2020 Supplemental Budget Decision Package

Agency: 303 - Department of Health
Decision Package Code-Title: BA - Improve Patient Safety/Care Quality
Budget Session: 2020 Supp
Budget Level: Policy Level
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Agency Recommendation Summary

Funding to support the Adverse Health Events and Incident Reporting program was eliminated in the 2011-2013 biennium. This program, required by chapter 70.56 RCW, improves the quality of health care by identifying medical errors and instituting changes to prevent them from reoccurring. The Washington State Department of Health requests funding to carry out the statutory obligations of the Adverse Health Events and Incident Reporting program to protect patient safety in Washington.

Fiscal Summary

Dollars in Thousands

Operating Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Fund 001 - 1	$0	$295	$290	$290
Total Expenditures	**$0**	**$295**	**$290**	**$290**
Biennial Totals		**$295**		**$580**
Staffing	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
FTEs	0.0	1.4	1.4	1.4
Average Annual		**0.7**		**1.4**
Object of Expenditure	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Obj. A	$0	$195	$195	$195
Obj. B	$0	$66	$66	$66
Obj. E	$0	$12	$11	$11
Obj. G	$0	$4	$4	$4
Obj. J	$0	$4	$0	$0
Obj. T	$0	$14	$14	$14

Package Description

Background:

Adverse health events are medical errors that health care facilities could have prevented. The National Quality Forum (NQF) – which sets standards and measures to improve health care quality – identifies a list of 29 serious reportable medical errors which may result in patient death or serious disability that health care facilities are required by law to report to the Department of Health (DOH). The National Quality Forum (NQF) was created in 1999 to promote and ensure patient protections and healthcare quality through measurement and public reporting.

The Legislature established the Adverse Health Events and Incident Reporting program (Chapter 70.56 RCW) with the intent to facilitate quality improvement in the health care system, improve patient safety, assist the public in making informed health care choices, and decrease medical errors in a non-punitive manner. The law requires certain health care facilities, including psychiatric and acute care hospitals, to report to the department whenever an adverse event is confirmed.

RCW 70.56.030 charges DOH to:

- Receive and investigate notifications and reports of adverse events, including root cause analyses and corrective action plans submitted as part of reports, and communicate to individual facilities the department's conclusions, if any, regarding an adverse event reported by a facility; and
- Adopt rules as necessary to implement the law (WAC 246-302).

DOH established the Adverse Health Events and Incident Reporting program in 2006. Funding for the program was eliminated in the 2011-2013 biennium. Since that time, the department has continued to receive reports of adverse events, aggregate data, and post quarterly reports on the department's website. However, DOH has been unable to proactively follow up on reports of adverse events, summarize trends and report those out to the health care system, and engage in other quality improvement activities.

Proposed Solution

This proposal requests funding to support the Adverse Health Events and Incident Reporting program. This includes the following positions and assumes the following responsibilities:

- Nurse Consultant Institutional position (1.0 FTE)
    - Provide program management, oversight, and supervision;
    - Provide outreach and consultation to health care facilities on the adverse event reporting requirements;
    - Review notifications of possible adverse events;
    - Update rules, as necessary, on reporting requirements; and
    - Serve as the subject matter expert and business liaison to health technology staff who support the reporting system.
- Health Services Consultant 3 (0.3 FTE):
    - Receive the notification of adverse events and other required reports;
    - Review reports for completeness and adherence to reporting requirements;

    - Communicate with facilities regarding timelines and expectations for the root cause analysis and corrective action plan;
    - Follow up with facilities to assure the department receives reports; and
    - Respond to public records requests and other requests for program information.
- Epidemiologist 2 (0.1 FTE):
    - Validate, analyze and evaluate data regarding notifications and reports of adverse events; and
    - Produce summary data for quarterly reports.

Desired Results:

This request will re-establish a statutorily required quality improvement program for adverse events that was eliminated during the recession. This proposal will reduce medical errors and improve patient safety.

Alternatives Considered

DOH considered seeking a repeal of 70.56 RCW. However, doing so would eliminate requirements on health care facilities to report adverse events, perform root cause analysis, and institute changes to processes and procedures to prevent future errors. This would not support the critical public health goals to facilitate quality improvement in the health care system, improve patient safety, and decrease medical errors.

Consequences

There are four main consequences if no action is taken:

1. The department will only continue receiving and logging basic adverse event notification information (date, type of report, facility). All other adverse event related 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 state will fail to meet a its own statutory mandate; and
4. The state will be at risk of public and political criticism should the Adverse Health Events and Incident Reporting program be questioned in relation to serious incidents in covered facilities.

Assumptions and Calculations

Expansion or alteration of a current program or service:

This is request provides funding to carry out the state's Adverse Health Event and Incident Reporting program. It allows DOH to expand the activities currently performed to improve the quality of health care throughout the state.

Detailed assumptions and calculations:

This request will fund 1.4 FTE ongoing to fulfill the department's minimum requirements per chapter 70.56 RCW.

1.0 FTE – Nurse Consultant Institutional will:

- Provide program management, oversight, and supervision;
- Provide outreach and consultation to health care facilities on the adverse event reporting requirements;
- Review notifications of possible adverse events;
- Update rules, as necessary, on reporting requirements; and
- Serve as the subject matter expert and business liaison to health technology staff who support the reporting system.

0.3 FTE – Health Services Consultant 3 will:

- Receive the notification of adverse events and other required reports;
- Review reports for completeness and adherence to reporting requirements;
- Communicate with facilities regarding timelines and expectations for the root cause analysis and corrective action plan;
- Follow up with facilities to assure the department receives reports; and
- Respond to public records requests and other requests for program information.

0.1 FTE Epidemiologist 2 will:

- Validate, analyze and evaluate data regarding notifications and reports of adverse events; and
- Produce summary data for quarterly reports.

Workforce Assumptions:

See attached financial calculator (FNCAL)

Strategic and Performance Outcomes

Strategic framework:

This request supports Results Washington Goal 4: Healthy and Safe Communities by ensuring access to quality healthcare.

This request also supports the following Agency Strategic Plan goals:

- Goal 1: Public Safety - Protect everyone in Washington from communicable diseases and other health threats. Resolve health care provider and facility complaints and allegations of misconduct or unsafe care.

Performance outcomes:

This request will fulfill the Legislature’s original intent by providing funding for complete implementation and administration of the Adverse Health Events and Incident Reporting program, to facilitate quality improvement in the health care system, improve patient safety, and decrease medical errors.

Other Collateral Connections

Intergovernmental:

This request does not have intergovernmental impacts.

Stakeholder response:

Health care facilities and consumer advocates support the Adverse Event Reporting program as a tool for quality improvement.

Legal or administrative mandates:

This request is not in response to litigation, an audit finding, executive task order, or task force recommendation.

Changes from current law:

This request does not require any changes to statutes or rules.

State workforce impacts:

This request does not impact existing collective bargaining.

State facilities impacts:

This request does not impact facilities and workplace needs.

Puget Sound recovery:

This request is not related to Puget Sound recovery efforts.

Reference Documents

- Improve Patient Safety-Care Quality-Other Sources and References.docx
- Minnesota Adverse Events 10 Year Program Evaluation_Janary 2014.pdf
- Minnesota Adverse Events 15th Annual Report_March 2019.pdf
- NQF Serious Reportable Events Fact Sheet 121411.pdf
- PL BA Improve Patient Safety-Care Quality-FNCAL.xlsm

IT Addendum

Does this Decision Package include funding for any IT-related costs, including hardware, software, (including cloud-based services), contracts or IT staff?
No