

Oregon Patient Safety Commission
September 14, 2004 (Non to 3 PM)
Draft (Not yet approved by the Commission)

Present: Sandra Douma, Andreas Goldner (acting chair), Judith Hibbard, Bruce Johnson, Gloria Larson, Roy Magnusson, Lewis McCoy, Andrew Picken, Glenn Rodriguez, Deandra Vallier, David Widen, Maureen Wright. Staff: Jim Dameron, Joel Young.

[Note: David Widen and Roy Magnusson arrived about 1:30 PM. Glenn Rodriguez left about 2 PM.]

Excused: David Hartwig, Grant Higginson, Susan King, George Miller.

Issues Heard:

- Approval of Minutes
- Public Comments
- Commissioner Updates
- Discussion of strategic goals
- Funding Update (including review of *Fund Raising* memo)
- Report from Reporting/definitions Subcommittee
- Legislative report: review of outline/draft

Call to order: Welcome. Quorum present.

Approval of Minutes: Commissioners reviewed, then approved the minutes from the August 3, 2004 meeting. No one opposed.

Public Comments: None

Commissioner Updates:

[Note: Susan King and Grant Higginson were in Salem making a presentation to the Interim Joint Committee on Human Services at the same time the Commission was meeting.]

Glenn Rodriguez told the Commission that the Health Policy Commission is currently holding public hearings around the state. He also mentioned that the HPC had considered, then rejected, requesting that the Legislature require mandatory reporting to the Patient Safety Commission.

Andrew Picken described some of the recent activities of the Public Employees' Benefit Board (PEBB) that might affect the Patient Safety Commission. As part of its 2006-2007 *visioning process*, PEBB is re-thinking its use of incentives. One possible idea (among a long list of ideas) is to withhold a proportion of hospital payment contingent on submission of data to the Patient Safety Commission. The Commission discussed the implications of this market response and generally seemed supportive. This led to a brief discussion about incentives in general. The Commission acknowledged that it has an obligation to create a series of incentives to participate in the voluntary reporting program. The Commission believes that such incentives should include more than financial incentives. Also,

creating incentives should be a collaborative process (the Commission should talk with groups about which ideas to foster). Finally, given PEBB's interest, the Commission thought that PEBB should be asked to donate directly to the Commission. [David Hartwig has had some initial conversations with PEBB.]

Strategic Goals:

Prior to the meeting George Miller had emailed a draft document called "Strategic Goals for 2004-2005" to Commission members for discussion and debate. During that discussion the strategic goals were described as a very good start. It was noted that they emphasize *time* (when to begin) and *volume* (percentage participation), but that perhaps they did not address a bigger question of 'Are we doing what we need to do?'

In addition, the Commission raised the question of how to begin the reporting program. Should the Commission encourage the use of a pilot? If so, which hospitals should be included? As an alternative, a retrospective approach was suggested: start with a subset of hospitals, focus on JCAHO sentinel event reporting, ask hospitals to send the Commission their already-collected data (for 6 months in 2004 for example). This would avoid a potential mismatch between what hospitals currently collect and what the Commission might ask them to collect. Once the Commission received these sentinel-event data, it could determine if the data were useful. Such an approach was felt to maximize collaboration and to allow for quick initiation of the reporting program. Simultaneously, the Commission would continue the work of preparing for a full roll-out of the reporting system in 2005. If adopted, this proposal would lead to a new strategic goal: Goal #1: in 2004, the Commission will collect JCAHO sentinel event data from X hospitals.

The Commission briefly discussed some of the implementation issues:

- How will JCAHO events actually be reported? The Commission might have to create an abstract for reporting events (it was argued that the typical RCA can run to many pages, and that the Commission should request a distillation, not the actual RCA).
- Important to seek feedback from reporters about the most efficient, least disruptive process.
- Maybe a working group should be charged with developing a plan for collecting retrospective data from existing data sources.
- Make sure to include small hospitals in trial.
- Might be better to put together a tool, collect information, then convene a subcommittee.
- What about bricks and mortar issues for the commission. Do we need an administrator before we can do these things?
- If you can't crosswalk the definitions (JCAHO versus Commission) who yields? To the extent that there is a disconnect doesn't necessarily mean that the Commission's list is flawed.
- We need to include more than hospitals. Bring in the other classes of reporting entities soon.

While many were interested in this retrospective approach, others cautioned that the Commission currently lacks the capacity to really do such work. Therefore, the Commission decided to

postpone a vote on this idea until after the definitions subcommittee gave its report later in the meeting (see below).

Funding Update:

Glenn Rodriguez announced that Providence Health System has contributed a total of \$50,000 to the Commission. OHSU has contributed \$15,000. In addition, Joel Young reported that the Oregon Medical Association has agreed to donate \$25,000. Bruce Johnson said that Mid Valley IPA is likely to contribute \$10,000. To combine celebration and marketing, one commissioner suggested that the Board of Directors should buy an ad in the Oregonian in order to publicly thank organizations for contributing.

Also, among other groups approached: Northwest Physicians Mutual is considering a donation (they have a budget meeting in October). The Oregon Health Care Association is also considering a donation (their board will review a funding proposal at their September 20th meeting). Blue Cross is likely to increase its initial donation by \$10,000. SAIF has declined, but will reconsider after the November elections. The trial lawyers association expressed support for the Commission, but has also declined to donate, citing November's *hard campaign*. The Commission has made contact with a number of other organizations.

All told the Commission now has \$130,000, with likely pledges for an additional \$25,000. The general sense of the Commission is that they have made good progress and that they should now *leverage* that progress into additional contributions. Among the strategies discussed: 1) Organize a campaign aimed at purchasers. 2) Go to big hospital systems directly. 3) Collaborate with OAHHS on how to approach the mid size and smaller hospitals.

In addition to discussions about how to continue raising money, the Commission began a discussion about whether it was time to hire its own staff. Maureen Wright said that Kaiser Permanente (which has donated \$25,000 to date) is still very willing to consider in-kind contributions. She again mentioned the possibility of offering space to Commission staff. The Commission discussed the perceived pluses and minuses of being housed in a KP facility.

Finally, the Commission reviewed a memo from George Miller ("Fundraising") calling for the consideration of mandatory user fees if the goal of \$400,000 was not reached by the November meeting. Since the Commission has made more progress than perhaps expected, Commissioners weren't sure whether to act on the suggestion. Some thought it premature and that it might interfere with ongoing fund raising efforts (*We don't want to commingle our messages*). Others thought that the commission should begin a separate process to discuss such fees. One commissioner called for a matrix to outline fee proposals and to describe possible steps for what an assessment project might look like. Another called for a working group to hold preliminary discussions and to generate ideas.

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

Roy Magnusson reviewed an updated “proposed list of reportable events” crafted by the subcommittee. Highlights/discussion:

- In response to earlier calls to create a list of examples to clarify/amplify the definition of “serious physical injury,” the subcommittee suggested a list of general guidelines instead. Such a list might link serious physical injury with unintended consequences such as *patient has an unexpected need to return to surgery* or *patient spend unanticipated extra days in the hospital*. The subcommittee will finalize this list at their next meeting.
- The subcommittee drafted a series of options on how to include nosocomial infections within the reporting framework. It will continue to refine these ideas at its next meeting.
- The Commission discussed if it would be difficult to determine where an event took place. Some said it didn’t matter, that the event should be reported when and where it came to light. Within a non-punitive system there should be no dis-incentive to report. However, it is conceivable that the commission might receive multiple reports of the same event. Some thought it might be possible to create a tracking system to figure out if events were being duplicated. Most thought that under-reporting would create a much bigger potential liability than over-reporting.
- Many commission members feel that hospitals already track most, if not all of the events included in the proposed list.

At this point, the Commission reviewed the subcommittee’s “11 steps needed to create a reporting program.” Afterwards, the conversation focused on how best to test the program. Ideas:

- Form a subcommittee to accept voluntarily reported JCAHO data.
- Make sure information collected matches the required data elements as defined by statute (including any ethnic/racial language).
- Ask Kaiser Permanente and other organizations to test the dataset against events it currently tracks to determine if there are any drawbacks to reporting within the proposed framework.

In summary, given the imagined workload (and lack of staff), the Commission didn’t think it was feasible to collect retrospective data from a subset of hospitals (see earlier proposal—page 2 of these minutes). Therefore, it asked KP and a few others to test the definition set against their internal reporting programs.

Proposed next steps:

- Finalize the definitions set. Include a list of principles to help define *serious adverse event*.
- Get it out for comment (one way will be to post it on the web).
- Ask KP, Providence and others to test their ability to report within given guidelines.
- Decide on process and timing of hiring an administrator (as a way to increase the speed of implementation).
- Have the subcommittee continue its work, including a review of medication errors, close calls and infections.

Review of Draft Legislative Report

The Board of Directors must report to the Legislature by September 30, 2004. The Commission reviewed a draft document prepared by staff. Comments included:

- Make sure to stress achievements
- The Legislature did not fund our activities. Fund raising takes time. Despite that a considerable amount of work has been accomplished.
- We have done the foundation work. We have an administrative structure.

Staff agreed to finalize the report and circulate to commissioners.

Next Steps/Follow-up

- Begin preparation of a list of incentives that would encourage full participation in the voluntary reporting program. Outline pluses and minuses of each approach.
- Revise the draft strategic goals to provide a larger context.
- Continue fund raising efforts. Find ways to leverage the success to date. In addition to current leads, work to obtain contributions from purchasers and from large health systems. Work collaboratively with OAHHS.
- Begin developing a contingency plan for collecting mandatory fees.
- Develop a job description, compensation package, and hiring strategy for OPSC administrator.
- Finalize report to legislature.
- Request that the Definitions Subcommittee meet again and continue its work.
- Continue to develop the process by which hospitals and others will actually report to the Commission.
- Work with Kaiser Permanente and others to develop useful tests of draft reporting framework.
- Post the definition set on the Commission's web site. Ask for comment. More generally, develop the vetting process for the Reporting Program (statute calls for the creation of rules—which has a specific set of obligations and protocols).
- Begin working with other reporting entities (long term care, ambulatory surgery, pharmacy, others) to find ways to include them in the Reporting Program.

Activities held over from previous meeting

- Make sure that confidentiality agreements are discussed, that protocols are in place and that each commissioner signs a copy.
- Develop an op-ed piece on patient safety, with the expectation of submitting it to the print media for publication.
- Continue effort to convene an information technology advisory panel.

Next Meeting of the Patient Safety Commission:

- Date: October 26, 2004
- Time: Noon until 3 PM.
- Location: To be announced.

Minutes prepared by Jim Dameron (9-21-04)