State Responses to the Problem of Medical Errors: *An analysis of recent state legislative proposals*

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INTRODUCTION

It has been more than two years since the Institute of Medicine (IoM) released its ground breaking report *To Err is Human: Building a Safer Healthcare System*. The report's most conservative estimate placed the annual death toll from medical errors at 44,000 Americans per year. Even more shocking was the report's finding that the medical error epidemic claims more lives each year than do other, more recognized, leading causes of death such as motor vehicle accidents, breast cancer, or AIDS.[1]

Recent news is not much better. A report issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in December 2001 cited a dramatic increase in the number of incidents of wrong-site surgery—most occurring in ambulatory surgical centers—since 1996.[2] Wrong-site surgeries represent the most blatant type of medical error and may be indicative of a not yet quantified epidemic at ambulatory care centers across the United States.

Achieving a meaningful reduction in medical errors will require a variety of efforts. The IoM has proposed several error prevention and reduction strategies including implementation of state-based mandatory reporting and public disclosure of reported information in order to hold providers publicly accountable for egregious errors. Other proposed strategies include establishing a national agency to provide leadership and research on patient safety and establishing voluntary reporting systems to collect information about "near misses" and errors that result in less serious injury or no harm.[3]

States are responding to the IoM recommendations by proposing a variety of strategies to reduce medical errors. To date, legislation addressing some aspect of the problem has been introduced in 26 states.[4] The National Academy for State Health Policy (NASHP) has tracked the progress of 106 state bills, introduced since the initial IOM report in 1999, that address the problem of medical errors from a variety of different perspectives. The first 45 of these were analyzed in NASHP's August 2000 report *How States are Responding to Medical Errors: An Analysis of Recent State Legislative Proposals.*

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[1]The report cites two seminal studies that found that between 44,000 and 98,000 Americans die each year because of preventable medical errors. These figures are believed by some to be underestimates for two reasons. First, many errors go undiscovered because they are never recorded (and thus are not captured by research studies); second, the studies cited in the IOM report are limited to hospital settings and do not capture events occurring in other health care settings. Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, December 1999), 1, 88.

[2]Joint Commission on Accreditation of Healthcare Organizations press release, *Simple Steps By Patients, Health Care Practitioners Can Prevent Surgical Mistakes*, December 5, 2001.

[3] Institute of Medicine, *To Err is Human: Building a Safer Health Care System*, 7-14.

[4] CA, CT, FL, GA, HI, IL, IN, IA, KY, ME, MD, MA, MI, MN, MO, NV, NH, NJ, NY, OR, OK, PA, SD, VA, WA, and WV.

During the 2001 legislative sessions, at least 61 more bills were introduced in state houses across the country and twelve were enacted, indicating that the issue is of significant importance to many state policy makers. This report:

- Analyzes bills introduced in state legislatures during the 2001 sessions;
- Identifies recent trends in states' efforts to reduce medical errors;
- Provides updates on bills that were not yet resolved when NASHP published its 2000 report; and
- Presents updated information on how bills enacted during states' 1999-2000 legislative sessions are being implemented.[5]

[5] Most of the bills discussed in this report were identified through a list generated by the Health Policy Tracking Service at the National Conference of State Legislatures. We believe that it represents a significant number of bills related to medical errors; however, we do not claim that it reflects all medical error legislation introduced in state chambers.

OVERVIEW OF STATE LEGISLATIVE ACTIVITY: 1999-2001

States responded quickly to the IoM report by proposing legislation to address the problem of medical errors. At least 11 medical-error related bills were introduced during states' 1999 legislative sessions; 34 during the 2000 sessions; and 61 during the 2001 sessions. The number of bills introduced in 2001 represents more than a five-fold increase over 1999; a 79% increase over 2000. Nine percent of the bills introduced in 1999 were enacted; 29% in 2000; and 20% in 2001. The increase is encouraging as it signals states' continued interest in understanding and combating the problem of medical errors.

SUMMARY OF STATE LEGISLATIVE ACTIVITY: 1999 - 2001

	1999	2000	2001
No. of bills introduced	11	34	61
No. of bills enacted	1	10[6]	12
No. of states introducing legislation	5[7]	14[8]	22[9]
Issues addressed by enacted legislation	whistleblower protections	whistleblower protections system-wide analysis; study commission; report to legislature reporting requirements improved safety through language access medication error reduction public disclosure of information	whistleblower protections system-wide analysis; access to data, study commission, report to legislature reporting requirements establishment of patient safety center required activities as condition of state licensure public disclosure of information

[6] Two California bills were enacted after NASHP published its legislative report in 2000 and are summarized elsewhere in this report. A Virginia bill was not enacted but was implemented in 2000 by request of the Speaker. That bill is counted as an enacted bill for 2000.

[7] HI, MA, NY, OK, and WA.

[8] CA, FL, HI, IL, MA, MN, MO, NJ, NY, PA, SD, VA, WA, and WV.

[9] CA, CT, FL, GA, IL, IN, IA, KY, ME, MD, MA, MI, MN, MO, NV, NH, NJ, NY, OR, PA, VA, and WV.

OVERVIEW OF STATE LEGISLATIVE ACTIVITY: 2001 SESSIONS

Twenty-two states introduced, debated, or enacted legislation pertaining to medical errors in 2001, compared to 5 states in 1999 and 14 states in 2000. In addition, 11 states introduced medical error legislation in 2001 for the first time since the IOM report was released.[10] Of the bills introduced during states' 2001 sessions: 12 were enacted, 20 died, 23 are still in committee, and the remaining bills were substituted, placed under study order, withdrawn, or remain on calendar.

States Introducing Bills in 2001 Sessions

- **California:** 3 bills, 1 enacted
- **Connecticut:** 2 bills, 1 enacted
- **Florida:** 3 bills
- **Georgia:** 2 bills, 1 enacted
- **Illinois:** 2 bills
- **Indiana:** 1 bill, enacted
- **Iowa:** 1 bill
- **Kentucky:** 1 bill
- **Maine:** 1 bill
- **Maryland:** 3 bills, 1 enacted
- **Massachusetts:** 12 bills, 1 enacted
- **Michigan:** 1 bill
- **Minnesota:** 6 bills, 2 enacted
- **Missouri:** 1 bill
- **Nevada:** 1 bill, enacted
- **New Hampshire:** 1 bill, enacted
- **New Jersey:** 4 bills
- **New York:** 8 bills
- **Oregon:** 1 bill
- **Pennsylvania:** 4 bills
- **Virginia:** 1 bill, enacted
- **West Virginia:** 2 bills, 1 enacted

[10]States introducing medical error-related bills in 2001 legislative sessions for the first-time include: CT, GA, IN, IA, KY, ME, MD, MI, NV, NH, and OR.

Bills Enacted in 2001 Sessions

Twelve bills (out of 61 that were introduced) were signed into law by governors in 2001. Despite increased levels of interest in the issue (evidenced by the increasing numbers of bills being introduced), there has not been a significant increase in the number of bills actually making it to governors' desks. Crowded legislative agendas, the political dynamics of the issue, and dwindling state budgets further complicated by the demands on state resources in the wake of the terrorist attacks of September 11, 2001, may be slowing the progress of many of these initiatives. Newly enacted laws are described below:

- **California:** Requires the Dental Board of California to submit a report to the Assembly Committee on Health and the Senate Business Professions Committee on or before January 1, 2003, regarding reports it has received on deaths or hospitalizations as a result of dental treatment.

- **Connecticut:** A new law took effect on October 1, 2001, requiring licensed hospitals to make their medical and surgical error reduction plans (which are required by the Joint Commission on Accreditation of Healthcare Organizations) available to the state Department of Public Health as a condition of licensure.

- **Georgia:** A law was signed by the governor on April 11, 2001, enacting the "Patient Right to Know Act of 2001," providing for the creation and dissemination of physician profiles and establishing a patient's right to file a grievance against medical providers. In theory, public availability of physician profiles may impact patient safety by causing consumers to avoid practitioners who have a history of unsafe practices.

- **Indiana:** The Indiana Commission on Excellence in Healthcare was created on May 10, 2001, to study issues related to quality of care in the state. The Commission must submit a report to the governor by October 1, 2001, that includes an analysis of the current quality of care in the state. NASHP will evaluate the final report for recommendations directly related to the reduction of medical errors and improved patient safety.

- **Maryland:** On April 20, 2001, a law was signed by the governor requiring the Maryland Health Care Commission to prepare a report on the feasibility of creating a medical error reporting and prevention system in the state. The final report is due in January 2003.

- **Massachusetts:** A law was enacted requiring the creation of the Betsy Lehman Center for Patient Safety and Medical Error Reduction. The Center is to serve as a clearinghouse for the development, evaluation, and dissemination of best practices for patient safety and medical error reduction.

- **Minnesota:** A law was enacted requiring the health commissioner to prepare a report on the factors influencing quality of care and patient safety. The report must be submitted by February 15, 2002.

- **Minnesota:** A law was enacted that allows review organizations (which are much like peer review/quality improvement committees) to participate in Internet-based standardized incident reporting for the purpose of identifying and analyzing trends in medical error and iatrogenic injury. The law also provides confidentiality protections, protects the work of review organizations from the legal process, and provides certain safeguards for patient and provider privacy.

- **Nevada:** A resolution was passed directing the Legislative Committee on Heath Care to appoint a subcommittee to prepare a report on the feasibility of implementing a state-wide medical error reporting system. The Commission's report is due to the 72nd session of the legislature.

- **New Hampshire:** A bill was enacted that will provide disclosure and discovery protections for quality information associated with hospital quality assurance activities.

- **Virginia:** On March 19, 2001, access to information in the Virginia Patient Level Data System was extended to the state's Department of Health to study ways to improve quality of care.

- **West Virginia:** Enacted April 30, 2001, this law protects employees who make good-faith reports to authorities on issues regarding patient safety and quality of care from employer retaliation (e.g., whistleblower protections). The law also requires employers to prepare and post a policy to that effect.

STATE LEGISLATIVE STRATEGIES TO REDUCE MEDICAL ERRORS: 2001 SESSIONS

Each bill described in this report reflects unique state problems and circumstances while attempting to address the problem of medical errors. The details of each bill vary, but a review of the bills reveals common elements in many of them. They include:

- **A comprehensive approach to error reduction** through a system-wide analysis of the problem of medical errors (18 bills). These bills often include studying the feasibility of implementing a reporting system for medical errors, data collection, and the establishment of patient safety centers (4 bills);

- Mandatory or voluntary **reporting of errors** occurring in certain venues (12 bills), disclosure protections for reported information (13 bills), and prevention of employer retaliation—whistleblower protections—(4 bills) for reporting errors or risks to patient safety.

- Patient safety-related activities as **conditions of licensure** by the state (11 bills).

- **Medication error reduction** (8 bills).

- Error reduction through **minimum nurse staffing requirements** (8 bills).

- **Financial incentives** to invest in medical error reduction (2 bills).

- **Funding** for patient safety activities (4 bills).

- Increasing public confidence in systems of care through a variety of **public disclosure requirements** (9 bills).

The section that follows provides more detailed information about these approaches and how states are using them as they seek to reduce medical errors.

Comprehensive Approach to Error Reduction

Many states are interested in taking a comprehensive approach to error reduction by conducting state-wide studies of the problem, including a thorough analysis of public and private data sources, by requiring the collection of certain types of data if they are not already being collected (11 states), and by establishing patient safety centers to lead and coordinate all state activities related to the reduction of errors (2 states).

System-wide analysis

A **California** bill (enacted) would require the state's dental board to study and collect information related to deaths or hospitalizations resulting from dental treatment. A bill enacted in **Indiana** creates a commission to study health care quality issues. It remains to be determined whether the study will include findings and/or recommendations directly related to the reduction of medical errors and patient safety improvements.

A bill pending in **Kentucky** would create a Hospital Medical Errors Task Force to make recommendations on how to reduce the incidence of medical errors in hospitals. The bill further requires a report to the Legislative Research Commission and the Interim Joint Committee on Health and Welfare by November 1, 2001.

Maryland enacted a law requiring a comprehensive study of medical errors, a determination of the feasibility of developing a system for reducing the incidence of preventable adverse events, and a report to the legislature. Three bills were introduced in **Massachusetts** calling for some kind of systems analysis. One would create a task force to study errors in prescription drugs. A second would require system-wide analysis of the quality of services provided by registered nurse first assistants (e.g., nursing assistants). The third **Massachusetts** bill would create a Patient Care Quality Program to conduct system-wide analysis and coordinate risk management and quality monitoring.

A bill introduced in the **Michigan** legislature would create the Governor's Commission on Patient Safety to study errors occurring in health facilities and in private practices. In **Minnesota**, three bills designed to take a system-wide approach to analyzing the problem of medical errors were introduced. The first would focus on analyzing nurse staffing levels and their impact on patient safety. The second, which was enacted, requires the Commissioner of Health to review available research and literature and identify the major factors influencing patient safety. The third would require peer review organizations to gather and review patient care and treatment information for the purpose of developing and publishing guidelines designed to improve patient care and safety.

A bill recently enacted in **Nevada** establishes a legislative subcommittee to evaluate existing medical error reporting systems and recommend to the legislature whether a reporting system should be implemented in the state. In **New Jersey**, two bills were introduced that would create a commission to identify policies and procedures to address

and reduce medical errors. A third piece of legislation introduced in **New Jersey** would create the New Jersey Office of Medical Error Reduction.

In **Oregon**, a bill was introduced that would create a Commission on Medical Safety to develop policies and procedures for reducing medical errors and promoting patient safety. Finally, **Virginia** enacted a law that will facilitate system-wide analysis and data collection by directing the Board of Health to collect hospital discharge data to study ways to improve health care quality.

Patient safety centers

Legislation introduced in **Maine** would establish the Maine Health Care Quality Improvement Center to coordinate and oversee improvements in the quality of patient care, conduct medical error research, educate on issues of patient safety, issue sentinel event alerts, and develop an annual report to the legislature.

Two bills introduced in **Massachusetts** sought to create a medical error reduction center in honor of Betsy Lehman, a reporter for the Boston Globe who died in a Massachusetts hospital from an overdose of chemotherapy. One of those bills was ultimately enacted, officially establishing The Betsy Lehman Center for Patient Safety and Medical Error Reduction. The center is designed to serve as a clearinghouse for the development, evaluation, and dissemination of best practices for patient safety and medical error reduction.

Another bill introduced in the **Massachusetts** legislature during the 2000 legislative sessions would establish the Center for Patient Safety and Medical Error Reduction. The center would make recommendations for patient safety and medical error reduction programs.

Reporting of Errors

Reporting requirements

There are potentially two types of reporting requirements: mandatory and voluntary. Mandatory reporting requirements impose a legal obligation to report error-related events to a governmental entity, a non-governmental entity (e.g., a hospital risk manager), or both. The IoM recommends that states establish mandatory reporting systems to collect information about errors causing serious harm or death and that voluntary reporting systems be established to collect information about "near misses" and errors that result in

no harm or minimal harm.[11] The focus of mandatory reporting is on oversight and accountability. Voluntary reporting requirements do not impose any obligations on the part of the reporter. The focus of voluntary reporting is on research, detection of systemic problems, and the identification of prevention strategies.[12]

Twelve bills dealing with some aspect of error reporting were introduced in seven states during the 2001 session. The measures would require mandatory reporting (6 bills) or voluntary reporting (5 bills) of adverse patient incidents or would strengthen existing reporting requirements.

A bill introduced in **California** would create a voluntary central reporting database to maintain medical error related data. In **Georgia**, a bill was introduced that would require the development and implementation of reporting standards. If passed, the bill would require the state to promulgate standards, but reporting would be voluntary. However, entities that submit voluntary reports would be required to comply with the reporting standards.

A bill in **Maryland** would establish a confidential mandatory reporting system for reporting of egregious and non-egregious medical errors. Another bill introduced in Maryland would require mandatory reporting to consumers, the prescribing health care provider, and the Board of Pharmacy of any error the pharmacy makes in compounding, dispensing, or labeling a prescription.

A bill was introduced in **Massachusetts** that would require any agency, board, department, or commission to report adverse events to the Secretary of the Executive Office of Health and Human Services beginning July 1, 2002, on a quarterly basis.

Legislation enacted in **Minnesota** would provide for voluntary reporting of near misses and adverse events through a publicly accessible web-based site. Patient and provider identities would be kept confidential and only aggregated trend data would be made available.

Three bills were introduced in **New York** that would require mandatory reporting. One bill would establish a public reporting system of adverse patient care incidents by licensed facilities related to inadequate staffing of direct care providers. Two other pieces of proposed legislation would require incident reporting by practitioners performing office-based surgeries. The Commissioner of Health would be required to define

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[11] Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, December 1999), 7-14.

[12] For a more complete discussion of reporting and the pros and cons of making reported information available to the public, see: 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, March 2001).

"reportable incidents" and to collect information about all incidents.

A measure introduced in **Pennsylvania** would create a mechanism for persons to report errors or threats to patient system through a voluntary system. Another bill introduced in Pennsylvania would require providers to submit information related to medical errors to the Health Care Cost Containment Council. The Council would then publish annual reports that would be made publicly available. Finally, in Pennsylvania a bill was introduced that would require health care practitioners working in health care facilities to complete and file internal incident reports in accordance with the facility's standard procedures within 48 hours of the occurrence of a reportable medical event. The bill would also require the risk manager to ensure that the involved patient is notified of the reportable medical event.

Disclosure protections

One type of protection would insulate certain types of information from the legal process. These types of protections are, in theory, designed to encourage open and honest critical analysis of issues in order to improve practices or systems. Another type of disclosure protection seeks to protect individuals and/or entities from being identified during a particular process. Often information about errors can be made available to the public without revealing the identity of patients, physicians, or facilities. Proponents of disclosure protections typically argue that, without these protections, reported information is likely to result in an increase in malpractice litigation and a reluctance on the part of providers to acknowledge and address errors, potentially undermining a state's oversight efforts.[13]

Thirteen bills introduced in twelve states[14] include provisions to protect error-related information from public disclosure and the legal process, protect the confidentiality of patient and/or provider information, or both.

Whistleblower protections

Whistleblower protections prevent employers from retaliating against employees for providing certain kinds of information to designated officials. Providing whistleblower protections for persons who report substandard care, medical errors, or threats to patient safety to either state officials or designated officials within the employing health care facility (e.g., a hospital risk manager) is viewed as a method for encouraging individuals

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[13] For a more complete discussion of disclosure protections, see *State-based Mandatory Reporting of Medical Errors: An Analysis of the Legal and Policy Issues* (Portland, ME: National Academy for State Health Policy, March 2001).

[14] FL, GA (enacted), MD, ME, MA, MN, MO, NH (enacted), NJ, NY (2 bills), PA, and VA.

to come forward and identify patient safety concerns. Policy makers hope that such reporting can trigger some kind of follow-up investigation and, ultimately, elimination of a substantiated risk.

Four bills introduced during states' 2001 legislative sessions seek to facilitate reporting of medical errors by providing legal protections for individuals who submit reports to designated authorities (e.g., whistleblower protections). Depending upon the specific bill, such protections typically apply to individuals who report to a state or federal agency or to an agent of the employing provider. A bill introduced in **Georgia** would require the adoption of standards for reporting violations of patient safety and would prohibit retaliation against health care providers who report, in good faith, information relating to the care provided by a health care facility. A bill introduced in the **Missouri** legislature would require hospitals and ambulatory surgical centers to adopt written policies concerning protections for whistleblowers who submit reports to the Department of Health.

In **Pennsylvania**, a bill was introduced that would require the Office of the Attorney General to establish a state-wide, toll-free number for health care professionals to report concerns about patient safety or the quality of patient care. The measure would provide whistleblower protections for persons submitting reports on the hotline. Finally, in **West Virginia**, a bill (introduced) would provide protection from employer retaliation for employees who, in good faith, report potential risks to patient safety to an appropriate agency. The bill would require employers to post written policies notifying employees of such protections.

Conditions of State Licensure

States as regulators of licensed health care facilities have the potential to mandate certain patient safety activities as a condition of licensure. Without such licensure, facilities would no longer be able to operate in the jurisdiction. Thus, requiring activities as conditions of new or continued licensure is a powerful tool for states. In the 2001 legislative session, eleven bills were introduced in six states seeking to use such authority to ensure that facilities conduct certain patient safety activities.

A bill introduced in **California** would strengthen existing peer review requirements and would impose penalties for non-compliance. A **Connecticut** bill (enacted) would authorize the Department of Health to review plans to reduce or eliminate medical errors by hospitals and other health care facilities as a condition of licensure. Two measures introduced in the **Florida** legislature would require licensed facilities to revise their internal risk management programs as a condition of continued licensure.

A bill in **Massachusetts** would condition professional licensure on participation in patient safety education programs. Another **Massachusetts** bill would require continued participation in quality assurance and risk management programs as a condition of

facility licensure. In **New Jersey**, a bill was introduced that would require pharmacies to undertake certain activities as a condition of licensure.

Four bills were introduced in **New York** that would condition licensure on compliance. The first would require certain safety measures by suppliers of in-home medical equipment. The second would require facilities to continue to implement risk management programs. The final two similar measures would require compliance with standards for office-based surgical procedures.

Reduction of Medication Errors

Medication errors have been identified as a leading cause of medical errors. In a widely reported incident involving a medication error, a well known Boston journalist died after receiving more than ten times the safe dose of chemotherapy.[15] Over the past two years, state policy makers have put forth a variety of creative strategies to prevent medication errors. Examples include: requiring mandatory handwriting classes for prescribing physicians, requiring pharmacies to report dispensing errors, and requiring pharmacies to conduct patient education activities when dispensing medications.[16]

Eight bills introduced in six states attempt to decrease the prevalence of prescription drug errors. A bill introduced in **Connecticut** would require adherence to certain standards for physician administration of non-local, outpatient anesthesia. A bill introduced in the **Iowa** legislature would provide legal remedies for patients who receive incorrect medication from a pharmacy. A bill in **Maryland** would require mandatory reporting of pharmacy errors.

Three bills in **Massachusetts** are aimed at reducing medication errors. The first would create a task force to study prescription drug errors and submit recommended safety improvements to the legislature.[17] The second would establish mandatory drug labeling requirements. The final measure would limit the type of licensed personnel able to administer controlled substances.

A bill introduced in **New Jersey** would create the New Jersey Board of Pharmacy to regulate the practice, to establish standards of practice, and to ensure that such standards are met. The bill would also require pharmacists to perform prospective drug utilization review and to offer counseling before dispensing prescriptions. Finally, a measure in

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[15] *To Err is Human: Building A Safer Health Care System* (Washington, D.C.: National Academy Press, December 1999).

[16] *How States are Responding to Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, August 2000).

[17] The bill does not provide a date for submission of the report.

New York would create the Prescription Review Board to study methods of reducing medication errors.

Minimum Nurse Staffing Requirements

The availability of adequate numbers of trained health care personnel may help reduce errors by ensuring that caregivers have time to spend with patients, are not rushed in the delivery of care, and have the time to attend to the level of detail required to provide safe care.[18] Making staffing-related information available to the public empowers consumers to make care-related decisions based on the amount and intensity of care they can expect to receive while in the care of a given facility.

Policy makers in five states introduced eight bills related to nurse staffing. A measure introduced in **Illinois** would require a health care facility to develop and implement a staffing plan to ensure that minimum nurse staff requirements are met. Another bill in Illinois would place limitations on mandatory overtime for hourly personnel responsible for direct caregiving.

Two similar bills were introduced in **Minnesota** that would require the health commissioner to identify major factors influencing patient safety, including the impact of nurse staffing levels.

Lawmakers in **New York** introduced two bills that would require public reporting of nursing staffing; one of the bills would further require public disclosure of nurse-to-patient ratios. The second bill would establish a public reporting system for adverse patient care incidents that occurred because of inadequate staffing levels.

A bill in **Pennsylvania** would require the Pennsylvania Health Care Cost Containment Council to collect information on nurse staffing, including case mix of various nursing professionals and total RN hours provided per patient day. A bill introduced in **West Virginia** would require public reporting of nurse staffing information by all licensed facilities receiving Medicaid funding.

Financial Incentives to Reduce Errors

Providing financial incentives is widely recognized as a promising strategy to encourage certain activities, induce changes in behaviors, and encourage individuals and/or entities to experiment with innovations that they might not otherwise have had the financial means to try.

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[18] The challenge for policy makers and care providers is determining what is adequate staffing under a variety of circumstances and deciding whether staffing levels are an appropriate focus for legislative action.

Two bills introduced in **Massachusetts** seek to create financial incentives for error reduction. The first, would provide interest free or low-interest loans to state agencies and a variety of provider types to conduct projects related to patient safety and medical error reduction systems and the development of health care technology and health training or education. The second would make one-time supplemental funds available to providers to use to implement technology designed to reduce medical errors.

Funding for Patient Safety Activities

Patient safety activities conducted by state agencies have the best opportunity to succeed if they are adequately staffed and funded. Resources are needed for the intensive work of investigating errors, evaluating institutional policies and practices, maintaining databases, and conducting a variety of follow-up activities associated with monitoring errors.

Two similar bills introduced in **Minnesota** would appropriate funds ($10,000,000) to carry out activities of the Minnesota Center for Health Quality. Two similar bills in **New Jersey** would allocate $95,000 for the creation of a commission to identify policies and procedures that address the issue of reducing medical errors and to develop recommendations for a state-wide medical error reporting system that could be integrated with a federal reporting system.

Public Disclosure Requirements

Making information about medical errors and patient safety available to the public accomplishes several goals. First, it provides information which consumers may use to hold providers accountable for the medical mistakes they make. Public availability of information about errors also supports the goal of learning from errors by providing researchers with data that they can use to determine the causes of preventable error. A third rationale for making information publicly available is to promote public trust in health systems by creating an atmosphere where neither the good things nor the bad things are hidden. Finally, public access to error and patient safety information gives consumers useful information to make informed choices about their health care.[19] Nine bills were introduced in six states that would include provisions to make certain types of information related to medical errors available to the public.

A **Georgia** bill would require standards for informing patients of physician qualifications through a publicly accessible physician profiling system.

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[19] For a more complete discussion of public disclosure issues see *How States are Responding to Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, August 2000).

A bill introduced in **Maryland** would require the Health Care Commission to conduct a public information campaign to increase knowledge and awareness of medical errors. A bill considered in **Minnesota** would provide for voluntary reporting of near misses and adverse events and increase consumer confidence by providing public access to reported information.

A bill in **New Jersey** would require a public disclosure of incidents related to inadequate nurse staffing.

Four bills were introduced in the **New York** legislature that could increase consumer confidence in health systems by requiring that certain information be made available to the public. Two of the bills would require public reporting of adverse incidents related to inadequate nurse staffing. The third bill would require the state to publish annual reports summarizing incident reports received from hospitals. A fourth bill would require practitioners to disclose known errors to patients unless the provider has a reasonable belief that the patient has already been informed of the error.

CONCLUSION

Medical error legislation at the state level is increasing. It is clear that state policy makers have identified the need to take action to protect the public and increase public confidence in health systems and are proposing a variety of creative strategies to accomplish these goals. As the issue continues to be of concern to states, the challenge ahead is to garner sufficient public and political support for enactment of more of these measures.

The proliferation of study commissions created this year (and last) and the emergence of patient safety centers are encouraging signs that more data will become available to guide lawmakers as they attempt to identify strategies to reduce errors, to tailor their response to the needs of their respective jurisdictions, and to evaluate the effectiveness of their approaches. It is also encouraging that states have not waited for federal action or funding but are taking the initiative to protect their citizens from avoidable harm during encounters with the health care system. Federal policy makers may find state efforts instructive as they seek to shape national medical error reduction policy.