2025 ANNUAL REPORT

Betsy Lehman Center for Patient Safety

APRIL 2026

BETSY LEHMAN CENTER
for Patient Safety

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About the Betsy Lehman Center

The Betsy Lehman Center is an independent state agency that catalyzes the efforts of providers, patients and policymakers working together to advance the safety and quality of health care in all settings.

Established by Chapter 224 of the Acts of 2012, the Center's mandate includes coordinating system-wide patient safety initiatives and conducting a program of research, data analysis, and education aimed at reducing preventable patient harm, and reporting on the Commonwealth's safety improvement progress.

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The *Roadmap to Health Care Safety*

Patient harm events remain frequent, harmful and costly. Today, almost one in four Massachusetts patients will experience at least one harm event during a hospital admission.[1] But preventable patient harm happens in all settings where health care is delivered.[2,3] Most of these events happen in routine care, with consequences that range from relatively minor to catastrophic. The *Roadmap to Health Care Safety* aims to overcome the barriers to change that have stood in the way of progress for decades – most notably, the lack of timely, reliable data.

The *Roadmap to Health Care Safety for Massachusetts* is a first-in-the-nation strategic plan to propel investment, action and transformative change across the Commonwealth's health care continuum. Its goals, strategies, and action steps are aligned with three dimensions of change: inform, incentivize, and implement.

The *Roadmap* guides the Betsy Lehman Center's everyday work and key initiatives – look for these icons throughout the report to see how each initiative relates to the theory of change.

INFORM

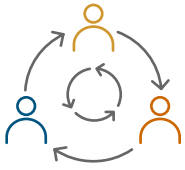
Build essential awareness, knowledge, and skills to enable everyone to recognize and fulfill their roles in health care safety

INCENTIVIZE

Motivate everyone to prioritize and invest in safety improvement with particular focus on those in leadership roles.

IMPLEMENT

Provide tools, peer learning opportunities, and other resources to support provider organizations in advancing safety



Massachusetts Health Care Safety and Quality Consortium

The *Roadmap* was developed by the Massachusetts Health Care Safety and Quality Consortium. The Consortium, convened by the Betsy Lehman Center in 2019, is an unprecedented public-private undertaking. It recognizes the potential for major breakthroughs in reducing preventable harm through a sustained multi-stakeholder effort to drive transformative, systemic change. It draws upon the deep expertise of the Commonwealth's health care community, bringing together over 35 organizations, including providers, patients, government agencies, and others, that play a role in the delivery, payment, or oversight of health care.

Patient harm in Massachusetts

Most information about patient safety outcomes comes from disparate state and federal data sources. The patchwork nature of these data systems prevents detailed analyses of statewide and facility-level rates and trends of preventable harm to patients. However, recent research findings allow us to estimate the incidence and cost of medical harm in Massachusetts hospitals.

Systemwide incidence & costs of medical harm

In 2019, the Betsy Lehman Center released its first report on the human and financial costs of medical error in Massachusetts, which found high rates of preventable patient harm across the health care continuum.[4] Since then, other Massachusetts-based research has found that, in hospitals, about one in four patients experience harm during their admissions.[5]

These findings allow the Center to calculate the annual cost of harm in Massachusetts hospitals with a high degree of confidence. In May 2025, it released an updated analysis that estimates 179,478 patients experience at least one harm event during their hospitalizations, resulting in $2.14 billion in excess claims for additional care necessitated by the harm.[6]

Missing from this analysis are the financial costs of harm to patients and families from lost wages and added living expenses. Also missing are costs that hospitals absorb, mainly in the form of lost revenues from extended stays for which they are not reimbursed under their health plan contracts.

Beyond the financial costs, big numbers mean other big system impacts. Preventable adverse events extend a patient's hospital length of stay by 6.6 days on average.[7] This slows patient throughput, increasing pressure on crowded emergency departments and scarce post-acute care services.

Although this analysis is limited to hospitals, patient harm events happen in all settings. Another Massachusetts-based study found adverse events in 7% of outpatient encounters.[8] Survey data from our 2019 report found 44% of errors happened outside of a hospital in settings like doctor's offices, pharmacies, dentists and nursing homes.[9]

Regardless of where they occur, harm events levy an array of human costs – including burnout and attrition among the health care workforce, and loss of trust and health care avoidance by patients. Our research finds that 57% of patients who experienced an error 3-6 years ago still avoid the doctor and facility where the event happened, and 37% avoid health care all together.[10]

179,478
harm events in hospitals

x $11,946
average cost per harm event

$2.14 billion
in excess claims

Facility-level reportable events

Most of what we know about patient harm events in individual Massachusetts health care facilities comes from mandated reporting of Serious Reportable Events (SREs). Hospitals and ambulatory surgery centers are required to report SREs to the Massachusetts Department of Public Health (DPH). This includes 27 so-called "never events," recognized nationally as events that are preventable. DPH shares the reports with the Betsy Lehman Center, and has made aggregated facility-level data available to the public online for the years 2015-2022.

In 2024, the most recent full year for which we have data, the Betsy Lehman Center received 1,706 SRE reports from DPH, all of which were from hospitals. Underreporting of patient harm events reflects and perpetuates low awareness and overconfidence — both of which are barriers to investment in the kinds of interventions that are needed to drive improvement in safety. In 2025, the Betsy Lehman Center partnered with DPH and the Massachusetts Association of Ambulatory Surgical Centers to raise awareness of reporting requirements in ASCs through conference presentations, webinars, and dissemination of informational resources to support safety event reporting and improvement.

The examples below are drawn from recent hospital SRE reports.

A patient died after a concerning glucose result was not escalated.

Confusing color-coded treatment sheets led to refractive lenses being placed in opposite eyes. An additional surgery was needed to correct the error.

A bladder biopsy specimen for cancer evaluation was lost. Production pressures and a cluttered operating room led staff to believe it was inadvertently discarded.

A child received an incorrect ketamine dose after his ID band was removed, leading to overnight hospitalization.

The limitations of safety outcomes data

State and federal reporting systems only reveal a small fraction of patient safety events. This is for three reasons: reporting is only required for a narrow scope of events; reporting is required of only certain health care settings; and facilities rely on frontline staff to identify and report events.

Manual reporting systems require frontline staff to "see something, then say something" by submitting reports of harms events and "near misses" through the facility's incident reporting system. But most staff do not "see" most safety events, often attributing patient harm to common complications of care, patient history, or other factors. Racial and other biases in event reporting have also been documented, with staff less likely to recognize or report on harm when the patient is a member of a minoritized group.[11] And when they are aware of a reportable event, some may fear the consequences of "saying" anything about it.

To explore state and federal patient safety reporting requirements, visit the Betsy Lehman Center's Patient Safety Navigator.

Priority *Roadmap* action steps

The *Roadmap to Health Care Safety* guides the Betsy Lehman Center's work and priorities. Since it was released, the Center has launched and made significant progress on three initial actions steps that were identified as foundational, high-yield activities.

Automated adverse event monitoring

The *Roadmap* calls for providers to have systems in place that enable leaders, managers, clinicians and staff to identify safety issues and resolve problems. But traditional methods for detecting harm events fail to capture more than a very small fraction of these events.[12]

Automated adverse event monitoring (AAEM) is a new technology-enabled approach that continuously scans every patient's EHR chart to detect preventable harm events in near-real time, allowing hospitals to respond and prevent future harm. Several hundred early-adopter hospitals outside of Massachusetts are finding 10 times more harm events than they were aware of before AAEM. They are reducing harm by an average of 25% – saving lives and reducing costs, with a high ROI.

The Betsy Lehman Center's FY26 budget included $895,450 in initial funding for the AAEM pilot. The Center is working with Pascal Metrics Inc., a pioneer in AAEM, to pilot this in a diverse cohort of Massachusetts hospitals. For the first time, findings will be published to provide visibility into real-world patient safety outcomes. This will set up the potential for statewide implementation in hospitals and future expansion to other care settings.

Beyond reducing harm and its associated costs, AAEM can:

Relieve pressures on hospital capacity. Each harm event increases length of stay by an average of 6.6 days and slows hospital throughput.[13]

Reduce payer costs. The cost of each harm event averages $12,000.[14,15]

Support the workforce. AAEM eases the burden of manual reporting and enables leaders and staff to prioritize safety improvement efforts.

Promote health equity. AAEM is not subject to the biases that lead to under-detection of harm to nonwhite, older, and disabled patients.

Inform health policy. The pilot will support development of statewide standards to improve patient safety monitoring and transparency.

Statewide health care safety curriculum

Inform | Incentivize | Implement

A core premise of the *Roadmap* is that everyone plays a role in safety. Yet no standards have been set for the knowledge and skills health care leaders, clinicians and staff must have to carry out their unique roles. Medical education and other training rarely provide an adequate foundation in health care safety principles for translation into practice, and resources to fill these knowledge gaps are limited.

To address this challenge, the Betsy Lehman Center is leading the development of first-in-the-nation:

- Statewide curriculum that fosters a shared understanding of fundamental safety principles and practices; and
- Educational standards on safety for licensed and certified health care professionals and leaders of licensed facilities.

The goal is for health care workers in all settings to take ownership of the unique roles they play in safety vigilance and improvement, understand the difference their participation can make, and have the information and knowledge they need to proactively address safety risks.

In the past year, the Center convened an advisory committee of health care safety and education experts that developed course content and continues to oversee production of the curriculum. The first foundational e-learning course will launch in 2026.

Patient and Family Advisory Councils

Inform | Incentivize | Implement

A key part of the *Roadmap's* operations and engagement goal is to include patients and families as partners in health care safety. Strong Patient and Family Advisory Councils (PFACs) are an effective way to achieve this. In Massachusetts, all acute and rehabilitation hospitals are required by law to convene PFACs.

The Betsy Lehman Center began supporting PFACs in 2024 as part of its implementation of the *Roadmap*. The Center now offers coaching, events, tools and other resources to groups across the state. Read more about this program's impact in the next section of this report (page 10).

Watch this video to learn more about Patient and Family Advisory Councils

Programmatic support to providers

The Betsy Lehman Center offers resources, technical assistance, learning collaboratives and other support to help providers across the state implement and sustain key health care safety programs. After assuming responsibility for PFACs in 2024, it became a priority for the Center to further integrate the three programs and pursue partnership opportunities. In the past year, our programs team has significantly increased collaboration through meeting and event presentations, regular check-ins between program directors, and networking between member organizations.

Communication, Apology and Resolution

Communication, Apology and Resolution (CARe) is a method for responding to adverse events that improves patient safety, reduces costs and enhances fairness and transparency. Health care organizations commit to:

1. Providing prompt, transparent communication with patients and families after an adverse event, and support for clinicians in disclosing these unexpected outcomes.
2. Reviewing the event to determine the causes. Findings are disclosed and, when possible, changes are made to prevent similar events from recurring.
3. Offering a sincere apology and working toward resolution together. If the event was preventable, this may include proactive financial compensation.

The Betsy Lehman Center offers implementation resources, tools, and experienced coaches to help organizations across the state launch and maintain this program. The new Patient Safety Structural Measure issued by the Centers for Medicare & Medicaid Services identifies transparency as crucial to patient safety, and includes CARe programs as part of that attestation metric. This has driven increased interest in evidence-based approaches like CARe, and to the Betsy Lehman Center resources.

In 2025, CARe implementation expanded to two more health care systems in the Commonwealth. We now have 17 partner sites that are using the CARe model, and four additional sites working to implement in the coming year. This past year, 491 cases were resolved through the CARe process at these sites.

The Center's 2025 annual CARe forum drew 208 attendees, the largest number to date, through a hybrid model. There was also a renewed effort to educate the attorney community about CARe through a Mass Bar Association webinar.

The case for CARe

Patients deserve transparency and honesty when adverse events occur, and not meeting these needs can motivate patients to file lawsuits.

CARe also offers potential cost savings and can reduce claims in institutions that use it. Research in Massachusetts and in Michigan has found evidence of reduced malpractice claims and costs when compared to institutions that did not use the approach.

The increased transparency that is integral to CARe advances patient safety, improves trust with patients and better addresses patients' needs after harm.

Peer support

Inform Incentivize **Implement**

When medical harm or other difficult medical events occur, people want to talk to someone with lived experience who understands what they're going through – a peer. Peer support is an effective way to alleviate stress and burnout amongst health care workers, and support patients and families when something goes wrong during their medical care.

Virtual Peer Support Network

The Betsy Lehman Center's Virtual Peer Support Network offers confidential, one-on-one support to clinicians and staff across the state. The Center recruits and trains volunteers, matches supporters with those in need, and provides administrative oversight for the program. There are currently 88 volunteers across the state available to provide peer support to others through the Virtual Peer Support Network.

In 2025, the Center began partnering with providers in Massachusetts that wanted to promote the Network as an additional resource within their own organizations. For these partnerships, the Betsy Lehman Center holds a training for staff, produces co-branded materials to distribute, and works alongside leaders to develop a communications plan specific to their organization.

The Center also convenes a Learning Collaborative for peer supporters and partner organizations with opportunities to connect, share experiences, and learn from one another. The collaborative hosted two virtual events this year and launched an email newsletter with news, resources, data and tools.

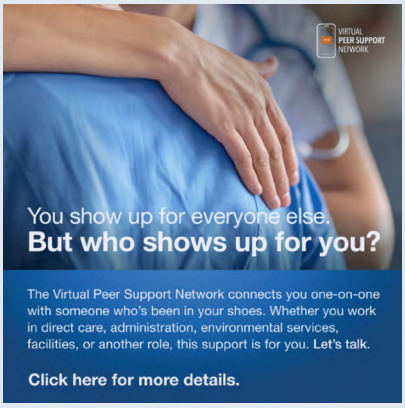
Patient and Family Peer Support Network

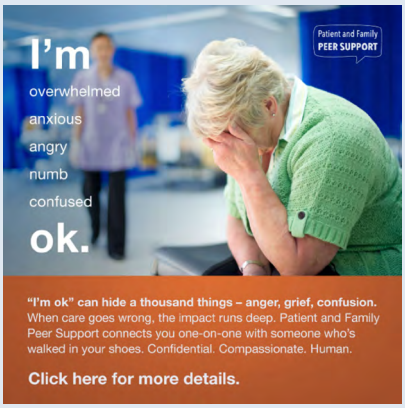
The Center also manages the Patient and Family Peer Support Network, connecting people in the state who have had something go wrong in their medical care with trained volunteers who have had similar experiences.

Linda Kenney, Director of Peer Support Programs at the Betsy Lehman Center, began this work because she experienced a medical error herself and, during her healing journey, discovered the power of peer support. She told her story in the Boston Globe as part of the Center's statewide awareness campaign for 2025.

A statewide campaign to promote peer support

This year, the Betsy Lehman Center launched a suite of new materials to promote the Virtual Peer Support Network and the Patient and Family Peer Support Network. Peer support volunteers helped hone the messaging and identify opportunities to use the materials. The Center is now working with health care providers across the state to spread the word about this important resource.





Patient and Family Advisory Councils

Patient and Family Advisory Councils (PFACs) help hospitals better meet the needs of their patients by tapping the expertise of people with lived experience. In 2008, Massachusetts became the first and only state to require all acute care and rehabilitation hospitals to establish PFACs.

The Massachusetts Department of Public Health has regulatory authority over PFACs, which must report annually on their activities. For more than a decade, Health Care For All received and published the annual reports and provided technical assistance to PFACs. In 2024, the Betsy Lehman Center assumed these responsibilities and established a program to reinvigorate PFAC reporting and support.

This initiative advances a key goal of the state's *Roadmap to Health Care Safety for Massachusetts*: that all provider organizations have systems in place "to continuously identify safety issues, resolve problems, integrate their operations with safety strategy and plans, and engage patients and families as partners in the work."

Since this work moved to the Betsy Lehman Center, the PFAC program has grown substantially and now offers educational forums, coaching and technical assistance, networking opportunities, and robust data collection and feedback.

This year, the Center developed a new annual reporting form to gather data about PFACs that hadn't previously been collected. The responses were used to create individualized reports and recommendations for each PFAC that can be shared with hospital leadership and stakeholders. They were also used to produce a statewide report, with information about demographics, ongoing work, challenges, and accomplishments of Massachusetts PFACs.

The report highlights the varied work of PFACs in 2025, including:

- Reviewing hospital safety and patient satisfaction data;
- Participation in local Community Health Needs Assessment and The Joint Commission Equity Certification processes;
- Development of patient education materials;
- Advising improvements to existing processes (Informed Consent, communication boards, phone queues/ transfers, institutional collaborations, welcome/orientation materials);
- Work on palliative and end-of-life care initiatives; and
- Service as patient guides within the hospital and community ambassadors for the hospital; and more.

Featured PFAC accomplishments

Improving emergency department layout: After multiple complaints about patients in the ED waiting area not hearing their names called, the hospital's PFAC proposed a redesign. After the new layout was implemented, related complaints ceased entirely, demonstrating the impact of patient-centered collaboration.

Understanding annual visit costs: To ensure transparency and build trust with patients, this PFAC developed a document to help patients understand annual visit costs. The group provided robust feedback on a notice for the hospital's treatment rooms and waiting areas that explains the costs, what is included in an annual physical or wellness visit, and what is not included.

Implementing patient rounding: This PFAC launched a patient and family rounding program, similar to the Nurse Leader Digital Rounding Program already in place. It has been used to provide support to patients and their families, and to gather valuable real-time patient experience feedback.

Read more on page 3 of the 2025 statewide report.

Interagency initiatives

The Betsy Lehman Center regularly performs convening, analytic and other services to support top Administration priorities and respond to the needs of other agencies. In addition to the Center's ability to quickly respond to pressing issues and organize professional events and webinars, many of these long-term projects leverage our unique access to data resources or statutory authority to maintain confidentiality.

Advancing safety in long-term care

The *Roadmap to Health Care Safety* highlighted the long-term care sector as an area of particular opportunity to strengthen statewide supports for patient safety, citing the rising share of health care encounters occurring in an increasingly diverse provider environment.

In response to a request by the Department of Public Health, the Betsy Lehman Center has convened an interagency working group on long-term care. The group has begun engaging stakeholders, and consists of the Center, MassHealth, the Executive Office of Aging and Independence, the Department of Public Health, and industry representatives from the Massachusetts Senior Care Association.

The working group planned informational webinars on timely safety topics for early 2026 with an initial focus on effective all-hazards emergency management and response protocols addressing issues of safety and quality in nursing homes and assisted living facilities. This webinar series will serve as a springboard to launch a longer-term learning collaborative that facilitates peer learning around effective safety practices. Provider organizations, associations, and patient representatives will help identify safety and quality topics for the learning collaborative to engage subject matter experts in. The collaborative will be piloted with a small number of organizations, evaluated and, resources permitting, spread more widely to extend safety improvement supports statewide.

The Betsy Lehman Center first began working in long-term care during the COVID-19 pandemic. In response to the need for PPE training for health care workers in home health and congregate care, the Center convened a group of experts to write, produce and disseminate a how-to video in multiple languages.

Maternal health data and improvement

The Betsy Lehman Center partners with the Department of Public Health, MassHealth, patients, and other members of the health care community to forge solutions to disturbing trends in maternal health, including rising rates of severe maternal morbidity and increasing racial disparities in outcomes. It is a member of the state's Maternal Health Task Force and serves as the data custodian for the Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN).

Levels of Maternal Care

Levels of Maternal Care is a strategy to reduce severe maternal morbidity and mortality by ensuring that patients receive care at hospitals that are appropriate for their anticipated needs.

The Betsy Lehman Center convenes the statewide Levels of Maternal Care Advisory Committee, and in 2025, launched two additional working groups. The first is creating standardized guidance and tools for the safe transport of pregnant and postpartum people and their newborns between birthing facilities to support the best outcomes. The second group aims to develop messaging and outreach strategies that effectively communicate to the public about Levels of Maternal Care.

Severe Maternal Morbidity Data

The Center monitors and analyzes trends in severe maternal morbidity (SMM) across the 39 birthing hospitals in Massachusetts. These trends inform statewide policies and help hospital teams track progress.

Across the state, SMM is on the rise. From January 2019 to June 2024, rates increased by nearly 34% (Figure 1). Within this data are stark racial and ethnic inequalities (Figure 2). From January 2019 to June 2024, SMM rates for Black, non-Hispanic birthing people were more than double those of white, non-Hispanic birthing patients. This gap has worsened in recent years. SMM rates for Black, non-Hispanic birthing people were almost triple that of White, non-Hispanic birthing people in early 2024. In the same period, SMM rates among Hispanic birthing patients were 1.6 times higher than white, non-Hispanic birthing patients.

There are also disparities by payer status (Figure 3). Medicaid-insured patients are 1.14 times more likely to experience SMM than birthing patients with private/commercial insurance. Though SMM rates have been steadily increasing among both payer groups, it is more pronounced for Medicaid-insured patients, whose rates of SMM almost doubled between July 2022 and June 2024.

Improving maternal health data collection

SMM is calculated from discharge data that is submitted to the state on a quarterly basis. Though this is helpful for statewide trends, it is too slow for the clinical teams who receive the information many months after events occured.

In an effort to get more timely, actionable data, the Center is leading a program in which hospitals submit data on a monthly basis and receive SMM analysis within just six to eight weeks. The hospitals in the program work with PNQIN to examine their SMM rates, share best practices, and engage with subject matter experts on specific SMM indicators. The Betsy Lehman Center also convenes clinicians and coders from participating hospitals through a learning collaborative to standardize definitions for key SMM indicators, identify best practices for SMM case review, and determine opportunities for improvement.

There are now 19 hospitals (representing 60% of deliveries in the state) in the program and the Center is working to expand this in 2026.

FIGURE 1 *Download: Figure 1 data*

Massachusetts Statewide Severe Maternal Morbidity (SMM) Rates *January 2019 - June 2024*

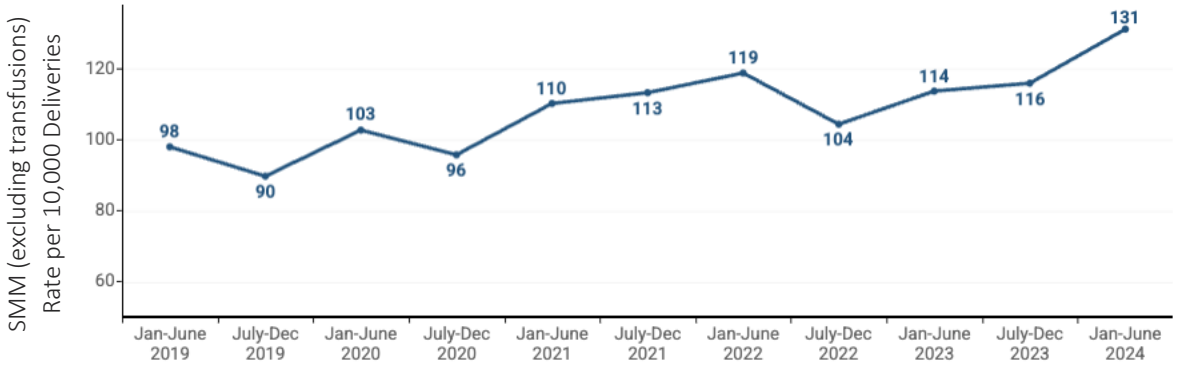


FIGURE 2 *Download: Figure 2 data*

Massachusetts Statewide Severe Maternal Morbidity (SMM) Rates by Race/Ethnicity *January 2019 - June 2024*

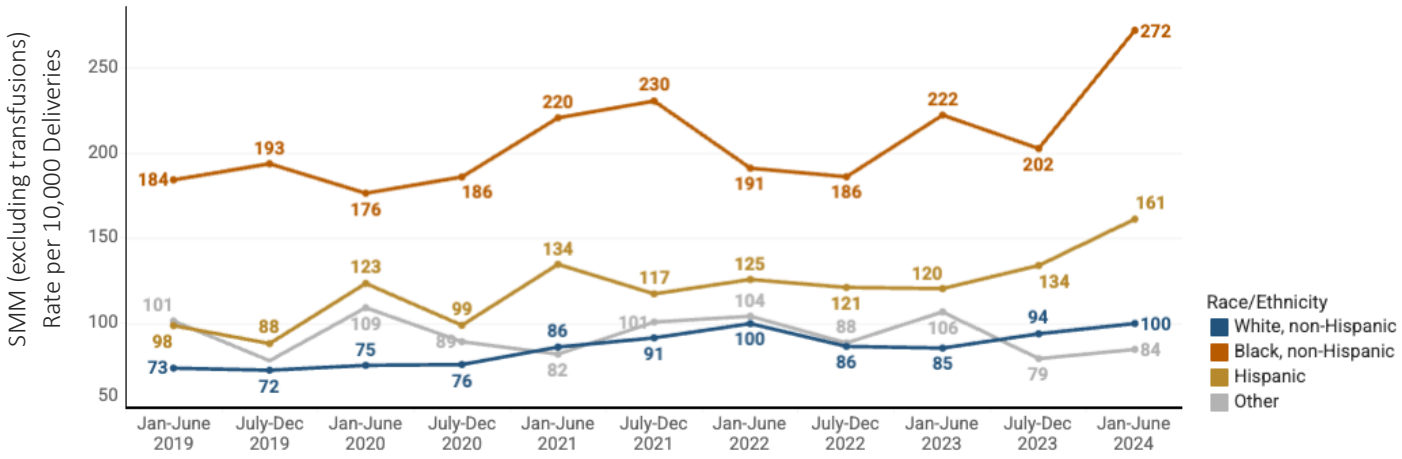
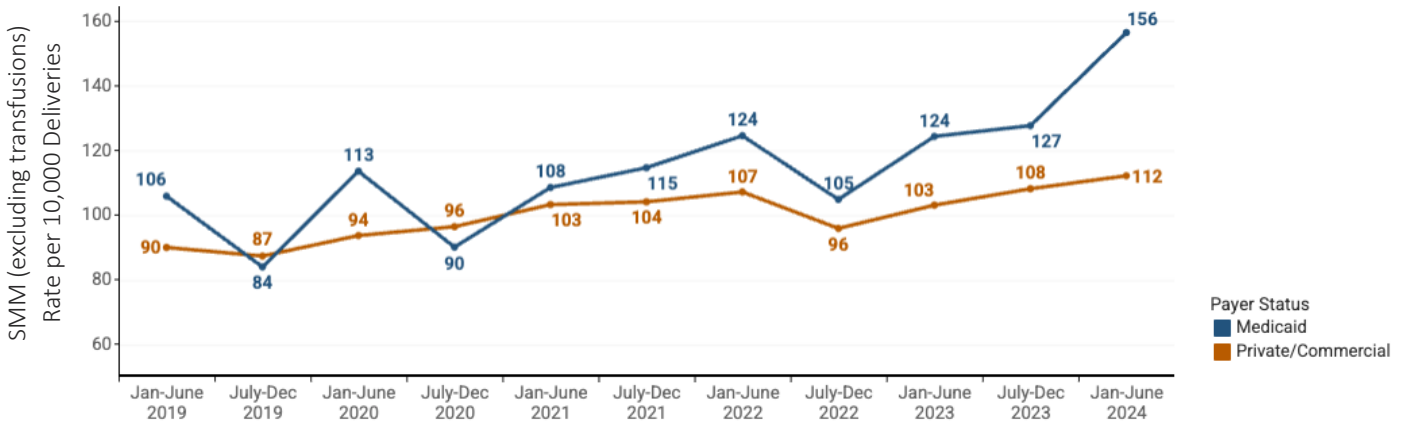


FIGURE 3 *Download: Figure 3 data*

Massachusetts Statewide Severe Maternal Morbidity (SMM) Rates by Payer Status *January 2019 - June 2024*



Conclusion

In creating the Betsy Lehman Center, the Legislature recognized that improving health care safety would require a sustained, coordinated effort. With a small but highly capable staff, the Center now provides a wide array of technical assistance and resources to help provider organizations prevent and respond to harm events. We also support other state agencies on data collection, analytics, and stakeholder convening.

We accomplish much of this work by leveraging the convening power we have built over our first decade. The state's *Roadmap to Health Care Safety* exemplifies this approach and will continue to guide our work in the years ahead.

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