

**Oregon Patient Safety Commission
December 7, 2004 Meeting
(Minutes approved 1-18-05)**

Present: Sandra Douma, Andreas Goldner, David Hartwig, Judith Hibbard, Grant Higginson, Bruce Johnson, Susan King, Gloria Larson, Roy Magnusson, Lewis McCoy, George Miller, Andrew Picken, Glenn Rodriguez, Deandra Vallier, David Widen. Staff: Jim Dameron

Excused: Maureen Wright

Issues Heard:

- Approval of Minutes
- Public Comments
- Commissioner Updates
- Report on Ambulatory Record Certification Program
- Update on Public Employees Benefit Board
- Ratification of Confidentiality Agreement
- Next Steps for Developing Pilot Project
- Funding Update
- Administrator: Job Description and Hiring Strategy
- Governor's Report

Call to order: Welcome. Quorum present.

Approval of Minutes: Commissioners reviewed, then approved the minutes from the October 26, 2004 meeting. No one opposed.

Public Comments:

Sarah Mason RN, addressed the Commission and told them that three and a half years ago her infant daughter died in a local hospital as the result of a medical accident. Ms. Mason began by expressing concerns about voluntary reporting programs. She urged the Commission to make the program mandatory. She argued that other serious events—such as suicides and cases of abuse—have mandatory reporting requirements, but not medical errors. “You need to be able to count them so we could see the extent of the problem and have a measure to see if we were making progress in decreasing deaths due to errors.” She believes that medical errors are “shoved under the carpet” and that hospitals will have very little incentive to report under a voluntary system, in part because hospital staff are able to rationalize such behavior (because errors often involve very sick patients who were at greater risk of dying anyway). Ms. Mason also stated that she didn't think the disclosure requirements went far enough. In such situations a letter is not adequate. It could lead to a devastating reaction if a hospital's single response is to hand a patient a letter. Ms. Mason then asked the Commission to expand its definition of reportable events relating to perinatal deaths so that it would include “any unexplained death of any previously stable premature baby.” Finally Ms. Mason raised this hypothetical: If a hospital chooses not to participate in the reporting program but a health care provider sees an error, can that person

report it? “I’d like to see an avenue that any health care provider could report to the Commission.”

The Commission thanked Ms. Mason for her testimony. While it reaffirmed its commitment to making a voluntary system work, the Commission acknowledged that she raised important issues, including how best to handle disclosure, the scope of reportable events, and about who actually reports. The Commission will continue to work on these issues.

Commissioner Updates:

George Miller is making a presentation to healthcare attorneys on December 17th. He also provided an update on the Patient Safety Convocation being planned by the OMA and others. That event is tentatively scheduled for early June, 2005.

Jim Dameron made a presentation to the Oregon Society of Healthcare Risk Managers on November 12th. OSHRM is supportive of the Commission but has concerns about confidentiality protections (including questions about ‘criminal’ activities) and about disclosure requirements (who must disclose: physicians or hospitals? In many cases they have parallel, if not rival, authority.)

Roy Magnusson talked about an incident that recently took place at Virginia Mason Medical Center in Seattle (a woman was mistakenly injected with a toxic antiseptic solution and died). He said that few Oregon hospitals seem to have heard about the incident, even though it was reported in the Washington papers. He argued that this points to a critical role for the Commission – “There will be no improvement unless the Commission disseminates such information.” This led to a brief discussion:

- The power of the Commission rests with its reach but also with the speed in which it could disseminate information.
- Hospitals already get a lot of alerts. It is difficult to know if such information is effectively used.
- The Commission might build some sort of evaluation tool into its dissemination process - - “Did you get the information? Did you use it?”
- Maryland’s experiences with ICU protocols (Peter Provenost at Johns Hopkins) suggests the potential effectiveness of such information distribution.

Presentation on Ambulatory Record Certification Program

Paul Frisch and Joanne Hazel gave the Commission an update on the ARC program. Twenty health plans take part. ARC evaluates office systems and represents a collaborative effort to improve patient safety in the ambulatory setting. There is room to collaborate with the Commission. “We are working on the same thing.”

Update on Public Employees Benefit Board

David Hartwig provided an executive briefing on PEBB's "Vision 2007." Key components of that vision include: An innovative delivery system that provides evidence-based medicine; a focus on improving quality and outcomes; the promotion of consumer education and informed choices; market and consumer incentives; system-wide transparency; affordable benefits. Mr. Hartwig stated that PEBB will expect hospitals to report to the Patient Safety Commission as a prerequisite to doing business with PEBB.

Commissioner Confidentiality Agreement

The Commission reviewed the draft version of the Statement of Compliance that is part of the signed confidentiality agreement. During discussion, Kathleen Haley of the Board of Medical Examiners asked the Commission what would happen if it specifically identified a violation of the Medical Practices Act, if for example, the Commission saw an error caused by an intoxicated physician? She wanted reassurance that the Agreement did not contradict statute (which states that Commissioners may not share information with regulatory agencies, but that Commissioners still have obligations under mandatory reporting laws).

After further discussion the Commission adopted this version (by a 15-0 vote) (CHANGES IN CAPS):

I, the undersigned, have fully read and understand ORS 442.820 to 442.835 and sections 1, 4 to 6, 8 to 10 and 12, chapter 686, Oregon Laws 2003, and I agree to comply with all requirements regarding maintaining confidentiality. I understand that, with the exception of disclosures specifically authorized by chapter 686 Oregon Laws 2003, I may not share CONFIDENTIAL patient safety data of any kind with anyone outside the Commission. This requirement to maintain confidentiality includes but is not limited to information that identifies OR **COULD BE REASONABLY USED TO IDENTIFY A PARTICIPANT OR AN INDIVIDUAL WHO IS RECEIVING OR HAS RECEIVED HEALTH CARE FROM THE PARTICIPANT.** It also means that I may not disclose CONFIDENTIAL patient safety data to any state agency if such disclosures are made for state regulatory purposes. I further understand that no CONFIDENTIAL patient safety data can be discussed during the public portion of a meeting. The requirement to maintain confidentiality remains in force even in settings outside of the conduct of official Commission business. Should I not comply with the requirement regarding confidentiality, I agree to resign immediately from the Patient Safety Commission, if requested by the Chair. Additionally, I understand that my failure to comply with all confidentiality requirements may result in my being held personally liable for unauthorized release of information provided to me in my capacity as a member of the Patient Safety Commission.

The Commission also agreed to a series of administrative procedures meant to clarify the handling of confidential data. These are:

- 1) Each January all members of the Board of Directors will sign the Confidentiality Agreement.
- 2) Prior to review of confidential patient safety data by members of the Board of Directors, staff will assure that identifying information is removed from such materials (such as names of individuals or name of reporting entity).
- 3) If, in spite of the above procedure, a Commissioner becomes aware of an event that requires mandatory reporting the Commissioner will ask the participating organization to report the event.
- 4) If the organization refuses, or if the resolution of the problem is uncertain, then the Commissioner will report the event, either directly or through the Chair.

Developing a Pilot Project: Next Steps

Roy Magnusson reported on the activities of the Definitions Subcommittee. That group met in November and recommends that:

- The Commission approve one change to the definitions matrix: add an additional example of a reportable event to list in General Category #1—“Event that results in an unplanned transfer to a higher level hospital.”
- The Commission adopt the matrix as the starting point for the pilot project.

The discussion:

- The Subcommittee was asked if there are ways to improve the definition set over time. The response: Yes, we envision a ‘cyclical review’ of the indicators occur. Over time, some indicators could be dropped, some added.
- Some Commissioners thought the definitions seemed quite broad. There was general agreement that the pilot will offer a fair test of such assertions. “We can look for feed-back during the pilot.”
- RCAs can be very intensive. Will all events require a RCA?

With regard to the pilot project, the definitions subcommittee recommends a two phase approach:

- Phase #1: Pilot hospitals will submit last 6 months of RCAs, action plans and follow-up plans to Commission:
 - Submit all RCAs, etc whether they fit the definition-matrix or not.
 - Begin as soon as possible.
 - Use the information to compare variation across hospitals
 - Consider information as part of the process to build reporting templates.
- Phase #2 : Pilot hospitals begin collecting specific adverse event data consistent with definition-matrix. The pilot should be:
 - As simple as possible
 - Congruent with current hospital practices

- Allow the Commission to obtain the information it need to assess completeness, thoroughness and credibility.

The Commission discussed which hospitals to include in the pilot project. The goal is to include 5 or 6 of different sizes and locations. Those mentioned included: Kaiser Permanente Sunnyside, OHSU, Salem General, St Anthony, Stayton, Sacred Heart–Eugene, Providence Medford, Rogue Valley, Tuality – Hillsboro, Mercy Medical—Roseburg. The Commission briefly discussed whether the pilot should be limited to hospitals represented by Commission members. Gwen Dayton of the Oregon Association of Hospitals and Health Systems volunteered to recruit other hospitals if asked. No firm decisions were made about the final participants.

The Definitions Subcommittee stated that it would like to continue to meet but that it did not want to manage the pilot project. For the pilot it would be willing to help assess the validity of the definitions matrix. However the subcommittee wants to begin the process of defining ‘serious adverse events’ for other eligible reporting entities. It will start with long term care. The Commission will be asked to revisit this at their next meeting in January.

The Commission agreed that the pilot will be managed by a workgroup consisting of participating hospitals and at least 3 Commissioners: Andreas Goldner, David Hartwig, Grant Higginson.

Funding Update

As of December 7, 2004 the Commission had \$181,150 in its bank account. An additional \$45,000 has been pledged, for a total of \$226,150.

Andrew Picken said that he is continuing to talk with a number of health insurers and believes some pledges are likely.

George Miller said that he sent thank you letters to all organizations that have contributed to date.

Lewis McCoy talked with the Oregonian about the possibility of donating space for a public service announcement. The Oregonian declined, citing a possible conflict of interest (giving free space while having to report and monitor governmental affairs). The Commission decided that it would not pursue this option further at this point.

Hiring an Administrator

The Commission reviewed a job description drafted by the hiring subcommittee (George Miller, Maureen Wright, Andy Goldner, Gloria Larson). Discussion:

- The salary range is pegged to the state grading system, specifically a “Principal Executive Manager G.” Some Commission members thought that the range was too high. The subcommittee agreed to look at it one more time.
- The person needs to be able to walk into a hospital and converse with administration.

- We need to beef up the leadership role. This is not a ‘reactive position.’ This person must initiate, have a strategic vision.
- Regarding the skill set: one group argued that the candidate should have a master’s degree in a health related field. Another group argued that work experience should substitute for education.

The Commission authorized the Hiring Subcommittee to reconcile these differences and to proceed. The subcommittee will post the administrator position as soon as it can. It will then present a selection process to the full Commission in January.

While the Commission has great latitude in how it selects an administrator, it will seek HR advice to ensure that it creates a fair and equitable hiring process.

Governor’s Report:

By statute (ORS 182.472), the Patient Safety Commission must submit a report to the Governor and the Legislative Assembly by the first day of each regular session of the Legislative Assembly. In 2005 this will be January 10th. Staff outlined an approach to accomplishing this task. The Commission agreed. Staff will draft a report and circulate it to the Commission by December 21st. Staff will then work directly with the chair to finalize and submit the report.

Next Steps/Follow-up

- Update bylaws to reflect changes to confidentiality agreement. Post most recent version on the Commission’s website.
- Pilot project subcommittee: continue to organize the pilot study. Select the final list of participants; agree to ground rules; begin phase #1.
- Definitions subcommittee: begin work on crafting reporting guidelines for long term care.
- Hiring subcommittee: Finalize administrator job description (including stronger emphasis on leadership, clarifying required skill set and salary range). Obtain HR review and advice. Develop posting strategy. Post job. Draft screening process.
- Funding efforts to continue.
- Staff will draft Governor’s report.

Next Meeting of the Patient Safety Commission:

- Date: January 18, 2005
- Time: Noon until 3 PM.
- Location:
Kaiser Permanente Building,
500 NE Multnomah
Portland, OR

Minutes prepared by Jim Dameron (12-9-04)