



## **Interview with a Commissioner Bruce Johnson, M.D.**

Dr. Johnson is an otolaryngologist in private practice in Salem since 1991 with Willamette Ear, Nose, Throat and Facial Plastic Surgery. His practice incorporates an ambulatory surgery center where the majority of the outpatient surgery is done. He is past president of the Mid-Valley Independent Physicians Association and is currently on the board of the Mid-Valley IPA Employee Benefit Trust which provides health insurance to physicians, their office personnel and families in Marion and Polk counties. Dr. Johnson has a strong interest in improving patient safety, both in his own practice and in the physician community at large. He has been on the board of the Oregon Patient Safety Commission since 2004.

*Q: You represent ambulatory surgery centers (ASCs), which are just beginning to participate in the Commission's reporting program for adverse events (medical errors). What patient safety issues are unique to ASCs and how do you see them handling this challenge?*

A: We share the same challenges and issues that are found in every operating room environment. Because the procedures done in ASCs tend to be more routine and the patients healthier than typical patients in the inpatient setting, the incidence of adverse events in ASCs tends to be very low. This low rate makes identification of trends more difficult. All surgery centers have some type of quality improvement program. In our ASC, we have adopted the guidelines of the JCAHO -- really the same guidelines used in the inpatient operating rooms -- to help keep our incidence of medical errors very low. I think the Patient Safety Commission's reporting program offers another way to leverage and combine the experience of multiple centers to further drive down the incidence of these events.

*Q: Nationally, hospitals and ASCs sometimes have strained relations. What's your take on things in Oregon?*

A: There is occasionally some tension between hospitals and ASCs in Oregon as well. Hospitals have been concerned about a loss of revenue as outpatient surgeries have moved out of the hospital setting into ASCs. This trend has been driven by two major factors. First, patients feel that ASCs provide a more personalized and less bureaucratic experience. Second, costs for surgery are significantly less in ASCs, due both to lower insurance reimbursement rates for ASCs and to the cost savings that come from a reduced case turnover time that allows more cases to be done in a day.

The goal of improving patient safety provides an area of common ground between hospitals and ASCs. I'm an enthusiastic supporter of the Patient Safety Commission as I believe it provides a forum where ideas and methods that promote improved patient safety can be gleaned and shared between all these facilities that perform surgery, whether in an inpatient or outpatient setting.

*Q: Currently, over half the state's ASCs have signed up to participate in the reporting program. Why does your ASC participate, and what would you say to non-participants to encourage enrollment?*

A: Our facility, River Road Surgery Center in Salem, was one of the first to participate because of my strong belief that, for several reasons, Oregon's voluntary system of reporting medical errors and serious adverse events is more enlightened than most states' mandatory systems. Chiefly, Oregon's system encourages reporting of events through its use of de-identified data for analysis and public reporting of results. Organizations that report events don't have to worry about being penalized for a particular adverse event. Rather, the goal is to look for patterns of error or system flaws that can be remedied and the "fix" then be made available to all. All of these centers have their own quality improvement programs and may feel they are already doing this work. The problem is that the numbers of adverse events tend to be so small for any one center that these patterns can be tough to pick out. Oregon's system allows for a powerful pooling of experience. This will allow the unfortunate experience of other centers to inform one's own practice and promote adjustment of procedures to avoid even potential problems.

The reporting system is malleable and the list and type of reportable events may change over time. Since the rate of really serious adverse events in ASCs is already very low, I'm excited at the prospect of using the system to drive improvement in areas that may not involve serious patient harm but which definitely affect patients' sense of satisfaction and well-being, such as post-operative control of pain and nausea (these may have been considered more "minor" issues for quality improvement programs in the past).

One of the major problems in recruiting ASCs to the Patient Safety Commission's reporting program has been the confusion of this program with a number of other state-mandated programs (like the demographic data reporting and the new infection reporting program) that are not in any way affiliated with the Commission. My experience has been that once doctors and staff in the ASC are educated about the nature of the program and the potential that it holds to improve their care of patients, they become strong supporters. Having these conversations takes time but I'm also hopeful that we've almost reached "critical mass" in this process and that word of mouth will begin to augment the efforts of Commission staff and its board in spreading this message.