

# Adverse Event Reporting in Massachusetts and Other States: Status and Trends in 2014

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# National Academy for State Health Policy (NASHP)



- Independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice
- A forum for constructive work across branches and agencies of state government on critical health issues facing states
- NASHP has surveyed, convened, and catalogued information about state adverse event reporting systems, and other patient safety initiatives, since 2000

# Adverse event reporting systems



- The Institute of Medicine (IOM) called for a nationwide, mandatory reporting system to provide for collection by state governments of standardized information about adverse medical events
  - Events that result in serious harm or death
  - To facilitate public accountability for occurrence of adverse events
- The IOM's recommendation has not been acted upon. States have pursued state-based reporting
  - Systems authorized and operated by state governments to collect reports from hospitals (and in some cases other types of facilities) about adverse events, with the intent of improving patient safety

# Study Methods

- Surveyed all states and the District of Columbia to identify adverse event reporting systems
- Conducted key informant interviews with stakeholders in Massachusetts and four other states: Maryland, New York, Oregon, and Pennsylvania
- Explored innovations, successes and challenges
- Conducted comparative analysis of Massachusetts and other states

# Key Findings

- MA is one of twenty-six states and the District of Columbia with adverse event reporting systems
- State administrators find reporting systems valuable, but they cannot be used to measure the extent of medical harm
- State administrators report that their systems have, to varying degrees:
  - raised awareness of patient safety issues
  - fostered a culture of transparency
  - improved communication among facilities
  - guided provider education
  - assisted facilities and providers in addressing patient safety issues
  - enabled states to track and trend patient safety needs

# Opportunities for Improving Value of Reporting in MA



- Massachusetts is the only state with two distinct adverse event reporting systems that require reporting from some of the same facilities
  - Streamlining, coordinating, or consolidating reporting processes across systems could help address provider concerns about reporting burden
- System administrators in Massachusetts could partner with other entities to leverage reporting system data
- Massachusetts has an opportunity to explicitly integrate patient safety more broadly into delivery system reforms
- Massachusetts could consider conducting a system evaluation to assess provider needs and areas for system improvement.