NATIONAL QUALITY FORUM

CONFERENCE CALL OF THE STATE-BASED REPORTING IN HEALTHCARE WORKING GROUP

November 29, 2010

Working Group Members Present: Mary Driscoll, Illinois Department of Health; Sydney Edlund, Oregon Patient Safety Commission; Barbara Fischer, Illinois Department of Health; Anne Flanagan, Maine Department of Health; Linda Furkay, Washington State Department of Health; Marie Kokol, Florida Agency for Healthcare Administration; Kimberly Johnson, Colorado Department of Health and Environment; Ruth Leslie, New York State Department of Health; Stacy Mitchell, Pennsylvania Department of Health; Jose Montero, New Hampshire Department of Health; Mary Noble, New Jersey Department of Health; Jon Olson, Connecticut Department of Health; Julia Peek, Nevada State Health Division; Ann Reed, Tennessee Department of Health; Diane Rydrych, Minnesota Department of Health; Lois Sater, Wisconsin Department of Health Services; Catherine Tapp, Arkansas Department of Health; Iona Thraen, Utah Department of Health; Renee Webster, Maryland Department of Health; Terry Whitson, Indiana Department of Health;

NQF Staff Present: Peter Angood, MD, FACS, FCCM; Eric Colchamiro, MPA; Armando Manzanares; Diane Stollenwerk, MPP

AHRQ Staff present: Diane Cousins

Other Participants Present: Laurene Baker, Pennsylvania Patient Safety Authority; James Booth, California Department of Health; Joanne Campione, North Carolina Quality Center; Carla Cicerchia, Massachusetts Department of Health; Chris Clarke, Tennessee Department of Health; John Clarke, Pennsylvania Patient Safety Authority; Lauren Gallagher, Illinois Department of Health; Caren Ginsberg, Westat; Elizabeth Kane, United States Department of Health and Human Services; Jessica Ledesma, Illinois Department of Health; Tom Leigh, California Department of Public Health; Jackie Malasky, American Association of Blood Banks; William Marella, Pennsylvania Patient Safety Authority; Lisa McGiffert, Consumers Union; Lance

Mueller, Anesthesia Quality Institute (AQI); Howard Neustadt, Pennsylvania Patient Safety Authority; Deepak Pillai, GE Healthcare; Susan Raetzman, Thomson-Reuters; Laura Raymond, AQI; Jill Rosenthal, National Academy for State Health Policy; Kathy Schmitt, Washington Department of Health; Keith Shalom, California Department of Health; Jennifer Sunshine, America's Health Insurance Plans; Thomas Weaver, Association for Professionals in Infection Control.

WELCOME AND REVIEW OF PAST WORK

Dr. Angood reviewed the survey and spoke briefly about the origins of this initiative. He explained that this convening activity began as the National Quality Forum (NQF) was conducting background research for its *National Voluntary Consensus Standards for Public Reporting of Patient Safety Event Information* report, and noted that the face-to-face meetings and conference calls have allowed states to collaborate and share information on event reporting. The initiative has also looked to facilitate the relationships between the states and federal agencies, as work such as the Common Formats for Patient Safety Event reporting, the Hospital Acquired Infection (HAI) Action Plan, and the Patient Safety Organizations (PSO) program have direct ties to state efforts.

In addition, NQF and the Agency for Healthcare Research and Quality (AHRQ) have reached out to three individuals from the Working Group to provide front-line input and strategic direction for the Work Group: Mike Doering, from the Pennsylvania Patient Safety Authority; Diane Rydrych, from the Minnesota Department of Health; and Iona Thraen, from the Utah Department of Health. This better allows the initiative to be organized by the states and to continue to meet the needs of state reporting managers.

STATE UPDATES

Dr. Angood next introduced the state updates portion of the call:

Dr. Montero, Director of Public Health for New Hampshire, spoke on their efforts and noted that his state's mandatory adverse event reporting system was still in its very early stages. While their HAI reporting is fairly advanced, and all hospitals are reporting into the Center for Disease

Control and Prevention's (CDC) National Healthcare Safety Network, their adverse event legislation (based entirely on NQF's list of *Serious Reportable Events in Healthcare*) did not become law until January 2010. Dr. Montero said that this legislation also requires a root cause analysis, often sent with the event report, within 60 days of the occurrence of the adverse event. He noted that the state's reporting form requires: a brief description of the event, when it was discovered, patient gender, admitting diagnosis, and the location of the patient and hospital. So far this year, New Hampshire has had 34 different events reported, almost a third of which are related to Stage 3 and 4 pressure ulcers and falls. He added that New Hampshire has no surveyors and no validation system and that the law requires New Hampshire to communicate its findings to NQF.

Ms. Reed, Director of Licensure for the Division of Healthcare Facilities at the Tennessee Department of Health, said that her state has scaled back its "Unusual Incident Reporting System" to abuse and neglect of patients, fires that disrupt the continuation of patient care services, misappropriation of patient property, and external disaster impacting facilities. As such, the state feels there is no need for corrective action plans. No data is collected, although there is a statistician on staff.

- A Working Group member asked about the number of events on Tennessee's list. Ms. Reed said that Tennessee's system originated as a result of the "Health Data Reporting Act of 2002." In 2009, the law was significantly amended to reduce the number of required reportable events.
- A Working Group member asked where this program is located within their Department of Health. Ms. Reed explained that Tennessee's work is concentrated within its regulatory arm.
- A Working Group member asked whether Tennessee has ever adopted NQF's list of serious reportable events (SREs). Ms. Reed responded that she did not think so, as the only other legislation that the state has had was the Health Data Reporting Act, which was not based on NQF's list.

Ms. Leslie, from the New York State Department of Health, provided the third state update for the call, and said that her state has had a mandatory system for many years, and went to a web-

based reporting system in 1995. New York's reporting system is located in the regulatory branch of its Department of Health. New York is examining its system currently and trying to chart an effective future for the program. It is exploring questions such as: Should the system be regulatory or focused on patient safety or try to take on both roles? How do they ensure completeness of reporting? How do they turn out meaningful analysis to provider systems, and give them a "return on investment" from this reporting requirement?

- Ms. Edlund from Oregon noted that her state is also going through a transitional phase, as their administrator in charge of the Patient Safety Commission is retiring.
- A Working Group member asked about how information is managed and about maintaining the balance between punitive and analysis/improvement of events. Ms. Leslie responded that New York currently maintains a dual balance of improvement and regulation; the state will go out and cite, on occasion, for care issues, although this is a difficult and sensitive issue. Ms. Webster of Maryland agreed and said that their staff reviews Root Cause Analyses and sends staff out to facilities, when necessary.
    - Ms. Thraen of Utah explained that they have a firewall between their regulatory and patient safety units, to try to prevent the tension that many have described. As she tries to facilitate improvement, however, they have had cases identified through chart review that could have been prevented; in perinatal deaths, she notes that 50 percent of cases could have been avoided. Their state Patient Safety Committee also reviews cases, and in areas of disagreement between the provider and the state analysis, sees opportunities for further training and individual case review with providers. As such, she believes that the regulatory component can provide some helpful feedback in adjudicating events. In addition, the regulatory arm can ideally facilitate increased reporting.
    - Ms. Driscoll from Illinois said they are still trying to get their reporting law implemented; in addition, they have a Request for Proposals out to get a vendor to construct their online reporting system. Illinois, whose law is patterned after Minnesota's, is not regulatory, but focused more on effective corrective action plans and measures of success. She believes that their adverse event reporting law will be a positive addition to their hospital report cards, which already use the National Healthcare Safety Network (NHSN) to assess HAI reporting. She added

that Illinois intends to work with their state Patient Safety Organizations, but is uncertain about the role that the state will play in this impending partnership.

SURVEY REVIEW

Mr. Colchamiro next presented the results of the survey on how states identify and address potential underreported events that was completed by Working Group participants.

Strategies *to identify potential underreported events* included qualitative approaches such as:

- the use of death records;
- attestations for providers to confirm that events have been reported; and
- individual review of event reports.

Quantitative strategies include:

- conducting chart review as part of Medicaid audit (New York);
- comparing data against national PSO reports (Oregon);
- trying to identify statistical outliers of in-state data (Ohio); and
- comparing report data to ICD-9 claims data (California).

Once identified, states have multiple methods to *address these events*:

- Outreach to hospital staff and administrators, to remind them to report and try to understand why the events occurred:
    - Massachusetts requires that providers revise their reports to include unreported events;
    - New Jersey sends e-mails and phone call reminders.
        - Ms. Noble of New Jersey noted that they send mass e-mail reminders, through their database, to all of the liaisons from provider organizations; while they have not analyzed this effort, it does generate some response from facilities. They also remind the provider liaisons that there are monetary/civil penalties which can be implemented, although New Jersey has not yet taken that action. They have also targeted hospitals with lower

reporting rates and asked them to explain how they identify their adverse events.

- Educational efforts:
    - Maine's program is cosponsored with their state hospital association;
    - States such as Kansas and Utah go out to providers and conduct best practice trainings.
- Citations or fines are an option for many states:
    - While such penalties are available, use varies. Citations or fines are available in some states, such as Indiana and Florida, but they prefer not to use them;
    - Other states may issue citations, but not monetary penalties. States such as Kansas, Utah, and Connecticut issue citations, but focus on the required corrective action plans.

SURVEY RESPONSE

Ms. Webster of Maryland provided the state response to the survey. She noted that it is difficult to, realistically, capture all events that occur. But she does expect that hospitals have an event reporting system that catches the "big things" such as wrong-site surgeries and retained foreign bodies. It is the "gray areas," such as falls with fracture, where underreporting most often occurs. In Maryland, hospitals are given protections; information is only reported on an aggregate level, and their analysis is done with their patient safety (not regulatory) division of their Department of Health.

Maryland also partners with state PSOs to help improve reporting rates; their PSO conducts most of the dedicated trainings for providers. The state does also attend and helps inform providers about reporting requirements. The PSOs do not, however, receive the root cause analysis; those go solely to the state agencies, as they are not deidentified. Ms. Kokol of Florida noted that in her state PSOs can get all information. But the PSOs do help in providing information back to hospitals; providers do not want to report without getting anything in return.

The Group continued with a brief discussion of attestations. Ms. Webster said that Maryland, in light of some staffing reductions, is considering implementation of this technique. Dr. Montero

inquired about getting more information, and was referred to Ms. Furkay of Washington. Ms. Kokol of Florida also noted that attestations urge providers to take responsibility for their reporting rates.

PUBLIC COMMENT

The call was opened for Public Comment. No questions were received

NEXT STEPS

Ms. Thraen reviewed past progress of the group and floated a few ideas for the Group to consider: the possibility of aggregate data collection to compare adverse event incidence rates nationwide; regional collaborations, to try to facilitate improved definitions of adverse events; joint surveying, such as on NQF's Safe Practices; or a closer look at strategies such as attestations. She noted that past references to PSOs as competitors was incorrect; states should know whether PSOs are getting more reports, and how they analyze data differently.

Dr. Angood reminded the Working Group that NQF's updated report on *Serious Reportable Events in Healthcare* was coming out for Public Comment on December 1, 2010, and encouraged individuals to comment. The report recommends that three events be retired: patient death or disability as a result of hypoglycemia; patient death or disability as a result of spinal manipulation; and kernicterus. The SRE Steering Committee has recommended adding four new SREs and expanded the list to include these non-hospital settings: office-based physician practices, ambulatory or office-based surgery; and long-term care environments, such as skilled nursing facilities.

The next state reporting conference call is tentatively scheduled for **Monday, January 24, 2011 at 4:00 pm ET**. Materials and dial-in information will be sent via e-mail prior to the call.