2009 SENATE HUMAN SERVICES

SB 2403

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2403

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 02/09/2009

Recorder Job Number: 8993, 9008

Committee Clerk Signature	Mary K Monson

Minutes:

Senator Lee Opened the hearing on SB 2403.

Senator Dever District #32. Introduced SB 2403. Spoke about his constituents request for this bill. I am going to let others tell you more about this bill. The really nice thing about this bill is that the money is coming from elsewhere so there is not appropriation or fiscal note.

Arnold Thomas President of the ND Healthcare Association. Spoke in support of 2403. See attachment #1.

John Kapsner Attorney with the Vogel Law Firm. Provided information on 2403 and proposed an amendment. See attachments #2 &3.

Senator Lee Have you visited with the other stakeholders about the amendment and everyone is buying in?

Kapsner Yes, I do need to add one more thing. I promised to explain that though the exemption for the medical examiner appears to be in 2 places there is no intent to change the available access of the board of medical examiners to all peer reviewed data.

Brief discussion

Arnold Thomas Explained the handouts attached to his earlier testimony.

Senator Dever Your enthusiasm is infectious.

Thomas This road is not without bumps but this is the direction we want to go.

Senator Lee I think it is great that the foundation is taking ownership of this.

Thomas By partnering with MN we will be eliminating many administrative expenses in ND. One of the reasons that it is important is that we discharge about 90,000 patients each year in ND, in order to develop an economically viable model for directing information, we need to partner with an existing apparatus.

Senator Dever The type of information you are including, is that collected by hospitals already?

Thomas Some is and some is not. As you get farther away from the big cities, the less information is collected. We have eliminated the financial burdens for all the hospitals. We need the same level of excellence at every facility, we do not support two tiers of medicine based on size.

There was no opposition testimony given.

Senator Lee Closed the hearing on SB 2403.

Job # 9008

Senator Lee Opened the discussion on SB 2403

Senator Erbele I move to adopt the amendment.

Senator Dever Second.

The Clerk called the role on the motion to adopt the amendment. **Yes: 5, No: 0, Absent: 1. (Senator Marcellais).**

Senator Erbele I move **Do Pass as Amended.**

Senator Dever Second

The Clerk called the role on the motion to **Do Pass as Amended. Yes: 5, No: 0, Absent: 1.**

Senator Lee will carry the bill.

Adopted by the Human Services Committee
February 9, 2009

2-10-9

PROPOSED AMENDMENTS TO SENATE BILL NO. 2403

Page 3, line 10, remove ", including that required by federal law"

Page 3, after line 23, insert:

"4. This section does not prohibit access of the department of health to peer review records to determine compliance with requirements of federal or state law for the survey and certification of a health care facility or for trauma center designation and as authorized under any rules issued under sections 23-01.2-01 or 23-01-11 to enable the state to be in compliance with any federal laws to qualify for any federal funds related to medical facilities or agencies licensed by the department of health."

Page 3, line 26, after the first underscored comma insert "data,"

Page 3, line 27, after "to" insert "the department of health or"

Renumber accordingly

Date: 2-9-09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2403

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-9-09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2403

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98322.0101 Title .0200

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment Senator J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2403: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2403 was placed on the Sixth order on the calendar.

Page 3, line 10, remove "<u>, including that required by federal law</u>"

Page 3, after line 23, insert:

"<u>4.</u> <u>This section does not prohibit access of the department of health to peer review records to determine compliance with requirements of federal or state law for the survey and certification of a health care facility or for trauma center designation and as authorized under any rules issued under sections 23-01.2-01 or 23-01-11 to enable the state to be in compliance with any federal laws to qualify for any federal funds related to medical facilities or agencies licensed by the department of health.</u>"

Page 3, line 26, after the first underscored comma insert "<u>data,</u>"

Page 3, line 27, after "<u>to</u>" insert "<u>the department of health or</u>"

Renumber accordingly

2009 HOUSE HUMAN SERVICES

SB 2403

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2403

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 23, 2009

Recorder Job Number: 11381

Committee Clerk Signature	Vicky Crabtree

Minutes:

Chairman Weisz opened the hearing on SB 2403.

Sen. Dick Dever, district 32 sponsored and introduced the bill: I received an e-mail a couple of weeks ago from a constituent asking why we don't publish infectionaries in hospitals. I was able to tell him that I was a prime sponsor to a bill to provide that very thing. Mrs. Thomas from the Healthcare Association will be describing that in better detail.

Arnold Thomas, President of ND Healthcare Association: See Testimony #1.

John Kapsner, attorney with Vogel Law Firm in Bismarck, ND: See Testimony #2.

Chairman Weisz: If you don't show up currently it appears if you don't have access that they have been and it is an ongoing (inaudible) may it clear they can have access.

John Kapsner: I didn't know they were actually doing this. Filling in the hospitals and looking for peer information. They have to or they become Medicare and Medicaid ineligible. Everybody is doing it and I wasn't aware of it the first time around that we'd make sure it was in there the second time around.

Rep. Frantsvog: Referring back to Section 3, does that mean it has information that is disseminated that maybe in error that may not be introduced as evidence and (inaudible) administrative proceedings. Is that right/

John Kapsner: No, it means all of it whether it is right or wrong. Any information that is published as starts out as peer review information and goes to an entity here in the Minnesota hospital association. They accumulate that data and produce analysis and summaries of that data. It comes back to (inaudible) ND healthcare foundation. It's published on the website. It is not published as individual patient data. There will be no individual patient identified data. You can look at generalized numbers to see if we are doing a good job.

Arnold Thomas: I'm going to walk you through the handouts. First page, chart was done on how well ND rates at time of study. And how they relate to costs in respect to those measures. Page 2 basically template of what we have made available to public. Page 3, compares stats between ND hospitals and other hospitals. Page 4 if you want work done on heart, you can compare with other facilities and their outcome. Page 5, has to do with safety information in the hospitals. Rest of the handouts are examples from ND and Minnesota hospitals. We hope to have this up and operation soon and fully operational by January 1.

Rep. Porter: How far back is the data going to go?

Arnold Thomas: I don't know.

Rep. Porter: It seems if you don't go back far enough you wouldn't get enough data to get a true representation.

Arnold Thomas: If you will notice on your format on the left hand side there are two (inaudible) that says, "understanding the data and frequently asked questions". Those are for questions such as you have. We can pool our lower volume providers with Minnesota's for a comparison basis.

Rep. Porter: Last week we had a bill talking about the upgrades and they are doing the same thing, taking key indicators from CMS and putting them into a data base and printing out and

saying, here is your rate. Is there anything that is going to prevent these facilities to advertise themselves? Can they do that?

Arnold Thomas: This is not a rating system it is a comparison system.

Rep. Potter: How do you know you are getting all the data or not leaving some out?

Arnold Thomas: If you fail to disclose in a timely fashion on the website, it will be failure to report. Failure to report will not stay private in ND very long. This was not done voluntarily in Minnesota. It was mandated by the attorney general.

Rep. Holman: Data entry on this seems like a (inaudible) task is everyone on board with the extra labor involved?

Arnold Thomas: It is all electronic and the hospitals in ND have had electronic data for quite a few years. They just make an electronic submission to Minnesota to allow to include them in our information exchange.

Rep. Conrad: (Something about physicians.) Will this be used to upgrade or punish programs?

Arnold Thomas: Physicians provide facts and solve methodology with clinical treatment and clinical patterns of the (inaudible). This is not physician specific. That is something that would be done within the institution. We are talking about here is organizational comparisons. I don't know at this conjuncture how the penalty will be conditioned.

Rep. Nathe: Why not bring the comparison down to the doctor level? Could you see adding physician button?

Arnold Thomas: Maybe down the line. We are prepared structurally for that right now. Right now you can go to the Board of Medical Examiners to see any complaints against doctors.

John Kapsner: To look at an individual practitioner maybe misleading.

Rep. Nathe: If you compare apples to apples as a patient I find that very useful. Like comparing doctors who do valve procedures.

John Kapsner: There are no two valve procedures the same. I don't think this would be productive to compare doctors.

Arnold Thomas: One more response to Rep. Nathe. In the future yes, but frustration getting there will also be great.

Rep. Frantsvog: How is this website funded?

Arnold Thomas: It is funded through off the capital base of ND Healthcare Foundation.

NO OPPOSITION.

ViceChair Pietsch closed the hearing.-

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2403

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 23, 2009

Recorder Job Number: 11430

Committee Clerk Signature Vicky Crabtree

Minutes:

ViceChair Pietsch: Let's take up 2403.

Rep. Conklin: Motion Do Pass.

Rep. Kilichowski: Second.

Rep. Conklin: I agree with them and think this is ok, but there could be a problem with the BlueCross/BlueShields using (inaudible) three days in one hospital versus two days in another hospital. I wanted to voice my concern.

ViceChair Pietsch: That was part of what they were talking about, the shortfall. They haven't gotten information from the insurance companies yet on how much they pay and how much the co-pay would be and that might be part of the reason.

Rep. Hofstad: Then they were just going to incorporate that into the data so that you could punch in your carrier so (inaudible) amount of insurance and amount of coverage you would have.

Rep. Nathe: Would (inaudible) use that information (inaudible) patients (inaudible).

Rep. Conklin: If one hospital is keeping them four nights and another is keeping them two nights, the insurance would say, we are only paying for two nights because some hospitals get by with two nights.

ViceChair Pietsch: I think that pre-authorization is always required for a stay so they would have to document that (inaudible).

Rep. Kilichwoski: They set limits on the stay of every patient.

Rep. Hofstad: On Section 2 about confidentiality, the confidentiality of the records I think would (drops sentence).

ViceChair Pietsch: They wouldn't know which hospital was giving what.

Rep. Nathe: They have this system right now in Minnesota, correct?

(Many talking at once saying, right.)

Rep. Nathe: (Inaudible) system and the insurance companies (inaudible).

(Many talking at once.)

Rep. Holman: I got the impression they are going to integrate this (drops sentence) (many say yes at once.) I still ah, kind of flippant about, well they'll just send it their field, well I thought 80,000 kids (inaudible) releases a year in ND, its still got to be a certain amount of labor intensive practice that it is adding. And I guess it is important that I think we heard this morning that it is 80,000 been released every year. Hope that's pretty close those that want to get in.

Rep. Frantsvog: I wondered if this was something that was being forced on the hospitals. If the hospitals agree to it then (drops sentence).

Rep. Nathe: It was forced in Minnesota. It's proactive here so it is not being forced at all.

Rep. Frantsvog: How do they make the money to keep up the website?

ViceChair Pietsch: Mr. Thomas said it was the interest accrued on that healthcare foundation. At least right now, it's making money.

Rep. Damschen: Just an observation. When I have to go to the hospital, I haven't gone because I've been shopping which hospital. It's a different concept for someone who isn't close

to a lot of choices of hospitals. Never thought of shopping, just word of mouth or someone you know of influences your decision as to what hospital you go to if you can't get it locally.

Rep. Frantsvog: If it is voluntary, why do we need legislation to do it?

Rep. Hofstad: A lot of it is putting confidentiality into (inaudible). I think that's important.

Rep. Potter: I like it because we are to be smarter with our healthcare.

Roll Call Vote: 9 yes, 0 no, 4 absent, Chairman Weisz, Rep. Porter, Uglem and Conrad.

Rep. Frantsvog made a comment when voting. "I'll vote yes, but I promised I may not vote the same way on the floor".

MOTION CARRIED.

BILL CARRIER: Rep. Conklin.

Date: 3-23-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2403

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Conklin Seconded By Rep. Kilichowski

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	A		REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	A	
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN	✓	
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI	✓	
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	A				
REP. GERRY UGLEM	A				

Total (Yes) 9 No 0

Absent 4

Bill Carrier Rep. Conklin

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2403, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (9 YEAS, 0 NAYS, 4 ABSENT AND NOT VOTING). Engrossed SB 2403 was placed on the Fourteenth order on the calendar.

2009 TESTIMONY

SB 2403

#1

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony on Senate Bill 2403
Senate Human Service Committee
February 9, 2009

Madame Chairman, Members of the Senate Human Services Committee. I am Arnold Thomas, President of the North Dakota Healthcare Association, here in support of SB 2403. With me to explain the content of SB 2403 is John Kapsner, NDHA Legal Counsel.

The goal behind SB 2403 is simple: advance the practice of medicine in ND using evidence based standards to compare hospital specific performance.

SB 2403 sets the framework for gathering the information necessary for hospitals to compare, critique, and publicly disclose patient safety, clinical and financial performance profiles and, most importantly, take such steps for medical practice advancement as indicated by evidence based practice standards.

ND hospitals are prepared to participate in the MN Hospital Association's established, nationally recognized, fully transparent, hospital performance program. Joining with MN allows ND hospitals access to a tried and proven informational template. Joining with MN also allows regional comparative analysis, an important benefit for the region, given the long standing clinical relationships between the two states. I have attached a handout of newspaper articles indicating how this information is made public in print media but most importantly its application for improving clinical practice.

Mr. Kapsner will explain the bills provisions and offer an amendment which addresses a concern raised by the Department of Health.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

After Mr. Kapsner's presentation, I will present a model of how we plan to proceed in the display and use of hospital specific indicators (attachment), how this information may be used for public information (attachment), and entertain questions you, Chairman Lee, or committee members may have.

NDHA

North Dakota Healthcare Association

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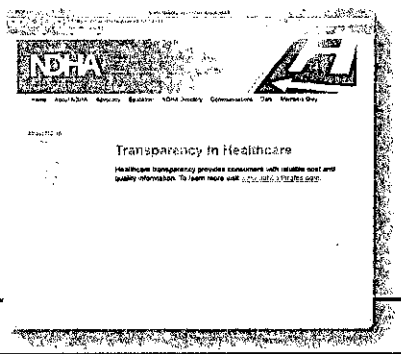
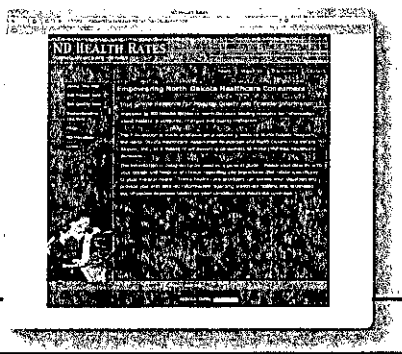
Transparency In Healthcare

Healthcare transparency provides consumers with reliable cost and quality information. To learn more visit www.ndhealthrates.com.





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MEDICARE

HEART PROBLEMS

HEART FAILURE & SHOCK

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Pricing Information

ABC Hospital
720 NORTH 4TH STREET
Fargo, ND 58122
701.234.2000

HEART FAILURE & SHOCK

	Individual Hospital	All Hospitals with Similar Patient Volume	All ND Hospitals
Number of Discharges	206	787	1515
Average Length of Stay	4.2 Days	4.4 Days	4 Days
Average Charge	$8,583	$9,698	$8,244
Average Charge Per Day	$2,063	$2,187	$2,062
Average Payment (Medicare)	$4,736	$4,818	$3,932
Average Payment (Medicaid)	$1,414	$2,436	$2,366
Median Age	80	82	83
Percentage Male	45.1%	47.5%	45.1%

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GENERAL SEARCH

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Quality Information

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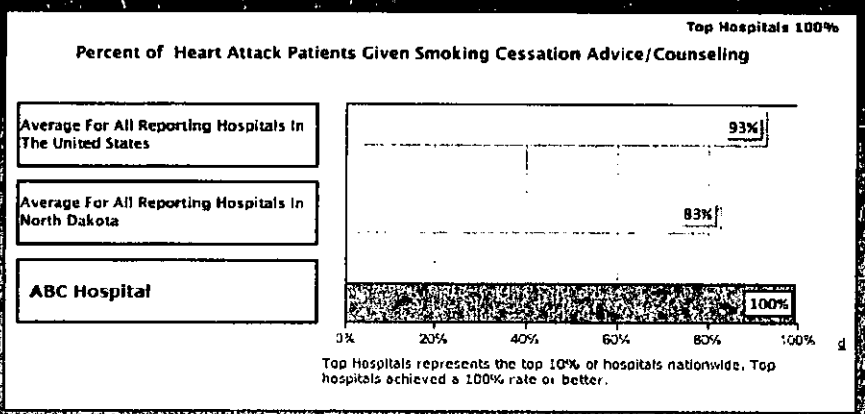
HEART ATTACK



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ABC Hospital

720 NORTH 4TH STREET
Fargo, ND 58122
701.234.2000

HOW TO READ THESE TABLES

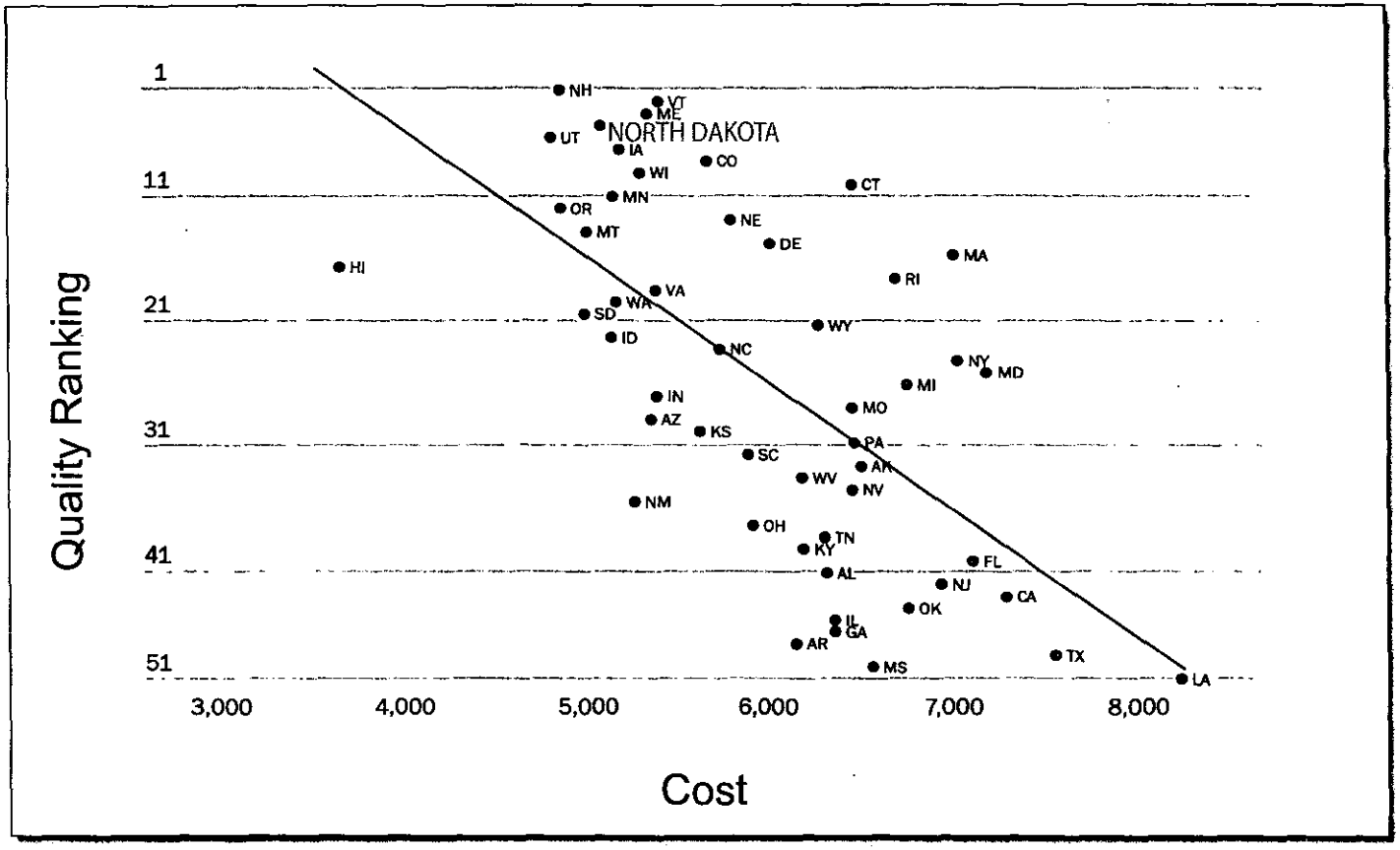
Reported Adverse Health Events
October 7, 2007 - October 6, 2008

Category and Type	Number	Background
Surgical/Invasive Procedure Events		
Retention of a foreign object in a patient after a surgery/invasive or other procedure	1	Deaths: 0 Serious Disability: 0 Neither: 1
Surgery/invasive procedure on the wrong body part	2	Deaths: 0 Serious Disability: 0 Neither: 2
Wrong surgery/invasive procedure performed	2	Deaths: 0 Serious Disability: 0 Neither: 2
Care Management Events		
Stage 3 or 4 pressure ulcers (serious bedsores)	2	Deaths: 0 Serious Disability: 0 Neither: 2

NDHA
North Dakota Healthcare Association

Relationship Between Quality and Medicare Spending, As Expressed By Overall Quality Ranking, 2000-2001

Source: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries. 1998-1999 to 2000-2001." Journal of the American Medical Association 289, no. 3 (2003): 305-312



KAALtv.com

Posted at: 01/16/2009 06:17:54 PM

State hospitals report more incidents in 2008

Related stories:

- REPORT: Hot particle caused fire that burned newborn

ST. PAUL, Minn. (AP) - Minnesota hospitals reported 312 serious problems - including 18 patient deaths - in the last year, according to an annual report released Friday.

The number of medical mistakes and other so-called "adverse health events" spiked considerably over the previous reporting period, but officials said the increase can be attributed to a new law that expanded what incidents hospitals should report to the Minnesota Department of Health.

Without the changes, officials said the number of incidents would have been 141 - slightly higher than the 125 incidents reported from October 2006 to October 2007. During that period, 13 incidents were linked to patient deaths and 10 resulted in a serious disability.

Ninety-eight incidents in the most recent reporting period led to a serious disability, but that increase was also due to the expanded reporting requirements, officials said.

The 28 reportable incidents include surgery on the wrong body part, items like sponges or surgical objects left in a patient's body during surgery, bed sores and patient falls.

Much of the increase in incidents came from reporting falls that led to disability instead of just death and reporting a less serious stage of bedsore in addition to advanced bedsores.

By having hospitals report 28 preventable problems, the state hopes to gradually reduce the number of incidents and thereby improve patient care, said Minnesota Health Commissioner Sanne Magnan.

"We're always interested in what the numbers show, while also recognizing that these events are very rare," Magnan said. Hospitals in Minnesota recorded 2.8 million patient days in 2007, the latest number available.

"It's not just the numbers alone, but what we're learning from each incident," Magnan said, noting that the health department is celebrating the fifth anniversary of the reporting system. "This transparency and public reporting has persevered. ... The fact that we have a safe environment to talk about safety is something we should really be proud of."

Hospitals supported expanding the reporting requirements to include falls that lead to serious disability and "unstageable" pressure ulcers (a less advanced type of bedsore), said Lawrence Massa, president of the Minnesota Hospital Association.

"We're disappointed that the numbers went up slightly," Massa said. "But overall we've elevated safety and we understand these events better."

Massa said the hospitals were pleased to see a decline for the second year in a row in stage three and four pressure ulcers (the more advanced form of bedsores). In addition, the number of retained sponges left in patients after childbirth declined, and all of those incidents occurred in the first half of the year, after which the hospital association sent an alert to its members to watch out for the mistake, Massa said.

The second-most errors - 37 - were reported by the Mayo Clinic's Saint Marys Hospital in Rochester, but the facility also sees one of the highest numbers of patients. Under the previous reporting requirements, the facility had 12 incidents the year before.

Dr. Michael Rock, chief medical officer for Mayo's Rochester hospitals, said the public will likely first see the jump in numbers. But he said Mayo's facilities and others are constantly improving patient safety, and that the transparency required by Minnesota law helps officials do that.

"Increasing the reporting requirements is only going to benefit patients and the institutions that care for them," Rock said.

In Rochester, health care workers have taken a closer look at reducing bedsores by alerting all medical staff involved in a patient's care when the person is first showing signs of the sores.

And to decrease falls, the hospitals are using innovations such as anti-slip tread on all sides of hospital-issued socks - just in case a patient puts them on upside down, Rock said. Health workers are also taking a closer look at patients with a history of

falls, he said.

But the prevention of mistakes also has to do with a "change in a culture of safety," Rock said. In addition to reporting the incidents to the state, Mayo's Rochester facilities publish an internal newsletter includes information about each adverse event as it happens.

"That degree of transparency can't be underestimated," he said.

Minnesota Department of Health: http://www.health.state.mn.us/patientsafety/index.html

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January 16, 2009

Hospital errors up in report

By Frank Lee
fclee@stcloudtimes.com

Minnesota's new reporting requirements for serious preventable hospital errors resulted in an almost three-fold increase in the number of reported errors from the previous year.

The number of adverse events in Minnesota hospitals, ambulatory surgical centers and community behavioral health hospitals increased from 125 to 312 in 2008. In the absence of the new reporting requirements, the number of reported adverse events would have been 141.

In addition to the seven falls and four ulcers included in this year's report, St. Cloud Hospital had seven "adverse health events" — one more than last year's, which predated reporting requirements approved during the 2007 legislative session.

None of the 18 adverse health events reported this year by St. Cloud Hospital resulted in death, according to the statewide report released today by the Minnesota Department of Health.

"Our newly expanded reporting system is a positive step toward creating an even more transparent and safer system of care," said Dr. Sanne Magnan, Minnesota Commissioner of Health.

The numbers

The new report says 96,975 surgeries or invasive procedures were performed at St. Cloud Hospital during the Oct. 7, 2007, to Oct. 6, 2008, reporting period. In three cases, a foreign object was still in a patient after a surgery or another procedure. Three surgeries or other invasive procedures were performed on the wrong body part.

"To a certain extent, the public would like to think that their hospital is absolutely perfect, and that every decision made is exactly the right one; mistakes happen not because people are goofing off," said Dr. Daniel Whitlock, vice president for medical affairs at St. Cloud Hospital.

"Certainly it's important to be open, to be transparent with the public. But the true reason for the reporting is for hospitals to learn from each other, to work together to fix any problems that exist and to try to prevent others," said Jeanine Nistler, director of communications for CentraCare Health System, which includes St. Cloud Hospital.

Among the adverse health events at St. Cloud Hospital that resulted in a "serious disability" were one medication error and the seven falls.

"A 'serious disability' can include, say, having a cast on for six weeks," Whitlock said.

Falls

The events cited in the statewide report occurred in 199 facilities covered by the state law. The 312 adverse events were reported by 59 hospitals and four surgical centers. Eighteen deaths and 98 serious disabilities are attributed to the events.

The most frequent adverse events statewide were pressure ulcers (122), falls (95) and foreign objects left in a patient after surgery (37).

"Falls are not benign things. There are a lot of people who have hairline fractures, for instance, as a result of a fall or need to go to surgery," Whitlock said.

Disorientation due to illness and the unfamiliar surroundings of a hospital are contributing factors to patient falls at any hospital.

Joy Plamann is a registered nurse who chairs the falls task force at St. Cloud Hospital. It has come up with ways of recognizing which patients are likely to fall.

"A lot of the interventions that we have done lately have been to promote and conduct hourly patient rounding, where the staff goes in and observes the patient and asks them if they need to use the restroom," Plamann said.

Surgery

The Greater Minnesota Initiative for Safe Surgery involves more than 30 area health care facilities whose representatives meet monthly to improve quality of care.

"We talk about what are best practices, what is it that we see on a state and national level, how can we improve patient safety, and that's been going on since early 2007," said Larry Asplin, clinical director of surgery at St. Cloud Hospital and a registered nurse.

Part of improving patient safety is getting back to basics.

"Before we actually make an incision or place scopes into body orifices, an absolute hard stop happens where we do a time out, and we verify for about the 14th time if it's the correct patient, if it's the correct side, if it's the correct procedure and so we do those things," he said.

Nistler said, "The wrong-site surgery category actually encompasses a broad array of invasive procedures, such as a radiation treatment for a cancer patient, so it isn't what the public would think of as surgery; it doesn't necessarily mean cutting someone wide open."

The hospital is also part of the Speak Up program created by The Joint Commission, a national health care accreditation organization that encourages patient involvement in care.

"Patient safety is our No. 1 priority at St. Cloud Hospital because if we can't ensure that our patients are safe when they come, then we are not doing what we need to do," said Linda Chmielewski, chief nursing officer/vice president of hospital operation.

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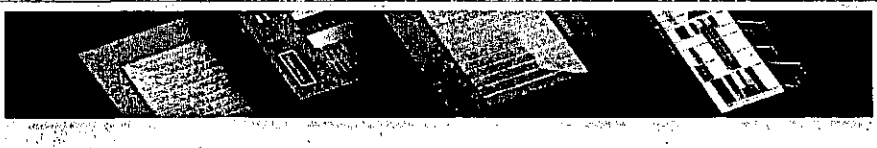

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MINNEAPOLIS ST. PAUL BUSINESS JOURNAL

Friday, January 16, 2009

Report: 'Adverse events' at MN hospitals up sharply

Minneapolis / St. Paul Business Journal - by Joey Peters Staff Writer

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Falls and pressure ulcers were among the most frequently-reported problems resulting from errors at Minnesota hospitals last year, according to a Minnesota Department of Health's annual report released Friday.

The number of "adverse events" more than doubled from 2007 to 2008, largely because of newly-enforced reporting requirements approved by the Legislature in 2007. The report, which gathered events that occurred in Minnesota hospitals, ambulatory surgical centers and community behavioral health hospitals, noted 184 more events in 2008 than in 2007, totalling 312. This year's study would have had 141 recorded events without the new reporting requirements, according to a press statement. Eighteen people died in Minnesota as due to errors.

In its fifth year, the report summarizes the number and type of events that occurred in the 199 facilities covered by the adverse health events law. According to the press release, the reporting has led to improvements in patient safety, including preventing retained sponges after childbirth and a 25 percent decline in reported stage three and four pressure ulcers.

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Robert Gauthier January 16, 2009 10:47PM EST

Add to the above factors is decreased staffing levels, mandatory overtime and increased employee stress. Not just reporting, as a observing physician.

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Minnesota hospitals strive for safety, but errors still increasing

By MAURA LERNER and JOSEPHINE MARCOTTY, Star Tribune staff writers
January 16, 2009

In spite of dramatic efforts to make Minnesota hospitals safer, the number of deaths and injuries from errors or accidents rose again last year, according to a report released Friday by the Minnesota Department of Health.

Minnesota Health Commissioner Sanne Magnan said that changing the attitudes among hospital staff has proved harder than adding new safety procedures. "We underestimated what it took to create change," she said.

At the same time, hospital officials and experts say there's a growing belief that Minnesota hospitals are safer today than they were five years ago, when they first started publicly disclosing mistakes.

They say the rising numbers are likely the result of better reporting and an increasingly open culture about acknowledging mistakes.

"They can expect ... that their rates will go up before they go down," said Jim Conway, senior vice president of the Institute for Health Care Improvement, a Massachussetts nonprofit that studies and promotes patient safety.

In all, 18 people died and nearly 100 were seriously injured as a result of medical mistakes, accidents or negligence in Minnesota hospitals between October 2007 and October 2008, the annual report said.

Ten of the deaths, and the vast majority of injuries, resulted from falls. Hospitals also reported 77 cases of surgical errors, including 21 operations on the wrong body part, and two on the wrong patient.

"All it takes is one unattended moment and boom, something bad happens," said Lawrence Massa, president of the Minnesota Hospital Association.

Hospital executives and safety directors said they've learned some lessons about changing hospital culture. While most physicians accept new safety procedures, buy-in is not universal, according to a survey that accompanied the report. Surgeons in particular are not always open to being questioned, they said, and others in the operating rooms may hesitate to speak up even if they think an error is about to occur.

Dr. Noel Peterson, president of the Minnesota Medical Association, said the majority of physicians support the new emphasis on safety and public disclosure, and that eventually it "will be second nature" to all of them.

Overall, the number of reported "adverse events" more than doubled in the past year -- from 125 to 312. Most of the increase was due to an expansion of the types of incidents that must be reported to the state health department. For the first time, hospitals had to disclose falls that caused "serious disability," as well as a new, broader category of pressure ulcers, or bed sores, that are potentially dangerous for frail patients.

But even without the new categories, the numbers went up by 13 percent, to 141 incidents.

This is the fifth year that hospitals have been required by state law to report what are known as "never events" -- problems that are thought to be preventable. Minnesota was one of the first states to require such reporting and make it public, and is still considered a national leader.

Part of the goal was to change a long-standing culture of secrecy that many say hindered understanding of how and why mistakes happen. Making them public allows hospital officials and employees to learn from each other's mistakes, advocates say.

This year, as in the past, the largest number of errors occurred at some of the busiest and most prestigious hospitals in Minnesota. The University of Minnesota Medical Center, Fairview, reported 52 incidents, including 35 pressure ulcers. The Mayo Clinic's two Rochester hospitals totaled 46, including five deaths.

Dr. Michael Rock, medical director of the Mayo hospitals, said the numbers are not surprising. "We tend to attract the highest acuity and the most difficult patients," he said. At the same time, he said, "I recognize the sense of frustration of consumers and the public out there." In the last few years, he said, "there has been a huge change in culture" to try to make hospitals safer.

Magnan said hospitals have made dramatic progress in being open about errors that five years ago would have been kept under wraps. Last year, she noted, Methodist Hospital announced that one of it surgeons mistakenly removed a patient's healthy kidney instead of a cancerous one. And Mercy Hospital acknowledged that a newborn had been badly burned when a fire burst out in his bassinet.

"We are safer because we are having conversations now that we never would have had before," Magnan said.

Still, some expressed frustration at how difficult it is to reduce the number of errors that, by definition, should never occur at all. For example, the number of pressure ulcers at the University of Minnesota hospital jumped dramatically despite an intensive effort to prevent them with new pressure-resistant mattresses throughout the hospital and other changes in patient care, officials said.

Marge Page, vice president of adult acute care services, said the number is high because the hospital cares for many fragile patients, who are especially vulnerable to the problem. The number may never drop to zero, she said, adding that those words "are hard for me to say."

Massa, of the hospital association, can sympathize. "It would be nice to say that we'd get to never – that no one would ever fall in a hospital setting. Practically, I think it's very difficult to imagine how that would happen," he said.

"We're working very hard at this," he added. "But we're not where we want to be."

Read the report at startribune .com/lifestyle/health.

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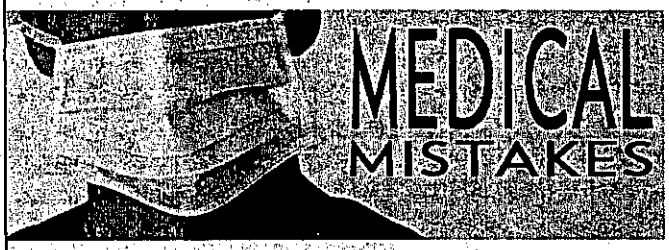
Minnesota hospitals reported more errors last year, state says

Increase expected due to new standards

By Jeremy Olson
jolson@pioneerpress.com

Updated: 01/16/2009 01:55:07 PM CST



(photos.com)

A man had the wrong kidney removed at Methodist Hospital. A 12-hour-old baby was badly burned in his bassinet at Mercy Hospital. A 35-year-old's face caught fire during a simple procedure at Regions Hospital.

All three generated headlines last year when they came out through lawsuits, police records and public statements. Now, all three are statistics in Minnesota's fifth annual report of preventable hospital errors, which seeks through public disclosure to prevent similar missteps from happening again.

Released today by the state Department of Health, the report linked so-called adverse events at hospitals to 18 deaths and 98 serious injuries in a 12-month period ended Oct. 6, 2008. While embarrassing and frustrating, hospital leaders said, the report has become a key source of motivation and education.

"This is the only way we can learn from each other and prevent these things," said Dr. Penny Wheeler, chief clinical officer of Allina Hospitals & Clinics.

Minnesota hospitals reported 312 events in the latest report, though more than half were due to new, stricter reporting standards for bedsores and falls. Using the old standards, the hospitals reported 141 errors last year, up from 125 in 2007.

Wrong surgeries (16) and fatal falls (10) were more common in the 2008 report, which also listed the first case in five years of a woman dying from a low-risk childbirth.

While health officials expressed concern over the increase, they also commended hospitals for becoming more open, accountable and committed to patient safety over the past five years.

"Of course, we would love to see the numbers going down," said Dr. Sanne Magnan, state health commissioner. "But the numbers alone don't reflect what's actually being learned from these events and what's actually happening."

Attention to hospital mistakes has increased since 2005, when Minnesota became the first state to identify hospitals with any of 27 specific errors — often called "never events" because they can be prevented through sound medical and organizational practices.

The state's insurers in 2007 stopped paying hospitals for any surgeries or care associated with such events. Medicare adopted the same stance last fall.

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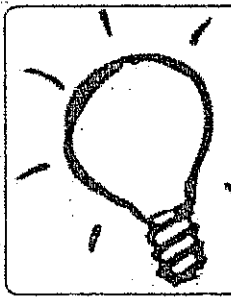

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Hospitals have started to publicly discuss these errors rather than hide them. Methodist Hospital leaders issued a public apology in March after removing the wrong kidney from a patient and leaving a cancerous one behind. Allina leaders likewise apologized last January after the bassinet fire at Mercy badly burned a newborn.

"It took us a while," said Allina's Wheeler, "but that transparency is a really positive development in health care."

Higher Error Numbers Expected / Three severe burn injuries were reported this year, compared with one in all four prior reports combined.

One involved Karine Hernandez, 35, whose lips and face were burned in a surgery fire at Regions. Caregivers acted quickly when the fire was discovered. The surgeon leaned against Hernandez's head to douse the flames while others threw a bucket of water over them.

Hernandez, of Inver Grove Heights, sued the hospital, alleging Regions didn't take proper steps to prevent a fire in the oxygen-rich environment of surgery.

Adverse events in surgery increased from 60 in 2007 to 77 last year, including 37 cases of foreign objects left in patients.

A cooperative effort by 70 hospitals has reduced one of the most common occurrences, however: sponges left in women after childbirth. The cases dropped from nine in the first six months of the reporting period to zero in the last six months.

Most hospitals now require so-called timeouts before the start of any surgery to verify the patient, the procedure and the exact body part involved. However, hospital officials acknowledged that timeouts aren't used consistently. A new solution at Regions is to place a sterile towel over surgical equipment until the timeout has taken place.

The removal of the wrong kidney at Methodist also has showed hospitals how errors can happen despite safeguards. A state inspection found the mistake started with a recordkeeping error long before the surgery.

Higher error numbers were expected this year because of the new reporting standards.

Hospitals previously reported fatal falls. Now, they also report disabling falls.

Similarly, pressure sores were reported if they were classified as level-three or level-four wounds — the most painful and problematic. Now, they must report pressure sores that for various reasons can't be classified.

The University of Minnesota Medical Center, Fairview, saw its number of reportable pressure sores increase from six in 2007 to 35 last year.

Fairview has responded with mattresses that protect patients' skin, and wound care nurses who are called in when patients appear at risk or have pressure sores when they are admitted.

Nurses are required to check their patients' skin for pressure sores every shift, though that can prove difficult with patients in extreme pain.

"They're telling you, 'If you move me, (I'll) be hurt,' " nurse Emily Rongitsch said. "You want to respect them to a certain extent. At the same time, this is something you need to see."

The University of Minnesota had 52 adverse events last year. Among east metro hospitals, Regions

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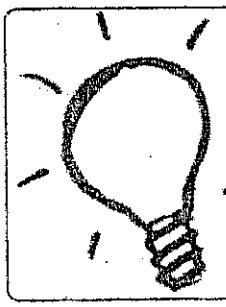

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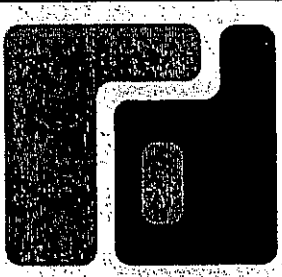

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reported 16, United Hospital reported 11, St. Joseph's and St. John's hospitals each reported four, and Woodwinds Health Campus reported three.

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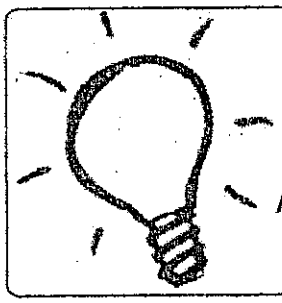

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State hospitals report more incidents in 2008

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ST. PAUL, Minn. (AP) - Minnesota hospitals reported 312 serious problems - including 18 patient deaths - in the last year, according to an annual report released Friday.

The number of medical mistakes and other so-called "adverse health events" spiked considerably over the previous reporting period, but officials said the increase can be attributed to a new law that expanded what incidents hospitals should report to the Minnesota Department of Health.

Without the changes, officials said the number of incidents would have been 141 - slightly higher than the 125 incidents reported from October 2006 to October 2007. During that period, 13 incidents were linked to patient deaths and 10 resulted in a serious disability.

Ninety-eight incidents in the most recent reporting period led to a serious disability, but that increase was also due to the expanded reporting requirements, officials said.

The 28 reportable incidents include surgery on the wrong body part, items like sponges or surgical objects left in a patient's body during surgery, bed sores and patient falls.

Much of the increase in incidents came from reporting falls that led to disability instead of just death and reporting a less serious stage of bedsore in addition to advanced bedsores.

By having hospitals report 28 preventable problems, the state hopes to gradually reduce the number of incidents and thereby improve patient care, said Minnesota Health Commissioner Sanne Magnan.

"We're always interested in what the numbers show, while also recognizing that these events are very rare," Magnan said. Hospitals in Minnesota recorded 2.8 million patient days in 2007, the latest number available.

"It's not just the numbers alone, but what we're learning from each incident," Magnan said, noting that the health department is celebrating the fifth anniversary of the reporting system. "This transparency and public reporting has persevered. ... The fact that we have a safe environment to talk about safety is something we should really be proud of."

Hospitals supported expanding the reporting requirements to include falls that lead to serious disability and "unstageable" pressure ulcers (a less advanced type of bedsore), said Lawrence Massa, president of the Minnesota Hospital Association.

"We're disappointed that the numbers went up slightly," Massa said. "But overall we've elevated safety and we understand

these events better."

Massa said the hospitals were pleased to see a decline for the second year in a row in stage three and four pressure ulcers (the more advanced form of bedsores). In addition, the number of retained sponges left in patients after childbirth declined, and all of those incidents occurred in the first half of the year, after which the hospital association sent an alert to its members to watch out for the mistake, Massa said.

The second-most errors - 37 - were reported by the Mayo Clinic's Saint Marys Hospital in Rochester, but the facility also sees one of the highest numbers of patients. Under the previous reporting requirements, the facility had 12 incidents the year before.

Dr. Michael Rock, chief medical officer for Mayo's Rochester hospitals, said the public will likely first see the jump in numbers. But he said Mayo's facilities and others are constantly improving patient safety, and that the transparency required by Minnesota law helps officials do that.

"Increasing the reporting requirements is only going to benefit patients and the institutions that care for them," Rock said.

In Rochester, health care workers have taken a closer look at reducing bedsores by alerting all medical staff involved in a patient's care when the person is first showing signs of the sores.

And to decrease falls, the hospitals are using innovations such as anti-slip tread on all sides of hospital-issued socks - just in case a patient puts them on upside down, Rock said. Health workers are also taking a closer look at patients with a history of falls, he said.

But the prevention of mistakes also has to do with a "change in a culture of safety," Rock said. In addition to reporting the incidents to the state, Mayo's Rochester facilities publish an internal newsletter includes information about each adverse event as it happens.

"That degree of transparency can't be underestimated," he said.

Minnesota Department of Health: http://www.health.state.mn.us/patientsafety/index.html

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#2

Testimony of John C. Kapsner, Counsel
North Dakota Healthcare Association

Senate given to the House

Senate Bill 2403

My name is John Kapsner. I am an attorney with the Vogel Law Firm in Bismarck, North Dakota, and counsel for the North Dakota Healthcare Association (NDHA). Mr. Thomas has broadly outlined the purpose of Senate Bill 2403. Achieving the goals outlined by Mr. Thomas has proven to be somewhat complicated in terms of drafting. In Senate Bill 2403, we have sought to, when possible, harmonize the terminology in North Dakota with the terminology used in the State of Minnesota. While making a variety of health quality information available to the public, we have continued to respect the purpose of peer review and the privileges currently provided such information.

1. You will note that wherever the existing statute on peer review references the term "committee" Senate Bill 2403 uses the term "organization". This change in terminology more closely aligns North Dakota's statute with Minnesota law and recognizes the expanded scope of entities that will be conducting peer review. For example, Section 1, lines 18-21, recognize that both NDHA and its Minnesota counterpart can be peer review organizations. Further, lines 20 and 21 recognize that peer review can occur across state lines. There are now hospitals in Minnesota and North Dakota that desire to perform joint peer review of patient care in their respective facilities.

2. The definition of "professional peer review" on page 2, lines 26 and following, has been amended to authorize North Dakota hospitals and organizations to provide information to peer review entities in other states in order to generate the type of data that will be made available to the public. Absent this provision, North Dakota peer review data could not be made available to such organizations.

3. Section 2 of the Bill authorizes the release of peer review records to both NDHA and the North Dakota Department of Health. Ultimately, one or both of those entities will provide quality information to the public – not patient specific data, but cumulative information which will render the quality of care being provided more transparent.

4. Section 3 of the Bill extends the privilege now applicable to peer review information to such information once it has been made available to the public. This provision is an essential provision of Senate Bill 2403. Without this provision, the kind of evaluation and public release of information contemplated by the Bill simply will not occur.

The remaining changes made by Senate Bill 2403 are, for the most part, stylistic.

#3

PROPOSED AMENDMENTS TO SENATE BILL NO. 2403

Page 3, line 10, remove "<u>, including that required by federal law</u>"

Page 3, after line 23, insert:

> **"<u>4.</u> <u>Nothing in this section shall be construed to prohibit the department of health from access to peer review records to determine compliance with requirements of federal or state law for the survey and certification of a health care facility or for a trauma center designation and as authorized under any administrative rules issued under sections 23-01.2-01 or 23-01-11, to enable the state to be in compliance with any federal laws in order to qualify for any federal funds related to medical facilities or agencies licensed by the department of health.</u>"**

Page 3, line 26, after the first comma, insert "<u>data,</u>"

Page 3, line 27, after "<u>to</u>" insert "<u>the department of health or</u>"

Renumber accordingly

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

SB 2403 Testimony
House Human Services Committee
March 23, 2009

Mr. Chairman, Members of the House Human Services Committee. I am Arnold Thomas, President of the North Dakota Healthcare Association, here in support of SB 2403. With me to explain the content of SB 2403 is John Kapsner, NDHA legal counsel.

The goal behind SB 2403 is simple: advance the practice of medicine in ND using evidence based standards to compare hospital specific performance.

SB 2403 sets the framework for gathering the information necessary for hospitals to compare, critique, and publicly disclose patient safety, clinical and financial performance profiles and, most importantly, take such steps for medical practice advancement as indicated by evidence based practice standards.

ND hospitals are prepared to participate in the MN Hospital Association's established, nationally recognized, fully transparent, hospital performance program. Joining with MN allows ND hospitals access to a tried and proven informational template. Joining with MN also allows regional comparative analysis, an important benefit for the region, given the long standing clinical relationships between the two states.

Mr. Kapsner will explain the bills provisions.~~and offer an amendment which addresses a concern raised by the Department of Health~~.

After Mr. Kapsner's presentation, I will present a model of how we plan to proceed in the display and use of hospital specific indicators (attachment), how this information may be used for public information (attachment), and entertain questions you, Chairman Weisz, or committee members may have.

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