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COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

F I N A L M I N U T E S

MEETING OF:

PATIENT SAFETY AUTHORITY

TIME: 9:36 A.M.

NORTH OFFICE BUILDING
HEARING ROOM 3
HARRISBURG, PENNSYLVANIA

DECEMBER 9, 2002

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Patient Safety Authority

December 9, 2002

Board Members:

Robert S. Muscalus, D.O., Chairperson, Pennsylvania
Physician General
Joan M. Garzarelli, MSN
Patricia Clancy Kienle, R.Ph.
Lorina L. Marshall-Blake - Absent
Danae Powers, M.D.
Stanton N. Smullens, M.D.
Nathan J. Zuckerman, M.D.
Cliff Rieders, Esquire
Howard F. Messer, Esquire
S. Marc Land, Esquire
The Hon. Mary Ann Dailey - Absent

Also Present:

Alan Rabinowitz, Board Administrator
John T. Henderson, Jr., Esquire, Chief Counsel,
Department of State
Bridget L. Racis, Office of the Physician General

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Patient Safety Authority

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Meeting of December 9, 2002

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The regularly scheduled meeting of the Patient Safety Authority was held on December 9, 2002. The meeting was called to order at 9:36 a.m. by Robert S. Muscalus, D.O., Chairperson.

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Approval of Minutes of the November 18, 2002, meeting
MS. KIENLE:

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I move to approve the minutes of the November 18, 2002, meeting as amended.

DR. SMULLENS:

Second.

DR. MUSCALUS:

Any discussion on the motion? All those in favor? Those opposed?

[The motion carried unanimously.]

Report of Board Chair

[Robert S. Muscalus, D.O. addressed the Board at 9:42 a.m. to report that the process of securing a vendor

1 to write the RFP is ongoing. He also noted it is his
2 hope to engage in a discussion concerning the specific
3 responsibilities of the elected officers at the
4 January meeting. Dr. Muscalus concluded his report to
5 inform the Board that a meeting of the National
6 Patient Safety Foundation will be taking place March
7 12-15, 2003, in Washington, D.C. and that anyone
8 interested in either attending or obtaining more
9 information about what the Foundation is should
10 contact him.]

11 ***

12 [Joan M. Garzarelli, MSN joined the teleconference at
13 9:44 a.m.]

14 ***

15 Report of Board Administrator

16 [Alan Rabinowitz, Administrator addressed the Board at
17 9:45 a.m. to provide the members with both a Post
18 Office Box address and email address that has been
19 established. Mr. Rabinowitz also noted he expects to
20 begin receiving responses by the end of the week from
21 the ten potential writers of the RFP. John T.
22 Henderson, Jr., Esquire, Chief Counsel, Department of
23 State addressed the Board at 9:49 a.m. to note that

1 the Governor's Code of Conduct does apply to members
2 of the Patient Safety Authority who were appointed by
3 the Governor, and those members are therefore
4 responsible for submitting the disclosure statements
5 by April 1, 2003.]

6 ***

7 RFP Update

8 [Robert Muscalus, D.O. addressed the Board at 9:47
9 a.m. to note that it is his belief that input
10 regarding the RFP from various hospital associations
11 and medical societies will be very valuable.
12 Discussion was held concerning the pros and cons of
13 soliciting such input.]

14 VERBATIM:

15 DR. MUSCALUS:

16 You will recall at the previous meetings
17 we've mentioned that we wanted to seek input
18 and comments from outside organizations, the
19 medical societies, the hospital
20 associations, to just listen to what they
21 have to say about the individuals and the
22 facilities that they represent. And once we
23 move along in this process we'll get a

1 better sense of the appropriate timing for
2 those meetings, but clearly their input is
3 something that will be valuable. I don't
4 know yet exactly at what point we'll look to
5 get that input. I think we'll know more as
6 we move along in the process.

7 MR. RIEDERS:

8 Well what kind of input -- what are you
9 looking for in the way of input? Hopefully
10 not a veto power.

11 DR. MUSCALUS:

12 No, Cliff the types of things that I would
13 be interested in is we know for example that
14 the Department of Health currently has an
15 online reporting system for serious events.
16 And it would be helpful to know if all
17 hospitals in the Commonwealth find this to
18 be a user friendly process. What about
19 ambulatory surgical facilities, how many of
20 them have capabilities for online reporting?
21 What about birthing centers do they have
22 online reporting capabilities? Are there
23 other types of things that we as a Board

1 should be aware of as we look at writing
2 this RFP and placing certain requirements on
3 these facilities? It's not...

4 MR. RIEDERS:

5 I guess what concerns me -- and, you know,
6 in the abstract that sounds reasonable but,
7 you know, there's a certain statutory duty
8 as to what has to be done. I suppose the
9 method of implementation, you know, is one
10 you want to be as seamless as possible and
11 therefore from a technological point of view
12 I can appreciate getting some input maybe
13 after the fact. My only concern is that,
14 you know, in writing the RFP I don't think
15 they should have any input and I don't think
16 that that is anticipated by the framers of
17 the statute. It is a question of temporally
18 a timing when you get that input, but I just
19 wanted to relay that thought and concern to
20 you.

21 DR. MUSCALUS:

22 And I understand your concern and I think
23 the ground we're on is solid and it's

1 reasonable ground. We're not looking to get
2 approval or permission or signoff. I think
3 over the last several months everyone has
4 developed a greater working experience with
5 the provisions of Act 13 and I think it
6 would be helpful to get some insight from
7 healthcare professionals regarding their
8 experiences regarding Act 13 and meeting
9 those requirements. And it may be that what
10 we hear from these organizations will not
11 impact in any way what we look to do in an
12 RFP. At the same time I think it would be
13 good to hear what some of their issues and
14 experiences are because we may find that we
15 want to add certain things that otherwise we
16 wouldn't add had we not heard from them,
17 things that ultimately will help to improve
18 quality and improve patient safety. So I
19 don't think we're looking at it from a --
20 from a -- the perspective of getting
21 approval. But I'll be the first to say
22 that, you know, I'm not an expert in certain
23 areas that hospitals and other facilities

1 have to operate within and I think it would
2 be helpful to just give them the opportunity
3 to express to us what some of their issues
4 are.

5 MR. RIEDERS:

6 Well then again of course, you know, they
7 have no experience under Act 13, nobody
8 does. And from the patient safety point of
9 view that's, you know, that's what we're
10 here to do. I guess I would have to dissent
11 from inviting that sort of input prior to
12 our formulating essentially what the RFP is
13 going to say.

14 DR. MUSCALUS:

15 Okay, and I respect your opinion. Are there
16 others on the Board who feel as Cliff does?

17 DR. POWERS:

18 I'm not sure if I feel exactly as Cliff does
19 but I have a thought. At the last meeting
20 we engaged in a discussion in executive
21 session, and without going into detail I
22 thought that that discussion was very
23 valuable and if continued it might help us

1 as a Board to address issues like how does
2 the RFP get formulated, where does the input
3 come, before or after? Because we could at
4 least if not reach consensus have an
5 understanding of what the different
6 viewpoints really are and have a chance to
7 really discuss them in depth. Is there any
8 way to engage in a process like that prior
9 to having input into the RFP to determine
10 the pros and cons of doing that?

11 DR. MUSCALUS:

12 Well I think that's a topic that is probably
13 best for when we meet again in a face-to-
14 face meeting and as we start looking at what
15 is included in the RFP and how certain
16 things are interpreted or defined clearly is
17 going to be beneficial. But I don't see
18 that really impacting one way or the other
19 anything that we might hear from
20 professional organizations. The other thing
21 Cliff is with regard to the provisions of
22 Act 13 hospitals have had to make a variety
23 of changes over the last several months from

1 the standpoint of having a patient safety
2 officer, patient safety committees. So I
3 mean hospitals have had to start the
4 process. It's not like nothing has happened
5 with regard to Act 13. Is there anyone else
6 on the Board with comments regarding this?

7 UNIDENTIFIED SPEAKER:

8 Rob the only comment I have is that
9 hospitals are still in a quandary in terms
10 of what defines an incident or a serious
11 event and in the discussions on even serious
12 event the Department of Health is still
13 unsure. I think the inquiry from certain
14 institutions in terms of their availability
15 of doing it by electronically would have a
16 good impact on the RFP. I also think the
17 RFP maybe should stipulate that in this
18 particular amount of time that we do require
19 electronic transmission.

20 DR. MUSCALUS:

21 And again I think those are the types of
22 things that would be beneficial from the
23 standpoint of hearing from these entities.

1 It may very well be that electronic
2 submission by hospitals is not an issue. By
3 the same token for ambulatory surgical
4 facilities it may be more problematic. I
5 really don't even know how many ASF's there
6 are in the state, probably more than we
7 think, and I don't know what their
8 capabilities are for electronic submission.
9 And if it's not something that's possible or
10 practical then we have to think about
11 submission via U.S. mail or faxes and how
12 that would be built into an RFP process.
13 So...

14 MR. MESSER:

15 Rob this is Howard Messer in Pittsburgh. I
16 tend to agree that what we need to do here
17 is define our role before we ask other
18 people I think to comment on what we have
19 done or what we should be doing in the
20 future. As somebody just mentioned, I think
21 the implementation of what we recommend is
22 different than the formulation of the policy
23 and I think the policy discussions should be

1 limited to us until we are in the situation
2 where we can ask for advice after we have
3 determined what we believe to be a basic and
4 fundamental policy for this RFP.

5 DR. MUSCALUS:

6 And I guess my only point is I don't view
7 these meetings as asking these entities what
8 they recommend. Rather my idea is to give
9 them the opportunity to discuss what their
10 experiences have been Act 13, what their
11 anticipations are with the reporting
12 requirements and we as a Board could use
13 that information in what we think is the
14 appropriate way to do what we believe our
15 charge is by Act 13 to establish this
16 reporting system. So I don't think we're
17 really in great disagreement. It may be
18 your interpretation of what I'm suggesting
19 is not accurate. I think it would be very
20 valuable for us to hear from these folks to
21 get a better sense of what their experiences
22 have been.

23 MR. MESSER:

1 I don't disagree with that. I think we need
2 as much information as we can possibly get
3 from every source that we can get it from.
4 I'm questioning the time at which we
5 recommend or we request that information.
6 I'm currently involved in a lot of
7 institutional debates with the state
8 government and I find that what happens
9 often is that an institution that's off to a
10 certain posture and it becomes written in
11 stone then all of a sudden the -- any attack
12 or any suggestion of change is met with
13 complete resistance. And I don't want us to
14 be in the position where we are as an
15 institution institutionally saying we want
16 to rely upon the people we're supposed to
17 police to give us the information or the
18 only source of information before we make
19 policy decisions.

20 DR. SMULLENS:

21 Rob, you know, I think if we go back to the
22 basic mission of the Authority which is a
23 learning organization, we're not the

1 oversight organization. That's still with
2 the Department of Health.

3 DR. MUSCALUS:

4 Well, you know, one more comment and then
5 I'm going to ask Mr. Henderson if he would
6 just comment on this. Mr. Messer you made
7 the comment about policing. We're not a
8 police organization. We don't...

9 MR. MESSER:

10 Wrong word to use.

11 DR. MUSCALUS:

12 Okay. And one of the things that I had said
13 very early on is we have to make sure that
14 the facilities that report to us have
15 confidence in the process and in what is
16 being done, and one way that we can show
17 them that we're serious about that is to
18 give them the opportunity to at least be
19 heard on what some of their issues are.
20 Clearly the Board has the authority to do
21 what we believe is the right thing to do. I
22 think we need as much information as
23 possible in order for us to make what we

1 think is the right decision. And I think
2 giving an opportunity to simply hear what
3 some of the issues are is a good thing, it's
4 a step in the right direction and ultimately
5 I think will result in a process that is
6 fair and one that is successful. Let me
7 just see if Mr. Henderson has any comment on
8 this.

9 MR. HENDERSON:

10 My comment would be is I don't see any of
11 these positions as being mutually exclusive.
12 I think you're quite correct that in setting
13 forth the foundation and the basic
14 philosophies and the basic standard
15 operating procedures that's certainly
16 within the province of the Patient Safety
17 Authority members, and you don't want to
18 cloud it unnecessarily with dross or any
19 input from outside entities that may have
20 agendas or biases that may cloud you as
21 you're setting forth your basic premise of
22 what you're doing and how to do it. Having
23 said that however, I think there is utility

1 when you're formulating -- trying to
2 implement a reporting procedure or a
3 statutory procedure that there is utility in
4 asking those who have engaged in other
5 reporting mechanisms to ask what their
6 experience has been that you can learn from
7 their experience. I think if you don't do
8 that you run a risk, as Dr. Muscalus has
9 mentioned, of a public relations problem
10 that you're setting arbitrary procedures in
11 a vacuum where there is experience that can
12 be learned from, not identical perhaps, but
13 at least analogous reporting mechanisms that
14 have taken place and that you can learn from
15 that experience. So I agree with both
16 positions quite frankly that, yes, from a
17 general perspective you don't want the
18 outside individuals who will be reporting to
19 you setting forth your agendas or writing,
20 you know, the basic underlying foundations
21 of what you do. But when it comes to
22 implementing some of your specific
23 procedures that have analogous procedures

1 already in place, that can be most help
2 experience, their experience. Not that you
3 would accept them in total, not that they
4 would have a veto power over what you do,
5 but I think the experience -- their
6 experience would be most helpful. I think
7 that's to be contrasted with what your
8 approach should be with prospective vendors.
9 Surely the vendors should not have an
10 ability to write a statement of work or have
11 input into the RFP and you should clearly
12 have one point of contact within the Patient
13 Safety Authority for dealing with vendors.
14 You do have problems -- if vendors are
15 getting mixed information or different
16 information from different Board members,
17 that can lead to problems in the awarding of
18 the RFP. So I would contrast the kind of
19 tight control in one kind of contact you
20 want with respect to vendors with respect to
21 looking at the population that's affected by
22 your policies and ensuring that they have at
23 least some input as you formulate your

1 policies going forward.

2 DR. MUSCALUS:

3 You know just one final comment on this. I
4 probably should have mentioned this under my
5 report. I was asked to go back to Florida
6 for a second time. Governor Bush has
7 established a task force that is looking to
8 deal with their own malpractice problems in
9 Florida and wanted to have input from what
10 we were doing in Pennsylvania. They asked
11 me to come back a second time, this time to
12 specifically talk about the patient safety
13 components of Act 13 and also on the Patient
14 Safety Authority. And I just want to again
15 reiterate that we're the first state in the
16 country to establish such an entity and I
17 think it's critical for us to make sure that
18 we go about our business with the intent of
19 doing it the right way, being deliberate and
20 making sure that we don't hurry through a
21 process just to get something done. And I
22 think we're moving in that direction. And
23 again I think a lot of other states are

1 watching what we do. I think we have a
2 great opportunity and I just want to make
3 sure we take advantage of that opportunity.

4 DR. POWERS:

5 Along those lines Rob, can I just throw out
6 that that's why I think it would be best not
7 to rush this process and to wait until we
8 can all meet just as the members of the
9 Board in executive session to really hash
10 out a lot of these issues. And really what
11 we're talking about is just three or four
12 weeks and then with that understanding a
13 little more firmly under our respective belt
14 and our collective belt we can then invite
15 all comment and input and data collection
16 that we feel is appropriate at that point.

17 DR. MUSCALUS:

18 Yes.

19 DR. POWERS:

20 I just don't want to see this process leave
21 a lot of doors open right now that we maybe
22 not have thought clearly through. And plus
23 I think we run the risk of making some

1 stakeholder groups feel disenfranchised
2 while others are empowered and I wouldn't
3 want that to be brought out either, you
4 know, that the doctors have input but the
5 patients don't or the -- you know, I
6 wouldn't want that process to start kind of
7 -- when we talk about trust I think it's
8 important that all the interested parties
9 feel that they have equal access because
10 that will build trust as well as the other
11 mechanisms we discussed.

12 DR. MUSCALUS:

13 Yes, I don't disagree with anything that
14 you've said. And I think at our next
15 meeting there will be ample opportunity to
16 have some of those deliberations.

17 DR. POWERS:

18 Okay.

19 END OF VERBATIM

20 ***

21 Report of Board Chair (Cont'd)

22 [Dr. Muscalus informed the Board that Governor Bush
23 has established a task force that is looking to deal

1 with their own malpractice problems in Florida. The
2 task force invited him back for a second time to
3 specifically talk about the patient safety components
4 of Act 13 and also about Pennsylvania's Patient Safety
5 Authority.]

6 ***

7 [A brief discussion was held concerning the next
8 meeting that will be held on January 13, 2003.]

9 ***

10 Adjournment

11 DR. POWERS:

12 I move to adjourn.

13 MS. KIENLE:

14 Second.

15 DR. MUSCALUS:

16 Is anyone opposed?

17 [The motion carried unanimously.]

18 ***

19 [The meeting was adjourned at 10:11 a.m.]

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Tim Wagner,
Minute Clerk,
York Stenographic Services

			PATIENT SAFETY AUTHORITY
			REFERENCE INDEX
			DECEMBER 9, 2002
		COUNTER	
	TIME	NUMBER	AGENDA
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8	9:36	0034	Call to Order, Robert Muscalus,
9			D.O., Chairman
10			
11	9:41	0353	Approval of Minutes of the
12			November 18, 2002, meeting
13			
14	9:42	0378	Report of Board Chairman, Robert
15			Muscalus, D.O.
16			
17	9:45	0520	Report of Board Administrator,
18			Alan Rabinowitz
19			
20	9:47	0680	RFP Update
21			
22	10:11		Adjournment
23			