

THE COUNCIL OF STATE GOVERNMENTS

RESOLUTION ON QUALITY AND PATIENT SAFETY IN HEALTHCARE FACILITIES

Quality and Patient Safety Summary

Health Care in the United States has been described as a disorganized system with lapses in quality and patient safety. Some health care studies have found that inadequacies in our nation's health care are responsible for 98,000 avoidable deaths, 41 million sick days, and \$11 billion in lost productivity each year.

According to a recent report from the Commonwealth Fund, one-third of patients with health problems in the United States report experiencing medical, medication, or test errors, the highest rate of the six industrialized nations studied. Improvements in quality and patient safety in our nation's health care facilities can be realized by adopting best practices through partnerships between states and health care providers.

This resolution seeks to outline the states' role in improving health care quality and patient safety through partnerships with health care providers and to show support for those states that are working for a change.

Internet addresses for additional information about patient safety

Centers for Medicare and Medicaid Services – www.cms.hhs.gov

The Joint Commission for Accreditation of Healthcare Organizations – www.jcaho.org

The Institute for Healthcare Improvement – www.ihl.org

The Leapfrog Group – www.leapfroggroup.org

Patient Safety Management Directives

- **Management Directive #1:** Support state efforts to partner with healthcare providers to enhance patient safety in healthcare facilities
- **Management Directive #2:** CSG staff will post approved resolution on CSG's web site, make available through its regular communication venues at the state and local level to ensure its distribution to the state government and policy community.
- **Management Directive #3:** Improvement of patient safety is a long term concern in the United States and a continuing focus of provider and state government initiatives.

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RESOLUTION ON QUALITY AND PATIENT SAFETY IN HEALTHCARE FACILITIES

- WHEREAS,** according to the 1999 Institute of Medicine report, as many as 98,000 deaths per year are associated with medical errors in hospitals;
- WHEREAS,** the Centers for Disease Control and Prevention estimates that two million people per year will suffer from hospital acquired infections;
- WHEREAS,** the United States spends the most money on health care of all advanced industrialized nations, but performs more poorly than most on many measures of health care quality;
- WHEREAS,** according to some studies, patients in all health care settings receive on average just slightly over half the tests, procedures, and other care that is recommended for their conditions;
- WHEREAS,** more than one million serious medication errors occur yearly in U.S. hospitals and as many as 7,000 patients die each year from medication errors;
- WHEREAS,** adoption of health information technology has the potential to improve healthcare safety and quality by reducing medical errors, and improving efficiency by saving time and reducing duplication and waste.
- WHEREAS,** the health care community is involved in addressing the identified patient safety issues and committed to the highest quality of care and patient safety for their patients.

BE IT NOW THEREFORE RESOLVED, that The Council of State Governments (CSG) encourages state legislators and other elected leaders to partner with health care providers to support and promote statewide efforts for improving quality of care and patient safety by:

- implementing programs aimed at diminishing medical errors
- supporting broader implementation of best practices
- encouraging the use of health information technology and other relevant new technology
- raising public awareness for patient safety and
- fostering communication about quality health care and patient safety

BE IT FURTHER RESOLVED, that CSG supports the efforts of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), which seeks to continuously improve the safety and quality of care provided to the public

through the provision of health care accreditation that addresses risk-reduction activities and compliance with standards intended to reduce the risk of adverse outcomes.

Adopted this 4th Day of December, 2005, at the
CSG Annual Task Force and Committee Meeting
In Wilmington, Delaware



Governor Ruth Ann Minner
2005 CSG President



Assemblyman Lynn Hettrick
2005 CSG Chair