

Improving Patient Safety through State-Based Reporting in Healthcare

Working Group Conference Call
November 29th, 2010, 4:00-5:30 p.m. ET

I. Welcome and Introductions

Peter B. Angood, MD, Senior Patient Safety Advisor,
National Quality Forum

Eric Colchamiro, MPA, Project Manager for the State-
Based Reporting in Healthcare Initiative

II. State Updates

Jose Montero, MD, New Hampshire Department of Health

Ann R. Reed, RN, MSN, MBA Tennessee Department of Health

Ruth Leslie, New York State Department of Health

State-Based Reporting Initiative:

**How States Identify and Address Potential
Underreporting of Adverse Events**

Eric Colchamiro, MPA
**Project Manager for the State-Based Reporting in
Healthcare Initiative**
National Quality Forum
November 29, 2010

Cycle for Improvement

Awareness and
Definition of Risk

Event Recognized
and Analyzed

Learning
Occurs:
Events
Reduced

REDUCE HARM

Event
Classified

Known Measures
Applied

Practices Evaluated

Cycle for Improvement

Awareness and
Definition of Risk

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~~REDUCE HARM~~

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Known Measures
Applied

Practices Evaluated

Strategies to Identify Potential Underreporting

- **Comparison Analysis**
 - **Qualitative:**
 - Use of death records
 - Event reports v. existing data
 - **Quantitative:**
 - chart review as part of Medicaid audit (NY)
 - National PSO reports (OR)
 - Statistical outliers of in-state data(OH)
 - ICD-9 data (CA)

More Strategies

- **Education**
- **“Complaint-driven”**
- **Attestations**
 - **WA: quarterly surveys**
 - **MN and OR: after each incident**
 - **CO: at the time of re-licensing**

Once discovered, how are these events addressed?

- **Outreach to staff and administrators**
 - **Understand why it happened**
 - **Required revisions (MA)**
 - **Phone calls and email reminders (NJ)**
- **Education**
 - **Co-sponsorship with state hospital association (ME)**
 - **Best practice training (KS, UT)**
- **Citation or fine**
 - **Varying usage of this approach (CA, IN, FL)**
 - **Corrective action plan (KS, UT, CT)**

Takeaways?



Survey Review: Identifying Implementable Strategies to Improve Potential Underreporting of Adverse Events

Renee Webster, MS
Maryland Department of Health and Mental Hygiene
Office of Healthcare Quality

Maryland Methodologies

Laws and Regulations

- No penalties for reported adverse events
- Event reports and submitted RCAs are not disclosable to the public
- Frequent references to medical review committee status throughout the regulations
- Fines for not reporting

Education

- Clinical Alerts and Annual Reports
- Presentations
- Algorithm to help hospitals determine if an event should be reported
- Staff available to discuss events with hospitals
- Developed abbreviated RCA tools for frequently reported events (Falls, pressure ulcers)

Maryland Methodologies

Statistical Review

- Look for patterns of reporting by looking at like hospitals

Complaints and Surveys

- Events may be identified as part of the regulatory oversight

On-Site Patient Safety Surveys

- Triggered by under-reporting or non-reporting hospitals
- Interviews with staff
- Review of documents
 - Committee meetings
 - Incident and accident reports
 - Sentinel events reported to TJC
 - RCA

Takeaways?

