

### Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
AL			
AK			<p><b>2007 SB 62</b> - Establishes the Advisory Committee on Public Reporting of Health Care Associated Infections within the Department of Health and Social Services to collect, analyze, and maintain databases of information related to health care associated infections, among previously noted items. <b>FAILED</b></p>
AZ			<p><b>2008 EO 23</b> - Orders and directs the Health Care Cost Containment System, Government Information Technology Agency, Department of Administration, and other appropriate agencies, to work with the Health-e Connection and its EAzRx initiative to significantly increase the utilization of e-prescribing in Arizona and to strive to improve patient safety and control costs by making Arizona a national leader in e-prescribing practices. The Executive Branch agencies shall work with Health-e Connection and the health professional licensing boards to educate prescribing clinicians, pharmacists, pharmacy technicians, hospital and long-term care facility professionals, other health care professionals and employers about the benefits of preventing adverse drug events through e-prescribing, and adopting information technology software that facilitates e-prescribing. Other measures shall be implemented to reduce medication errors for individuals enrolled in certain health systems and to control costs related to such errors through increased e-prescribing use by contracted health plans and providers. <b>Adopted 5-1-08</b></p>
AZ-O	<p><b>HB 2255</b> – Requires Board of Pharmacy to establish rules regarding pharmacy implementation or participation in a continuous quality assurance program addressing pharmacy medication errors. (Enacted 4-24-</p>		

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	07)		
AR	PSO - Arkansas Patient Safety Initiative		
CA	<p><b>SB 801</b>- Requires facilities to implement a formal plan to reduce medication-related errors. (Enacted 3/21/02)</p> <p><b>SB 1339</b>- Requires medication error reporting by pharmacies (Enacted 9/26/00)</p> <p>PSO – California Institute for Health Systems Performance</p>	<p><b>Mandatory reporting – Medical Errors –</b> Specific occurrences are required to be reported by designated health care facilities. The state reviews the reported event and determines if an onsite visit is warranted. (1972)</p> <p><b>CA Health and Safety Code Sec. 1339.63</b> Legislation in 2000 created a medication error reporting system. (2000 SB 1875) – Licensed facilities are required to adopt a formal plan to eliminate or substantially reduce medication errors.</p>	<p><b>2008 AB 2542</b> - States the intent of the legislature to enact legislation that would enhance patient safety. <b>PENDING</b></p> <p><b>2007 SB 158</b> - Requires the Department of Public Health to establish a health care infection surveillance, prevention, and control program. Further, the Department is required to require hospital staffing levels, as specified, for hospital infection surveillance, prevention, and control programs. Each hospital is also required to annually prepare a written report on the effectiveness of the hospital's infection surveillance, prevention, and control program. <b>PENDING</b></p>
CO	<p>Colorado Revised Statutes, sec. 25-1-124 Code of Colorado Regulations, Ch. 2, Sec.3.2</p> <p>PSO – Colorado Patient Safety Coalition</p> <p><b>EO 6</b> – Creates the Nurse Workforce and Patient Care Task Force to empower consumers of healthcare while improving patient safety and the quality of care provided in hospitals. (Issued 3/29/07)</p>	<p><b>Mandatory reporting - Medical Errors –</b> <b>CRS sec. 25-1-124</b> State -licensed health care facilities are required to report specific occurrences to the Department of Public Health and Environment. (2000)</p>	<p><b>2008 SB 188</b> - Creates the Pilot Program Implementation Committee to set forth guiding principles for the establishment of a pilot program for hospitals and their direct-care nursing staff to model professional nursing practice involvement in the decision-making and planning for patient care. <b>Signed by Governor 5-6-08</b></p> <p><b>2008 SJR 27</b> - States the resolve of the General Assembly to encourage efforts to ensure transparency in all transactions when physicians or other health care practitioners receive financial compensation for clinical decisions to prescribe certain medications; support the complete disclosure of information on all prescription medications that are available and the benefits of each option so that a physician and a patient can work together to make decisions about prescription medications; support efforts to examine the status of access to</p>

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			quality health care, including prescription medications; strongly support efforts to improve and publicize information about public and private health care and prescription drug programs that improve access for patients in need and include foreign language education and outreach programs, if necessary, to facilitate enrollment in those programs; and encourage these programs to be crafted in ways that best respond to the health care needs of all the communities within the state. <b>Adopted 5-5-08</b>
CT	<p><b>HB 5715</b>- Creates a quality of care program (Enacted 6/7/02) – Public Act No. 02-125</p> <p><b>HB 6941</b>- Requires hospitals to make available to the Commissioner of Public Health its plan for the remediation of medical and surgical errors. (Enacted 7/6/01)</p> <p><b>SB 566</b> – Establishes that any private or public organization may apply to the Dept. of Public Health to be designated as a patient safety organization. Providers may contract with a patient safety organization to conduct activities intended to improve patient safety. A patient safety organization must ensure confidentiality of the patient safety work product, which is defined in the bill. The bill also requires hospitals and outpatient surgical facilities to report adverse events to the Dept. of Public Health within 7 days. (Enacted 6/1/04)</p>	<p><b>Mandatory reporting – Medical Errors Public Act No. 02-125</b></p> <p>Adverse events are classified into four categories, Classes A-D. Hospitals and outpatient surgical facilities are required to report Classes A-C adverse events to the Department of Public Health within 24 hours of the occurrence and Class D events on a quarterly basis. Reports must include corrective action plans.</p>	<p><b>2008 HB 5539</b> - Establishes the Connecticut Health Quality Partnership to develop and implement a plan for the collection of administrative data from each health insurer licensed to operate in the state for the purpose of supporting quality improvement initiatives and enabling consumers to make better informed choices with respect to health care providers. <b>FAILED</b></p>
DE			
DC			
FL	<p>Fla. Stat. Ch. 395.0197 (2003) – Requires licensed facilities to have an internal risk management program that includes investigation and analysis of specific types of adverse incidents.</p> <p>PSO – Patient Safety Steering Committee</p>		
GA	<p>Georgia Rules 290-9-7-.07</p> <p>PSO - Partnership for Health &amp; Accountability</p>	<p><b>Voluntary reporting system</b></p>	<p><b>2007 HB 61</b> - Requires individual hospitals and ambulatory centers to collect data on hospital</p>

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			<p>acquired infection rates for certain categories of procedures, and for hospitals and ambulatory centers to submit quarterly reports to the Department of Human Resources. <b>FAILED</b></p> <p><b>2008 HR 1557</b> - Encourages physicians to take steps to ensure transparency when physicians or other health practitioners receive financial compensation for clinical decisions. Offers support for efforts to improve and publicize information on both public and private health care and prescription drug programs that can help improve access for patients in need, with these efforts to include foreign language education and outreach programs, if necessary, to facilitate enrollment in these programs. <b>FAILED</b></p> <p><b>2007 SB 150</b> - Creates a website for the purpose of providing consumers information on the cost and quality of health care in GA. Requires health care providers to provide patients with a copy of their medical records at least once per year at no cost, either electronically or print. <b>FAILED</b></p>
GU			
HI	<p><b>HCR 190/SCR 75</b>- Requests the Patient Safety Task force to submit a report of its efforts to reduce medical errors. (Passed both houses in April 2002)</p> <p><b>SB 2577</b> – Provides for confidentiality for the proceedings and records of health care review organizations and case review forums. (Enacted 5/5/04)</p> <p><b>HB 1253</b> - Allows individuals, corporations, and government entities to offer apologies or other expressions of sympathy without fear of such gestures being used against them to establish civil liability.</p>		

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	(Enacted 5/23/07)		
ID			
IL	<p><b>HB 4580</b> - Appropriates funds to maintain and improve patient safety and quality of care. (Enacted 6/28/02)</p> <p><b>HB 2345</b> - Created the Electronic Health Records Taskforce to create a plan for the development and utilization of electronic health records in the State in order to improve the quality of patient care, increase the efficiency of medical practice, improve safety, and reduce medical errors. (Enacted 8/22/05)</p> <p><b>SB 867</b> – Amends the Hospital Licensing Act to add a section regarding nurse staffing by acuity. (Enacted 8/24/07)</p>		
IN	<p><b>EO 5</b> - This order encourages health plans and providers to provide high quality care and patient safety by taking consistent actions to achieve the following goals: (1) support health information technology; (2) provide pricing information; and (3) promote quality and efficiency of care. (Issued 3/7/07)</p> <p><b>SB 207</b> - Requires a health care facility to file patient safety incident reports concerning certain acts that have caused or could have caused harm to a patient. (Enacted 5/2/07)</p>		
IA	<p>PSO – Patient Safety Advisory Committee</p> <p>Peer Review Reporting – Iowa Code 147.135(3)</p>		<p><b>2008 HB 2471</b> - Instructs the Department of Public Health to establish an initiative to address patient safety through the identification of medical errors if federal funding is received. The initiative shall also address the option of establishing a statewide billing policy for health care made necessary by preventable medical errors. <b>FAILED</b></p> <p><b>2008 HB 2485</b> – States a health care worker, who reasonably believes a particular practice the health care worker has observed occurring at</p>

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			<p>the health care worker's place of employment or at the health care entity where the worker is rendering health care services, based on the worker's professional standards of care, professional code of ethics, or established guidelines, is a material violation of health and safety laws or a breach of public safety that has caused serious harm to or creates a significant probability of serious harm to patients or health care recipients, may report the information within fourteen calendar days of its occurrence, in order that investigation can be undertaken and, if appropriate, corrective action be initiated. <b>FAILED</b></p> <p><b>2008 HB 2539</b> - Creates an electronic health information commission to promote the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals with comprehensive, real-time medical information to provide continuity of care and make the best health care decisions. <b>Signed by Governor 5-13-08</b></p>
KS	KSA 65-4923 (2002) Kansas Admin. Code, 25-52-1	<p><b>Mandatory reporting – Medical Errors</b> <b>KSA 65-4923 – Chapter 65, Article 49</b> Medical providers and employees of health care facilities are required to report an act by a health care provider that (1) is or may be below the applicable standard of care and has reasonable probability of causing injury to a patient or (2) may be grounds for disciplinary action by the appropriate licensing board.</p>	<p><b>2007 HB 2156</b> - States that a court may not admit into evidence a communication of sympathy that relates to a loss, an injury, pain, suffering, a death, or damage to property. However, an admission of fault, including a statement of fault that is part of a communication of sympathy, may be admitted. <b>FAILED</b></p> <p><b>2007 HB 2271</b> - Requires each health care provider to make available for public disclosure the health care provider's quality and</p>

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			<p>performance indicators for certain and common health or medical care services. <b>FAILED</b></p> <p><b>2008 HB 2846</b> - Requires certain medical facilities to establish a committee on the safe handling of patients. The committee shall design a program for the safe handling of patients at the facility to include policies regarding the use of lifting teams or lifting equipment, policies regarding the manual handling of patients, annual training in such procedures for employees on all shifts and in all units of the facility, and a policy that allows an employee of a facility to refuse to be involved in the handling of a patient. <b>FAILED</b></p>
KY	Reporting Actions Taken Against Licensed Physicians - KRS 311.606	<p><b>Mandatory Reporting</b> <b>KRS 311.606</b></p> <p>Contains requirements for professional medical associations and hospitals to report actions taken against a licensed physician to the medical board. Also requires clerks of the Circuit and District Courts to report all criminal convictions of licensees to the medical board.</p>	<p><b>2008 HB 602</b> - States that if a health care facility or service fails to respond, investigate, or take action, if appropriate, in a timely manner upon report of an agent or employee of the facility or service, the agent or employee may submit the report to the Office of Inspector General in the Cabinet for Health and Family Services. Provides for monetary penalties for a health care facility or service that violates the requirements of this section. <b>FAILED</b></p>
LA			<p><b>2008 SB 287</b> - Requires the Department of Health and Hospitals to identify and define the health care cost, quality, and performance data elements to be reported to the Department in accordance with existing national and international data standards for consumer's meaningful comparison of costs for specific health care services and specific quality of care measures between and among medical facilities and health care providers. <b>PENDING</b></p>
ME	<b>SB 419</b> - Establishes the Maine Health Care Quality Improvement Center and creates a mandatory reporting system for medical errors, events and incidents. It	<p><b>Mandatory reporting – Medical Errors</b> <b>MRSA - Title 22, Chapter 1684</b></p> <p>Legislation created the Maine Health Care</p>	

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	requires health care facilities to report medical errors, events and incidents within one business day of discovering the occurrence. (Enacted 4/11/02) – Me. Rev. Stat. Ann. Title 22, 8753	Quality Improvement Center under the Department of Health and Welfare and requires Health care facilities to report medical errors, Events, and incidents to the Department of Health by the next business day after the occurrence is discovered. The Center will use sentinel event reports to conduct research and analyze data, and create a clearinghouse to educate the public and health care providers on how to reduce medical errors and improve patient safety. (2002 – SB 419)	
MD	<p><b>HB 1274-</b> Requires the Maryland Health Care Commission to study the feasibility of developing a system for reducing the incidences of preventable adverse medical events including a system of reporting incidents. (Enacted 2001)</p> <p><b>MD Code, Health Occupations, Section 14-413</b></p> <p><b>PSO – Maryland Patient Safety Coalition</b></p>		
MA	<p><b>Medical Malpractice Reform Act of 1986 -</b> Mandated the Board of Registration in Medicine’s Patient Care Assessment (PCA) function.</p> <p><b>M.G.L. Chapter 112, Section 5</b> – Provides that the Board of Registration in Medicine establish a risk management unit to provide technical assistance and quality assurance programs designed to reduce or stabilize the frequency, amount, and costs of claims against physicians and hospitals licensed or registered in the commonwealth. Requires board to promulgate regulations requiring physician participation in the risk management programs as a condition of licensure.</p> <p><b>M.G.L. Chapter 111, Section 203 (d)</b> - Requires every licensed hospital, as a condition of licensure, and every public hospital to participate in risk management programs established by the Board of Registration in</p>	<p><b>Board of Registration in Medicine Regulations 243 CMR 3.00 – 3.16</b> – Specify in detail the requirements of the patient safety and adverse event reporting systems. The Patient Care Assessment function is responsible for the oversight of institutional systems of quality assurance, risk management, peer review, utilization review, and credentialing.</p>	<p><b>2007 HB 1370 (SB 987)</b> - States that in any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding and shall not constitute an admission of liability or an admission against interest. <b>PENDING</b></p>

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	<p>Medicine.</p> <p><b>M.G.L. Chapter 111, Sections 204 and 205;</b>  <b>243 CMR 3.04 –</b>                      Provides that PCA information is confidential and not subject to subpoena, discovery or introduction into evidence.</p> <p><b>HB 4800-</b> Established the Betsy Lehman Center for Patient Safety and Medical Error Reduction. The center will coordinate the efforts of state agencies and those individuals or institutions licenses to provide health care to meet their responsibilities for patient safety and medical error reduction; assist health care providers, including institutions, to work as part of a total system of patient safety; develop and administer a patient safety and medical error reduction education and research program; and develop appropriate mechanisms for consumers to include in a statewide program for improving patient safety. The center will coordinate state participation in any appropriate state or federal reports or data collection efforts relative to patient safety and medical error reduction. The center will also analyze available data, research and reports for information that would improve education and training programs that promote patient safety. (Enacted 2001) <b>M.G.L. Chapter 6, Section 16E.</b></p> <p><b>PSO – Massachusetts Coalition for the Prevention of Medical Errors</b></p>		<p><b>2007 HB 2072 (SB 1271)</b> - A hospital shall report each never event occurrence listed in regulations to the Betsy Lehman Center for Patient Safety and Medical Error Reduction, the Department of Public Health, the Board of Registration in Medicine's Patient Care Assessment division, and the Health Care Quality and Cost Council, as soon as is reasonably and practically possible, but no later than 15 working days after discovery of the never event. Any licensed hospital in the Commonwealth, which does not comply with this section and the rules and regulation set forth by the department may have its license revoked or suspended by said department, be fined up to \$1,000 per day per violation, or both.  <b>REPLACED BY SB 2517</b></p> <p><b>2007 HB 2226 (SB 1277)</b> - Requires a health care provider who reasonably believes that an adverse event has occurred shall report the adverse event to the management of the facility where the event occurred unless the health care provider knows that a report has already been made. <b>REPLACED BY SB 2517</b></p> <p><b>2008 HB 4700</b> - Appropriates the budget for the Division of Health Care Quality and requires the Division to coordinate its work with the Board of Registration in Medicine and the various other boards of registration under the Department of Public Health to promote quality patient care in licensed facilities, and to report specific instances of preventable medical error that involve an individualized component investigated by the Board of Registration, and ways in which coordination promotes quality patient care, fairness and accuracy in</p>

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			<p>disciplinary actions, and better provider and facility education. <b>REPLACED</b></p> <p><b>2007 SB 419</b> - Requires the Betsy Lehman center for patient safety and medical error reduction, to convene a task force, which shall develop recommendations on methods for reducing medication and prescription errors including recommendations on: (1) increasing prescription legibility; (2) minimizing confusion in prescription drug labeling and packaging; (3) developing medication error reporting plans; (4) researching the effect of proven medication safety practices, including the use of automated drug-ordering systems; (5) reducing confusion created by similar-sounding drug names; (6) increasing patient education on the medications they are prescribed; (7) developing education programs for any person who writes prescriptions and reviewing the education programs for new practitioners and the continuing education requirements of established practitioners, including, but not limited to, programs offered to practitioners to educate them on the cost effective therapeutic alternatives to prescriptions; and (8) studying the issue of whether any dispensed prescription medication, other than those in unit dose or unit of use packaging, shall be labeled with its physical description, including, but not limited to, color, shape and any identification code that may appear on tablets and capsules. <b>PENDING</b></p> <p><b>2007 SB 1246</b> - Directs a hospital within 24 hours of instituting any disciplinary action against any physician providing services within the hospital or becoming aware of any disciplinary action taken by the hospital or by</p>

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			<p>any subsidiary of the hospital or any physician group contracting to provide services within the hospital against any physician providing services within the hospital, shall notify all patients being cared for by that physician within that hospital. <b>PENDING</b></p> <p><b>2007 SB 1264</b> - Calls for the establishment within the Executive Office of Health and Human Services, a special commission to investigate and make recommendations on the establishment of performance standards for physicians that will improve patient outcomes and the means of measuring professional performance. <b>PENDING</b></p> <p><b>2007 SB 1284</b> - Encourages health professionals to apologize for medical mistakes and states that any statement of apology shall be exempt from public disclosure, subpoena or discovery. <b>REPLACED BY SB 2517</b></p> <p><b>2008 SB 2517</b> - Promotes healthcare transparency and consumer-provider partnerships. Also states that in an action for malpractice, negligence, error, omission, mistake, or the unauthorized rendering of professional services against a provider of health care, statements or writings by such provider of health care expressing apology or sympathy relating to the pain, suffering or death of a person that is not the result of intentional misconduct by such provider of health care and made to such person or to the family of such person shall be inadmissible as evidence in such action. <b>PENDING</b></p> <p><b>2008 SB 2526</b> - Establishes the Health Care</p>

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			<p>Quality and Cost Council to promote public transparency of the quality and cost of health care and to establish health care quality improvement and cost containment goals designed to promote high-quality, safe, effective, timely, efficient, equitable and patient-centered health care. <b>REPLACED</b></p> <p><b>2008 SB 2650</b> - Establishes the Health Care Quality and Cost Council to promote public transparency of the quality and cost of health care and to establish health care quality improvement and cost containment goals. The secretary of Health and Human Services shall adopt regulations to create a list of serious reportable events consistent with the list established by the National Quality Forum. Establishes an Institute for Health Care Innovation, Technology and Competitiveness to transform care delivery and the utilization of care process redesign supported by a statewide, interoperable electronic health records system in order to improve patient safety and quality. States that no pharmaceutical manufacturer agent shall knowingly and willfully offer or give to a physician a gift of any value. A person who violates this chapter shall be punished by a fine of not more than \$5,000. <b>REPLACED</b></p> <p><b>2008 SB 2660</b> - Establishes the Health Care Quality and Cost Council to promote public transparency of the quality and cost of health care and to establish health care quality improvement and cost containment goals. The secretary of Health and Human Services shall adopt regulations to create a list of serious reportable events consistent with the list established by the National Quality Forum.</p>

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			Establishes the Institute for Health Care Innovation, Technology and Competitiveness to transform care delivery and the utilization of care process redesign supported by a statewide, interoperable electronic health records system in order to improve patient safety and quality, and to lower costs. <b>PENDING</b>
MI	<p><b>HB 5260-</b> Requires the establishment of an electronic monitoring system to monitor the dispensing of Schedules II-V controlled substances. (Enacted 1/03/02)</p> <p><b>PSO – Michigan Health and Safety Coalition</b></p>		
MN	<p>Minnesota Statutes, Sec. 144.706 et seq.</p> <p><b>SB 4a-</b> Directs the Commissioner of Health to conduct a patient care and safety study. (Enacted 6/29/01)</p> <p><b>MN SB 1019 --</b> Establishes a medical error reporting system for health care facilities. Facilities must report to the Commissioner of Health within 15 days of an adverse incident. The bill lays out what events are required to be reported. (Enacted 5-27-03)</p> <p><b>MN SB 2365 -</b> Modifies the reporting system under the Minnesota Adverse Health Care Events Reporting Act of 2003. Expands the exclusion of maltreatment of vulnerable adults from adverse health events to maltreatment of minors and to neglect under both the minors or vulnerable adults maltreatment reporting acts; modifies certain investigation requirements and classifying certain data; requires certain additional reports from the health related licensing boards; exempts members and employees of the boards of medical practice, chiropractic examiners, pharmacy and podiatric medicine from liability for making certain reports or for maintaining certain records, requires the boards to maintain records of events qualifying as adverse health</p>	<p><b>Mandatory Reporting - Medical Errors</b> Reporting system requires hospitals to report a list of 27 significant events or incidents to a system mandated by the Commissioner of Health and operated by the MN Hospital Association. Commissioner must analyze adverse event reports, corrective action plans, and findings of the root cause analysis and communicate recommendations to health care facilities and publish an annual report. (2003 – SB 1019)</p>	<p><b>2007 HB 2343 -</b> States that in any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to that civil action, statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as a result of the unanticipated outcome of medical care is inadmissible as evidence of an admission of liability or as evidence of an admission against interest or as an excited utterance. <b>FAILED</b></p>

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	<p>care events and to forward the reports to the commissioner of health; modifies the notice requirement of the commissioner relating to implementation of the +reporting system . (Enacted 5-11-04)</p> <p><b>PSO – Minnesota Alliance for Patient Safety</b></p>		
MS			<p><b>2008 SB 2091</b> - Enacts the Mississippi Patient Safety Act to develop a patient safety program for hospitals, ambulatory surgical centers, and mental hospitals. An annual report shall be made available to the public with a summary of the events reported under this act. <b>FAILED</b></p>
MO	<p><b>RSMO – Section 383.133</b>  <b>MO EO 6</b> – By means of an Executive Order the Governor created the Missouri Commission on Patient Safety to study and recommend legislative, administrative, clinical, behavioral, and technological measures to improve medical outcomes, prevent errors, upgrade healthcare delivery, and improve education of medical providers and patients with the goal of reducing the incidence of preventable medical errors and reducing the number of medical malpractice claims. The Commission is assigned to the Missouri Dept. of Insurance and is directed to report recommendations to the Governor by July 1, 2004. <b>Issued 2-3-04.</b></p>		<p><b>2008 HB 1816</b> - States that no supervisor or individual with authority to hire, fire, or discipline in a hospital or ambulatory surgical center shall retaliate or otherwise take any adverse action against an employee based on his or her protected activity, or in any manner attempt to dissuade, prevent, or interfere with an employee who wishes to engage in protected activity. Protected activities include the reporting or disclosure of any information related to alleged facility mismanagement, fraudulent activity, or billing errors, or unethical, immoral, or illegal business practices; alleged violations of federal or state laws or regulations regarding patient care, patient safety, or facility safety; or alleged violations of professional standards of conduct or accepted standards of quality patient care; or the ability of employees to perform their assigned duties consistent with professional standards of conduct or accepted standards of quality patient care. <b>FAILED</b></p> <p><b>2008 HB 2450</b> - Requires as a part of each</p>

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			<p>hospital's quality assurance and quality improvement program, every hospital shall create a nursing advisory board to establish a standardized acuity-based patient classification system for each individual direct-care unit in the hospital. <b>FAILED</b></p> <p><b>2008 SB 1216</b> - Requires the Department of Health and Senior Services to implement a health care quality program for the purpose of making available a health care quality report card to allow consumers to compare and assess the quality of health care services. <b>FAILED</b></p> <p><b>2008 SB 1264</b> - Establishes the Patient Safety Authority to, among other duties, contract with an entity or entities to collect, analyze and evaluate data regarding reports of serious events and incidents regarding patient care, to transmit to the authority recommendations for changes in health care practices and procedures that may be instituted for the purpose of reducing the number and severity of serious events and incidents, and to directly advise reporting medical facilities of immediate changes that can be instituted to reduce serious events and incidents. <b>FAILED</b></p>
MT	HB 254 - Makes writing illegible prescriptions a civil offense. (Enacted 4/28/05)		
NE	NRS 71-168.02 requires facilities licensed under the Health Facility Licensure Act to report when the facility has made payment due to adverse judgment, settlement or award of a professional liability claim against it or a licensee and when the facility takes action adversely affecting the privileges of a licensee due to alleged incompetence, professional negligence, unprofessional conduct or physical or chemical impairment.	<p><b>Mandatory reporting</b>            Title 172, Chapter 5; Mandatory Reporting by Health Care Professionals, Facilities, Peer and Professional Organizations, and Insurers            Establishes mandatory requirements for self-reports by a health care professional; reporting within a health care profession; reporting between health care professions; reporting by peer review organizations and professional</p>	

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	<p><b>LB 373</b> - States any and all statements, affirmations, gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, which are made by a health care provider to the alleged victim or victim's family of unanticipated health care outcomes, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. (Enacted 5/21/07)</p>	<p>associations; and reporting by insurers</p>	
NV	<p>Nev. Rev. Stat. Ann. 439.835 (2003)</p> <p><b>ACR 7</b>-Studying the development of a system for reporting medical errors. (Adopted 5/9/01)</p>	<p><b>Mandatory Reporting – Medical Errors</b>                      Legislation requires employees of a medical facility to notify a designated patient safety officer of any sentinel events that occur in the facility within 24 hours. Such events must then be reported to the Repository for Health Care Quality within the Health Division. The repository will function as a clearinghouse of information relating to aggregated trends of sentinel events. (AB 1 – 2002)</p>	
NH	<p><b>HB 396</b>- Encourages physician practices to improve quality of care through quality assurance programs. (Enacted 6/26/01)</p>	<p><b>Mandatory reporting</b>                      The Board of Medicine has formulated written guidelines for what actions must be reported to the Board under <b>RSA 151-6-b</b>. They include reduction, restriction, suspension, revocation, termination or denial of clinical privileges or medical staff appointment or employment unless the change was voluntary because of the licensee's desire to limit practice, but not as a result of a past clinical quality of care issue. Behavior incompatible with the role of a Physician including illegal, immoral or unethical behavior shall also be reported.</p>	
NJ	<p>New Jersey Regulations NJAC 8:43G-5.6</p>	<p><b>Mandatory reporting</b></p>	
NM		<p><b>Voluntary reporting system</b></p>	
NY	<p>New York PHL, Sec. 2805(1)                      New York Code of Rules and Regulations Title 10, Section 405</p> <p><b>SB 8127</b>- Patient Health Information and Quality</p>	<p><b>Mandatory reporting</b>                      Hospitals are required to report any unintended adverse and undesirable development in an individual patient's condition. A list of 47 occurrences are included in the list of reportable</p>	<p><b>2007 AB 3790</b> - Requires a health care provider to disclose to his or her patient or patient's representative any error in diagnosis, treatment, or other service by the health care provider that the provider knows has caused substantial harm</p>

## Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	<p>Improvement Act of 2000. The bill established a patient safety center within the Department of Health in order to maximize patient safety, reduce medical errors and improve the quality of health care by improving public access to health care information. The Center will collect information on medical error reduction and establish goals and best practices. (Enacted 10/6/00)</p>	<p>events.</p>	<p>or significant risk of substantial harm to the patient. A health care provider shall not be liable for failure to disclose an error, harm or risk of harm if the provider reasonably believes that another health care provider has already made such disclosure. <b>PENDING</b></p> <p><b>2007 AB 4963 (SB 2810)</b> - Requires the Commissioner of Health to develop and implement a system for color-coding standardization of patient wristbands of medical safety conditions for use in all health care facilities. <b>PENDING</b></p> <p><b>2007 AB 5196 (SB 1267)</b> - Requires certain health facilities to disclose to the public information regarding nurse staffing and patient outcomes. <b>PENDING</b></p> <p><b>2007 AB 5525</b> - Requires the Commissioner of Health to make regulations to establish and ensure safe staffing standards for all health care facilities that apply only to registered professional nurses, licensed practical nurses and assistive nursing personnel. <b>PENDING</b></p> <p><b>2007 AB 7899</b> - Establishes the Consumer Assistance Unit on Professional Medical Conduct to act as a liaison for consumers to assist them in dealing with the Office of Professional Medical Conduct. Requires the Office of Professional Medical Conduct to conduct a professional misconduct investigation of a provider upon receipt of a certain number of reports of incidents within specified time limits. Further, medical experts in cases referred to an investigation committee involving issues of clinical practice must be qualified by</p>

### Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
			<p>sufficient training or experience to render an opinion on the matter at issue. Further, a health care provider is required to disclose to a patient any error in diagnosis, treatment or other service by the provider that the provider knows has caused substantial harm or significant risk of substantial harm to the patient. <b>PENDING</b></p> <p><b>2007 AB 8106 (SB 5648)</b> - Encourages cooperative, collaborative and integrative arrangements among general hospitals, among physicians, and among general hospitals and physicians involving clinical integration in order to seek improvements and efficiencies in health care and reduce medical errors. <b>PENDING</b></p> <p><b>2008 SB 8087</b> - Establishes a physician performance measurement reporting program to improve patient outcomes and enhance physician performance through a standardized approach for evaluating the quality and cost-effectiveness of physician services provided through health insurance entities based upon an aggregation and validation of data collected from health insurance entities. <b>PENDING</b></p>
NC	<p><b>NCGS 90-14.13</b> – Requires hospitals, HMOs, and other health care institutions to report to the Board any revocation, suspension, or limitation of a physician’s privileges. Insurance companies are required to report any award for damages or any settlement of any malpractice complaint affecting a physician within 30 days of the award or settlement.</p> <p><b>HB 1738</b> – Establishes the Advisory Commission on Hospital Infection Control and Disclosure. (Enacted 8/29/07)</p>	<b>Mandatory reporting of certain actions or events</b>	
ND	<b>HB 1333</b> - Provides that expressions of empathy by health care providers are inadmissible in a civil action,		

### Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	arbitration proceeding, or administrative hearing regarding the health care provider. (Enacted 3/2/07)		
NMI			
OH	OH Dept. of Health Reporting Requirements, Rev. Code Sec. 3702.11 OH Administrative Code Chapter 3701-84  <b>PSO – Ohio Patient Safety Institute</b>	<b>Mandatory reporting</b>	
OK			<b>2008 HB 3169</b> - Requires the Department of Health to promulgate rules requiring hospitals to use established public health surveillance methods to maintain a program of identifying and tracking certain types of hospital-acquired infections. The Department shall establish a statewide database of all risk-adjusted, hospital-specific infection rates and make it available to the public on a website and in printed materials that can be used to compare the performance of individual hospitals, and the aggregate performance of hospitals in the state with those in other states and nationwide. <b>FAILED</b>
OR	<b>HB 2349</b> – Creates the Oregon Patient Safety Commission. The Commission is required to establish a voluntary adverse event reporting system that will gather data and analyze that data to identify quality improvement techniques and best practices that will reduce systems errors that contribute to patient harm and to disseminate that information. The Commission must create incentives to encourage participation in the reporting program. (Enacted 8-14-03). - <b>ORS 677.415</b>	<b>Voluntary reporting – Medical Errors</b> Voluntary reporting system created by the Oregon Patient Safety Commission to receive voluntarily reports of serious adverse events, root cause analyses of such events, and action plans established to prevent similar events. (2003- HB 2349)	
PA	Pa. Stat. Ann. Title 40, 1303.308 (2003) Pa. Stat. Ann. Title 40, 1303.313  <b>HB 1802</b> - Creates the Patient Safety Authority. The Authority will be responsible for contracting with an organization to collect, analyze and evaluate data regarding reports of serious events and incidents, including identifying patterns. (Enacted 3/20/02)	<b>Mandatory reporting – Medical Errors</b> A Patient Safety Authority was created to receive mandated reports, from hospitals, birthing centers and ambulatory surgical facilities, of serious events (occurrences that are undesirable and result in injury that requires additional medical care) and incidents (occurrences that are undesirable that could have resulted in injury).	<b>2007 HB 353</b> - Enacts the Adverse Health Care Events Reporting Act to require health facilities to report adverse health care events to the Department of Health as soon as is reasonably and practically possible but no later than fifteen working days after discovery of the event. <b>PENDING</b>

## Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	<p><b>PSO – Pennsylvania Patient Safety Collaborative</b></p> <p><b>SB 968</b> – Amends the Medical Care Availability and Reduction of Error Act to require health care facilities to develop an infection control plan. (Enacted 7/20/07)</p>	<p>Anonymous reports are permitted. Authority must collect, analyze, and evaluate reported data. (HB 1802 – 2002)</p>	<p><b>2007 HB 742 (SB 217)</b> - Enhances patient safety by establishing meaningful whistleblower protection and a reporting system for medical errors which is responsive to legitimate concerns. <b>PENDING</b></p> <p><b>2007 HB 1010</b> - Amends the Medical Care Availability and Reduction of Error (Mcare) Act by adding a section on patients' visitation rights. It authorizes the right of a patient to designate individuals as visitors so that these designees may accompany the patient while the patient is receiving treatment from a health care provider. <b>PENDING</b></p> <p><b>2007 HB 1552</b> - Establishes the Infection Control Advisory Committee to encourage cooperation among federal, state and local agencies, academic institutions and the private sector to assist in improving best practices and promoting those practices and programs that reduce or eliminate health care-associated infections; to serve as a forum for presenting information and studying programs being used within the state; to develop recommendations regarding best practices to effectuate screenings of high-risk patients; to identify financial and technological needs of health care facilities; to develop recommendations on how best to implement an outreach process that includes notifying a receiving health care facility of any patient known to be colonized prior to transfer to another facility; to develop recommendations regarding evidence-based screening protocols of patients and residents for MDROO upon admission and randomized screening of inpatients and residents for MDROO after admission; to recommend a process for</p>

### Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
			<p>establishing benchmarks based upon a uniform database that identifies and quantifies health care-associated infections; to provide recommendations to the department on the distribution of any available funds to collaboratives; to issue reports on health care facility infection control and prevention; and to develop annual infection control and prevention priorities. <b>PENDING</b></p> <p><b>2007 SB 12</b> - States the State Board of Medicine shall not approve for accreditation any graduate medical education program that does not require a minimum of six hours of patient safety training. Also states Board of Medicine may utilize a program similar to the impaired professional program through which a licensee may be referred for a clinical skills assessment to improve clinical skills or address any clinical skills deficiencies. <b>PENDING</b></p>
PR			
RI	<p>Rhode Island Statutes, Section 23-17-40</p> <p><b>SB 2675</b>- Requires hospitals to report adverse events as a condition of licensure. (Enacted 6/28/02)</p>	<p><b>Mandatory reporting – Medical Errors</b> Hospitals are required to report a list of events that are not expected or probable that result in extended hospital stay or death of the patient. (2002 SB 2675)</p>	<p><b>2008 HB 7099</b> - States that statements, writings or benevolent gestures of a health care provider made to a patient or to the family of such patient expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of such patient in connection with or relating to the patient’s condition or the outcome of such patient’s medical care and treatment are inadmissible as evidence of an admission of liability in a civil action against a health care provider. <b>FAILED</b></p> <p><b>2008 HB 7465</b> - Creates a health care quality and value database designed to make available to consumers transparent health care price information, quality information, and such other information as the director determines is</p>

### Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
			<p>necessary to empower individuals to make economically sound and medically appropriate decisions. <b>PENDING</b></p> <p><b>2008 HB 7561 (SB 2474)</b> - Enacts the Patient Safety Act of 2008 to promote patient safety, reduce patient safety events, and encourage better reporting of patient safety events and related incidents by requiring entities to contract with a certified Patient Safety Organization. <b>HB 7561 PENDING, SB 2474 FAILED</b></p> <p><b>2008 SB 2280</b> - Creates the Patient Safety and Medical Error Reduction Act to require each hospital in the state to participate in a comprehensive program to improve patient safety and reduce medical errors in that hospital. <b>FAILED</b></p> <p><b>2008 SB 2677</b> - Enacts the Patient Safety and Quality Improvement Act of 2008 to promote patient safety, reduce patient safety events, and encourage better reporting of patient safety events and related incidents. <b>PENDING</b></p>
SC	SC Code of Regulations, No. 61-16	<b>Mandatory reporting</b>	<b>2007 HB 3912</b> - States that if a physician makes a medical error or knows about or witnesses a medical error committed by another physician that results in great bodily injury or death, the physician shall report the medical error to the Board. <b>FAILED</b>
SD	Administrative Rules of SD 44:04:01:07 <b>SB 55-</b> Medication Error Reporting (Enacted 3/3/00)	<b>Mandatory reporting</b> All licensed health care facilities are required to report specific occurrences to the State Health Department.  Medication error reporting system (2000 SB 55)	
TN	Tennessee Rules Chapter 1200-8-1. SB2316	<b>Mandatory reporting – Medical Errors</b> Legislation requires health facilities to report a	<b>2007 HB 1334 (SB 1347)</b> - Establishes the Sorry Works! Pilot Program to require

### Medical Error and Patient Safety Legislative Activity by State

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	<p><b>SB 2316-</b> Requires health facilities to report unusual or adverse events to the Department of Health within 7 business days (Enacted 3/19/02)</p> <p><b>PSO – Tennessee Improving Patient Safety</b></p>	<p>list of unusual events to the Department of Health within seven business days. Facilities are also required to submit a corrective action plan. (2002 SB 2316)</p>	<p>participating hospitals and physicians to promptly disclose and identify, acknowledge and apologize for mistakes in patient care and promptly offer fair settlements. <b>FAILED</b></p>
TX	<p>TX Health and Safety Code Sec. 241.201-241.210 (2003)</p> <p>The Texas Board adopted rules in <b>April 2004</b> that require hospitals and ambulatory surgical centers to establish patient safety programs. The program must define medical errors, adverse events, and reportable events. Specific events must be reported, including: medication errors; suicide of a patient; abduction of a patient; sexual assault of a patient; blood transfusion reaction in a patient; surgical procedure on the wrong patient or on the patient’s wrong body part; patient death or serious disability; and a foreign object left in a patient during a procedure.</p> <p><b>PSO – Texas Patient Safety Alliance</b></p>	<p><b>Mandatory hospital reporting</b></p>	
UT	<p>UT Division of Administrative Rules, R380-200</p> <p><b>PSO – Utah Patient Safety Consortium</b></p>	<p><b>Mandatory Reporting</b></p>	
VT			
VA	<p><b>SB 316-</b> Related to civil immunity, privileged communications, and confidentiality of patient safety data. (Enacted 4/6/02)</p> <p><b>HB 2763-</b> Requires other entities (in addition to hospitals) to report certain health care data. (Enacted 3/19/01)</p> <p><b>PSO – Virginians Improving Patient Care and Safety (VIPCS)</b></p>		
VI			
WA	<p>Washington Administrative Code, Section 246-320-145</p>	<p><b>Mandatory hospital reporting</b></p>	<p><b>2008 HB 2670</b> - Requires medical facilities to submit a report to the Department of Health</p>

## Medical Error and Patient Safety Legislative Activity by State

STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	<b>HB 2798</b> - requires the Department of Health, consulting with the Board of Pharmacy and professional licensing boards, to develop recommendations on ways to reduce medication errors. Among other provisions the law requires a medication error reporting system and improve prescription drug labeling to reduce mistakes. (Enacted 3/17/00)	Legislation in 2000 required the Department of Health to develop recommendations on ways to Reduce medication errors. Creates a medical error reporting system.	submit a report to the Department of Health when it confirms that an adverse event has occurred, with notification of the event occurring within forty-eight hours, and a report of the event within forty-five days. The Department shall make available to the public the notification of adverse events. <b>FAILED</b>
WV	<b>HB 2506</b> - Whistleblower protection (4/30/01)		
WI	<b>PSO – Wisconsin Patient Safety Institute</b>		<b>2007 AB 53</b> - Establishes that a statement or gesture of a health care provider, or a health care provider's employee or agent, that expresses apology, benevolence, compassion, condolence, or sympathy to a patient or to his or her relative or representative is not admissible into evidence or subject to discovery in any civil action or administrative hearing regarding the health care provider as evidence of liability or as an admission against interest. <b>FAILED</b>
WY		<b>Voluntary reporting system</b>	
<b>Federal</b>	SB 544 - The "Patient Safety and Quality Improvement Act of 2005" establishes a voluntary and confidential reporting system in support of initiatives to reduce preventable medical errors. (Enacted 7/29/05)		