Oregon patient safety Commission

July 10, 2007
Minutes Approved 08/21/07

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.*

Commission Members Present: Sandy Douma, Leonard Friedman, Andy Goldner, Bruce Johnson, Susan King, Gloria Larson, Roy Magnusson, Lewis McCoy, Jim Martin, Glenn Rodriguez, Dave Widen, Joel Young (designee for the Public Health Officer).
Staff: Jim Dameron, Linda Goertz, Amy Gryziec, Leslie Ray, Dana Selover.
Excused: Nancy Chi, Joyce DeMonnin, Brett Sheppard, Maureen Wright.
Also: Guest speaker Bruce Bayley; Diane Waldo; Molly Daniels; Claudia Halbert, Lauren Rhoades.

Issues Heard:
- Approval of May 29 minutes
- Administrator's Report
- Executive Advisory Committee / Treasurer / Finance Committee considerations
- Stakeholder Presentation
- Electronic Reporting
- Public Health Officer Certification
- Legislative Update

1) **Call to Order:** Meeting was called to order at 12:10 with a quorum present. As new Chair, Lewis declared that he would like to begin meetings with a thought from the patients we serve or from healthcare providers. He shared a humorous, but insightful tale -- "What a potato peeler can tell us about patient safety."
2) **Introductions:**
    a) One of our new Commissioners was present: Dr. Leonard (Len) Friedman from Oregon State University introduced himself. He is Director of OSU's Healthcare Administration program; his work and research on how healthcare organizations adapt to change aligns closely with the Commission's work.
    b) Amy Gryziec is our new Field Coordinator; her degree is in Healthcare Administration (from OSU), with a certificate in gerontology. She has been a nursing home administrator and has managed quality improvement efforts within a multi-hospital system (at Legacy, where she obtained her Certification of Professional Health Care Quality, CPHQ).
    c) All others present introduced themselves.

3) **Commissioner Updates:**
   a) David Hartwig has retired; we need to fill the Public Purchaser Commissioner position, as well as Treasurer.
   b) Four commissioners have been re-appointed: Nancy Chi, Sandy Douma, Gloria Larson and Glenn Rodriguez.
   c) The retained object task force will meet one more time on July 11.
4) **Minutes:** It was moved and seconded to accept the minutes for the May 29 meeting as written. The motion passed.
5) **Administrator's Report:** Jim highlighted a few items:
   a) Staff have been doing much work on recruitment for the newer programs, working with associations and getting support.
      i) Nursing Homes -- we have seven verbal agreements and one signed to date– there is much interest (there are 142 long-term care facilities in the state). We are approaching the bigger multi-facility companies first.
      ii) Pharmacies – the larger chains want to join at the same time but have not done so yet; one independent with two stores has signed.
      iii) Ambulatory Surgery Centers – Bruce's group has signed up; Dana and Amy are working with others.
      iv) How can Commissioners assist? Roy suggested a formal letter from the Commission to prospective members would be useful. **ACTION ITEM:** There was general agreement to move forward on that.
   b) The George Miller Patient Safety Award is in the planning stages (to start in 2008); guiding principles have been outlined. The Miller family has expressed interest in making a donation towards that award.
   c) Staff have been working with Thomas Gallagher, MD (University of Washington) about the possibility of a Robert Wood Johnson grant to study Oregon's written notification statute.
      i) Jim notes that professional liability carriers are not aligned behind inclusion of written notification.
      ii) Should the Commission be in conversations with medical malpractice insurers on this topic? Should we devote part of our meeting to an in-depth discussion of this? Claudia Halbert of AIG stated their support for disclosure (including written).
6) Establishing an Executive Committee: During transitions in leadership, it might be helpful to have an Executive Committee to provide continuity between administrations. Such a committee would include Chair, Vice-Chair, immediate Past Chair, and Administrator. It was moved and seconded to establish such a committee. Discussion followed and members agreed this could be useful and practical, as long as the entire board remains informed of focus and actions. *Note, however*, that the Executive Committee cannot make policy decisions; such decisions are to be made in public meetings. The focus for the Executive Committee would be advisory; it was moved and seconded to rename this the Executive Advisory Committee, and amended to include the Treasurer. Motions passed.

7) Treasurer / Finance Committee: The position of Treasurer is now vacant. It was moved and seconded to nominate Jim Martin for that role; a vote was held and Jim Martin was confirmed as Treasurer. The Finance Committee is in need of new members: both Gloria and Andy volunteered to be part of this committee.

8) Stakeholder Presentation: Dr. Bruce Bayley of Providence Health System presented a stakeholder perspective on "A Safe Health System." How do you spread good safe practices? Some elements include: sentinel event reviews; RCAs, debriefs; FMEA (Failure Modes Event Analysis); sharing action plans. Can an investigation promote participants becoming safety champions rather than simply having "survived a grilling"? How do we promote detection of active harm and appropriate follow-up and covering more common, less severe events than the sentinel events. How can we craft feedback systems for physicians? IHI Trigger Tool Definition of Harm: "Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or results in death." If it's related to medical care and results in harm (creates a symptom), that's harm. Dr. Bayley discussed "Research on Adverse Drug Events" – wide variation in these, but some studies suggest ¼ of admissions include an ADE. Recommendation: focus on a new definition of Adverse Events (more on harm) rather than the old definition (focus on errors). Focus should be on practice implementation, building culture to prevent harm; focus on injury rates. It is helpful to focus on transition issues – moving from "whose fault it was / where it happened" to "this is an injury that caused harm, let's address it." Ascertaining / detecting an event is key. The Institute of Safe Medical Practices has a useful assessment of medicine management (insulin, narcotics, anticoagulants). As we measure, are we exploring the linkage between measurements and practice and impact on patients of our "fixes"? See IOM's *Keeping Patients Safe.*

9) Electronic Reporting Options: A paper system of reporting adverse events is not workable for the future as we expand to long-term care, ambulatory surgery and pharmacies. Kaiser Permanente has donated $25,000 toward development of a secure electronic reporting system. Jim has looked at five possibilities and has narrowed down to two options:

   a) Use the State of Oregon's Form Factory, an E-Government project working with Adobe's Intelligent Form product and EDS data management. Experts say this is good technology. It requires Adobe 8.0, which not all facilities may have. There are some concerns about support and responsiveness, but they have worked with us in pricing structure.

   b) Work with a survey vendor.

   It is possible we might need a consultant to help us devise the template. The security consultant we used previously feels the E-Gov system is secure. Jim Martin asks if there are any systems in other states that we could use, since development costs are already paid; Jim Dameron will look into this. Where would data "live"? The easiest option would be in a server in Texas; it could be arranged to send back to us, but this would cost more. Pricing depends in large part on a form; we need to merge them into one large form with branching logic. Ongoing costs are based upon number of transactions and what we want to do with data (about $30K to develop, $5-8K/year to maintain). There are concerns about pharmacies – how to map their existing internal electronic forms to our forms, how to make it user-friendly? Concerns were also raised about technical support. Commissioners agreed that,

since we have already approved budget and concept, Jim is authorized to make a decision when all questions have been answered – or to take back to the Executive Committee or the entire board if he has remaining questions.

10) Public Health Officer Certification: This is a milestone in the Commission's history, providing some official external accountability to confidential and protected data. The intent has been to frame the certification work with fairness, recognizing the first year is a developmental one. The report notes clear accomplishments by the Commission, as well as some needs for improvement. Dana briefly outlined the process in developing this certification; the Public Health Office determined that overall integrity of the program, as well as the quality of hospital reporting in the early stages, are good. However, the absolute quantity of reports is too low, although progress is expected. It appears that although Oregon's reporting system is voluntary, we have comparable numbers on NQF events (see report) to other states. Discussion: only 18% of serious reports had satisfactory event descriptions; is the form design faulty? We need to consider this, together with the certification report's comment that says descriptions are not as robust as they should be. The Technical Advisory Committee has now reviewed 15 reports and has seen quite a bit of variability in hospitals' abilities to understand, communicate, and analyze adverse events. Are we giving appropriate feedback on reports and their adequacy? What are we doing to increase quality of reports? In part: (a) revising form; (b) partnering with OAHHS on root cause analysis training; (c) providing feedback without creating "blame;" a fourth item would be electronic reporting. Roy commented that this is good report; it acknowledges progress made and challenges us for the next steps. Glenn remarked that we must follow up on all recommendations. Jim suggested we can use the Public Health Officer's report to spark conversations with reporting facilities and to encourage improved reporting. The goal is to teach organizations how to do root cause analyses well and to share that ability and ownership of the process. We see the importance here of active board involvement and engagement. The Public Health Office released a news release on the report this morning. Oregon is the only state patient safety organization that has public health certification. The report is posted on http://oregon.gov/DHS/ph/hsp/index.shtml and Dana will also post to other patient safety sites of interest. On the Commission website, we will be posting our hospital report that includes 2007 data as well as 2006. Talking points about the certification are also included in this meeting's packet.

11) Postponed to Next Meeting:
    a) Communications Subcommittee discussion
    b) Commission's Challenge to Oregon ("Audacious Goal" discussion)

12) Legislative Update:
    a) **SB 36** passed; this was a technical fix that allows us to collect participation fees from all listed entities, regardless of decision to participate in the reporting programs. **QUESTIONS:** Do we need a formal communication plan to share this information? A formal letter to lay out what's changing? Include hospital feedback along with this (especially important to hospitals that have been participating). Should we include communication about the certification report?

b) **HB 2524** on healthcare-acquired infections also passed; Commission played an important role in creating the consensus that let to a redraft of the original bill. The Bill creates an advisory board to develop the infection reporting program – The Commission has one seat on that board.

c) **SB 329** on healthcare reform sets up a "health trust fund" and mentions the Commission in two places. Need to become actively involved in the development work.

13) Evaluation and Adjournment: Please fill out the evaluation forms. Meeting was adjourned at 3:00 p.m.