NATIONAL QUALITY FORUM

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

January 24, 2011

Working Group Members Present: Michael Doering, Pennsylvania Patient Safety Authority (co-chair); Diane Rydrych, Minnesota Department of Health (co-chair); Iona Thraen, Utah Department of Health (co-chair); Andrea Alvarez, Virginia Department of Health; Loriann DeMartini, California Department of Public Health; Mary Driscoll, Illinois Department of Health; Sydney Edlund, Oregon Patient Safety Commission; 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; John Morley, New York State Department of Health; Ann Reed, Tennessee Department of Health; Lois Sater, Wisconsin Department of Health Services; Lynn Searles, Kansas Department of Health; Kaliyah Shaheen, Ohio Department of Health; Darlene Skorski, Rhode Island Department of Health; Don Swartz, Vermont Department of Health; Catherine Tapp, Arkansas Department of Health; Cheryl Theriault, Connecticut Department of Health; Renee Webster, Maryland Department of Health; Terry Whitson, Indiana Department of Health

NQF Staff Present: Peter Angood; Eric Colchamiro; Anisha Dharshi; Nicole Silverman; Diane Stollenwerk

AHRQ Staff Present: Diane Cousins, Carol Sniegoski, Susan Terrillion

Other Participants Present: Sharon Alroy-Preis, New Hampshire Department of Health; Carla Cicerchia, Massachusetts Department of Health; John Clarke, Pennsylvania Patient Safety Authority; Wanda Clevenger, University Healthsystems Consortium; Maureen Dailey, American Nurses Association; Barbara Fischer, Illinois Department of Health; Ellen Flink, New York Department of Health; Adrian Forero, Nevada Department of Health; Lauren Gallagher, Illinois Department of Health; Daniel Gallardo, United States Department of Health and Human Services; Carrie Hanlon, National Academy for State Health Policy; Jessica Ledesma, Illinois

Department of Health; Jamie Maddox, Trinity Mother Frances Health System; Lisa McGiffert, Consumers Union; Deepak Pillai, GE Healthcare; Leslie Ray, Oregon Department of Health; Susan Raetzman, Thomson-Reuters; Laura Raymond, Anesthesia Quality Institute; Lacy Strickler, General Electric; Jennifer Sunshine, America's Health Insurance Plans; Barbee Whitaker, American Association of Blood Banks

WELCOME AND REVIEW OF PAST WORK

Dr. Angood re-introduced the project co-chairs, and briefly reviewed the agenda. Mr. Doering then welcomed the group and spoke briefly about the value of convening this group; he emphasized the value that a SharePoint site will bring to the group.

STATE UPDATES

Following Mr. Colchamiro's roll call of the Working Group members, Ms. Rydrych introduced the state updates section of the call. She noted the value of hearing from both states that do and do not have mandatory adverse event reporting systems. This opinion was echoed by other Working Group members, who added that they find these calls provide important information that they integrate into their work. Following a previous e-mail exchange amongst members of the Working Group, those giving updates were also asked to briefly discuss the nature of their "apology" law and whether there is any sort of mandate for a clinician to discuss an adverse event with the patient or family members after it has occurred.

Colorado

Ms. Johnson spoke on Colorado's law; she noted that it was created to minimize the amount of medical malpractice litigation and that it cannot be used against a provider as part of a lawsuit. She also noted that the risk manager or the attending doctor or nurse is allowed to deliver the apology. She added that anyone associated with the victim can receive the apology and that any content expressing regret is protected from lawsuit. The event report can, however, be discussed with state medical boards; which provides insight into the provider's thought process as to when an adverse event occurs. As part of the Colorado update, it was also noted that the state just released its central line-associated bloodstream infection (CLABSI) and surgical site infection

(SSI) data within hospital ICUs; in the coming year, the state will begin introducing processes to validate this information.

Maine

Ms. Flanagan provided an update on their work. She noted that in the first three years of Maine's law, which requires root cause analyses (RCAs) to be provided, between 23 and 25 incidents were reported each year. In 2007, state regulators visited all hospitals that had not reported an adverse event and reviewed what documents and policies were being used to identify their sentinel events (these visits are now known as "audits"). These audits continue today, as the state will request and review incident reports, RCAs, death logs, meeting minutes where cases are discussed, patient complaints, and ICD-9 codes that were reported in the past year (which proved, along with death logs, to be the least successful of the validation efforts). They now also require each hospital's CEO to submit an annual attestation that all adverse events have been reported. In 2009, Maine's law was updated to require reports of all of NQF's Serious Reportable Events; in the year following, the number of cases reported tripled to 150. They have found that:

- There is a high number of failure-to-rescue cases.
- There is a high correlation between morbid obesity and sentinel events.
- Weekends and holidays correlate with an increase in sentinel events.
- In 2010, there was a high number of sentinel events correlated with on-call issues.

For 2011, they will be continuing on-site audits and will try to help physicians share lessons learned from adverse events and to focus on education overall.

In response to this presentation, Ms. Rydrych asked whether—with the dramatic increase in reported events—they have seen a change in reporting patterns and gained an understanding of why events were not being reported. Ms. Flanagan responded that she senses that providers are seeing value from reporting; for example, the state's record review can be very helpful to inform RCAs. Ms. Rydrych also suggested that best practices from hospitals with high reporting rates be compiled and shared with others.

Ms. Thraen asked whether Maine had defined or displays its audit strategy publicly. Ms. Flanagan responded that they do not share this information with hospitals, but would be happy to share their more successful strategies with the group. In response to a follow-up question, she said that the state does not assess financial penalties in initial audit visits because this visit is considered to be under the umbrella of education. They are currently struggling with how to deal with hospitals with a lower volume of reported events and with a potential second audit visit.

Wisconsin

Ms. Sater reminded Working Group participants that, in Wisconsin, there is no mandatory reporting of adverse events, nor is there a statute that requires providers to inform patients or their families that an adverse event has occurred. She believes, however, that due to The Joint Commission, there is a general urging for doctors to inform patients when an adverse event has occurred. Hospital bylaws also dictate expectation for informing patients in some cases. A state audit would only occur as a result of a filed complaint.

Wisconsin hospitals have been very responsive about voluntary public reporting of certain quality data through the Wisconsin Hospital Association (WHA) program called CheckPoint which is available on its website (www.wha.org). For example WHA encourages review of Centers for Medicare & Medicaid Services (CMS)-required data and will soon begin putting hospital acquired infection (HAI) data on this site. Ms. Sater also noted that there has been a significant increase (from 20 to 75 percent) in the hospitals reporting into the Agency for Healthcare Research and Quality's (AHRQ's) National Healthcare Safety Network database; she expects that there will, as a result, be an increase in state-level aggregate HAI data available. In addition, recent state legislation has also provided new protections for quality improvement data, a change which she believes may increase comfort with sharing data with the WI Division of Public Health.

Ms. Rydrych asked about the Wisconsin's efforts to review data, and whether providers (although not required) are more readily submitting information to the state. Ms. Sater said there has been more of a good faith effort to post data such as Healthcare Effectiveness Data and Information Set (HEDIS) measures and to make information public through the WI

Collaborative for Healthcare Quality (www.wchq.org) along with what data is available through WHA CheckPoint. She was, however, not able to provide hospital-specific HAI data in response to a recent media request to the state since peer review statutes protect it as privileged information and any HAI data that the state has access to is also covered by Data Use Agreements that only allow for aggregate data reporting. She senses that it is unlikely that the State of Wisconsin will ever serve as the repository for hospital-specific HAI and other adverse event information.

PATIENT SAFETY ORGANIZATIONS: THE UNIVERSITY HEALTHSYSTEM CONSORTIUM (UHC) PERSPECTIVE

Mr. Colchamiro thanked participants for their updates and introduced Wanda Clevenger, from UHC, an Illinois-based patient safety organization (PSO) and Diane Cousins, who works on PSOs with AHRQ.

AHRQ

Ms. Cousins spoke first to provide an overarching perspective on the current state of PSOs. She reminded participants that the Patient Safety and Quality Improvement Act of 2005 provides a uniform national protection from litigation for reports on patient safety event information submitted by facilities or individual providers. The Act also established a network of patient safety databases; PSOs can report into this network after their data is made de-identifiable. The Act also established the Common Formats for Reporting Patient Safety events, which provides the federal government with a common, comparable set of aggregated data. AHRQ will be responsible for providing the results of this data collection to the National Health Disparities report. Ms. Cousins noted that there are currently 78 PSOs; AHRQ is responsible for day-to-day PSO oversight and for disseminating the Common Formats, which standardize the way PSOs collect information.

Ms. Cousins also reviewed the regulations for PSOs and noted that PSOs can collect a variety of information; they are authorized to collect information about adverse events, but also to analyze root cause analyses and other processes. She noted that PSOs have faced challenges in starting

up and 16 have de-listed; some of these have unsuccessful business models and others simply have not planned or made the necessary connections to grow their businesses.

UHC

Ms. Cousins introduced Ms. Clevenger, who introduced herself and the UHC PSO. She noted her goals for the discussion and that she hoped that there would be many potential areas of collaboration.

UHC, she noted, collects information about adverse events, data for AHRQ's Common Formats, and other events or unsafe conditions that occur in hospitals. She added that UHC is developing an electronic platform to facilitate data sharing (in both directions) for Vermont, New York, and Pennsylvania. They also work with providers to ensure adherence to state requirements; if a provider submits information, which is supposed to go to a state, the PSO will relay that information back to the state. She also said that providers have expressed satisfaction with the PSO services, and specifically, that the information they submit is protected (as Patient Safety Work Product) from liability or public disclosure; many states UHC deals with have limited peer review protections. As a result, she feels that PSOs get more information than states, and often times, higher quality information. However, because there is a budget crunch and PSOs have no direct funding, providers are charged for the analytical services the PSOs offer.

Ms. Clevenger said UHC deals with 40 different providers. She feels that the Common Formats provide an outstanding base for shared, standardized learning for meaningful results. In the end, however, providers must receive effective analysis from PSOs for their services to be worthwhile.

Ms. Thraen spoke next and noted her concern that the PSOs are receiving more information than states and questioned whether it is good that PSOs "know more than states know." She also added that it would be interesting to look more at shared issues; what type of events or aggregate analysis does UHC receive the most inquiries about? Ms. Clevenger responded that she would be very interested in discussing this information at a later date.

The conversation was then opened for general comments. Mr. Colchamiro addressed a few of the states that have worked with PSOs. Dr. Swartz said that while PSOs may have been working in Vermont, they have not connected with the state agency. Ms. Clevenger said that they have been working with a provider in Vermont who would like to electronically submit to the state; UHC's role would simply ease the burden on the provider in terms of getting information to the state. Dr. Swartz said that they use the Quantros system to receive data electronically, but that they also receive paper copy, which they upload themselves. He expressed concern that the analysis/event reporting is not always done thoroughly and felt that PSOs could be helpful in this case.

Ms. Kokol asked whether data submitted to PSOs can then be sent back to a state. Ms. Clevenger said that if an event report submitted is eligible for state submission, UHC will automatically alert the provider to give them the option of sending it to the state. Ms. Kokol said that her event reporting forms are being redesigned to mirror the Common Formats, and that the PSOs could help with this effort. Mr. Doering noted that the PSOs work in Pennsylvania and said that the state does receive required information from providers first; as UHC has proven to be helpful in sorting through volumes of information.

Mr. Doering asked Ms. Cousins how many PSOs have submitted events to the National Patient Safety Database (NPSD) that AHRQ maintains. Ms. Cousins responded that AHRQ opened up the NPSD for submissions just this month, so they should have a better picture of participation in the next few months; by the fall, the NPSD and its data will be open to the public. At that time, AHRQ will post aggregate analyses of what is collected.

Ms. Thraen asked whether AHRQ data will provide an opportunity for others. She noted that states have varying levels of reports, and AHRQ data could provide a benchmark for them; will it provide a framework or boundaries? Mr. Doering disagreed and said that since only some facilities are reporting, it would be difficult to use it for comparison. Ms. Cousins said that the project was developed to be a learning and sharing system; so while it may not be an accurate "measuring stick," it will provide an opportunity to see what is similar amongst reported events, and to learn from that data.

Mr. Colchamiro asked Ms. Driscoll about the role for PSOs in Illinois' emerging system. She responded that Illinois has just posted its RFP for a vendor to help set up its electronic reporting system, but they have not defined the role for PSOs yet. She added that since providers are required to work with the state on root cause analyses and a corrective action plan, there could be a role for PSOs in helping with this submission and analysis process.

PUBLIC COMMENT

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

NEXT STEPS

Materials and dial-in information will be sent via e-mail prior to the next conference call.