



04 - 0253

*Protecting, maintaining and improving the health of all Minnesotans*

January 26, 2004

The Honorable Steve Kelley  
Minnesota Senate  
205 Capitol  
75 Dr. Martin Luther King Jr. Blvd.  
St. Paul, MN 55155-1606

The Honorable Lynda Boudreau  
Minnesota House of Representatives  
559 State Office Building  
100 Dr. Martin Luther King Jr. Blvd.  
St. Paul, MN 55155-1206

Dear Senator Kelley and Representative Boudreau:

Significant progress has been made in implementing Minnesota's Adverse Health Events Reporting Law. Much work remains as we move toward full implementation of this law scheduled for July 1, 2004. This letter provides an overview of the work done to date and a summary of the next steps in moving forward to full implementation.

The Minnesota Department of Health (MDH) believes firmly that this law and the efforts surrounding its implementation are a change from past regulatory practice and represent the best opportunity we have to identify serious problems in the health care system and prevent them from occurring again. MDH also recognizes the need to carefully balance the goals of health system quality improvement and accountability in the implementation of this law.

**Non-State Funds Secured:**

As required by law, non-state funds have been secured to begin the implementation of the reporting system. The effort to secure these funds was lead by the Minnesota Hospital Association (MHA). MHA was able to build a broad coalition to support this effort. The organizations across the state who have contributed to this effort include; Blue Cross Blue Shield of Minnesota, Midwest Medical Insurance, the Buyers Health Care Action Group, Stratis Health and St. Jude Medical Foundation. Efforts to raise funds for the second year of implementation are well underway. As a result of this fundraising effort the Minnesota Department of Health has hired a senior staff member to oversee the implementation of the law.

**Reporting System Development:**

MHA has also developed a preliminary electronic reporting system for reporting the adverse events defined in the law and has begun receiving reports of these incidents. The law requires a summary of incidents by type be provided to the legislature. A copy of these events is attached to this letter.

General Information: (651) 215-5800 ■ TDD/TYY: (651) 215-8980 ■ Minnesota Relay Service: (800) 627-3529 ■ [www.health.state.mn.us](http://www.health.state.mn.us)

For directions to any of the MDH locations, call (651) 215-5800 ■ An equal opportunity employer

January 26, 2004  
Page Two

MDH and the hospitals have encountered a number of issues related to the complexity and sensitivity involved in transitioning from the old VAA requirements to the new adverse events system. MDH will focus a significant amount of time in the upcoming weeks working with the Hospital Association and the hospitals to clarify the issues during this transition period and to get hospitals reporting the required events to MDH by July 1<sup>st</sup> under the full implementation of the law.

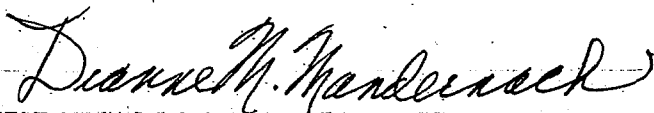
**Community Input on Reports, Feedback & Health System Improvement:**

The next major undertaking by MDH will be to refine and develop the reporting system to meet the requirements outlined in the law. MHA has done a tremendous amount of work to date to get the initial system up and running. We will work closely with them as we move to full implementation of the law and the reports required to MDH. At this point, we presume that the system we will have up and running by July 1 will need further refinement and updates as we get input from the hospitals, other health care stakeholders and the community. We seek out this broad input and will look for the "best practices" in other states and at a federal level, always keeping in mind that this reporting system is only one facet of the broader patient safety initiatives taking place in health care settings.

MDH believes firmly that, with the input of hospitals, providers, purchasers, consumers and patients we can develop a system for preventing harm to patients in Minnesota's hospitals. MDH will use this community input to develop a meaningful way to analyze and communicate the leanings from this reporting system.

We value your input and recommendations as we implement the Adverse Health Events Reporting law. Please feel free to contact us at any time. The Department's primary contact for the implementation of the Adverse Health Events Reporting law is Marie Dotseth, Senior Policy Advisor for Patient Safety. Marie's phone number is 651-297-7733. You may always contact me as well at 651-215-5806.

Sincerely,



Dianne M. Mandernach  
Commissioner  
P.O. Box 64882  
St. Paul, MN 55164-0882

**MHA Patient Safety Registry for Adverse Health Care Events in Minnesota**

Events Captured as of 1/22/2004

<u>Count</u>	<u>Event Type</u>
<u>2003</u>	
1	Care Management - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
2	Care Management - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
3	Care Management - Patient Death or Serious Disability associated with hypoglycemia
4	Care Management - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
5	Care Management - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
6	Environmental Events - Patient Death or Serious Disability associated with a fall while being cared for in a healthcare facility
7	Surgical Events - Wrong surgical procedure performed on a patient
8	Surgical Events - Retention of a foreign object in a patient after surgery or other procedure
9	Patient Protection - Suicide or attempted
10	Care Management - Hypoglycemia
11	Surgical Events - Wrong surgical procedure performed on a patient
12	Surgical Events - Retention of a foreign object in a patient after surgery or other procedure
13	Surgical Events - Retention of a foreign object in a patient after surgery or other procedure
14	Care Management - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
<u>2004</u>	
15	Patient Protection - Suicide or attempted