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CONFERENCE CALL OF THE STATE-BASED REPORTING

IN HEALTHCARE WORKGROUP

September 13, 2010

Working Group members present: Kathleen J. Billingsley, RN, California Department of Health; Elizabeth Daake, MBA, MPH, Massachusetts Department of Health; Michael Doering, Pennsylvania Patient Safety Authority; Sydney Edlund, Oregon Department of Health; Barbara Fischer, Illinois Department of Health; Anne Flanagan, MS, RN, Maine Department of Health; Linda Furkay, Washington State Department of Health; Marie Kokol, LHRM, Florida Agency for Healthcare Administration; Jay Kvam, Nevada Department of Health; Kimberly Johnson, Colorado Department of Health and Environment; Stacy Mitchell, Pennsylvania Department of Health; Mary Noble, New Jersey Department of Health; Jon Olson, Connecticut Department of Health; Diane Rydrych, Minnesota Department of Health; Lynn Searles, Kansas Department of Health; Kaliyah Shaheen, MPH, Ohio Department of Health; Bob Stahl, South Dakota Department of Health; Iona Thraen, MSW, Utah Department of Health; Renee Webster, Maryland Department of Health; Terry Whitson, Indiana Department of Health; Feseha Woldu, PhD, District of Columbia Department of Health

NQF Staff present: Peter Angood, MD, FACS, FCCM; Eric Colchamiro, MPA; Melinda L. Murphy, RN, MS, CNA;

AHRQ Staff present: Jennifer Devine; William B. Munier, MD; John Moquin

Other Participants present: Ley Arquisola, California Department of Health; James Booth, California Department of Health; Joanne Campione, North Carolina Quality Center; John Clarke, Pennsylvania Patient Safety Authority; Venesa Day, Centers for Medicaid, CHIP, and Survey Certification; Lauren Gallagher, Illinois Department of Health; Rita Gallagher, American Nurses Association; Daniel Gallardo, CMS Office of Healthcare Quality; Caren Ginsberg, Westat; Carrie Hanlon, National Academy for State Health Policy; Elizabeth Kane, United States Department of Health and Human Services; Carol Koeble, North Carolina Quality Center;

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Jessica Ledesma, Illinois Department of Health; Tom Leigh, California Department of Public Health; Pamela Lovinger, Washington Department of Health; Terri Mack, California Department of Public Health; Jackie Malasky, American Association of Blood Banks; Russ Mardon, Westat; William Marella, Pennsylvania Patient Safety Authority; Lance Mueller, AQI; Julia Peek, Nevada State Health Division; Deepak Pillai, GE Healthcare; Susan Raetzman, Thomson-Reuters; Laura Raymond, AQI; Jill Rosenthal, NASHP; Kathy Schmitt, Washington Department of Health; Keith Shalom, California Department of Health; Sara Singer, Harvard Medical School; Lacy Strickler, GE Healthcare; Catherine Tapp, Arkansas Department of Health; Julie Terese, University HealthSystems Consortium; Scott Vivona, California Department of Health Licensing and Certification; Gretchen Wyatt, American College of Cardiology; Deborah Yokoe, SHEA;

WELCOME AND REVIEW OF STATE MANAGERS SURVEY

Dr. Angood welcomed participants to the conference call, and roll call was taken. Mr. Colchamiro reviewed the survey conducted after the June 28 conference call, which will be used to determine future topics for this ongoing conference call series.

Participants were asked to assess a value (1-5, with 5 being most interest) to the topics. Those in bold received the highest average ratings across the 24 respondents:

- **safety measurement – How can states effectively use measures to report out data? (4.21)**
- **auditing and data validation – How can states know whether events are being captured? (4.09)**
- **developing standard definitions for event reporting (4)**
- **role for consumers (3.78)**
- HAI action plans (3.67)
- patient safety organizations (3.30)
- serious reportable events (3.48)
- root cause analysis (2.88)

Dr. Angood added that, in determining future topics, NQF will think critically about the educational issues that NQF can help deliver and the practical issues that are important but may be out of the realm of this current dialogue.

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He introduced the topic for today's discussion, auditing and data validation. Questions were discussed such as, How do we minimize non-reporting? How do we double-check data and ensure that accurate information is coming into state reporting mangers?

UPDATES

Dr. Angood introduced the state updates portion to the call, and noted the importance to other states and federal agencies in hearing how states are performing.

- Linda Furkay, patient safety adverse event officer, Washington State Department of Health, spoke on Washington State's adverse event website, which has received over 70,000 hits since it was released. The website includes adverse event counts, and the results of a facility survey, which asks individuals to notify the state if an adverse event has taken place. The state then follows up with facilities that do not respond, and receives virtually 100 percent compliance from all institutions (except ambulatory surgical centers). Linda also noted that the Healthcare Associated Infections (HAIs) program in Washington has developed a statistical validation program that is consistent with the international organization for standardization standards; this initiative is in the final stages of development, and can be adapted to multiple HAIs.

- Jon Olson, epidemiologist, Connecticut Department of Public Health, noted that Connecticut's adverse event reporting system started in 2002, and NQF's list of Serious Reportable Events (SREs) was adopted in 2004. In 2010, Connecticut added another specific category to its list of required adverse events to report, surgery resulting in death or serious injury, which is not otherwise reportable. There have been six reports in this category since January. There has also been legislation that mandated changes for 2011, including facility-specific reporting in the Connecticut annual report, instead of aggregated numbers. Connecticut has also recently using its electronic database for vital records as a screening tool for possible unreported fatal adverse events.

- Lynn Searles, risk management specialist, Kansas Department of Public Health and Environment, said its system is confidential and privileged paper-based reporting, which presents a challenge for state regulators and consumers. Lynn is a member of the HAIs

advisory group in Kansas, which is working on public reporting; and she is working on education through providers and surveyors. The Kansas program has consistent statutory funding of $200,000, which covers their expenses. They are trying to determine ways to increase buy-in to their reporting initiative, for facilities that are not compliant.

- Dr. William B. Munier, director of the center for quality improvement in patient safety (CQUIPS) at the Agency for Healthcare Research and Quality (AHRQ), spoke on the common formats for reporting patient safety events to patient safety organizations (Common Formats), which is now moving to address health information technology (HIT) and device issues. Common Formats are an attempt to allow reporting on all types of events, so that the consumer can use one type of reporting system to address all types of events. He also said that AHRQ is moving to allow downloads from the National Healthcare Safety Network (NHSN) to give users the complete set of events be populated by HAIs, and also for device reporting to be accomplished through the FDA, as AHRQ seeks to simplify hospital-based reporting.

- Dr. Angood updated the group on NQF's patient safety measures project, which is currently moving quickly to review HAI measures, including a standard on Central Line Associated Bloodstream Infections (CLABSIs). The serious reportable events (SREs) in healthcare project is also fully underway, and a preliminary report should be up for comment in three to four weeks. He noted that some of the current SREs will be submitted for retirement, and others will be added to the overall (or facility-specific) lists.

WORKING GROUP DISCUSSION

Mr. Olson, in response to a question from Dr. Angood about Connecticut's process for identifying potential underreporting, said that Connecticut legislators defined both the numerator and the denominator for the rate required for facility-specific reporting by hospitals and ambulatory surgery centers. It is a composite metric that allows for comparisons among facilities, yet it presents problems, because of contextual factors (such as a hospital's payer mix, age, or simply reporting culture) which create unadjusted variation.

Ms. Flanagan asked about the electronic database used by Connecticut. Maine's electronic database where Ms. Flanagan is from is paper based. Entries are entered into an electronic database, and a determination of underreporting is based on screening death certificates.

Ms. Rydrych said that Minnesota also reviews death records, but they have an electronic keyword search in their database to cull unreported adverse events along with Medicaid administrative data. Mr. Olson noted that Connecticut solely uses ICD-10 codes to gather information. Ms. Edlund said that Oregon has discussed this type of analysis at the patient safety commission, but needs to get access to the data, which Oregon is currently working on obtaining. In Maryland, Ms. Webster said that the state has looked at data from its discharge database for its pay-for-performance program, and gives hospitals more money if they are below the threshold for underreporting. Maryland has found some incidents of underreporting, but this initiative has not been wholly successful.

AUDITING AND DATA VALIDATION

Dr. Angood introduced the core discussion topic for today's call, on issues related to auditing and data validation (specifically issues encompassing underreporting and data accuracy).

Pennsylvania

Ms. Mitchell spoke first and gave an overview of the adverse event reporting law in Pennsylvania, including the state requirement that a letter must be served from the facility to the patient each time a serious event occurs. In Pennsylvania, the current rate is four adverse events per 1,000 admissions; while this is still a critical issue, it also means that they cannot send a staff member out to review such rare occurrences. As a result, the state must find a better way to catch people who are underreporting or failing to report, and make an example of them. The state uses WebEx, so that staffers do not have to individually review charts at each institution, and electronic medical records can be reviewed remotely. Claims data is also reviewed, and the insurer market is engaged so that the state maintains a multi-faceted, broad-based surveillance program.

The state collects information from many individuals including consumers and whistleblowers, which helps pinpoint facilities of concern, and audits can be undertaken. A recent whistleblower case has wound up with the state taking action to fine the facility, but only after an expensive chart-review process was undertaken to validate the claim.

In addition, the state continues to do HAI reporting through the NHSN. The state reviews this reporting and looks for missing data frequently; with the changeovers in facility staff, this effort takes a lot of care. Pennsylvania has taken the position that a facility will be in trouble if they do not care to report, or if they fail to learn from the data that is reported.

California

Ms. Billingsley addressed California's efforts to effectively report events. As their system was brought live, the primary question was whether the event was actually an adverse event? On-site review is required to be undertaken after each of these events occurs; yet there were issues for providers and the state in accurately interpreting adverse events. To create efficiencies, the state created a major provider communication effort, and asked them to re-review whether each effort qualified as an adverse event; this initiative has been effective. The state also currently has a registered nurse on staff to review each adverse event report, and determine whether it was correctly classified.

Communication from the state also involves the Department of Health field offices contacting providers, and providing reminders about mandatory reporting requirements. She noted that if an event is not reported in the correct way to her department, there is a $100 per day penalty; since the program was launched in July 2007, penalties of over $1.2 million have been levied. California has also contracted with Professor Patrick Romano, at the University of California at Davis, to gain more information about underreporting and conduct an analysis of adverse events based on patient discharge data and ICD-9 codes. Auditing of individual events is difficult in California, simply because of the sheer number of events reported; a recent two-year review of retained foreign objects was enlightening, but time consuming. She also praised the attestations done by Minnesota, which ask providers to sign a document noting that they have reported all of their adverse events that occurred.

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Ms. Day spoke last and noted that Medicaid has been charged with developing a payment adjustment for healthcare acquired conditions (HACs), which is similar to Medicare's work to adjust payment for HACs. In coming up with these regulations, Medicaid is looking at reporting requirements nationwide; CMS cannot currently give recommendations on how to address underreporting or data accuracy at this time. A survey has been issued to all states, that was published in the federal register, on how states have identified HACs.

TOPIC DISCUSSION

Ms. Flanagan asked about whether other states use hospital incident reports to identify cases for underreporting. Participants noted that in Maine and Maryland, hospital incident reports can be used by the state. Ms. Rydrych noted that they do not have access to a hospital's internal reporting, but Minnesota is considering expanding its attestations to ask which sources are used (incident reports, trigger tools, etc.) to report fully. Other strategies used by states include board of medicine reports and lawsuits filed against hospitals. Participants agreed that a survey, listing tools used for validation, should be distributed after and would be of value to the group.

Ms. Thraen said that in Utah, they have tried to determine how many facilities are not reporting. She then hopes to leverage those who are actively reporting, and the industry as a whole, to encourage new strategies for those states without regulatory authority over providers.

Mr. Doering said that in Pennsylvania, letters (explaining the benefits of reporting) were sent to CEOs of providers with the lowest reporting rates; this resulted in a 250 percent increase in event reporting. This served as a nudge to encourage increased reporting and engagement.

PUBLIC COMMENT

Mr. Clarke said that individuals often mention a lack of resources to address underreporting. He noted if states clearly communicate the information that has been reported out, that they are more likely to report.

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Ms. Gallagher spoke and called attention to the National Coordinating Council for Medication Error Reporting and Prevention, which has taken a position in opposition to the reporting of error rates. That position is available on their website at www.nccmerp.org.

NEXT STEPS

The next state reporting conference call will be on Monday, November 1, 2010 at 4:00 pm ET. Materials and dial-in information will be sent via e-mail prior to the call. A survey to capture tools for validation was sent separately to participants.