HOUSE RESEARCH

Bill Summary

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Version: Second Engrossment

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Subject: Reporting of adverse health care events

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Overview

This bill creates an adverse health care events reporting system that requires reports of certain specified events to the commissioner of health. The requirements of this act would replace the reporting requirements of the Vulnerable Adults Act for hospitals and other entities licensed under sections 144.50 to 144.58.

Section

1 **Data classification.** Provides that data collected for purposes of the adverse health care event reporting system are classified under new section 144.7067, subdivision 4.

2 **Title.** Provides that the new law may be cited as the "Minnesota Adverse Health Care Events Reporting Act of 2003".

3 **Definitions.** Defines "commissioner," "facility," "serious disability" and "surgery" for purposes of the act.

4 **Reports required.** Establishes requirement that facilities report adverse health care events to the commissioner as soon as possible and within 15 working days of discovery. Reports are to be in the form specified by commissioner, and are to identify the facility but not to name any individuals involved. Six categories of reportable events are established:

- Surgical events. Includes surgery performed on the wrong body part or on the wrong patient, performance of the wrong surgical procedure, retention of a foreign body in a patient after surgery or death during or immediately after

Section

surgery in normal, healthy patients undergoing certain localized operations.

- Product or device events. Includes certain deaths or serious disabilities resulting from: contaminated drugs, devices or biologics; improper function of a device; or intravascular air embolism.
- Patient protection events. Includes discharge of an infant to the wrong person, death or disability associated with patient disappearance of more than four hours, and suicide or attempted suicide resulting in disability if due to patient actions while in a facility.
- Case managements events. Includes patient death or disability associated with medical error, administration of incompatible blood, labor and delivery in a low-risk pregnancy, hypoglycemia, or failure to treat neonatal hyperbilirubinemia. Also includes stage 3 or 4 ulcers acquired after admission and death or disability from spinal manipulative therapy.
- Environmental events. Includes death or disability from electric shock, burns, falls, or use or lack of restraints or bedrails, as well as any incident in which a line designated for oxygen or other gas contains the wrong gas.
- Criminal events. Includes instances of care provided by someone impersonating a health care provider, abduction of a patient, sexual assault on a patient, or death or injury of a patient or staff member resulting from assault.

Facilities are required to complete a root cause analysis and corrective action plan with regard to each reportable event and file it with the commissioner within 60 days. Commissioner must implement an electronic means for filing these reports. Events reportable under this act are not subject to the reporting requirements of the Vulnerable Adults Act.

5 **Duties of commissioner.** Requires commissioner to establish adverse event reporting system to consist of: mandatory reporting of the events listed in section 4, mandatory root cause analysis and corrective action plans, analysis of reports by commissioner to identify patterns of health care system failure and methods of correction, imposing sanctions for failure to comply with reporting requirements and communications with specified parties to maximize use of reporting system. Reports submitted under this act are provided the protections and immunities of section 145.64, subdivision 1, paragraph (b), which allows release of nonpatient-identified trend data without liability. Further requires the commissioner to analyze reports received, communicate conclusions and any recommendations to facilities, and publish an annual report. Commissioner may sanction a facility for failure to file required reports, analysis and corrective action plans. Commissioner may suspend, revoke, place conditions on or fail to renew a facility's license for failure to develop and implement a mandated corrective action plan.

6 **Interstate coordination.** Requires the commissioner of health to report the list of reportable events included in section 4 to the National Quality Forum. Requires commissioner to monitor the Forum's list of reportable events and recommend changes in Minnesota's list to the legislature as necessary.

7 **Appropriation.** Provides an unspecified appropriation from the general fund for purposes of the act.