

# 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 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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December 6, 1999

**Lawmakers Target Medical Mistakes**A.P. INDEXES: [TOP STORIES](#) | [NEWS](#) | [SPORTS](#) | [BUSINESS](#) | [TECHNOLOGY](#) | [ENTERTAINMENT](#)

Filed at 8:44 p.m. EDT

By The Associated Press

WASHINGTON (AP) -- Propelled by a report that medical mistakes kill thousands of Americans, President Clinton and congressional lawmakers are putting together plans to quickly cut down the number of deaths.

The president, at a White House ceremony Tuesday, will direct federal agencies that administer health plans to find ways to reduce room for errors at hospitals. Meanwhile, in Congress, Sen. Edward Kennedy, D-Mass., is putting together legislation for next year, also requiring precautionary actions.

Both efforts will track suggestions made last week by the Institute of Medicine on ways to reduce mistakes at the nation's hospitals.

"I believe we can have a strong bipartisan bill in the next session," Kennedy, the senior Democrat on the Senate Health, Education, Labor and Pension Committee, told reporters. He said Republican senators, including Chairman James Jeffords, R-Vt., and Bill Frist, a doctor from Tennessee, are interested in holding hearings on the issue.

A senior White House official, who spoke on condition of anonymity, said late Monday that Clinton plans to meet Tuesday with officials from the Institute of Medicine, health care providers and hospitals to discuss initiatives that can be taken.

Afterward, the official said, Clinton will announce a series of first steps toward making mistakes less likely. They include a partnership with the American Hospital Association, which will ask its 5,000 members to produce a report on ways to cut down on errors.

Clinton also will issue an executive memorandum directing an interagency coordination task force to report back to him in 60 days on threats to patient safety. Federal agencies, too, will be required to

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put in place a system to reduce errors, the official said.

Kennedy's legislation, among other things, would create a national center for patient safety that would set safety goals, track progress in achieving them and serve as a clearinghouse for organizations seeking tips on improving medical safety.

Meanwhile, Clinton signed a bill Monday that provides \$40 million to improve health care and help train new pediatricians. The Healthcare Research Quality Act authorized a new grant program to support children's hospitals that train doctors.

"In an increasingly competitive health care market dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training," Clinton said in a statement, adding that the new program would "provide much needed support for the training of these critical health providers."

The Institute of Medicine said a center like Kennedy's would cost \$35 million to set up. Eventually, the report said, Congress should spend \$100 million a year in safety research, even building prototypes of safety systems.

Still, that would be just a fraction of the estimated \$8.8 billion spent each year as a result of medical mistakes, the report calculated.

The legislation also would provide grants and contracts for research on preventing medical errors and on creating error-reporting systems.

Kennedy said that Republican senators, including committee chairman James Jeffords of Vermont and Bill Frist, a Tennessee doctor, have expressed interest in such a bill.

Both the legislation and the White House action would be based, Kennedy said, on the Institute of Medicine report and recommendations last week.

Kennedy called the institute's goal of reducing medical errors by 50 percent "optimistic," but he also said any legislation would adopt similar goals.

The institute said it found flaws in the way hospitals, clinics and pharmacies operate. It cited two studies that estimate hospital errors cost at least 44,000, and perhaps as many as 98,000, lives a year.

Some problems are familiar, it suggested: Doctors' famously poor handwriting too often leaves pharmacists squinting at tiny paper prescriptions, and too many drug names sound alike.

Also, medical science advances so rapidly that it is difficult for health care workers to keep up with the latest treatments and new dangers. Technology poses a hazard when device models change from year to year.

And most health professionals do not have their competence regularly re-tested after they are licensed to practice, the report said.

Indeed, health care is a decade or more behind other high-risk industries in improving safety, the report said.

Kennedy's other proposals include requirements for reporting errors. About 20 states now require such reports, but how much information they require and what penalties they impose for errors varies widely, the report said.

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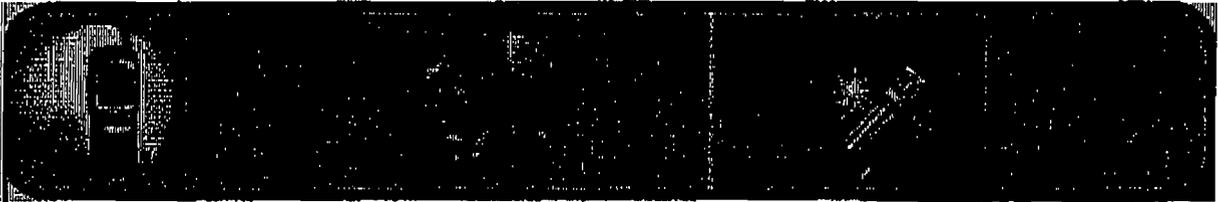
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## Doctoring a sickly system

*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

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of medical errors are simply unacceptable in a medical system that promises 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

handwritten. And bar codes labels, attached to a 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 Reser, 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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Written by Robert Abitbol

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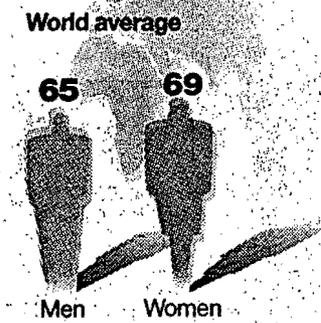
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Report 1999 By James Abundis and Julie Stacey, USA TODAY

From soap makers to stock exchanges, non-Y2K glitches are cutting a wide swath of mischief in corporate offices, schools and government 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-

triches, not the calendar, says Peter de Jager, a technology consultant who was among the first to warn the masses about Y2K glitches in "Doomsday 2000," his 1993 report in *Computer World* magazine.

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

Please see COVER STORY next page ▶

# Medical errors targeted

By Susan Page USA TODAY

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

WASHINGTON — President Clinton and members of Congress are moving quickly to implement 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 executive actions today aimed at reducing the rate of medical errors for patients in the Medicare, Medicaid, Veterans' Administration and federal employees' 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 medical mistakes and develop rec-

ommendations to avoid them. Reporting would be mandatory for mistakes that result in serious 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 discuss a bipartisan bill.

The Institute of Medicine report is having a greater effect on health care than any independent 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 include illegible prescriptions, nurses delivering the wrong dosages and doctors misinterpreting 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 political 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 personal computers. To vote from home, they would need a personal identification code.

"This is the first thing that will increase turnout since repealing 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 referendum to legalize e-voting.

▶ Several other states, including 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 — Texas, Florida, South Carolina and Utah — who are stationed overseas 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 participate," 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 someone'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

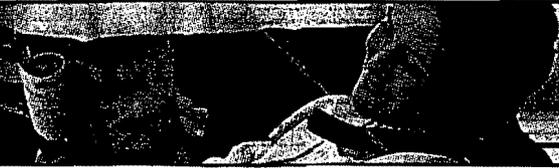
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THE WHITE HOUSE

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 QulC 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

## **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.**

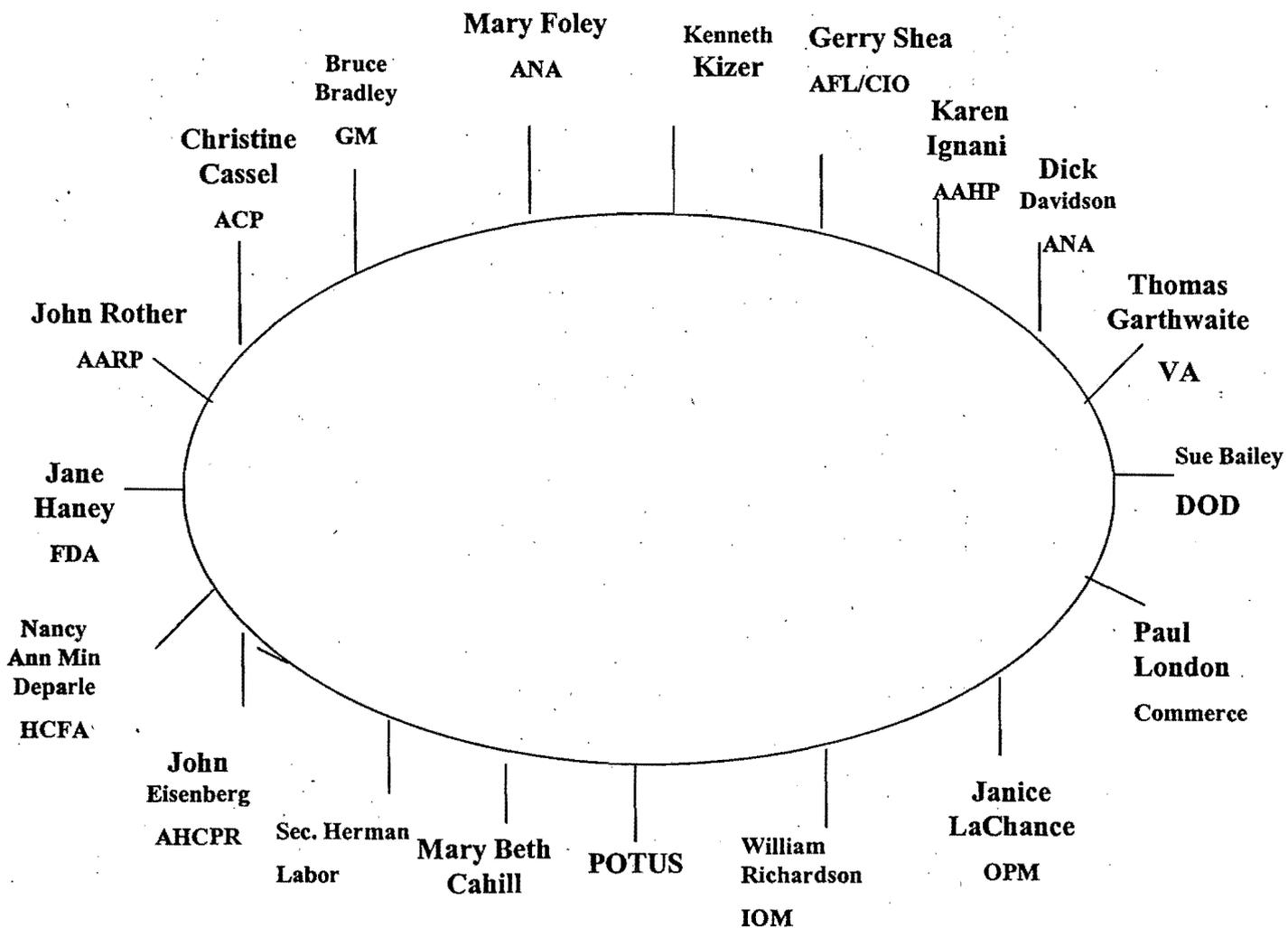
**Instructing Federal agencies administering health plans, including Departments of Health and Human Services, Veterans Affairs, and Defense, and others participating within the Quality Interagency Task Force to evaluate and, where feasible, implement the latest error reduction techniques.**

**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.

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



## **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.



Shaping New York's Health Care: Information, Philanthropy, Policy.

Empire State Building  
350 Fifth Avenue, 23rd Floor  
New York, NY 10118-2399  
212 494-0700  
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TO: Chris Jennings  
FROM: Jim Tallon  
DATE: December 2, 1999  
SUBJECT: Names

T: 202 456-5560  
F: 202 456-5557  
Three pages

Attached is a list of the Board of Directors of the Quality Forum, and a list of the members of the Quality Forum Framework Board.

As you will recall, the Framework Board is the "expert group" which will take the lead in developing a national strategy for quality information.

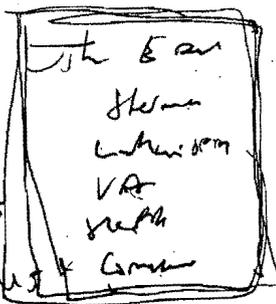
I have checked the Framework Board members who served on the IOM committee.

Note that Gail Warden, Chairman of the Board of Directors of the Quality Forum, also served on the IOM committee. I'd suggest that you use him as the lead representative of the Quality Forum in developing your plans. I've given him a heads-up on our conversation.

Call Jim  
Carmen

- ~~Stems~~
- Consumer
- Provider: Gail Warden - AHA
- Quality: Gail Warden, Theresa Horner, John E
- Business Reg
- Doc/Nurse

OF Misc/22



Alledis  
POTUS

- ANA
- AHA
- AMA
- OIE

John / LeChase  
- NCA, BM / JCAR IVA

- Boby Ram
- IOM - Brent Janner
- Business Reg - Labor Reg
- Consumer Reg

## National Forum for Health Care Quality Measurement and Reporting

### Board of Directors

☆ Gail L. Warden, chair of the National Forum for Health Care Quality Measurement and Reporting, is President and Chief Executive Officer for Henry Ford Health System in Detroit, Michigan.

J. Michael Cook, retired Chairman and Chief Executive Officer of Deloitte & Touche LLP in Wilton, Connecticut.

Nancy Ann Min DeParle, Administrator for the Health Care Financing Administration in Washington, DC.

John M. Eisenberg, MD, Administrator for the Agency for Health Care Policy and Research in Rockville, Maryland.

Lisa I. Iezzoni, MD, Professor of Medicine at Harvard Medical School in Boston, Massachusetts.

John R. Lumpkin, MD, MPH, Director, Illinois Department of Public Health in Springfield, Illinois.

Patricia E. Powers, President and Chief Executive Officer of Pacific Business Group on Health in San Francisco, California.

William L. Roper, MD, MPH, Dean of the School of Public Health at the University of North Carolina in Chapel Hill, North Carolina.

☆ John C. Rother, Director for Legislation and Public Policy at the American Association of Retired Persons in Washington, DC.

☆ Gerald M. Shea, Assistant to the President for Government Affairs at AFL-CIO in Washington, DC.

Michael A. Stocker, MD, MPH, President and Chief Executive Officer of Empire BlueCross BlueShield in New York, New York.

Marina L. Weiss, Senior Vice President for Public Policy and Government Affairs at the March of Dimes in Washington, DC.

Linda K. Wertz, State Medicaid Director, Texas Health and Human Services Commission in Austin, Texas.

#### Liaison Members

☆ Janice R. Lachance, Director, Office of Personnel Management in Washington, DC represents the Quality Interagency Coordinating Task Force (QuIC).

Margaret E. O'Kane, President of the National Committee for Quality Assurance in Washington, DC.

Dennis S. O'Leary, MD, President of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, Illinois.

Randolph D. Smoak, Jr, MD, Chair, Governing Body, American Medical Accreditation Program, American Medical Association, in Chicago, Illinois.

#### Officers and Staff

Kenneth W. Kizer, MD, is President and Chief Executive Officer.

Robyn Y. Nishimi, PhD, is Chief Operating Officer.

Tracy E. Miller, Clinical Associate Professor in the Department of Health Policy at Mount Sinai School of Medicine in New York, New York, is Director of the Framework Board.

James R. Tallon, Jr., President of United Hospital Fund in New York, is Acting Secretary – Treasurer.

Stephanie L. Davis, Assistant to the President at United Hospital Fund, is staff for the Quality Forum.

**The National Forum  
for  
Health Care Quality Measurement and Reporting  
Framework Board**

- Donald M. Berwick, MD, President and Chief Executive Officer, Institute for Healthcare Improvement (Boston, Massachusetts) ✓
- Christine K. Cassel, MD, Professor and Chairman, Department of Geriatrics and Adult Development, Mount Sinai School of Medicine (New York, New York) ✓
- Molly J. Coye, MD, Senior Vice President and Director, The Lewin Group (San Francisco, California) ✓
- Robert S. Galvin, MD, Director, Health Care, General Electric Company (Fairfield, Connecticut)
- Judith H. Hibbard, PhD, Professor of Health Policy, University of Oregon Department of Planning, Public Policy and Management (Eugene, Oregon)
- Brent C. James, MD, Vice President for Medical Research and Continuing Medical Education, and Executive Director, Institute for Health Care Delivery Research, Intermountain Health Care (Salt Lake City, Utah) ✓
- Sheila Leatherman, Senior Fellow, University of Minnesota School of Public Health (Minnetonka, Minnesota)
- Elizabeth A. McGlynn, PhD, Director, Center for Research on Quality in Health Care, RAND (Santa Monica, California)
- Helen L. Smits, MD, Visiting Professor, New York University Graduate School of Public Service (New York, New York)