

Issue Brief – Patient Safety Initiative

HEALTH – HEALTH SYSTEMS IMPROVEMENT

DOH IB 08-06

SUMMARY

The Governor has proposed a Patient Safety Initiative to improve the health care in the state of Utah. The funding request for this initiative is \$77,400 ongoing General Fund.

OBJECTIVE

The objectives of this initiative are to:

- Provide ongoing monitoring of patient safety events;
- Improve surveillance methodologies;
- Establish state-wide interventions to improve patient safety;
- Provide ongoing leadership and influence at the national level.

DISCUSSION AND ANALYSIS

Estimates suggest that on average there are 300-400 deaths a year occurring as a result of patient safety events. Current reports are 30-40 per year, a ten fold underreporting.

Program History

On October 15, 2001 the Utah Department of Health instituted two Patient Safety Rules that impact hospitals and ambulatory care surgical centers. These rules were an outgrowth of several months of conversations with the local Utah Hospital Association in recognition of the numbers of medical errors identified by the Institute of Medicine in their 2000 report "To Err Is Human". The activities associated with these rules were absorbed by existing resources. Six years later over 200 Sentinel Events (wrong site surgeries, deaths, physical harm, suicides,) have been reported annually. Although this number is growing, it represents a significant underreporting according to the Institute of Medicine (IOM) methodology.

The current rules require that when a sentinel event is identified (one that results in death and/or major loss or permanent harm) they are reported to the Health Department and the facility must conduct a Root Cause Analysis (RCA) within 45 days of determination of the event. The findings and the action plan is then submitted to the Department and the facility

implements the plan. There is a user group made up of representatives of the hospital and ambulatory surgical centers who recommend what sentinel events are to be reported to the Health Department. Examples include wrong site surgeries, fires resulting in burns, falls, hospital acquired infections, suicides, abductions, device failures, etc all resulting either in death or major loss or permanent harm. The hospitals or ambulatory care centers conduct the investigations and pay for it through in-kind contributions with the use of their own staff and resources.

Additionally the rate of adverse drug events in Utah facilities is 4.416 per 100. The Department indicates that it needs ongoing and dedicated budget support from the state of Utah to improve its surveillance and identification of the accurate number of events occurring and to respond to the growing demands for patient safety involvement (Perinatal mortality, hospital acquired infections, long term care events, prescription based overdoses) to support state wide interventions to improve the safety of health care.

Funding Requirements

Additional funding would be necessary in order to conduct data analysis and state wide epidemiology on emerging safety issues.

The Department is currently funding 1/2 FTE. Without additional funding, the program will not be able to respond effectively to growing demands.

Additional healthcare sectors including perinatal deaths, ambulance services, emergency rooms, nursing homes, hospital acquired infections and other segments of the healthcare continuum have not been included in the current rules. Additional funding would be necessary.

LEGISLATIVE ACTION

The funding request of \$77,400 ongoing General Fund would increase the current FTE devoted to this activity to one full FTE. The additional resources would be used to increase surveillance and support the user group to develop and implement interventions to improve patient safety in Utah's medical facilities. An additional consideration would be to request contributions from the user group to supplement funds.