January 23, 2007
Minutes approved March 6, 2007

Our Vision: *Healthcare for all Oregonians will be safe.*
Our Mission: *To improve patient safety by reducing the risk of serious adverse events occurring in Oregon's healthcare system and by encouraging a culture of patient safety in Oregon.*

Present: Joyce DeMonnin; Sandy Douma; Bruce Johnson; Roy Magnusson, Jim Martin; Lewis McCoy; George Miller. Also: Grant Higginson; Joel Young. **Staff**: Jim Dameron, Linda Goertz, Leslie Ray, Dana Selover.
Absent: Susan Allan, Nancy Chi, Andy Goldner, David Hartwig, Susan King, Gloria Larson, Glenn Rodriguez, Dave Widen, Maureen Wright.

Issues Heard:

- Update on Oregon Quality Community
- Leapfrog Initiative on "Never" Events
- Evaluation of Hospital Reporting Process
- Colored Wristband Issue
- 2006 Draft Report of Hospital Findings (initial review)
- Financial Update
- 2007 Strategic Objectives

1) **Call to Order:** Meeting was called to order at 12:12 p.m. without a quorum present; the meeting was held as an informational meeting. Members present introduced themselves.
2) **Update on Oregon Quality Community** (OQC)**:** Gwen Dayton and Paul Frisch provided an update on this group formed by OAHHS and OMA:
   a) OQC is looking at safety collaboratives, beginning with infection / infection control. They are looking at ways that hospitals can measure and display quality in broad ways, working to align with existing programs and platforms.
   b) Paul noted that OQC will also focus on maintenance of certification and continuing education issues. The "data warehouse" section noted in the handout is seen as a way to serve as an information interface between entities and the many reports they are required to make.
   c) The handout suggests the possibility of OQC becoming the state's Patient Safety Organization (PSO); Commission members inquired about this. Gwen responded that they have not fleshed out details or addressed how this would coordinate with the Oregon Patient Safety Commission.
   d) A workforce development effort is in collaboration with OHSU and would be focused on bringing physicians back into certification. Maintenance of certification is a reflection of a movement towards ongoing/continual certification of individuals and facilities.
   e) Commissioners asked about the connection between OQC and Oregon Patient Safety Commission. Gwen feels they can be a "safe table arena" where we work to improve

specific problems that surface in the reporting program. Paul added that OQC is looking for relationships and collaboration.

3) **Leapfrog Initiative on "Never" Events**: Leapfrog has four tenets related to 28 "never" events (apologize to patient; report the event; perform a root cause analysis; waive costs directly related to the never event). In our last discussion, the Commission members supported the first three (noting the need to be clear about what "apology" means) but did not come to a conclusion regarding endorsement of the non-payment position. Some purchasers have agreed to stop payment for "never" events; CMS is working out the details of a similar decision. Do we have a role in stating an opinion here? Discussion followed; Some have concerns about a third party making a list of "never" events that the healthcare organization doesn't control. Would implementing this policy contribute to increased patient safety? The Commission should be sensitive to consumers on this issue rather than appearing to reflect providers only. What information does the Commission need to make a decision? What would be the impact of Commission taking a stand or not? Since no quorum was present, no action was taken.

4) **Evaluation of Hospital Reporting Process:** Surveys were submitted to member hospitals (those who have submitted reports and those who have not yet done so). In general, the adverse event reporting system is off to a good start.

   a) There are some issues around visibility of the reporting program, especially among clinicians and front-line staff, and some suggestions of ways to improve the ease of reporting. Jim noted that our system is still a "high-touch" one depending on the nature of our relationships with hospitals, rather than firmly within the mechanisms of a hospital's operations; this needs to be improved and our program become more integral. We have demonstrated our utility but we need to aggressively pursue reporting improvement; formation of the technical advisory group should facilitate this. We also need to find more ways to make safety tips public. Staff are working on ways to implement report improvement and eliminate barriers to reporting.

   b) *Concern for the future:* as we bring on more programs (long-term care, pharmacies, ambulatory surgery centers), we must have a more effective / streamlined reporting system, although first steps will clearly involve relationship-building in each program. *Note:* Our enabling legislation states that the legislature may determine in 2007 whether the voluntary system should be made mandatory. The current evaluation may be a useful tool showing the outcome of our work thus far, but it underscores the need for additional funding/ resources for improvement of the program now and in the future.

5) **Colored Wristband Issue**: Several states have raised the issue of standardizing wristbands; although wristband-related errors are of relatively low probability, the impact of such an error could be great. Our assessment is that a change to standardization (for facilities that choose to use them) would not be unduly burdensome. Staff propose that the Commission make this recommendation and then continue working in collaboration with OAHHS on the issue. *Suggestion:* we might want to share / coordinate with nursing homes and ambulatory surgery centers as well. This can be passed along to the OAHHS for implementation; Commission members support this action. Final vote at next meeting.

6) **2006 Draft Report of Hospital Findings:** The handout provided is a first draft of the hospital report (operating May 1 – December 31). The program received 53 adverse event

reports from 27 of 52 member hospitals. This is similar to Minnesota's reporting rate in their first year. 10 of 53 cases related to retained objects; the Commission already has formed a workgroup to understand this issue and to make recommendations for improvement. Other issues include "getting the board on board" (using IHI suggestions), and further understanding the role of communication issues in serious errors. As an IHI node, perhaps we should note for hospitals the issues we've found regarding senior management notification, and encourage engagement with related Five Million Lives campaign suggestions. We appear to be doing a better job than other states at getting root cause analysis information from reporting hospitals; perhaps we should follow up to help hospitals (and later, long-term care facilities) improve their RCA processes. This draft report will be further refined in February; the final report will go to the State, legislature, hospitals, public, and press; we hope to provide quarterly reports in future. Should we send copies directly to board members / head of medical staff as well? Urge in cover letter that this be shared within the facility, providing a reminder of the program's operations? Dr. Magnusson offered the use of an OHSU statistician in analyzing results.

7) **Finance Report:**
   a) As of January 19, the Commission has $285,000 in assets including accounts receivable. Jim Martin commented that we can fund what we have, but need at least two additional staff persons to fulfill future needs and to complete services that we have pledged to do. More staff would be needed to support expanded programs.
   b) Next immediate step – as administrative rules go on line, work to get buy-in and agreements signed so we can submit invoices. There was discussion about the various programs – long-term care facilities and ambulatory surgery centers may be easier to sign up than the pharmacies. Marketing/recruitment/enrollment of the new programs is not supported by current staffing. We continue to hope to get at least some of the larger pharmacy chains signed up in the near future.
   c) Senate Bill 36 has been introduced in the 2007 legislature. It would clarify the Commission's ability to assess fees and would go a long way to assure stable funding.

8) **2007 Goals and Objectives**: The group reviewed and discussed the handout on goals. Could we ask the state for support funding consumer involvement activities (these are not paid for by participant fees)? We need money for web-based data-sharing capacity – it's not in the budget but is a critical barrier to reporting. There was discussion about the burden of multiple activities on limited staff resources and some consensus that, among these goals, the reporting programs and organizational stability are of primary importance. Vote postponed until next Board meeting.

9) **Long-Term Care Facility Administrative Rules**: These have been shared electronically but not yet voted upon; board oversight is still needed. Final action at next meeting.

10) **Evaluation**: Please consider our needs for a quorum and suggest any improvements.

11) **Adjournment**: Meeting was adjourned at 3:05 p.m.