What is the Oregon Patient Safety Commission?

The Oregon Patient Safety Commission is a semi-independent state agency charged with reducing the risk of serious adverse events occurring in Oregon’s health care system and encouraging a culture of patient safety. In partnership with ambulatory surgery centers, our goals include:

- Improving patient outcomes and quality of care in ambulatory surgery centers by reducing the number of adverse events;
- Encouraging a culture of safety, in part by approaching patient safety from a systems perspective and less as an issue of individual blame;
- Learning and reinforcing better approaches to adverse event investigation;
- Providing ambulatory surgery center leaders with a means to demonstrate their commitment to quality improvement.

How is the Patient Safety Commission organized?

The Commission was created by the state Legislature in 2003 with the active support of a wide range of health care organizations, including the Oregon Medical Association. It is run by a 17 member Board of Directors appointed by the Governor and confirmed by the state Senate. By design, the members reflect a wide range of health care interests.

Ambulatory surgery centers are represented by Dr. Bruce C. Johnson MD. Dr. Johnson is a physician at the River Road Surgery Center in Salem and has been a member of the Commission’s Board of Directors since 2004.

How is the Patient Safety Commission addressing the problem of adverse events in ambulatory surgery centers?

We believe the Patient Safety Commission offers a new approach. The Commission is developing a cooperative model of quality improvement based on the confidential sharing of adverse event information. Ours is a non-regulatory approach that emphasizes systems thinking and non-punitive solutions. Via our reporting program facilities can safely share information. In return they can gain a wider knowledge of what other organizations face, what other solutions are available, and what priorities make sense.

What sort of track record does the Patient Safety Commission have?

The Commission’s hospital reporting program has been operational since May 2006. Fifty-six of Oregon’s 58 hospitals have signed participation agreements with the Commission. These 56 represent more than 99% of hospital care provided in Oregon. We’ve used hospital data to issue alerts and bulletins, to develop safety tips applicable to a wide audience, and to identify quality improvement efforts. In January 2007 we published our first annual hospital report.

We have also convened statewide groups to address serious patient safety issues, including patient notification and healthcare-acquired infections. With our hospital partners we created a workgroup to look at the problem of retained objects after surgery. Further, we analyzed statewide variation in the use of colored wristbands worn by patients. And, we have created a technical advisory group—including
clinicians, human factors engineers, and an ethicist—to provide multi-dimensional insights into specific adverse events.

In addition, we are partnering with the Institute for Healthcare Improvement to champion evidence-based best practices. While most of these practices apply to hospitals, many are useful to ambulatory surgery centers, including ways to prevent or reduce: surgical site infections, adverse drug events, surgical complications, harm from high alert medications and MRSA infections. Within this partnership, we have organized content-rich teleconferences on emerging patient safety issues (medication reconciliation; rapid response teams).

Are adverse events and medical errors really a big problem in Oregon ambulatory surgery centers?

Following the national trend, the growth of freestanding ambulatory surgery centers in Oregon is impressive: from 19 licensed ASCs to 80 in the past decade. The result is a continually increasing volume of procedures and operations being done outside the hospital setting.

The little information available for ambulatory surgery centers suggests that adverse events represent a serious problem.

- Pennsylvania Patient Safety Authority (PSA) reporting program received over 700 reports of serious events from about 225 ASCs[^1] in 2006[^2].
- The Pennsylvania PSA found that about 35% of total reports involved the need to provide unanticipated patient care or to transfer the patient to another provider.[^3]
- A 2004 study of 621 surgery centers found 1,378 significant sequelae over a period of two years with these top events: hematoma, infection and necrosis, cardiac events and respiratory distress[^4].

So, while ambulatory surgery centers may be doing a good job with regard to quality of care, there is evidence that, collectively, they can do better. This is especially important as the volume of patients cared for in ASCs continues to grow and that care becomes more complex. In some ways the types of medical errors faced by ambulatory surgery centers are similar to the problems faced by surgery units in hospitals (adverse drug events, infections). But in other ways ambulatory surgery centers and hospitals are very different (availability of resources, patient demographics, length of stay). One solution will not fit all situations. We need to work together to address issues specific to ambulatory surgery centers.

Were ambulatory surgery centers involved in the development of the reporting program?

Yes, the Patient Safety Commission worked closely with the ambulatory surgery center leadership and personnel in developing its reporting program. In fact we created two related work groups. The first, the “tool-development” group, created the necessary building blocks of an adverse event reporting program for ambulatory surgery centers. The group included representation from Oregon Ambulatory Surgery Center Association (OASCA), River Road Surgery Center (Salem), Redmond Surgery Center, Kaiser Permanente Surgery Centers, Oregon Surgery Center (Roseburg), Bend Surgery Center and the Center for Outpatient Medicine (Salem).

The second group worked with the Commission to pilot-test the reporting tool. This group included participants from River Road Surgery Center (Salem), Redmond Surgery Center, Interstate Medical Office, South Ambulatory Surgery Center (Kaiser Permanente), Oregon Surgery Center (Roseburg), Bend

[^1]: exact numbers not available since birthing center data is combined with ASCs (there were five birthing centers in 2005)
[^2]: Pennsylvania Patient Safety Authority 2006 Annual Report, available at [www.psa.state.pa.us](http://www.psa.state.pa.us)
Surgery Center, the Petroff Center (Lake Oswego) and the Gastroenterology Endoscopy Center (Tualatin).

Throughout this process we have refined the reporting framework and have identified ways to incorporate and honor existing reporting so as not to duplicate administrative efforts.

**What types of information will ambulatory surgery centers report to the Commission?**

The Commission is collecting data about “serious adverse events.” This will include events that are “unanticipated and usually preventable” and result in death or serious physical injury. The intent is to identify events that are caused, at root, by an issue of medical or patient management, rather than the underlying disease. The list includes:

1. **SURGICAL EVENTS**
   - A. Unplanned admission to the hospital within 48 hours of discharge from an ambulatory surgery center
   - B. Postoperative nausea that requires hospital admission
   - C. Any blood products transfusion
   - D. Immediate postoperative bleeding that requires surgical treatment in the operating room (before discharge)
   - E. Deep vein thrombosis with or without pulmonary embolism
   - F. Unplanned retention of a foreign object in a patient after surgery or other procedure
   - G. Death postoperatively directly attributable to surgical procedure
   - H. Intraoperative or immediately postoperative death
   - I. Surgery performed on the wrong body part.
   - J. Surgery performed on the wrong patient.
   - K. Wrong surgical procedure performed on a patient.

2. **HEALTHCARE-ASSOCIATED INFECTIONS**
   - A. Surgical site infection up to 30 days postoperatively

3. **EQUIPMENT/PRODUCT/DEVICE EVENTS**
   - A. Patient death or serious physical injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
   - B. Patient death or serious physical injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended or is difficult to use as intended.
   - C. Patient death or serious physical injury associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

4. **CARE MANAGEMENT EVENTS**
   - A. Patient death or serious physical injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration).
   - B. Patient death or serious physical injury associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
   - C. Patient death or serious physical injury associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.

5. **ENVIRONMENTAL EVENTS**
   - A. Patient death or serious physical injury associated with an electric shock while being cared for in a healthcare facility.
   - B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
C. Patient death or serious physical injury associated with a burn incurred from any source while being cared for in a healthcare facility.
D. Patient injury associated with a fall while being cared for in a healthcare facility.
E. Patient death or serious physical injury associated with the use of restraints or bedrails while being cared for in a healthcare facility.

6. OTHER CATEGORY
A. Any unanticipated, usually preventable consequence of patient care that results in patient death or serious physical injury.

For each event reported, we will ask ambulatory surgery centers to provide information that describes the event, pinpoints the causes, and outlines the ambulatory surgery center’s action plan.

How does this reporting program compare to those from ASC accrediting organizations (Joint Commission, AAAHC, AAAASF)?

The common ASC accrediting organizations do not require reporting of a comprehensive list comparable to that of the Patient Safety Commission. However, while developing the specific reportable events for the Patient Safety Reporting Program for ASCs we were mindful to include similar adverse events to those already being tracked by accredited facilities. It was the intention of the Advisory Group to support the current valuable patient safety work in ASCs and build on that for the statewide reporting program.

What are the benefits of participating in the Commission’s reporting program?

- **A chance to learn from others in your peer group.** Currently, data collected by accrediting organizations are limited in their scope to patient safety improvement. In contrast, we are creating learning tools and the means to identify/share best practices.

- **On-going quality feedback from the Commission.** We are building the staff and the analytical capability to provide useful quality information to ambulatory surgery centers. We will combine data from all locations into a unique data set, make sense of that information and report it back to ambulatory surgery centers. The information will help us identify quality improvement priorities, offer examples of local successes, and highlight the exact reasons why adverse events occur over and over again.

- **Access to an early alert system.** We will have the ability to provide virtual real-time notification of emerging issues, and early warnings about potential trouble areas. A similar program for hospitals has been very successful.

- **A new way to address the risks of transition issues.** Our reporting program includes hospitals, pharmacies, and nursing homes. As we collect adverse event data from these different healthcare settings we can ask the critical questions about handoffs and communications and continuity of care.

- **A means to leverage professional credibility.** Since we run a voluntary program, ambulatory surgery centers will have a lot of say in how that program evolves. Participating offers another way to stand before your community and say, ‘we are leaders in quality improvement.’

The Patient Safety Commission is the only organization in Oregon that combines:

- A single focus on patient safety
- A legal safe haven (similar to peer review protections)
- An ability to collect and share data across institutions
- An ability to gather data on how adverse events occur
- Independence
- Public accountability
- Non-regulatory approach
What does the written notification statute mean?

The Patient Safety Commission, by statute, requires that ambulatory surgery centers notify the patient or patient’s representative, in writing, of a serious adverse event. The simple intent is to keep the patient at the center of any conversation about his or her care, even when things don’t go as planned. The Commission strongly urges ambulatory surgery centers to honor this patient-centered philosophy and to integrate written disclosure into their overall communication strategies. To help, the Commission has created a toolkit of ideas.

Hospitals have found a way to meet this requirement. The Commission believes that ambulatory surgery centers – with their focus on providing patient-centered quality care - will be able to as well.

What legal ground rules apply to the Commission’s work?

The Commission was designed as a legal safe haven. Information flowing to and from the Commission will be legally protected. Per statute, “Patient safety data and reports obtained by a patient safety reporting program from participants are confidential and privileged and are not admissible in evidence in any civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding.” This protection means that patient safety data, patient safety activities and reports are not subject to civil or administrative subpoena; discovery; or disclosure under state public records law and, if permissible, federal public records laws. With regard to HIPAA Privacy Rules, the Patient Safety Commission is a “public health authority,” so that covered entities are authorized to disclose protected health information for public health activities and purposes. [Note: We’ve published a separate, and detailed, analysis of the legal framework protecting the Commission and its reporting partners. Available upon request.]

Will the Commission share information with State regulatory agencies?

No. Any patient safety data reported to the Oregon Patient Safety Commission or developed as part of the Commission’s auditing and oversight role is legally off limits to any state agency.

How is the work of the Commission paid for?

As defined by statute, the Commission can seek funds from four sources:

- Fees assessed on all health care facilities (and retail pharmacies).
- Grants
- Donations
- In-kind support

Currently, most of our revenues are generated from fees pegged to our annual operating budget (about $500,000 per year). We have the statutory authority to assess fees on hospitals, nursing homes, retail pharmacies, ambulatory surgery centers, birthing centers and outpatient renal dialysis centers, independent of reporting status. We have asked ambulatory surgery centers to support about 11% of our work, which translates to $850.00 per year for each ambulatory surgery center in Oregon. We believe this is a modest amount. For comparison, hospitals pay about 40% of the Commission’s work (with fees as high as $8,500 for large hospitals).

What’s your best argument for participating?

The Patient Safety Commission offers ambulatory surgery centers an opportunity to define themselves as leaders in quality. By sharing information with the Commission, ambulatory surgery centers will have a new way to learn from each other about the nature of adverse events. The Commission will create a real-time alert system to notify ambulatory surgery centers about potential causes of serious errors. The Commission will help the ambulatory surgery centers move away from the focus on individual blame and towards quality improvement activities. By participating, ambulatory surgery centers will demonstrate their commitment to identifying best practices in the profession; they will also gain a process to share those experiences and observations with all facilities in Oregon.
Sue Nance, administrator at the Bend Surgery Center, recently commented in the Bend Bulletin: “I think it offers transparency, and I think it will clear up some of the misconceptions about (ambulatory surgery centers). I think if you are accredited you shouldn’t be afraid to participate. It just makes us a more credible entity all around.”

**What would I have to do to sign up my organization with the Commission?**

Enrollment is easy. All an ambulatory surgery center has to do is sign a participation agreement. The annual fee of $850.00 is required, even if you choose not to participate. Our field coordinator will work directly with your staff to learn more about your existing reporting infrastructure and to explain the mechanics of identifying an adverse event and submitting a report.

**Who can I contact if I have more questions?**

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