State of Washington
Decision Package

FINAL

Agency: **303 Department of Health**
Decision Package Code/Title: **R4 Adverse Events Reporting**
Budget Period: **2015-17**
Budget Level: **PL -Performance Level**

Recommendation Summary Text:

The Adverse Health Events and Incident Reporting System funding was eliminated in the 2011-13 biennial budget. Without this funding the department is unable to meet the statutory requirements for adverse health events and incident reporting in RCW 70.56. This request will facilitate quality improvement in the healthcare system, improve patient safety, and decrease preventable medical errors.

Fiscal Detail

Operating Expenditures		**FY 2016**	**FY 2017**	**Total**
001-1	General Fund- State	0	226,000	226,000
Total Cost		**0**	**226,000**	**226,000**

Staffing	**FY 2016**	**FY 2017**	**Annual Avg**
FTEs	**0.0**	**1.4**	**0.7**

Package Description:

Adverse events are medical errors that healthcare facilities could and should have avoided. The National Quality Forum (NQF) defines these errors, which are also called serious reportable events. It lists 29 adverse events as reportable errors. The events may result in patient death or serious disability.

Washington State law (Chapter 70.56 RCW) requires healthcare facilities to report to the Department of Health whenever they confirm an adverse event. Facilities required to report are: hospitals, psychiatric hospitals, child birthing centers, Department of Corrections medical facilities and ambulatory surgical facilities according to Chapter 246-302 WAC. The department manages aggregate data on adverse events and posts quarterly reports on the department's website.

The department is the only state agency that collects adverse events data in Washington. Over 2,050 adverse events have been reported to the department since 2006. Counting and reporting the frequency of events is vital, but the most important improvements in patient safety will come from proper evaluation of root cause analyses across the health care system.

The department continues to impose legal obligations on healthcare facilities even though the funding was cut. Consequently DOH continues to absorb some program work including receiving adverse event notifications and root cause analyses, sending out quarterly check-in surveys to all appropriate facilities; compiling and posting quarterly reports online and responding to facilities, the press and public disclosure requests. Staff time expended on this work impacts other critical funded agency projects. In addition, the department may be at risk of public and political criticism should the Adverse Health Events system be questioned in relation to serious incidents in covered facilities.

RCW 70.56.030 has two core requirements for the department related to adverse events.

1) Receive and evaluate notifications and reports of adverse events from facilities, including root cause analyses and corrective actions plans, and communicate back the department's conclusions, if any.

To accomplish this work the department needs 1.0 FTE Nursing Consultant Institutional (NCI) position. This position would provide overall system administration that directly fulfills the department's minimum requirements per 70.56 RCW, including contractor oversight. Also, it would act as the liaison between the department and others regarding patient safety, including restoring the Patient Safety Adverse Event Advisory Committee, representing the department at patient safety conferences, and responding to miscellaneous inquiries.

2) Contract with an independent entity to receive notifications and reports of adverse events, establish a web-based data collection system, and analyze and evaluate the data.

To the extent that funds are appropriated, the department was also directed to contract with an independent entity to collaborate with the department to establish an internet-based system for medical facilities and their health care workers to submit notifications and reports on adverse events and incidents. The independent entity is also to perform duties including but not limited to: evaluating data, developing and issuing statewide improvement recommendations, monitoring adverse event systems in other states, and annually reporting to the governor and the legislature with improvement recommendations. To determine the availability and cost of this system the department must develop detailed requirements and issue a Request for Information (RFI). To prepare and issue this (RFI), the department needs 0.4 FTE Information Technology Specialist 5. This staff would research potentially qualified data suppliers, determine the appropriate analytical methodology the state should apply, inventory other states' systems, draft the RFI in compliance with the statute, collect and assist in selecting bids, and begin implementation.

The department has received legislative inquiries on the cost to implement all or part of the internet-based system. Based on information gathered through the RFI, funding would be sought for a system and contracting with the independent entity. The nurse consultant would have ongoing contract oversight if funding were approved and a contract executed.

The results would be: (1) statutory compliance, (2) recommendations to improve health care facilities, (3) increased patient safety, and (4) reduction of risk to the department.

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

- Fulfill the legislature's original intensions by providing funding for complete implementation and administration of the Adverse Health Events and Incident Reporting system, to facilitate quality improvement in the health care system, improve patient safety, and decrease medical errors.
- Assist in achieving the department's strategic goals 2 and 3, which are protecting people from injuries through incorporation of public health and prevention practices.

Performance Measure Detail

Activity: A015 Patient and Consumer Safety

Is this DP essential to implement a strategy identified in the agency's strategic plan?

Yes, Goal 3: Improve access to quality, affordable, and integrated care for everyone in Washington
Objective 2: Ensure safe, quality healthcare
Objective 3: Incorporate public health and prevention practices in reforming healthcare system

Does this decision package provide essential support to one of the Governor's priorities?

Yes, Goal 4: Healthy and Safe Communities

Does this decision package make key contributions to statewide results?

Yes

What are the other important connections or impacts related to this proposal?

Minnesota's Department of Health has had a full functioning adverse event system for 11 years. Its 2014 program evaluation confirmed that the adverse event program has been a catalyst for patient safety, increasing awareness and leading to real change. Specifically noted, events previously seen as "inevitable" are now nearly always seen as "preventable." For example, this has moved the culture of accepting events such as pressure ulcers and falls as inevitable, to learning how events occur and can be prevented in the future. Like Washington, the Minnesota system was designed as a non-punitive learning system; Minnesota reports this primary goal is being met. Facilities are implementing policies and procedures and the Department of Health issues Safety Alerts. It has found that reporting increases after a Safety Alert is issued (increased awareness), then numbers begin to decline as best practices are implemented. Overall, deaths and serious disability from adverse events in Minnesota have declined since the program's inception.
http://www.health.state.mn.us/patientsafety/ae/2014ahetenyearreview.pdf

What alternatives were explored by the agency and why was this alternative chosen?

Two other alternatives that were considered are: (1) repeal the statue and completely discontinue the program, (2) continue the significantly reduced program resulting in an escalating backlog of root cause analysis and inquiries for assistance. Neither of these supports the critical public health goals to facilitate quality improvement in the health care system, improve patient safety, and decrease medical errors. In addition, the second alternative has unacceptable impacts on other critical programs.

What are the consequences of not funding this package?

There are four main consequences if no action is taken:

1. The department will only be able to continue receiving and logging of basic adverse event notification (date, type of report, facility). All other Adverse Events program activities would stop including analysis of root causes and response to calls for technical assistance.
2. Critical public health goals to facilitate quality improvement in the health care system, improve patient safety, and decrease medical errors will remain unrealized.
3. The department will fail to meet a statutory mandate (albeit unfunded).
4. The department will be at risk of public and political criticism should the Adverse Health Events system be questioned in relation to serious incidents in covered facilities.

The Adverse Health Events system has been stressed for the last five years. It is important to take action now for several reasons. One, the department can no longer shift resources from other funded programs as demands for those other programs continue to grow. Two, over the last two years, the governor and department have developed strategic goals regarding improving quality of health care to Washingtonians. Without a proper Adverse Health Events system in place, as per statute, the department will not be able to achieve fully strategic goals 2 and 3.

What is the relationship, if any, to the state capital budget?

N/A

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

N/A

Expenditure and revenue calculations and assumptions:

Revenue:

None

Expenditures:

Costs in fiscal year 2017 will fund staff and associated costs of $226,000 and will include 1.0 FTE Nurse Consultant program manager (NCI) and 0.4 FTE Information Technology Specialist 5. Starting in fiscal year 2018 and ongoing costs will include 1.0 FTE NCI and $168,000.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

All costs are ongoing

Object Detail		FY 2016	FY 2017	Total
A	Salaries and Wages	0	151,000	151,000
B	Employee Benefits	0	46,000	46,000
C	Personal Service Contracts	0	0	0
E	Goods and Services	0	20,000	20,000
G	Travel	0	3,000	3,000
J	Capital Outlays	0	3,000	3,000
T	Intra-Agency Reimbursements	0	3,000	3,000
Total Objects		**0**	**226,000**	**226,000**