Enrolled
Senate Bill 23

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CHAPTER .....

AN ACT

Relating to Oregon Patient Safety Commission; creating new provisions; and amending ORS 442.820 and sections 1 and 4, chapter 686, Oregon Laws 2003.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2009 Act is added to and made a part of sections 1 to 12, chapter 686, Oregon Laws 2003.

SECTION 2. (1) The Oregon Patient Safety Commission is the central agency in Oregon responsible for the collection of data and analyses produced by all entities in Oregon that are certified by the United States Department of Health and Human Services under 42 U.S.C. 299b-24 as patient safety organizations.

(2) The commission shall incorporate the data and analyses collected under this section in the preparation of reports required by section 4, chapter 686, Oregon Laws 2003.

SECTION 3. Section 1, chapter 686, Oregon Laws 2003, is amended to read:

Sec. 1. As used in sections 1 to 12**, chapter 686, Oregon Laws 2003** [*of this 2003 Act*]:

(1) "Participant" means an entity that reports patient safety data to [*a*] **the Oregon** Patient Safety Reporting Program, and any agent, employee, consultant, representative, volunteer or medical staff member of the entity.

(2) "Patient safety activities" includes but is not limited to:

(a) The collection and analysis of patient safety data by a participant;

(b) The collection and analysis of patient safety data by the Oregon Patient Safety Commission established in [*section 2 of this 2003 Act*] **ORS 442.820**;

(c) The utilization of patient safety data by participants;

(d) The utilization of patient safety data by the Oregon Patient Safety Commission to improve the quality of care with respect to patient safety and to provide assistance to health care providers to minimize patient risk; and

(e) Oral and written communication regarding patient safety data among two or more participants with the intent of making a disclosure to or preparing a report to be submitted to [*a*] **the** patient safety reporting program.

(3) "Patient safety data" means oral communication or written reports, data, records, memoranda, analyses, deliberative work, statements, root cause analyses or action plans that are collected or developed to improve patient safety or health care quality that:

(a) Are prepared by a participant for the purpose of reporting patient safety data voluntarily to [*a*] **the** patient safety reporting program, or that are communicated among two or more participants with the intent of making a disclosure to or preparing a report to be submitted to [*a*] **the** patient safety reporting program; [*or*]

(b) Are collected or prepared by a patient safety organization certified by the United States Department of Health and Human Services under 42 U.S.C. 299b-24; or

[*(b)*] **(c)** Are created by or at the direction of the patient safety reporting program, including communication, reports, notes or records created in the course of an investigation undertaken at the direction of the Oregon Patient Safety Commission.

(4) "Patient safety reporting program" [*includes but is not limited to*] **means** the Oregon Patient Safety Reporting Program created in section 4**, chapter 686, Oregon Laws 2003.** [*of this 2003 Act and any other patient safety reporting program established to improve the safety and quality of patient care.*]

(5) "Serious adverse event" means an objective and definable negative consequence of patient care, or the risk thereof, that is unanticipated, usually preventable and results in, or presents a significant risk of, patient death or serious physical injury.

SECTION 4. ORS 442.820 is amended to read:

442.820. (1) The Oregon Patient Safety Commission is established as a semi-independent state agency subject to ORS 182.456 to 182.472. The commission shall exercise and carry out all powers, rights and privileges that are expressly conferred upon it, are implied by law or are incident to such powers.

(2) The mission of the commission is to improve patient safety by reducing the risk of serious adverse events occurring in Oregon's health care system and by encouraging a culture of patient safety in Oregon. To accomplish this mission, the commission shall:

(a) Establish a confidential, voluntary serious adverse event reporting system to identify serious adverse events;

(b) Establish quality improvement techniques to reduce systems' errors contributing to serious adverse events; and

(c) Disseminate evidence-based prevention practices to improve patient outcomes.

(3) ORS 192.410 to 192.505 do not apply to public records created or maintained by the commission that contain patient safety data or to reports obtained by the program.

(4) ORS 192.610 to 192.690 do not apply to portions of a meeting of the Oregon Patient Safety Commission Board of Directors, or subcommittees or advisory committees established by the board, to consider information that identifies a participant or patient and the written minutes of that portion of the meeting.

(5) Notwithstanding ORS 182.460, ORS 293.250 applies to the commission for the purpose of collecting unpaid fees established under section 6, chapter 686, Oregon Laws 2003, that are owed to the commission and are past due.

SECTION 5. Section 4, chapter 686, Oregon Laws 2003, is amended to read:

Sec. 4. (1) The Oregon Patient Safety Reporting Program is created in the Oregon Patient Safety Commission to develop a serious adverse event reporting system. The program shall include but is not limited to:

(a) Reporting by participants, in a timely manner and in the form determined by the Oregon Patient Safety Commission Board of Directors established in [*section 7 of this 2003 Act*] **ORS 442.830**, of the following:

(A) Serious adverse events;

(B) Root cause analyses of serious adverse events;

(C) Action plans established to prevent similar serious adverse events; and

(D) Patient safety plans establishing procedures and protocols.

(b) Analyzing reported serious adverse events, root cause analyses and action plans to develop and disseminate information to improve the quality of care with respect to patient safety. This information shall be made available to participants and shall include but is not limited to:

(A) Statistical analyses;

(B) Recommendations regarding quality improvement techniques;

(C) Recommendations regarding standard protocols; and

(D) Recommendations regarding best patient safety practices.

(c) Providing technical assistance to participants, including but not limited to recommendations and advice regarding methodology, communication, dissemination of information, data collection, security and confidentiality.

(d) Auditing participant reporting to assess the level of reporting of serious adverse events, root cause analyses and action plans.

(e) Overseeing action plans to assess whether participants are taking sufficient steps to prevent the occurrence of serious adverse events.

(f) Creating incentives to improve and reward participation, including but not limited to providing:

(A) Feedback to participants; and

(B) Rewards and recognition to participants.

(g) Distributing written reports using aggregate, de-identified data from the program to describe statewide serious adverse event patterns and maintaining a website to facilitate public access to reports, as well as a list of names of participants. The reports shall include but are not limited to:

(A) The types and frequencies of serious adverse events;

(B) Yearly serious adverse event totals and trends;

(C) Clusters of serious adverse events;

(D) Demographics of patients involved in serious adverse events, including the frequency and types of serious adverse events associated with language barriers or ethnicity;

(E) Systems′ factors associated with particular serious adverse events;

(F) Interventions to prevent frequent or high severity serious adverse events; [*and*]

(G) Analyses of statewide patient safety data in Oregon and comparisons of that data to national patient safety data; and

[*(G)*] **(H)** Appropriate consumer information regarding prevention of serious adverse events.

(2) Participation in the program is voluntary. The following entities are eligible to participate:

(a) Hospitals as defined in ORS 442.015;

(b) Long term care facilities as defined in ORS 442.015;

(c) Pharmacies licensed under ORS chapter 689;

(d) Ambulatory surgical centers as defined in ORS 442.015;

(e) Outpatient renal dialysis facilities as defined in ORS 442.015;

(f) Freestanding birthing centers as defined in ORS 442.015; and

(g) Independent professional health care societies or associations.

(3) Reports or other information developed and disseminated by the program may not contain or reveal the name of or other identifiable information with respect to a particular participant providing information to the commission for the purposes of sections 1 to 12 [*of this 2003 Act*], **chapter 686, Oregon Laws 2003,** or to any individual identified in the report or information, and upon whose patient safety data, patient safety activities and reports the commission has relied in developing and disseminating information pursuant to this section.

(4) After a serious adverse event occurs, a participant must provide written notification in a timely manner to each patient served by the participant who is affected by the event. Notice provided under this subsection may not be construed as an admission of liability in a civil action.

Passed by Senate May 6, 2009

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Secretary of Senate

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President of Senate

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Speaker of House

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Approved:

.....M.,....., 2009

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Governor

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