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

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# Minnesota Background

- 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

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# 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.

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# 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.

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# 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

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# What must be reported?

- Any of the 27 events defined in law.
- A description of the event ASAP, but no later than15 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.

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# 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

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# 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.

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# 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.

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# 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.

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# 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.

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# 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)

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# 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.

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# 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.

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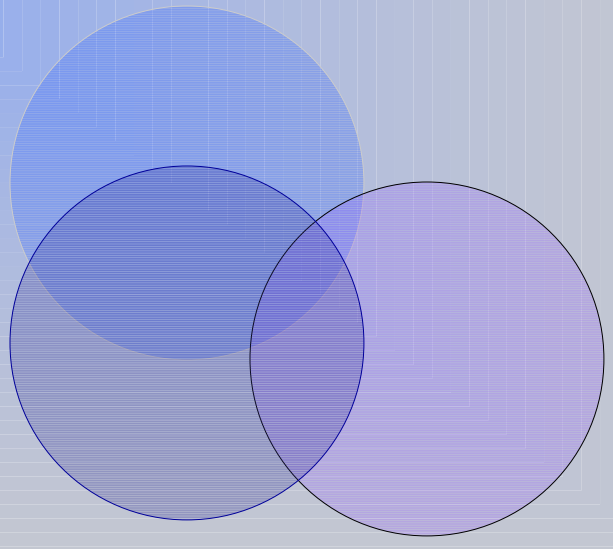
# AE Relationship to Other Laws & Requirements

State & Federal
Licensing & Complaints



AE Reports

VAA &
Maltreatment of Minors

# 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

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# 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?

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# For more information:

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