CHPSO
California Hospital Patient Safety Organization

Patient Safety News
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ONC Takes Steps to Promote Common Formats

The Office of the National Coordinator for Health Information Technology (ONC) has taken several steps to increase reporting to PSOs and facilitate providers' ability to collect data and solve problems. Among other actions, ONC has established prizes for application development and has proposed placing Common Formats (the national standard taxonomy and electronic format for reporting to PSOs) into meaningful use criteria.

Incident report system vendors are already moving toward supporting Common Formats, as hospitals nationwide are linking up with PSOs (see next story). With these new efforts by ONC, CHPSO anticipates that Common Formats will become widespread.

The Challenge

ONC is offering $70,000 in prize money to the top three contestants that develop applications to:

- Increase the ease of reporting patient-safety events to the provider or parent organization.
- Enable providers to import relevant EMR, PHR and other electronic information, including screen shots, to the patient-safety report and, in turn, submit an Agency for Healthcare Research and Quality (AHRQ) Common Formats-compliant report to one or more PSOs.
- Capture useful demographic and other relevant information from each patient including age, gender, race and relevant diagnoses.
- Capture information about the type of organization submitting the report using AHRQ's PSO information format.
- Reduce the burden of reporting by enabling the provider or parent organization to have the option of submitting information in the patient-safety report to non-PSO public health or health oversight organizations, including state or federal programs, or accrediting or certifying bodies.
- Be platform-agnostic.
- Leverage and extend Nationwide Health Information Network (NwHIN) standards and services including, but not limited to, transport, content and standardized vocabularies.

Additional information is available at challenge.gov/ONC/349-reporting-patient-safety-events.

Meaningful Use

The HITECH Act includes financial incentives for demonstrating meaningful use of electronic health record (EHR) technology. Now, ONC is considering an addition to the meaningful use criteria that would support reporting events, close calls and unsafe conditions involving EHRs to PSOs. This proposal is included in the recent Notice of Proposed Rule Making available at 77 FR 13832, in Section 170.314(g)(4) *Safety-enhanced design*.

—Rory Jaffe, MD, MBA, rjaffe@chpso.org

Incident Report System Vendors Readying for Data Collection

CHPSO now has the capability to receive data from many of the major incident reporting systems and, with assistance from ECRI Institute, is working with other vendors to build their capabilities. In addition, CHPSO now can receive information from home-grown systems and will provide technical support for hospitals if needed.

Of the incident report system vendors contacted, RL Solutions and Midas+ report that their systems successfully connect with the CHPSO database. Verge Solutions is in the testing phase and Quantros expects to connect some time this year. Hospitals working with other vendors are asked to notify CHPSO so we can contact them.

Now Accepting Reports

CHPSO can accept reports in one of two formats:

XML, which is the standard for PSO data interchange. Once data is in the AHRQ XML format, it is readily accepted.

CSV, which is a simplified version of a spreadsheet. The layout is specific, and CHPSO will assist hospitals in designing the reports to conform to our format.

Vendor Updates

Midas+: Midas+ offers a toolkit to clients that wish to report patient-safety event data to CHPSO using the Agency

for Healthcare Research and Quality (AHRQ) Common Formats. The toolkit includes data-collection forms that incorporate the Common Formats, as well as a standard report that produces a data-extract file in CDA format suitable for submitting data electronically to CHPSO. Midas+ has worked extensively with ECRI Institute to ensure this data-extract file can be easily uploaded to the CHPSO-ECRI Institute Data Portal. Hospitals interested in using this toolkit for their patient-safety event data collection and reporting should contact their Midas+ regional consultant.

RL Solutions: Many RL Solutions clients have had success submitting data to PSOs powered by the ECRI Institute from RMPro and RL6:Risk incident reporting software. RL Solutions clients participate via a data mapping exercise that maps their fields to those in the AHRQ Common Formats. Hospitals interested in using RL Solutions to send their data to CHPSO should contact their RL Solutions representative.

Quantros: Quantros should have the ability to export event data from SEM in AHRQ 1.1 XML format by the end of the year. In the interim, hospitals that want to send an individual event to CHPSO can use the SEM ad hoc report writing tool to generate a report that can then be translated into a format compatible with the CHPSO database. This ad hoc report tool is not designed, however, to be a bulk data export utility.

Verge: Verge is actively testing the transfer of data to the CHPSO database.

For progress information on **Meditech** and **Landacorp**, contact your account representative.

Presentations Now Available on Website

CHPSO First Annual Meeting

Slides and audio recordings of CHPSO's first annual meeting on March 13 are available for both CHPSO members and conference attendees. Members and attendees will receive access information in a separate mailing.

Respectful Management of Serious Clinical Adverse Events

On February 28, CHPSO hosted a talk by Frank Federico, RPh, Executive Director, Strategic Partners, Institute for Healthcare Improvement (IHI), one of the authors of the IHI white paper, *Respectful Management of Serious Clinical Events*. A recording of the web seminar is now available at www.chpso.org/webinar/20120228.php.

From the introduction to the paper:

Every day, clinical adverse events occur within our health care system, causing physical and psychological harm to one or more patients, their families, staff (including medical staff), the community, and the organization. In the crisis that often emerges, what differentiates organizations, positively or negatively, is their culture of safety, the role of the board of trustees and executive leadership, advanced planning for such an event, the balanced prioritization of the needs of the patient and family, staff, and organization, and how actions immediately and over time bring empathy, support, resolution, learning, and improvement. The risks of not responding to these adverse events in a timely and effective manner are significant, and include loss of trust, absence of healing, no learning and improvement, the sending of mixed messages about what is really important to the organization, increased likelihood of regulatory action or lawsuits, and challenges by the media.

Reference

Conway J, Federico F, Stewart K, Campbell MJ. *Respectful Management of Serious Clinical Adverse Events* (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org).

CHPSO Member Support Options

Both ECRI and CHPSO stand ready to help our members develop trouble-free electronic reporting with free support. Contact ECRI Institute with questions about data transmission or file formats. Contact CHPSO for support or with any other questions.

ECRI	CHPSO
866.247.3004	916.552.2600
psohelpdesk@ecri.org	info@chpso.org
8 AM to 4:30 PM ET	8 AM to 5 PM PT

Subscription service: www.chpso.org/lists/
Questions or comments: Rory Jaffe, MD MBA rjaffe@chpso.org

Pharmacies Reminded to Use Only Board-Licensed Wholesalers

Important Message from California State Board of Pharmacy

"The California State Board of Pharmacy reminds pharmacies and pharmacists that when purchasing drugs from wholesalers that they must purchase prescription drugs only from wholesalers licensed by the Board. Even if a wholesaler is located out of state, the wholesaler must also be licensed with the California State Board of Pharmacy if it is shipping product or arranging/brokering sales into California.

"During times of drug shortages, it may be tempting to turn to new sources to secure prescription drugs that are in short supply or are currently unavailable from your current wholesalers. However, unlicensed wholesalers – who have not taken the time to become licensed in California to operate legally – may also have taken business "shortcuts" elsewhere and may be selling drugs that are expired, adulterated, counterfeited, have been diverted, or are in other ways compromised, which could result in harm to patients.

"To avoid problems with the safety and quality of prescription medications and comply with the law, use only Board-licensed wholesalers.

"How can you tell if a business is licensed in California as a wholesaler? Go to www.pharmacy.ca.gov and click under verify a license.

"To see a list of current drug shortages, please visit the FDA's webpage on Drug Shortages."

—Virginia Herold, Executive Officer, Virginia.Herold@dca.ca.gov

Learning From Defects

From QA to QI

Now that we have gained a common vision of possibilities for a QI Model of peer review, it will be useful to return to our framework for improving patient safety to take a deeper dive into learning from defects.

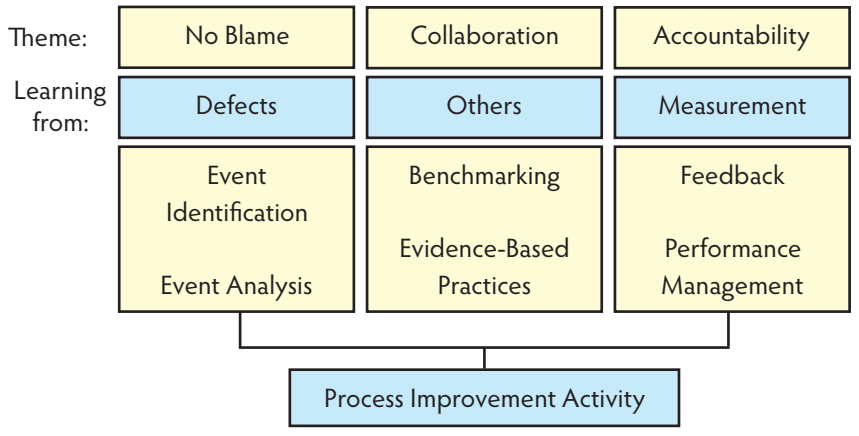
Clinical peer review is the dominant mode of event analysis in U.S. hospitals, but it is not widely recognized as such. My 2007 study found that the median case review volume is 1 percent to 2 percent of hospital inpatient volume. This is more than an order of magnitude greater than the typical volume of formal root-cause analyses (RCAs). The problem is that the outmoded QA Model fails to generate organizational learning.

Case review volume is an element of the QI Model. Those of you who adhere to the principle that quality should be designed into a process in preference to inspection for defects might think this strange. The reality, however, is that health care is a poorly controlled process. Preventable adverse events run about 7 percent of admissions. Near misses and hazardous conditions are likely even more prevalent. If a hospital reviews only a small fraction of these, many opportunities for improvement will be missed.

Remember that the QI Model asks, "What can we learn from this case to improve clinical performance?" System and process issues are on the table along with handoffs and other issues of clinician-to-clinician communication/coordination. This vastly expands the return for the effort invested.

The causal analysis done during case review brings the experiences of all the review committee members into play — projected into the shoes of the responsible clinicians. It's hindsight with empathy. It takes a little practice to start thinking more broadly about the factors influencing the outcomes of care, but it's certainly not difficult. Once we get beyond the limitation of looking ONLY at clinical judgment, the door to real improvement opens. The conversation about judgment can still occur, but it needs to happen in the context of all potential contributing factors.

In a formal RCA, the exploration of potential contributing factors unfolds systematically. The exercise is time and resource intensive. In QI Model peer review, it's much more abbreviated and intuitive. A search for strong interventions to prevent recurrence is required to get the desired payback. It helps if reviewers are given basic training in cause analysis so that they favor process



improvement and forcing functions over education and reminders. Graber has shown this is easy to do and has substantial benefit.

Peer review is certainly not the only option to expand the potential for learning from defects, but it does represent low-hanging fruit ripe for picking. Some hospitals have adopted the Hopkins Comprehensive Unit-Based Safety Program (CUSP), whereby each nursing unit studies one problem each month and comes up with solutions. An added benefit of CUSP is that it teaches systems thinking to nurses and helps to balance the profession's over-reliance on primary problem solving through workarounds. When many nursing units participate, the volume of learning from defects will fall somewhere between RCAs and peer review. Many staff will be engaged in the process and that's a good thing for building a culture of safety.

If only we could solve the problem of efficiently identifying events, near misses and hazardous conditions that are worthy of analysis. We can. Stay tuned for my next column.

Coming Next: Self-Reporting

— Marc T. Edwards, MD MBA, QA to QI Consulting, marc@QAtoQI.com

References

Graber ML. Physician participation in quality management: Expanding the goals of peer review to detect both practitioner and system error. *Jt Comm J Qual Improv*. 1999;25(8):396-407.

Pronovost PJ, Berenholtz SM, Goeschel CA et al. Creating high reliability in health care organizations. *Health Serv Res*. 2006 Aug;41(4 Pt 2):1599-617.

Don Berwick to Keynote Accelerate Change Today Event on May 17

Register for this complimentary event by May 10

California hospital executives and quality leaders are invited to *Accelerate Change Today* May 17. This complimentary event marks the next step to accelerate quality improvement and patient safety initiatives already underway among California hospitals. Former Centers for Medicare & Medicaid Services Administrator Don Berwick, MD, MPP, a visionary leader in the patient safety movement, will address the work of California hospitals participating in the national Partnership for Patients Hospital Engagement Network initiative.

The event will be held twice May 17: 8:45 AM – 11 AM at John Muir Health, Walnut Creek; 2:30 PM – 4:45 PM at Newport Beach Marriott Hotel. To register go to: www.calhospital.org/accelerate-change-today. While there is no charge for this program, preregistration is required. Continuing education will be provided. If you have questions please contact Ann Marie Giusto, CHA Vice President, Quality, at (916) 552-7657 or agiusto@calhospital.org. You may also contact the CHA Education Department at (916) 552-7637 or education@calhospital.org.

This event is hosted by CHA in collaboration with CHPSO, Hospital Council of Northern and Central California, Hospital Association of Southern California, Hospital Association of San Diego and Imperial Counties, and the Health Research & Educational Trust.

Hospital Council Calendar Notes

June 5 — *BEACON Patient Safety First Central Valley Regional Meeting*, Marriott Visalia and Convention Center

Join the Hospital Council for a full day of networking and learning with peers, as hospitals share their successful efforts in reducing sepsis mortality, hospital acquired infection and perinatal harm. For more information: www.hospitalcouncil.net/post/beacon-central-valley-regional-meeting.

Hospital Association of Southern California Calendar Notes

May 15 — *Patient Safety Collaborative Meeting*, Pacific Palms Conference Center

HASC is hosting a meeting focused on surgical safety with keynote speaker Verna Gibbs, MD, of *No Thing Left Behind*. For more information and to register go to www.hasc.org/education-event/southern-california-patient-safety-collaborative-track-i.

CHPSO Calendar Notes

Except as noted, these events are for CHPSO members only.

Important Q&A Member Call May 14

Learn how your organization can benefit fully from its participation in CHPSO. This month's Member Call format will be a Q&A. CHPSO will answer member questions, as well as commonly asked questions received over the past several months, including:

- What does it mean to join a PSO?
- What are members required to do? What's optional?
- How do members submit data?

Members also will learn about the many resources available from CHPSO and its data collection partner, ECRI Institute. Resources include free technical support, template policies and procedures, educational tools, safety alerts and more.

May

14: *CHPSO*: Members Call, Participation Q&A with CHPSO and ECRI. 10–11 AM

21: *CHPSO/ECRI*: User Group Meeting, Infrastructure Issues in Patient Safety. 11:30 AM–12:30 PM

June

11: *CHPSO*: Members Call. 10–11 AM

TBD: *CHPSO/ECRI*: Disruptive Behaviors that Undermine Culture of Safety. Web seminar time TBD.

July

9: *CHPSO*: Members Call. 10–11 AM

16: *CHPSO/ECRI*: User Group Meeting, Knowledge Transfer: A Patient Safety Essential: Training as a contributing factor in adverse events. 11:30 AM–12:30 PM

August

13: *CHPSO*: Members Call. 10–11 AM

20: *CHPSO/ECRI*: User Group Meeting, Topic Same Name/Look-alike Name Alerts. 11:30 AM–12:30 PM

September

10: *CHPSO*: Members Call. 10–11 AM

TBD: *CHPSO/ECRI*: Strategies to Prevent Falls. Web seminar time TBD.

October

8: *CHPSO*: Members Call. 10–11 AM

15: *CHPSO/ECRI*: User Group Meeting, Topic TBD. 11:30 AM–12:30 PM

November

12: *CHPSO*: Members Call. 10–11 AM

19: *CHPSO/ECRI*: User Group Meeting, Topic TBD. 11:30 AM–12:30 PM

December

10: *CHPSO*: Members Call. 10–11 AM

TBD: *CHPSO/ECRI*: Radiology Patient Safety. Web seminar time TBD.

For further information on these events:

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Editor's Note

In April, you may have noticed an increased number of email announcements from CHPSO. Now that we have the capability to collect data from major incident reporting systems, CHPSO, in partnership with ECRI Institute, has been holding a series of related web seminars to support member hospitals. These programs have been in addition to CHPSO's regular member calls and education opportunities. To better serve you, we are looking at ways to streamline our communications. Last month, we chose not to publish the April edition of *CHPSO Patient Safety News*. This month, we are looking at ways to consolidate our email announcements. If you have comments or feedback, please contact Frances Sutz Brown, Director of Operations and Communications, fsutzbrown@chpso.org.

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Newsletter subscription is free and open to all. If you wish to receive this newsletter and other email updates from CHPSO, sign up at www.chpso.org/lists/. This same link may be used to unsubscribe.

About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient-safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter are archived on the CHPSO website (www.chpso.org).

Prospective authors may submit articles to Frances Sutz Brown: fsutzbrown@chpso.org, 916.552.7598. Typical articles will be brief — between 200 and 600 words. A completed publication agreement form must be submitted prior to publication.

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