

# STATE OF COLORADO

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Dedicated to protecting and improving the health and environment of the people of Colorado

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Colorado Department  
of Public Health  
and Environment

## HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION

### MINUTES.....

#### OCCURRENCE ADVISORY COMMITTEE MEETING Submitted by Sharon Haney and Sue Neff

**Date:** April 24, 2012

**Time:** 8:15 AM

**Place:** HFEMSD Training Room

**Attending:** Shelley Hitt, State Ombudsman  
Ann Kokish, St Andrew's Village  
Jeanne Crane, Children's Hospital  
Lisa Bennett, Sky Ridge Medical Center (for Diane Cookson)  
Jay Moskowitz, QLM  
Cynthia Haskell, QLM  
Mick Krantz, Presbyterian /St Luke's Medical Center  
Sharon Haney, CDPHE  
Larry Roblek, CDPHE  
Tracy Koller, CDPHE  
Sue Neff, CDPHE  
Kim Johnson, CDPHE, Patient Safety  
Judy Hughes, CDPHE, Section Chief  
Carol Cambria, CDPHE, Acute Program Manager

Sharon Haney brought the April 2012 Occurrence Advisory Committee Meeting to order at 8:15 AM, on April 24, 2012.

#### New Committee Members

Mick Krantz joins us from Presbyterian/St Luke's Medical Center where he is the Risk Manager. Ryan Burmood, Assistant Administrator from Woodridge Park Rehabilitation and Nursing Center, has also agreed to join the Committee but was unable to attend this meeting.

### **October 2011 Minutes**

There were no corrections to the Minutes.

### **Sharon Haney, Retirement**

Sharon introduced Kim Johnson as the “heir apparent” of the Occurrence Program. Sharon will be retiring at the end of July.

### **Physician Peer Review Discussion**

Judy Hughes and Carol Cambria were present at this meeting to discuss Peer Review at the hospitals. Sharon stated that when we changed the elements for neglect several years ago, facilities did start reporting the types of incidents we had hoped to capture. However, some of the hospital occurrences involve physician neglect or abuse allegations. The hospital sends these to Peer Review. We are then not able to obtain the information we need to ascertain if the facility has acted appropriately. Carol Cambria then explained that if the Occurrence Team is not getting enough information to determine that the hospital taking appropriate action, it becomes a complaint investigation. The Hospital Team then ends up citing under Governing Body, because that entity oversees everything in the hospital. They do not mention Peer Review in their deficiency; they stated that they looked at hospital documentation. Shelley Hitt asked how that was working and Carol stated that we do get some “push back” from the hospitals, but they have to be able to prove that they investigated, took some type of action with the physician, and reported to the Board of Medical Examiners when appropriate.

The advantage to providing this information in the occurrence report is that occurrence information is protected by statute. If the incident is turned into a complaint, the information is not as protected. The Committee suggested that we develop and distribute a guidance letter concerning this information.

### **Occurrence Reports**

Kim said that she likes the manner in which the reports are broken down by facility type. There were no comments about the occurrence numbers at this time.

The number of facilities/agencies expanded from 1929 facilities/agencies on 10/17/11 to 1969 facilities/agencies as of 4/5/2012. Home health agencies had the biggest increase in numbers.

### **Changes to the Occurrence Reporting Forms**

The forms are being reviewed and revised by the Patient Safety Team. The members of that team are mostly epidemiologists, and have the most experience using data. We will try to bring a report draft to the next Occurrence Advisory Committee meeting. We are still waiting for a new programmer to be hired to replace Susan Skutvik, and there is no time frame for when these reports might be put into place.

### **Elder Justice Act (EJA) Occurrences**

Jay Moskowitz asked if we are getting incidents reported under the EJA. We have only had 3 or 4 reported as such so far. These incidents must rise to the level of a criminal act, and most of the occurrences do not involve any charges being made.

### **Ambulatory Surgical Center Examples**

Jay said that he liked the idea of facility specific examples. Sue told him that we are in the process of developing examples for all the facility types, and they will be available on the Internet.

### **Next Meeting**

We will continue to meet on our current bi-yearly schedule for now. That might change in the future as some of the new projects begin.

The next meeting of the Occurrence Advisory Committee will be held on October 23, 2012, at 8:15 AM in the HFEMSD Training room.

#### **Possible Agenda:**

- New Reporting Form Draft
- Facility Specific Example
- Changes under the new Occurrence Program Manager?

The April 2012 Occurrence Advisory Committee Meeting was closed at 9:15 AM.

### **2012 Meetings**

October 23, 2012 – HFD Training Room