other areas to address patient safety in healthcare practitioner offices through health information technology. The Commission believes that successful patient safety efforts in ambulatory care settings will depend on the adoption of health information technology. Efforts to change the culture of a dispersed system of care depend fundamentally on having an effective information infrastructure that can deliver appropriate information about the patient, about recommended treatments, and about patient safety considerations directly to the time and place of care.

The necessary information infrastructure includes the retrieval of current pharmacy, lab, and radiology data, diagnostic information, allergies, and previous treatments. It also includes either e-prescribing or more extensive computerized physician order entry with decision support, to alert the practitioner to appropriate treatments and potential patient safety concerns. In addition to warning about potential errors, the system must address errors of omission, including reminders of immunizations, recommended preventive screening, and essential clinical monitoring. Finally, electronic medical records and health IT infrastructure must enable a transformation of patient care processes to produce safer care, more efficient practice, better outcomes, and higher levels of patient and provider satisfaction.

There are, however, substantial barriers that must be addressed. Foremost among these are concerns about the privacy and security of patient information. Issues of how patient records from different sources are matched, how users are authenticated, and how appropriate authorizations for access are obtained and verified must be solved. Secondarily, the economics of health IT adoption must be addressed. While providers bear the primary costs of health IT, the financial and other benefits flow primarily to health plans, payers, and the patients themselves. To assure the adoption of health IT, the system must be organized in a way that either delivers value and cost savings to providers or provides some compensation for the costs associated with its adoption and use. In addition, concerns about provider liability must be resolved.

The Commission's goal is to address these fundamental health IT issues up front through the deliberations of the legislature's multi-stakeholder Task Force on the Electronic Medical Record, staffed by the Commission. In addition, the Commission will apply for a federal subcontract to examine privacy concerns and potential statutory and regulatory barriers to the adoption of health IT in Maryland. Because federal efforts to promote the adoption of health IT are in high gear, Maryland's efforts will also need to be coordinated with federal efforts to standardize health data, to certify electronic health records, and to develop specific infrastructure tools.

The Commission has discussed patient safety and health IT with a range of stakeholders. The MHCC Executive Director presented a plenary speech on patient safety and health IT at an October 2005 MedChi convention. We have had a series of initial discussions with the Med Chi leadership and with major payers in Maryland. The Delmarva Foundation, a partner in the MPSC, is also intimately involved in facilitating the adoption of health IT in practitioner offices as part of its responsibilities as a Medicare Quality Improvement Organization (QIO). Delmarva's Health IT Committee brings together representatives of MedChi, the Maryland Hospital Association, the providers themselves, and payers. MHCC participates in and supports these efforts.

Finally, the MHCC and the Health Services Cost Review Commission are collaborating on the development of an RFP for planning contracts for a Maryland regional health information exchange organization. These planning contracts will provide proposed solutions to crucial design, governance, financing, and business process questions. Following receipt of the planning contract reports, an RFP for an implementation contract will be designed, to be funded in part through the HSCRC rate setting process.

These actions implement our considered conclusion that health IT provides the most efficient and cost-effective way to address patient safety concerns in practitioner offices throughout the State.