



September 30, 2007

2007 Report to the Legislature

By statute: The Commission shall report, *No later than September 30, 2007, to an interim committee of the Seventy-fourth Legislative Assembly regarding reporting results and whether performance goals have been met. The board shall offer recommendations for any changes to the system, including possible implementation of a mandatory serious adverse event reporting system. [2003 c.686 §10]*

Introduction:

The Patient Safety Commission is a semi-independent state agency, created by the Legislature in 2003 to reduce the risk of adverse events in Oregon and to encourage a culture of patient safety. The Commission is governed by a 17-member board of directors appointed by the Governor and confirmed by the Senate. The board represents a cross-section of diverse health care interests in the state. As such, the Patient Safety Commission offers an independent viewpoint on quality of care in Oregon. Our website: www.oregonpatientsafety.org.

Our Perspective on Patient Safety:

We last reported to the Legislature in September, 2006. Since then we have made steady progress and continue to gain visibility. We strongly believe that we represent a necessary means to improving patient care in Oregon. Our focus is the delivery system. Our role is to offer practical ways to learn from mistakes, to eliminate unnecessary variation, and to introduce and champion best practices. We have much work ahead:

- Oregon still has too many errors within its healthcare system. Whatever the healthcare system has done in the past, it isn't enough.
- Oregon is still struggling to develop a vision of patient-focused quality. Too often, health care has been organized into self-contained silos with quality only addressed (and measured) within those silos. We need more and better cooperative ventures; we need to work across organizational boundaries.
- Oregon must continue to nurture new ways to reduce patient harm. We've said it repeatedly – we need to focus on non-punitive solutions. We need to emphasize teamwork and system thinking.

Our toolkit:

The Commission represents a purposeful mix of independence and accountability. We offer a centrist and balanced approach to patient safety:

- Clear mission focusing on one key component of quality: reducing harm to patients by reducing the risk of adverse events; encouraging a culture of safety.
- Multi-stakeholder table.
- Emphasis on non-punitive, system approaches. We are not regulators.
- Protected legal framework (quasi-governmental body, offering stringent legal safeguards).
- Ability to work across healthcare boundaries (i.e. transitional care projects).
- Wherewithal to champion cooperative ventures.
- Capacity to act as independent patient safety consultant to participating organizations.
- Ability to champion the perspective of patients and families.

The Commission's accomplishments in 2006-2007:**1. We've established a stable and dynamic organization without state funding.**

- We worked with the 2007 Legislature to pass SB 36 clarifying the Commission's ability to assess fees on all health care facilities and retail pharmacies, even those that refuse to participate in our voluntary reporting program. SB 36 caps those fees at \$1.5M per year.
- We raised the visibility of Commission within the state. In the process we generated a great deal of positive press, including editorials, news articles, radio and TV spots.
- We earned (and maintained) the support of many statewide organizations, including the Oregon Health Care Association, Oregon Alliance of Seniors and Health Services, Oregon Association of Hospitals and Health Systems, Oregon Ambulatory Surgery Association, Oregon State Pharmacy Association, Oregon Medical Association, and others.
- We are gaining a national reputation—for example, the Administrator will speak at the National Academy for State Health Policy's 20th Annual Conference (Denver, October 25th).

2. We are building a unique reporting program with in-depth data about medical errors in Oregon. Progress by area:

Hospital Reporting:

- 54 of 57 Oregon hospitals have signed participation agreements—representing 99% of hospital patients. Hospitals began reporting in May, 2006.
- As promised to hospitals when we initiated the reporting program, we called a brief *time out* after six months to evaluate our progress (November, 2006). We made improvements based on the findings.
- We published a 2006 aggregate report and a 2007 (January – June) update. More than 100 serious adverse events have been reported so far.

- The state Public Health Officer published the first ‘certification’ report in July, 2007. This report acts as an independent audit on the work of the Commission. The report declared that **“The Patient Safety Commission has achieved an important milestone toward fulfilling their mission by establishing the Patient Safety Reporting Program for hospitals in 2006. The program plays a key role in reducing the harm from serious adverse events in Oregon. The program is demonstrating good overall integrity as seen in the strong design and implementation of the reporting program.”**
- We received a \$25,000 grant from Kaiser Permanente to develop an electronic reporting capacity. This work is underway.

Nursing Homes:

- We’ve effectively partnered with the Oregon Health Care Association and Oregon Alliance for Senior and Health Services (the two large long term care trade organizations in the state).
- We’ve been very successful in recruiting nursing homes into our reporting program. To date 74 nursing homes have signed agreements. At least 22 more have offered oral commitments to participate. Every large multi-facility organization is on-board. We plan to publish a “charter member” list on or about October 1, 2007.
- We have begun implementation of the reporting program, and we are developing training materials and meeting with nursing home teams to integrate our program into their systems.

Ambulatory Surgery Centers (ASCs)

- We’ve gained the support of the Oregon Ambulatory Surgery Association (our recruiting material is posted on their website).
- We are making slow, but real progress in recruiting. Nine ASCs have signed agreements; five more have offered oral agreements (about 20% of total). Many more are still considering.

Retail Pharmacies

- We are working effectively with the Oregon State Pharmacy Association.
- Now recruiting participants. Fred Meyers (50 stores) has agreed to participate. In addition, about 10 independents have either signed or orally committed to signing.

3. We are identifying and championing quality improvement efforts (much of this work is based on data we collected via our reporting program).

- Helped to create Oregon 5 Million Lives Network. Network now includes six organizations: Oregon Association of Hospitals and Health Systems, Oregon Medical Association, Acentra, Oregon Nurses Association, CareOregon. The network champions IHI’s strategies for reducing patient harm—by encouraging enrollment in the campaign, offering technical assistance and convening training sessions.
- Initiated an effort to bring consistency in the use of colored wrist bands in Oregon hospitals. We identified the patient safety risks, documented the variation-in-use across

hospitals, developed policy options, and partnered with OAHHS to implement a new approach.

- We are actively working with OAHHS to improve the ability of hospitals to investigate their own adverse events (training in root cause analysis).
- We convened a work group to offer strategies for reducing the risk of retained objects after surgery. The expert panel offered recommendations to the Commission's Board of Directors in August, 2007. This issue came to light as a result of the high number of cases reported to the Commission. We are now promoting the draft recommendations throughout the state.
- We issued two additional alerts and bulletins to Oregon hospitals based on cases reported to the Commission. These real time alerts offer a new way to quickly disseminate emerging patient safety information.
- We disseminate monthly updates to participating hospitals offering quality improvement tips and summaries of hot topics.
- We formed a Technical Advisory Committee (TAC) to offer case-specific analysis of hospital adverse events. This expert panel (including physicians, pharmacist, nurses, an ethicist, a systems engineer from the nuclear industry, and others) meets every six weeks. We are now developing similar TACs for ambulatory surgery centers and nursing homes.

4. We are using our independent table to develop consensus on challenging patient safety issues.

- Written patient notification of adverse events: The Commission requires organizations reporting serious adverse events to *notify patients in writing* of those events. The idea is a good one—to reinforce that healthcare organizations have a responsibility to communicate with patients, openly and directly, about what happened. To help organizations implement this requirement:
 - The Commission hosted a workshop on October 11, 2006 to generate ideas. Sixty-two people participated in the workshop. Thirty five hospitals and health systems were represented, as well as two nursing home chains. We developed a white paper as a result of the meeting. Our continuing goal is to put together a tool kit of best practices. At least one state (Pennsylvania) has embraced our approach.
 - The Commission has partnered with a national researcher in an effort to obtain funding from Robert Wood Johnson to take an 'on-the-ground' look at how hospitals are attempting to implement their notification policies. RWJ will decide by late 2007. In the meantime we are organizing a survey of current notification practices within hospitals.
- Healthcare-acquired infections: In January and February, 2007 the Patient Safety Commission convened a group of experts to discuss the issue of healthcare acquired infections (HAI) in Oregon. The goal was to explore the scope of the problem and to establish consensus-driven remedies. The Commission contracted with the Center for Evidence Based Policy to facilitate the meetings and to bring the best current research to the table. The Advisory Group created a consensus vision: *Oregon should be free from infections acquired as a result of healthcare delivery. Actions to prevent infections should be: trustworthy, effective, transparent, and reliable.* In addition the group agreed that a mandatory reporting program for HAIs would be useful, but only if it could meet 11

specific tests. This vision and these 11 tests became the consensus framework for the passage of HB 2524.

- Transitional care: The Commission has helped focus attention on the need for better transitional care planning. We brought together IHI's 5 Million Lives Campaign (hospitals only) and the Advancing Excellence campaign (nursing homes only) to develop a statewide strategy for reducing the pressure ulcer rate in Oregon. To date the group has talked with 68 wound care and transitional care experts in order to develop a master plan. Preliminary report due on October, 17, 2007.

Expectations for a Voluntary Reporting Program

The original framework:

The Patient Safety Commission was first imagined in 2002-2003 by a group of ten stakeholders with very different perspectives. At that time one of the most pointed debates concerned the tradeoffs between voluntary and mandatory models of reporting. At the end of the day the 2003 Legislature drafted a compromise – we would begin with a voluntary approach, add strong accountability measures, and reconsider the decision in 2007.

So, the Commission was charged with organizing a **voluntary and confidential reporting program**. What can we reasonably expect from such an approach? A few beliefs:

- The Commission's reporting program, as designed, can drive quality improvement. We are looking for frailties within the existing delivery system. We are looking for lessons learned. How can we do this? One answer hinges on the richness of the data we collect. We go beyond a "check the box, error/no error" framework. We are gathering case-specific information that includes a narrative description of what happened, a detailed inventory of root causes, and a concrete list of remedies.
- Our voluntary reporting program is not yet an active surveillance system of patient harm events in Oregon. Until the number of reports increases, we probably have gaps in the 'true' pattern of events. For example hospitals have reported many events involving retained objects, but fewer adverse drug events than expected. As a result we need to be careful when using our data to set *harm reduction priorities*.
- Organizations will sign up to participate in a voluntary model. Hospitals have done so. And initial results from nursing homes are also very positive. However we have some concerns about ambulatory surgery centers and retail pharmacies. In all cases, recruitment into a voluntary system takes longer than in a mandatory approach. We must make our case and convince organizations one by one. It takes time. But, on the upside, it forces us to be smart about delivering value to participating organizations.
- Organizations will share data when working within a voluntary model. Perhaps this is the most contentious claim. The Public Health Officer has implicitly raised the issue of 'under-reporting'—is the Commission receiving information about all harm events? This is a surprisingly difficult question to answer, but we need to face it directly.

- Once collected, data can be analyzed and then distributed in meaningful ways. Certainly the need exists. Without organizations like the Commission, healthcare organizations don't have efficient ways to learn from one another. The Commission's *Alerts*, its Technical Advisory Group, its workgroups-organized-around-substantive-issues (retained objects, for example) suggest we can harness data to drive change.
- We will see a shift in the pattern of reports over time. We believe the number of reports will slowly increase. In addition, over time we expect to see a higher proportion of *low harm*, even *no-harm* events reported. Experts consider these sorts of events 'free lessons.' It is also one sign of a robust reporting program.
- Voluntary reporting is finding its place in Oregon's evolving quality measurement landscape. Oregon is in the process of creating its own mix of mandatory and voluntary reporting strategies. For example, reporting of healthcare acquired infections will become mandatory in 2009 (this program will be run by the state, not by the Patient Safety Commission). In this changing environment, the debate about whether Oregon should have a voluntary or mandatory reporting system is quieting. A mixture of approaches is healthy. The programs serve different, though reinforcing goals. More important than distinctions between voluntary and mandatory are discussions about adequacy of funding, earned trust, and demonstrated benefit.

Actual experience with a voluntary model:

- The Public Health Officer's independent certification of our program (July, 2007) suggests we are on the right track. Overall, the Patient Safety Commission remains committed to a voluntary reporting program.
- We have gained the widespread participation of hospitals and nursing homes. We are less optimistic about the participation of ambulatory surgery centers and retail pharmacies. However the Commission has not yet exhausted all its recruitment tools, and it is therefore too early to reach any final conclusions.
- As mentioned above, the Public Health Officer expressed concern about the volume of reports from hospitals. While our numbers are comparable to other state reporting programs (all of which are mandatory), they fall short of expectations based on best available research.
- Given our strong success with hospitals and initial success with nursing homes, we recommend continuing the voluntary approach. However, we intend to put together a 2009 legislative agenda (funding, definition clarification, etc). As part of those discussions, we will offer our updated assessment on the utility of a voluntary approach.

Next Steps/Summary

We stand by the words of our last report: “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 constantly learning and adapting new strategies.”

Some of our significant challenges in the coming year:

- We need to keep an eye on short term funding. While SB 36 will assure stable funding into the future, we have an exceedingly lean budget and zero cash reserves. The next six months will require much fiscal caution.
- We must create a sense of urgency about patient safety improvements. Collectively we have not made enough progress in reducing harm to patients within Oregon’s health care delivery system. The Commission plans to adopt an ‘audacious patient safety goal’ at its next Board meeting (October 2, 2007) and to use that goal to rally health care leaders and citizens around faster and better improvements. This will require having a *conversation* with the state.
- We must keep our true goal in mind. Our ultimate purpose isn’t to create a reporting program, but to reduce patient harm. We must continue to add value – by championing best practices, by setting priorities, by keeping the pressure on.
- We need to find our appropriate place at the table in creating Oregon’s comprehensive health care road map as envisioned in SB 329 (Healthy Oregon Act). The bill specifically acknowledges our role “**to increase collaboration and state leadership to improve health care safety**” (Section 13 (2) (e)).
- We need to continue to demonstrate the utility of focusing on transitional care issues. The Commission is uniquely suited for this work, since we collect information about so many different types of organizations.
- We need to pay attention to the Federal Patient Safety and Quality Improvement Act of 2005 and how it plays out in Oregon. We mentioned this in our last report, since at that time it looked as if it would be implemented in 2006-2007. However, the Federal government has been very slow to file its administrative rules (now scheduled for 2008). 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 find ways to include consumers in our work. We intend to do this in part by engaging consumers in a discussion about our ‘audacious goal.’

- With regard to reporting, we need to work with hospitals to improve the quality of reports (via training in root cause analysis) and the volume of reports (in part by creating an e-form).
- We need to make a good faith effort to recruit pharmacies and ambulatory surgery centers. If we fail to gain serious participation we need to then have a frank discussion about what that means.

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