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NEWS RELEASE

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Utah Data Drives Improvement in Patient Safety

(Salt Lake City, UT) - There is growing recognition in health care research that there is room for improvement in patient safety, and Utah is no exception, according to a new report from the Utah Department of Health's (UDOH) Health Data Committee. Based on the Utah Hospital Discharge Database (UHDD), the report titled, "Adverse Events Related to Medical Care in Utah, 1995-99" provides preliminary information on care at 40 acute care hospitals in Utah. Looking at Utah data is a first step in improving the safety of Utah's health care system.

Fortunately, Utah hospitals and the UDOH are already partnering to address the issue of patient safety and formulate practical solutions to improve and prevent adverse outcomes. The Utah Hospital and Health Systems Association and Utah Medical Association organized a Utah Hospital Patient Safety Task Force, taking initiative to prevent medical errors in hospital care. The efforts will be continued by two proposed UDOH administrative rules that the Task Force has endorsed. The rules will be published in mid-June 2001 and will be available for public comment until September 28. These proposed rules require hospitals to set up a patient safety-reporting program and to report adverse drug events. The UDOH's Utah Health Data Committee is committed to monitoring these efforts through its research reports on this issue.

The "Adverse Events Related to Medical Care in Utah, 1995-99" report shows that from 1995 to 1999 in Utah, about one in 250 hospital discharges or 4,248 patients had a "misadventure of surgical and medical care." An overwhelming majority of those (93% or 3,939 discharges) involved cuts,

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punctures, or perforations during medical care. A total of 60,000 (6 % of all discharges) involved other complications of medical and surgical procedures. Finally, 25,000 discharges (2.5 %) involved complications due to medications.

Patients with adverse events and complications were about 2.5 times more likely to die in the hospital than patients as a whole. While 1.39 percent of all patients died while in the hospitals, 3.58% of patients with misadventures of surgical and medical care; 3.04% with complications of medical and surgical procedures; and 1.71% with medication complications died in the hospital. It can't be determined from the data to what extent adverse events increase the likelihood of death and to what extent patients who are sick and more likely to die are at greater risk of an adverse event.

The report also found that older patients were at a higher risk, probably because they tended to have more complex conditions than other patients. A slightly greater proportion of males suffered adverse events than females. However, the actual number of adverse events was considerably higher for women because they were hospitalized more often than were men.

The availability of relevant data is a necessary ingredient for meeting the patient safety challenges being pursued by the Patient Safety Task force and Utah hospitals. This report provides preliminary estimates of rates of adverse events and some subgroup differences.

Although the data lack clinical details and do not reflect "true prevalence," the information presented in this exploratory study plays an important role in providing baseline information for all hospitals in Utah, enhancing public awareness of the importance of addressing patient safety and measuring the success of the Task Forces efforts.

The report and administrative rules are available to the public at <http://www.healthdata.state.ut.us>.

(Please see additional Release attached)

*The Following News Release was issued
by the Utah Hospital Association and
the Utah Medical Association*

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FOR IMMEDIATE RELEASE
June 6, 2001

UHA-UMA TASK FORCE ANNOUNCES TWO NEW PATIENT SAFETY PROGRAMS

Salt Lake City—UHA, Utah Hospitals and Health Systems Association and the Utah Medical Association have announced their support of two new programs aimed at improving the safety of patients and reducing errors in Utah's hospitals.

An Institute of Medicine (IOM) report released in November 1999 estimated that between 44,000 and 98,000 patients in U.S. hospitals die each year due to "medical errors." A later follow-up IOM report released in March 2001 proposed a major overhaul of the health care system aimed at overall quality improvement. It provided 13 recommendations that could assure the nation a new vision of safe, effective, patient-centered, timely, efficient and equitable health care delivery.

For decades Utah hospitals have been making major strides in improving health care quality through reliance upon proven quality assurance/improvement guidelines and practices, effective risk management policies, innovative Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements and other such initiatives. Nevertheless, when the IOM reports were issued, UHA, Utah Hospitals and Health Systems Association (UHA), and the Utah Medical Association (UMA) convened a jointly-sponsored task force to re-examine patient safety practices and to create and recommend additional tactics to improve and assure continued patient safety.

In addition to consumers, representatives of hospitals, health systems and physicians, other representatives on the UHA-UMA Patient Safety Task Force included:

- Altius Health Plans (AHP)
- American Association of Retired Persons (AARP)
- HealthInsight, Inc. (HI)
- Utah Department of Commerce (UDC) - Occupational & Professional Licensing
- Utah Department of Health (UDOH) - Executive Director's Office
- Utah Dept. of Human Services, Division of Aging/Adult Services
- Utah Nurses Association (UNA)
- Utah Pharmaceutical Association (UPA)
- Utah Society of Hospital Pharmacists (USHP)

At the conclusion of several meetings, the task force proposed creation of a Facility Patient Safety Program and a Patient Safety Sentinel Event Reporting Program. Both of these initiatives are presently in draft rule format, about to be taken through the rule-making process by the Utah Department of Health (UDOH).

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According to the report “To Err is Human: Building a Safer Health System,” medical errors are estimated to cost the nation more than \$37.6 billion each year, of which \$17 billion are attributable to preventable errors. Adverse drug events (ADEs) are common in hospital care and medication errors play a key role in these events. ADEs include overdoses, allergic/ idiosyncratic reactions, drug-drug interactions, and errors in route, rate, timing or patient. Increased inpatient hospital costs alone of preventable ADEs are costing about \$2 billion for the nation as a whole. One study in a Salt Lake City hospital disclosed that ADEs complicated 2.43% of hospital admissions and elevated hospital costs (an excess of \$2,013/per case), prolonged hospital stays, and yielded higher risk of mortality. Elsewhere, ADEs occurred in 1.43% of admissions, 28% of which were preventable.

Because ADEs are a significant problem and to address it first, the task force endorsed the UDOH Facility Patient Safety rule. The Facility Patient Safety rule would require all hospitals and ambulatory surgical centers to have a patient safety program with effective internal processes to identify and report to the UDOH all adverse drug events. Each hospital’s program will be audited at least once every three years by an independent auditor approved by the UDOH’s Facility Licensing Committee. There are other known sources of medical errors, which may eventually added to the reporting requirement so that programs can be developed to lessen their impacts, i.e., hospital-acquired infections (post-operative, urinary tract, lower respiratory, etc.); deep venous thrombosis/pulmonary embolism; bed sores; loss of strength, agility and cognition; blood product transfusion; management of patients in extremis, and other (fluid/electrolyte management, anesthesia/procedures, etc.).

The Patient Safety Sentinel Event Reporting rule would require the same facilities to report serious patient injuries (e.g., wrong patient or wrong body part surgery, suicide, abduction of a patient, alleged sexual assault of a patient, etc.) and to allow an independent, external review by the UDOH to assure the thoroughness and credibility of the processes used by the hospital in the investigation and response to these events, often referred to as “root cause analyses.”

The reporting requirements for both of these programs will help the UDOH and providers understand patterns of system failures and enable statewide improvements to reduce the incidence of patient injuries. It is anticipated that these new programs will take effect around October 1, 2001, following a public comment period.

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