

Oregon Patient Safety Commission
August 3, 2004
Approved by the Commission

Present: Sandra Douma, Andreas Goldner (vice chair), David Hartwig, Bruce Johnson, Susan King, Gloria Larson, Roy Magnusson, Lewis McCoy, George Miller (chair), Glenn Rodriguez, Deandra Vallier, David Widen, Maureen Wright. Staff: Jim Dameron, Joel Young.

Excused: Judith Hibbard, Grant Higginson, Andrew Picken

Issues Heard:

- Approval of Minutes
- Public Comments
- Commissioner Updates
- Confidentiality Agreements
- Amending bylaws to handle simultaneous absence of chair and vice chair
- Funding Update
- Report from Communications Subcommittee
- Report from Reporting/definitions Subcommittee
- Agreements on website design and content
- Initial discussion on information systems
- Other Business

Call to order: Welcome. Quorum present.

Approval of Minutes: Commissioners reviewed, then approved the minutes from the June 22, 2004 meeting. No one opposed.

Public Comments: A member of the public stated that she had been “following the patient safety legislation since it passed.” She was attending the meeting “to see if you are making progress.” She wanted to know more about the new national report on medical errors (HealthGrades, July 2004). She was especially interested in the conclusion that errors in the U.S are under-reported. She was also interested in knowing what definition of adverse events the Commission was using. The Chair thanked her for her comments.

Update on NASHP conference: On July 22, 2004 George Miller and Jim Dameron attended a patient safety conference sponsored by the National Academy for State Health Policy (NASHP). Oregon is one of 6 patient safety centers that have a quasi-governmental status and some independence from regulatory agencies (Oregon, Pennsylvania, Maryland, New York, Massachusetts, Florida). Other states (including Missouri and Minnesota) are interested in this approach. NASHP hosted (and paid for) the conference in the belief that the 6 centers represent a good new idea about how to organize patient safety activities. Dr. Miller identified a number of lessons learned: Using simple definitions such as those created by NQF are attractive. Coalitions are important. Start small. Go after low-hanging fruit. Incentives work. Look for support from malpractice insurers. Avoid an overly-specific mandate.

Other comments from the conference: Maryland had gained the financial support of their state hospital association and quality improvement organization (QIO). In collaboration with the QIO Maryland plans to hold a conference on the Culture of Patient Safety in the fall of 2004. Maryland also identified a hospital that had gone 18 months without a MRSA (methicillin-resistant *Staphylococcus aureus*) on their surgical unit. Pennsylvania has created an impressive web-based reporting tool that is getting good marks from hospitals (in part because hospitals can use it to compare their patterns of errors to statewide patterns). NASHP is writing a report based on the conference. Staff will make it available to the Commission as soon as it is published.

Update on Health Policy Commission's Quality Work group: Glenn Rodriguez (who is a member of HPC's Quality Work Group) said that there are 4 work groups organized within the HPC (Quality, Access, Cost, Health Status). Each is drafting a document summarizing strategies and possible activities. He thought that the Patient Safety Commission should work collaboratively with the Quality Work Group and encourages the two bodies to find ways to do so.

Review of Signed Confidentiality Agreement: At the June 22nd meeting the Commission decided that each Director should sign a confidentiality agreement to underscore the seriousness of their commitment to protecting patient safety data from unwarranted disclosure. At that time the Commission directed staff to draft an agreement for review at the next meeting (Aug 3rd). Important issues raised during the Aug 3rd discussion:

- The Commission restated their general commitment to public meetings and an open process.
- Since many of the Commissioners work in health care settings, there was some concern about conflicts of interest if Commissioners were asked to review (or even have knowledge about) a case involving their home institution.
- The group then discussed whether commissioners should have access to the specifics of a case. The general sense of the group is that Commissioners did not want such access.
- As a result, Commissioners suggested that a policy be developed to routinely de-identify patient safety data prior to review by Commissioners. However, such a policy would not do away with the need for a signed confidentiality agreement.
- The Oregon Association of Hospitals and Health Systems requested that the Commission make sure that language in the confidentiality agreement (concerning 'patient safety data') was consistent with Oregon statute.
- The Commission agreed that Directors should initially sign the agreement as soon as they are confirmed by the Senate, and that all Directors will re-sign the agreement on an annual basis (as a way of emphasizing the importance of the agreement).

In conclusion, the Commission requested that staff update the confidentiality agreement in light of discussions and ask the Department of Justice for a legal review. Then, the revised (and DOJ-approved) agreement would be brought to the Commission for discussion and possible ratification at the next meeting. At that time the bylaws would be amended to make it clear that Directors must sign a confidentiality agreement (though the agreement itself would not be part of the bylaws).

Amending Bylaws: At the last Commission meeting, both the chair and vice-chair were absent. For that meeting George Miller asked Andrew Picken to chair in his stead. But since the bylaws did not specifically address the will of the entire board on how to handle such situations, Dr Miller asked that guidelines be established. Therefore the Commission discussed this change to Article IV of the bylaws: "In case of a scheduled absence of both the Chair and Vice-chair, the Chair will select another commissioner to preside over that upcoming meeting." Staff reminded the Commission that bylaws may be amended by a two-thirds vote of the **entire** Board of Directors (which translates to 11 votes since the board currently has 16 members). After review the Commission agreed (13-0) to amend Article IV of the bylaws using the language as drafted.

Funding Update:

Maureen Wright announced that Kaiser Permanente had donated \$25,000 to the Patient Safety Commission. She also said that KP would consider additional in-kind contributions as needed. The Chair thanked her on behalf of the entire Board of Directors. The Commission now has \$40,000 in its bank account.

Other Commissioners discussed their efforts at fund raising:

Susan King said that she had talked with Tim Nesbitt of AFL-CIO. Mr. Nesbitt said that the Commission should make an appeal to the AFL-CIO in March, 2005 which is the beginning of their next funding cycle.

Dee Dee Vallier said that she had been asked to approach the trial lawyers, but was hesitant to do so. She wondered about the environment in which so many of the original sponsors of patient safety legislation had given large sums to a tort reform effort aimed at capping non-economic damages, but had not yet contributed to the Commission.

The general sense of the group is that the preliminary work has been completed and that it was now time to begin a serious effort to raise monies. The Commissioners agreed to assume their 'ambassador' roles. They agreed to develop organization-specific strategies and communicate with key leaders. Staff will reissue, in electronic form, the funding materials and the list of assignments. Staff are available for consultation and support. Deadline: September 14, 2004 (date of next Commission meeting).

Update from Communications subcommittee (Members: David Hartwig, Grant Higginson, Judith Hibbard, David Widen):

Jim Dameron provided a quick update. He reminded the Commission of progress to date: key audiences have been identified and prioritized; objectives, strategies, tools and activities have been drafted for addressing each audience. As next steps the subcommittee suggested 4 initial activities: 1) finalize the website (see below); 2) ask George Miller and Grant Higginson if they would draft an op-ed style piece on patient safety; 3) begin the work of crafting a report for the Legislature (due to that body by September 30); 4) consider a Patient Safety Summit or Conference for year-end 2004 or early 2005.

Discussion/next steps:

- Dr. Miller agreed to work on an op-ed piece. Staff will assist as needed.
- Regarding a report to the Legislature: Staff will outline a concept paper and distribute it to the Commission prior to next meeting.
- Regarding a conference: Commissioners seemed interested in this idea, but some thought it would take a great deal of energy and might distract the Commission from more pressing activities. Dr. David Shute (OMPRO) told the Commission that the Oregon Medical Association's Patient Safety Committee, in collaboration with the OAHHS was working on such a conference. After discussion, Commissioners decided that the Patient Safety Commission should not attempt to lead such a conference but that it could help coordinate activities of mutual interest with OMA/OMPRO/OAHHS organizers.

Report from the Definitions/Reporting Program Subcommittee (Members: Sandy Douma, Bruce Johnson, Susan King, Roy Magnusson, Lewis McCoy, Dee Dee Vallier. Staff: Jim Dameron):

Dr. Magnusson reviewed the work of the subcommittee and provided an overview of its initial proposal for defining serious adverse events. Highlights included:

- The subcommittee studied approaches used by others and organized them into three categories: "Explicit list" models, "general-definition" models, and hybrids.
- The subcommittee drafted guidelines/principles to frame their work.
- The key proposal for a core data set: Combine a general definitions approach (similar to definition used by Joint Commission on the Accreditation of Healthcare Organizations) with an explicit model approach (similar in approach to National Quality Forum).
- The core data set can grow or be modified over time, but we have to start somewhere. This is a reasonable beginning.
- Reporting about healthcare acquired infections would be treated as a separate category. Further developmental work is needed to select which specific types of infections should be reported.
- The subcommittee believes that close calls should be included at some point. But further elaboration is needed. The subcommittee will continue to work on an approach.

Questions/Discussions about the definitions:

- 'This is a great work, an outstanding start.'
- Question: Do we know what hospitals are currently reporting? Response: Not much. JCAHO accredited hospitals are collecting data sentinel events, but they are not reporting it to JCAHO or anyone else. Every hospital has a different reporting system, using different definitions and different priority ratings.
- Question: Why did you change NQF's language of "serious disability" to "serious physical injury?" Two reasons were offered: 1) the idea of disability introduces the concepts of permanent and temporary disability. Disabilities play out over time, and thus make reporting more difficult. 2) "serious physical injury" is the language used in Oregon statute.

- “Serious physical injury” is still vague. We might have to create a list of examples to help reporting entities know what to report. Show the scope of what might be reported. Focus on ‘significant injuries.’
- Even if the general definition is a little vague, we want to create an invitation to report. ‘If this is a problem in your hospital, share it. It is probably a problem somewhere else too.’
- For the specific NQF-like definitions, we might need even more elaboration.
- The definition for healthy babies might need work. Not all babies at 28 weeks and 1000 grams are healthy. Maybe the definition should be left general: ‘death or serious physical injury to an otherwise healthy neonate.’

The discussion about how to include infections within a definition of serious adverse events included many points of view. A sampling:

- Reporting about infections could be overwhelming.
- JCAHO already has guidelines in place to define someone who dies from an infection as a sentinel event.
- Half the community has MRSA. We don’t know where they are coming from. It isn’t something we can deal with at the hospital. This is a public health issue. Some physicians believe we can do nothing to impact the rates of infections in hospitals.
- Yet, some hospitals (and some countries) have shown they can reduce rates of infection.
- If we are to include infections we’d need a well-defined list. NISS has one. The Commission could stake out a role in defining infections to report. If we can have a subset that we can report, it would be helpful.
- A group of epidemiologists meets in Portland every month. Maybe one or more could come talk to the subcommittee about healthcare-acquired infections.
- This is an important issue. We need to continue to work on this.

Next steps for the reporting/definitions subcommittee:

- Clean up the definitions. Give examples to help reporting entities understand the intent of the definitions.
- Ask an OB group to help define healthy neonates.
- Continue to explore the category of infections. Invite an epidemiologist to the next meeting of the subcommittee to outline possible categories for inclusion. Consider including the state epidemiologist in these discussions.
- Define ‘medication error’ more closely.
- Ask commissioners representing non-hospital reporting entities to consider if list would work for their institutions. What applies to your venue? What factors should be on the list, but are not?
- Begin to consider using ‘internal focus groups’ (such as hospital based quality managers) to provide feedback about the proposed list of reportable events. *“If you were asked to report these events...would it be doable, how much of a hardship, what have we left off the list?”* Roy Magnusson, Maureen Wright, Glenn Rodriguez and George Miller all agreed to test it within their organizations.

Review of new website: The Commission reviewed the test version of the Patient Safety Website. Two additions were suggested: add a list of Commission members. Add a list of donors. With those changes, the test website can be converted to a publicly accessible site. Also, staff was asked to investigate whether it can purchase the rights to the Internet domain names of “Oregon Patient Safety Commission” and similar combinations.

Initial discussion on information systems: As part of creating a “Patient Safety Reporting Program” Jim Dameron suggested that the Commission begin to think about how it will receive and handle data. While there are many ways to consider this issue, one approach makes a distinction between:

- Creating a minimum data set (Common definitions. The commission becomes the passive receiver of data)
- Creating a technical assistance approach (Commission has an interactive relationship with reporting entities. Commission has a helper role.) Such an approach would require the Commission to define user specifications that would include such issues as system architecture, security, user tools, protocols for sharing.

Staff recommended that the Commission consider the technical assistance approach by convening an advisory panel. That panel might consist of interested Commissioners plus knowledgeable IT staff from Commissioners’ home organizations.

The Commission agreed that a panel should be created. Roy Magnusson (OHSU), Maureen Wright (Kaiser Permanente), and Lewis McCoy (Generations) stated they had IT people and IT models that the Commission should consider.

Other business:

Staff asked the Commission to review a document entitled “draft guidelines: Accounting and Internal Control Procedures.” After doing so, the Commission voted unanimously to approve the procedures for signing authority and for expenditure approval. These state:

Signing authority

- Require two signatures for all bank withdrawals over \$500. Chair and Administrator.
- If chair not available then vice-chair.
- Until an administrator is hired, Jim Dameron.

Expenditure approval

- All expenditures will take place within the context of a Commission-approved budget and spending plan.
- The Commission delegates review and approval authority to the Chair.
- Administrator may independently approve expenditures for amounts up to \$2,500. Administrator will routinely update the Commission on all expenditures.
- Expenditures above \$2,500 will be approved in advance by the Commission Chair.

Next Steps/follow-up:

- Staff will update the Confidentiality Agreement and ask DOJ to review it.
- Commissioners will begin/continue active fund raising efforts. Staff will distribute funding materials and list of assignments. Jim Dameron and Joel Young are available for support.
- Dr. Miller (and possibly Dr. Higginson) will draft an op-ed piece on patient safety, with the expectation of submitting it to the print media for publication. Staff will support as needed.
- Staff will take the first steps in drafting a report to the Legislature.
- The Commission (most likely the Chair) will coordinate the planning of a patient safety conference with the OMA and OMPRO.
- The definitions subcommittee will meet again and continue its work.
- Roy Magnusson, Maureen Wright, Glenn Rodriguez and George Miller all agreed to vet the proposed list of reportable events within their organizations. Others are invited to do so.
- Staff will finalize changes to the patient safety website, then make it available to the public. Staff will also obtain Internet domain names for “Oregon Patient Safety Commission” if possible.
- Staff (and others) will begin work on convening an information technology advisory panel.

Next Meeting of the Patient Safety Commission:

Date: September 14, 2004

Time: Noon until 3 PM.

Location: Kaiser Permanente Building, 500 NE Multnomah Street, Portland.