

From Public Testimony to Vehicle for Statewide Action: Experience of the Michigan State Commission on Patient Safety

Diane Valade, MS; A.B. Orlik; Ruth Mohr, RN, MPH, PhD; Vicky Debold, RN, PhD; AkkeNeel Talsma, RN, PhD; Beverley McDonald; Thomas Simmer, MD

Abstract

In 2004, Michigan Governor Granholm appointed the Michigan Health and Safety Coalition (MH&SC)—an already established voluntary collaborative of diverse health care stakeholders—as the Michigan State Commission on Patient Safety. The Commission’s final report, released publicly in 2006, presents a detailed set of objectives and action steps designed to engage the entire State in a coordinated effort to accelerate patient safety improvement and transform Michigan’s health care culture. Through this unique opportunity to provide policy recommendations to State government, the MH&SC increased awareness of patient safety as a statewide concern; demonstrated the value of a transparent, inclusive, consensus-based process for setting a statewide agenda; and identified individuals and organizations committed to non-competitive, collaborative patient safety improvement. Here we summarize the Commission’s methods for transforming diverse public input into a consensus-based policy document; describe the results of its process; and discuss the factors that contributed to its success.

Introduction

The overwhelming majority of people working in health care share a deep commitment to healing; they do not go to work intending harm. Our health care system, however, is far from perfect. Its interdependent people, processes, tools, and environments still do not ensure the safety of every patient every time, despite increased attention since 1999, when the Institute of Medicine (IOM) released *To Err is Human: Building a Safer Health System*.¹ The IOM’s estimates of 44,000 to 98,000 deaths and \$17 billion to \$29 billion in lost income, disability, and health care costs attributable to medical errors each year spurred unprecedented research, activity, and funding opportunities focused on reducing harm caused by the processes of health care.

In many States, public dialogue about health care quality and safety was initiated in the legislative arena.² By contrast, Michigan stakeholders responded to the challenge of the “quality chasm” by forming the Michigan Health and Safety Coalition (MH&SC), a voluntary collaborative developing system-level solutions for making patient care safer. MH&SC participants include the Michigan associations of physicians, nurses, pharmacists, and hospitals;

health plans; consumer and employer groups; MPRO (the State's Quality Improvement Organization); and the Michigan Department of Community Health. Through their participation in the MH&SC, these individuals and organizations have developed constructive, cooperative relationships and have engaged in creative problem-solving in the complex arenas of patient safety and health care quality.

In 2004, Michigan policymakers requested formal guidance from this voluntary coalition. Following legislative action, Governor Jennifer Granholm invited the MH&SC to serve as the Michigan State Commission on Patient Safety (Commission) to “examine means to improve patient safety and reduce medical errors in this State.” The Commission’s enabling statute provided detailed requirements regarding the Commission’s membership, activities, and timeline. The Commission had 14 months in which to take public testimony, conduct a complementary literature review, and issue a report to the Governor containing “recommendations for improvements in medical practice and a system for reducing medical errors, both in health facilities and in private practice.”³

The Commission recognized that the credibility of its recommendations—and their influence in fostering behavioral change to improve the quality of health care—would depend on the integrity of the process used to develop them. The Commission met this challenge by developing an intentionally transparent process for considering public testimony in the broader context of health care quality and safety. The results include a detailed health policy agenda designed to involve affected segments of the health care arena in implementation. The Commission’s final report, signed by every Commission member, is a road map for improving patient safety in Michigan. It includes both destinations and major landmarks along the way, engaging everyone with a stake in health care safety—whether providing care, paying for it, or depending on it—in navigating toward a safer Michigan health care system.

Anecdotally, the authors are aware that many States have engaged in collaborative efforts to improve patient safety, with or without a joint, consensus-based patient safety agenda. A thorough review of these efforts is beyond the scope of this paper. However, the authors believe that the combination of the following characteristics is unique to Michigan’s approach:

- Its genesis as an input to policymakers: The Commission was established by the Michigan Legislature and reported to the Governor.
- The enlistment by policymakers of an established coalition of health care stakeholders with a long track record of trust and collaboration, and the continued efforts of this broad-based coalition to promote implementation after its service was complete.
- The engagement of a team of health care researchers to develop and implement a transparent process to interpret the public testimony collected and incorporate findings from a complementary literature review.
- The presentation of the Commission’s findings in a final report combining excerpts of the testimony, narrative rationale, and lists of action steps to be used modularly and over time by various stakeholders.

This paper is not a summary of that final report. Instead, included here is a description of the innovative methods used by the Michigan State Commission on Patient Safety to transform a large quantity of public testimony into a cohesive set of recommendations for coordinated

statewide action, a brief summary of the resulting policy agenda, and a discussion of how and why the Commission’s process led to the results it did. We present this information as part of the Commission’s commitment to transparency, and so it may serve as a model or starting point for other States or regions interested in building broad consensus for systems-based solutions to health care safety and other critical issues of public concern.

Methods

Context and Overview

The Commission’s choice of methods served its public policy purpose. From its inception, the Commission was committed to rigor, credibility, accountability, transparency, inclusivity, and consensus in its work. Commission members’ commitment to shared decisionmaking arose not from familiarity with the literature on consensus building, but from an understanding of the likely political and economic implications of its recommendations and recognition that members had to be willing and able to support and implement the proposals they put forward.

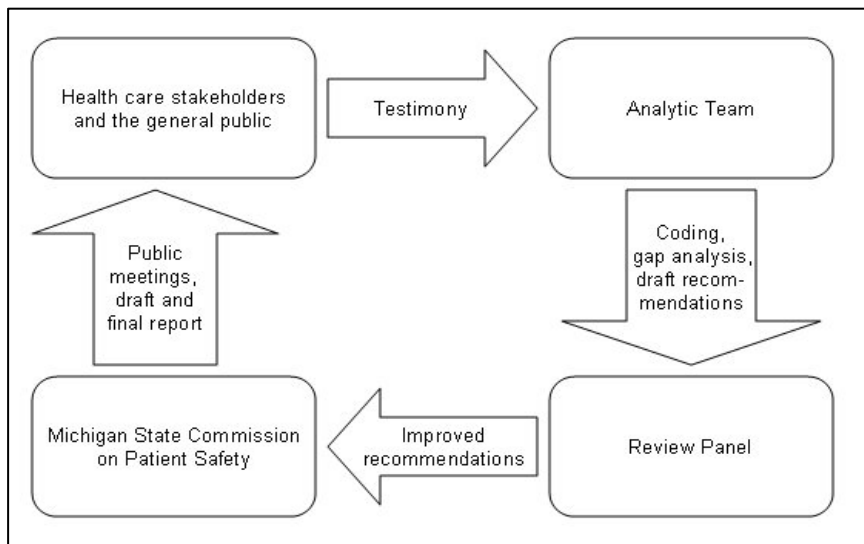


Figure 1. Process overview: Michigan State Commission on Patient Safety.

The core steps of the Commission’s process are illustrated in Figure 1:

- Health care stakeholders and the general public provided testimony regarding patient safety concerns and recommendations.
- A team of researchers (the Analytic Team) coded and categorized the testimony, conducted a complementary literature review, and summarized the findings.
- In two rounds of deliberations, a subgroup of the Commission plus two Michigan patient safety experts (the Review Panel) refined and enhanced draft recommendations.
- The Commission oversaw the process, periodically reported progress to the public, invited public comment on the draft report, and issued the final report, signed by all 25 members.

Throughout the process, participants aimed to foster respect, trust, inclusiveness, and openness; create an environment in which differences of opinion could be voiced; and successfully manage conflict.⁴

Preparation

In anticipation of the need to make sense of a large number of diverse concepts and suggestions from public testimony, the Commission engaged a team of nine analysts. This Analytic Team included experienced health policy and health services analysts and clinicians, many with expertise in qualitative and quantitative methods in research, evaluation, and policy settings. Their charge: to gather from the public testimony recommendations for creating a safer health care environment and translate these data into usable information for the Review Panel and Commission. They were expected to develop a valid approach to reduce the volume of information, identify significant patterns in the data, and construct a framework for communicating the essence of what the data revealed. The team also was tasked with consulting published and unpublished sources to determine if what was recommended in the testimony was supported in the patient safety arena and identify areas of improvement discussed in the literature that did not appear in the testimony. Three objectives guided the analysts' approach:

- The Commission should understand the range of patient safety concerns in the State.
- Interested stakeholders should be able to follow how the final report and its specific recommendations emerged from the original testimony.
- The team's methods should enhance the Commission's efforts to build broad-based support for eventual implementation of its recommendations.

To these ends, the Commission and Analytic Team took great care to design processes to convey accurately the words and intent of those supplying testimony and generate results independent of the influence of any individual Commission member or analyst.

A pragmatic mixed model approach⁵—blending qualitative and quantitative methods throughout—was adopted for overall project design, as well as for data analysis and interpretation. Use of a pragmatic approach was dictated by the Commission's limited timeframe, which was established by the Michigan Legislature. As a result, the framework used to structure the request for testimony and guide development of *a priori* codes drew upon the IOM's work in patient safety, rather than relying completely on what emerged from the testimony, as a strictly qualitative research approach would suggest. Four categories suggested by the IOM proved useful throughout the Commission's process—from suggesting topics on which the public might wish to provide testimony to organizing the Commission's final recommendations into a model of safe care in Michigan (Figure 2):

- Develop leadership and knowledge.
- Identify and learn from errors.
- Implement safety systems in health care organizations.
- Set performance standards and expectations.

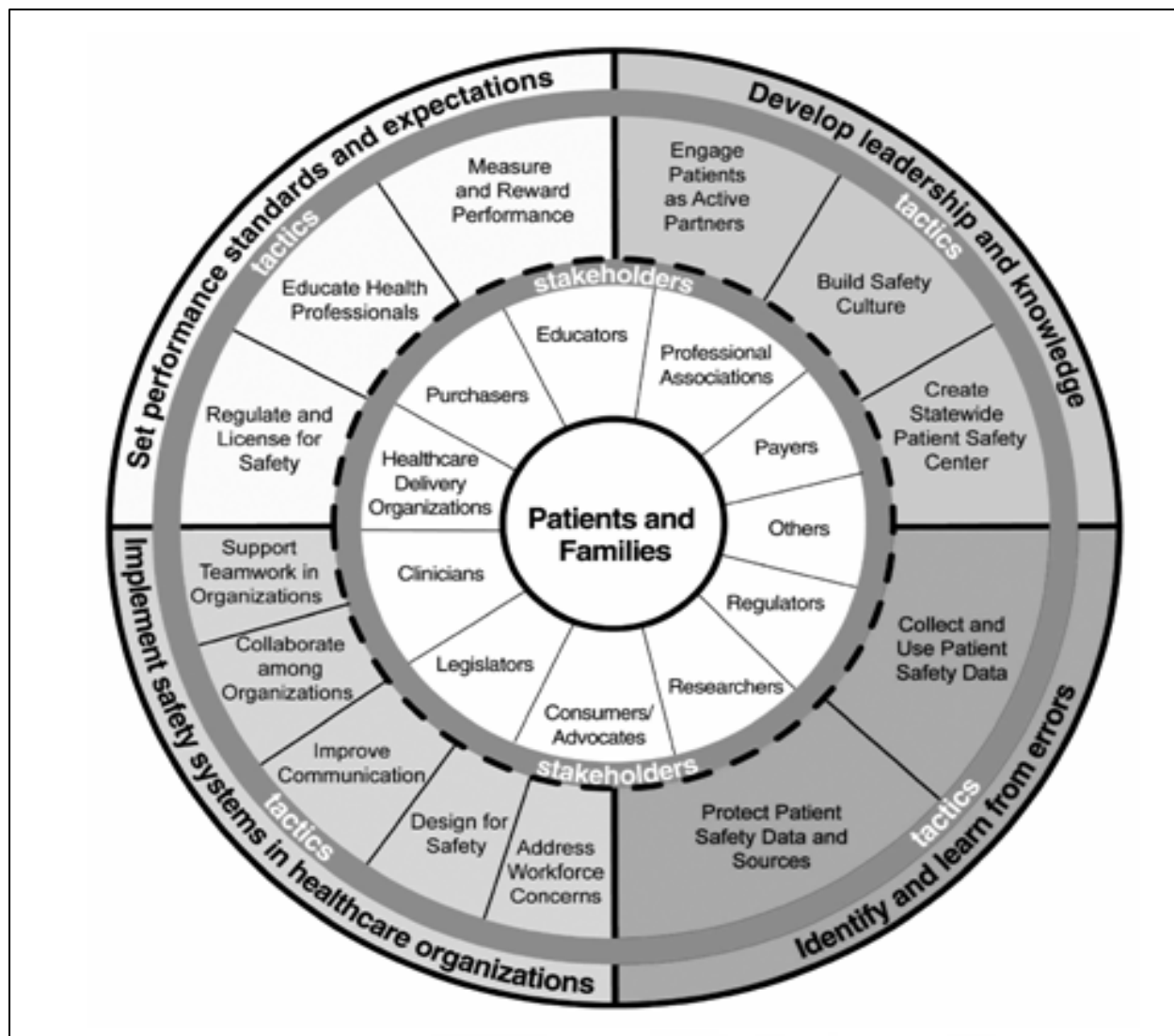


Figure 2. A model for safe care in Michigan. As its framework, the Michigan State Commission on Patient Safety adopted categories suggested by the IOM's report, *To Err is Human*.¹ These categories appear in the outer ring of the model, within which appear the areas in which the Commission developed recommendations. At the center, the diverse stakeholders, who must be united to realize the Commission's vision of a safer Michigan health care system, are arrayed around patients and families, as a reminder that those who receive health care should be at the center of all efforts to improve patient safety.

Data Collection

In October 2004, the Commission extended a request for testimony to 279 health care organizations, associations, professionals, consumers, researchers, and others with an interest in patient safety, some of whom were identified in the Commission's enabling statute. To reach the general public, the request also appeared in major newspapers around the State. Three public hearings were held 1 month later, in Lansing, Southfield, and Traverse City. Those unable to attend were encouraged to supply written testimony.

The Commission received testimony from an impressive array of health care stakeholders, many of whom expressed a desire to continue working with a State-level entity to improve patient safety in a variety of health care settings. A total of 77 informants provided testimony verbally, in writing, or both. Informants included 19 of 43 listed in the Commission's enabling statute. All oral testimony was transcribed by professional services. For tracking purposes, each piece of testimony was assigned a unique 3-digit identifier. Oral and written testimony from one organization was considered one submission from one informant, and this testimony was given a single 3-digit identification code. Informants included seven hospitals; 12 health professionals not representing an organization; five educators, including faculty and schools; 17 consumers and organizations representing consumers; two employer groups; three insurers; 26 health professional associations/organizations; and five classified as other, including research institutes.

Analysis

The major phases of data reduction, data display, and conclusion drawing and verification⁶ are described in the following sections.

Data reduction. The team's first task was to organize and condense the data so meaning could begin to emerge. An initial reviewer's guide provided team members with detailed instructions for close reading of the text, identifying text fragments that contained meaning units, and implementing standardized coding and documentation processes. The first set of *a priori* codes included in the guide was developed to satisfy the policy aims of the analysis; it used as a foundation the IOM's *To Err is Human*,¹ from which the four categories of the Commission's framework were drawn.

Because there are no absolute rules for how to implement a qualitative analytic approach, only standards and principles applied with judgment to a particular situation⁷; and because the analysts brought diverse perspectives and backgrounds to this process, safeguards that supported the analysts' consistency, impartiality, and neutrality were essential. Before coding began, inter-rater reliability was tested at two training sessions. While consistency of coding across analysts improved with the second exercise, additional quality assurance measures were instituted as reviewing and coding got underway: continued testimony review and feedback sessions; a requirement that at least two team members review and code each piece of testimony; and a deliberative process for resolving coding disagreements. Leadership of each of the team's four subgroups by an experienced qualitative analyst, subgroup-to-subgroup support, and inter- and intrasubgroup communication strategies (e.g., regular e-mail and weekly phone conferences) were critical to the successful transfer of information and consistent implementation of quality control measures as they evolved.

The team also established a formal process for adding and clarifying codes for new ideas that emerged from the testimony. Eventually, 30 testimony recommendation codes (for "what" should be done) were identified. Each code was assigned a 2-digit identifier, an abbreviated name, and a narrative description. For example, code 01, labeled "StateFocal," indicated that the testimony recommended "identification and adoption of an institutional focal point for providing State-level leadership related to patient safety."⁸ The team also established nine recommendation target codes for "who" should make a recommendation happen. These included, for example, State government, health professionals, and third-party payers.

From the testimony of 77 informants, analysts extracted and coded 353 unique recommendations. Some testimony fragments were coded with multiple codes. Analysts did not code statements, complaints, observations, and other comments that did not clearly contain recommendations for improving health care safety.

Data display. The coding of testimony recommendations allowed this information to be retrieved and organized so analysts could quickly find, pull out, and cluster segments related to a particular theme or question. To discern patterns and interrelationships in the data, the four major categories of the Commission’s framework were used to cluster the 30 recommendation codes. Initial assignments were based on the code’s face-value fit with the category definition. Analysts then performed code and data consistency checks on each category, agreed upon the assignment of each code to a framework category, and developed a reliable process for identifying and correcting coding errors.

Conclusion drawing and verification. The team also consulted a variety of sources to identify gaps in recommendations emerging from the testimony and to determine if emerging recommendations were supported in work done by others. For this broader perspective, the team read journal articles, books, and Web sites, and spoke with individuals active in patient safety improvement across the country. In some cases, information from these sources provided external support for recommendations the Commission might otherwise have been reluctant to include. For example, testimony in favor of a statewide focal point for patient safety activities was strengthened by research into the structures, roles, and funding sources of patient safety centers across the country.⁹ In some cases, the gap analysis broadened the scope of a recommendation. For example, with support from the literature, public testimony specific to nursing education evolved into a recommendation to incorporate safety principles in the education of all health professions.^{10, 11, 12, 13} In other cases, the analysts’ synthesis of external sources provided needed focus. In the area of statewide reporting of health care errors and near misses, for example, the testimony pointed in many and often conflicting directions. Should a system be mandatory or voluntary? What events should be reported? By whom? To whom? For what purposes? The analysts’ research^{14, 15} provided critical information regarding the opportunities and challenges of various approaches.^a

Deliberations

The Review Panel consisted of 15 Commission members and two of the State’s recognized patient safety experts. In two rounds of facilitated deliberations, this group considered reports prepared by the Analytic Team, requested further research or clarification, brought additional information to light, and refined and prioritized recommendations for consideration by the full Commission.

In its first round of deliberations, the Review Panel considered a series of reports—one for each of 20 topic areas (some testimony codes were presented together for this purpose)—containing verbatim excerpts from the testimony, draft recommendations and related rationales, evidence

^a Note: Analysts reviewed a variety of texts in each of the areas discussed in this section; only a few of the more helpful texts are cited here as examples.

and information about comparable initiatives in other States, a discussion of benefits and barriers to recommended approaches, and initial thoughts regarding implementation.

A second round of reports (in which 20 topics were reduced to 12) followed a template designed to facilitate consensus-building. All of the relevant information for each subject area was assembled in a single document, and recommendations were developed with enough detail and simplicity to promote thoughtful consideration. These second-round reports included refined recommendations and justifications; expanded supporting evidence and assessment of advantages, barriers, and implementation issues; an overview of related testimony and non-testimony evidence; and notes from the Review Panel's first round of deliberations. Additional information or clarification requested by the Review Panel in its first round of meetings was highlighted.

The group was polled during this second round to gauge the level of agreement with emerging recommendations and to identify areas of concern and the degree to which disagreement existed. The Review Panel's limited discussion time was then focused on modifying or rewording recommendations with promise (those not rejected outright) that had the least agreement.

At the end of its second round of deliberations, the Review Panel used a two-stage structured ranking process to prioritize the 12 broad recommendation categories that had emerged from the original 30 numbered codes. Individual objectives and action steps were not voted on separately.

Initially, each panel member rated each recommendation category on a Likert scale (1 = strongly disagree to 5 = strongly agree) in response to three statements:

- Recommendation has great potential for reducing patient harm.
- Recommendation should be addressed with a sense of urgency.
- Recommendation is a high-priority funding opportunity.

In the final round of voting, each panel member ordered the 12 broad recommendations in terms of importance by using a scale from 0 = least important to 11 = most important. Scores from 11 voting members were totaled, and the results of this prioritization process guided the order in which the Review Panel proposed that the Commission present its recommendations in the final report. (Two codes conflated for this second round of deliberations were restored as separate recommendation areas in the final report, resulting in the 13 report sections listed in Table 1.)

To reach final consensus, the Review Panel and full Commission conducted a piece-by-piece review of a number of draft reports, each more clearly defining the range of underlying concerns and possible courses of action, until a final set of objectives and concrete action steps emerged. The Review Panel, with support from the Analytic Team, used the consistent formatting of the chapters in these draft reports to confirm that action steps for each relevant stakeholder group had been identified. Members were encouraged to share the detail in these drafts with their organizations and constituents to gauge the level of support or concern and to bring any objections to the Review Panel or Commission for discussion.

Table 1. Objectives of the Michigan State Commission on Patient Safety

The substance of the Commission’s recommendations is contained in the detailed recommended action steps in each section of the final report. These “to-do” lists—too long to reproduce here—provide the roadmap to accomplishing the objective(s) set out in each section. For this detail, please refer to the Commission’s full report, available at www.mihealthandsafety.org/statecommission/barefoot/final_report.html.

Report Section	Objectives	Action Steps Provided For...
A. Build a safety culture	<ul style="list-style-type: none"> Continue to transform Michigan’s health care culture to one characterized by a commitment to safety, learning, collaboration, and systems thinking. Reinforce a culture in which the State of Michigan, all clinical and administrative leaders who influence health care delivery, all individuals involved in the caregiving process, and those who use health care services act consistently from a deep commitment to decreasing harm to patients. 	<ul style="list-style-type: none"> State of Michigan Michigan Center for Safe Health Care Health professionals and organizations All health care stakeholders
B. Establish a statewide patient safety center	<ul style="list-style-type: none"> Establish and fund the Michigan Center for Safe Health Care as a statewide center for leadership, information, and advocacy to reduce patient harm across a range of health care settings. 	<ul style="list-style-type: none"> State of Michigan
C. Collect and use data about errors and near misses	<ul style="list-style-type: none"> Establish and fund a statewide voluntary, confidential, peer-protected, nonpunitive error reporting system. Ensure that important findings are disseminated regularly to improve health care safety. Complement, to the extent possible, emerging national data definitions and measurement criteria. 	<ul style="list-style-type: none"> State of Michigan Michigan Center for Safe Health Care
D. Protect patient safety data and sources	<ul style="list-style-type: none"> Protect patient safety data and reporting activities under statute without denying patients and families access to information through normal channels when medical errors or unexpected events occur. 	<ul style="list-style-type: none"> State of Michigan
E. Measure and reward performance	<ul style="list-style-type: none"> Establish or adopt standards for patient safety performance across the continuum of care, develop or adopt a common vocabulary and standardized data definitions, set dynamic benchmarks to measure progress, use the measured performance of Michigan’s health care providers to inform ongoing improvement efforts, and reward excellence. 	<ul style="list-style-type: none"> Michigan Center for Safe Health Care Health professionals and organizations
F. Address workforce shortages effectively	<ul style="list-style-type: none"> Address health care workforce shortages without compromising patient safety while improving practice environments and the availability of qualified health professionals. 	<ul style="list-style-type: none"> State of Michigan Michigan Center for Safe Health Care Health professionals and organizations

Table 1. Objectives of the Michigan State Commission on Patient Safety (continued)

Report Section	Objectives	Action Steps Provided For...
G. Design facilities and processes for safety	<ul style="list-style-type: none"> Adapt tools and methods from human factors engineering, facility design, and industries with demonstrated error prevention records to improve patient safety in health care. Prevent or correct system defects in ways that respond to patient and staff needs rather than training staff or teaching patients to accommodate poor system design. 	<ul style="list-style-type: none"> State of Michigan – Certificate of Need Commission Michigan Center for Safe Health Care Health professionals and organizations
H. Improve communication of critical information	<ul style="list-style-type: none"> Promote improved use of communication and technology to ensure that information critical to patient safety (e.g., health history, medication history, and critical lab values) is available to patients and health care providers within and across organizational boundaries. 	<ul style="list-style-type: none"> State of Michigan Michigan Center for Safe Health Care Health professionals and organizations
I. Involve patients as active health care partners	<ul style="list-style-type: none"> Empower consumers/patients/clients/residents and their families/caregivers/advocates to better assume their roles as partners in the health care encounter. Promote open and clear communication between patients/families and health professionals about health issues, treatments, patient safety concerns, and adverse events. Embed the consumer/patient voice in the structure and process of designing safe care. 	<ul style="list-style-type: none"> State of Michigan Michigan Center for Safe Health Care Health professionals and organizations
J. Embrace safety in health professions education	<ul style="list-style-type: none"> Weave the teaching and demonstration of patient safety principles, knowledge, and skills into health professions education and continuing education requirements. 	<ul style="list-style-type: none"> State of Michigan – Michigan Dept of Community Health working with health professions licensing boards Michigan Center for Safe Health Care Educators of health professionals
K. Emphasize collaboration among organizations	<ul style="list-style-type: none"> Expedite the translation of patient safety-related evidence into practice, accelerate the spread of successful programs and processes for improving patient safety, and promote creative problem solving for patient safety challenges through cross-organization collaboration. 	<ul style="list-style-type: none"> State of Michigan Michigan Center for Safe Health Care Health professionals and organizations
L. Support teamwork within organizations	<ul style="list-style-type: none"> Improve teamwork across disciplines by providing training and support for cross-disciplinary teams. 	<ul style="list-style-type: none"> Michigan Center for Safe Health Care Health professionals and organizations Educators of health professionals
M. Regulate and license with safety in mind	<ul style="list-style-type: none"> Explore use of the State’s licensing and regulation functions to improve the culture and processes of safety among health professionals and organizations. 	<ul style="list-style-type: none"> State of Michigan – Michigan Dept of Community Health, Bureau of Health Professions

Stakeholder Checks

Ultimate accountability to the public rested with the full Commission, which oversaw the entire process of transforming public testimony into the final report and approved the subprocesses used by the Analytic Team and Review Panel. To enhance the credibility of the final recommendations, the Commission solicited feedback from those who provided testimony and the broader community. Two high-profile public hearings were held in April and June 2005 to summarize the process of obtaining and considering public testimony and additional research, present the Commission's preliminary findings, and invite public comment. These meetings were announced in the press, and notices were sent to those who provided testimony and to those who were invited to provide testimony but did not. The Commission also invited public comment following the final report's public release in March 2006.

Results

Policymakers have to master myriad complex, substantive issues in a short time. Term-limited legislators often are called upon to make decisions based on incomplete or imperfect information. In establishing the Commission, Michigan's legislature requested that the best available information about a pressing public policy issue, along with the best courses of action, be collected and presented in a way that its members could understand and use. The Commission's efforts, therefore, began with the collection of data for a specific public policy purpose and culminated in the organization and presentation of a report that discusses complex issues as simply as possible and provides clear recommendations for action.

The final report of the Michigan State Commission on Patient Safety, *Call to Action: A Plan to Improve Patient Safety in Michigan's Health Care System*,¹⁶ embodies the consensus-based agenda resulting from its 14-month process. In it, the Commission recognizes ongoing efforts to make health care safer and makes the case that Michigan can accelerate system improvement by undergoing a cultural transformation, from blaming individuals to creating organized systems and cultures that lead to more consistent, less error-prone health care services. The Commission goes on to articulate a detailed and workable plan to create this culture of safety focused on learning rather than blaming.

The report contains a set of 16 objectives (Table 1) and nearly 150 action steps organized into 13 chapters. Each chapter begins with a description of the specific concern and a brief summary of what is known about potential solutions; contains one or more clear, concise objectives; and concludes with recommended action steps for relevant stakeholders. Consistent naming conventions allow stakeholders—the State of Michigan, the proposed Michigan Center for Safe Health Care, health professionals and organizations, educators of health professionals, and professional societies and organizations—to access their list of action steps quickly and easily.²

² Note: See sample pages and/or download the Commission's report at http://www.mihealthandsafety.org/statecommission/barefoot/report/SCPS_Final_Report_Vol1_Nov7.pdf.

Rather than include specific action steps for patients and families and for health care purchasers and payers (including health plans, insurers, employers, consumers, and State government in its role as purchaser for State employees and underserved populations), the Commission: incorporated the patient/family voice throughout, to remind health professionals, organizations, and policymakers to make a permanent place for patients and families at the table; and urged purchasers and payers to participate actively by providing incentives, research grants, subsidies, rewards, and public recognition in support of the Commission's recommendations.

Each chapter of the final report also includes verbatim excerpts from the testimony to allow the reader to connect the thoughts of individuals and organizations with the Commission's recommendations. The report also contains a table of milestones for measuring progress toward meeting the Commission's objectives and a chapter highlighting specific areas for future research identified during this process.

The order in which the chapters appear in the report was guided by the Review Panel's prioritization process and further Commission discussion. Chapters were identified using capital letters (rather than numbers) to indicate that recommended objectives and action steps are not, for the most part, sequential; work can begin on many concurrently.

Consistent with the testimony and Michigan's tradition of collaborative approaches to patient safety improvement, the Commission recommended the establishment of an independent, nonprofit Michigan Center for Safe Health Care and a statewide voluntary, confidential, non-punitive health care error and near-miss reporting system. The proposed Center would catalyze, measure, and coordinate progress toward a safer Michigan health care system. It would serve as a primary source of information about the wide variety of successful Michigan patient safety improvement projects and encourage new projects across the continuum of care, particularly among health care stakeholders not yet involved in collaborative efforts. The proposed patient safety reporting system would respond to concerns raised in the testimony by focusing on learning and prevention. While the proposed Center, with oversight responsibility for the proposed voluntary reporting system, would not be a governmental entity, legislative action would be required to authorize its establishment and to assign a source of restricted, dedicated, sufficient, reliable, and ongoing funding. To facilitate legislative action, the Commission included a Model Act in its final report.

Putting these new structures in place will take time. However, progress on many of the Commission's other recommendations need not wait. The Commission urged Michigan stakeholders to begin immediately to work toward a health care system in which:

- Patients and family members are engaged as active, valued members of the health care team.
- Critical information about health status and medication history travels with each patient as he or she moves through the health care system.
- The quantity and qualifications of health professionals on duty are carefully matched with patient need.
- Factors such as light, noise, and fatigue are taken into consideration when facilities and processes are being designed.

- Effective cross-disciplinary teams and cross-organization collaborations flourish.
- Patient safety principles, knowledge, and skills are woven into health professions' education programs.
- The State's licensing and regulation function is used to improve the culture and processes of safety.
- Patient safety standards are established across the continuum of care so that years from now, Michigan can look back and measure how far it has come.

As a result of the Commission's participatory policy recommendation development process, awareness of patient safety as a statewide concern increased among all health care stakeholders, including consumers, providers, purchasers, payers, and policymakers. The Commission also was able to identify individuals and organizations committed to noncompetitive, collaborative patient safety improvement.

Discussion

When the Michigan Health and Safety Coalition first accepted the Governor's invitation to serve as the State Commission on Patient Safety, it had yet to prove that a transparent, inclusive, consensus-based process that started with an invitation for public testimony and synthesized the best from the research and activities in Michigan and beyond could result in a focused, actionable statewide policy agenda. Without a doubt, the Commission delivered just that.

Along the way, the Commission transformed a number of limitations and barriers into strengths and lessons learned. These fall into three broad areas:

- Financing the effort without public funds.
- Collecting diverse points of view and managing data with limited time and resources.
- Strengthening trust and working relationships.

This effort required a total investment of approximately \$400,000, including just over \$10,000 for transcription and printing services and nearly \$257,000 for 3,000 hours of consulting (analysts, meeting facilitator, writer). No State funds were appropriated for this legislatively mandated project. Before accepting the Governor's invitation, the MH&SC secured a generous combination of grants and approximately \$140,000 of in-kind contributions from those acknowledged at the conclusion of this paper. In-kind contributions included the professional and administrative staff at Blue Cross Blue Shield of Michigan, who managed the project, and hundreds of donated hours from two of the consultants. Without these considerable resources, it is likely the project would have floundered.

The Commission also worked within the very tight timeframe established in its enabling legislation. These limitations on time and resources were both a strength and a challenge. The Commission's commitment to timely submission of a final report that respected and incorporated the testimony served as a beacon from beginning to end. It led to tight project management of parallel and iterative processes, affected development of the Analytic Team's mixed methods

approach, focused the Review Panel’s deliberations, supported the Commission’s consensus-building efforts, and informed both content and layout of the final report.

This short timeframe contributed a sense of urgency about the Commission’s work that overcame the potential for “perfection paralysis” inherent in such complex undertakings. Rather than become overwhelmed by the large volume of public testimony with which it started, the Commission chose to view the diversity of perspectives and suggestions as a rich and valuable resource. With unlimited time and financing, additional public hearings might have been held. Instead, the Commission publicized the hearings in newspapers around the State, granted radio interviews, and encouraged statewide associations to promote the call for testimony among their members. Even so, only 77 (28 percent) of 270 entities invited to submit testimony chose to do so. The thoughtful consideration of the public testimony by the Commission’s diverse membership, the involvement of additional Michigan patient safety leaders, and the solicitation of further public input in several modes were designed to address this potential limitation.

Most commissions established to develop policy recommendations are assembled for a single purpose and disbanded once their mission is accomplished. This effort, by contrast, both drew upon and strengthened the trust and working relationships among members of the well-established Michigan Health and Safety Coalition, which served as the Commission. This advantage proved extremely useful. Through persistent and patient effort and with respect for all opinions, members faced and overcame conflict, explored potential courses of action, and searched for solutions that went beyond their own limited vision of what was possible.^{17, 18} Through this work, Commission members also developed a higher degree of “political competence”:¹⁹ they are better equipped to analyze policy initiatives from a broader perspective and exert influence in the public policy arena. In short, the MH&SC emerged from its service as the Commission stronger, ready to face the difficult issues inherent in implementation of the final recommendations. While the MH&SC’s role as the Commission ended in 2005, members remain committed to moving forward individually and together to improve the safety of health care for all who seek care in Michigan.

Conclusion

“The challenge in driving safety and quality improvements in health care is to provide the right information—in the right way, at the right time, and to the right user—in order to maximize uptake and the conversion of knowledge to action.”²⁰

In September 2004, Governor Jennifer Granholm designated the Michigan Health and Safety Coalition to act as the Michigan State Commission on Patient Safety. The MH&SC was honored to undertake this important project. The Commission set high standards for itself, working respectfully and collaboratively throughout the process. It captured concerns and suggestions through public hearings, analyzed them within a framework based on the IOM’s reform ideas, viewed them through the lens of related research findings and change literature, synthesized them into a manageable number of specific recommendations, reached consensus on the relative importance and potential effectiveness of the proposals, and developed a set of activities designed to involve affected segments of the health care arena in implementation.

The effort's success is measured, most importantly, in the timely submission of a report containing broadly supported, consensus-based, actionable recommendations for a coordinated, statewide approach to patient safety improvement. The Commission accomplished its mission, and every member signed the final report. This process also produced many unintended benefits:

- Strengthening the culture of collaboration among those who served on, assisted, or provided testimony to the Commission.
- Identifying a broad network of health care stakeholders willing to engage in ongoing efforts to improve patient safety.
- Improving the ability of these stakeholders to understand public policy processes and communicate effectively in the public policy arena.
- Discovering the challenges and opportunities involved in using a mixed methods approach for consensus-based agenda setting.

The Commission believes that the innovative processes it used to transform public input into a well-articulated set of objectives and action steps could serve as a model for other States or regions committed to identifying systems-based solutions to issues in health care and other areas of public concern. Documentation of the process, including original letters soliciting testimony, verbatim testimony from the public, and the Analytic Team's reports, are collected in a technical appendix to the Commission's final report.²¹

While the public testimony collected and analyzed in Michigan represented the point-in-time concerns and recommendations of a self-selected group of organizations and individuals in the State, the recommendations that emerged are remarkably consistent with those of other State-level and national policymaking bodies. As a result, other States or regions interested in developing meaningful, integrated, broadly supported solutions to the patient safety challenge may wish to avoid unnecessary costs by using the Commission's report as a starting point for consideration within the context of their own health care infrastructures, adjusting the priorities and implementation strategies in response to local circumstances.

It makes sense that providing safe care in our complex health care system is far from simple. It is also becoming clear that systems and design improvement, no matter how well intentioned, is not enough; cultural transformation is required. Culture change is hard and requires a long-term commitment. As a first step, the Commission asks all health care stakeholders to recognize the complexity of health care interactions, choose to learn rather than blame when the unexpected happens, and set aside competition when it comes to keeping patients safe. In its final report, the Commission presents a road map with a worthy destination. Though its service as the Commission has ended, the MH&SC continues to lead efforts to get everyone in Michigan—whether providing care, paying for it, or depending on it—on the road together, spreading a culture of safety and preventing patient harm across the continuum of care.

The authors hope other States and regions find this summary valuable, because the Commission felt that if its report resulted in a change that saved even one life, whether in Michigan or elsewhere, its effort would have been worth it.

Acknowledgments

We gratefully acknowledge the Michigan Health and Safety Coalition Board and Steering Committee, the Michigan State Commission on Patient Safety, members of the Review Panel and Analytic Team, and all who provided the testimony on which the Commission's recommendations were based. We also acknowledge generous financial and in-kind contributions to the Commission made by the Blue Cross Blue Shield of Michigan Foundation, Blue Cross Blue Shield of Michigan, the Michigan Health and Safety Coalition, MPRO, and the Michigan Department of Community Health.

Author Affiliations

All authors are affiliated with or consultants to the Michigan Health and Safety Coalition.

Address correspondence to: Diane Valade, Michigan Health and Safety Coalition, Mail Code B713, 27000 West Eleven Mile Road, Southfield, MI 48034; telephone: 248-448-6266; e-mail: dvalade@bcbsm.com.

References

1. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. A report of the Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academies Press; 1999.
2. Weinberg J, Hilborne LH, Nguyen QT. Regulation of health policy: Patient safety and the states. *Advances in patient safety: From research to implementation*, Vol. 1, Research findings. AHRQ Pub. 05-0021-1. Rockville, MD: Agency for Healthcare Research and Quality. 2005 Feb. Available at: www.ahrq.gov/downloads/pub/advances/vol1/Weinberg.pdf. Accessed March 6, 2008.
3. Michigan PA 119, MCL 333.20188 (May 27, 2004). Available at: www.michigan.gov/documents/Part201mcl-368-1978-17-201generalprovisions_62376_7.pdf. Accessed March 6, 2008.
4. Lasker RD, Weiss ES, Miller R. Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *Milbank Q* 2001; 79: 179-205.
5. Johnson RB, Onwuegbuzie AJ. Mixed methods research: A research paradigm whose time has come. *Educ Researcher* 2004; 33: 14-26.
6. Miles MB, Huberman AM. *Qualitative data analysis: An expanded sourcebook*, 2nd ed. Thousand Oaks, CA: Sage Publications; 1994.
7. Patton MQ. *Qualitative evaluation and research methods*, 2nd ed. Newbury Park, CA: Sage Publications; 1990.
8. Tracking testimony recommendations from original coding to final report. Michigan Health and Safety Coalition acting as the Michigan State Commission on Patient Safety. [Web-based technical appendix]. 2005 November. Available at: www.mihealthandsafety.org/statecommission/barefoot/tech_appendix/code_crosswalk.pdf. Accessed March 6, 2008.
9. Rosenthal J, Booth M. *State patient safety centers: A new approach to promote patient safety*. The Flood Tide Forum; Portland, ME: National Academy for State Health Policy; 2004.
10. Greiner AC, Knebel E, eds. *Health professions education: A bridge to quality*. A report of the Committee on the Health Professions Education Summit, Board on Health Care Services, Institute of Medicine. Washington, DC: National Academies Press; 2003.
11. Finnocchio LJ, Dower CM, Blick NT, et al. *Taskforce on health care workforce regulation – strengthening consumer protection: Priorities for health care workforce regulation*. San Francisco: Pew Health Professions Commission. Available at: www.futurehealth.ucsf.edu/pdf_files/RTF.PDF. Accessed March 6, 2008.

12. Missouri Commission on Patient Safety. Report presented to Governor Bob Holden. 2004 July. Available at: www.insurance.mo.gov/reports/PatientSafety.pdf. Accessed March 6, 2008.
13. A comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement. Report to the governor and the legislature. 2001 Feb 1. Tallahassee, FL: Commission on Excellence in Healthcare. Available at: doh.state.fl.us/Mqa/FCHCE/FCHCEfinalrpt02-01-01.pdf. Accessed March 6, 2008.
14. Cohen MR. Why error reporting systems should be voluntary. *Br Med J* 2000; 320: 728-729.
15. Marchev M, Rosenthal J, Booth M. How states report medical errors to the public: Issues and barriers. Portland, ME: National Academy for State Health Policy; 2003 Oct. Available at: www.nashp.org/Files/GNL52_medical_errors_reporting_for_the_web.pdf. Accessed March 6, 2008.
16. Michigan Health and Safety Coalition acting as the Michigan State Commission on Patient Safety. Call to action: A plan to improve patient safety in Michigan's health care system. Southfield, MI: Michigan health and Safety Coalition; 2005. Available at: http://www.mihealthandsafety.org/statecommission/barefoot/report/SCPS_Final_Report_Vol1_Nov7.pdf. Accessed May 5, 2008.
17. Kaner S. Facilitator's guide to participatory decision-making. Gabriola Island, BC: New Society Publishers/Canada; 1996.
18. Gray B. Collaborating: Finding common ground for multiparty problems, 1st ed. San Francisco: Jossey-Bass; 1989.
19. Longest BB. Health policymaking in the United States, 3rd ed. Chicago: Health Administration Press; 2002.
20. McNeill D, Holland H, Henriksen K. Beyond the dusty shelf: Shifting paradigms and effecting change. *Advances in patient safety: From research to implementation*, Vol. 3, Implementation issues. AHRQ Pub. 05-0021-3. Rockville, MD: Agency for Healthcare Research and Quality; 2005 Feb. Available at: www.ahrq.gov/downloads/pub/advances/vol3/McNeill.pdf. Accessed March 6, 2008.
21. Michigan State Commission on Patient Safety. Volume II: Technical Appendix. Available at: www.mihealthandsafety.org/statecommission/barefoot/technical_appendix.html. Accessed March 6, 2008.