

Oregon Patient Safety Commission
March 1, 2005 meeting
Final/Approved by the Commission on April 12, 2005

Present: Sandra Douma, Andreas Goldner, David Hartwig, Grant Higginson, Bruce Johnson, Gloria Larson, Roy Magnusson, Lewis McCoy, George Miller, Glenn Rodriguez, David Widen, Maureen Wright. Staff: Jim Dameron.

Excused: Judith Hibbard, Susan King

Absent: Deandra Vallier

Issues Heard:

- Approval of Minutes
- Public Comments
- Commissioner Updates
- Consumer Involvement in patient safety activities
- Fee assessment work group report
- Progress reports
- Clarifying mandatory reporting obligations
- Balancing the mission: continued discussion
- Disclosure of adverse events – toward developing a policy

Call to order: Welcome. Quorum present.

Approval of Minutes: Commissioners reviewed the draft minutes from the January 18, 2004. Minutes were unanimously approved with no changes. As always, minutes will be posted on the Commission's website:

Public Comments: None.

Commissioner Updates:

Grant Higginson announced that the state of Oregon has hired a new Public Health Director (Susan Allan, MD, JD, MPH). Dr. Allan will also assume the statutory role of State Public Health Officer. Since the Public Health Officer is an ex-officio member of the Commission's Board of Directors, Grant Higginson stated that this may be his last Commission meeting. The Commission thanked him for his hard work and dedication to patient safety. It remembered that in 2002 Grant convened the group of stakeholders that eventually drafted patient safety legislation.

Maureen Wright told the Commission that May 6-12 is National Patient Safety Week. The Commission considered ways in which it might take part, including letter writing efforts and an op-ed piece for the print media. Jim Dameron and George Miller agreed to further explore options.

Jim Dameron told the Commission that he received a query of interest from Linda Lang of the Rural Hospital Quality Network. This new group has just received a HRSA planning grant. They are working with OHSU and with OMPRO. Ms. Lang wants to explore possible ways the Commission and the Quality Network might work together. The Commission decided that it would monitor the progress of the Network.

Consumer Involvement in Patient Safety Activities

The Commission discussed the question: “What role should the Commission have in engaging consumers in patient safety activities?” Staff presented a range of possible options. Highlights of the discussion:

- Some commissioners felt there is a lack of trust. ‘It should be one of our priorities to build connections.’
- Regarding the idea of an ombudsman – Some commissioners felt that consumers already have a way to file complaints. ‘We need a way to go beyond that, to see the big picture.’
- Regarding the staff-presented options, one Commission said, “These options are all over the place. Maybe we need to create a consumer work group.”
- Another point of view -- In those areas where we have a priority, get consumer input.
- Create opportunities to get consumer input. But it should be a narrow focus, not a complicated connection of consumer involvement. It has to represent added value.
- The website would be a good place to engage consumers.
- Go out into the community.
- The main focus should be reducing errors.
- Consumer input is often diffuse and hard to understand.
- What about payers? They represent a subset of consumers.

The Commission decided that it would not create a consumer advisory panel at this point. No other firm agreements were reached.

Fee Assessment Committee

Maureen Wright presented a report from the Fee Assessment Subcommittee. She said that the most difficult fee-related questions were: 1) should fees be phased-in or should all entities be required to pay, from the beginning; 2) What is fair, especially with regard to how much of the bill should be assigned to each entity type? Among the discussion points:

- We need to be careful about what fees are meant to pay for – product or infrastructure or both?
- But we are not selling infrastructure, we are selling a product.
- Our startup budget is closer to \$400,000, not \$700,000. We could incrementally phase it in.
- Margaret Carley of the Oregon Health Care Association: The Commission has a statutory problem. It isn’t clear that you have a legal right to assess fees. You should get that clarified first. This is a threshold issue. Get an Attorney General ruling, then get a statutory fix.

- With regard to Long Term Care – I don't think they will feel comfortable paying for infrastructure. They would prefer the 'product' model.
- It would be harder to sell if it was only infrastructure.
- Some disagreed with the 'product-only' approach. 'Fees should be inclusive. Everyone will say they represent the marginal costs.'
- Whatever the fees, they should be based on publicly reported data. Let's find out exactly what data are reported publicly.
- Gwen Dayton (Oregon Association of Hospitals and Health Systems): if you do an assessment based on beds, need to be clear about whether you are using available beds or licensed beds.
- Formula should be simple, comprehensive and equitable.

The Commission agreed that it needed an AG ruling to clarify its ability to assess fees.

The Commission asked the subcommittee to prepare a series of concrete fee assessment options for consideration at the next Board meeting.

Filling Board Vacancies

The Commission currently has 2 vacancies: one vacant position would represent health insurers, the second would represent private employers who purchase health care for employees. Staff said that at least two candidates had expressed an interest in the insurer vacancy. The Commission then considered ways to create a pool of candidates for the private purchaser spot ("The Commission's role is limited to encouraging candidates to come forward.") The Purchasers Coalition was again suggested as a possible ally. Their current chair is Patrick Pine of ESCO. Staff will consult with Glenn Rodriguez on best way to proceed. Intel was also suggested as an employer with an interest in quality of care and patient safety issues.

Annual Election of Officers

Chair and Vice chair are elected to one year terms. Those terms expire on May 10, 2005. George Miller (Chair) mentioned that he has had health problems. However, he hoped those problems were behind him. He would be willing to serve a second year if asked. Andy Goldner (vice-chair) said he was willing to serve a second term as well. Other candidates are encouraged to submit their names to George Miller or to Jim Dameron.

Pilot Demonstration Project

Four of five hospitals have agreed to a Memorandum of Understanding. The fifth has some concerns about the confidentiality of data. Specifically the hospital wants clarification about what information would be discussed at public meetings and what would be exempt from such meetings. Negotiations continue.

The Commission requested that staff work with the Attorney General to clarify how it may handle confidential data in meeting situations.

Gwen Dayton also reminded the Commission that it should set the rule making process in motion.

Milestone Workgroup

The workgroup has not yet met, though it plans to do so.

Update on legislation calling for mandatory reporting of healthcare acquired infections

Grant Higginson explained that the Legislature is considering at least 3 bills that call for mandatory reporting of infections. He noted that the Department of Human Services is opposed to such legislation on 2 grounds: First, infection data need to be risk-adjusted. In the opinion of DHS, the science of how to do that is not yet sufficiently developed. Second, the legislation calls for DHS to run the program and no funds have been allocated in the Governor's budget.

Grant then reviewed the position paper he drafted for the Commission which stated that the Commission's "voluntary reporting system and emphasis on quality improvement and dissemination of evidence-based practices will help lower the incidence of such infections." The paper also concluded that the Patient Safety Commission:

- Understands the public's concern about health-care acquired infections.
- Appreciates that HB 2366 (one of the three bills) separates this new reporting system from Commission responsibilities because it's not a good fit with current Commission reporting activities (mandated vs. voluntary reporting; public disclosure by facility vs. participant confidentiality).
- Is neutral on the bill and will remain so until it is asked for input and has additional time to consider differing opinions on the issue.

The Commission will continue to track the progress of this legislation.

HIPAA Clarification

On advice from the Attorney General's Office, the Commission clarified its status with regard to HIPAA Privacy Rules. After review of a letter written by Linda Grimms, Senior Assistant Attorney General, the Commission adopted the following resolution (moved, seconded, and unanimously approved):

The Commission declares that when it requests or uses patient safety data, the Commission is acting in its capacity under state law as a public health authority.

The Commission further declares that the Commission is not a covered entity for purposes of HIPAA privacy regulations.

Hiring an Administrator

The Commission has screened candidates for the administrator position and reduced the field to 3 finalists. The hiring subcommittee will interview the finalists. Other Commissioners will participate in the interviews when possible.

Clarifying mandatory reporting obligations

Dave Widen reported on efforts to clarify the relationship between mandatory reporting obligations and patient safety confidentiality protections. Dave, Susan King, and Jim Dameron had a phone conference with the Nursing Board, the Pharmacy Board and the Board of Medical Examiners. Dave presented a summary of that discussion to the Commission. He recommended that the Commission alter its internal procedural guidelines to the following:

- Each January all members of the Board of Directors will sign the Patient Safety Commission's Confidentiality Agreement.
- Commissioners should understand that if they are mandatory reporters by virtue of their professional license, then their reporting obligations will remain in effect, whether they are acting on behalf of the Board or otherwise. This is true as long as they have first hand information of a violation.
- Prior to review of confidential patient safety data by members of the Board of Directors, staff will make every effort to redact sensitive information. Most critically, names of patient, clinicians, and facility will be removed from such materials. If a Commissioner reviews material that has not been properly redacted, he or she will stop reading immediately and return materials to staff.
- If, in spite of the above procedure a Commissioner becomes aware of an event that requires reporting, then the Commissioner has a duty to report, if he or she has sufficient first hand information. Such information would include clinician name. It is the opinion of the Commission that without clinician name, there is no obligation to report.
- Staff will consult with the Chair of the Commission if they believe that possible events are going unreported.

The Commission moved, seconded, and unanimously voted to approve these internal procedural guidelines.

Balancing the Mission

The Commission continued its on-going discussion about how to honor its mission. The Commission, by statute is to accomplish its mission (to reduce the risk of serious adverse events and to encourage a culture of patient safety) by a) establishing a reporting system; b) establishing quality improvement techniques; and c) disseminating evidence-based prevention practices.

Since the Commission has made some progress toward building a reporting system, it discussed how to accomplish points b and c. After a brief discussion, it decided to wait until it had more information from the Milestone workgroup before further deliberations.

Disclosure of Adverse Events

The Commission discussed its role in defining how and when patients are told about disclosure occurs. From the discussion:

- This is a tough topic.
- Perhaps written notification be an acknowledgement that “a conversation took place.” If that were the standard, a verification process would require a participant to provide evidence of written notification.
- We should use the pilot to learn more about what hospitals are doing.
- Core value should include flexibility to craft it.
- OMA and OAHSS has published draft disclosure language – a notice that something happened. Would be given at the end of a conversation. “As we discussed...”
- A lot of this information is already there. Only missing piece is the written disclosure.
- I favor the pilot group working on this.
- The requirement for written disclosure represented a compromise between a voluntary system and consumer protection. A trade off between publicly reported aggregate data versus individually useful information.

The Commission agreed that the pilot advisory group take up the issue of disclosure as part of its charge. It will start by learning more about hospital-specific disclosure policies.

Next Steps/Follow-up

- Staff will call Linda Lang of the Rural Hospital Quality Network to learn more about this new organization.
- Staff will obtain a ruling from the Attorney General in order to clarify its ability to assess fees. Staff will work with interested parties to initiate a ‘legislative fix’ if necessary.
- The Fee Assessment subcommittee will prepare a series of concrete fee assessment options for consideration at the next Board meeting.
- Regarding vacancies on the Board: Staff will consult with Glenn Rodriguez on contacting the Health Care Purchasers Coalition. Staff will also consult with commissioners on contacting Intel about their interest in participating in the Commission.
- Any Commissioner interested in running for Chair or Vice-chair should contact George Miller or Jim Dameron.
- Staff will work with the Attorney General’s Office and with hospital attorneys to clarify confidentiality protections.
- Staff will initiate rule making process.

- The Milestone subcommittee will convene before April 12th.
- Staff will continue to track legislation calling for the mandatory reporting of healthcare acquired infections. The chair will determine if the Commission should ‘weigh-in’ on the subject with the legislature.
- The Commission agreed that the pilot advisory group take up the issue of disclosure as part of its charge. It will start by learning more about hospital-specific disclosure policies.

Next Meeting of the Patient Safety Commission:

- Date: April 12, 2005
- Time: Noon until 3 PM.
- Location:

The Kaiser Permanente Building
500 NE Multnomah Street
Portland, OR 97232

Minutes prepared by Jim Dameron (3-22-05)