

January 19, 2005

Governor Mitch Daniels  
Statehouse Room 206  
200 W. Washington St  
Indianapolis, IN 46204

Dear Governor Daniels:

On behalf of the membership, the Board of the Indiana Society of Health-System Pharmacists would like to commend you on your dedication to improving the safety of healthcare for Indiana residents. Your executive order for the establishment of a medical errors reporting system has the potential to dramatically improve the quality of healthcare and to change how consumers select their healthcare providers.

The medication use system is one of the largest and most complex processes in most hospital settings, and is the source of a significant percent of reported medical errors. The severity of these errors ranges from minor inconvenience to death, and pharmacists have long made it a priority to implement systems that reduce both the frequency and severity of these errors. This executive order will help to advance these efforts in a coordinated fashion throughout the state.

To ensure that the medication error reporting system is of the highest possible value to the citizens of Indiana, please consider the following points deemed essential to an effective medication error reporting system:

- A practicing health-system pharmacist should actively participate in the development of this part of the medical error reporting system. This will help ensure the practicality, reliability, and functionality of the system. Theresa Salazar, Assistant Professor of Pharmacy Practice at Butler University College of Pharmacy and Health Sciences, has volunteered her services as a representative of both ISHP and the health-system pharmacists throughout the state of Indiana.
- Raw medication error numbers should not be reported to the public. Instead, the numbers should be normalized by using a universally accepted denominator. Selection of this denominator should be made by representatives from a wide variety of acute care practice settings and it should be designed to normalize the medication error rate across hospitals with varying acuities, sizes, patient types, and medication use systems.
- Great care should be exercised in defining and classifying medication errors. It is suggested that one of the nationally recognized reporting standards be adopted for use with this system to ensure consistency and accuracy of the medication error data across institutions. An example of a widely used definition set is the United States Pharmacopeia/Institute for Safe Medication Practices (USP-ISMP) Medication Error Reporting System.
- Special emphasis should be placed on the sharing of best practices between hospitals to ensure the most efficient and largest magnitude of improvement.
- The process for data submission should be simple and efficient to make the system as reliable as possible.

- Reported medication errors are an invaluable source of data for hospital quality improvement programs. Since virtually all hospitals have voluntary reporting systems, administrators are constantly searching for ways to improve reporting rates. It is essential that the structure and publicity of this reporting system be designed carefully so it does not further reduce reporting rates. Any reduction in medication error reporting rates caused by fear or intimidation is doubly counterproductive, causing a false reduction in error rates that may lead consumers to make incorrect decisions about the safest providers of healthcare, as well as hampering existing hospital performance improvement initiatives.

We at ISHP are very excited to be a part of this process and welcome any questions or comments you or your staff may have regarding the issues listed above. For any such questions or comments, please contact Mr. Lary Sage, Executive Vice President of the Indiana Pharmacists Alliance, at 317-634-4968. Thank you very much once again for your commitment to improving healthcare for all Hoosiers.

Sincerely,

The Indiana Society of Health-System Pharmacists (ISHP) Board of Directors