UTAH HOSPITALS & HEALTH SYSTEMS
ASSOCIATION

May 28, 2008

Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Congressman Waxman:

On behalf of UHA, Utah Hospitals & Health Systems Association, I appreciate the opportunity to comment on our state-wide patient safety activities and our recent efforts to address the issue of healthcare-associated infections (HAI). Utah has long been recognized as a national leader in patient safety initiatives. In cooperation with HealthInsight, our state's Quality Improvement Organization (QIO), the Utah Department of Health (UDOH) and the Utah Medical Association (UMA), we have undertaken a series of voluntary efforts designed to improve the quality and safety of care in our state's hospitals.

In October of 2001, the Utah Department of Health, with the support of the above mentioned organizations, adopted rules governing the reporting of potential patient safety incidents. This includes Sentinel Events and Adverse Drug Events reporting. Healthcare -Acquired Infections will be added to the rule this year. UHA staffs three Patient Safety Users Groups, one for each of the reportable events categories. The Healthcare- Acquired Infections Users Group was added in 2006.

While we find reporting of the events useful, the true value of the process in Utah is the sharing of best practices which leads to improved care at all healthcare facilities. I would encourage you to visit our website www.uha-utah.org or http://health.utah.gov/psi/ for more detailed information on our events reporting.

To address your questions specifically …

1. Hospitals began voluntarily reporting central line-associated bloodstream infections (CLABSI's) in ICU's in January, 2008. First quarter 2008 data is currently being validated and the results will be available on May 30th.
2. As previously noted, we organized a Healthcare -Acquired Infections Users Group in 2006 and expect this reporting to be included in the state's existing patient safety reporting rules in the next several weeks. The adoption of rules is necessary to provide appropriate peer review protection.
3. The Group's action plan includes outreach and training on the use of an on-line database for data submission; development of four webinars and manuals for individual users; on-going voluntary submission and collection of surveillance data; development of a Failure Effects Mode Analysis (FMEA) for

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publication on the UHA website and sharing of best practices. Finally, an analytic workgroup is being formed to study the data submitted and monitor the overall rates of CLABSI's. These activities will be ongoing.

Healthcare providers in the state remain committed to and strongly supportive of voluntary efforts to improve patient safety. As an example, we have adopted state-wide protocols for "Correct Site Surgery" and "Safe Patient Lifting" and most recently developed a policy on the standardization of the use of color-coded bracelets in hospital facilities. These activities have been undertaken in a non-punitive and collaborative environment. I want to recognize the contributions of our partnering organizations in these efforts -- HealthInsight, UDOH, UMA and the member hospitals of UHA.

Again, I appreciate the opportunity to highlight the numerous patient safety improvement initiatives underway in Utah. I am willing and available to provide any additional information you may require.

Sincerely,

Joseph M. Krella
President and Chief Executive Officer

Cc: Honorable Tom Davis, Ranking Minority Member
Sarah Despres, Committee Staff