



November 14, 2006

Approved March 6, 2007

Following is a translation (and in some cases an elaboration) of the November 14, 2006 strategic planning session into action steps.

Proposed 2007 Goals

1. Continue to build a robust voluntary and confidential reporting program

- Hospital Reporting
 - Enrollment goals
 - Ensure that the 52 hospitals already signed up, continue in 2007 (submit reports/pay fees)
 - Enroll last 5 hospitals
 - Administrative goals
 - Build web-based data-sharing capacity
 - Reporting/Dissemination goals
 - Publish 2006 annual report to public – January, 2007.
 - Begin routine quarterly reporting
 - Continue to demonstrate value by putting information to use – bulletins, safety tips, quality improvement strategies.
 - Begin helping to set statewide patient safety priorities based on reported information
 - Quality improvement goals - better data
 - Make improvements to reporting tool based on 2006 evaluation
 - Increase number of reports and number of reporting hospitals
 - Work with hospitals to improve identification and investigation of adverse events. Initial focus -- Root Cause Analysis training.
- Pharmacy Reporting
 - Administrative rules in place – January, 2007
 - First state-wide pharmacy chain signs participation agreement – February, 2007
 - 5 largest chains sign up – June, 2007
 - Top 5 chains begin reporting data – August, 2007
 - 50% of independent pharmacies sign participation agreements – 3rd quarter.
 - 50% of eligible pharmacies have paid fee – June, 2007.
- Nursing Home Reporting
 - Administrative rules in place - March 1, 2007.
 - 70% sign participation agreements – May 1, 2007.
 - 50% reporting data – July 1, 2007.

- 70% of eligible nursing homes have paid fee – June, 2007.
- Ambulatory Surgery Center Reporting
 - Administrative rules in place -- May 1, 2007
 - 50% sign participation agreements by June 1, 2007.
 - 33% reporting data by August 1, 2007.
 - 50% have paid fee – July 1, 2007.
- Birthing Centers and Renal Dialysis Center reporting—begin groundwork for 2008 implementation.
- Seek Certification as Federal Patient Safety Organization
 - Organize Board session on what PSOs are and why they matter – January, 2007.
 - On-going environmental scan – pay attention to federal progress as they define the ‘certification’ process, monitor what are other states and other organizations are doing.
 - Consider possible partnership options.
 - Apply for certification when appropriate.

2. Work to achieve and extend organizational stability

- Make sure the Commission has adequate funding
 - 2007 Legislative strategy – passage of SB 36; possible request for partial state funding
 - Seek outside funding – consider hiring (or locating volunteer) grants/funding coordinator
- Build toward appropriate staffing model
- Continue to create effective partnerships with like-minded organizations
- Enhance the Commission’s visibility

3. Identify and champion improvements that reduce risk of adverse events (combines quality improvement and evidence-based best practices)

- Create technical advisory group to help interpret adverse event data and to identify successful interventions.
- Continue working with Oregon IHI network – gain 100% enrollment of hospitals, identify mentor hospitals, introduce new ‘bundles.’
- Hold policy summit on healthcare-acquired infections.
- Continue to organize patient safety teleconferences in 2007 based on successful programs completed in 2006.
- Determine if possible to launch a Nursing Home transitional care project – focus might include adverse drug events or communication hand offs. Consider partnering with Oregon Department of Human Services (Bruce Goldberg) and other organizations such as Acumentra.
- Develop strategies for reducing risk of retained object during surgery.
- Finalize work-to-date on use of colored wristbands. Make policy recommendation, then work with OAHHS as appropriate to develop consistent standards.

- Develop patient safety training for hospitals, pharmacies, nursing homes, and ambulatory surgery centers (focus on error detection, analysis and reduction).
- *Other possible projects (as time, resources, and opportunity allow):*
 - Develop a joint project with Board of Pharmacy.
 - Work with nurse leaders to design nursing work environment and care processes to reduce error (surveillance of health status, transfers/handoffs, complex patient care, reducing non-value added activities).
 - Publish monthly patient safety updates – email/web-posted with links to hot topics, good info from various agencies (AHRQ, JCAHO, IHI, etc).
 - Establish a monthly patient safety roundtable to discuss issues and concerns.

4. Engage patients and consumers as partners in patient safety

- Develop an overall strategy for consumer engagement in 2007.
- Continue to encourage consumer participation in advisory/work groups.
- Work with patients and families to develop (or make available) patient safety information.

5. Work to actively encourage a culture of safety

- Make the reporting program work – safe reporting, useful information, quick feedback, collaborative solutions for healthcare providers and consumers [see Goal #1].
- Other possible “culture of safety” ideas (as time, resources, and priorities allow)
 - Complete a statewide culture of safety survey – organized to help hospitals and others complete *self-assessments*.
 - Work directly with Hospital boards – “do you know your hospital’s quality status as well as you know its financial status?”