NATIONAL QUALITY FORUM

Creating a Vision for Patient Safety Event Reporting

Wednesday, October 28, 2009
8:00 a.m. – 4:30 p.m.
Westin Grand Hotel DC
2350 M Street NW
Washington, DC 20037

To Enter This Meeting Via Conference Call
DIAL: 866-891-0576
CONFERENCE ID: 37625756

7:15 am **Registration and Continental Breakfast**

8:00 am **Welcome and Charge for the Meeting**
Peter Angood, MD, NQF Senior Advisor, Patient Safety
Janet M. Corrigan, PhD, MBA, NQF President and CEO

8:10 am **The Mandate and Opportunities for Patient Safety Event Reporting**
Janet M. Corrigan, PhD, MBA, NQF President and CEO
Peter Angood, MD, NQF Senior Advisor, Patient Safety

8:30 am **Patient Safety Event Reporting: State Perspectives**
• *Diane Rydrych, MA, Assistant Director of the Division of Health Policy, Minnesota Department of Health*
• *Linda Furkay, PhD, RN, Patient Safety-Adverse Event Officer, Office of Community Health Systems, Washington Department of Health*
• *Michael C. Doering, MBA, Executive Director, Pennsylvania Patient Safety Authority*

9:15 am **Classifying Events and Reporting for Learning – The WHO Perspective**
Edward T. Kelley, Head Strategic Programmes and Coordinator, WHO Patient Safety Geneva

9:30 am **Patient Safety and National Health Reform**
Kathleen Nolan, MPH, Health Division Director, National Governors Association Center for Best Practices

9:45 am **Breakout Groups: Explanation and Expected Outcomes**
Peter Angood, MD, NQF Senior Advisor, Patient Safety

10:00 am **Break and Move to Breakout Rooms**

10:15 am **Breakout Groups**

1. **Broadening the Base of SREs or HACs.** *This group will engage in a two-part activity to discuss potential additions or deletions to current SREs and discuss potential approaches for expansion of HACs across settings of care.*

2. **Identifying a Cycle for Improvement.** *This group will engage in a three-part discussion that reviews and suggests an improvement cycle for HACs/SREs. This cycle will address measurement/evaluation and public reporting as well as the overlap to event classification, near misses, safe practices, evaluation and reporting.*

3. **Successes, Barriers, Unintended Consequences.** *This group will engage in a two-part discussion that identifies successes, barriers, and unintended consequences of the current approach to patient safety event reporting and then it will envision strategies to enhance improved reporting – including how to incentivize reporting.*

4. **The Elements of Meaningful Reporting.** *This group will engage in a two-part discussion on the individual work of measuring, evaluating, and public reporting as distinct - but also linked - processes within patient safety event reporting. Then the group will suggest specific learning strategies that are needed to better capitalize on and refine the cycle of improvement for reporting and learning at multiple levels in healthcare.*

NOTE: A working lunch, available at 12:00 p.m., is included in the breakout time

12:45 pm **Patient Safety Event Reporting: State Perspectives**
• *Linda Chasson, MS, Administrator, Preventive Health and Safety Division, Wyoming Department of Health*
• *Ruth Leslie, Deputy Director, Division of Certification and Surveillance, New York State Department of Health*
•*Marie W. Kokol, LHRM, Program Administrator, Risk Management & Patient Safety Program, Florida Center for Health Information and Policy Analysis, Florida Agency for Health Care Administration*

1:30 pm **Breakout Group Reports**
• *Anne Jones, RN, BSN, MA, Nurse Surveyor II, Patient Safety, Office of Health Care Quality, Hospital and HMO Quality Assurance Unit, Maryland Department of Health and Mental Hygiene* **(Broadening the Base of HACs and SREs)**
• *Kaliyah Shaheen, MPH, Health Program Administrator, Center for Public Health Statistics and Informatics, Ohio Department of Health* **(Identifying a Cycle for Improvement)**
•*Terry L. Whitson, JD, Assistant Commissioner for Health Care Quality and Regulatory Services Commission, Indiana State Department of Health* **(Successes, Barriers, and Unintended Consequences)**
•*Dana Selover, MD, MPH, Patient Safety Policy Lead, Office of Community Health & Health Planning, Oregon State Public Health Division* **(Elements of Meaningful Reporting)**

2:30 pm **Break**

2:45 pm **Discussion of Breakout Group Recommendations**
• *Mary Driscoll, RN, MPH, Division Chief, Patient Safety and Quality, Illinois Department of Public Health*
• *Iona M. Thraen, ACSW, ABD, Director, Patient Safety Initiative, Division of Health Systems Improvement, Utah Department of Health*
•*William B. Munier, MD, MBA, Director, The Center for Quality Improvement and Patient Safety, the Agency for Healthcare Research and Quality*

3:45 pm **NQF Member Comment**

4:00 pm **Next Steps and Future Directions**
Peter Angood, MD, NQF Senior Advisor, Patient Safety

4:30 pm **Closing Remarks and Adjourn**