UTAH DEPARTMENT OF HEALTH

Patient Safety Surveillance and Improvement Program (PSSIP)

Carl Letamendi
OHCS Director, UDOH

August 21, 2020

SPECIAL THANKS

- Navina Forsythe, Director Center for Health Data and Informatics
- Mary Dy, Contracts & Project Manager
- Lori Savoie, Business Informatics Lead
- Brantley Scott, Data Quality Project Manager
- Sterling Petersen, Analytics Lead
- Sri Bose, Research Consultant III & Economic Analyst

MISSION & VISION

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Our vision is for Utah to be a place where *all* people can enjoy the best health possible, where *all* can live and thrive in healthy and safe communities.

STRATEGIC PRIORITIES

Healthiest People – The people of Utah will be among the healthiest in the country.

Optimize Medicaid – Utah Medicaid will be a respected innovator in employing health care delivery and payment reforms that improve the health of Medicaid members and keep expenditure growth at a sustainable level.

A Great Organization – The UDOH will be recognized as a leader in government and public health for its excellent performance. The organization will continue to grow its ability to attract, retain, and value the best professionals and public servants.

ABOUT THE OFFICE OF HEALTH CARE STATISTICS

Office of Health Care Statistics oversight includes:

- **Collect:** We collect and produce data that are relevant and useful to our stakeholders
- **Analyze:** We create valuable enhancements to our data resources and our systems have the analytic capacity to transform them into useful information
- **Disseminate:** We make the data and information we collect and produce available to the *right people* at the *right time* for the *right purposes*

Responsible for the following data series:

- **CAHPS** – Annual customer satisfaction surveys relating to health plan performance.
- **HEDIS** – Annual quality measures relating to health plan performance.
- **Healthcare Facility Data** – A collection of information about all inpatient, emergency room, and outpatient surgery/diagnostic procedures performed in the State.
- **All Payer Claims Data** – A collection of data about health care that is paid for by third parties, including insurers, plan administrators, and dental and pharmacy benefits plans.

UTAH ADMINISTRATIVE CODE

The rules that apply are:

- R380-200. Patient Safety Surveillance and Improvement Program (PSSIP).
- R380-210. Health Care Facility Patient Safety Program.
- R434-150. Adverse Events from the Administration of Sedation or Anesthesia; Recording and Reporting.

IMPROVING PATIENT SAFETY

The **possibility of a second surge of COVID-19** in a few weeks or months, is **bringing new urgency to these efforts**.

All hospitals must:

- **Assess** their current safety-related processes
- **Identify** optimization opportunities, and
- **Implement** new approaches that foster a safer environment

*July 15, 2020 **on PSQH** by David Goldsteen, MD*

2020 HOSPITAL PATIENT SAFETY REPORT

An **independent survey** of **100 hospital and health system leaders**

The Goal:

- **Learn** hospital front line **top patient safety challenges.**
- About **1,000 people will die from a preventable hospital error daily.**

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

2020 HOSPITAL PATIENT SAFETY REPORT – cont.

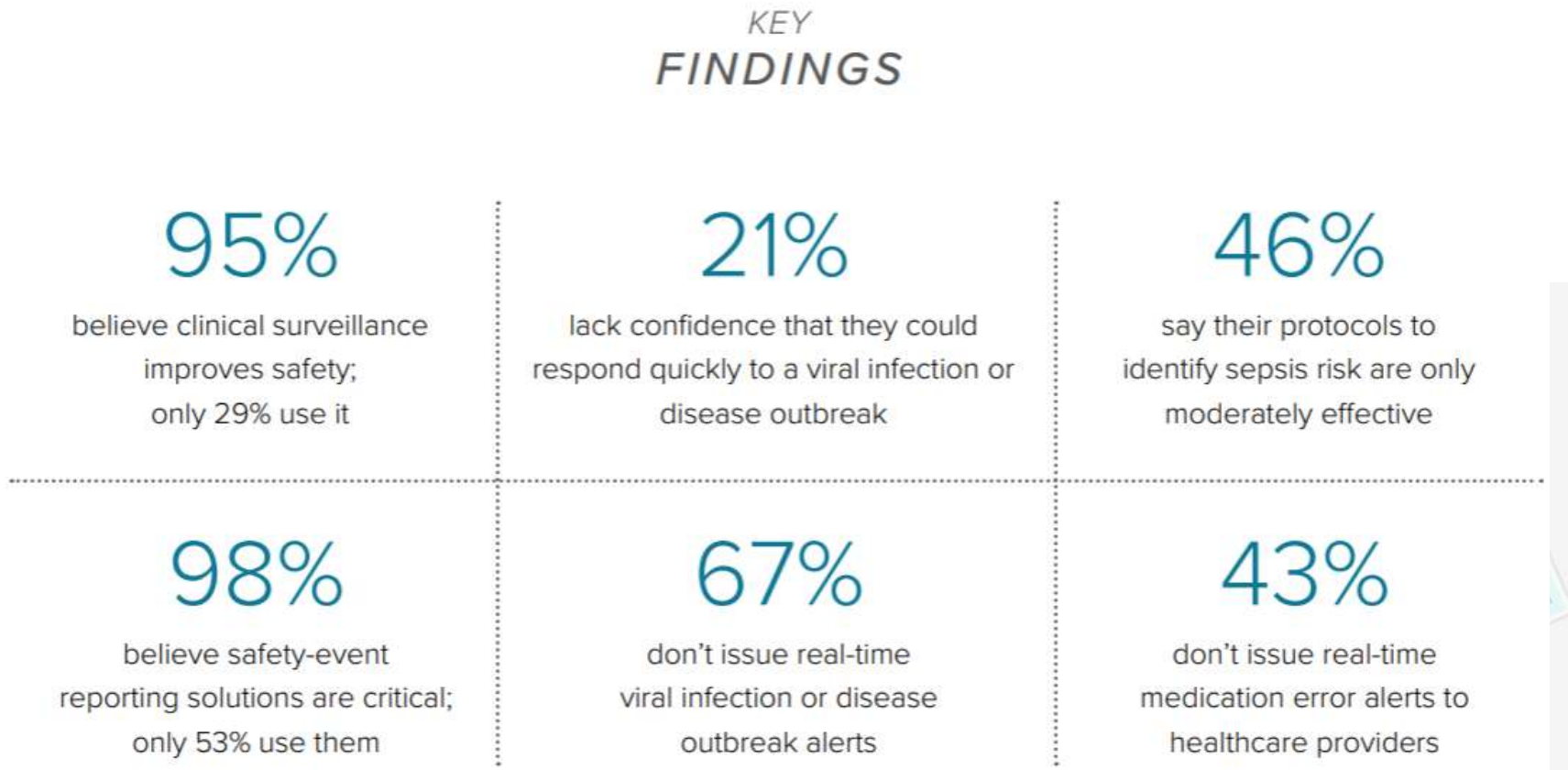
The report includes:

- **Where** the most **patient safety progress is occurring**
- **If technology** is **enhancing patient safety**
- **What** the most **successful** patient-safety **improvement approaches are**

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

KEY FINDINGS:

2020 Hospital Patient Safety Report



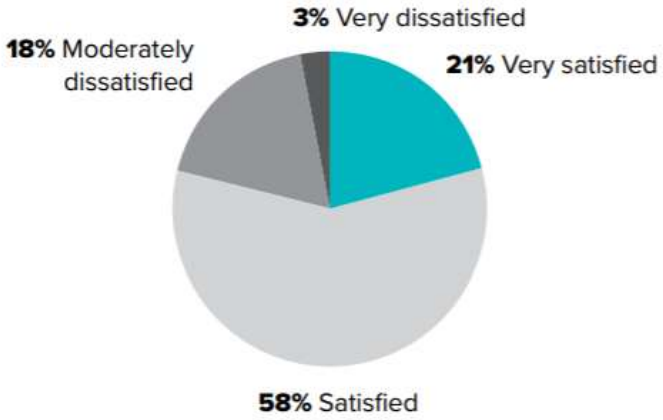
Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

KEY FINDINGS – cont.

2020 Hospital Patient Safety Report

Nearly **One-Quarter** of **Hospital and Clinical Leaders** are **Unhappy** with their **Organization's Safety Performance.**

How do you feel about your hospital's safety performance in 2019?



As a hospital leader, my confidence in the safety of U.S. hospitals, compared to a typical consumer, is:

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

KEY FINDINGS – cont.

2020 Hospital Patient Safety Report

Hospitals' top safety challenges: Medication Errors and Hospital-Acquired Infections (HAIs)

What is the biggest safety problem in hospitals?

#1 - Medication errors (28%)
#2 - HAIs and HACs (26%)
#3 - Failure to report safety events in a timely manner (18%)
#4 - Antibiotic overuse/nonoptimal use (12%)
#5 - Falls (11%)
#6 - Opioid over-prescribing/misuse/abuse (3%)
#7 - Other (2%)

What is your hospital's top safety improvement initiative in 2020?

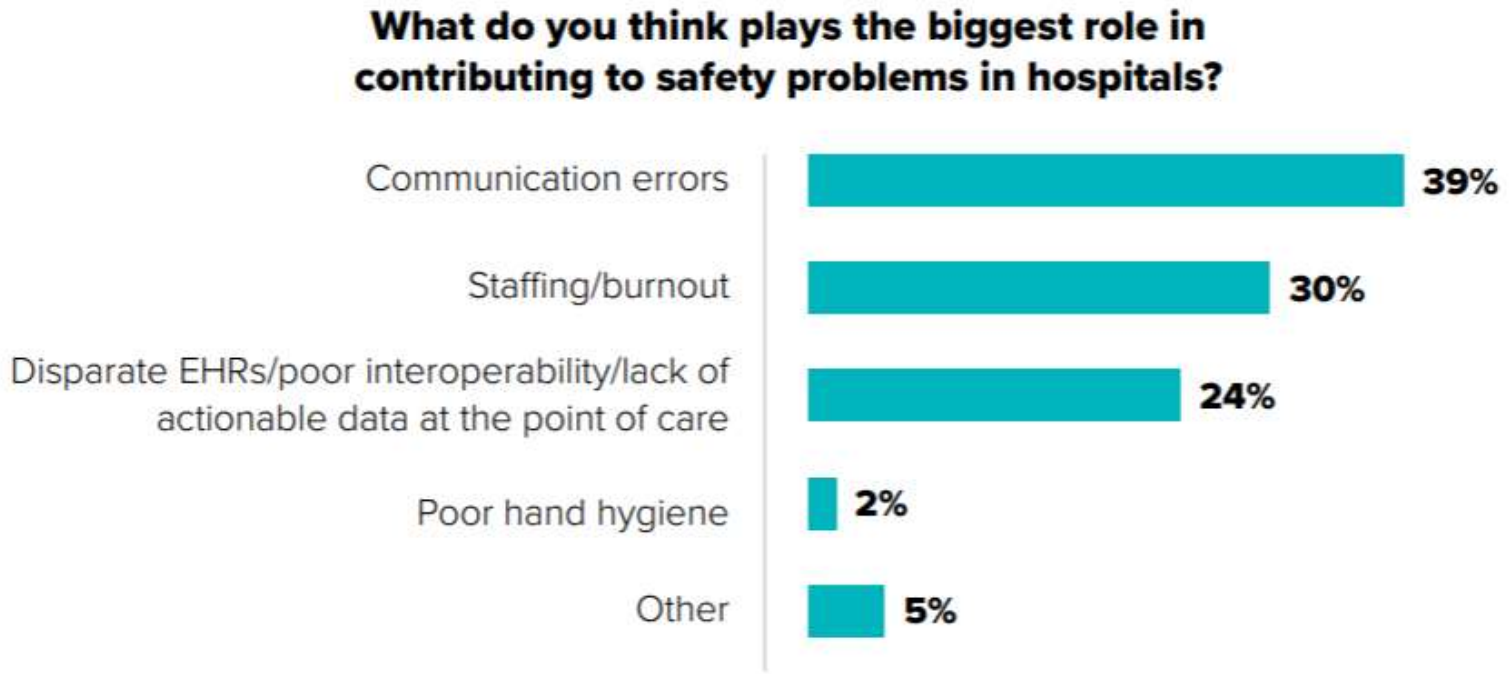
#1 - Reducing medication errors (29%)
#2 - Reducing HAIs and HACs (26%)
#3 - Reducing falls (18%)
#4 - Ensuring the reporting of safety events in a timely manner (16%)
#5 - Reducing antibiotic overuse/nonoptimal use (7%)
#6 - Reducing opioid over-prescribing/misuse/abuse (4%)

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

KEY FINDINGS – cont.

2020 Hospital Patient Safety Report

Top contributors: Communication Errors, Overworked Clinicians, and Technology Gaps



Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

KEY FINDINGS – cont.

2020 Hospital Patient Safety Report

Top three priorities to **improving patient safety**

What are your organization's top strategic priorities?

#1
Delivering high-quality care

#2
Increasing efficiency and reducing costs

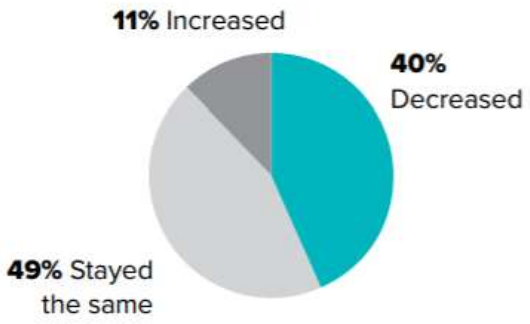
#3
Improving patient safety

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

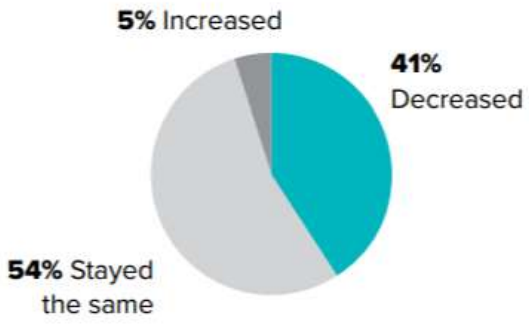
POSITIVE FINDINGS:
Patient Safety Improvements

Hospital and clinical leaders indicate **significant progress** in **reducing** Medication Errors, Sepsis Mortality, and Opioid Prescribing

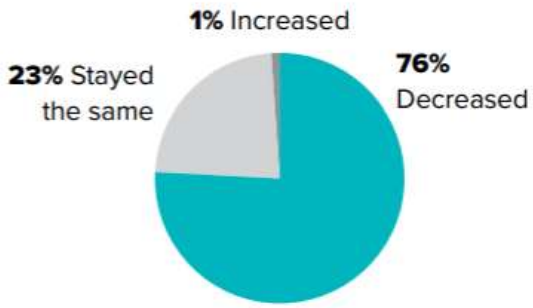
Over the past year, how have medication error rates changed at your hospital?



Over the past year, how have sepsis mortality rates changed at your hospital?



Over the past year, how have opioid prescribing rates changed at your hospital?

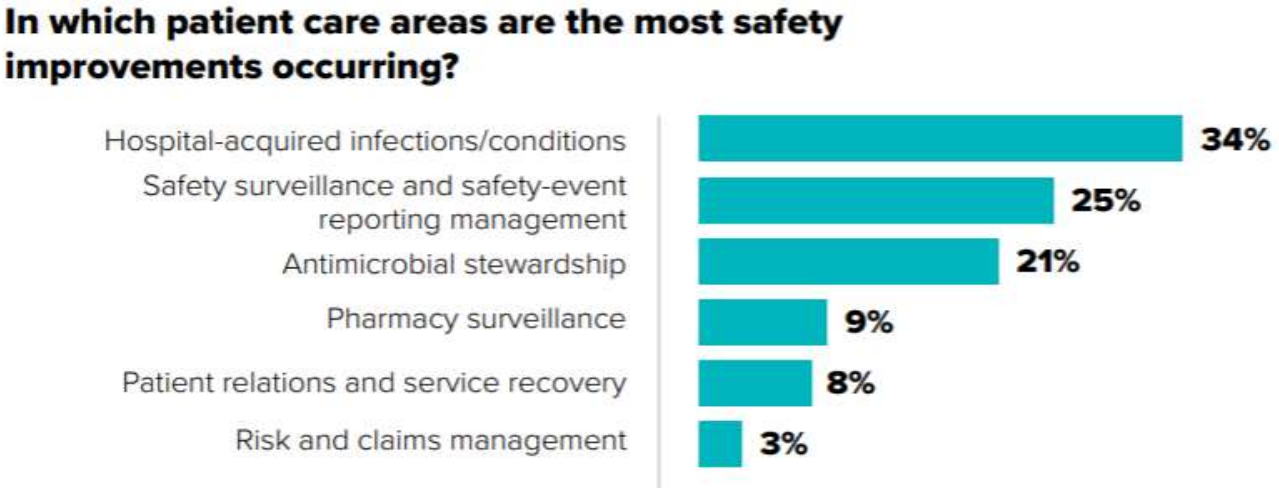


Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

POSITIVE FINDINGS: - cont.
Patient Safety Improvements

Top area to watch: Infection prevention is experiencing the most safety improvements

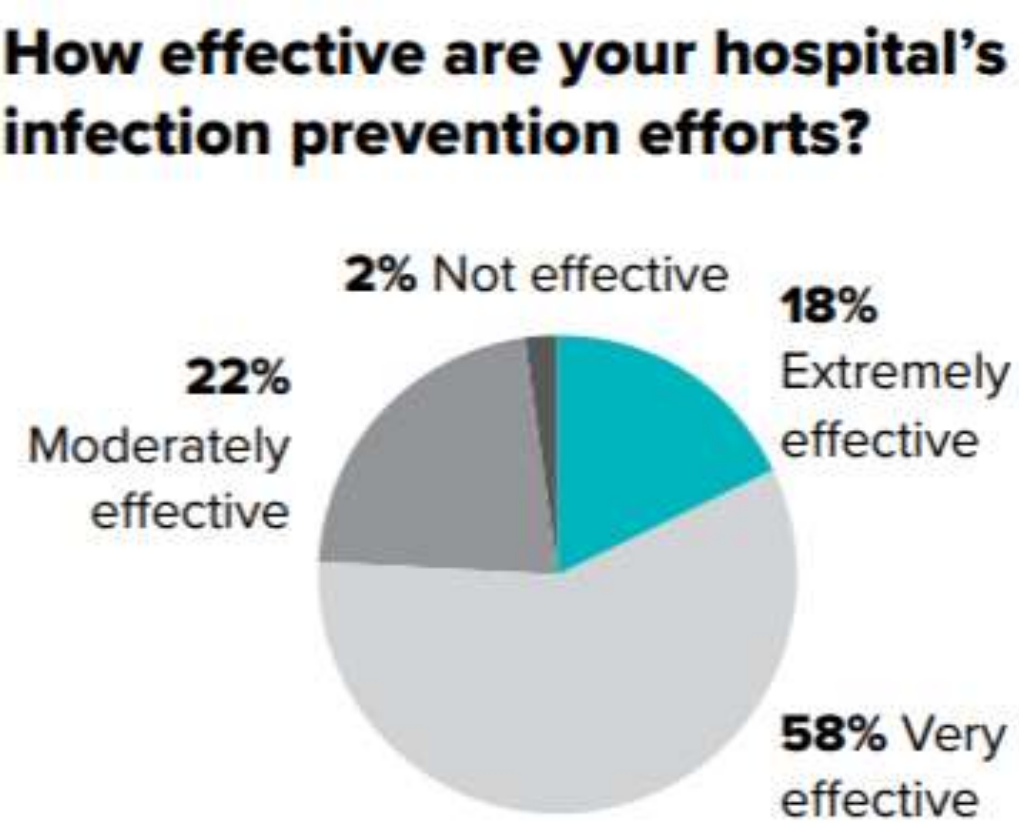
Biggest challenge: 76 percent also said their hospital's infection prevention **efforts are extremely or very effective.**



Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

POSITIVE FINDINGS - cont.

Patient Safety Improvements



Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

BIGGEST TAKEAWAYS

Time to **look beyond** for **safety support**

Top benefits:

- **Identifying** and **managing** safety **events**
- **Identifying** medication **errors**
- **Identifying** opportunities to **improve antibiotic use**
- **Ensuring** safer **opioid prescribing**

29% are **implementing** clinical **surveillance technology** and **95%** feel it **improves patient safety**

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

BIGGEST TAKEAWAYS

Hospitals that **use real-time alerts** have **stronger** safety **performance**.

Are more likely to:

- Say their **organization could respond** to a **viral** or **disease outbreak immediately**.
- Say their **process** for **identifying patients** at **risk for sepsis** is **very** or **extremely effective**.
- Say **medication error rates** and **opioid prescribing rates** had **fallen** in the **past year.**

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

BIGGEST TAKEAWAYS - cont

Hospital leaders say **safety-event reporting tools** are **critical to fostering improvement.**

- **98%** said a **robust safety-event management** system is **important** or very important **to supporting patient safety initiatives**.
- **50% use safety-event management tools** to **support safety improvement** efforts.
- **51%** said their **approach to safety-event reporting** is **extremely** or **very effective.**

These findings are particularly concerning given the possibility of a second COVID-19 surge.

Source: VigiLanz commissioned Sage Growth Partners, a healthcare consultancy
https://www.healthleadersmedia.com/clinical-care/three-things-every-hospital-should-be-doing-now-improve-patient-safety

PATIENT SAFETY EXCELLENCE AWARD 2020 Recipients

Peninsula Regional Medical Center: To **add capacity** in case of a **COVID-19 surge**, they **converted a vacant pediatric unit** next to the ED to an **8-bed ICU** and a **conference center** into a **44-bed ICU**. Nurses **improvised** by **building dividers with PVC pipes and black Hefty bags**. PRMC also **adapted** its **care transition and discharge processes** to prevent the virus from spreading throughout the community.

"*When COVID-19 first arrived, I was admitting in the ER and had no idea what I was looking at. I'm a hospitalist who has been in practice for 25 years. I felt like a first-year med student.*" Dr. Chris Snyder, DO

Cone Health System: One of the best things they did during the pandemic was **communicate — internally, to patients, their families, and the community**. The **zero-visitation policy** during the pandemic also drove home the **importance of communicating with family members during care transitions**.

"Hospitals are redoubling efforts to keep patients safe by increasing the use of UV robots, cleaning more areas more often and configuring waiting areas to accommodate social distancing. It could be a silver lining that by taking the steps to lower the risk of COVID-19 we have fewer healthcare associated infections of all types going forward." Bruce Swords, MD, PhD

Source: https://www.healthgrades.com/quality/patient-safety-excellence-award-2020-recipients

Patient Safety Excellence Award 2020 Recipients – cont.

Hackensack Meridian Jersey Shore University Medical Center: **New Jersey was hit hard by COVID-19** and being part of an **high reliability organization (HRO) culture helped prepare** their teams to meet and take COVID-19 head on. Confidence in knowing they were providing the best patient care possible helped clinicians through the most difficult times, even as they fought a little understood virus.

"We can't take our foot off the gas pedal and patient safety." Kenneth N. Sable, MD, MBA, FACEP

West Jefferson Medical Center: COVID-19 **patients** were **cohorted to two units**, with a **PPE czar outside** of the unit **24/7** to ensure **appropriate PPE** and **hand hygiene procedures** were followed upon entrance and exit. The hospital was **diligent in keeping patients** and **employees safe**, taking extra measures to ensure staff had appropriate and available PPE. **iPads** were also **used by physicians** for **telemedicine** at the bedside and within our clinics so they could **continue to address community healthcare needs.**

"*West Jefferson Medical Center is committed to the healthcare needs of our community.*" Darlene Gondrella

Source: https://www.healthgrades.com/quality/patient-safety-excellence-award-2020-recipients

Patient Safety Excellence Award 2020 Recipients – cont.

White Plains Hospital: Staff **loaned their iPads** and other **mobile devices to patients** so they **could communicate with their loved ones**. Being able to communicate with friends and family they feared they would never see again brought smiles and tears of happiness to patients' faces — and staff members' too. After seeing the impact of the video chats, White Plains Hospital wanted to **make sure patients would feel as loved as possible in their final hours.** Thanks to these efforts, patients who had once felt defeated became more involved in their care and less anxious about not seeing their family.

"Patients fought harder to beat COVID-19 and many of them were able to return home to their loved ones." Michael Gelormino

Maine General Health: Staff have **never lost focus** on **providing the best care to every patient. Leaders** have made every **effort to give additional support and help staff** to balance work, family, and their own fears.

"Our employees have stepped forward to make sure we're taking care of our community and each other. They are true heroes." Chuck Hays

Source: https://www.healthgrades.com/quality/patient-safety-excellence-award-2020-recipients

Patient Safety Excellence Award 2020 Recipients – cont.

PIH Health: To **keep the community informed** during the pandemic, PIH Health **provided community health officials** with COVID-19 **case volume and count information.** The organization also **provided** as much **remote care as possible**. Instead of treating patients when they first experience symptoms, clinicians are seeing patients with late-stage diseases.

"*We also hope that the American public will stop letting fear of COVID-19 prevent them from coming to hospitals for the care they need, when they need it.*" Chief Medical Officer Dr. Jaime Diaz

Source: https://www.healthgrades.com/quality/patient-safety-excellence-award-2020-recipients

CURRENT DATA: OCCURRENCE CATEGORY

Number of Events Reported, by Year and Occurrence Category

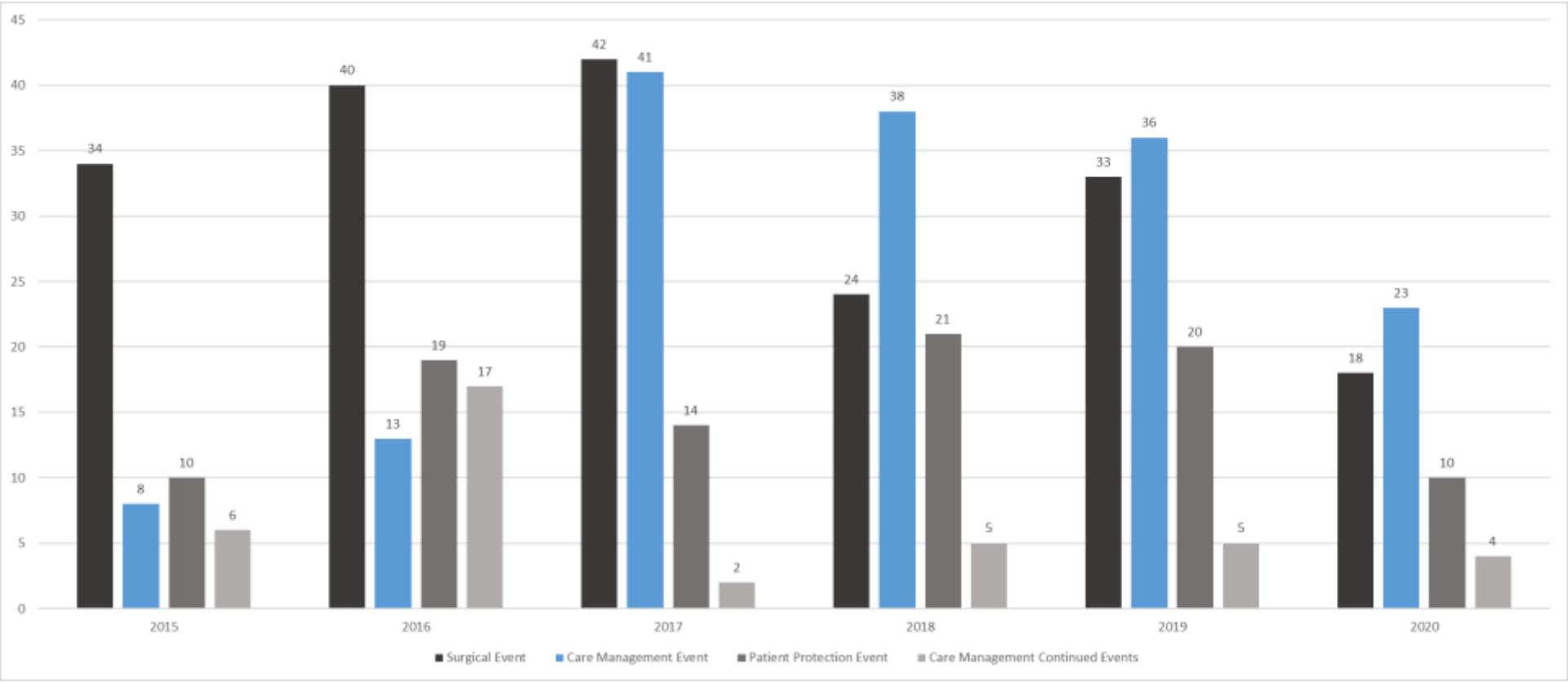
Occurrence Category	2015	2016	2017	2018	2019	2020	Total
Surgical Event	34	40	42	24	33	18	191
Care Management Event	8	13	41	38	36	23	159
Patient Protection Event	10	19	14	21	20	10	94
Care Management Continued Events	6	17	2	5	5	4	39
Unknown	6	6	1	8	7	3	31
Not Sentinel Event	0	0	1	0	1	1	3
Product Device Event	2	3	5	9	10	2	31
Criminal Event	1	1	2	7	4	2	17
Environmental Event	1	5	1	4	1	4	16
							581

Legend:
Dark red denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

CURRENT DATA: OCCURRENCE CATEGORY

Over the years, the **main driver of adverse patient events were surgical events**. In recent years**, care management events have overtaken surgical events as the leading cause** of reported adverse patient events. This chart represents the number of surgical, case management, and patient protection events reported from **2015 to date**.



Source: REDCap/Patient Safety Database, UDOH

CURRENT DATA: CONTRIBUTING FACTORS

Reported Contributing Factors, by Year

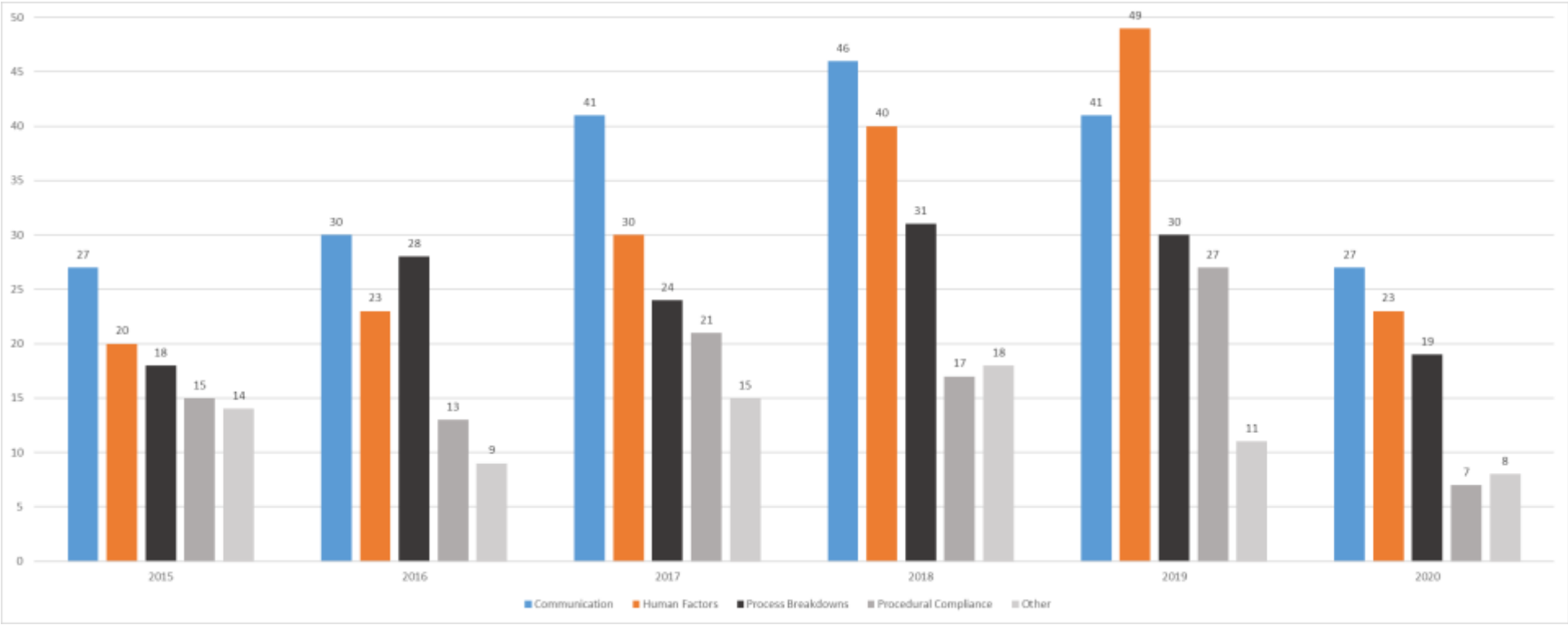
Contributing Factors	2015	2016	2017	2018	2019	2020	Total	Percent
Communication	27	30	41	46	41	27	212	16.6%
Human Factors	20	23	30	40	49	23	185	14.5%
Process Breakdowns	18	28	24	31	30	19	150	11.8%
Procedural Compliance	15	13	21	17	27	7	100	7.8%
Other	14	9	15	18	11	8	75	5.9%
Patient Assessment	8	11	17	12	14	6	68	5.3%
Availability of Info	15	11	21	7	4	4	62	4.9%
Equipment - List Equipment used	5	9	7	8	6	6	41	3.2%
Failure to recognize changes	6	11	15	10	8	5	55	4.3%
Orientation / Competency / Training	3	10	11	11	14	5	54	4.2%
Care Planning	4	5	8	11	13	7	48	3.8%
Lack of Monitoring	4	9	8	8	13	6	48	3.8%
Organization Culture	2	12	6	10	12	4	46	3.6%
Environ. Safety / Security	7	6	11	8	6	3	41	3.2%
Continuum of Care	0	1	3	14	7	5	30	2.4%
Device Breakdowns	3	5	6	3	3	1	21	1.6%
Staffing	3	2	5	1	6	1	18	1.4%
Leadership	0	1	1	9	8	1	20	1.6%
							1274	

Legend:
Darker red denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

CURRENT DATA: CONTRIBUTING FACTORS

Communication issues and **Human Factors** have been the **top 2 reported** contributing factors to **adverse patient events** through the years. The following chart represents the number of top reported contributing factors for patient safety events, by year, from 2015 to date.



Source: REDCap/Patient Safety Database, UDOH

CURRENT DATA: ACTIONS TAKEN

Reported Actions Taken, by Year

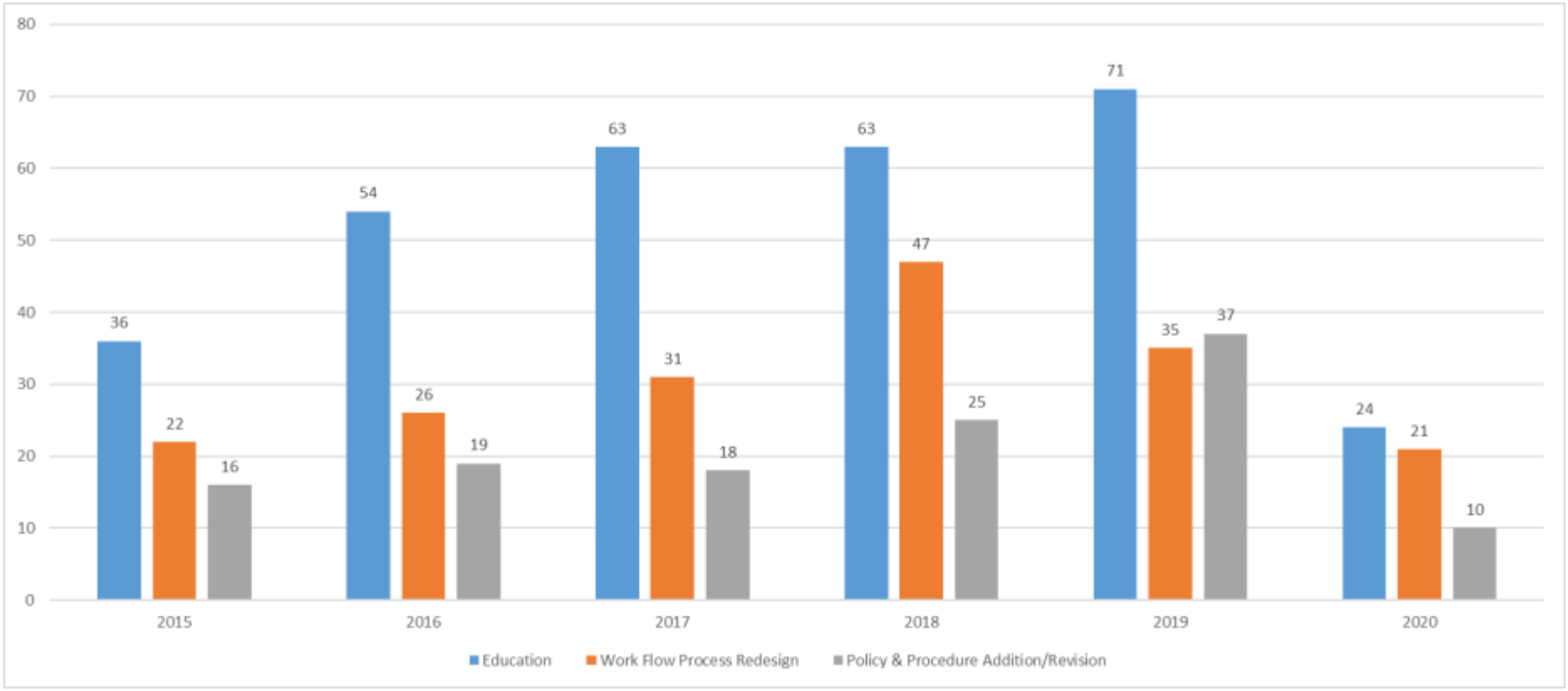
Actions Taken	2015	2016	2017	2018	2019	2020	Total	Percent
Education	36	54	63	63	71	24	311	35.1%
Work Flow Process Redesign	22	26	31	47	35	21	182	20.6%
Policy & Procedure Addition/Revision	16	19	18	25	37	10	125	14.1%
Other	19	13	9	27	21	7	96	10.8%
Documentation Changes Other	5	1	7	12	9	5	39	4.4%
Documentation Changes Checklist	4	4	8	8	6	2	32	3.6%
Information System Change	3	1	2	6	8	3	23	2.6%
Documentation Changes Charting Tool	3	4	5	3	6	3	24	2.7%
Staffing Changes	0	5	7	2	5	1	20	2.3%
Equipment taken out of service	1	5	5	4	3	2	20	2.3%
Documentation Changes Form	1	3	2	2	4	1	13	1.5%
							885	

Legend:
Darker green denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

CURRENT DATA: ACTIONS TAKEN

Education after an adverse patient event was the **most common action taken**. However **Work Flow Process Redesign** is **increasing through the years**. The following chart represents the number of top reported actions taken following a patient safety event, by year from 2015 to date.



Source: REDCap/Patient Safety Database, UDOH

DEEPER DIVE: ACTIONS TAKEN FOR COMMUNICATION ISSUES

Communication issues

Actions Taken	2015	2016	2017	2018	2019	2020	Total	Percent
Education	18	21	30	36	32	18	155	36.6%
Work Flow Process Redesign	14	9	12	23	19	17	94	22.2%
Policy & Procedure Addition/Revision	8	9	5	15	17	8	62	14.6%
Other	7	0	1	10	7	2	27	6.4%
Documentation Changes Other	3	1	4	8	5	4	25	5.9%
Documentation Changes Checklist	3	3	1	5	3	2	17	4.0%
Information System Change	2	0	1	3	7	2	15	3.5%
Documentation Changes Charting Tool	2	2	2	1	3	2	12	2.8%
Staffing Changes	0	0	2	2	4	1	9	2.1%
Equipment taken out of service	1	1	0	0	0	0	2	0.5%
Documentation Changes Form	0	1	1	0	3	1	6	1.4%

Legend:
Darker green denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

DEEPER DIVE: ACTIONS TAKEN FOR HUMAN FACTORS

Human Factors

Actions Taken	2015	2016	2017	2018	2019	2020	Total	Percent
Education	11	11	22	28	36	15	123	31.5%
Work Flow Process Redesign	9	10	17	23	20	10	89	22.8%
Policy & Procedure Addition/Revision	3	7	9	11	17	6	53	13.6%
Other	9	3	3	11	9	5	40	10.3%
Documentation Changes Other	1	1	5	6	3	5	21	5.4%
Documentation Changes Checklist	2	2	5	4	4	1	18	4.6%
Information System Change	1	0	1	6	5	1	14	3.6%
Documentation Changes Charting Tool	2	2	3	1	4	2	14	3.6%
Staffing Changes	0	2	4	1	1	1	9	2.3%
Equipment taken out of service	1	1	0	0	1	0	3	0.8%
Documentation Changes Form	0	0	1	1	3	1	6	1.5%

Legend:
Darker green denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

DEEPER DIVE:
CONTRIBUTING FACTORS FOR SURGICAL EVENTS

Surgical Event

Contributing Factors	2015	2016	2017	2018	2019	2020	Total	Percent
Communication	16	14	21	13	17	8	89	20.6%
Human Factors	10	10	14	11	19	9	73	16.9%
Process Breakdowns	14	12	11	8	13	9	67	15.5%
Procedural Compliance	9	6	12	9	8	3	47	10.9%
Other	7	3	5	0	1	2	18	4.2%
Patient Assessment	1	1	3	1	1	1	8	1.9%
Availability of Info	8	6	10	4	2	2	32	7.4%
Equipment - List Equipment used	3	1	3	2	2	2	13	3.0%
Failure to recognize changes	2	1	3	1	2	1	10	2.3%
Orientation / Competency / Training	2	3	6	3	2	3	19	4.4%
Care Planning	3	3	1	1	2	2	12	2.8%
Lack of Monitoring	1	0	0	0	0	0	1	0.2%
Organization Culture	1	3	2	2	4	2	14	3.2%
Environ. Safety / Security	0	0	0	0	0	1	1	0.2%
Continuum of Care	0	0	0	1	1	1	3	0.7%
Device Breakdowns	2	3	1	1	0	0	7	1.6%
Staffing	1	2	2	0	2	1	8	1.9%
Leadership	0	0	1	4	4	0	9	2.1%
							431	

Legend:
Darker red denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

DEEPER DIVE: CONTRIBUTING FACTORS FOR CARE MANAGEMENT EVENTS

Care Management Event

Contributing Factors	2015	2016	2017	2018	2019	2020	Total	Percent
Communication	3	5	10	15	11	10	54	14.5%
Human Factors	2	3	10	18	14	5	52	13.9%
Process Breakdowns	0	3	11	15	7	6	42	11.3%
Procedural Compliance	0	0	5	3	7	2	17	4.6%
Other	2	1	7	7	3	3	23	6.2%
Patient Assessment	2	1	9	7	6	3	28	7.5%
Availability of Info	2	0	5	2	0	1	10	2.7%
Equipment - List Equipment used	0	3	4	2	2	1	12	3.2%
Failure to recognize changes	1	4	6	6	3	1	21	5.6%
Orientation / Competency / Training	0	5	3	3	6	0	17	4.6%
Care Planning	0	0	5	4	6	2	17	4.6%
Lack of Monitoring	1	4	7	3	5	3	23	6.2%
Organization Culture	0	1	4	4	6	0	15	4.0%
Environ. Safety / Security	3	3	7	1	3	1	18	4.8%
Continuum of Care	0	0	2	6	2	1	11	2.9%
Device Breakdowns	0	0	1	0	0	0	1	0.3%
Staffing	1	0	1	1	3	0	6	1.6%
Leadership	0	0	0	2	4	0	6	1.6%

Legend:
Darker red denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

Deeper Dive: Actions Taken for Surgical Events

Surgical Event

Actions Taken	2015	2016	2017	2018	2019	2020	Total	Percent
Education	20	19	22	12	24	7	104	33.9%
Work Flow Process Redesign	14	14	13	11	15	5	72	23.5%
Policy & Procedure Addition/Revision	9	7	5	9	12	4	46	15.0%
Other	8	3	3	3	7	4	28	9.1%
Documentation Changes Other	3	0	3	1	4	3	14	4.6%
Documentation Changes Checklist	1	3	2	5	2	1	14	4.6%
Information System Change	1	0	0	3	2	2	8	2.6%
Documentation Changes Charting Tool	1	1	2	0	2	1	7	2.3%
Staffing Changes	0	3	3	0	1	0	7	2.3%
Equipment taken out of service	1	1	1	0	0	0	3	1.0%
Documentation Changes Form	0	3	0	0	0	1	4	1.3%

Legend:
Darker green denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

Deeper Dive: Actions Taken for Care Management Events

Care Management Event

Actions Taken	2015	2016	2017	2018	2019	2020	Total	Percent
Education	3	11	24	24	19	8	89	35.9%
Work Flow Process Redesign	0	3	16	16	8	8	51	20.6%
Policy & Procedure Addition/Revision	0	6	8	10	10	1	35	14.1%
Other	5	0	2	9	3	2	21	8.5%
Documentation Changes Other	0	0	3	6	3	1	13	5.2%
Documentation Changes Checklist	0	1	5	2	0	0	8	3.2%
Information System Change	0	0	2	2	2	0	6	2.4%
Documentation Changes Charting Tool	1	0	3	2	3	1	10	4.0%
Staffing Changes	0	1	4	1	2	0	8	3.2%
Equipment taken out of service	0	1	1	0	0	0	2	0.8%
Documentation Changes Form	0	0	2	2	1	0	5	2.0%

Legend:
Darker green denotes higher frequency

Source: REDCap/Patient Safety Database, UDOH

CONCLUSION: THOUGHTS FOR DISCUSSION AND FURTHER EXPLORATION

- Given that **surgical and care management events constitute the bulk of patient safety events**, and that **education and workflow process redesign are the top action taken** – to **what degree** are education and work flow process redesign **effective in mitigating** surgical and care management **events**?

- Given that **communication is the top driver** of **surgical and care management events**, what can **help facilitate** ensuring that **communication is strengthened**?

- Could there be **other drivers** which present as **communication issues** – such as *burnout*? Would it be **worthwhile to explore including** it **in our reporting mechanism**, and if we **discover that burnout is a driver** – **what actions could be taken**?

Source: REDCap/Patient Safety Database, UDOH

THANK YOU!

Carl Letamendi, PhD, MBA, GStat
Bureau Director, Office of Health Care Statistics
Patient Safety Surveillance & Improvement Program Manager

O: (801) 538-7052
C: (385) 249-4871
cletamendi@utah.gov

UTAH DEPARTMENT OF HEALTH
Office of Health Care Statistics