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001, note	re: meeting with President (5 pages)	n.d.	P5 <i>AMS 4/6/15</i>

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:

Medical Errors [Event]

2012-0463-S

rc695

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

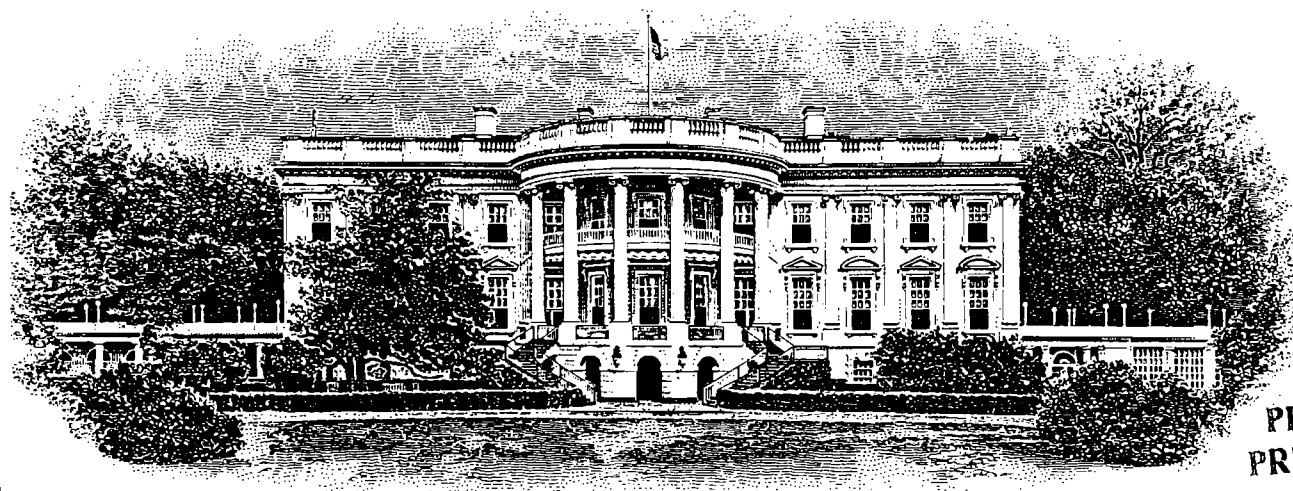
Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

~~7~~ MED
ERRORS



The White House



PHOTOCOPY
PRESERVATION

Briefing Memo

**PHOTOCOPY
PRESERVATION**

THE WHITE HOUSE

WASHINGTON

December 6, 1999

MEETING AND STATEMENT ON MEDICAL ERRORS

DATE:	December 7, 1999
LOCATION:	Cabinet Room (Meeting) Rose Garden (Statement)
BRIEFING TIME:	10:20am – 10:45am
MEETING TIME:	10:45am – 11:15am
STATEMENT TIME:	11:20am – 11:45am
FROM:	Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

You are unveiling a new initiative to improve health care quality, improve patient safety, and prevent medical errors.

II. BACKGROUND

Today, you will:

- **Issue an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.** Today, you will sign an executive memorandum directing the QuIC to report back recommendations to you, through the Vice President, within 60 days that: identify prevalent threats to patient safety and reduce medical errors that can be prevented through the use of decision support systems, such as automated patient monitoring and reminder systems; evaluate the feasibility and advisability of the recommendations of the Institute of Medicine on patient safety; develop additional strategies, including the use of information technology, to reduce medical errors and ensure patient safety in Federal health care programs; evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to further strengthen FDA's response to this challenge; and identify opportunities for the Federal government to take specific action to improve patient safety and improve health care quality through collaboration with the private sector, including the newly constituted National Forum for Health Care Quality Measurement and Reporting.

- **Announce that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives.** Today, you will announce that the Office of Personnel Management, which oversees plans serving 9 million Americans, will include in its annual call letter to be issued next spring a requirement that FEHBP plans use error reduction and other patient safety techniques in order to improve the quality of care in the program. In addition, OPM will supplement this initiative using workplace campaigns to improve mammography and medical screening rates among Federal employees, retirees, and their families. Finally, OPM will initiate new ways to measure and report on the quality of care that plans deliver to enrollees.
- **Instruct Federal agencies administering health plans to evaluate and, where feasible, implement the latest error reduction techniques.** You will request that the Departments of Health and Human Services, Veterans Affairs, and Defense, and the Office of Personnel Management evaluate and, where feasible, implement the latest error reduction techniques in a manner consistent with the Administration's recently released draft regulations on patient privacy. These agencies administer Medicare, Medicaid, CHIP, the Federal Employees Health Benefits Program, the nationwide network of veterans hospitals and outpatient clinics, and the military health care system, serving over 85 million Americans.
- **Announce the reauthorization of the Agency for Healthcare Research and Quality, ensuring a multi-million dollar investment in research programs to improve health care quality.** You will announce that you signed legislation yesterday reauthorizing the Agency for Healthcare Research and Quality (AHRQ). To achieve the goals of this legislation, which is the result of the bipartisan efforts of Senators Frist and Kennedy and Congressmen Bliley and Brown, the FY 2000 budget increases the agency's resources by 16 percent over FY 1999 funding levels, for a multi-million dollar investment in health care quality. These new funds will be used for important quality improvement research, including the over-and-under utilization of services, variation in the delivery of services, and efforts to prevent medical errors. In recognition of the critical role that states do and will play in assuring and improving health care quality, AHRQ will hold a nationwide conference this March with senior state health officials to promote best medical practices, to prevent medical errors and improve patient safety, and to better develop a working relationship between the Federal and state governments in this area.
- **Direct the Office of Management and Budget, the Domestic Policy Council, and other agencies to develop additional health care quality and patient safety initiatives for the FY 2001 budget.** You will direct the Office of Management and Budget, the Domestic Policy Council, and the Office of the Vice President to work with the Department of Health and Human Services and other agencies to develop additional initiatives within the context of the FY 2001 budget that build on our current error prevention, quality improvement, and patient safety initiatives.

- **Praise the American Hospital Association for launching a new medication safety campaign.** You will praise the American Hospital Association for launching a new partnership with the Institute for Safe Medication Practices to prevent patient medication errors. Today, the AHA will send a list of "best practices" on prevention medication errors to all 5,000 of their member hospitals. In the coming months, they will also begin to: develop a medication safety awareness test that surveys hospitals' medication error prevention systems; track implementation by the hospital and health system field of the practices for reducing and preventing errors; and working with national experts to develop a model medication error reporting process. By taking these actions today, the AHA joins numerous other health care organizations making an important commitment to this area, including the American Medical Association's initiative to establish the National Patient Safety Foundation.

HIGHLIGHT THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO IMPROVING HEALTH CARE QUALITY. Over the past two years you and Vice President Gore have provided critical consumer protections to the 85 million Americans enrolled in Federal health plans and set the stage for the Congress to pass a strong, enforceable, Patients' Bill of Rights. In March of 1998, you established the Quality Interagency Coordination Task Force, which has been instrumental in promoting advances in health care quality nationwide. You also asked the Vice President to help launch the National Forum for Health Care Quality Measurement and Reporting, a broad-based, widely representative private advisory body that develops standard quality measurement tools to help all purchasers, providers, and consumers of health care better evaluate and ensure the delivery of quality services. In addition to the work and significant potential of the QuIC and Quality Forum, the Departments of Veterans Affairs and Defense have been leaders in patient safety and quality improvement programs. The Department of Veterans Affairs also spearheaded the development of the National Patient Safety Partnership to address issues related to adverse medical events. Finally, the Health Care Financing Administration has implemented new quality improvement initiatives through its peer review organization efforts, and the Food and Drug Administration is working to implement new reporting systems that allow for a rapid response to medical errors causing patient injury.

III. PARTICIPANTS

Briefing Participants:

Bruce Reed
Mary Beth Cahill
Loretta Ucelli
Joe Lockhart
Chris Jennings
Sam Afridi

Meeting Participants:

YOU

Federal participants:

Secretary Alexis Herman

Director Janice LaChance

FDA Administrator Jane Henney

HCFA Administrator Nancy Ann Min DeParle

John Eisenberg, Director of the Agency for Healthcare Research and Quality

Paul London, Department of Commerce

Tom Garthwaite, Acting Undersecretary for Health at the Department of Veterans Affairs

Private sector participants:

Bruce E. Bradley, Director of Managed Care Plans for General Motors

Dr. Christine Cassel, Chairman of the Department of Geriatrics and Adult Development
at Mt. Sinai School of Medicine

Richard J. Davidson, President of the American Hospital Association

Mary Foley, MSN and RN, First Vice President of the American Nurses Association

Karen Ignani, President and CEO of the American Association of Health Plans

Dr. William Richardson, Chair of the IOM Committee on Quality of Health Care in
America and President and CEO of the W. K. Kellogg Foundation

John C. Rother, Director for Legislation and Public Policy of the American Association
of Retired Persons

Gerald M. Shea, Assistant to the President for Government Affairs of the AFL-CIO

Dr. Kenneth W. Kizer, President and CEO of the National Forum for Health Care Quality
Measurement and Reporting

IV. PRESS PLAN

Meeting – Closed Press

Statement – Open Press

V. SEQUENCE OF EVENTS

- **YOU** will meet with representatives of the health care academic and advocate, consumer, provider, and business communities.
- **YOU** will proceed to the Rose Garden to make a statement.
- **YOU** will make opening remarks and introduce Richard Davidson, President, American Hospital Association.
- Richard Davidson will make brief remarks.
- **YOU** will make remarks and depart.

VI. REMARKS

To be provided by speechwriting.

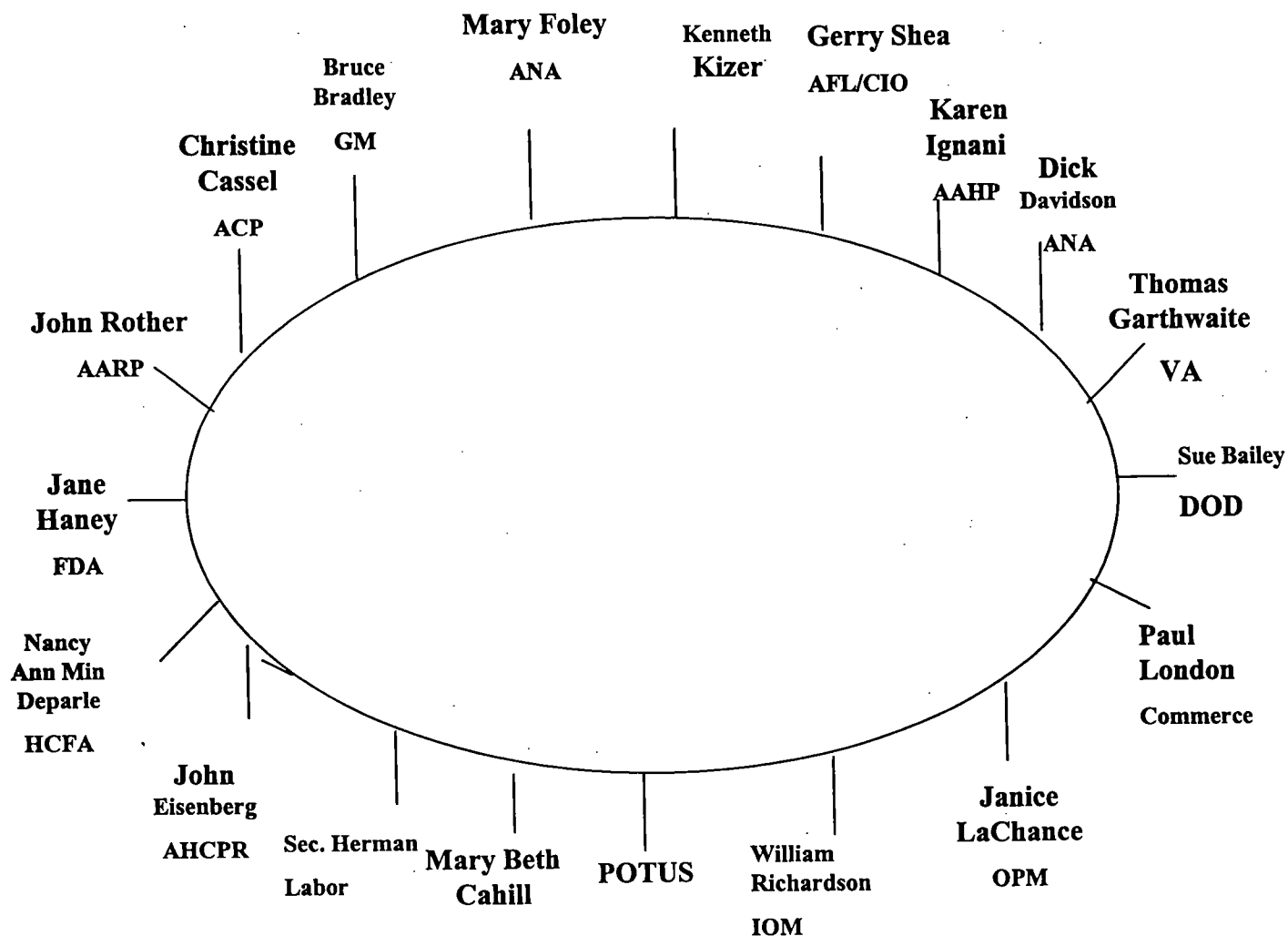
VI. ATTACHMENTS

Seating Chart

Talking Points

Participant Biographies and Statement Summaries

Medical Errors Event
December 7, 1999
Cabinet Room
10:45-11:15 AM



SUGGESTED TALKING POINTS ON ENSURING PATIENT SAFETY

BEFORE THE DISCUSSION:

- Thank you for coming today to discuss how we can reduce medical errors, enhance patient safety, and improve overall quality in the health care delivery system. You all come from different backgrounds, but you share a strong and unified commitment to this issue, and I appreciate your presence today.
- Just last week, as we all know, the Institute of Medicine, under the leadership of Ken Shine, , William Richardson, and Janet Corrigan, released their report on medical error prevention entitled "To Err Is Human: Building a Safer Health Care System". I want to commend the IOM and their staff for their fine work, and in a moment I'll want to ask Dr. William Richardson to briefly summarize its findings.
- But first, I want to ask Secretary Herman to make a few opening remarks. As you know, under her and Secretary Shalala's extraordinary leadership, the Quality Commission produced an extremely impressive report on these issues, and the Quality Interagency Coordination Task Force (QuIC), which I established last year, has begun to help coordinate Administration efforts in this area. Almost every one of the member agencies on the QuIC are represented today, and I am pleased that John Eisenberg, who coordinates its work, is here as well.
- The Vice President has also exhibited a great deal of leadership in this area. He helped launch the Quality Forum, a private entity that is developing measurement tools to help evaluate and ensure the delivery of quality health care services. And I am pleased that Ken Kizer, the new President and CEO of the National Quality Forum, is here with us today.
- All of us in this room have been working on this issue for years. Your collective work has been impressive, and I think that you have come a long way in helping the nation address these important issues. I want to thank each and every one of you for your dedication. Now I'd like to turn it over to Secretary Herman.

AFTER THE DISCUSSION:

- I think that the announcement that AHA is making today represents great progress, and I want to commend Dick Davidson and the AHA for it. In addition to highlighting the AHA's initiative, as many of you know, I will be highlighting a number of announcements I'll be making today in order to continue to focus much needed attention on this issue and move forward to apply some of the best practices for avoiding errors and improving patient safety.
- The announcements I'll be making today include:

Issuing an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.

Announcing that each of the more than 300 private health plans serving more than 9 million Americans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives.

Instructing Federal agencies administering health plans, including Departments of Health and Human Services, Veterans Affairs, and Defense, and others participating within the Quality Interagency Task Force to evaluate and, where feasible, implement the latest error reduction techniques.

Announcing the reauthorization of the Agency for Healthcare Research and Quality, ensuring a multi-million investment in research programs to improve health care quality.

Direct the Office of Management and Budget, the Domestic Policy Council, and other agencies to develop additional health care quality and patient safety initiatives for the FY 2001 budget.

- I believe that these initiatives will further build on the contributions you have already made. I know that I speak for the whole Administration when I say that I look forward to working with each and every one of you. Now, I'd like to invite you to join me in the Rose Garden for these announcements.

PARTICIPANT BIOGRAPHIES AND STATEMENT SUMMARIES

Secretary Herman, the co-chair of the Quality Commission and the QuIC, together with Secretary Shalala, will acknowledge your role as well as the role of everyone in the room for their commitment to improving quality health care. She will speak immediately after your opening remarks and will introduce Dr. William Richardson, the Chairman of the Institute of Medicine's Committee on the Quality of Health Care in America.

Dr. William Richardson is the Chairman of the Institute of Medicine's Committee on the Quality of Health Care in America and the Chief Executive Officer of the W.K. Kellogg Foundation of Battle Creek, Michigan. He will acknowledge the role of Quality Commission in successfully highlighting these issues, present some of the key findings from the report the Institute of Medicine released last week on medical errors, and provide a summary of its key recommendations.

John Rother, Director for Legislation and Public Policy of the AARP, will represent the consumer's perspective and underscore the importance of a proactive effort to eliminate medical errors to patients. He is likely to use the analogy of the safety initiatives at the Federal Aviation Agency as an analogy for what should be done in the health care system. He will also briefly reference the importance of balancing the need for improvements in this area with the importance of protecting the privacy of medical records, although he wants to make sure that we do not overreact to the concerns of privacy advocates and lose out on the opportunity to improve quality.

Chris Cassell, former President of the American College of Physicians and Professor and Chairman, Department of Geriatrics and Adult Development at the Mount Sinai School of Medicine, will present the physician's perspective on quality assurance and the importance of creating approaches to medical error reductions that are designed to improve quality rather than threaten providers. She will acknowledge, however, that numerous errors do take place that are preventable, and that research similar to that put forth by the Institute of Medicine and the Quality Commission are essential to enhancing quality and constraining cost.

Bruce Bradley, the Director of Managed Care Plans for General Motors, will represent General Motors and the entire Business Round Table (BRT). Mr. Bradley has been instrumental in engaging the business community's interest in this issue and has been essential in getting the BRT to support quality improvement tools such as the Health Employer Information Data and Information Set. The business community is extremely interested in being associated with this issue, not only because of its potential to constrain costs and improve quality, but because it allows them to be associated with a pro-patient initiative at a time when they are primarily associated with their opposition to the Patients Bill of Rights.

Mary Foley, a First Vice President of the ANA, will focus on the unique role that nurses play as a front line deliverer and enforcer of quality health care. She will thank you and the Administration for the consistent recognition of their role in the health care delivery system and our consistent records of ensuring that they are at the table for discussions on these and other important health policies.

Kenneth Kizer is the President and CEO of the National Quality Forum and the former Undersecretary for Health at the Department of Veterans Affairs. Ken left the Administration under less than ideal circumstances, as he and OMB frequently tangled over his unwillingness to follow protocol on decisions related to Veterans Affairs health programs. As a consequence, he was not reappointed to his position. Having said this, he is a great innovator on health systems issues and an visionary on the use of information technology to improve the health care delivery system. We are expecting him to praise the Quality Commission's work and the launch of the Quality Forum by the Vice President. He will also emphasize the need for uniform quality standards to evaluate health care delivery, and may compare the use of such standards with the desirability of utilizing similar standards to improve education in the schools.

Gerry Shea, the Assistant to the President for Government Affairs for the AFL-CIO, will represent Labor's commitment in this area. The AFL-CIO has been extremely active in the quality debate, at least partly because they believe it to be useful camouflage for their interest in assuring adequate staffing in health care settings rather than insisting upon specific patient to health care personnel ratios. They believe tough quality standards will serve to achieve that outcome without an explicit personnel to patient ratio mandate. Having said this, they, like the business industry, are always looking for ways to constrain costs so that dollars spent on health benefits for the workforce are not wasted.

Karen Ignagni is President and Chief Executive Officer of the American Association of Health Plans. Although AAHP has been a strong defender of the managed care industry and a steadfast critic of the Administration on the Patients Bill of Rights, she will no doubt highlight the constructive role that managed care plans can play in implementing error reduction programs and improving the quality of care. She has agreed not to raise our differences on the Patients Bill Of Rights publicly at this meeting, but will indicate her commitment to work with the Administration on at least this element of the health care quality agenda.

Dick Davidson, the President of the American Hospital Association, is likely to thank you for your assistance in passing the Balanced Budget Refinement Act, which returned over \$16 billion to Medicare providers over the next five years. He will highlight the commitment that the AHA has in reducing medical errors and summarize the initiative he and the Institute for Safe Medication Practices are unveiling with you, including: sending a list of "best practices" on prevention medication errors to all 5,000 of their member hospitals; developing a medication safety awareness test that surveys hospitals' medication error prevention systems; tracking implementation by the hospital and health system field of the practices for reducing and preventing errors; and working with national experts to develop a model medication error reporting process.

John Eisenberg is the head of the Agency for Research and Healthcare Quality, which you reauthorized yesterday when you signed the Healthcare Research and Quality Act of 1999, and also serves as the lead quality coordinator for the QuIC. John's role will be to wrap up the discussion and underscore the importance of all the interests in and outside of this meeting working together for the common purpose of patient safety enhancement, error reduction, and quality improvement. He will focus on the role of Federal agencies in serving as model programs in these areas and might cite a few examples. He will then turn the meeting over to you to make a few final comments about your announcements for today and your appreciation for work of the parties in the meeting on this issue.

Revised Final 12/7/99 10:00 am
Sam Afridi

PRESIDENT WILLIAM J. CLINTON

REMARKS ON HEALTH CARE QUALITY

AND PATIENT SAFETY

THE WHITE HOUSE

December 7, 1999

Acknowledge: Secretary Herman, other officials from the federal government; leaders representing consumers, health care providers, business, labor and quality experts.

Last week, the Institute of Medicine released a disturbing report about patient safety and medical errors in our nation's health care system. According to its study, as many as 98,000 Americans lose their lives each year as a result of preventable medical errors. Up to 7,000 Americans die because of errors in prescribing medicine. And the costs of all of these medical errors add as much as \$29 billion to America's health care bill.

But this is about more than dollars or statistics. It's about the toll that medical errors take on people's lives and on their faith in the health care system. I just finished a good meeting with the leaders here to talk about what we can do together to save lives, prevent medical errors and promote patient safety.

We have the finest health care system in the world—and the best professionals to deliver that care. But too many families have been the victims of medical errors that are avoidable, mistakes that are preventable and tragedies that are unacceptable. Everyone here with me agrees: America's health care system does wonders, but first it must also 'do no harm'.

No American should ever have to fear that their health care could jeopardize their health.

Now, I want to be clear. Ensuring patient safety is not about fixing blame, it's about fixing problems in a complex system. It's about creating a culture of safety—and an environment where medical errors are not tolerated. In short, it's about working together to zero in on patient safety and zero out preventable medical errors.

This morning's meeting builds on our Administration's long-standing record to improve health care quality.

Almost three years ago, I established the Commission on Consumer Protection and Quality Health Care—chaired by Secretary Shalala and Secretary Herman. That Commission produced a landmark report and led to my own executive action to provide patient protections to the one out of three Americans enrolled in federal health plans. It also set the stage for the Congress to pass a strong, enforceable Patients' Bill of Rights.

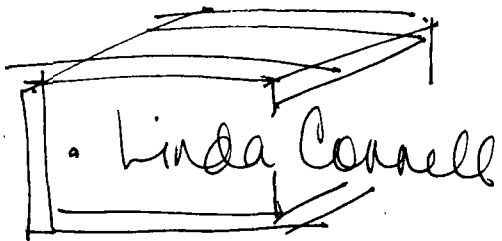
But—as the Commission's work has made clear—the challenge goes beyond patient protections for all Americans in all plans. We also must improve the quality of care that patients receive.

That's why I created an interagency Task Force to coordinate Administration efforts in this area. And it's why I asked the Vice President to launch the Quality Forum, a private advisory panel to develop uniform quality standards--so that health plans can compete on quality, not just cost—and consumers and businesses have better tools to judge what plan is best for them.

In a few moments, I'm going to announce new steps our Administration is taking to promote quality and reduce medical errors. But first I want to turn it over to one of our partners in that effort.

If there's one thing we have learned, it is that effectively managing the prescribing and dispensing of drugs is one of the best ways we can improve quality and hold down costs. The President of the American Hospital Association, Dick Davidson, is here this morning to announce a major new medical safety campaign that they're launching with the Institute for Safe Medication Practices. It is truly a prescription for better health for all Americans. I'd like to ask President Davidson to tell you about it.

(President Davidson makes remarks. Following his remarks, you return to the podium)



Thank you Dick for your words and your leadership in this new campaign. Now I'm proud to announce new executive action I'm taking at the federal level to target medical errors and promote patient safety.

First, I'm signing an Executive Memorandum this morning directing our Health Care Quality Task Force to analyze the Institute of Medicine's landmark study—and to report back to me through the Vice President within 60 days about the ways we can implement their recommendations. I'm also calling on the Task Force to evaluate the extent to which medical errors are caused by the misuse of medications and medical devices and to develop additional strategies to reduce these errors.

Second, I want the federal government to lead by example. So I'm instructing government agencies that administer health plans for 85 million Americans to take an inventory of the good ideas out there to reduce medical errors. They should apply those techniques to the health programs that they administer—and do so in a way that protects patient privacy.

As a first step, I'm announcing today that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will now be required to institute quality improvement and patient safety initiatives.

PHOTOCOPY
PRESERVATION

Third, ongoing research to enhance patient safety and reduce medical errors is critical—so we're increasing our investment in this area. Yesterday, I signed legislation reauthorizing the Agency for Health Care Quality and Research and providing \$25 million for research to improve health care quality and prevent medical errors. Through the work of the Agency, we are also engaging our partners at the state level. In March, we will convene the first national conference with state health officials to promote best practices in preventing medical errors.

Finally, I'm directing my budget and health care teams to develop quality and patient safety initiatives for next year's budget to ensure that we're doing all we can to combat this problem.

**PHOTOCOPY
PRESERVATION**

I want next year's budget to provide our largest investment to eliminate medical errors, improve quality, and enhance patient safety.

The Institute of Medicine's report makes clear that a systematic approach to reducing medical errors gives us the best chance of success. Years ago, we took that approach in aviation and we've dramatically reduced errors and saved lives. By working together, we can achieve the same goals in the health care industry.

The American people deserve quality health care—through the protections we're fighting for in the Patients' Bill of Rights—and the safety measures we're putting in place today.

I'm committed to working with everyone here to do even more. And by working in partnership, we will do our part to save lives, end needless medical errors and make the best health care system in the world even better for the 21st century.

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Harman
Cooperative
effort

ATA
announcements

ISMP
not a lot of resources
necessary

LOM
magnitude only
high.
did recommendations

pushed
hard
on liability
issue

Q: What needs to done
at Fed level

Q: save harbor for
liability

Q. System A&S?

100

200

Q: AHCAR

A:

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POTUS

let's right resolve issues @ core
of PBOB event / issue

AHA

Dick Davidson solutions
announcements.
pledge to be supportive

Eisenberg

POTUS

work together in harness get this right w/c
needs to be uninterrupted

Third, ongoing research to enhance patient safety and reduce medical errors is critical—so we're increasing our investment in this area. Yesterday, I signed legislation reauthorizing the Agency for Health Care Quality and Research and providing \$25 million for research to improve health care quality and prevent medical errors. Through the work of the Agency, we are also engaging our partners at the state level. In March, we will convene the first national conference with state health officials to promote best practices in preventing medical errors.

Finally, I'm directing my budget and health care teams to develop quality and patient safety initiatives for next year's budget to ensure that we're doing all we can to combat this problem.

AFL-CIO

Thank you to POTUS - OSH a great example
labor they think that hospitals are
great & safe - we're at least a decade
away from having FAA like system.
PDR → Role

Systems need consumers role -

POTUS

labor unique position - people on both sides
of the issue - industrial people work of
health care people

AFL-CIO

Team work

POTUS

AFL-CIO needs to be involved

AAHP

stand up you & appreciate the leadership -
not just one wk story - sustained
leadership - Mgt care org have much
to contribute - bipartisan grp on Hill -
ATA & AMA wr w/ them no one in blame
game.

I want next year's budget to provide our largest investment to eliminate medical errors, improve quality, and enhance patient safety.

The Institute of Medicine's report makes clear that a systematic approach to reducing medical errors gives us the best chance of success. Years ago, we took that approach in aviation and we've dramatically reduced errors and saved lives. By working together, we can achieve the same goals in the health care industry.

The American people deserve quality health care—through the protections we're fighting for in the Patients' Bill of Rights—and the safety measures we're putting in place today.

GM

loses 1 to 2 people every day b/c
Medical error — 2 people every 5
years on the job @ their plants. Enormous
bsp of purchasers. Reward rather
than penalties for their plan. Fortune 500
3 strategies @ GM — Public private
partnership — OPM, HZFA, ATCPR —
① National attention
② Liability controls
③ 10M min 50% — challenge nation to go
for 80%

ANA

Thank you to POTUS — excited by 10M
report — involved in issues of medication
delivery — continued competency

Ken Kiser

When left Admin last summer — thanks Admin
Quality Cmn. focusing on how to improve
quality measurement & reporting. Education
analogy.

POTUS

Ed — you're preaching to choir — we
assume that we know the answer
break down into small pieces

I'm committed to working with everyone here to do even more. And by working in partnership, we will do our part to save lives, end needless medical errors and make the best health care system in the world even better for the 21st century.

10M

emphasized not bad apple problem; public perception issue; need for public attention - magnitude

POTUS

Airline safety & safety in workplace - rigorous process to get to defects in manufacturers
22 states already have reporting systems -
need to address concerns of reporting → malpractice climate need to correct these errors.

AARP

Bill of gratitude for 10M; Issue of closet - move as quickly as possible to address - FAA analogy expectation for fix & remedies. privacy issue thanks for draft privacy regulations - AHA leadership & hospital assn.

ACP (Cassel)

Report engendered resp - likes not forum's Q&A rapid resp short period of time. Aging - prob but really success story; elderly pts at greatest risk - more time in health system, dosages, more players & specialists. importance of no enemies list.

POTUS

prescription drug benefit & Medicare PBM - deals with this issue but all solutions are high tech computer resolutions.



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December 7, 1999

Clinton to Order Federal Agencies to Reduce Medical Errors

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- [Health Industry Sees Wish List Made Into Law \(Dec. 6, 1999\)](#)
- [Group Asking U.S. for New Vigilance in Patient Safety \(Nov. 30, 1999\)](#)
- [The New York Times: Issue in Depth: Health Care](#)

Forum

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-

By ROBERT PEAR

WASHINGTON -- President Clinton will order federal agencies to take steps to reduce medical errors blamed for tens of thousands of deaths, administration officials said on Monday.

The steps include precautions to prevent pharmacists from dispensing the wrong drugs and procedures encouraging hospitals to investigate any errors that cause serious injuries or deaths.

At a White House ceremony on Tuesday, the officials said, Clinton will instruct federal agencies that provide or finance health care for 85 million people -- one in three Americans -- to adopt the latest techniques for reducing medical errors, so far as such steps are feasible.

In effect, the officials said, Clinton has decided to accept major recommendations from a report issued last week by a panel of the National Academy of Sciences. The report said that medical mistakes caused tens of thousands of deaths a year and that health care providers could reduce the number of errors by 50 percent in the next five years, by collecting and systematically analyzing data on accidents, as the aviation industry does.

The federal government has immense leverage over the health care industry because it buys or subsidizes large amounts of health care and regulates hospitals, nursing homes and many other health care providers.



Adverti

Clinton has the authority to make some changes unilaterally. Thus, White House officials said, any health insurance plan that wants to cover federal employees in 2001 will have to take steps to reduce medical errors and protect patients, as recommended by the National Academy of Sciences.

This directive will affect more than 300 private health plans that insure nine million Americans through the Federal Employees Health Benefits Program, officials said.

Clinton will order other federal agencies that provide or finance health care to "evaluate and, where feasible, implement the latest error-reduction techniques," a White House document says.

This instruction will be addressed to the Department of Health and Human Services, which runs Medicare and Medicaid; the Department of Veterans Affairs, which provides medical care to millions of veterans, and the Defense Department, which provides health care to military personnel.

Chris Jennings, the health policy coordinator at the White House, said the federal government would try to use its leverage as the nation's biggest purchaser of health care to improve the quality of care for all Americans.

In March 1998, Clinton created a task force of federal agencies to find ways of measuring and improving the quality of health care. On Tuesday, officials said, Clinton will order this interagency group to report back to him within 60 days on ways to carry out recommendations from the National Academy of Sciences.

The interagency group will develop proposals that can be included in the president's next budget, which he intends to submit to Congress in late January or early February, administration officials said.

White House officials said they had not figured out how Clinton's new initiative would deal with the concerns of health care providers who fear they will be more exposed to lawsuits for medical malpractice if they openly acknowledge more of their mistakes. The Clinton administration has generally opposed efforts by health care providers to limit the damages they may be required to pay in such cases.

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The hospital association is sending a list of error-reduction

techniques to each of its 5,000 hospitals. Richard H. Wade, senior vice president of the association, said his group was forming a partnership with the Institute for Safe Medication Practices, a nonprofit organization based in Huntingdon Valley, Pa., to reduce errors in the prescribing and dispensing of medicines.

The institute reviews medication errors reported by doctors and nurses across the country, and it advises drug companies how to change the labeling or packaging of products to prevent such errors.

Clinton will praise the hospital association for its efforts to prevent medication errors, White House officials said.

Sen. Edward Kennedy, D-Mass., said on Monday that he would introduce a bill to carry out all the recommendations of the National Academy of Sciences, including "mandatory reporting" of serious errors and creation of a new Center for Patient Safety in the federal government. The center would have an annual budget of \$30 million, rising to \$100 million in five years.

Currently, about 20 states require hospitals or other health care providers to report their mistakes, but compliance is uneven, and many states have no such requirements.

Kennedy said that his effort would be bipartisan and that he intended to work with two Republican senators, James Jeffords of Vermont and Bill Frist of Tennessee, as well as with Sen. Joseph Lieberman, D-Conn.

Kennedy's bill would require hospitals and nursing homes to adopt policies to reduce medical errors as a condition of participating in Medicare or Medicaid, just as many Clinton administration officials want to do.

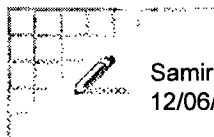
Medicare, which finances health care for 39 million people who are elderly or disabled, and Medicaid, which insures a similar number of low-income people, provide more than 40 percent of the revenues for hospitals and nursing homes. So standards for these two programs become virtual mandates for the entire health care industry.

In ordering Cabinet officers to evaluate the recommendations of the National Academy of Sciences, Clinton is following a pattern he established in 1997 and 1998. He appointed a panel of experts to draft a "bill of rights" for patients, and he embraced its recommendations eight months later. He ordered federal agencies to grant such rights to people enrolled in federal health programs, and he urged Congress to enact similar standards for private health insurance.

The Senate and the House of Representatives have passed different versions of the legislation, and they will try to negotiate a compromise after Congress reconvenes in January.

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Samir Afridi
12/06/99 10:20:32 PM

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To: See the distribution list at the bottom of this message
cc: Devorah R. Adler/OPD/EOP@EOP, Michele Ballantyne/WHO/EOP@EOP, Lindsay R. Drewel/WHO/EOP@EOP, Melissa G. Green/OPD/EOP@EOP
Subject: Medical Errors Final Draft



medical.errors.draft.5.d

Final 12/6/99 10:00 pm
Sam Afridi

**PRESIDENT WILLIAM J. CLINTON
REMARKS ON HEALTH CARE QUALITY AND PATIENT SAFETY
THE WHITE HOUSE
December 7, 1999**

Acknowledge: Secretary Herman, other officials from the federal government; leaders representing consumers, health care providers, business, labor and quality experts.

Last week, the Institute of Medicine released a disturbing report about patient safety and medical errors in our nation's health care system. According to its study, as many as 98,000 Americans lose their lives each year as a result of preventable medical errors. Up to 7,000 Americans die because of errors in prescribing medicine. And the costs of all of these medical errors add as much as \$29 billion to America's health care bill.

But this is about more than dollars or statistics. It's about the toll that medical errors take on people's lives and on their faith in the health care system. I just finished a good meeting with the leaders here to talk about what we can do together to save lives, prevent medical errors and promote patient safety.

We have the finest health care system in the world—and the best professionals to deliver that care. But too many families have been the victims of medical errors that are avoidable, mistakes that are preventable and tragedies that are unacceptable. Everyone here with me agrees: America's health care system does wonders, but first it must also 'do no harm'. No American should ever have to fear that their health care could jeopardize their health.

Now, I want to be clear. Ensuring patient safety is not about fixing blame, it's about fixing problems in a complex system. It's about creating a culture of safety—and an environment where medical errors are not tolerated. In short, it's about working together to zero in on patient safety and zero out preventable medical errors.

This morning's meeting builds on our Administration's long-standing record to improve health care quality. Almost three years ago, I established the Commission on Consumer Protection and Quality Health Care—chaired by Secretary Shalala and Secretary Herman. That Commission produced a landmark report and led to my own executive action to provide patient protections to the one out of three Americans enrolled in federal health plans. It also set the stage for the Congress to pass a strong, enforceable Patients' Bill of Rights.

But—as the Commission's work has made clear—the challenge goes beyond patient protections for all Americans in all plans. We also must improve the quality of care that patients receive. That's why I created an interagency Task Force to coordinate Administration efforts in this area.

And it's why I asked the Vice President to launch the Quality Forum, a private advisory panel to develop uniform quality standards—so that health plans can compete on quality, not just cost—and consumers and businesses have better tools to judge what plan is best for them.

In a few moments, I'm going to announce new steps our Administration is taking to promote quality and reduce medical errors. But first I want to turn it over to one of our partners in that effort.

If there's one thing we have learned, it is that effectively managing the prescription and dispensing of drugs is one of the best ways we can improve quality and hold down costs. The President of the American Hospital Association, Dick Davidson, is here this morning to announce a major new medical safety campaign that they're launching with the Institute for Safe Medication Practices. It is truly a prescription for better health for all Americans. I'd like to ask President Davidson to tell you about it.

(President Davidson makes remarks. Following his remarks, you return to the podium)

Thank you Dick for your words and your leadership in this new campaign. Now I'm proud to announce new executive action I'm taking at the federal level to target medical errors and promote patient safety.

First, I'm signing an Executive Memorandum this morning directing our Health Care Quality Task Force to analyze the Institute of Medicine's landmark study—and to report back to me and the Vice President within 60 days about the ways we can implement their recommendations. I'm also calling on the Task Force to evaluate the extent to which medical errors are caused by the misuse of medications and medical devices and to develop additional

strategies to reduce these errors.

Second, I want the federal government to lead by example. So I'm instructing government agencies that administer health plans for 85 million Americans to take an inventory of the good ideas out there to reduce medical errors. They should apply those techniques to the health programs that they administer—and do so in a way that protects patient privacy. As a first step, I'm announcing today that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will now be required to institute quality improvement and patient safety initiatives.

Third, ongoing research to enhance patient safety and reduce medical errors is critical—so we're increasing our investment in this area. Yesterday, I signed legislation reauthorizing the Agency for Health Care Quality and Research and providing \$200 million for research to improve health care quality and prevent medical errors. Through the work of the Agency, we are also engaging our partners at the state level. In March, we will convene the first national conference with state health officials to promote best practices in preventing medical errors.

Finally, I'm directing my budget and health care teams to develop quality and patient safety initiatives for next year's budget to ensure that we're doing all we can to combat this problem. I want next year's budget to provide our largest investment to eliminate medical errors, improve quality, and enhance patient safety.

The Institute of Medicine's report makes clear that a systematic approach to reducing medical errors gives us the best chance of success. Years ago, we took that approach in aviation and we've dramatically reduced errors and saved lives. By working together, we can achieve the same goals in the health care industry.

The American people deserve quality health care—through the protections we're fighting for in the Patients' Bill of Rights—and the safety measures we're putting in place today. I'm committed to working with everyone here to do even more. And by working in partnership, we will do our part to save lives, end needless medical errors and make the best health care system in the world even better for the 21st century.

Message Sent To:

Christopher C. Jennings/OPD/EOP@EOP
Joel Johnson/WHO/EOP@EOP
Joseph P. Lockhart/WHO/EOP@EOP
John Podesta/WHO/EOP@EOP
Bruce N. Reed/OPD/EOP@EOP
Richard L. Siewert/WHO/EOP@EOP
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Douglas B. Sosnik/WHO/EOP@EOP
Loretta M. Ucelli/WHO/EOP@EOP

A Clinton Order Seeks to Reduce Medical Errors

By ROBERT PEAR

WASHINGTON, Dec. 6 — President Clinton will order federal agencies that provide or finance health care to take steps to reduce medical errors blamed for tens of thousands of deaths, administration officials said today.

The order would require pharmacists to take more precautions to avoid dispensing the wrong drugs and would encourage hospitals to investigate errors that cause serious injuries or deaths and report their findings to state health agencies. The standards would apply to health care providers under direct federal control, but would serve as an example for the rest of the industry.

At a White House ceremony on Tuesday, the officials said, Mr. Clinton will instruct the agencies, which deal with the health care of 85 million people, to adopt all feasible techniques for reducing medical errors. In so doing, the officials said, Mr. Clinton is recognizing medical mistakes as a serious problem in the health care system.

In effect Mr. Clinton has decided to accept major recommendations from a report issued last week by the National Academy of Sciences. The report said that the medical mistakes that cause tens of thousands of deaths each year could be reduced by half in the next five years if health care providers collected and analyzed data on unsafe practices, as the aviation industry does.

Some health care providers already investigate errors, and about 20 states require that they report their mistakes. But compliance is uneven, and many states have no such requirements.

The federal government has immense leverage over the health care

Continued on Page A17

probes that were supposed to penetrate the Martian ground at about the same time of the lander's arrival. They were designed to examine the subsurface for signs of water ice.

The search for water by both the probes and the lander was an effort to answer the consuming question about Mars: Could life have arisen there in the past? Water is considered essential for life, and other research has shown that some water ice and vapor exists on Mars and might have been more abundant and in liquid form earlier.

The mission's apparent failure has been acutely painful for Mr. Zimmerman and others who have invested years, sometimes decades, in

Continued on Page A19

Airline Contractor Is Guilty in Jet Crash

An airline maintenance company was convicted in a Miami federal court of mishandling hazardous materials in the crash of ValuJet Flight 592, which killed 110 people in 1996. The company's chief of hangar operations and a mechanic were acquitted of lying on repair records. The company was accused of failing to install safety caps on oxygen generators that started a fire in a hold.

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Clinton Will Order Agencies To Reduce Medical Errors

Continued From Page A1

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The interagency group will develop proposals that can be included in the president's next budget, which he intends to submit to Congress in late January or early February, administration officials said.

White House officials said they had not figured out how Mr. Clinton's new initiative would deal with the concerns of health care providers who fear they will be more exposed to malpractice lawsuits if they acknowledge more of their mistakes. The Clinton administration has generally opposed efforts by health care providers to limit the damages they might be required to pay in such cases.

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Hillary Rodham Clinton supervised the decorating yesterday the White House pastry chef, Roland Mesnier, who created

Start Spreading the News, S

By MARIAN BURROS

WASHINGTON, Dec. 6 — Between about a dozen holiday parties at the White House, the elaborate plans for the millennium celebration and a full campaign schedule in New York, Hillary Rodham Clinton is sneaking in a little packing.

At the annual unveiling of White House Christmas decorations (this year's theme reflects times past), the first lady said today that the timing of her move into the Dutch Colonial house in Chap-

paqua, N.Y., that she and the president bought for \$1.7 million depended on the Secret Service.

"I don't know if we'll be in the house before the end of the year," she said.

But she added, "While I'm packing, I'm trying to get everything ready. We are pulling things out of storage to see what has been covered."

There will not be any final shopping for the move, she said, because "We are moving to use what we have."

Embattled Head of Laborers Union Annou

By STEVEN GREENHOUSE

Arthur A. Coia, the embattled president of the laborers' union, announced his retirement yesterday, two months after several union and federal officials said he would soon step down as part of a deal in which he would plead guilty to fraud charges.

Mr. Coia, 56, one of President Clinton's biggest labor supporters, said he was retiring because of illness and because he and his family thought it was time for him to step down. Officials with the Laborers' International Union of North America, one of the nation's largest building trades unions, insisted that his retirement had nothing to do with a deal with federal prosecutors.

Justice Department officials declined to comment.

In October, Mr. Coia angrily accused the department of leaking incriminating information about him. Those attacks came after newspapers reported that he would soon resign and would later plead guilty to charges involving his purchase of a \$450,000 Ferrari from a supplier to

the 750,000-member union.

In October, a government official and a union official said the plea would not result in a prison term but would bar Mr. Coia from future contacts with the union, which a president's commission described in 1985 as one of the nation's most corrupt.

In its announcement yesterday, the union said Mr. Coia would become president emeritus. He would stop serving on the union's board, but would receive part of his salary.

In March, after a five-year investigation, an independent union hearing officer cleared Mr. Coia on charges that he had ties to organized crime. But the officer fined Mr. Coia \$100,000 for an ethics violation concerning his purchase of the Ferrari.

In a statement, Mr. Coia said, "For too many years, my position in the union has caused me to be investigated nonstop, top to bottom and inside out. For far too many years, my entire life has been scrutinized — every action reviewed, every motive analyzed, every decision questioned, every good deed doubted."

Mr. Coia, who has largely recov-

ered after bouts of Hodgkin's disease and prostate cancer, said it to retire rather than continue his family in a secondary role.

Mr. Coia was a co-chairman of several fund-raisers for Mr. Clinton and Republicans pushed for investigation of whether the president asked prosecutors to go after Mr. Coia and his union. Administration officials have denied Clinton asked any such favor they went easy on Mr. Coia.

Mr. Coia has long been one of the nation's most flamboyant union officials. He drove a Ferrari and owned luxury cars, he had a large home in his native Rhode Island, and he loves to golf.

At the same time, he made his union, making it more on organizing additional members and improving health and safety programs.

Mr. Coia's father was once a tory-treasurer of the union and his brothers were prosecutors said, associated with Raymond Patriarca Jr., New England's longtime crime boss.

The union said yesterday

Clinton to Urge Steps to Curb Medical Errors

By AMY GOLDSTEIN
Washington Post Staff Writer

President Clinton plans to announce steps today to curb dangerous medical errors, including a requirement that all 300 health plans serving federal workers must adopt new safeguards to avoid accidents that can injure or kill patients.

Clinton also will direct every agency that runs government health

programs—including those for children, veterans, the military, and people who are elderly or poor—to explore additional ways to improve patients' safety. And he will ask advisers to include initiatives designed to reduce medical mistakes in the budget that the administration is preparing to send to Congress early next year.

The president also plans to laud the nation's hospital industry, which is also planning to unveil a campaign today to begin spreading among all 5,000 of the nation's hospitals information about how to avoid mistakes involving medication.

The White House is swinging into action just a week after the release of a major independent report that documents the alarming frequency of fatal mistakes—between 44,000 and 98,000 Americans a year are killed—by a health care system that has been regarded for decades as the finest in the world.

Judging by the swift response from the administration, lawmakers and various health care constituencies, the cause of "patient safety"

could blossom into a prime political issue, emerging alongside the bitter debate over how much to regulate HMOs.

Already, the issue of medical errors appears certain to spill into Congress shortly after lawmakers return to work in January.

Yesterday, Sen. Edward M. Kennedy (D-Mass.) said he intends to introduce legislation that would for the first time require every hospital to notify state governments of all mistakes that cause serious injuries or deaths. Kennedy told reporters that his bill would encourage health care organizations to report errors with less drastic consequences confidentially and on a voluntary basis. And it would create a new federal Center for Patient Safety within the Department of Health and Human Services.

The ideas in Kennedy's legislation, which he said appear likely to attract bipartisan support, were proposed in last week's report, sponsored by the respected Institute of Medicine, a branch of the National Academy of Sciences.

The report estimates that preventable deaths and injuries in hospitals and other health care settings cost the United States as much as \$29 billion a year. The most common kinds of mistakes, it says, involve drugs that are given at the wrong time, in the wrong dose, in hazardous combinations, or to the wrong patients.

The IOM study concludes that the nation's health care system lags behind airlines, the nuclear industry and other parts of the country that have long collected information about accidents—and gleaned from that information ideas about how to operate more safely.

Today, Clinton is expected to stop short of endorsing the report. Instead, he will assign a relatively new federal task force on medical quality to spend the next two months studying the "feasibility and advisability" of its recommendations. In draft remarks prepared for a White House event today, the president notes that efforts to ferret out medical mistakes must be balanced against another goal of the administration: protecting the privacy of patient records.

Republicans, perennially sensitive to any efforts to add to federal bureaucracy, could prove cool to the idea of a national reporting system for medical mistakes. Sen. James M. Jeffords (R-Vt.), chairman of the Senate health committee, has said he plans to convene a hearing on errors early next year. But a committee spokesman said yesterday that Jeffords was not inclined to support a federal law requiring all errors to be reported to the government.



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outside the U.S. Interests Section. "I have two children, and as a mother you want to see the best for the child."

The White House takes a "dim view" of the threat posed by anti-U.S. demonstrations, spokesman Joe Lockhart said. "We take the safety of our diplomats and American personnel very seriously, and we expect Cuba to live up to the obligations they've undertaken to keep those Americans safe," he said.

The political pressures continued to mount for the administration, as a three-day deadline granted by a furious Castro was set to lapse Tuesday evening. Asserting that the boy had been kidnapped by U.S. officials and his exile relatives in Miami, Castro vowed to unleash "a battle of public opinion that will move heaven and earth" to return him to his father in Cuba.

In Havana on Monday, a government crane installed a reviewing stand in front of the U.S. mission while government workers delivered portable toilets, refreshment stands and loudspeakers, sparking speculation that Castro would speak there in the next few days.

The confrontation comes just days before U.S. and Cuban officials are set to meet for regularly scheduled migration talks on Monday. Those talks monitor the status of two historic accords reached between Havana and Washington in 1994 and 1995, which curtailed a rafter exodus by allowing the repatriation to Cuba of illegal migrants and facilitating the orderly outflow of more than 20,000 Cubans a year to the United States.

Cuban officials have made plain that they believe the decision not to repatriate Elian Gonzalez immediately was a violation of those accords. Over the weekend, National Assembly President Ricardo Alarcon hinted that the talks might be scrapped because "it is very hard to imagine that we could have any type of constructive discussion" while the controversy over the child simmers.

But as far as U.S. government officials are concerned, the talks will be held on schedule and preparations are proceeding accordingly.

With the prospect of a renewed Cuban exodus never far from the minds of U.S. policy makers, Foley said it was the State Department's view that the migration talks were in the "mutual interest" of both nations.

U.S. officials noted that Castro's angry outburst Sunday, when he branded the U.S. decision to let Florida courts handle Elian's case a "kidnapping," was the fourth strong attack he has launched against U.S. policies over the past few weeks.

"Castro is clearly orchestrating a major anti-American campaign with all this, and now the child," one U.S. official said. "The question is, where is he going with all this? We just hope it doesn't get out of control."

Clinton to announce strategies to reduce medical errors

By Andrea Gerlin

Knight Ridder Newspapers

PHILADELPHIA President Clinton is expected to sign an executive order Tuesday directing a task force to find new strategies to reduce medical errors and instructing government agencies to evaluate and implement error reduction techniques.

White House officials said Clinton will announce the measures in the Rose Garden after a planned morning meeting with representatives of health-care providers, consumers, purchasers, lawmakers and the Institute of Medicine.

"The President believes we should move quickly in this area and is unveiling a series of initiatives to reduce medical error and improve patient safety," said Christopher C. Jennings, deputy assistant to the president for health policy.

The executive order will direct the Quality Interagency Coordination Task Force to report, through Vice President Gore within 60 days, its recommendations for preventing medical errors. The federal Office of Personnel and Management will be ordered to require 300 private health plans that cover government employees to institute patient safety standards.

In making the announcement, Clinton is expected to direct the Office of Management and Budget, the Domestic Policy Council and other agencies to develop initiatives for combating errors and include them in the 2001 fiscal year budget. He is expected to highlight the American Hospital Association's plan to

American Hospital Association president Dick Davidson said the group looked forward to working with Clinton. The AHA said it would work with the Institute for Safe Medication Practices, based in Huntingdon Valley, Pa. The non-profit institute collects 50 to 60 confidential reports of drug errors each month and sends weekly alerts to 5,800 hospital pharmacies around the country.

In September, The Inquirer published a four-part series about medical mistakes. Based on internal hospital records, the articles described cases in which patients suffered injuries and deaths caused by errors in their care. In some cases, the patients or their survivors were never told about the mistakes.

Clinton is expected to review a new law, which he signed Monday, reauthorizing the Agency for Health Care Policy and Research and renaming it the Agency for Health Research and Quality. That agency, whose focus already includes health-care quality, may ultimately play a significant role in a rapidly developing national effort to reduce medical errors.

In a report issued Nov. 29, a panel of experts convened by a division of the National Academy of Sciences estimated that as many as 98,000 people die as a result of mistakes made in care at U.S. hospitals alone more than auto accidents, breast cancer and AIDS. The panel concluded that the number of deaths due to medical errors could be cut in half within five years.

The report, from a committee of the Institute of Medicine, recommended that Congress establish a center for patient safety within the Agency for Health Research and Quality at an initial cost of \$30 million to \$35 million a year, which is anticipated to grow to \$100 million a year. It also recommended that national guidelines be developed for mandatory public reporting of errors that kill or injure patients, and that Congress extend confidentiality protections to voluntarily report errors that do not harm patients.

Jennings said the executive order does not obviate the need for legislation. Sen. Edward M. Kennedy, D., Ma., Monday proposed legislation that would implement the recommendations for Congressional action suggested by the Institute of Medicine panel.

Kennedy is the ranking minority member of the Senate Health and Education Committee. The committee chairman, Sen. James Jeffords, R., Vt., said last week that it would hold hearings when Congress reconvenes on Jan. 24.

Kennedy's spokesman, Jim Manley, said, the senator "would rather lay this legislation down before going into hearings."

Although Congress is not in session, there has been a flurry of activity in the last week, with lawmakers' staffs racing to take action on an issue likely to be popular with voters in the upcoming election year. Sen. Arlen Specter, R., Pa., chairman of the Senate Appropriations subcommittee on labor, health and human services, and education, also said last week that the subcommittee would hold hearings on the matter.

Specter's chief of staff, David Urban, said Monday that those hearings might be held as early as Dec. 13 if subcommittee members and witnesses are available then. "We're moving pretty quickly," Urban said.

In the House, representatives and officials continue to study the Institute of Medicine report. Peter Sheffield, a spokesman for the House Committee on Commerce, said the committee is "holding open the option to hold hearings next year."

One of the first members of the House to address medical errors, Rep. Bruce Vento, D., Minn., met Monday with Agency for Health Research and Quality administrator John Eisenberg. Vento said he wrote to Eisenberg in September after he read The Inquirer's series, reprinted in his hometown newspaper, and became interested in the issue. He said a sister who had been hospitalized was mistaken for another patient and nearly received a hysterectomy not intended for her.

Vento, a biologist, raised the medical error issue on the floor of the House during a subcommittee on health and environment debate of the agency's reauthorization bill on Sept. 28. He asked then if the agency could compile state-by-state statistics on the number of injuries and deaths from medical errors to better monitor and reduce them.

He said Eisenberg told him Monday that the agency has the authority to assess quality and house a patient safety center but has only \$2 million in its budget for a program to address medical errors this year. Vento said he agreed with the Institute of Medicine's recommendations to Congress.

"We're going to have to respond to this," Vento said. "We know a lot of this happens. This is not something that can be pushed aside."

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Written by Robert Abitbol

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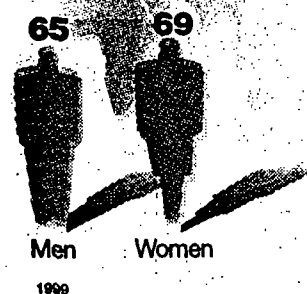
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years longer than
life expectancy averages:

World average



By James Abundis and Julie Stacey, USA TODAY

From soap makers to
stock exchanges, non-Y2K
glitches are cutting a wide swath of mischief
in corporate offices, schools and govern-
ment agencies from Washington, D.C., to
Washington state. The glitches are creating
delays, outages, garbled data and general
snafus, proving Murphy's Law that anything
that can go wrong probably will.

Clearly, technology provides incalculable
productivity and efficiency gains. But indus-

tries, not the calendar,"
says Peter de Jager, a tech-
nology consultant who was among the first
to warn the masses about Y2K glitches in
"Doomsday 2000," his 1993 report in *Com-
puter World* magazine.

Almost daily, glitch woes are becoming
more pervasive and troublesome. Candy gi-
ant Hershey Foods experienced delays that

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Medical errors targeted

By Susan Page
USA TODAY

WASHINGTON — President
Clinton and members of Con-
gress are moving quickly to im-
plement recommendations in
an Institute of Medicine report
last week that found up to
98,000 Americans a year are
killed by medical mistakes.

Clinton will announce execu-
tive actions today aimed at re-
ducing the rate of medical er-
rors for patients in the
Medicare, Medicaid, Veterans'
Administration and federal em-
ployees' health care systems.

Sen. Edward Kennedy, D-
Mass., announced Monday that
he would submit legislation to
put in place the report's most
far-reaching recommendation:
Establishing a new federal
agency to collect data on med-
ical mistakes and develop rec-

Clinton orders task force today
to find new ways to reduce deaths

ommendations to avoid them.
Reporting would be mandatory
for mistakes that result in seri-
ous injury and voluntary for
lesser injuries or "near-misses."

Sen. James Jeffords, R-Vt.,
chairman of the Senate's health
committee, has indicated that
he will hold hearings next year.
Staffers for Jeffords, Kennedy
and Sen. Bill Frist, R-Tenn.,
plan to meet this week to dis-
cuss a bipartisan bill.

The Institute of Medicine re-
port is having a greater effect
on health care than any in-
dependent study in the past
decade, says Rick Wade of the
American Hospital Association.

"People can tell you this is
not some abstract government
study," he says. "This touches a

common set of experiences
that people have when they go
to the doctor, when they go to
the hospital."

The report estimates that
medical errors kill 44,000 to
98,000 Americans a year, more
than traffic accidents, breast
cancer or AIDS. Mistakes in-
clude illegible prescriptions,
nurses delivering the wrong
dosages and doctors misinter-
preting symptoms.

Clinton will order a federal
task force to report back within
60 days with "new strategies" to
protect patient safety. Agencies
will be instructed to implement
"error reduction techniques."

In a sign of the issue's politi-
cal potency, the task force will
report to Vice President Gore.

States to test online voting

By Richard Wolf
USA TODAY

Seeking to boost turnout and
appeal to younger voters, a
growing number of states are
considering Internet voting.

► Arizona Democrats plan
to allow online voting at their
presidential primary March 11.
Voters could use computers at
polling places or their own per-
sonal computers. To vote from
home, they would need a per-
sonal identification code.

"This is the first thing that
will increase turnout since re-
pealing the poll tax," party
chairman Mark Fleisher says.

► A California task force will
recommend this month that In-

ternet voting be phased in over
several years. But proponents
might force a November refer-
endum to legalize e-voting.

► Several other states, in-
cluding Florida, Iowa and
Washington, are moving toward
online voting. Tests might come
at polling places rather than in
private. "We think we can do it
now," says Paul Craft, Florida's
manager of voting systems.

► The military plans to have
about 350 troops overseas cast
ballots online in November.
Residents of four states — Tex-
as, Florida, South Carolina and
Utah — who are stationed over-
seas would participate.

► A bill introduced by Rep.
Jesse Jackson Jr., D-Ill., calls

for a federal study of Internet
voting. "It has the potential to
broaden our democracy for
more Americans to partici-
pate," Jackson says.

Most officials want to go
slowly. Fears range from voter
fraud and privacy violations to
professional hackers and
jammed lines. Some say online
voting could disenfranchise
people without Internet access.

"Buying toys at Christmas
over the Internet is significantly
different than ensuring some-
one's right to vote," says Gary
McIntosh, Washington state's
elections director. "We're going
to take a lot of baby steps."

► Security concerns, 6A

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Doctoring a sickly system

Deadly medical mistakes are rampant. One expert thinks they can be avoided

By Joseph P. Shapiro

James Baglan has investigated deadly mistakes before. Following the 1986 Challenger space-shuttle explosion, the physician, engineer, and astronaut supervised the capsule's recovery from the ocean floor, after first diving 95 feet into the warm Atlantic Ocean waters to find the remains of his friends and fellow astronauts. Then he redesigned the shuttle, adding an escape hatch, pressure suits, and parachutes to prevent another such tragedy. But even with the drama and derring-do of that mission, he says, the most important challenge of his life came two years ago when he was asked to figure out why medical errors were killing so many patients in hospitals run by the Veterans Health Administration.

It's not that the VA's 172 hospitals were more dangerous than others. Deadly medical errors are the health care system's dirty little secret, as an astonishing new survey from the Institute of Medicine made clear last week. That report, "To Err Is Human," estimated that 44,000 to 98,000 Americans a year die from preventable mistakes—from drug mix-ups to inattentive treatment—made in hospitals by physicians, pharmacists, and other health care professionals. Even the lower figure ranks hospital errors as the nation's eighth most frequent killer, taking more lives than car crashes.

Air-crash model. Unlike car accidents, however, these avoidable deaths have attracted little attention—and scant effort by the health care system to prevent them. To "break this cycle of inaction," the IOM recommends creating a new federal center to monitor such deaths—much the same way airline crashes and workplace accidents are tallied and analyzed—and to promote public health policies that would prevent them. It also calls for mandatory reporting of all blunders that result in serious harm. Says William Richardson, president of the W. K. Kellogg Foundation and chair of the

Students can't meet standards, so states let them pass

Ex-chancellor Kohl denies having sold political favors

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of medical errors are simply unacceptable in a medical system that promotes first to 'do no harm.' "

The IOM is the medical research arm of the prestigious National Academy of Sciences, and its recommendations often lead to congressional action. But change will not come easily. Doctors fear that any system that scrutinizes and reports medical missteps will expose them to serious legal liability. Still, it was a sign of how grave the problem has become that groups representing doctors, pharmacists, and hospitals generally praised last week's report.

Anyone looking for a model of what the IOM envisions could start with the VA. This year, it began instituting many of Baglan's reforms, ones that are almost identical to the idealized system proposed by the headline-grabbing IOM report. A new National Center for Patient Safety, headed by Baglan, tracks errors at VA hospitals and clinics and spreads the gospel of prevention. "The VA has done perhaps the most impressive work in the country so far," says Donald Berwick, chief of the Institute for Healthcare Improvement and a member of the IOM panel. "And hiring an astronaut to head that system was brilliant," he says, noting that aviation is one of the few industries that routinely investigates its own death-causing errors.

Indeed, Baglan frequently compares the investigation of medical errors and airplane crashes. "Aircraft-investigation people don't come in and say, 'whose fault is it?'" says Baglan, a lanky, hyper-energetic 47-year-old with ice-blue eyes. "They say, 'what happened?'" Still, Baglan had to convince doctors and hospital administrators that he was more interested in the system's failures than in individual screw-ups. "The best of physicians make stupid errors," says Kenneth Kizer, the visionary former head of the VA health system who hired Baglan and made safety a priority. But these mistakes, he says, usually have little to do with a doctor's competence: "Mistakes are so prevalent and inevitable because health care is so complex."

Solutions, however, are often astoundingly simple. One of the first things the VA did, for example, was to move bottles of concentrated potassium chloride, an essential bodily electrolyte given intravenously to patients, off hospital floors and into the pharmacy. That easy step ensures that a nurse will not inadvertently inject the solution in its deadly, undiluted form.

Physician scrawl. Drug mix-ups are one of the most frequent causes of harm. More than 7,000 Americans a year die from avoidable medication errors—more deaths than from workplace accidents. Confusion results because different drugs often have similar names and because of physicians' notoriously sloppy handwriting. In October, in what is thought to be the first case of its kind, a Texas jury found a doctor liable for a fatal medication foul-up that resulted from an illegible prescription. The 42-year-old patient died after taking a dangerous dosage of Flendil, a drug for high blood pressure, instead of Isordil, a drug for his angina.

The VA hospitals are making clever use of bar-coding technology to avoid medication bumbles. Prescriptions are typed into computers, not

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medical system that promotes first to 'do no harm.'

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The VA hospitals are making clever use of bar-coding technology to avoid medication bumbles. Prescriptions are typed into computers, not

patient's wrist and a nurse's charts, are scanned each time a patient gets a pill, to check against mistakes. The idea came from a nurse at the Topeka VA hospital who, returning a rental car one day, noticed the wireless scanner used to check in her car. The system will be in place in every VA hospital by June.

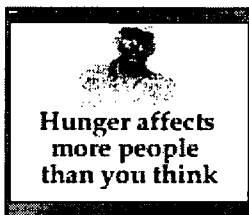
Although the VA system is becoming a model for quality improvement, there are things that make it peculiarly suited for change. It is a large, integrated system of in-patient hospitals, nursing homes, and out-patient clinics. That makes it easy to track the care given each patient and to absorb the costs of putting in new error-prevention programs. Further, VA doctors don't need to purchase malpractice insurance because the government compensates patients harmed by a physician's negligence.

Still, other hospitals are coming up with their own innovations. Even a small regional one, like Luther/Midelfort Health Care System in Eau Claire, Wis., through intensive data collection, has dramatically reduced discrepancies in drug prescriptions of patients following surgery. As a result, says Roger Resar, the physician who oversees the effort, rates of rehospitalization have been cut. Doctors, says Baglan, will respond to hard numbers that show where they fall short and how they can improve. That's another lesson from the aviation industry: Learn from the close calls. But the most daunting task of all, he concedes, will be to change the whole culture of medicine from responding to crises to preventing them in the first place.

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Clinton to Urge Steps to Curb Medical Errors

By Amy Goldstein
 Washington Post Staff Writer
 Tuesday, December 7, 1999; Page A14

President Clinton plans to announce steps today to curb dangerous medical errors, including a requirement that all 300 health plans insuring federal workers must adopt new safeguards to avoid accidents that can injure or kill patients.

Clinton also will direct every agency that runs government health programs—including those for children, veterans, the military, and people who are elderly or poor—to explore additional ways to improve patients' safety. And he will ask advisers to include initiatives designed to reduce medical mistakes in the budget that the administration is preparing to send to Congress early next year.

The president also plans to laud the nation's hospital industry, which is also planning to unveil a campaign today to begin spreading among all 5,000 of the nation's hospitals information about how to avoid mistakes involving medication.

The White House is swinging into action just a week after the release of a major independent report that documents the alarming frequency of fatal mistakes—between 44,000 and 98,000 Americans a year are killed—by a health care system that has been regarded for decades as the finest in the world.

Judging by the swift response from the administration, lawmakers and various health care constituencies, the cause of "patient safety" could blossom into a prime political issue, emerging alongside the bitter debate over how much to regulate HMOs.

Already, the issue of medical errors appears certain to spill into Congress shortly after lawmakers return to work in January.

Yesterday, Sen. Edward M. Kennedy (D-Mass.) said he intends to introduce legislation that would for the first time require every hospital to notify state governments of all mistakes that cause serious injuries or deaths. Kennedy told reporters that his bill would encourage health care organizations to report errors with less drastic consequences confidentially and on a voluntary basis. And it would create a new federal Center for Patient Safety within the Department of Health and Human Services.

The ideas in Kennedy's legislation, which he said appear likely to attract bipartisan support, were proposed in last week's report,

sponsored by the respected Institute of Medicine, a branch of the National Academy of Sciences.

The report estimates that preventable deaths and injuries in hospitals and other health care settings cost the United States as much as \$29 billion a year. The most common kinds of mistakes, it says, involve drugs that are given at the wrong time, in the wrong dose, in hazardous combinations, or to the wrong patients.

The IOM study concludes that the nation's health care system lags behind airlines, the nuclear industry and other parts of the country that have long collected information about accidents--and gleaned from that information ideas about how to operate more safely.

Today, Clinton is expected to stop short of endorsing the report. Instead, he will assign a relatively new federal task force on medical quality to spend the next two months studying the "feasibility and advisability" of its recommendations. In draft remarks prepared for a White House event today, the president notes that efforts to ferret out medical mistakes must be balanced against another goal of the administration: protecting the privacy of patient records.

Republicans, perennially sensitive to any efforts to add to federal bureaucracy, could prove cool to the idea of a national reporting system for medical mistakes. Sen. James M. Jeffords (R-Vt.), chairman of the Senate health committee, has said he plans to convene a hearing on errors early next year. But a committee spokesman said yesterday that Jeffords was not inclined to support a federal law requiring all errors to be reported to the government.

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CLINTON-GORE ADMINISTRATION TAKES STRONG NEW STEPS TO IMPROVE HEALTH CARE QUALITY AND ENSURE PATIENT SAFETY

December 7, 1999

Today, President Clinton will meet with representatives of the Institute of Medicine (IOM), health care consumers, providers, purchasers, and members of the business and labor communities, and sign an executive memorandum directing the Federal Quality Interagency Coordination (QuIC) Task Force to report back within 60 days, through the Vice President, with recommendations to improve health care quality through the prevention of medical errors and enhancements in patient safety. The President will also: announce that each of the over 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives; instruct Federal agencies administering health plans to evaluate and, where feasible, implement the latest error reduction techniques; direct the Office of Management and Budget, the Domestic Policy Council, and other agencies throughout the government to develop meaningful health care quality and patient safety initiatives for the FY 2001 budget; and announce his signing of the reauthorization of the Agency for Healthcare Research and Quality, ensuring a new, multi-million dollar investment in research programs to improve health care quality. In addition, the President will praise the American Hospital Association for its landmark announcement of a multi-faceted campaign to prevent unnecessary, harmful, and expensive medication errors in 5,000 member hospitals.

INCONSISTENCIES AND AVOIDABLE ERRORS IN MEDICAL PRACTICE COST LIVES AND UNDERMINE HEALTH. Inappropriate utilization of services, unnecessary variations in the delivery of health care, and preventable medical errors are responsible for tens of thousands of deaths, unnecessary illnesses, and instances of prolonged disability each year. In addition to these severe health consequences, these variations in medical practice increase national health care spending by billions of dollars annually.

- **Preventable medical errors.** A study released last week by the Institute of Medicine estimates that more than half of the adverse medical events occurring each year are due to preventable medical errors, placing as many as 98,000 Americans at unnecessary risk. The cost associated with these errors in lost income, disability, and health care costs is as much as \$29 billion annually. The financial cost of these errors are far outweighed by the impact they have on the lives of patients and the trust of patients in the quality of the care they receive.
- **Under-utilization of services.** Early detection and treatment for illnesses prevents unnecessary complications, higher costs, and premature mortality. For instance, despite the fact that early detection of breast cancer can prevent up to 30 percent of breast cancer deaths annually, 30 percent of women aged 52 to 69 do not receive regular mammograms.
- **Overuse of services.** The excessive and unnecessary delivery of health care services can increase costs without improving health and place patients at greater risk for injuries and complications. For example, the overuse of antibiotics creates unnecessary health care costs and contributes to the emergence of antibiotic-resistant pathogens, resulting in as much as \$7.5 billion in unnecessary expenditures annually.
- **Variation in services.** There is a continuing pattern of wide variation in health care practice that cannot be accounted for by differences in the health status of patients, available resources, patient preferences, or clinical uncertainty. For example, hospital discharge rates and lengths of stay in the Northeast were over 40 percent higher than in Western states.

NEW ACTION TO IMPROVE HEALTH CARE QUALITY AND ENSURE PATIENT SAFETY.

Today, President Clinton will:

- **Issue an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.** Today, President Clinton will sign an executive memorandum directing the QuIC to report back recommendations to him, through the Vice President, within 60 days that: identify prevalent threats to patient safety and reduce medical errors that can be prevented through the use of decision support systems, such as automated patient monitoring and reminder systems; evaluate the feasibility and advisability of the recommendations of the Institute of Medicine on patient safety; develop additional strategies, including the use of information technology, to reduce medical errors and ensure patient safety in Federal health care programs; evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to further strengthen FDA's response to this challenge; and identify opportunities for the Federal government to take specific action to improve patient safety and improve health care quality through collaboration with the private sector, including the newly constituted National Forum for Health Care Quality Measurement and Reporting.
- **Announce that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives.** Today, the President will announce that the Office of Personnel Management, which oversees plans serving 9 million Americans, will include in its annual call letter to be issued next spring a requirement that FEHBP plans use error reduction and other patient safety techniques in order to improve the quality of care in the program. In addition, OPM will supplement this initiative using workplace campaigns to improve mammography and medical screening rates among Federal employees, retirees, and their families. Finally, OPM will initiate new ways to measure and report on the quality of care that plans deliver to enrollees.
- **Instruct Federal agencies administering health plans to evaluate and, where feasible, implement the latest error reduction techniques.** The President will request that the Departments of Health and Human Services, Veterans Affairs, and Defense, and the Office of Personnel Management evaluate and, where feasible, implement the latest error reduction techniques in a manner consistent with the Administration's recently released draft regulations on patient privacy. These agencies administer Medicare, Medicaid, CHIP, the Federal Employees Health Benefits Program, the nationwide network of veterans hospitals and outpatient clinics, and the military health care system, serving over 85 million Americans.
- **Announce the reauthorization of the Agency for Healthcare Research and Quality, ensuring a multi-million dollar investment in research programs to improve health care quality.** President Clinton will announce that he signed legislation yesterday reauthorizing the Agency for Healthcare Research and Quality (AHRQ). To achieve the goals of this legislation, which is the result of the bipartisan efforts of Senators Frist and Kennedy and Congressmen Bliley and Brown, the FY 2000 budget increases the agency's resources by 16 percent over FY 1999 funding levels, for a multi-million dollar investment in health care quality. These new funds will be used for important quality improvement research, including the over-and-under utilization of services, variation in the delivery of services, and efforts to prevent medical errors. In recognition of the critical role that states do and will play in assuring and improving health care quality, AHRQ will hold a nationwide conference this March with senior state health officials to promote best medical practices, to prevent medical errors and improve patient safety, and to better develop a working relationship between the Federal and state governments in this area.

- **Direct the Office of Management and Budget, the Domestic Policy Council, and other agencies to develop additional health care quality and patient safety initiatives for the FY 2001 budget.** The President will direct the Office of Management and Budget, the Domestic Policy Council, and the Office of the Vice President to work with the Department of Health and Human Services and other agencies to develop additional initiatives within the context of the FY 2001 budget that build on our current error prevention, quality improvement, and patient safety initiatives.
- **Praise the American Hospital Association for launching a new medication safety campaign.** The President will praise the American Hospital Association for launching a new partnership with the Institute for Safe Medication Practices to prevent patient medication errors. Today, the AHA will send a list of "best practices" on prevention medication errors to all 5,000 of their member hospitals. In the coming months, they will also begin to: develop a medication safety awareness test that surveys hospitals' medication error prevention systems; track implementation by the hospital and health system field of the practices for reducing and preventing errors; and working with national experts to develop a model medication error reporting process. By taking these actions today, the AHA joins numerous other health care organizations making an important commitment to this area, including the American Medical Association's initiative to establish the National Patient Safety Foundation.

THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO IMPROVING HEALTH CARE QUALITY. Assuring quality through providing patient protections is a longstanding priority for the Clinton-Gore Administration. Over the past two years President Clinton and Vice President Gore have provided critical consumer protections to the 85 million Americans enrolled in Federal health plans and set the stage for the Congress to pass a strong, enforceable, Patients' Bill of Rights. In March of 1998, the President established the Quality Interagency Coordination Task Force, which has been instrumental in promoting advances in health care quality nationwide. The President also asked the Vice President to help launch the National Forum for Health Care Quality Measurement and Reporting, a broad-based, widely representative private advisory body that develops standard quality measurement tools to help all purchasers, providers, and consumers of health care better evaluate and ensure the delivery of quality services. In addition to the work and significant potential of the QuIC and Quality Forum, the Departments of Veterans Affairs and Defense have been leaders in patient safety and quality improvement programs. The Department of Veterans Affairs also spearheaded the development of the National Patient Safety Partnership to address issues related to adverse medical events. Finally, the Health Care Financing Administration has implemented new quality improvement initiatives through its peer review organization efforts, and the Food and Drug Administration is working to implement new reporting systems that allow for a rapid response to medical errors causing patient injury.

CLINTON-GORE ADMINISTRATION TAKES STRONG NEW STEPS TO IMPROVE HEALTH CARE QUALITY AND ENSURE PATIENT SAFETY

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INCONSISTENCIES AND AVOIDABLE ERRORS IN MEDICAL PRACTICE COST LIVES AND UNDERMINE HEALTH. Inappropriate utilization of services, unnecessary variations in the delivery of health care, and preventable medical errors are responsible for tens of thousands of deaths, unnecessary illnesses, and instances of prolonged disability each year. In addition to these severe health consequences, these variations in medical practice increase national health care spending by billions of dollars annually.

- **Preventable medical errors.** A study released last week by the Institute of Medicine estimates that more than half of the adverse medical events occurring each year are due to preventable medical errors, placing as many as 98,000 Americans at unnecessary risk. The cost associated with these errors in lost income, disability, and health care costs is as much as \$29 billion annually. The financial cost of these errors are far outweighed by the impact they have on the lives of patients and the trust of patients in the quality of the care they receive.
- **Under-utilization of services.** Early detection and treatment for illnesses prevents unnecessary complications, higher costs, and premature mortality. For instance, despite the fact that early detection of breast cancer can prevent up to 30 percent of breast cancer deaths annually, 30 percent of women aged 52 to 69 do not receive regular mammograms.
- **Overuse of services.** The excessive and unnecessary delivery of health care services can increase costs without improving health and place patients at greater risk for injuries and complications. For example, the overuse of antibiotics creates unnecessary health care costs and contributes to the emergence of antibiotic-resistant pathogens, resulting in as much as \$7.5 billion in unnecessary expenditures annually.
- **Variation in services.** There is a continuing pattern of wide variation in health care practice that cannot be accounted for by differences in the health status of patients, available resources, patient preferences, or clinical uncertainty. For example, hospital discharge rates and lengths of stay in the Northeast were over 40 percent higher than in Western states.

NEW ACTION TO IMPROVE HEALTH CARE QUALITY AND ENSURE PATIENT SAFETY.

Today, President Clinton will:

- **Issue an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.** Today, President Clinton will sign an executive memorandum directing the QuIC to report back recommendations to him, through the Vice President, within 60 days that: identify prevalent threats to patient safety and reduce medical errors that can be prevented through the use of decision support systems, such as automated patient monitoring and reminder systems; evaluate the feasibility and advisability of the recommendations of the Institute of Medicine on patient safety; develop additional strategies, including the use of information technology, to reduce medical errors and ensure patient safety in Federal health care programs; evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to further strengthen FDA's response to this challenge; and identify opportunities for the Federal government to take specific action to improve patient safety and improve health care quality through collaboration with the private sector, including the newly constituted National Forum for Health Care Quality Measurement and Reporting.
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SUBJECT: IMPROVING HEALTH CARE QUALITY AND ENSURING PATIENT SAFETY

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The United States has some of the finest medical institutions and best trained health care professionals in the world. However, as the Quality Commission reported last year, millions of Americans are harmed - or even killed - each year as a result of inappropriate or erroneous medical treatment. These health care quality problems include the underutilization of needed services, the overutilization of unnecessary services, and medical errors in the delivery of care. In addition, there is a continuing pattern of wide variation in health care practice.

As the recent Institute of Medicine study confirms, preventable medical errors present an extraordinary example of the importance of improving the quality of health care in our nation. Over half of the adverse medical events that occur each year are preventable, causing the deaths of as many as 98,000 Americans annually and adding as much as \$29 billion to our nation's health care spending. These costs are far outweighed by the impact these errors have on the lives of individuals and families and in the trust of the American people in the quality of the care they receive.

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NEWS RELEASE

EMBARGOED FOR DEC. 7, 11 A.M. EDT

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HOSPITALS LAUNCH NATIONAL INITIATIVE ON MEDICATION SAFETY AT WHITE HOUSE BRIEFING **Partnering with the Institute for Safe Medication Practices**

Washington (December 7, 1999) – In a White House briefing today, Dick Davidson, president of the American Hospital Association (AHA), announced the initiation of a campaign to help hospitals examine and further improve medication safety. Davidson joined President Clinton in a public/private effort to address medical errors.

A recent Institute of Medicine report has thrust the issue of medical errors into the forefront. Hospitals are addressing medication errors because they are the most common cause of medical errors.

"We are pleased that President Clinton is showing significant leadership in this area, by taking an in-depth look at the Institute of Medicine's findings," said AHA President Dick Davidson. "It is going to take all of us working together to continue to improve the safety of our medical system."

As part of the effort, the AHA will partner with the Institute for Safe Medication Practices (ISMP), Huntingdon Valley, Pa. – a national leader in medication error safeguards and reporting. The ISMP will help AHA provide hospital leaders with an inventory of successful practices for reducing errors that can be adopted in every hospital. The practices are formulated from the work of experts and organizations that have been studying medication safety, including ISMP, the Institute for Healthcare Improvement, the Massachusetts Coalition for the

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Prevention of Medical Errors, the National Coordinating Council on Medication Reporting and Prevention, the National Patient Safety Partnership and many others.

"Our nation's hospitals deliver the best health care in the world, but we also need to be the best at providing that care with as little risk as possible," Davidson said. "It is tragic when any patient's safety is compromised. Hospitals are committed to helping their doctors, nurses and other caregivers do a better job. We're pleased to partner with the Institute for Safe Medication Practices to provide leadership and technical expertise to hospitals."

The objectives of the campaign include:

- Sharing the successful practices list with every hospital and health system.
- Developing a "medication safety awareness test" for use by hospitals developed by ISMP that surveys hospitals' progress on medication error prevention.
- Tracking implementation by the hospital and health system field of the practices for reducing and preventing errors.
- Working with national experts to develop a non-punitive model medication error reporting process.
- Serving as a clearinghouse of information and resources for the hospital field on medication error.

"We are pleased to be working with AHA on this medication safety effort because it means we can more effectively partner with hospital and health system leaders who can make a real difference in patient safety," said Michael R. Cohen, ISMP president. "We already have a good working model for reporting of errors nationally and many health care professionals are taking advantage of it. But because better understanding of medication errors is at the heart of any prevention effort, more must always be done to improve and increase reporting. This initiative is an ideal way to do just that."

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A nonprofit organization, ISMP is well known as an educational resource for the prevention of medication-system errors. The Institute provides independent review of errors reported through the United States Pharmacopoeia (USP) Medication Errors Reporting Program (MERP), which ISMP was instrumental in founding. Through MERP, health care professionals across the nation voluntarily complete pre-addressed mailers or dial a toll-free number (800-23-ERROR) to report actual and potential medication errors with complete confidentiality. As an official MedWatch partner, ISMP shares all information and prevention ideas with the U.S. Food and Drug Administration (FDA) and other professional and policy organizations. Working with practitioners, regulatory agencies, healthcare institutions, professional organizations, and the pharmaceutical industry, ISMP provides timely and accurate medication safety information and encourages safe use of medications by working toward improvements in drug distribution, naming packaging, labeling, and delivery system design.

The American Hospital Association is a not-for-profit association of health care provider organizations and individuals that are committed to health improvement of their communities.

The AHA is the national advocate for its members, which includes 5,000 hospitals, health care systems, networks, and other providers of care, and 37,000 individuals. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA web site at www.aha.org.