SAFER California Healthcare Coalition Meeting

September 28, 2005
University of California
Oakland, California

Prepared for
California HealthCare Foundation

Prepared by
The Strategic Alliance for Error Reduction in California Healthcare
(SAFER California Healthcare)

Forward

The University of California's five medical campuses (Davis, Irvine, Los Angeles, San Diego, and San Francisco) formed the Strategic Alliance for Error Reduction in California Healthcare (SAFER California Healthcare) to serve as a platform to increase awareness about patient safety and bring together partners across the state with the common goal of improving patient safety. SAFER California Healthcare was funded by the federal Agency for Healthcare Research and Quality (AHRQ) with a developmental grant through September 2005. Because one of the primary goals of SAFER California Healthcare is to bring together those across the state with common interests, we used remaining funds from the developmental center to sponsor this meeting, and we appreciate the interest each participating organization and individual has shown.

SAFER California Healthcare is grateful for the support and guidance we received over the last four years from patient safety leaders at AHRQ, including Eileen Hogan (our project officer), Jim Battles, and Marge Keyes. We are also very appreciative of the time and effort that Vicky Curtis spent to keep the project on track and on budget and to ensure that all SAFER activities were conducted with the utmost professionalism. The inspiration, encouragement, and hard work of the staff from Lumetra, California's quality improvement organization—particularly Mary Giammona—helped make this discussion a reality.

We also wish to thank the California HealthCare Foundation for providing support to record and document this meeting and to the University of California Office of the President for providing a venue where we could meet.

As the first phase of SAFER California Healthcare now concludes, those of us who began this work four years ago hope that it will be the springboard for further discussion and development across the state.

Lee Hilborne, M.D., M.P.H.

January 2006

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Goals of the Meeting

The purpose of the meeting was twofold:

• To provide an opportunity to discuss what represented organizations are doing in California to advance the patient safety agenda.

• To develop concepts or thoughts about how, as a group, we might be able to work together now and in the future as a coalition of people and organizations interested in collectively improving California's patient safety.

Participant Introductions

Jim Barber, Hospital Association of Southern California president. HASC is trying to advance the concept of hospital quality measurement and outcomes reporting through the California Hospital Assessment and Reporting Taskforce (CHART) project. Barber has been working with a coalition of organizations to determine what measures and reporting systems to use and how to fairly portray hospital quality data.

Janie Cordray, Medical Board of California.

Cheryl Damberg (Ph.D.), Pacific Business Group on Health.

Loriann DeMartini (doctor of pharmacy), chief pharmaceutical consultant for the California Department of Health Services licensing and certification program. The program is making a transition from a punitive approach to a proactive approach to help improve safety.

Nancy Donaldson (R.N., doctor of nursing science), director of the UC San Francisco Patient Safety Investigation Center.

Jenna Fischer, Lumetra, senior project manager for the Lumetra hospital team.

Mary Giammona (M.D., M.P.H.), senior medical director for medical review at Lumetra. The organization is committed to improving the quality of care in California and is now using index or sentinel cases to focus on quality improvement with hospitals and practitioners.

William Goodson (M.D.), California Pacific Medical Center.

Gina Henning (R.N., P.H.N.), California Department of Health Services licensing and certification program.

Lee Hilborne (M.D., M.P.H.), RAND Corporation health services researcher and professor of pathology and laboratory medicine at UCLA. He has directed SAFER California Healthcare for the past four years.

Terry Hill (M.D.), medical director for quality improvement at Lumetra. He works with hospital, nursing home, physician office, and home health teams to improve quality.

Rory Jaffe (M.D., M.B.A.), UC Office of the President's executive director for medical services.

Tony Linares (M.D.), Lumetra's vice president for medical affairs. He has been focusing on the four hospital measures selected first by the Centers for Medicare and Medicaid and Services (CMS) and also on systems improvement.

Theresa Manley (R.N., M.B.A.), Palo Alto Medical Foundation.

Richard Marken (Ph.D.), RAND health services researcher. Marken is engaged in a national evaluation of state reporting systems.

Marsha Nelson (R.N., M.B.A.), California Institute for Health Systems Performance president and CEO.

Ernest Ring (M.D.), UC San Francisco chief medical officer.

Angela Scioscia (M.D.), UC San Diego medical director.

Teryl Nuckols Scott (M.D., M.S.), RAND health services researcher. Scott has analyzed patient safety and quality data and recently completed a study, funded in part by SAFER California Healthcare, to examine the reporting of incidents and adverse events.

Al Seifkin (M.D.), UC Davis chief medical officer.

Maribeth Shannon (M.S.), California Healthcare Foundation director. Shannon oversees the section of CHCF that addresses quality improvement and cost reduction in California's hospitals and nursing homes.

Marybeth Sharpe (Ph.D.), Gordon and Betty Moore Foundation. Sharpe is a member of the Moore Foundation team focusing on nursing care in the San Francisco Bay Area. Patient safety is part of the funding strategy of the foundation to improve patient care in California.

Jill Silverman (M.S.P.H.), Institute for Medical Quality. IMQ's primary focus is on physician accreditation and education. The institute is helping health care facilities implement some of the standards and methodologies that are developed by quality leaders in the field.

Maggie Skillman, Lumetra. Skillman participated in the meeting by taking minutes that were helpful in producing this document.

Eugene Spiritus (M.D.), UC Irvine chief medical officer and co-founder of SAFER California Healthcare.

Bruce Spurlock (M.D.), Convergence Health Consulting. Spurlock consults with organizations to improve patient safety.

Clark Stanton (J.D.), attorney with Davis, Wright, and Tremaine. Stanton works with hospitals, usually after a patient-safety problem has been identified.

Sandra Tone (R.N.), Gordon and Betty Moore Foundation. Tone is a member of the Moore Foundation team focusing on the foundation's nursing initiative strategy.

Specific Organization Activities

SAFER California Healthcare (Lee Hilborne)

The Strategic Alliance for Error Reduction in California Health Care (SAFER California Health Care) was initiated four years ago when the University of California medical directors were meeting together and realized that we could probably do some things collectively that we may not have been able to do individually. This meeting represents the conclusion of what turned out to be a four-year endeavor. Over the course of the four years, not entirely related to SAFER, but as part of the work of the group, we implemented an event-reporting system that now has the potential to analyze patient safety/medical error events across the UC system. We sponsored a successful conference in Irvine to address patient safety issues. We started to work across the UC system to further research issues related to patient safety. SAFER also funded a few specific projects:

- Norms of disclosure of errors, including organizing focus groups within the five different UC campuses studying nurses, doctors, patients, administrators, and their approaches to patient safety.
- Analysis of event reports and their link to patient safety.

UC Irvine (Eugene Spiritus)

UCI acknowledged that most event reports continue to be made by nurses and pharmacists. UCI has been trying to figure out how to improve the reporting by physicians because physicians see different errors and near misses than do nurses and pharmacists. It is important for physicians to accept the concept of reporting when things go wrong without fear of punishment. UCI has been training third-year medical students in their clinical rotations to confidentially report any event that they believe affected patient safety. The report then goes to Dr. Eugene Spiritus, the program director, an ethicist, and the risk manager**,** and the team meets with the student to discuss the report. Some interesting reports have been filed that allowed hospital leaders to examine problematic processes.

The Patient Safety Committee has debated the issue of submitting reports anonymously as a strategy to instill confidence that there really is a no-blame culture. Although this was discussed at the highest levels, it was ultimately rejected. There was also discussion about an open system in which anybody could report, but this was not adopted, in part because there was concern about a very large increase in malicious reporting and reporting of issues that could not be verified. However, when the system previously tested anonymous reporting, 90 percent of the reporters still identified themselves in the report.

UCI has also been struggling with medical record documentation in the electronic era. It is easy to transfer or copy information from one screen or field to another without fully considering the content. Sometimes students remark that they didn’t see one of their physicians actually do what the report states, and so it is important to ensure that physicians’ reports are accurate.
UCI is aligning students with faculty mentors. Students and young physicians model behaviors they witness. UCI is examining how to get residents, medical students, and faculty members aligned with the hospital's goals. The safety committee includes the dean of the medical school, the chief operations officer of the hospital, and the vice chancellor or the associate dean for

education. The biggest problem right now is the volume of information. So much time is spent collecting data that there is insufficient implementation time to fix identified problems.

UC San Diego (Angela Scioscia)

• Incentives: UCSD is putting safety and quality into the incentives for everybody across the organization using core measures as well as patient safety goals.

• Education: A group of hospital staff members are helping with patient safety and process improvement training. Learning quality improvement with formal training creates leaders who then teach others.

• Technology: UCSD has implemented computerized order entry, is implementing electronic medical records in the ambulatory system, and is implementing bar coding.

UC Davis (Al Siefkin)

As a large provider organization with hospitals, faculty practice, and clinical practice in the community, much of UCD's efforts focus on following the patient safety priority areas identified at this meeting.

• Pay for performance response: UCD developed a reporting system for individual doctors in their network that provides data on individual performance. Ten percent higher pay was a motivation, making a business case that has changed performance, particularly for quality issues as opposed to safety. Information is now online so individual doctors and their medical directors review their own performance (e.g., mammography).

• Access: UCD moved their internal medicine physicians into the county clinic under a grant project. When one of the local hospitals closed their obstetrician program, UCD filled the gap by using telemedicine to provide obstetrician consults.

• Patient evaluation of performance in California (PEP-C): Four years ago, UCD performed 30th out of 32 hospitals in California on PEP-C. There was an article in the editorial column of the Sacramento Bee saying, "Shame on you, UCD" for not disclosing your data. Our hospital director provided resources to address the problem. Over the next two surveys, our PEP-C scores dramatically improved.

• Ongoing initiatives: UCD is involved in the Leapfrog, Institute for Healthcare Improvement (IHI), and quality initiatives and has work groups to ensure the highest scores. UCD was the first academic hospital to change the culture of safety by having the leadership visit departments. The CEO held a town hall meeting where 200 employees gave suggestions for changes in safety.

UC San Francisco (Nancy Donaldson)

With funding from the Gordon and Betty Moore Foundation, UCSF completed a private study examining medication administration accuracy, nurse preparation, and delivery of medications using direct observation. The literature on medication administration errors indicates that, in most situations, the nurse is completely unaware when making an error. So reported errors

represent the tip of the iceberg; there may be as many as 300 errors committed for each one where the nurse was sufficiently aware of it to report. Of course, if people were aware they were making errors, they probably wouldn't make them. But observation is difficult and time-consuming. When discussing incident reports and the method of highlighting awareness, there is fairly compelling literature that suggests we have to use other methods than just self-reporting.

Regarding the use of equipment and materials to improve safety, we heard a vignette about a decision made by an important hospital opinion leader who was involved in purchasing a new pump and said we don't need one of its principal safety features. Therefore, when the pump was implemented, this particular safety feature was disabled. We asked what mechanisms were in place in the selection of equipment to ensure its implementation and the safety features for which we selected it. How does one prevent an important stakeholder (e.g., nursing director, physician) from saying, "I don't think I want that particular feature?" It appeared the primary concern was efficiency, and the individual believed the feature was a barrier. The message was that we need to have an awareness—not only in the selection but in the implementation of new technologies—to optimize the safety features. And then there must be a system to address problems when there is an effort to disable or bypass one system that would thwart our patient safety efforts.

During systems transformation, there are these gaps—moments during transition—when usual safety features may be compromised. The culture of safety needs to be pervasive, embedded in the organization. But there is confusion regarding safety issues that we don't even know yet. We are stumbling over the implications. Once you start raising consciousness, many more threats become apparent and need to be addressed.

I'm the research coordinator and director for the California Nursing Outcomes Coalition. We started ten years ago to standardize data. We successfully recruited 42 percent of the hospitals in California. Some people are working in isolation and don't want to be part of the community process. But we are using data for research to improve performance. We looked at daily and monthly nursing staffing and learned about what is associated with pressure ulcers. Then the California Hospital Assessment and Reporting Taskforce (CHART) came along. Given relationships in the UC system, we were able to contribute data as a vendor. We are very clear that the hospitals in our coalition should only report events once, and we will send it wherever it is needed.

A toxic relationship exists between all the parties in healthcare, between hospitals and doctors and health plans, and consumer groups on health. Each group is arguing its piece and doesn't trust others around the table. CHART is an attempt to bring all of those people together to agree on one measure set.

UC San Francisco (Ernest Ring)

• Regional networks: UCSF is involved with the Moore Foundation in regional networks that have created a great buzz about patient safety.

• Structured patient safety rounds: These began in July using an observational methodology.

• Rapid response: UCSF instituted the pilot project as part of the IHI campaign. It is not intended to replace the staff members who should respond to urgent calls but allows them an hour to respond. If they haven't responded, the rapid response team is called. People now are reluctant to allow the rapid response team to get in, and so the traditional team responses—primarily surgery—have improved. UCSF looks back at ICU admissions to see if any would have been appropriate for the rapid response team.

• Incentives for patient safety: UCSF made patient safety a component of the bonus opportunity for all employees. We identified 19 patient safety measures and determined that 90 percent compliance (with 16) would be required for employees to reach the maximum bonus. We explained the initiatives so that everybody is amenable—not just physicians and nurses, but people at every level—because their bonuses depend on it.

RAND/UCLA (Teryl Nuckols Scott)

Regarding the analysis of event reports, several thousand were sampled from two hospitals. Even though underreporting is a problem, reported incidents happen in about 8 percent of hospitalizations per year, which is actually quite high. Several thousand reports represent a lot of affected people. From this study, most reported events are non-physician events. Yet a prior study found that most of the things that really hurt people and kill them are physician events. The type of events captured are not as well-defined as they could be, so we need to more consistently identify which events are most helpful. People don't know what they should report. Also, people do not really describe what happened. They might report an adverse outcome (e.g., cardiac arrest) and not know the precipitating cause. We see very fragmented reports and bits of information but not a lot of the information that would enable organizations to take action and make system changes.

RAND (Richard Marken)

The RAND Corporation completed a project for the Agency for Healthcare Research and Quality (AHRQ) in support of the agency's development of a national reporting database. RAND researchers studied state agencies that collect data on errors and incidents; they wanted to know the kind of incidents that were reported and how they were classified. RAND looked at public health agencies and found 23 state-level reporting systems and also looked at the types of information included, guided by the 2004 Institute of Medicine (IOM) report on the standards for what should be reported. The IOM report identified 19 different kinds of information that should be reported (e.g., the role of the person who discovered the event, how the event was discovered). Some states report only about 5 percent of the IOM data elements, some just include a narrative of the event, and some (e.g., Pennsylvania) already contain about 75 percent of the IOM data. California only includes a narrative.

Stanford (Bruce Spurlock)

Dr. Bruce Spurlock has worked with the Stanford group for the past five years. One of the things the group learned in the culture study of 20 hospitals in California and then 100 hospitals across the United States is that every hospital—whether for-profit, nonprofit, community, or academic—has a significant gap between the perceptions of senior leaders and the frontline staff

about patient safety and the frequency of medical errors. What is less clear is what can be done to reduce that gap. In the study, the group suggests specific interventions to see whether it is possible to more closely align senior management perceptions with frontline employee perceptions.[1]

The Stanford project was an outgrowth of the managed care task force the governor established in the late '90s. The group has learned a lot about what a reporting system takes, what it looks like qualitatively, and what issues are pre- and post-cycle. Reporting systems take data into cyberspace, so it is quickly forgotten. Lessons learned paved the way in other areas.

Safety plans (SB 1835): The Stanford group studied more than 80 percent of the hospital's medication safety plans. There is a lot going on, but nobody knows conclusively whether the safety plan is making a difference because there are no good ways to determine whether the hospital is actually safer. A project addressing this is under discussion.

Collectively, hospitals and doctors do only about 55 percent of the things we should be doing correctly, and that we all agree on. The IHI 100,000 Lives campaign seeks to improve that percentage. When we talk about the business case, we make sure all stakeholders are at the table; many missing participants would be valuable contributors.[2] As we talk about Patient Safety Organizations (PSOs) as something to benefit patients, providers, policymakers, and researchers, we have to think not only about the business case but also about issues of oversight, governance, and participation.

Palo Alto Medical Foundation (Theresa Manley)

The Palo Alto Division of the Foundation has had drug-to-drug interaction alerts embedded into the electronic health record since 2001. A recent study completed on prescribing patterns based on drug-to-drug interactions found that the amount of medications prescribed with potential drug-to-drug interactions did not decrease, even when using this system. Many physicians who received the alerts didn't acknowledge them. This was in part because the physicians are overloaded in their daily work. Therefore, one must be very particular about the type of alerts used so that the system doesn't become overloaded.

Alerts also have to occur at the right time. For example, the foundation issued a safety alert about monitoring non-steroidal anti-inflammatory drug (NSAID) use that was followed only 22 percent of the time. The alert was issued at the wrong time. Now, because this alert appears at a time when physicians can deal with it, it is followed 60 to 80 percent of the time. If alerts are being ignored, clinicians should be asked why. If one places too many alerts, and in the wrong places, they start to be routinely dismissed.

The second effort is an analysis of the Patient Safety Culture Survey that was completed in September 2005.

Institute for Medical Quality (Jill Silverman)

The Institute for Medical Quality (IMQ) is a nonprofit subsidiary of the California Medical Association and has a separate board of directors. IMQ evolved about ten years ago so that organized medicine could have an arm that focused exclusively on quality.

• Accreditation and education: IMQ is in the hospitals through its partnership with the California Department of Health Services (DHS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and surveys the medical staff component of the surveys. IMQ surveys against existing standards and presents its findings to DHS and JCAHO to render licensure and accreditation decisions, respectively. IMQ has its own ambulatory accreditation program for physician offices, surgery centers, and medical groups. IMQ integrated patient safety into its programs, and the institute's strength, as a CMA subsidiary, is access, particularly to physicians. IMQ uses the accreditation role to help educate primarily physicians about systems and patient-safety issues. IMQ also accredits the care within the correctional facilities. IMQ's role here is really an operational and functional one. Showing data is a critical first step for physicians, but then they must have a chance to react and respond and have ownership. This seems to be the most effective way of achieving change and eliminating defensiveness.

California Institute for Health Systems Performance (Marsha Nelson)

The California Institute for Health Systems Performance (CIHSP) is an independent, nonprofit corporation, and its mission is to improve health care quality in California and to increase provider accountability.

• Medication safety: In response to a law that Sen. Jackie Speier (D-San Francisco, San Mateo) sponsored to have hospitals develop medication error prevention education plans, CIHSP provided technical assistance for hospitals in writing and analyzing those plans, funded by the California HealthCare Foundation.

• IHI 100,000 Lives campaign: CIHSP is working with the Blue Shield of California Foundation, specifically for rural public and district hospitals and trying to operationalize their participation in the IHI 100,000 Lives project and support them. Twenty-three hospitals have received scholarship awards for us to help them.

• PEP-C: CIHSP has worked with patient experiences and in the 2004 survey incorporated the AIDS test questions from the national survey. They also included some patient-safety questions, asking patients about things they can actively report on (e.g., Was there a clean bed? Were ID bands checked? Did they have trust and confidence that their physician knew about their condition?). It is valuable information that wasn't recorded before, and research supports that a good patient experience also encourages good patient outcome. In California, that patient experience survey is now evolving into the CHART project, a bigger umbrella that will provide even more patient experience data.

Lumetra

Continuity of Care Collaborative (Terry Hill)
Lumetra brought hospitals together with home health and nursing homes to look at a given population leaving the hospital, and it arbitrarily picked patients and some clinical conditions. Lumetra wanted to see whether it could get hospitals, nursing homes, and home health agencies to work together. The first challenge was to get the relevant places to identify themselves as a team. Lumetra had trouble getting teams of more than two because, although these organizations

refer to each other every day, they rarely do anything face-to-face unless they are part of closed systems. Lumetra assembled these threesomes, focused on transitions in care, started measurement and had traction, at least at the pilot level. Topics like medication reconciliation will continue to foster collaboration.

Culture Change within Nursing Facilities (Terry Hill)

Empowering people to make change helps teams function well, consistent with the 2001 IOM report. But when people talk about culture in nursing homes, they are talking about something different, not what this group has been talking about as a safety culture. And yet those two things overlap, as people are pointing out.

Integrating Population and Index-Case-Based Quality Improvement (Mary Giammona)

Lumetra now carries out case review activities, many of which involve quality issues, from a systems improvement standpoint. Some of the impetus came from a report from the federal Office of the Inspector General (OIG) that was critical of the Medicare beneficiary complaint response program. The OIG found generally that all that happened was that the involved provider was told to do better next time. In the last CMS Medicare Quality Improvement Organization (QIO) contract, Lumetra made a shift to focus on systems or practice patterns instead of individual cases. Compared with the 2001 OIG report, which found only two or three quality-improvement efforts that were the result of case review, from 2003 to now there have been 1,614 quality-improvement efforts from QIO case review work nationally. California represents about 10 percent of that effort. These incidents arose through regular case reviews or from beneficiary complaints. When a problem is confirmed, Lumetra identifies the root causes, works with the facility, the physician practice, the nursing home or others, and finds out why that happened, what systems were in place, and what failed. This doesn't focus on errors in judgment but rather on errors in systems or practices. Hospital facilities have been very cooperative; Lumetra receives letters in which people say, "Thank you for pointing this out, or guiding us" because not only is an improvement plan requested, but it is monitored. The whole QIO case review infrastructure has changed. When we analyzed California data, 70 percent of complaints involved patient-safety issues. Lumetra is already working on how to use these data to connect with the collaboratives of our population-based quality-improvement efforts.

Hospital Association of Southern California (Jim Barber)

Discussion of opportunities and threats:

• Alignment: There are some issues that we have to deal with, or we're not going to get too far in any kind of measurement or reporting system. It is a matter of getting doctors, hospitals, consumer groups, unions, funders, and health plans acting collectively.

• California Hospital Assessment and Reporting Taskforce (CHART): When HASC tried to put together a coalition of individuals to achieve some meaningful work in this area, there was such misunderstanding and misaligned objectives and goals that it almost destroyed the entire process. Today's group is much more consolidated and collaborative than the CHART group ever dreamed of being.

• Breaking down barriers: So much good is happening that is done in isolation or with minimal connection. How long do we have to be a cottage industry before we can start coming together? So much good is going on that could save lives tomorrow, but the general hospital community is not understanding it.

• Funding for research: Researchers are scarce, and we are not getting help from the state government, the federal government, or the health plans or the folks who seem to have more money than hospitals and doctors do. Not just money, but money to sustain efforts and make them more robust.

California Department of Health Services Licensing and Certification Program
(Loriann De Martini, Gina Henning)

The Department of Health Services (DHS) is committed to patient safety and physician safety, although some find this difficult to believe when DHS representatives show up at facilities. Most DHS activities, though, are reactive although at times they are proactive, such as when DHS participates in surveys. In skilled nursing facilities, DHS activities are very proactive. The biggest challenge is to move DHS proactively to take on leadership in patient safety. DHS has tremendous access to information that individual health care institutions would not. They therefore have the opportunity to evaluate trends. What DHS is really spotty on is the data, but it has been able to identify trends such as medication errors in nursing homes. DHS started interacting with long-term care facilities to share observations, to provide incentives to correct problems before they come in to inspect, and to reduce the medication error rate.

In hospitals, DHS identified serious deficiencies with the provision of emergency medication and poor medical management of pediatric patients. The department developed an all-facilities letter to inform facilities to look closer at pediatric medication. The DHS bureaucracy does not encourage those types of activities, but DHS is trying to move to a more proactive patient-safety stance. DHS led a team through the AHRQ-Veterans Administration patient safety improvement corps, which started in September 2004 and ended in May 2005 as a collaboration between DHS and the hospital departments. Four hospitals contacted us proactively, and three were selected to work on developing a patient-safety program manual. The group decided to focus on all health care facilities, and so our audience includes hospitals, long-term care facilities, and home health agencies for 32 different types of organizations and licensed health care facilities. The team identified critical elements that should be considered in a patient-safety program. They are working to get approval and hope to have it uploaded to the DHS Web site by the end of 2005.

• Impact of nurse-to-patient ratios: There will be an evaluation of California's regulations and their impact on the industry, the nursing workforce, and patient care. There is also a study (mandated by AB 1629) to evaluate the relationship between pay-for-performance and specific rates of pay for nursing homes and maintenance of the statutory 3.2 nursing hours per patient day. SAFER should make sure that everybody knows when the program manual and report are available.

Medical Board of California (Janie Cordray)

The Medical Board is usually involved in practitioner licensure incompetence or in helping people make the decision not to practice. Janie Cordray suggested that the Medical Board will probably not want to be part of a PSO, nor would others want them to be, if the goal is voluntary compliance.[3]

When Cordray came to Sacramento to start a new agency, they were dealing with a law that was not well-defined. Questions arose like, "What are you doing: making this up as you go along?" And the answer was “Yes,” because the legislation didn't include enough detail. We are in a similar place with the vagueness of the Patient Safety and Quality Improvement Act. This is an opportunity for those who are going to be a part of the PSO movement, particularly the hospitals. Probably you're going to have to seek regulation; there will be acrimony because everybody has to have their say. It is important to weigh in so that the proper regulations are written, and if you want access or if you want something different, particularly if critical, people should make that known. The Medical Board, particularly our members, has wanted to get involved in proactive patient safety. The board would like to be a conduit of information for those people and possibly a recruitment tool for participation. Cordray thinks it will be a couple of years before they actually certify the regional or local PSOs. They are going to have to develop regulations. In California, that process takes anywhere from six months to a year.

Gordon and Betty Moore Foundation (Sharon Tone and Marybeth Sharpe)

• Patient outcome (Sharon Tone): So far, the Moore Foundation has done a lot to improve nursing education, focusing on helping to identify more resources for nurses at the front line that will better enable them to provide safe care. The foundation wants to identify more linkages between what nurses do and patient safety and hospital operations. One of the foundation’s strategies is the systems approach to traditional safety.

• IHI campaign support: The foundation is funding 20 Bay Area hospitals for implementation of the IHI program and a hospital council to organize a Bay Area Collaborative, consisting of 20 rural hospitals and an additional 12 of 39 hospitals in the area. This collaborative is designed to provide practical information to hospitals on implementing this campaign. Currently, the Moore Foundation is not focused on reporting, although it does require participating hospitals to report their mortality data to IHI, and then the foundation receives a confidential report from IHI looking at the mortality trends in the area in the hopes that some lives will be saved over the next 18 months.

• Hospital culture: The foundation is trying to identify interventions that can measurably improve the hospital safety culture. This is being led by the UCSF schools of Medicine, Nursing, and Pharmacy, and the foundation is really excited by that multidisciplinary leadership. The real challenge here is whether this can this be done in a unit where teamwork, communication, and morale may be a little bit lower than in some of the other units. The foundation hopes that other Bay Area hospitals may implement some of these interventions.

Given the reporting demands of hospitals, how can a PSO and these collective reporting efforts help hospitals learn more and be incremental to what they're already doing? How to get hospitals

to participate is something that will need to be figured out in the planning stages. The foundation has found that when getting hospitals together to work on a foundation initiative, they must see that the foundation is delivering something that is of more value than what they were being asked to contribute, particularly given staff time constraints.

California HealthCare Foundation (Maribeth Shannon)

The California HealthCare Foundation (CHCF) is working for change within hospitals. The foundation is looking at report systems/ reporting mechanisms, and better aligned financial incentives as the key levers for improving quality. Maribeth Shannon wants to address the business case for a PSO. Who will work on this, and is there some kind of role for a foundation to help?

CHCF is also providing some funding for the California Regional Health Information Organization (CalRHIO) and how those regional organizations would be set up. They can be very small or very large, and there are advantages and disadvantages to both. There was conversation today that PSOs may not be like RHIOs, but maybe we can think about that more. It would be nice if they were, if the structures were the same so that you could potentially work with one entity.

Legal Issues (Clark Stanton)

Clark Stanton has seen some pressure to look at some of the means, particularly with confidentiality, to make PSO systems more of an end in themselves. The group should be aware of certain pressures to move it in that way. For example, one national law firm published a piece suggesting that individual hospitals might be their own PSOs to provide an umbrella of protection for their peer review systems across states.

Pacific Business Group on Health (Cheryl Damberg)

Dr. Cheryl Damberg would like to go back and talk to the Pacific Business Group on Health (PBGH) about SAFER participation because PBGH was not fully prepared to come to the meeting given the timing. She anticipates to the extent that there is a collaborative statewide, PBGH would certainly be interested in trying to work with it and provide some kind of support.

Review of the Patient Safety and Quality Improvement Act of 2005

In August 2005,Congress finally passed and the president signed the Patient Safety and Quality Improvement Act. The goal is to provide privilege and confidentiality, to create a network, and to establish patient safety organizations. Most people in health care agree this act is long overdue.

Slide Presentation: Features of the Act

Definitions: Identifiable vs. non-identifiable patient-safety work.

- Identifiable patient-safety work
    - Allows identification of providers involved in the patient-safety work
    - Contains individually identifiable health information under HIPAA
    - Allows identification of the individual reporting information
- Non-identifiable patient-safety work
    - Doesn't meet the requirements above

Definitions: Patient-safety organizations

- A public or private corporation
- Currently certified by HHS as a PSO

Definitions: Patient-safety activities

- Efforts to improve health care safety and quality
- Collection and analysis of patient-safety data
- Development and dissemination of patient-safety best practices
- Use of patient-safety work to improve culture
- Maintaining and providing confidentiality and security
- Using qualified staff members

Definitions: Patient-safety work product

- Reports, analyses, records, statements
    - Developed by providers for reporting to a PSO
    - Developed by a PSO
    - Excludes medical records, billing information, discharge information
    - Can't put data maintained for other purposes into a patient safety evaluation system to avoid disclosure
- Discussions regarding the development of a patient-safety evaluation system

Privilege and confidentiality

- Patient-safety work products are *privileged*
    - Cannot be subpoenaed, even for disciplinary proceedings
    - Not discoverable for proceedings
    - Immune from Freedom of Information Act
    - Not used as evidence in any proceeding
    - Not used for professional discipline by licensing agencies and boards
- Patient-safety work is *confidential*
    - Considered confidential and shall not be disclosed

Exceptions

- Privilege and confidentiality exceptions
  - Patient-safety work contains evidence of a crime and is material to criminal proceedings
  - Necessary to investigate a person aggrieved by patient-safety participation
  - Disclosure agreed to by all identified parties
- Confidentiality exceptions
  - Disclosure to carry out patient-safety activities
  - Disclosure of non-identifiable work products
  - For research when compliant with HIPAA
  - Disclosure when required by the FDA
  - Voluntary disclosure by a provider to accrediting agency
  - Does not involve quality of care problems or processes
- Privilege exceptions
  - Voluntary disclosure of non-identifiable patient safety work products
- The privilege and confidentiality continues after disclosure
  - Disclosure for an exception does not forever waive these rights
  - Entity accepting information under exception is bound by the same restrictions
  - Patient-safety confidentiality "cover" is blown if disclosed in a criminal proceeding
  - If disclosure is required, all other information remains protected

Specific protections

- Protection of providers
  - Action cannot be taken against a provider based on good faith participation
  - Accrediting body does not have access to provider-PSO discussions
- Reporter protections
  - Providers cannot take an adverse employment action (loss of employment, promotion or benefit, adverse licensing, credentialing, or certifying decision)
    - Reports to provider to facilitate PSO reporting
    - Direct PSO reporting

Penalties for violation

- Civil monetary penalty of $10,000 for each violation
  - No double jeopardy: PSQIA and HIPAA
- Equitable relief for those improperly affected
  - May take civil action against provider to redress the violation

HIPAA issues

- PSOs are business associates
- PSO activities in relation to the provider are health care operations

Criteria to become a PSO

- Mission and primary activity is to improve patient safety and quality of health care
- Appropriate staff (licensed and certified)
- Must have contracts with more than one provider
- Not a health insurance issuer
- Discloses relationships with contracting providers
- Collects patient-safety work from providers in standard ways to facilitate comparisons
- Uses patient-safety work to provide direct feedback and assistance to minimize patient risk
- If part of another organization
  - There is a "firewall" between the PSO work product and other activities
  - Refrains from disclosure to other parts of the organization
    - Joint Commission Resources PSO to JCAHO
    - QIO PSO to QIO Quality Division
  - There's not an inherent conflict of interest in the mission of the organization and the PSO

Creating a PSO

- Must be initially certified by HHS
  - Policies and procedures to perform patient-safety activities
  - Complies with PSO criteria
  - HHS determines the organization is in compliance
- Subsequent certification
  - Show evidence of continual compliance
  - Required every three years
- HHS publishes a list of certified organizations

The law creates a network of databases

- Needed to maximize collective learning from errors
- Provides an evidence-based management resource for providers, PSOs, others
- Network must accept, aggregate, and analyze non-identifiable patient-safety work products from PSOs, providers, others
- Single point of access for researchers wishing to analyze the data
- HHS must establish data standards and common formats
- Data used for regional and national analysis and included in the national quality report

Congress expects results

- Draft report 18 months after any network of patient-safety databases is operational
  - Effective strategies to reduce errors and improve patient safety
  - Include any measure determined appropriate to encourage use of the strategies
  - Period of public comment then submitted to IOM for review
- Final report
  - To be made to Congress at 30 months
- Report in February 2010 on the effectiveness of the act

Discussion of AHRQ's Activities Related to Implementation

The act specifically directs the Department of Health and Human Services (HHS) to provide technical assistance. AHRQ has been charged with figuring out how the Patient Safety and Quality Improvement Act of 2005 is actually going to be implemented. This is a huge job. We asked William Munier, M.D., and Jim Battles, Ph.D., from ARHQ to join us to shed some light on the discussion. They introduced themselves:

AHRQ Staff Introductions

• William (Bill) Munier: "I'm a physician by training. I've been involved in quality, safety, performance measurements for a long time—decades, I guess. So it's an area that I'm comfortable in, although I think the crux of the current activities in patient safety, this legislation, definitely put it in a new light, and it's very challenging and interesting. I came at the tail end of 2004. The last thing I did in the private sector before coming in was to run an electronic medical record company that produces a product for doctors' offices. So I'm acutely aware of the variety of different approaches out there and what some of the challenges are in trying to build on what's out there in the electronic world as well as the paper world."

• Jim Battles: "I've been with AHRQ since the fall of 2000 and am beginning to do work on patient safety here. I'm a recovering academic from the University of Texas Southwestern Medical Center, doing patient-safety research prior to the issuance of the Institute of Medicine (IOM) study and, since coming to AHRQ, have worked on grants and contracts and other things, and worked closely trying to keep up with Lee (Hilborne) and others of our grantees who do important patient-safety work. So AHRQ has been involved in things that I have an interest in, and I have been following the initial machinations around this legislation almost from the day I arrived. So it's been gratifying to see something actually get through the legislative process. But I'm reminded of the government classes that I studied as an undergraduate and how a bill

becomes a law; it's interesting having to actually live one from its conception to final assignment."

Comments from AHRQ about the Act

There are some principle strategies that we are talking about here, our principles with which we move forward. The first is to build on existing work. There is a lot of work that is being done, there is an existing infrastructure, there are many people collecting information about patient safety. AHRQ wants to make sure they are cognizant of and learn from what exists. There is going to be a certain amount of disruption as we start to come to common ground with different definitions and different ways of doing things. But AHRQ will try to build on existing work and make the process as simple as possible.

AHRQ will use private sector resources where possible and build on previous conceptual work, to the extent it is consistent with the current direction. AHRQ will begin at home by trying to coordinate existing federal efforts. There are at least 12 incident-reporting systems in the federal government, principally the FDA and the Centers for Disease Control (CDC), but also others, including the VA and Department of Defense. There is a desire to use information technology to the maximum extent practical while also allowing for paper reporting.

The last guiding principle is to keep it simple, which means probably defining patient safety in a relatively narrow way initially so that this initiative doesn't bleed over into the whole broad area of performance measurements.

The law boils down to two basic tasks. One is to foster a completely voluntary, operational program of PSOs, as discussed above. The law is intended as much as possible to allow PSOs to either be existing operations or ones that are pretty much formed without a heavy hand from the federal government. That requires that some guidelines be set that AHRQ will need to follow to interact with PSOs, a new programmatic aspect for the agency. Second, the law requires that an operational network of patient safety databases be created that includes a federal component to allow AHRQ reporting.

The first things AHRQ has to do are to develop an infrastructure and clarify who is doing what at the federal level. They are currently sorting out delegations of authority and their own responsibilities. The law amends the AHRQ statute so the major responsibilities rest with the agency, but others will be involved. AHRQ is also creating an information technology (IT) system to allow AHRQ to manage patient-safety events using the inventory reporting systems and the inventory incident definitions. It will also probably be used as a suggestions and inquiries tracking system to keep track of inquiries to the department.

The agency is starting to define what the outlines of the PSO program itself will look like, where a certain patient processing system is needed. The law calls for PSOs to certify themselves and for the secretary to accept or reject them. But AHRQ must elaborate what that means so that the department is a responsible steward of that task. There needs to be a system to handle complaints and a mechanism for revoking certification, should that need arise. AHRQ is considering a meeting of pre-PSOs to discuss what that review process might be like to get input, and to talk about the *modus operandi* of the network of patient safety databases.

Although a bit down the road, AHRQ must provide technical assistance and establish an annual meeting of PSOs. In the near future, AHRQ is creating Web sites with information. They are considering publishing a request for information to gauge the interest in becoming a PSO, seek input for how criteria should be developed, and establish a forum for questions.

The second main track is creating a network of, or participating in the creation of, a network of patient-safety databases. AHRQ has the responsibility to define the terms and definitions of patient-safety incidence and to encourage their widespread adoption. AHRQ is supposed to generate information relevant to preventing harm of patients in the health care system so they will aggregate and analyze incident data and disseminate results. Of course, the timeline is several years because the data first need to be collected.

AHRQ is trying to simplify incident reporting. To the extent possible, the agency will provide benchmarking information and share de-identified data for use in improving patient safety. That process has already started, even before the law was passed, by inventorying existing reporting systems, including an effort with the RAND Corporation. The goal is to facilitate defining terms and definitions for patient safety incidents, by learning from previous work rather than starting from scratch. The challenge is addressing the same event defined differently in different databases because there has to be one working definition. AHRQ will need to choose among different working definitions and experience and define some events that haven't been previously described. Once the definitions format is established, AHRQ will provide them as technical assistance to emerging PSOs. There also needs to be a system to accept data from PSOs and then use the data to provide input to the National Quality Report.

Questions and Answers (speakers are identified by name wherever possible)

Q: Could you discuss what some activities in other states may be in reaction to the passage of the law and where things are with the variation of state preparedness across the country?

A: Regarding what has been done following the passage of the law to gear up for this act: We actually don't know that right now. We have received a number of calls from organizations (e.g., the American Hospital Association, the Joint Commission, the National Quality Forum) but have had little direct contact with states. It's very new, and when people ask what we are doing, we tell them we are getting organized. We don't have information to share yet. People are trying to figure out whether they want to become a PSO, what it means, how they are going to fund it. No money is included in the law. AHRQ doesn't have specific information from any of the states, per se.

Q: Would a state that has an existing reporting system and mechanism in place want to become a PSO?

A: One could envision scenarios in which that might be advantageous because in most states the data are protected within the boundaries of that state. But sharing data across state lines gets into fuzzy areas. Now, with the patient safety legislation, having a co-existing PSO along with whatever the state organizations might be presents an interesting question.

Q: How do you anticipate the PSOs will be organized? Are you going to have a certain number per state or per region? Or if 30 organizations in one state want to do something, and nobody in another, what have you thought about as far as being sure that there is not duplication of effort, not making it complicated for providers, and at the same time covering the nation?

A: There are some implicit assumptions that you make in your question. I was a government employee many, many years ago, and I've been associated with federal programs before, but I can't remember being associated with one that was entirely voluntary. The law has such a gentle tone that it essentially says if an organization designates itself as a patient safety organization and it meets the criteria, it pretty much can be certain that HHS will certify it. I'm not sure that we can forestall what you're talking about, which is, it's overlapping with some states having many PSOs. I'm not sure that we have the authority or the tools to do that. There is an awful lot of work to do to get started. And the fact that the government does not have all the answers at the outset may work to everyone's advantage.

If there are things that need to be changed, we can probably get them changed, perhaps working in concert with the private sector. All the wisdom doesn't rest with the government. But I don't think we have necessarily addressed all of your issues. Regarding the integrity of the reporting process itself, we have our eyes on this, but what we don't have solutions for is this overlapping of organizations. We need to not double medical error incidents where we can avoid it, yet we are prevented from having any identifiable data here at AHRQ. So in a sense, the very mechanism by which you would identify the same event is not available to us.

Q: What about developing the areas of information sharing, of having regional areas for health information sharing in certain areas (i.e., regional health information organizations, or RHIOs). Is there some reason not to think about the RHIOs as a potential marriage of both the RHIO and patient safety? It seems that this could be the repository or mechanism that starts to get you health information in a population surrounding a certain area and then marries it to the safety organization. Has anybody thought about marrying the two together?

A: We have thought about that idea, but from our standpoint we have to lay out the PSO criteria and then see who comes in. That is one of the reasons we are talking about a pre-meeting. We don't know what the interest is. And if the local areas get together and decide they want to organize in a certain way and come in and coordinate it, that's great. But if the scenario that you just suggested unfolds, there may be other organizations that don't mesh with that in the same area that want to come as PSOs. If so, they are free to do that. So it does set up a situation where there can be potentially competing organizations.

Q: One thing that's confusing is that you've got this mandate to essentially let anybody be a PSO. On the other hand, you have a mandate which simplifies reporting mechanisms for incidents. Do you have any thoughts about how you're going to do that second mandate?

A: The first step will be to have uniform definitions for the incidents. One of the things likely to emerge has to do with market forces of individual institutions that probably would rebel at having many separate places to report. So the extent to which a PSO can provide a service to the provider organizations for one-stop shopping may have some marketplace value in terms of, in

some ways, a customer-driven entity. It may be even that a regional group of health care entities could try to drive to a specific PSO.

Q: Something like that is likely to emerge relatively quickly. We know that one of the complaints from institutions is that they have multiple places (e.g., federal, state, and accreditation agencies) that they are expected to report to. How can you simplify that process? And is that something that may emerge through this PSO process?

A: I think that is. To get back to your question related to the RHIOs: I think when this legislation started its developmental process, people were thinking primarily about rather traditional reporting systems where someone observes something, generates a report, and submits it through an organization. As basic safety research matures, we have a variety of different, interesting ways of looking at incidents using administrative data, such as the development of patient safety triggers that work directly with electronic health record (EHR) systems. A cross of that kind with your RHIOs shows some great promise. And we do have research that is looking at integrating the administrative data into the trigger mechanism. RHIOs will need to think about the value to them and to the people involved in creating a co-existing PSO. The combination of the voluntary nature of the program and no funding may combine to limit the interest to jump on board.

Q: What are you looking at as far as time frames? When are you thinking of having the pre-meeting, when are you expecting to have your certification process for PSOs, and so forth?

A: We are trying hard to have the pre-meeting sometime in this calendar year (2005), but it's going to be a challenge to do that. With respect to the PSOs, there are so many things that have to be developed, things that we have to get that we haven't even solicited, that I don't know about that time frame, but certainly not before early summer 2006.

Q: What vision do you have for how you're going to get the PSOs to take the reported information and then turn it into something that people can actually act on and put into practice?

A: This question also ties into the question of: What is AHRQ going to do to take the reported information and turn it around and provide it back so people can actually use it to improve patient care and improve safety of care of patients? Two things come to mind. One is providing information on what we find, which local institutions can then use to compare their own performance to what we're finding on a broader scale—which is always instructive—although we are hampered by not having a surveillance system and limited in what we can do with denominators. I still think there will be useful information that will allow institutions to compare themselves perhaps even at the level of just how many incidents get reported for a given size institution. The second is that as we collect and analyze information, our researchers and others will combine the databases and learn from them. Successful strategies and approaches can be disseminated throughout the community.

Q: Do you anticipate that then the PSO will only be sending data to you? Do you expect the analyses and the recommendations will come from AHRQ? Or are you going to expect the PSOs to do that as well?

A: We expect the PSOs to do it, but we expect them to send us what they have learned. We cannot get first-order information (e.g., the information on the patient). So the institution must work with the PSO. The local institution is going to have to provide some real information on what happened to the PSO. We're the last one on the "food chain." So what we can do is aggregate what we get, but we're not going to be getting identified information.

Q: What is the accuracy of that information? What structure will you put in place for active access to aggregated analysis of information?

A: I think ideally we'd like to have Web access. There has been some discussion related to the network of patient safety databases. As the language from Lee's PowerPoint presentation says, the law creates a network of patient safety databases. And bullet No. 2 is to have evidence-based management resources per provider, PSO, and others. There is an expectation for a degree of interactivity to the aggregated databases so one can offer user-driven research capacities to query the national database at a local, individual institution, regional response. Furthermore, if somebody reports an event, he or she should be able to determine whether similar events have occurred either at their institution or elsewhere, along with collective wisdom regarding how that situation was addressed.

Q: So you're going to be also determining, then, database structure, it sounds like, for all the PSOs?

A: We're not going to necessarily determine the database structure. We're going to give a number of specifications for how they need to report the data to us.

Q: If everybody agrees on the terminology, you would have an active database to allow exchange of information. It just seems to me that the real key is the terminology.

A: Also the fields.

Q: We talked about how the PSOs would share information with AHRQ. In terms of identifiable information, suppose that we all around the table decided to form what would be a "grand PSO," and as you pointed out, there are multiple stakeholders, each wanting information that was relevant. It may be that the Institute for Medical Quality PSO would want to analyze specifically physician performance, the California Hospital Association hospital performance, and the California laboratory people laboratory practice, and so on. Is there any provision or any thought about creating a system that would ease reporting and then allow triage of that information to sub-organizations or other PSOs that represented perhaps more focused constituencies?

A: Interestingly, a lot of times you can network patient safety databases, and the law talks about data being shared among them. So I think it actually contemplates allowing a situation like you just described. That would be my read of it. For example, some hospital systems might choose to be PSOs because under the provision of the legislation, data are protected when shared with PSOs, whereas traditionally, I think data lose some of that protection once they cross state boundaries. And we all know the difficulty of institutional peer review protection of data once they cross the threshold of local institutions. The ability to have data moved around and still

retain the protections within the boundaries of the PSO system and the network of databases is one of the powerful provisions of the PSO legislation. Moving data from PSO to PSO would need protection, so the scenario that you painted there would have to be all within one giant PSO, which is, I think, what you suggested.

Q: One of the things that helped me envision this large patient safety network was thinking of it as a meta database, taking all the PSO databases and bringing them together as one for research, for development, for benchmarking. The other piece we talked about briefly at the Patient Safety Coordinating Center's Steering Committee meeting was in answer to your question "So what are you going to do for us in terms of improvement? Where's the opportunity here?" It is quite feasible that as this becomes established, users could examine their data, identify a patient-safety concern, and be immediately connected with AHRQ tools, resources, information that could immediately be applied. This is consistent with AHRQ's implementation mission. AHRQ has an exploding portfolio, and it's only going to grow in terms of tools and strategies to improve patient safety. So there's the automatic connection there. Do you think I'm in the ballpark there?

A: Sure. You'll notice that there are provisions in the law for researchers. So the intent of Congress was to facilitate that activity. There probably won't be enough people within AHRQ or even the PSOs to think of all the more interesting kinds of questions that we may not have either thought of or approached, that someone may find ways to tease out new knowledge from the existing data.

Q: If we have provider-identifiable information that the PSO has, who will have access to that information? Is it just the PSO? Is that going to roll up to AHRQ? Within this network of databases who will have access to sensitive data?

A: Once you get outside the PSO, if you send that information to AHRQ or to another PSO, you face monetary penalties. That information has to stay within the PSO and the institution where the event occurred.

Q: It almost argues whether you have a bottom-up or a top-down approach. If we in California wanted to share among ourselves to create a big PSO, then it would be the individual members (constituencies) who receive the data, and that would be OK. But if each of us collected data and then wanted to pass it up to a California PSO it would have to be de-identified.

A: I try to think about it as best I can from the national databases that I've dealt with before. I don't think that de-identification makes much difference. You don't need the patient's name, and it is better not to have it, except when you need the source data to do the quality measurement on the data itself, quality assurance, checking the validity, and sorting out data entry errors. Those quality activities must go on within the PSO. We're going to have to figure out what to do, if anything, about the problem of duplication potentially from overlapping PSOs. If you talk about specialized PSOs that deal with different aspects, you could be potentially getting the same incident reported to more than one PSO.

Q: Have you considered something similar to what has been set up by the QIOs for our collaboratives, where a provider could put in their data and the provider is the only one to get

access to their identified data? Then the de-identified data only includes the information that everyone could have. The provider's a protected entity as well, not just the patient. You would have to be sure that cell sizes were large enough not to implicitly identify someone.

A: About two years ago, AHRQ looked at Minnesota and the concept of going to the state legislature. There were about 30 organizations, and we started asking how to do it in California. People can now report these data outside the organization to the PSO because of federal protection, rather than changing individual state laws. The federal legislation now creates some real interesting opportunities that didn't exist before. Bill Rollow at CMS has had some discussion regarding the role of the QIOs with the PSOs.

Q: (Lee Hilborne) That was why we got together today for this discussion. Perhaps we could maximize the benefit in California if we created an umbrella organization of some sort. If we had one, it would allow us to share information within our larger PSO. But we need to construct it so individual stakeholders (e.g., systems or associations) don't lose out in the process. Perhaps we could ask Clark Stanton his thoughts as our legal representative in the room.

A: (Clark Stanton) The primary issue is that many people, particularly hospitals, are thinking only about how the hospital systems become PSOs and keep all their data within their system. I think this is looking at it the wrong way. I had not thought about the "grand PSO" issue, but it seems to me it's a better way of looking at it. It has a great ability to share. I'm encouraged to see that the Patient Safety Act provides for the ability to share across, for example, state lines. And that removes the issue of different levels of state law protection, some of which are not as good as Section 1157 of the California Evidence Code (the California peer review confidentiality statute). We should have protection even within California, between organizations and partners that exist or would exist.

Q: California has a statewide hospital discharge database; if there were some way to crosslink that, it would be an excellent resource. There will be many opportunities to crosslink with different databases, to the extent that we will have identifiable links. It will require a lot of thought about how to structure this. Some large chains have concerns about sharing information; now they would be protected.

A: We just had a presentation from Walgreens, one of the largest national retail pharmacy chains. This legislation gives them an opportunity to do things that they couldn't have done otherwise, if they become a PSO. Regarding linking of administrative data, we are working with our patient safety investigators (PSIs). New York is working with their administrative data. So there are some interesting opportunities and challenges.

Nancy Donaldson: I think it's quite courageous to take on this work, Bill and Jim. And I think that Lee talked about the potential challenge of this, or the opportunity, the unprecedented opportunity. But it will also take unprecedented goodwill. Because you are in the unenviable position of having to synthesize the state of the nation, literally, in this field, come up with definitions and agreements within our community, to standardize the data elements so that the actual network can be accomplished. That will take enormous wisdom, shared, and great goodwill to achieve this outcome.

Maribeth Shannon: If the PSO system was set up as a membership organization, I know why hospitals would want to join: because you want to have access to the information to achieve goals and improve your performance. And I can see why some institutions wouldn't join: because they are part of a system and feel like the greater good is for them to report within their system across state lines. If they don't see sufficient benefit from getting the information from other entities, the benchmarking component might still be useful. But are there other reasons that people would join or not join? Are there individual hospitals that just don't want to join because this is not an issue that they want to spend any time or money on?

Mary Giammona: How much time it takes will influence decisions because if people think it is labor-intensive and they already have their own system, they won't want to duplicate it for somebody else.

Eugene Spiritus: Hospitals will appreciate the benchmarking. An episode of one becomes an episode of four or five, creating a real opportunity to improve things. If we talk about this from the top down, which is an organization of culture, an institution in which the CEOs say, "This is Job 1, I'm not killing patients anymore, I'm not going to do that," then it flows logically that the reason for being and benchmarking is in fact that your primary responsibility is patient safety and quality.

If an organization says they are not interested in doing this, they're not going to be engaged anyway. If the organization wants a safety culture, a CEO can't say, "I'm not going to be involved in the thing." We spent most of two years with CEOs convincing them that they have got to measure. And the reason they have got to measure it is they have got to benchmark it so they can collect data and improve.

Nancy Donaldson: The benchmarking is limited. The denominator issue is not something that we should ignore because using this quantitatively is very difficult. We want to be part of the learning community that could grow out of the PSO. That is really where the value-added is.

Rory Jaffe: The challenge is making the reports simple to make and useful for others to read. What you must do is mesh with internal systems of looking at problems within organizations.

Terry Hill: We talked before about getting real experts and champions in this state who already covered this turf. You are all from hospitals and major organizations so we at least have physician offices represented. We don't have long-term care organizations represented. There is a large safety knowledge and resource gradient as you move from urban to rural hospitals, to community-based long-term care, to nursing facilities or physician offices. If we make the RHIO the PSO, all we have captured are the innovators. What we must do as a leadership group is think how we ensure that what we decide is attractive to the people without money and with different structures than a hospital. We have got some five-physician offices and skilled nursing facilities (SNFs) that don't have the resources. And we don't know what happens there. We know anesthesiology deaths happen in 1 in 400,000 and how many die each year in our hospitals. But the IOM couldn't publish data on what happens anywhere else.

It may be that we have multiple PSOs at different types of providers/organizations. It may be that to get an SNF to participate, we must have fairly low expectations for incident reporting. Even though there are cross lessons, limited reporting may be OK because first you want them to participate. To be useful to a hospital, we want a lot of information; to be useful to an SNF, we want them to participate. But it still has to be the same PSO. Many more people are harmed in care transitions than in the operating room.

Tony Linares: The more participation we have, the greater value will come out. This whole thing of "one becomes four" is critically important because we are talking about the change in senior management culture to realize that we are saving lives. Once you standardize on a taxonomy, it will overlap into nursing homes or physician offices. In our physician office project on electronic health records, we came up with standard presentations. So when people say heart failure, ACE inhibitors, and aspirin for myocardial infarction (MI), you use one field to indicate it. Those will be the same in hospital settings, and the government (Department of Defense, AHRQ, CMS) has agreed to use similar standards.

The standardization process is going to overlap. What is critical is if you tie into a RHIO, you will get significant economies of scale in these non-funded initiatives. Although RHIOs are non-funded entities, they exist, and they may provide a venue for raising money and finding a way to maintain that financial base. Once you tie it in, you will see other, overlapping networks and be able to get data from physicians' offices, from nursing homes, from emergency rooms, making the data very rich.

William Munier: I was wondering who was involved in setting standard definitions for heart failure for outpatient records. That's an interesting task.

Tony Linares: We have that posted on our Web sites nationally so any vendor that wants to work with the Medicare program can use those standard definitions and participate in the certification process. That is where the architecture systems are important, because then regardless of location—hospital, nursing home, doctor's office, home health agency, managed care—you have one field for those clinical patient safety indicators.

Jim Battles: We definitely want common definitions regardless of site, although there will be some events that only occur in certain sites. But things do need to be defined the same way, assuming they represent the same thing. The bill doesn't specify a given institution. You are right; the economics are very different once you move from the hospital. A large number of hospitals are interested in being part of this, but those numbers drop off as you move to a doctor's office.

Mary Giammona: Have you looked at tying this in with other federal initiatives like pay for performance? Because if you at least could tie it in with payment, like Medicare payments, that might keep recruitment up, or is the law too soft on that and you are not able to do that? Does it prohibit it in any way?

William Munier: I think the law is too soft, to use your words, to do that. We are setting up a culture of safety and trying to get people to voluntarily participate. If suddenly you turn around

and say, “If you report, we are going to dock your pay,” that could be a problem. By the nature of the data, just a whole bunch of those kinds of relationships would be difficult. From a conceptual standpoint, speaking at the federal level of aggregating this information, we need to walk before we run. Those kinds of ideas are all things that people are thinking about. This current legislation doesn’t necessary address tying those things together.

Someone implied that other organizations, for their own reasons, might tie to this legislation now that it exists. That would be a decision of tying it to pay for performance that CMS might make independently of the law. Now that the law exists, would a standard for participation of committing data to a PSO be one of the required patient safety practices that might emerge from JCAHO? Those would be independent from this law but would influence people to want to participate.

Bill Goodson: One of the things discussed, in terms of improving patient safety, has been an anonymous or protective reporting system, much as what is used with the FAA and airline pilots, where you call in something and you get a code number, which protects you from discipline. Have you thought about how you would go about implementing that on a national level?

William Munier: We’re not going to have any identifying data, so by definition it’s not our issue, but Jim, do you want to address the local level?

Jim Battles: We are in a different space than aviation in terms of a model, given the aviation safety reporting system. In fact, this patient safety legislation is probably the most powerful safety legislation in terms of protecting the individual practitioner so that the need for anonymity is removed from the playing field. One of the things that will be interesting is to look at the parallel systems in the VA because they are modeling that two-track system, one of reporting inside the VA through their own systems, and then that which is run by NASA out of Moffett Field. That kind of system may not be necessary, given that we have this protection, which is far greater than exists in the airline industry. A colleague of mine in the FAA looked at the legislation and suggested that since Congress has passed this law, maybe they’ll have similar legislation for aviation, which is kind of ironic.

Theresa Manley: Being at a physician organization, which is really in a hospital organization, Sutter Health affiliate, I can tell you that you can make a choice. I understand having the right incident terms, but when we look at trying to replicate systems in an outpatient setting that have been built in a hospital, 90 percent of that information is irrelevant. It is very difficult for physicians to buy into the fact that what they’re doing has any safety issue, especially when things go well. “We don’t have that many patient falls; we don’t have all of these things happening.” So I certainly understand the desire to keep it the same, but it is not the same. If you want to get physician organizations to participate in the effort, then you’re going to have to build something a little different. We heard the statistic the other day that 70 percent of physicians are not in multi-specialty groups; they are in single practices. It may not be the low-hanging fruit that you go for, but I would just recommend keeping this in mind.

William Munier: I agree with those comments. I only meant to say if there is an incident that occurs in both settings, then it should be defined the same way. There will be incidents that only

occur in one setting. The doctor's office is a very different place from a hospital, and so we will have a different arena to address. We will probably start with the hospitals, and then move into other settings. But the issue of collecting data, the abilities of the institution, how disruptive it is, and the expense is very different in a doctor's office. It is potentially a showstopper in the doctor's office if it becomes labor-intensive and disruptive of workflow.

That's really all I can say right now. The best I can promise you is that we will remain sensitive to practical as well as scientific issues. We want to never lose sight of the fact that our overall goal is to have a scientifically valid system that collects information and data about patient safety that can provide information that allows end-users to actually provide better care back in the setting where it is delivered. If we ever lose sight and start mindlessly writing regulations and setting up programs for the sake of doing it without remembering why we're doing what we're doing, I think we get in trouble.

Teryl Nuckols Scott: Have you all given any thought to which setting might be higher priority? If resources are limited or non-existent, perhaps starting in a more focused way might be helpful, and I was wondering if that was something you wanted to address.

William Munier: Well, I certainly would define safety relatively narrowly and probably start with hospitals. So I think that speaks to what you're talking about.

Teryl Nuckols Scott: What resources within AHRQ have been used on this program?

William Munier: Basically Jim and me. We have set some monies aside that fortunately we're able to get our hands on. And we're looking for some additional physicians, and we're working with some outside consulting groups where they can be helpful to us. I talked about setting up a support structure as part of what we have to do. We do need additional resources to adequately address what has to be done.

Marybeth Sharpe: For the data to be protected, must it go directly from the provider to the PSO, or could it go through another data intermediary and then to the PSO? Any thoughts about that? Could a PSO be, for example, more of an umbrella of different existing data collecting entities that already are working?

William Munier: Since the kind of data the PSO itself will get contains identifiable information, I think the law is silent about a route by which it gets that information.

Jim Battles: One thing we have to be careful of, which is quite clear in the legislation, is the path from the provider to the PSO should be direct to protect the data.

William Munier: It doesn't lose protection that would exist under state peer review statues to cross outside organizations. But involving an intermediary or something that isn't a PSO, it would not have the PSO protection.

Theresa Manly: That would be a state issue.

Jim Battles: Yes. However, the PSO legislation overrides the state laws on peer review.

William Munier: They explicitly say in the law that if there is voluntary disclosure to the accrediting body, those data are not protected if it then comes from the accrediting body.

Jim Battles: If you report it to another agency, then it's not protected under the law.

William Munier: Very large and complex organizations that would come together to be a PSO have some decided advantages, but the larger and more complex you get, the more chances information gets mishandled, too. So we need to consider that in thinking about how to handle sensitive information.

Jim Battles: One of the things that will be a challenge to make this legislation work is protection of the data. We have some great horror stories from aviation and some other places where confidentiality was in fact breached. I think New Zealand is the poster child of what happened with their aviation reporting system when information was leaked about a pilot's name, and now nothing gets reported. The critical element will be to make sure that data are in fact protected as they move outside an institution into the PSO because if any PSO screws it up or we screw it up, we've got some real big problems.

Mary Giammona: What would happen if the information went to a protected entity (i.e., the PSO), and then to another protected entity (e.g., a quality-improvement organization)? Has there been any thought about what would happen if they were the intermediary?

Jim Battles: I think that's a discussion that probably would be useful to have around the QIO community because the relationship of QIOs and PSOs is yet to be determined.

William Munier: That is an issue that needs to be resolved. There are some QIOs that are talking about becoming PSOs. Your question pertains to being an intermediate stop. I think we don't have the answer on those yet, but we need to get them.

Teryl Nuckols Scott: Once the PSO has information, I'm assuming that it has the right to use the aggregated information as part of its patient-safety efforts, assuming all the individual identities are gone, that it still is allowed to disseminate aggregated information as part of its educational mechanisms.

Jim Battles: Yes. That would be an expectation. Part of the whole notion of creating PSOs was to bring the opportunity for data and sharing much closer to the local level and not being in some large repository that never gets information back.

William Munier: Take some of the remarks by some of the members of the legislative branch, probably not necessarily big supporters of this kind of information. Their main concern is how the information is used to improve health care. That is what we must prove, and that is what Congress is going to be looking for.

Lee Hilborne: I think we're going to have more come out of our discussion. I certainly want to thank you for taking the time out of your busy schedule to join us. I hope that our questions have raised some things that will be important for AHRQ to think about as well.

William Munier: Yes. We both want to thank you all for getting together and having us as part of this discussion because you raised some extremely powerful questions. I think it's been as helpful a discussion as I've been part of since the law passed. So I think your quality of thinking, the nuances, the different questions that you raised are really very, very helpful, and we appreciate the opportunity to talk with you very much.

Discussion of Potential SAFER California Healthcare Opportunities

This section identifies some of the opportunities for future SAFER California Healthcare activities/initiatives that were identified over the course of the discussion.

Leadership and Priorities

Opportunity: Setting Priorities

Not that long ago in anesthesia, one out of every 7,500 healthy people died; now it is around one in 400,000. Perhaps one of the problems is that there are so many potential priorities that we should start focusing specifically on some of the easy targets. We all have the same problems, such as hospital infection. Yet we accept a death rate, like anesthesia did, that shouldn't be acceptable. Just saying patients get infections as an explanation is unacceptable.

Opportunity: Creating Buy-In for Patient Safety

A recent University HealthSystem Consortium (UHC) meeting discussed examining quality and safety and looking at report cards. UHC has conducted many benchmarking projects, summarizing best-performer practices for the entire membership. They examined the institutional perspective that creates best performers. Success depends on the senior management's message (e.g., the CEO, chief medical officer, chief nursing officer). Senior management must be fully engaged with a presence, or success is not possible. The ones that stand out have senior management engaging everybody at all levels and communicating that safety is a priority.

Part of our goal should be to determine how each hospital can be enabled to demonstrate this leadership and make it second nature. The best way of proving that you are a non-punitive organization is to run effective, intensive reviews where people come in scared and walk out saying, "You know what? This is really helpful, I learned something," and go back to the floors and say, "You know what? I made a mistake, and I don't feel like somebody pounded me into the ground. I've got something to go back and do, and I'm going to prevent this from happening to somebody else." If a reporting culture is part of the management culture, it really drives success, and if you don't have that culture, you don't get anywhere.

Opportunity: Developing Interventions with Tangible Outcomes

The California HealthCare Foundation would consider funding a project such as developing a curriculum or safety stories that would then be disseminated to spread the message to those who have not otherwise heard it. It would be interesting to have a safety goal where 75 hospitals agree to participate. A measurable outcome would be the goal (e.g., X people who agree to do certain things). The idea of renewing tools might be something CHCF could fund, if the focus was finding ways for getting the tools into the hands of people who will actually use them.

Opportunity: Developing the Business Case for a PSO

The CHCF might, if regulations are clear, fund the development of a business case for how to set up a PSO, including the steps and membership.

Education and Team Building

Opportunity: Forums for Discussing Issues
Because there are different stakeholders, we could host a couple of forums to address important issues, such as ambulatory medication prescribing. Maybe there is a safety goal to be met by each of a series of forums. Some of them might be primarily hospital-based, but one would focus on, for example, nursing home care. Although ARHQ declined SAFER's earlier conference application, the agency might consider something now that SAFER has a track record. If SAFER is going to continue, it would need funding. CHCF could consider funding if the outcome is tied to something tangible.

Opportunity: Creating Team Education Programs Together
One project could be organizing a practical session for senior management, medical directors, and incoming chiefs of staff that presents what is known about patient safety in a practical way. Academic research discussions should be included only if the findings have a direct, actionable impact on hospital operations. Then, when the director returns home, change begins. Bringing together the hospital CEOs and medical directors would be positive because they represent different important constituencies needed. A training program around a non-threatening topic could be very positive.

There was discussion about acknowledging that there are two different cultures in health care. Specifically, physicians are different than nurses and other hospital staff members. Nursing and pharmacy, for example, are very hierarchical, and physicians are more of a confederacy. These differences must be acknowledged as approaches to culture change are explored.

Opportunity: Team Building within the Coalition
The heart of the matter is communication and collaboration across disciplines and teamwork. We might come up with patient strategies, resources, and tools. Better practices for enhancing collaboration, communication, and teamwork are at the heart of the patient-safety enterprise. Patient-safety stories are a part of that. What would happen if we made a conscious effort to break down some walls and engage each other with us? Consider a pilot project where an acute-care hospital buddies with a nursing home. We could pilot using the acute-care hospital as a resource, minimizing any extra work for SNFs of trying to accelerate performance improvement. To accelerate performance improvement in SNFs, giving them a buddy/coach provides richer support than they currently have.

Reporting

Opportunity: Addressing Underreporting, Particularly by Physicians
There has been significant underreporting of adverse events. People do not like to report themselves or their colleagues. Regardless of the hospital, it is difficult to get out from the blame-and-shame culture and assure people that information will be used confidentially and constructively. Yet creating that atmosphere is essential. The culture must change to where people feel it is their responsibility, and privilege, to report events (i.e., make a contribution to improve care).

This approach requires moving from secrecy to transparency, something counter to the usual physician education where there is an expectation that any errors are "your fault" and you must take responsibility. It is important to recognize differences between disciplines. For example, in medicine there is a strong code of silence compared to surgery, where there tends to be a better discussion of events. Looking to surgical reporting may provide insight to how to begin to encourage others to report.

Opportunity: Increasing Near-Miss Reporting

Aviation spends a lot of time looking at near misses. In health care, for every death related to a medication adverse event, 10 injuries are reported. And for all those injuries, there are at least 100 per 1,000 or so near misses.

At Palo Alto Medical Foundation some reports come from patients in addition to staff members. Reporting is publicized and encouraged.

UCI offers a "thank you" with $2 and some gold fish. It's called the "great catch" award. When prizes were first sent out, people didn't know how to respond to that. They wondered what they had done wrong.

A similar thing occurred at UCLA where, during nurse appreciation week, the unit that reported the most errors or near misses was rewarded. We provided a pizza party for the unit. The message was not that we were rewarding errors, but we were rewarding honesty in reporting those errors that do occur. Any unit that wanted to win next year had to report errors. We weren't incentivizing error making—just encouraging the staff to report the errors already occurring.

Opportunity: Patient Safety from a Public Health Perspective

There are parallels between patient safety and public health initiatives (e.g., reporting medical errors has similarities with reporting sexually transmitted diseases: the desire for anonymity vs. the need for contact tracing). The issue is sensitive, but when you know who has a condition, you can track and address it. Framing error reporting using a public health approach might make transparent public reporting more acceptable, creating a culture where professionals communicate and adopt reporting rules because of its broad health impact. Starting with new trainees has virtue. Unless you get to people at the medical, nursing, pharmacy, or other professional student level, or perhaps during residency training, and train them that error reporting is a necessary—even routine—part of medical practice, it will be hard to achieve culture change.

Developing Partnerships

Opportunity: Involving Patients

Organizational efforts made across California may not include specific outreach to consumer groups, but patients must be involved. Their perception of how safe or unsafe care is differs completely from that of health care professionals. Strategies to bring patients and patients' advocates into the discussion are the key.

Opportunity: Working with Aviation
SAFER California Healthcare has worked with United Airlines to understand how they transformed their reporting culture. Members of SAFER went to United's Flight Training Center in Denver. Two important aviation approaches may warrant consideration:

• The airline industry rewards reporting. A pilot that reports a near miss receives a tracking number from the airline safety reporting system. Obtaining the tracking number guarantees them immunity from discipline for the event they reported. It's actually a carrot, not a stick.

• They have an open approach to analyzing reported events. Each week, United receives and reviews each of about 120 pilot events. What is most fascinating is who reviews the events. There is United Airlines and the pilot and their group (including the human factors specialist) along with the FAA, the licensing organization, and the airline pilots' union. Could that happen in medicine? Could we imagine a future when there's an adverse nursing event, that our chief of nursing, the California Nurses' Association, and the Board of Registered Nursing (or for physicians, the Medical Board, our medical staff, and IMQ) sit together to discuss unanticipated outcomes?

Patient Safety Organizations and Data Collection

Opportunity: Beginning to Set Standards for Common Data Collection in California
California now receives only narrative data (Richard Marken, RAND). We can determine more objective data collection recommendations. It may be worth waiting, however, for AHRQ to complete its set of assessments.

Opportunity: Summarizing PSO Findings into Case Reports
There was discussion about a monthly safety report, such as AHRQ's Web M&M. This would be a more sophisticated analysis with the PSO, which would then turn the story into prose. The analysis could also operate as a clearinghouse to record not only the problems but how people solved them. It might be useful for experts to review cases and distill implementable lessons.

Opportunity: Assisting in Patient-Safety Data Analysis
Another potential topic is a prelude to a PSO. Most hospitals have some kind of internal reporting system, but they don't know what to do with the data. What is the value of collecting these data if they aren't analyzed and turned into action? There is some pre-work needed to help hospitals understand what they are collecting and how they might be able to use that kind of information.

Focusing on Areas Beyond the Hospital Setting

Opportunity: Patient Safety outside Hospitals
It is important to work with people across the state, perhaps with primary care offices and pharmacies that are getting prescriptions filled. There may be a way to get physicians' offices together with pharmacy chains to look at safe prescribing. Pharmacy and physician professional groups could seek funding from a pharmacy chain or chains, having the chains be a safety partner, accelerating change.

Opportunity: Care Transitions
One area where there are preventable medical errors, including medication errors, is in the handoff transferring the individual from acute care into long-term care, where discharge summaries are not showing up at the nursing home for two or three weeks. There are also problems with handoffs between hospitals, long-term care, emergency, dialysis, home health, and hospice care. Within hospitals there are problems with handoffs from ICU to the floor, ED to floor, etc. Handoffs are a health care—not a hospital—issue. Reduced resident work hours have increased this risk at teaching hospitals.

Opportunity: Assisting Small Physician Practices
In very small offices, some non-clinical things can be affected that don't directly involve the physician. Follow-up on lab results involves communication, whether it is with a receptionist or an office manager or somebody else. Some are very interested in working on issues that they can implement without changing the physician's behavior but almost working around the physician.

Opportunity: Nursing Home Safety
Our nursing homes represent twice the number of hospitals in this state, and we have an aging population. One out of every ten nursing home residents is injured every month by medication errors. Consider a symposium that brings together the long-term care providers with acute-care providers.

Opportunity: Geriatric Pharmacology
The lack of geriatric pharmacology to address drug appropriateness has been problematic in hospitals but is even more of an issue with nursing homes. This idea is similar to a Lumetra collaborative on care transitions. Terry Hill commented that it would be possible to assemble the broader group, perhaps under the auspices of SAFER, to address the issue.

Opportunity: Patient English Fluency
UCI now documents English proficiency when errors are reported. One of the big issues in hospitals is whether or not patients understand. In nursing homes where some employees barely speak English, how can they follow safety guidelines?

The Future of SAFER California Health Care

SAFER has spent four years building the effort, and it makes sense to keep moving forward. Lee Hilborne should be encouraged to think about how to continue to use the SAFER vehicle to develop a proposal for CHCF. The goal in the initial proposal was that SAFER would start among the UC facilities with the medical directors. But it wasn't meant to involve only UC, and a number of participants at today's meeting were at or spoke at the statewide conference we had because we wanted to expand SAFER's focus. SAFER is intended to be a "strategic alliance for error reduction in California health care." The title makes sense. If nobody objects, why don't we continue using it to represent this coalition of interested organizations? The group concurred.

Suggestions for additional future participants:
High-reliability organization experts, including colleagues from UC Berkeley and Stanford University
Kaiser system
California Hospital Association
California Medical Association
California Nurses Association
California Pharmacists Association
More participating hospital groups, including children's hospitals, Tenet Hospitals, etc.
Long-term care facilities
Community clinics
RHIOs
Legislators (There was a consensus that we should invite them when we are ready to offer more specific proposals.)

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Appendix B: Welcome Letter

UNIVERSITY OF CALIFORNIA, LOS ANGELES

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September 28, 2005

Welcome!

Thank you for taking the time to meet today to discuss the future of patient safety in California. As mentioned in the introductory letter, it has been over five years since the Institute of Medicine's *To Err Is Human* report. We were challenged in that report to have reduced harmful errors by 50 percent by the end of last year. Probably that goal was a bit ambitious. However, most of us feel quite positive about the progress in patient safety we have made in California through the efforts of our organizations and our colleagues. At the same time, it's probably safe to say that the more we know the more we feel the frustration with the challenges that remain.

With the passage of the Patient Safety and Quality Improvement Act of 2005 and sensitive to the need for and eventually the creation of Patient Safety Organization(s) in California, we hope this will be a forum to discuss opportunities to work together to advance California's patient safety agenda. I hope that we will spend a few hours sharing among ourselves what each of our organizations is doing related to improving the quality and safety of health care in California. Once requirements for Patient Safety Organizations become clear, having the beginning of a coalition in place may be quite valuable.

I want to thank the University of California Office of the President for co-hosting the meeting today and acknowledge the contributions of the RAND Corporation toward helping SAFER California Healthcare meet its goals. I also want to thank the Agency for Healthcare Research and Quality for supporting SAFER California Healthcare activities and this meeting.

Thanks again for being here today.

Sincerely,

Lee H. Hilborne, M.D., M.P.H.
SAFER California Healthcare

Endnotes

1. UC completed the survey, and almost all the indicators were in the right direction. The one that was most problematic was whether people felt they would be punished if they reported an error. And while there was only a small percentage who strongly felt that they would be punished, only 50 percent pretty strongly believed that they wouldn't be punished, and 30 percent were kind of neutral on it, and 20 percent thought they would. If you think you will be punished, why would you report such an error?

2. There was agreement regarding the importance of having the right people in the discussion.

3. Comment from Lee Hilborne: We do hope that the licensing boards, if we go forward, will be involved. What we saw when we went to the airline industry is that their licensing board was there with the organization when reviewing near-misses. At some point, we do need to get there, where everybody has a same common interest. Aviation is doing it; they finally agreed to get beyond the issues dividing them, and there is no question aviation is infinitely safer now than before.