February 26, 2013

Hospital Administrator:

In January 2013, the Minnesota Department of Health released its ninth annual report on adverse health events in Minnesota hospitals and ambulatory surgical centers. This report provides valuable information to policy makers, health care providers, and consumers about the types of adverse events that occur in these facilities. More importantly, it helps to shed light on why these events happen and what is being done to prevent them from happening again.

We would like to take this opportunity to remind all facilities that under Minnesota Statutes 144.7063-144.7069, all hospitals and licensed ambulatory surgical centers in Minnesota are required to report the occurrence of any of the 28 Adverse Health Events (see attached document) as soon as is reasonably and practically possible, but no later than 15 working days after discovery of the event.

In 2012 we had a higher than usual number of facilities reporting events into the registry system after the 15-day deadline. In some cases, events were not reported until weeks or months after they were originally discovered, during the facility's end-of-year review. Late reporting can cause system causes delays in identifying trends in reportable events, effects our ability to quickly recognize and address needs and resources that are helpful to facilities, and is time consuming when finalizing the final report.

We have always strived to have reasonable flexibility with the reporting timeline, because we understand that staff turnover and competing priorities can lead to events temporarily falling through the cracks; however, reporting events within 15 days of discovery is a statutory requirement. Each Minnesota facility needs to have a process for reviewing and/or reporting adverse health events into the registry system in a timely fashion. We would like to ask that each facility take time to examine their review process for adverse health events and make sure that it meets the statutory requirements for timely reporting. This will ensure a much more streamlined process for everyone involved.

To help in your review process we have attached to this letter the list of 28 reportable Adverse Health Events, the list of invasive procedures that are considered reportable, an algorithm for determining serious disability, and the guidance and recommendations document. These documents are also available through the MHA Patient Safety Registry.

We hope that this letter has provided useful guidance about your obligations under the law. We will continue to work with health care facilities and patient safety stakeholders to clarify the reporting law where needed, and to provide information and resources. Questions about any of the issues in this letter can be directed to Diane Rydrych at diane.rydrych@state.mn.us or Rachel Jokela, MDH, at (651) 201-5807 or rachel.jokela@state.mn.us.

Sincerely,

Diane Rydrych
Division Director, Health Policy

Cc: Patient Safety Registry Contacts