The Reporting of Adverse Events in Health Care: Minnesota's Law

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Minnesota Alliance for Patient Safety (MAPS) formed in 2000

Not really one public “trigger” event, several “smaller” media stories

MN vulnerable persons statute basically says mistakes = abuse & neglect

Serious underreporting under previous laws and no tracking or feedback
Goals of the Law

- **Not** …”to punish errors by healthcare practitioners or health care facility employees.”

- To balance quality improvement and accountability for public health & safety.
Who must report?

- Minnesota Hospitals & Outpatient Surgical Centers
  - Minnesota Statutes 2003 Supplement, section 144.7063, subdivision 3, is amended to read:

  "Facility" means a hospital or outpatient surgical center licensed under sections 144.50 to 144.58.
Who must report?

- Boards that regulate physicians, physician assistants, nurses, pharmacists, and podiatrists are to report to MDH events that come to their attention that may qualify as adverse health care events.
What must be reported?

- Any of the 27 events defined in law.
- A description of the event ASAP, but no later than 15 working days after discovery of the event.
- Within 60 days, the findings of the root cause analysis & the corrective action plan.
- NO identifying information for any health professionals, employees or patients.
Sample NQF Reportable Events

✦ Surgical Events
  – Wrong surgery
  – Retention of foreign object
  – OR or Post-op death

✦ Product or Device
  – Contaminated drugs or blood
  – Air embolism

✦ Patient Protection
  – Infant discharged to wrong person
  – Patient elopement

✦ Care Management
  – Medication error
  – Maternal death
  – Death from hypoglycemia
  – Stage 3 or 4 pressure ulcers

✦ Environmental Events
  – Death from electric shock
  – Wrong gas delivered
  – Patient burns
  – Patient falls

✦ Criminal Events*
  – Abduction
  – Sexual assault
How do facilities make a report?

- The Minnesota Hospital Association has developed a password protected, web-based registry that hospitals have been using to report events during the “transition period”.

- MDH is working with MHA so that this system can be used by all facilities upon full implementation of the law.
When is the law effective?

- Hospitals have been reporting events to MHA since July 1, 2003, as part of the “transition period”.
- **Full implementation** of this law is contingent on securing non state funds & on MDH providing **written notification** to all facilities.
- Full implementation will begin on **December 6, 2004**. MDH will receive reports from hospitals, surgical centers & boards.
What is required of MDH once the law is fully implemented?

★ Track, assess and analyze incoming reports, findings and corrective action plans for thoroughness and appropriateness.

★ Determine patterns of process and system weaknesses and successful methods to correct identified issues.

★ Share findings with individual facilities, provide follow-up and feedback as needed.
What is required of MDH once the law is fully implemented?

- Provide analysis of reported events for trends, opportunities for improvement, and best practices.
- Develop statewide education on best preventive practices through seminars, newsletters, listserve and web site.
- Publish an annual report of events and corrective actions. Communicate with purchasers & the public about lessons learned to improve health care quality.
What is publicly reported?

Minnesota Statutes 144.7067
Subd. 2. The commissioner shall
(4) publish an annual report:
(i) describing, by institution, adverse events reported;
(ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses; and
(iii) making recommendations for modifications of state health care operations.
How are the data protected?

- 2004 Legislation establishes that the reported data submitted by facilities & the boards to MDH are classified as non-public except as required to complete the annual public report.

- The reports submitted electronically are also peer review protected. (145.64, Subd. 1)
What about the VAA & Maltreatment of Minors Acts?

- The 2003 legislation provided that an adverse health event, if properly reported, was excluded from the reporting requirements of the Vulnerable Adults Act.*
- The 2004 legislation extends that exemption to apply to the Maltreatment of Minors Act.

* The 4 criminal events must still be reported as VAA or Maltreatment of Minors. May be other events falling outside of 27, but still meeting other state or federal reporting requirements.
What about MDH obligations under other laws & federal agreements?

- An investigation under the VAA or the Maltreatment of Minors Act is not **required** by MDH if the incident was properly reported as an adverse health care event.*

- MDH retains its authority under state licensing statute and under its agreement with the federal government.

- Facility self-reports will not be considered “complaints” for the purposes of the MDH contract with CMS.
AE Relationship to Other Laws & Requirements

State & Federal Licensing & Complaints

VAA & Maltreatment of Minors

AE Reports
Once we Answer all of this – What’s Next?

★ Standardize Reporting across the states & other requirements
★ Automate Reporting as part of the “process of care”
★ Refine regulatory role in light of QI
  – CMS, JCAHO, Licensing boards
★ Figure out state role, if any, in other aspects of patient safety
The Big Questions

★ How do we know the “problem” has been corrected?
★ Is the state/ facility/ public learning anything from the reports?
★ Is any of this making a difference?
  – How will we know?
  – How do we keep improving?
★ How do we work on these questions?
  – Patience? Trust?
For more information:

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