



September 30, 2006

2006 Report to the Legislature

Introduction:

By statute: “The Oregon Patient Safety Commission Board of Directors shall report: *No later than September 30, 2006, to an interim committee of the Seventy-third Legislative Assembly on the implementation of a retail pharmacy serious adverse event reporting system.*”

Overall Progress of the Patient Safety Commission:

The Patient Safety Commission is a semi-independent state agency governed by a 17-member Board of Directors appointed by the Governor and confirmed by the Senate. Our mission, defined in statute, is to reduce the risk of adverse events in Oregon. We are the only organization in Oregon exclusively dedicated to patient safety. We aim to encourage a culture of patient safety by emphasizing shared data, quality improvement, and quick absorption of new approaches. We combine confidentiality guarantees to participating organizations with accountability to the public. In these ways we offer a centrist and independent perspective on patient safety efforts in Oregon.

The Patient Safety Commission has made real progress in the last year. A partial list of activities:

- We have successfully enrolled 51 hospitals in our voluntary, confidential reporting program for adverse events. These 51 (of the 57 in the state) provide care for 98% of all hospitalized patients in Oregon. To date we have received 36 adverse event reports. We expect that the volume of reports will increase as hospitals gain confidence in the reporting program and we continue to demonstrate added value. The Commission believes it is proving that a voluntary approach to reporting has real merit.
- We are using the hospital data in meaningful ways. For example we have issued two Patient Safety Bulletins. These bulletins represents the first statewide effort to identify and share information about high risk, emerging patient safety situations. We are also preparing our first quarterly report for participating hospitals that will summarize findings of all cases reported so far. Finally we have found some surprises in the data (for example, why so many cases of inadvertently retained objects after surgery?) and will soon issue a report on those findings.

- We have made significant progress in developing similar reporting programs for retail pharmacies (details below), and for nursing homes and ambulatory surgery centers. The nursing home reporting program is in the pilot stage; the ambulatory surgery reporting program just finished its template building stage and is about to enter a pilot as well.
- We have successfully partnered with OMA, OAHHS, Acumentra Health, and CareOregon to champion the Institute for Healthcare Improvement's 100,000 Lives Campaign in Oregon. And, within the last week the Oregon Nurses Association has also joined the leadership team. This effort brings concrete patient safety information about six evidence-based interventions to hospitals across the state. In support of this effort, we have organized two teleconferences in the last four months (medication reconciliation; rapid response teams in rural hospitals). More than 20 hospitals participated in the last teleconference. Having learned how to organize such events, we now plan to offer one such conference each quarter.
- We have organized a 'disclosure forum' scheduled for October 11, 2006. Oregon is one of only two states that requires reporting participants to notify patients of serious adverse events in writing. This workshop will allow participants to explore ways to make written disclosure an important element of patient-centered care.
- We are taking preliminary steps to become certified as Oregon's Patient Safety Organization for the national adverse event reporting program (scheduled for 2007 implementation).
- We are working with partners to develop a "Policy Summit" on healthcare-acquired infections. Our goal is to bring together legislators, healthcare leaders and scientists to outline plausible policy options for lowering the risk of an iatrogenic infection. Probable date: January, 2007.

Retail Pharmacy Adverse Event Reporting Program

Oregon is the only state in the country that is implementing an adverse reporting program for retail pharmacies. While adverse drug events are well documented as causing patient harm in hospitals and other institutional settings, not much is known about medication errors in retail environments.¹ However, the potential risks are real and growing. The lack of comparative experience, coupled with the sheer number of retail pharmacies (more than 700 stores in Oregon) make the implementation of such a program a real challenge.

Even with the challenges, we have made substantial progress and are on track to have the program in place by January 2007 when we will begin enrollment. We expect to have 80% of the large pharmacy chains enrolled by March 2007 and 50% of the smaller chains and independent pharmacies enrolled by June, 2007 (80% by YE 2007).

¹ Adverse drug events that occur in hospitals, nursing homes, and ambulatory surgery centers will be captured in the reporting programs specific to those entities.

The key to our initial success has been our ability to partner with retail pharmacy chains and independent pharmacies, with the school of Pharmacy (Oregon State University), and with the Pharmacy Association. We have a three phase implementation plan – two of the three phases have been completed. An overview:

Phase 1: Identify reporting needs; advise the Patient Safety Commission on an appropriate definition of adverse event; develop a reporting framework (March 2006 – June 2006).

Progress:

- We established a Pharmacy Task Group, chaired by David Widen, R.Ph, Commissioner (and Director of Pharmacy, Safeway Inc). Members of the group include: Marc Cecchini, R.Ph., Vice President and Director of Pharmacy, Fred Meyer Stores; Brian Osborne, Pharm, D., Assistant Director of Pharmacy Services, Oregon State University Student Health Center; and Diane Nauman R.Ph., Director of Early Experiential Education, Oregon State University College of Pharmacy;
- The Pharmacy Task Group reviewed existing reporting systems, evaluated the types of pharmacy-related errors seen in retail settings, and outlined the essential dimensions of a retail pharmacy reporting system;
- The Pharmacy Task Group developed a draft Adverse Event Reporting Form. The group took the bold move of urging that reporting be expanded include serious adverse events, less serious adverse events, and even close calls.

Phase 2: Organize a pilot to test the feasibility of retail pharmacy reporting; develop a program implementation/rollout strategy (June, 2006 – September 2006).

Progress:

- Five pilot sites agreed to test the reporting tool. Pilot group offered a purposeful mixture of large chain pharmacies, small chain independent pharmacies, and single store pharmacies;
- The Task Group, having met its charge for developing a reporting template, was expanded into a Pharmacy Advisory Group in order to include representation from a broad array of stakeholders, including consumers;
- The Pharmacy Advisory Group: Jim Thompson, Executive Director, Oregon State Pharmacy Association, (representing the professional organization); Mike Douglas, R.Ph., Owner, Mike's Medical Pharmacies (representing independent pharmacists), Kathy Crabtree DNSc, FAAN, APRN-BC, Professor, OHSU School of Nursing (representing prescribers), Paul Gorman, MD, Evidence-Based Practice Center OHSU, Providence Portland Medical Center (representing prescribers), Arline Smith, (representing patients/families) and Barbara Getty (representing patients/families);

- The Advisory group:
 - reviewed the definition of reportable adverse event and recommended a revised definition to the Commission;
 - reviewed the pilot comments and recommended a revised reporting form to the Commission;
 - identified stakeholders and communication strategies for publicizing the program as widely and thoroughly as possible;
 - identified goals for program enrollment based upon type of pharmacy (chain, independent, number of prescriptions);
 - reviewed draft administrative rules for appropriateness, clarity, impact of fees on all participants.

Phase 3: Propose administrative rules; revise draft rules based on public input; adopt rules (October – December 2006).

Progress:

- The Advisory Group and staff have drafted initial administrative rules;
- Rules have been vetted with the Department of Justice;
- Time line has been established (Public hearing will occur in November);
- Notification of interested parties has begun;
- Planned effective date -- January 2007.

Summary

The Patient Safety Commission is a small, scrappy organization with a big mission but limited resources. So far we have been successful – by forging meaningful partnerships, by staying true to our core beliefs, and by our willingness to learn and adapt strategies.

In the coming year we will face significant challenges:

- We need to continue to develop stable funding. Currently we receive no state funding, but instead rely on participant fees. These fees are meant to be mandatory, but the Commission's ability to collect such fees has been challenged. This requires a legislative remedy. With more secure revenue streams we could accelerate our progress.
- We need to keep our focus. Our ultimate goal is to reduce adverse events in Oregon, not simply to create reporting programs or additional requirements for already busy healthcare organizations. We must add value. We must be able to demonstrate that value. As a next step we are about evaluate our hospital reporting program – we will systematically ask all 51 participating hospitals to give us structured feedback on what is working and not working.

- We need to be smart about how we implement the Federal Patient Safety and Quality Improvement Act of 2005. This law mandates a federally-run voluntary and confidential reporting program. In structure and intent the federal legislation mirrors the Oregon statute that created the Patient Safety Commission. It remains to be seen if this federal program strengthens our role as Oregon's exclusive reporting program, or if it leads to the creation of competing programs.
- We need to continue to build alliances and to help align patient safety priorities in the state. In this regard we have held tentative discussions with the Board of Pharmacy (about offering quality improvement alternatives to fine-based punishment); we continue to expand the Oregon 100,000 Lives Network (now with a leadership team of six statewide healthcare organizations); we are active participants in the OMA's Patient Safety Forum.
- We need to continue to find ways to include consumers in our work. We have made progress, and have begun to include consumers in our advisory groups. Finding consumers who are knowledgeable and interested in patient safety can be difficult, but we have developed strategies for the recruitment, training, and support of patients in advisory activities.

Submitted by Jim Dameron
Administrator,
Oregon Patient Safety Commission
October 2, 2006

503.224.9226

Jim.Dameron@OregonPatientSafety.org