

SB248

PA 10-122

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2010**

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Please check the roll call board and make sure your votes were properly cast.

If all the members have voted, the machine will be locked and the Clerk will please take a tally. The Clerk will please announce the tally.

THE CLERK:

Senate Bill Number 400 as amended by Senate "A," in concurrence with the Senate.

Total Number Voting	132
Necessary for Passage	67
Those voting Yea	132
Those voting Nay	0
Those absent and not voting	19

SPEAKER DONOVAN:

The bill is passed.

Will the Clerk please call Calendar 486.

THE CLERK:

On page 25, Calendar 486, Substitute for Senate Bill Number 248, AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES, favorable report of the Committee on Judiciary.

SPEAKER DONOVAN:

Representative Betsy Ritter.

REP. RITTER (38th):

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Thank you, Mr. Speaker.

Mr. Speaker, I move for acceptance of the joint committee's favorable report and passage of the bill, in concurrence with the Senate.

SPEAKER DONOVAN:

The question is on acceptance of the joint committee's favorable report and passage of the bill, in concurrence with the Senate.

Will you proceed?

REP. RITTER (38th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill amends the existing, adverse event reporting law. The Senate has two amendments to this bill, Mr. Speaker, and the Clerk is currently in possession of Senate Amendment "A." That is LCO Number 4794. I would ask the Clerk to please call that amendment and then I be granted leave of the chamber to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO 4794, which is designated Senate "A."

THE CLERK:

LCO Number 4794, Senate "A," offered by Senators Harris and Debicella, Representatives Ritter and

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Giegler.

SPEAKER DONOVAN:

Representative seeks leave of the chamber to summarize the amendment.

Is there any objection?

Hearing none, Representative Ritter, you may proceed.

REP. RITTER (38th):

Thank you, Mr. Speaker.

Mr. Speaker, this amendment clarifies the underlying bill in requiring that the Department of Public Health's annual report to the Legislature on adverse medical events include aggregate information for each hospital and each outpatient, surgical facility. It has specific requirements about the contextual information that must surround that information; it allows those entities to provide additional informational comments related to the event which must be included in that annual report. And I move adoption.

SPEAKER DONOVAN:

Question is on adoption.

Is there -- will you remark? Remark further?

Anyone remark further?

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If not, I'll try your minds. All those in favor of the amendment, please signify by saying aye.

REPRESENTATIVES:

Aye.

SPEAKER DONOVAN:

Those opposed, nay.

REPRESENTATIVES:

Nay.

SPEAKER DONOVAN:

The ayes have it. The amendment is adopted.

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker.

Mr. Speaker, the Clerk is in possession of a second amendment; that would be Senate Amendment "B." I would ask the Clerk to please call that amendment, LCO Number 3698 and then I be granted leave of the chamber to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO 3698, which is designated Senate "B."

THE CLERK:

LCO Number 3698, Senate "B," offered by Senator McDonald.

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SPEAKER DONOVAN:

Representative seeks leave of the chamber to summarize.

Any objection?

Hearing none, Representative Ritter, you may proceed.

REP. RITTER (38th):

Thank you, very much, Mr. Speaker.

Mr. Speaker, this amendment requires that the Department of Public Health provide certain information to patients if they have filed complaints with the department surrounding complaints of incompetence, negligence, fraud or deceit by health care providers. It has specific requirements from the department to give those patients notice about the complaint status and disposition, and it goes on to require a mandatory mediation phase for all civil actions involving allegations of negligence by health care providers resulting in personal injury or wrongful death.

I move acceptance -- I move adoption.

SPEAKER DONOVAN:

Question is on adoption of Senate "B."

Will you remark? Remark further? Remark further

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on Senate "B?"

If not, let me try your minds. All those in favor of the amendment, please signify by saying aye.

REPRESENTATIVES:

Aye.

SPEAKER DONOVAN:

Those opposed, nay.

The ayes have it. The amendment is adopted.

Remark further on the bill as amended?

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

I have a couple of questions to the Chairman of the Public Health Committee.

SPEAKER DONOVAN:

Please proceed, madam.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

Does the bill before us improve the quality of care and add safety for our patients?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker, and I want to thank

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Representative Giegler for that question.

I will briefly remind the Chamber that for some years there has been discussion about the relationship between required reporting of adverse medical events to the department, to the public, and the relationship to the quality of healthcare that is given to the citizens of the State of Connecticut. This bill as amended requires the presentation of corrective action reports with follow-up reports from the facilities. Those corrective action reports must be directed towards steps that will permanently improve the quality of health care that is delivered by these institutions, through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

Will this bill before us help to insure that the reporting will be confidential and that the clinicians will provide honest communication?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, yes.

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SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

Will the Department of Public Health have to consult with the bill before us with the AG regarding audits?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Excuse me, Mr. Speaker. If the Representative could clarify her question, I was not able to hear the second part.

SPEAKER DONOVAN:

All right. Representative Giegler, if you could repeat your question.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

Will the Department of Public Health have to consult with the Attorney General regarding audits in the bill before us?

REP. RITTER (38th):

I have no idea.

SPEAKER DONOVAN:

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Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, one moment.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill as amended by the Senate does not change any of that investigation that exists under current law today.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

Just one comment on that particular issue, I note that during testimony it was expressed that the AG's Office does not have the expertise regarding health care facility inspections and public disclosure of incidents. And there was a concern about whether they could undermine patient privacy and discourage actual reporting, which is while I -- why I asked the question.

But the bill before us has had a lot of hard work, and a lot of effort was put into this. And it's

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an important bill for the safety of our patients that are using hospitals and health facilities.

And I urge my members' support.

Thank you.

SPEAKER DONOVAN:

Thank you, Representative.

Would you care to remark further on the bill as amended? Care to remark further?

If not, staff and guests please come to the well in the House. Members take their seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is voting by a roll call. Members to the chamber, please.

SPEAKER DONOVAN:

Have all the members voted? Have all the members voted? Have all the members voted?

Please check the roll call board, to make sure your votes were properly cast.

If all the members have voted -- I see a few people still need to vote. Remember, this is the last day. People need to be close to the chamber. You may miss a few votes if you're not close by.

If all members have voted, the machine will be locked, and the Clerk will take a tally.

Representative Boukus, waiting for you.

Representative Ritter. Representative Ritter.

REP. RITTER (38th):

Thank you, so much, Mr. Speaker.

Mr. Speaker, I would ask that my vote be cast in the affirmative.

SPEAKER DONOVAN:

Representative Ritter, in the affirmative.

Will the Clerk please announce the tally.

THE CLERK:

Senate Bill 248 as amended by Senate Schedules "A" and "B," in concurrence with the Senate.

Total Number Voting	136
Necessary for Passage	69
Those voting Yea	136
Those voting Nay	0
Those absent and not voting	15

SPEAKER DONOVAN:

The bill, as amended, is passed.

Again, I remind everyone that this is the last day. Bills will be going more quickly than usual, so please stand by close to the chamber. Our machine

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Calendar page 28, Calendar Number 189, File
Number 246, substitute for Senate Bill 248, AN ACT
CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUT PATIENT
SURGICAL FACILITIES, Favorably Reported, Committee on
Public Health and Judiciary.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Thank you, Mr. President. I move acceptance of
the Joint Committee's Favorable Report and passage of
the bill.

THE CHAIR:

Acting on acceptance and approval, sir, will you
remark further?

SENATOR HARRIS:

Thank you, Mr. President. Mr. President, this
bill actually modifies a practice that we have here in
the state and have had since the early part of this
decade. And that is the reporting of so called
adverse events. When things occur at hospitals that
should not occur, the classic one that everyone has
heard of is leaving, say, a glove, inside somebody
during an operation. There are falls that sometimes

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occur in hospitals that should not occur. There are various infections that occur in hospitals that should not occur. Those are the types of events known as adverse events that we need information about. One, so that the hospitals can do what they can internally to prevent them from occurring in the future, and, two, so that consumers, our health care consumers can understand which hospitals are doing it appropriately, which, maybe, are doing it less appropriately.

Mr. President, one of the issues that came up in the wake of some recent incidents at hospitals, one in particular, is the fact that under the current law, these adverse events are only reported in the aggregate, by raw numbers. But we thought it would be helpful for the consumer to be able to have information that identifies specific hospitals so that it could be better used to make health care decisions by our citizens.

And that's what this bill seeks to do. Mr. President, the Clerk is in possession of an amendment, 4794. I ask that it be called and I be granted permission to summarize.

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Mr. Clerk.

THE CLERK:

SECO 4794, which will be designated Senate

Amendment Schedule A. It's offered by Senator Harris
of the 5th District, et al.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Thank you, Mr. President. I move adoption.

THE CHAIR:

Please proceed, sir.

SENATOR HARRIS:

Thank you, Mr. President. Mr. President, where I just left off in describing this bill, we talked about consumers being able to use this information. And one of the things that we're trying to work on here is a balance. A balance so that we get information out that is actually useful, not information that causes undue fear. A balance so that we require hospitals to produce information and investigate so that they can improve internally and keep people safer, but not have a draconian reporting system that actually does the opposite, that gives incentive to hide and not

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disclose information.

One of the pieces, important pieces, which is in this amendment -- and this is also an agreement that has been put together by a lot of discussions -- Public Health Committee, legislators on both sides of the aisle, in the House and in the Senate, the Hospital Association, patient's advocates, trial lawyers -- so everybody has come to an agreement on this. One of the important parts is that there be some contextual information with respect to the particular adverse event. And, Mr. President, this amendment accomplishes that.

I'll give an example of contextual information so people can understand it. A fall. There's a difference in falls and we'll take one where you have a young, healthy person that, say, just had their arm mended and they're staying overnight at the hospital and they have to get up for whatever reason out of their bed and they trip over something. That's not a good thing to have happen, but did the hospital do anything wrong in that situation? The person didn't need to be restrained, didn't need to be watched. So there was probably no harm, no foul on the part of the

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hospital.

In another situation, an older, frailer person with Alzheimer's, gets up in the middle of the night and falls. In that case, the hospital probably didn't take the steps that were necessary to prevent that fall from happening. And we need some context to know the difference.

The other part is a quantitative analysis. It's one thing to say in a hospital with, say, a thousand patients that there were ten falls, but in a hospital where there were a hundred patients, there were five falls or seven falls. You've got to figure out the size of the hospital or the outpatient facility, the number of patient days, the number of surgical opportunities in an outpatient facility and to be able to put that event into context of the total amount of business, if you will, being done. This amendment does that.

The other thing that this amendment does is strike a penalty, which the way it was -- the way it was in the bill, appeared to maybe give an incentive or was described as maybe giving an incentive not to disclose, so we came to an agreement that we would

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monitor it and get rid of the penalty at this point.

So that's what this amendment does and I urge passage of the amendment.

THE CHAIR:

Thank you, sir.

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And again, because I don't now serve on the Public Health Committee, I would -- I'm going to ask Senator Harris a couple of questions that will help to refresh my recollection.

Through you, Mr. President, to Senator Harris. Was Senator Harris here in the legislature when we passed the first adverse events reporting requirement? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I was an attorney down in the House so I probably had more knowledge and more power then, but I was not a legislator.

THE CHAIR:

Touche.

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Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. But the people you surrounded yourself with weren't of the same quality as they are today. Is that correct? Through you, Mr. President, to Senator Harris?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. If you say so, Senator Roraback.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. The reason I'm asking the question is that my recollection was that it was probably six or eight or ten years ago that we passed an adverse events reporting requirement and then when it kicked in if you went to the newspaper, you would see that hospital A in Hartford was reporting 64 adverse events in a month and hospital B was reporting 3 adverse events. So you either had to say, "Geez, hospital A is really bad and hospital B is really

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good," or else the hospitals are interpreting what they need to do in very different ways. And, through you, Mr. President, to Senator Harris, I don't know if he remembers that phenomenon or if it's me alone who was kind of taken aback when he saw what differences there were in the reporting. Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. That was one of the issues. And again, since everything was just done in the aggregate, it was hard to actually cut through that information and get a useful read on it as a consumer, an advocate or whatever hat you might wearing.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And through you, Mr. President. I would imagine there's a continuum from saying in hospital A, ten bad things happened this month as -- that's one end of the continuum, but it

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doesn't tell us much. What were the bad things? Who did they happen to? At the other end of the continuum would be at 11:47 on April 26th, Mrs. Jones fell down on her way to the ladies room and broke her hip. And, through you, Mr. President, to Senator Harris, would that kind of represent the other end of the continuum in terms of getting contextual information to the authorities, to the Department of Public Health and then, of course, to the public, those that want to educate themselves about what's going on in our hospitals? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I would agree with that basic continuum.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

And so those are two ends of the continuum, Mr. President. What I'm trying to understand is this bill moves us closer to the more information side of the

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continuum than the less information. side of the
continuum. Is that correct, Mr. President? Through
you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, but with,
again, certain contextual information so that when you
get more information, you know how to accurately judge
its impact.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

And so I heard Senator Harris say and I
understand that if Senator Harris or I fall after we
have an appendicitis operation in the hospital, that's
a different thing than if somebody who's supposed to
be under total supervision falls when they're in the
hospital. So through you, Mr. President, to Senator
Harris, is the bill going to require the Department of
Public Health to develop criteria so that we can more
-- so that we can better define the nature of the
adverse event or are we going to leave it to the

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hospitals to do that, Mr. President, through you to
Senator Harris -- or some other third party?

THE CHAIR: ~~SEN~~

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. The bill actually --
and you can see in the amendment -- where it's clear --
- actually helps to provide some of the definition of
the contextual information. How is it that you
actually quantify that, if you will. How you actually
describe that. There is also part -- in, I believe,
the existing law, for regs, too.

I'm looking through now.

Through you, Mr. President, I can keep looking if
he has another question, also.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

And I'm reading the amendment and, again, I
apologize for no longer having the pleasure of serving
on Senator Harris' committee. But unless you lived
this stuff, you read the amendment and it's kind of
Greek to the lay person, which I would call myself

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these days. So through you to Senator Harris, I was just wondering if he could help give some context to what contextual information is? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President, yes. One of the -- one of the pieces I actually described a little bit before. And I can go into more detail and you can see it in the amendment where it defines -- starting at line 60 -- "contextual information includes." The relationship between the number of adverse events and patient days in a hospital setting or in the outpatient setting, the total number of surgical encounters. So again, you're trying to say, how much business, essentially, is the facility doing compared to the number of adverse events.

There is also a part under B in line 24 -- information about the patient population. So giving kind of a flavor of who is at the particular facility, the hospital outpatient to be able to say -- because in some places, if you're taking care of people that

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might be more susceptible to bad things happening, you have to take that into account. Through you, Mr.

President.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I appreciate Senator Harris' answer. As I'm reading the bill -- I guess I'm now trying to understand does this bill ask more of the hospitals or other medical settings or is it asking more of the Commissioner in terms of how he presents information so we as consumers in the annual report? Through you, Mr. President, the amendment seems to suggest that the Annual Report is now going to provide greater detail, not necessarily that the hospitals are going to be asked to report in a different way. It's just that the information that they report is going to be distilled and disseminated in a more complete way to the consuming public. And Mr. President, through you, to Senator Harris, I was just wondering whether anything changes in terms of a hospital's responsibility in connection with adverse events or whether it's just a change in the way the

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your superiors. When it's all happening at three in the morning on some floor how do we make sure that that information flows as it should ultimately to the Commissioner?

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And, through you, Mr. President, to Senator Harris, have there been any efforts in his committee to better understand compliance with the reporting requirements? Because the information the Commissioner gives can only be as good as the information he or she gets from reporting hospitals. Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President, one of the things I thought I heard Senator Roraback say is what constitutes an adverse event. They're pretty specific. The National Quality Forums list of serious reportable events, and also, under current law and consistent with this bill, the Commissioner may adopt regs to actually add further types of adverse events to that list. So there is a clear list that is already demarked. And there are other areas of health

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care that utilized these particular lists. And all that we're asking is that when one of these events happen and the hospitals do their internal investigation, and when they report what has occurred to DPH and DPH then reports it to the public, that it is done in a way that is user friendly, that will help the consumer.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And I understand that. I appreciate Senator Harris' response, but, through you, Mr. President, the issue I'm trying to get at is it's one thing if Mrs. Jones falls and breaks her hip, it's hard to conceal that adverse event, right? "Oh, my gosh, my mom's hip was broken last night." "Well, what happened?" "She fell on her way to the bathroom." Well, if you don't report that that's going to be a big problem for the hospital. But what if Mrs. Jones falls on her way to the bathroom and doesn't break her hip? Thought you, Mr. President, to Senator Harris, how do we gain confidence that there's compliance on the floors with reporting adverse events

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which don't necessarily result in a visible -- or maybe, through you, Mr. President, to Senator Harris, is it only an adverse event if you get hurt? Through you, Mr. President, to Senator Harris, if you fall?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. There are a lot of different definitions of the adverse event. Any type of fall where there is some sort of injury is an adverse event. If somebody falls down and there's no -- nothing occurs, unless, I would say, that person needed to be restrained and in some ways wasn't, then there's no adverse event there. Through you, Mr. President.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you and through you, Senator Harris, I mean, I understand that. There's no adverse event because, thankfully, nobody got hurt, but the conditions that give rise to the fall are still present and the fact that the person was lucky enough

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in this fall not to break their hip doesn't mean, in my opinion, that it should be swept under the rug. I still think -- and that goes to my concern about the uniformity of reporting between and among institutions and through you, Mr. President, to Senator Harris, I was just wondering whether the Public Health Committee this year had an opportunity to drill down a little bit deeper and better understanding the operation of adverse event reporting and any modifications to it that would capture the universe not just when someone gets hurt, but when something happens that shouldn't happen if appropriate protocols were in place? And I know that -- well, anyway -- through you, Mr. President, that's enough of a question that I would ask for Senator Harris to respond.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President, this year, with the short session, our challenge was to deal with how best to report the information. We did not go through and -- I did read all of them several times and I can go back and give you some of the definitions of various

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adverse events, but we did not go through and try to take a look at each of the adverse events. That is something that has already been defined by this National Quality Forum and that we leave up to the Department of Public Health and the Commissioners through the regulatory process to further define. It could be a subject, though, in the future that this committee would like to undertake.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I appreciate Senator Harris' answers, so I guess when I look at this really, what this bill is trying to do is to say if you have a 20-bed hospital, if you have a 20-bed hospital that has ten adverse events and you have a 200-bed hospital that has the same number of adverse events, unless you give people a barometer by which to evaluate intelligently the numbers, they could be left with the impression that hospital A is a more dangerous place than hospital B, when, in fact, on a patient population basis, hospital A has a much better track record than hospital b. So, through you, Mr.

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President, for purposes of clarification, that's really what lies at the heart of this bill, is a place to be comparing apples to apples, I guess, when it comes to adverse event reporting. Through you, Mr. President, to Senator Harris, is that kind of what this is about?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President, yes, from that quantitative analysis that you described, Senator Roraback, also again, patient population. And in addition, this bill also will allow the facility to submit informational comments. So once there's an investigation done and there is information compiled by DPH, the facility will also be able to make comments on that, also to provide further context of what's going on. And part of this whole law -- and this is -- we're not talking about it because it's current law -- is for there to be an incentive and a report in taking corrective measures. This is not just about saying, "Okay, we need to know whether Mrs. Jones fell." This is "Mrs. Jones fell and this is

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why, let's put it into context, and oh, by the way, the facility at which she fell has taken steps A, B and C to make sure that Mrs. Smith doesn't fall next week."

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I will be supporting this bill and I just want to say I want to thank Senator Harris for his hard work on it. It is an important area.

And just one last point. My point about if Mrs. Jones falls and doesn't get hurt, that doesn't mean that we shouldn't take corrective actions to make sure that that doesn't happen again. So I guess my fear is that we may be under capturing -- we ought to perhaps, next year be looking at how we define adverse events because you don't want to wait until something bad happens before you take corrective measures if there are potentially dangerous things which are happening, we should know about them so we can put the corrective measures in place before the bad thing happens.

I thank you, Mr. President, for your patience as

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Senator Harris and I engaged in our conversation. I thank the distinguished chairman of the Public Health Committee for his answers. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate A? Senator Kane.

SENATOR KANE:

Thank you, Mr. President, good afternoon.

THE CHAIR:

Good afternoon, sir.

SENATOR KANE:

Unlike Senator Roraback who hasn't served on the Public Health Committee in awhile and unlike our distinguished chairman of the Public Health Committee, I'm new to the Public Health Committee this session. But actually enjoyed it very much, very diverse, going from pickles to town fairs to adverse events in hospitals.. So I give the chair a lot of credit for running this committee.

In regards to this bill an this amémdment more specifically, I do have a few questions to the proponent of this amendment, through you, Mr.

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President.

THE CHAIR:

Senator Harris.

SENATOR KANE:

Thank you, Mr. President. The two of you, Senator Roraback and yourself were talking earlier about how this adverse event was legislated years ago. You, yourself, said you were a staff attorney in the House. Is this annual report that is mentioned in the amendment, is that from that long ago? Is that something that is typically done or always done? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, there is a reporting requirement under current law.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you and then the reporting requirement by the Commissioner to the Legislature, through you, Mr. President?

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THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I believe it's just a report to the general public that is published. It's not something that's given to a committee of cognizance.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Okay, good, thank you. I wanted to clear that up. I wasn't sure how that works.

And this report is published where? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I'm looking, I thought this part was struck, it's not, it's here. Actually, under current law, it looks like under the file copy of 246, there is a report to the Public Health Committee.

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Senator Kane.

SENATOR KANE:

Okay, can you point, show me where that is?

Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Lines 32 through 35.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I'm glad we were able to clarify that part up.

The outpatient surgical facilities that are mentioned in here. It's not just hospitals, I guess, it's outpatient surgical facilities. Are those surgical facilities the same that are, let's say, through the hospital or can they be competitors of the hospital? For example -- I don't know if St. Francis or Hartford hospital has outpatient surgical facilities, I'm assuming they do. I know in our area, St. Mary's Hospital and Waterbury Hospital have the -- I think it's Naugatuck Valley Surgical Center. I

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think it's a division of -- although I think they may compete with them on some level, but, through you to Senator Harris, what does that cover when you talk about the outpatient surgical facilities?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Exactly what you described, Senator Kane.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Through you, Mr. President. Which is all of them or -- through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. If I'm understanding correctly, the typical outpatient surgical center is like Hartford Hospital does have one, say, at Blueback Square there is an outpatient facility. There are others, though, that might not be directly affiliated with hospitals to my understanding. I know there's

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certain surgeries that go on, colonoscopies, for example, in various doctor's offices, if you will.

But there is outpatient surgeries that are done in those contexts also. This would include any of those outpatient surgical facilities.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. And some, I would imagine, like you mentioned Hartford Hospital or in West Hartford are probably busier than others. We're going to measure all of them? And that's kind of where I was getting to my questions is I think you were talking with Senator Roraback about the number of occurrences versus the number of actual procedures. And I'm just wondering how worthwhile it is? Is it every single one or do you need to reach a threshold? You know, just to that effect. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. If there is an

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adverse event at any of these facilities, it will have to be reported and that will be part of the annual report that the commissioner compiles and at least in this case, I think it's also when I was talking about the public website, you've seen it, you know, reported in the paper. And again, reported to the Public Health Committee.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I guess the reason I ask is because part of the bill talks about the relationship between the number of adverse events and patient days. And these outpatient facilities are that, they're outpatient. They're not -- to the opposite -- so there are no patient days. So that's why I'm wondering how we are able to measure them in this regard, because it has a relationship according to the bill. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. In the hospital it's

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patient days, you can see in the amendment I have one instance here in line 19 when it's an outpatient surgical facility, it's the total number of surgical encounters. So it's the total number of surgeries done. Again, as I described, the amount of business that is being done, essentially.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Oh, good. Thank you, thank you, Mr. President. I'm glad for that clarification as well. Because I wanted to understand that relationship.

Just a couple more things that I have a couple questions on. It talks about the hospitals being able to provide comment in this report. And I'm wondering how that works. Are they -- have a -- is it based upon the actual occurrence, is it based on their annual reports, is it based on some type of calendar or is it based on a public hearing process? How does the hospital include their comments? Through you, Mr. President.

THE CHAIR:

Senator Harris.

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SENATOR HARRIS:

Through you, Mr. President. What the amendment says in lines 26 through 29 that in addition to the other contextual information, the hospital or outpatient surgical facility may provide informational comments relating to any adverse event reported to the commissioner pursuant to this section. So my understanding of the flow of work would be that there would be an adverse event reported, there'd be an investigation, and then once that investigation were compiled, the hospital or outpatient surgical facility would be allowed to comment on the results of that reporting of that investigation. So again, to try to provide some context to what occurred at that facility.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. And just a couple more things.

It also mentions in here about the payer or case mix. Can you speak to that at all? Through you, Mr. President.

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THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Again, what this is trying to do by providing contextual information is to give citizens, the health care consumers, the ability to judge an adverse event in context. And there might be a facility that has more people that are frail and therefore, just because of that, might be more susceptible to certain types of adverse events versus someone -- some place with a different type of mix. Here, it also might include different types of payments. What type, who's paying for the services might have an indication of the mix of the population in the particular facility. Just again, trying to come up with a way that there is context. A way to judge an event so we balance the reporting that we know needs to be done so people have the information, so that people can make appropriate decisions without just -- you know, making people afraid because they're hearing oh, all these bad things are happening, when it might not be as bad as it seems if you knew, as Paul Harvey said, the real story.

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THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I guess the reason for my question is I can understand what you're talking about when you talk about the case mix, because there are individuals that may be frail. But I don't see the correlation with the payer. You know, whether it's Medicaid or some type of private insurance, I don't understand how that has an effect on the actual adverse event. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. It might not have an effect on the actual adverse event, but it might provide you, again, with a little bit more of a picture about the facility. And that's what we're trying to get at here, as many ways as we can try to take a snapshot of that facility.

THE CHAIR:

Senator Kane.

SENATOR KANE:

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Thank you, Mr. President. So that is -- but that line of logic would make me assume that you can have more or less adverse events based on the type of insurance that is coming through your door? I don't understand that correlation. Because this hospital has more Medicaid patients, all of a sudden they have more adverse events? This hospital takes in more private insurance, they have less adverse events? I don't -- I fail to see that. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. It's just another perspective.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President, I guess. If that's -- I thought we'd kind of take those things out of the mix, you know. Trying to make assumptions or make -- I shouldn't say assumptions -- even categorize things based on a person's ability to pay, so I'm curious as

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to why that would still be in there.

My last question to you, I think you mentioned about the fines and I think you said that that part of it was taken out. Is that true? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, the penalty, it was taken out by the amendment.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Great. Thank you, Mr. President. And I thank Senator Harris for answering my questions. I know that I did vote for this bill in the Public Health Committee and I just wanted to make sure we were able to clarify these number of changes that are here and I will be supporting the bill. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate A? Senator

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Prague.

SENATOR PRAGUE:

Thank you, Mr. President. Through you a question to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR PRAGUE:

Senator Harris, when these reports of adverse events are reported to the Department of Public Health --

THE CHAIR:

Senator Harris.

SENATOR PRAGUE: - would a family member of somebody who suffered from an adverse event have access to that report?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. It's my understanding that once the investigation is completed, that adverse event reporting is public information and it can be given to anybody, not just the family.

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THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

Through you, Mr. President. Senator Harris,
would the details of that report be public
information?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes.

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

Okay. Through you, thank you, Senator Harris,
for those answers.

THE CHAIR:

Will you remark further on Senate A? Senator
Boucher.

SENATOR BOUCHER:

Thank you, Mr. President. Mr. President, I rise
on a -- for some inquiry into this bill, since some of
us have not had the fortune of being on this committee
when the bill was being discussed and moved through.

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Apparently it has received a few changes, and, I also -- I know that we're on the amendment at this point ~~and~~ not the bill so I would ask, if I could, through you, the proponent of the bill -- the amendment goes to line 8 and again, I apologize if this questions was already asked by other Senators prior to my entering the chamber, but it does ask that we insert the words, "on reflective of evidence-based best practice and that." Could I please ask the proponent to, again, define the evidence-based best practices, as best as he could? Through you, Mr. President.

THE CHAIR:

- Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I believe that that's self explanatory. Evidence-based is the compilation of information, evidence. Best practices is a term of art not only used in health care, as we all know, but throughout many contexts, which is what's been proven to work. So evidence-based, best practice is, "I have information showing that it works."

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Senator Boucher.

SENATOR BOUCHER:

Thank you for the answer, Mr. President.

I guess he is referring to, then, ways in which to reduce, if that's what I understand it to be, to reduce these serious instances at hospitals. If that's what his particular statement is referring to? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Thank you very much.

Also on this amendment, in lines 15 it references relevant contextual information, if I'm not mistaken, and for this section, contextual information "includes but not limited to" and it goes on between line 16 to 24 to explain this in a manner that may not be very clear. So if I could impose upon the good Senator to clarify and explain lines 16 through 24. Through you,

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Mr. President.

THE CHAIR:

Senator Harris. ~~2:52~~

SENATOR HARRIS:

Sure, Mr. President. If -- through you, with indulgence for the third time, I'll explain it. That what this is is trying to get an accurate picture of the adverse events, of putting them in the context and this particular section that Senator Boucher refers to is trying to put it in a quantifiable context. So as I had said several times, Senator Roraback said, there's a difference between ten falls at a hospital where there are a thousand patient days and nine or eight falls at a hospital where there are a hundred patient days. While if you just saw the nine and the ten you might think the ten was worse but because you know the number of patient days, the place with ten falls actually is probably doing a better job than the one with fewer falls, with nine falls.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Thank you, Mr. President. That's a very good

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distinction and very important clarification for this kind of reporting. There's no question that there is a concern that ~~has~~ been expressed by others regarding the way in which this data could be used, particularly as was stated that it could be made public, that it can be very misleading and possibly create a wrong impression of a particular health care institution.

It goes on to say that including information about the outpatient surgical facilities payer or PACE mix as well. And that is important, through you, Mr. President, to explain why having that information of the facility's payer or PACE mix also plays into the proper reporting of this data and not misleading the public. Because this is a pretty important data that hospitals and surgical would be exposed to to the general public. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Case mix is important, again, to get that picture, the perspective. Is it a place that tends to have people that are more frail, that are more sick? There could

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be more of a chance, for instance, to be exposed or get an infection if you are, say, have more elderly there. People on Medicare, that's where I didn't get into the details with Senator Kane, but, say, more Medicare patients means that you have an older population in your facility. So it's to try, again, to put it into context and make it meaningful.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Thank you, Mr. President. Mr. President, the question I had that came before us is the rationale for this particular bill in that I was under the impression that many hospitals do already keep some records of this or could the proponent please explain why this would be new data that would have to be collected that is not normally kept at the hospital? Thank you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. It's not about data collection, really. This bill focuses on data

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reporting, what the public gets and that's what we're changing under this bill is what needs to be reported, the level of detail and how it's expressed so it's meaningful.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Yes, thank you, Mr. President, for that information. The reason that I ask this is because we know that our hospitals, many of them, are working under some pretty strenuous situations. Many of them are burdened with high cost and low reimbursement rates, and growing populations. So that it was important to distinguish if this refers to data that they already keep and, in fact, maybe already reporting to other associations, national boards or hospital associations, but they already keep it so it would not be that far of a stretch in the use of manpower should they need to just gather that information and send it to a different agency, such as our Department of Public Health here at the state level. So my inquiry had to do with just how much are we adding to the burden to an individual hospital or

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health care facility? Is this information readily available as far as we know at this time, Mr.

President? Thank you, through you.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Information of this sort is kept by hospitals all the time. Again, this is about reporting. One of the things that hospitals do, should do, and if they don't we need to know when they don't, is compile this information because part of the purpose of the reporting in this law is about corrective action and, so hospitals from the testimony that we received in the meetings pay close attention to these types of adverse events, not just so they can be reported, but because they want to prevent them. One, because they are in the business of care, and, two, because there are liability issues. So the more that they can prevent in their self interest even, bad things occurring, the better off they are.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

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Yes, thank you, Mr. President. I concur with the good Senator with regards to that statement. There is no question that hospitals do keep a close watch on this. From the standpoint of quality of care, most importantly, but there's also a liability exposure and a risk management exposure to these particular instances, and oftentimes -- and I don't know if the chamber members availed themselves to some of the national publications that oftentimes rank hospitals as far as putting out reports of the best hospitals in America rankings. It's very similar to publications when they do the top private and public universities.

There is a wonderful publication that also talks about the very best hospitals in the country with regards to not only generally overall, but also individual specialties that they're renowned for. And there's a series of parameters that they are judged on and I would presume that this would be one of those very important parameters that would put them at the top levels. We're very fortunate in this country to have so many outstanding hospitals, one, by the way, that gets a hundred percent rating over the last ten or fifteen years that I've been following that

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publication.

So certainly, keeping track of this and the reduction of this not only helps the public, but it also helps the institution with regards to how it's regarded. It also helps them to attract individuals from not just this country, but from all over the world. So I do -- I think this is a good idea. I would hope that it, again, is information readily available. I'm also hopeful that the information, should it become publicly available, not only helps the public, but also would help the individual health care facilities to have another evaluation. And you know how we have that incentive when we do a lot of testing on our schools throughout Connecticut and we compare them to their different economic reference groups to see how well they're doing in each and every category, that hospitals will focus on this because -- and how they do with their peers throughout Connecticut as a way to increase the quality throughout Connecticut.

So, Mr. President, I thank the Senator for his answers to this. I hope this does go a long way to improving quality. Particularly in a very fast

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growing field, where we do have an aging populations
and the prospects for something like this to occur
might increase.

Thank you, Mr. President.

(Senator Coleman in the Chair.)

THE CHAIR:

Thank you, Senator.

Do you care to remark further? Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. Mr. President, to the
proponent of the bill. If I can, Senator Harris, on
line 89 through 93, it's just for legislative intent.
For violations, speaking of line 90, if I may, each
violation shall be a separate and distinct offense and
in the case of continuing violation, each day of the
continuance thereof shall be deemed a separate and
distinct offense. If we're looking at death or
serious injury with respect to an adverse event, which
is a blood product, which is, as I understand it to
be, a transfusion, let's say. And that is one of the
issues. And that transfusion is an order that's

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wrong, it's carried out wrong, it's given to the wrong patient and injury results, assume that for this hypothetical. Every time that transfusion is given, even though it's under the same instruction, would that be considered an adverse event each and every time it is given with respect to this? Through you, Mr. President.

THE CHAIR:

Senator Fasano, let me first inquire. We're on Senate Amendment Schedule A. Is your question referring to the amendment or to the bill?

SENATOR FASANO:

Thank you, Mr. President. I will hold that question for the bill. Yes, thank you, Mr. President.

THE CHAIR:

Thank you, sir. Are there further comments? Are there further remarks regarding Senate Amendment, Schedule A?

If there are no further remarks to be made on the amendment, Chair will try your minds regarding the Amendment. All those in favor of the amendment please indicate by saying aye.

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Aye.

THE CHAIR:

All those opposed say nay.

The ayes have it, Senate A is adopted.

Will you remark further on the bill as amended?

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. So back to my hypothetical that I did a little earlier through you, Mr. President, to Senator Harris. Rather than repeat the hypothetical, perhaps, with the indulgence of Mr. President, maybe Senator Harris can answer the question, through you.

THE CHAIR:

Senator Harris, did you appreciate Senator Fasano's question?

SENATOR HARRIS:

Through you, Mr. President. I do, but the simple answer is lines 89 through 93 are struck by the amendment, they are no longer part of the bill.

SENATOR FASANO:

Okay.

THE CHAIR:

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Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. Through you, Mr. ~~President~~
President. Is there a penalty clause therefore in the
bill or has that been completely removed? Through
you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. No more penalty
clause.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. And what would be the
penalty -- if there isn't penalty clause -- this is
just reporting without the punitive nature of a
violation? Through you, Mr. President.

THE CHAIR:

Senator Harris.

THE CHAIR:

Through you, Mr. President. Yes, this is a
reporting bill. Besides other powers that the

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Department of Public Health might have under other areas of the statute, we do not add a penalty here.

~~the~~ The reason for that was trying to strike that balance between giving incentives for full reporting and not taking certain actions where some might say a penalty would actually chill the hospital from reporting, would actually provide a disincentive to full reporting.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. And, Mr. President, therefore in line 63 through 68 of the original bill, did the amendment leave that language as is or was that removed, Mr. President, for the purpose of letting Senator Harris know what I'm referring to, that would be the discharge or refusal to hire or retaliate against any employee who apparently makes the complaint over an adverse event? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

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Through you, Mr. President. That whistle blower language was not struck by the amendment, it is still part of the bill.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President and to the extent that those lines are still in the bill, when I initially read it, I read the punitive penalty that has been removed, the civil penalty as applying to these lines. Understanding that that has been removed, would the employee, for legislative purposes, be entitled to their own civil recourse, then, by virtue of this language? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, through this and existing statutory and case law.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. That is to say that

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the whistle blowing philosophy or policy has case law to it that supports any legal claims that can be brought by the employee. Is that the import of the answer from Senator Harris?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, although I have not done this for a very long time, I seem to remember a case, Sheets against Teddy's Frozen Food. Many, many years ago, a couple decades ago, which actually established whistle blower law in case law here in the great state of Connecticut.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

I am now trumped by that, Mr. President. So I will move on.

Mr. President, through you. It's my understanding that one of the adverse events that can take place is a patient death or serious disability due to spinal manipulation therapy. Is that Senator Harris' understanding of one of the adverse events

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that can take place? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. If the good senator could repeat the question?

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

It's my understanding that one of the adverse events that require reporting is the patient death or serious disability due to spinal manipulative therapy. Would that be Senator Harris' understanding? Is that one of the events?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I don't have the list out in front of me, but that does ring a bell.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. Mr. President, for

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the purposes of my question previous, I'm reading from the State of Connecticut, Department of Public Health legislative report to the General Assembly with respect to adverse events reporting, which lists a number of adverse events over several pages and one of the adverse events listed in 4G is a patient death or serious disability due to spinal manipulative therapy, and I guess my question to Senator Harris is it's my understanding, based upon that information that a manipulation causing serious injury -- or a disability, I should say or death, serious disability or death would be considered a very serious consequences by virtue of it being listed as one of those items. Would that be -- would the good Senator agree or disagree with that statement?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. The fact that it is reported would indicate to me that it reaches a certain level of seriousness, yes.

THE CHAIR:

Senator Fasano.

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SENATOR FASANO:

And that -- thank you, Mr. President. And that degree of seriousness is such that not only do we have it listed as an adverse event over the number that one could choose from, this was listed as an adverse event and now we feel it's even more important that we identify all the particularities that this bill does to show where that may have happened -- along with others, but where that may have happened, who was in the room, the time, et cetera, so in reviewing this, we've kept this adverse event and, in fact, added that we need more details. Would that be correct? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, that's correct. We don't just want a number, we also want to have some information reported to give some shape and context to the event.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

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Thank you, Mr. President. I thank Senator Harris for his answers. Mr. President, I point that out only because I believe that manipulation of the neck, if that results in serious disability is an issue. And I bring that out because there's been -- there's some issues that float around this chamber and I push that issue and the seriousness of it and I just want to be clear that it is considered an adverse event for the purposes of hospitals, it's considered an adverse event with the way the state views those issues and I just felt I'd take this opportunity. I thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Senator McDonald.

SENATOR MCDONALD:

Thank you, Mr. President. Mr. President, I believe the clerk is in possession of LCO Number 3698. I ask that it be called and I be granted leave to summarize.

THE CHAIR:

Will the clerk please call LCO 3698 to be designated Senate B.

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THE CLERK:

LCO 3698, which will be designated Senate
Amendment Schedule B. It is offered by Senator
McDonald of the 27th District.

THE CHAIR:

If you would move adoption, Senator McDonald.

SENATOR MCDONALD:

Yes, Mr. President. I move adoption.

THE CHAIR:

The gentleman has also requested leave to
summarize the amendment. Is there objection to
summarization? Seeing none, please proceed, Senator
McDonald.

SENATOR MCDONALD:

Thank you, Mr. President. Mr. President and
members of the circle, this amendment is in sum and
substance the content of a piece of legislation that
we passed last year, I believe it was unanimously in
this circle. But for reasons that are still murky, it
never found time in the floor of the House to seek
final passage. And it would allow, Mr. President,
individuals who have filed complaints with the
Department of Public Health regarding the professional

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competence or negligence or fraud of a medical professional to have a meaningful opportunity to participate in any administrative hearing process undertaken by the Department of Public Health. In particular, Mr. President, it would allow a individual who had filed such a complaint to have the status of a party during the proceeding with the rights attendant to that status.

Mr. President, we have learned all too frequently that the Department of Public Health in undertaking its review of such claims, talks extensively with the medical professional involved, but really doesn't involve or incorporate into that analysis or investigation any ongoing dialog with the complainant. So this legislation would cease that process and allow the individual to participate and review records in the Department of Public Health.

It is true that under this legislation the complainant would not have a right to copy or remove from the Department of Public Health those records, but would have an opportunity to comment before any consent order was entered into and if there was probable cause found by the department, would have an

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opportunity to supplement information and provide
context to any response filed by the medical
professional.

In addition, Mr. President, there is a second component of this legislation that is the result of a very collaborative effort between the Connecticut State Medical Society and the Connecticut Trial Lawyers Association with respect to medical malpractice cases. One of the things that we have been trying to encourage in this state is litigation avoidance strategies. And under this legislation, Mr. President, any time there is a medical malpractice case filed, there would be an obligation to have that case refereed to a mandatory mediation session conducted by a judge of the Superior Court. If at the end of that mediation process before the judge, there was a mediation or settlement achieved, it could be entered as a judgment of the court at that time. If, however, at the end of that process there was not a successful mediation, but the parties think that it would be useful, then the case could be referred to an attorney for further mediation efforts.

Mr. President, this legislation would hopefully

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encourage a relatively small group of attorneys with specialized expertise in medical malpractice cases to serve as those mediators so that individuals with expertise not only in the law and the risks of mediation, but also in the substantive areas of medical practice would be able to facilitate and hopefully reach a resolution of those claims. So I want to commend the parties who have participated in the negotiation of this. I want to thank Senator Harris for his involvement and his support of this amendment, and I believe that this will be yet another effort in our ongoing efforts to alleviate or reduce the amount of needless litigation, particularly in the area of medical malpractice. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

The Senate is considering Senate Amendment Schedule B. Do you care to remark further?

Senator Boucher.

SENATOR BOUCHER:

Thank you, Mr. President. Very briefly, any time we have a colleague that stands before us and says

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that this was a great amendment that was negotiated between the trial lawyers and the medical societies of Connecticut it is an occasion for a celebration, I might say. I think that is quite an accomplishment given the many years, I know, of angst and discussions that many of us have been involved in in trying to mediate between the two sides, where much has been said about Connecticut's hostile -- oftentimes hostile legal environment with regards to practicing medicine in Connecticut, particularly for some very difficult specialties in the area of obstetrics and neurosurgery and so on. So I am here to heartily endorse this particular amendment and hope it gets a unanimous approval. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

Senator Kissel -- I'm sorry.

SENATOR KISSEL:

Thank you, Mr. President. It's great to see you there this Saturday afternoon.

THE CHAIR:

Always a pleasure to see you, sir.

SENATOR KISSEL:

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And you know, I think the people of the state of Connecticut are well served knowing that their legislature is hard at work on a sunny, 85 degree, April Saturday afternoon.

Just very briefly, just a couple or two quick questions just to clarify -- because I know that one of our colleagues definitely would like to vote on this particular bill and I'd like to accommodate our friends.

Regarding the aspect of the bill in section 12 regarding an ability to go and -- actually, it's -- yeah, it's in section 12 regarding the ability to review the information when there's a complaint filed. I note that it says that one can go in there and review the file and the documents, but one may not copy those documents. To me, if you're able to sit there and review them all, if you're going to use anything in there, I don't understand why you can't copy portions. But to make it even more clear in the legislative history, since one is afforded and opportunity to sit, go to the -- with ten days written notice -- go to the Department of Public Health, sit there, review the file, can one bring in a pad and

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paper and write down information from the review?

Through you, Mr. President.

THE CHAIR:

Senator McDonald.

SENATOR MCDONALD:

Thank you, Mr. President. Through you to Senator Kissel, there would be nothing that would prohibit an individual from making notations while reviewing the file. But the limitation on the copying was because there could be information relating to pending litigation that would otherwise not be publicly disclosable, but there's nothing in the legislation that would prevent an individual from taking personal notes.

I should also mention, as long as I have the floor -- I should have said this earlier, this legislation would only apply to complaints filed on or after October 1st of 2010. and I just -- though it says it in the legislation, I did want to make it clear for legislative intent purposes, that it would only apply to claims filed on or after that date.

THE CHAIR:

Senator Kissel.

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SENATOR KISSEL:

Thank you very much and I appreciate that response because I can definitely see an individual in charge of facilitating this in the Department of Public Health perhaps being overly cautious and saying, "Listen, you can review the documents but we're not going to even allow you to take down notes because it says in there you cannot copy the documents." And clearly that's not the intention of this legislation. One can take individualized notes on these matters and there is nothing that would allow the Department of Public Health to prohibit that.

The other part -- and believe me, I could go on for an hour on this particular amendment, but I won't. But I won't. But I did have an awful lot of questions in the second part as far as the formalized procedures. Because it does allow for a 120 procedure, but I did note in the statutory framework that at every turn there's also -- and that's 120 calendar days -- but then, at every turn there is allowed for the assignment, again, to the judge in the first instance and then to the attorney in the second instance, 20 business days, which actually would have

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the effect of gobbling up half the time period that had been allowed at the outset to conduct this. So there really might only turn out to be a fairly limited window in order to move forward with this, but the very precise second question that I have is that on the second referral -- the first referral are the mandatory mediation goes to the presiding judge and/or his or her appointee in the judicial system. The second referral goes to an attorney. And I understand that attorney would have experience in the field of medical malpractice, but would only necessarily have to have been admitted before the Bar for just five years, which, A, seems to me, not a lot of time to build up expertise, especially in an area as nuanced as medical malpractice, but also, I'm just wondering where or who's charged and where would there be found a list of the potential attorneys that could be used to draw from at that next referral period? And what I mean by that is this. What I'm driving to is this. Where that attorney gained his or her experience may have a major impact on how that attorney views the case. If that attorney's wealth of medical malpractice experience came from the defense bar, that

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may raise certain concerns by a plaintiff's attorney. If that individual's wealth of experience came from the trial bar in pursuing medical malpractice cases, that may affect how a defense counsel looks at that particular mediator. And I'm just wondering if it would be the court's responsibility, since in the last section of this amendment they are charged -- they are given authority to adopt such rules as they deem necessary for the conduct of the mediation -- if it would be the court's responsibility to come up with a list of attorneys and then it would be up to the plaintiffs and the defendants to sit down and together pick out a name or is it contemplating that it's like picking a name out of a hat? I just don't know how -- there's nothing in here that tells me how that process might unfold and I can see that as having a tremendous impact, not only on the results of the mediation process, but how it's really sort of -- I'd like to see this process embraced by both sides going forward and I'd like to make sure that we set it off on a good trajectory. Through you, Mr. President.

THE CHAIR:

Senator McDonald.

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SENATOR MCDONALD:

Thank you, Mr. President and through you to ~~the~~ Senator Kissel, the legislation contemplates that ~~the~~ the presiding judge would make such a referral. It's not unlike a situation where judges already can appoint special masters to facilitate particular cases. Sometimes that is to facilitate complex discovery disputes, to be, in essence, an extension of the court outside of the court room. And oftentimes, that falls to very seasoned attorneys, though this legislation only requires that such an attorney have practiced for at least five years, it doesn't mean that it is necessarily be somebody who's only practiced for five years. And in my experience, when judges make referrals to special masters or attorneys such as this they are individuals who are highly respected in the legal community by all sides. The reality is that there won't be buy-in into the mediation process unless both parties have faith in that process.

And under this legislation there's nothing that compels continued mediation. So that if either party feels that the process is not productive, that it is not fair and even to every party, they can discontinue

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it and resume the litigation. Through you, Mr. President.

THE CHAIR:

Senator Kissel.

SENATOR KISSEL:

Thank you very much. Just as a final follow up to that last statement by Senator McDonald, there would not -- it's not anticipated that if an individual felt that they had a problem with the appointed attorney mediator that they could perhaps object and ask for a different one, it's simply that they would just say, "I don't feel that this is productive." They would fall out of the mediation program and then continue along with the litigation? Through you, Mr. President.

THE CHAIR:

Senator McDonald.

SENATOR MCDONALD:

Thank you, Mr. President. Through you to Senator Kissel, this legislation doesn't get into that level of detail. Again, in my experience, most litigants would seek to suggest a name. Most judges would ask the litigants, "Do you have a name of an attorney you

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can both agree on? And if you don't have a name then I would, as a judge, give you a name." So given the opportunity, most litigants pick their own name so that they can be in charge of the process, at least to some extent.

I should also say finally, if that informal process isn't sufficient, the legislation does allow the judges of the Superior Court the ability to adopt rules under Section 51-14 to implement the mediation process. Through you, Mr. President.

THE CHAIR:

.. Senator Kissel.

SENATOR KISSEL:

Thank you very much and I appreciate the colloquy with Senator McDonald. I didn't want to delay this for any extended period of time.

I think this is an important step, again, as Senator Boucher so eloquently put it, any time that the lions sleep with the lambs on any given day you can choose who is the lion and who is the lamb, but if the trial lawyers and the medical society can sit down and hammer out a forum where they can iron things out, I can only hope that Republicans and Democrats can do

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the same in the next five days of our legislative sessions.

So with that, I'm happy to support this amendment. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

Do you care to remark further on Senate B? Do you care to remark further?

If not, the Chair will try your minds. The question before the Chamber is the adoption of Senate B. All those in favor please indicate by saying aye.

SENATORS:

Aye.

THE CHAIR:

All those opposed say nay.

The ayes have it. Senate B is adopted.

Will you remark further on the bill as amended?

Will you remark further on the bill as amended?

Senator Harris.

SENATOR HARRIS:

Thank you, Mr. President. If there's no objection, I request this matter be placed on the consent calendar.

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THE CHAIR:

Is there objection? Is there objection? Seeing
none, so ordered. 1/5/10

Mr. Clerk.

THE CLERK:

Calendar page 31.

SENATOR LOONEY:

Mr. President.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, we'd
call for a vote on the consent calendar at this time.

THE CHAIR:

Would the clerk please call the consent calendar
and make the appropriate announcement.

THE CLERK:

An immediate roll call has been ordered in the
Senate on the consent calendar. Will all Senators
please return to the chamber? An immediate roll call
has been ordered in the Senate on the consent
calendar. Will all Senators please return to the
chamber?

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Mr. President, the items placed on the first consent calendar beginning on calendar page 7, Calendar Number 348, Senate Bill 250. Calendar page 14, Calendar 471, substitute for House Bill 5339.

Calendar page 23, Calendar number 77, Senate Bill 262.

Calendar page 28, Calendar 189, substitute for Senate Bill 248. And Calendar page 38, Calendar number 349, Senate Bill 272.

Mr. President, that completes the items placed on the first consent calendar.

THE CHAIR:

The machine is open.

THE CLERK:

The Senate is voting by roll on the consent calendar. Will all Senators please return to the chamber? The Senate is voting by roll on the consent calendar. Will all Senators please return to the chamber?

THE CHAIR:

Would all Senators please check the roll call board to make certain that your vote has been properly recorded.

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If all Senators have voted and all votes are properly recorded, the machine will be locked and would the clerk please announce the tally.

THE CLERK:

The motion is on adoption of Consent Calendar Number 1.

Total number Voting	34
Those voting Yea	34
Those voting Nay	0
Those absent and not voting	2

THE CHAIR:

Consent calendar 1 is adopted.

Mr. Clerk. Senator Looney.

SENATOR LOONEY:

Yes, Mr. President, if the clerk would continue with the call of the calendar. I believe calendar page 31, Calendar 219.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Calendar page 31, Calendar 219, File Number 304, Substitute for senate Bill 402, AN ACT CONCERNING THE BEHAVIORAL HEALTH PARTNERSHIP,

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 1
1 – 325**

2010

Next, we'll hear from Wendy Furniss from the Department of Public Health.

WENDY FURNISS: Thank you, Representative Ritter, Senator Harris and members of the committee. Good morning. I'm Wendy Furniss from the Department of Public Health. I'm the branch chief in health care systems and a registered nurse. And I would like to briefly comment on just four of the bills that are before you this morning.

SB 262
SB 270
HB 5286

The first one is Senate Bill 248, AN ACT CONCERNING ADVERSE EVENTS IN HOSPITALS AND OUTPATIENT SURGICAL FACILITIES. The Department opposes this bill as it's currently written. The Department has regulations that have been in place since 2004 mandating the report of adverse events by these two types of health care facilities. In addition, when the Department does on-site inspections at these facilities we do a review of compliance with the reporting law and we compare facility reports against complaints that we've received from patients and families, referrals from other agencies and sources and from data that we collect during our licensure or Medicare certification reviews.

So a good bit of the oversight that's required by the bill, in terms of audits, is already being completed by the Department. Certainly, our expectation is that all health care facilities will comply with the law. We do, as I said, audit for compliance with the law. We have found, since 2004, in six years, we've only found, I believe, one or two instances where facilities failed to report an adverse event that should have been reported under the law and we did cite violations in those instances.

I think it's important to remember that half the states in the country do not require reporting of adverse events from health care facilities. So Connecticut is moving at the forefront of this reporting process. We were the second state in the country to begin mandatory reporting. Though the system may not capture everything that we wish it would, I think it's doing a pretty good job.

Are there other things -- other kinds of information that I think should be shared with the public? Absolutely. And I think through the Department and the patient safety organizations perhaps we can begin to publish more information along the lines of Pennsylvania. They choose an area like pressure ulcers; they publish information about what hospitals are doing to improve the care for patients with those conditions. And I think that could be very useful information.

The other thing in Senate Bill 248 that the Department had some concerns about was in Section 4, which requires reporting of infection rates of health care associated infections. It was unclear to us whether all infection rates would need to be reported or only those that have been selected by the commissioner of Public Health's Health Care Infections Advisory Committee. The Department would like to focus on selected infectious processes where evidence-based research exists that show that particular preventive efforts really can make a difference.

For example, the central line infections that currently all institutions are collecting data on, there's a bundled set of interventions that we know can prevent this type of infection. Every infection of that type that's prevented saves the health care system \$50,000. So we

would rather focus efforts on a cost benefit sort of analysis of which infections could we have the most impact on by data collection and reporting.

Data collection and reporting requires huge amounts of staff time. So the Department would require additional staff just to track all of the reports and rates that were coming in from other health care entities. At this point, the Department cannot support that because the Governor's budget does not allow additional staff for the department.

I would like to just briefly mention Senate Bill 262, collaborative drug therapy management agreements. The Department opposes the bill in its current form. Not that we oppose protocols for drug therapy management because I think those are necessary. But the Department of Consumer Protection is the licensing agency for pharmacists. They are the agency that regulates pharmacists and has regulations in place for their practice.

The Department of Public Health should not write the regulations about collaborative drug management protocols when the Department of Consumer Protection is the agency of cognizance. So we would recommend that DCP promulgates the regs and the Department of Public Health would be more than happy to assist with that process.

Senate Bill 270, which is an act concerning gifts from pharmaceutical and medical device manufacturing companies, I believe is a very important bill. A similar bill was proposed last year. This bill bans all gifts to health care providers from these types of companies. The Department opposes this bill only in that the Department of Public Health would be

substantially similar to any way or the same as our requirements.

A reciprocity would be your licensed in another state and by virtue of that license you can automatically come and work in our state. So we don't have any reciprocity for I don't think any of the professions that we regulate right now.

REP. HEINRICH: Okay. Thank you.

My other question is actually a different bill. It was 248. With regard to the publishing of adverse -- or I mean reporting of adverse events --

WENDY FURNISS: Uh-huh.

REP. HEINRICH: Are -- are those results published publically?

WENDY FURNISS: What's published currently are aggregate results.

REP. HEINRICH: Okay.

WENDY FURNISS: The Department publishes an annual report on adverse events and we list out by the, I think, it's now 35 categories of reports; that we had 40 percent were falls and how many falls we had, but it's not split out by institution.

REP. HEINRICH: Is there a reason for that?

WENDY FURNISS: There -- there is, in that, in order to have the data split out by institution meaningful to the public a great deal of risk adjustment would need to be done to the statistics. I'm not a statistician but the folks at the Department who say we need to do

that say that if we reported just raw numbers to people it would be meaningless, because clearly the larger tertiary care centers, as we find in Hartford or in New Haven, would have lots more probably of everything, just based on large patient population, a sicker population that they're dealing with, and the types of procedures they do.

So you need to risk adjust because otherwise you can't make comparisons.

REP. HEINRICH: Uh-huh.

WENDY FURNISS: And I think the desire for public information is in order for consumers to be able to make reasonable decisions. So the Department does not want to publish information that wouldn't contribute that in a meaningful way. I do think we could be doing a better job in Connecticut of publishing the efforts that institutions are currently making. There's a statewide pressure ulcer collaborative. There's a statewide fall prevention collaborative, which probably nobody in this has heard about but that I believe where patient safety activities are occurring that really will benefit every person who goes to the hospital or surgical facility.

REP. HEINRICH: Thank you.

Thank you, Madam Chair.

REP. RITTER: Further questions from the committee?

I have, I guess, it's perhaps more of a comment on -- regarding Senate Bill 248, and -- and this is a distinction that I've had perhaps a little difficulty making myself in talking about this bill is that I believe the testimony really concerns two types of events. One is

the hospital acquired infection.

WENDY FURNISS: Uh-huh.

REP. RITTER: And I know you talked about the pressure ulcers and -- and some of the other reporting that we've done in association with hospital acquired infections but it's also my understanding the impetus for the bill is not hospital acquired infections so much as it is other adverse event outside of hospital acquired infections. And I just wanted to point that out for the committee because the current reporting system we have for the hospital acquired infections, which was referred to in the testimony several times has -- has been around for a little while and I -- it's my understanding that the Department has been making plans to perhaps make that reporting more robust.

WENDY FURNISS: Yes.

REP. RITTER: But the instances that brought the bill at least to -- this proposal to my attention were not hospital acquired infections but more in the category of adverse events. Probably before the day is over we'll have a chance to hear a little more clarity about those adverse events but I just wanted to make -- put that on the record that those are perhaps two different things. And if you want to comment on that, certainly, I would be --

WENDY FURNISS: You're absolutely correct, Representative Ritter. That was probably a good way to distinguish that the bill does look at two different sets of events.

REP. RITTER: Thank you.

Representative Esty.

REP. ESTY: Just as a further follow-up on that, I think it's important for the public to understand, we are trying to get at how do we get to best practices dissemination and this is really part of that effort. It isn't happening as much as it should in the infection area, where we know what to do and it's still not being done. And -- and it is possible to make comparisons when its publicly published.

I can use an example of when my father got a hospital acquired infection at Stamford University Hospital. Well, in fact, Stamford does a lousy job compared to other similarly situated hospitals. They are not following checklist procedures.

And so part of this is, in fact, a stick and it's shaming of institutions that are not doing what we know would help and part of the expansion is to find what are other areas which will both protect the public, and frankly, help lower cost of care by preventing things that are being done out there, which could be corrected, if we actually knew what was going on and people weren't so worried about malpractice that they actually were forced to disclose what is happening so we can find out about and try to fix it.

And I think it is really the effort we're undertaking here. And if you can help us figure out how to get that goal.

WENDY FURNISS: Uh-huh.

REP. ESTY: If this is not the way to do it -- what we're doing now isn't getting to those --

WENDY FURNISS: And I think --

REP. ESTY: What we're doing now is not working.

WENDY FURNISS: I think the two points that you mentioned are probably the ones that we all need to then focus on. One is to compare similarly situated medical centers and then the second is that checklist of interventions, there are evidence-based bundles of care, that you described, that do work and we know that. And we have scientific studies that say that.

I couldn't agree more that those are the best practices we would like to disseminate to everyone and have everyone in Connecticut using them in their institutions. I think then we might see a real benefit. Thank you.

REP. RITTER: Any further questions from the committee?

Senator Harris.

SENATOR HARRIS: Thank you, Madam Chair.

Good morning.

WENDY FURNISS: Good morning.

SENATOR HARRIS: I don't know if you have the bill in front of you or not but on line 69, actually the sentence that starts on line 68 and it ends on line 70, which I'll read, states that, "the department shall --

WENDY FURNISS: Uh-huh.

SENATOR HARRIS: -- in a public forum, select those hospitals or outpatient surgical facilities that are to be subject to such audits." What's your interpretation of in a public forum? Do we have to rent out the Civic Center to --

WENDY FURNISS: I wasn't sure, Senator Harris, exactly what that meant. And perhaps in later testimony, we'll have clarification on that.

Department of Public Health certainly feels it is the expert agency in terms of health care acquired conditions, auditing health care -- we utilize primarily registered nurse inspectors to assess care in hospitals because we feel that we are the experts in doing that. I'm not sure what the attorney general's office will bring to us in terms of those audits or, quite frankly, what's meant by the public forum.

SENATOR HARRIS: Do you -- you do random annual audits in other contexts?

WENDY FURNISS: We do both licensure inspections. We do Medicare inspections. We do complaints in response to any public complaint that comes in. So we're in these institutions multiple times in a year doing an audit, if you will, we call it inspection of care or evaluation of care, I believe it's the same thing as an audit where you review medical records and compare those against, as -- as the other committee member mentioned, evidence-based best practices.

SENATOR HARRIS: But do you do -- those sound like those are regularly scheduled not random. I think --

WENDY FURNISS: They are random. They are unannounced. They are random in that I have to, for example, license a hospital every four years, but I'm in there a lot more often than every four years in response to complaints, in response to the need for Medicare certification inspections. Audit isn't really a term that's used a lot in the health care inspection vernacular. So that to me sounds more like

financial audit.

SENATOR HARRIS: Okay. We'll ask the Attorney General about that. Thank you.

WENDY FURNISS: Thank you.

REP. RITTER: Further questions from the committee?

Thank you very much for you testimony.

WENDY FURNISS: Thank you.

REP. RITTER: Next, we will from OPM Deputy Secretary Michael Cicchetti.

And yes, he's here.

MICHAEL CICCHETTI: Good morning, Representative Ritter, Senator Harris. For the record, my name is Michael Cicchetti, deputy secretary at the Office of Policy and Management. I'm here to offer some comments on House Bill 5289, AN ACT CONCERNING THE SALARIES OF THE CHIEF MEDICAL EXAMINER AND DEPUTY MEDICAL EXAMINER.

You have my testimony so I wont read it word for word, but I just wanted to outline a couple of points.

Number one, this is identical to a provision that was passed last year out of this committee. Two, this really is not -- commenting on the level of salary that the two individuals make. It's really just putting in place the checks and balances that we believe are necessary. There's no other positions in the state that -- that deal with directly, that are entirely funded by the general fund that have no provision for oversight from the Office of Policy and Management in terms of the level of salaries and the amounts of raises that are

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PUBLIC HEALTH COMMITTEE

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Speak for other facilities. I don't know but it didn't seem like it.

REP. RITTER: Thank you. And that may or may not become a clarifying issue but I just wanted to have that on the record.

Are there any other questions from the committee?

Hearing none, thank you, Representative, for your testimony.

REP. CHRISTOPHER WRIGHT: Thank you.

REP. RITTER: Our next speaker will be Senator Gary LeBeau.

SENATOR LeBEAU: Thank you, Madam Chairman, Mr. Chairman, members of the committee. I'm going to be very brief. I'm here to talk on Senate Bill 248, an act concerning adverse events at hospitals, et cetera. And I'm just going to say one item, which I'm sure you're aware of, but I want to make sure people understand this, that there are 100,000 preventable deaths in the United States hospitals, and this equals 20 preventable deaths per hospital.

And I brought up with Felecia Gerardi, who is a constituent of mine, who is a constituent of mine who has had one of these adverse events. And -- that took about 30 seconds. I'm going to stop right there and give her my time, if that's okay.

FELECIA GERARDI: Good morning, Senator Harris and Representative Ritter and other distinguished members of the Public Health Committee. My name is Felecia Gerardi. I live in Ellington, Connecticut. I am here strongly supporting the Senate Bill 248, requiring hospital specific

information on adverse event reporting.

I had a really bad experience in a hospital. My story has been submitted. What is important for you to know is that instead of one day in a hospital, I was there for over 30 due to medical error. I am going to be filing a complaint with the Department of Public Health against my doctor who did the surgery during which she severed my ureter and put two holes in my intestine. I wonder if what happened to me was ever reported to the Department of Public Health. I nearly died.

The public has a right to know. And by passing this bill, the public could access -- access the information on the DPH website. They could see if there was a pattern of errors, whether one hospital had more infections, or medications errors, falls or wrong site surgeries. I believe that the very visibility of the report will create urgency in the hospitals to increase measures and oversight, thereby creating greater safety and better outcomes.

Hospitals complain about the punitive nature of the fines of up to \$10,000. What about the punishment victims of error and negligence experience. I face lifelong pain due to an eight by ten inch mesh that holds my organs in place. And think of the cost, over \$250,000 on what was supposed to be a one day surgery.

Please pass this bill and help the people of Connecticut. Thank you.

REP. RITTER: Thank you very much for sharing your story. And I think we wish you the best -- to a person, wish you the best.

FELECIA GERARDI: Thank you.

cetera.

SENATOR KANE: Thank you.

Thank you, Madam Chair.

REP. RITTER: Any other questions?

Senator Debicella.

SENATOR DEBICELLA: Thank you, Madam Chair.

Just a question about current law is -- right now is it prohibited smoking inside child care facilities and this bill would simply expand that to the entire grounds or -- is my understanding of that correct?

DAWN MAYS-HARDY: In day care facilities? Is smoking prohibited in day care facilities? Yes, during operating hours smoking is prohibited.

SENATOR DEBICELLA: So basically the effect of this bill would simply be to say that now you can't smoke anywhere on the grounds because right now people might be smoking outside but not inside. Is that correct?

DAWN MAYS-HARDY: That's correct.

SENATOR DEBICELLA: Great. Thank you.

And thank you, Madam Chair.

REP. RITTER: Further questions from the committee?

Hearing none, and I had announced Dr. Salner next but we have our last public official, who will come before him, and that is Attorney General Richard Blumenthal.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Thank you, Chairman Ritter and Chairman Harris. I thank the committee for permitting me the opportunity to testify about Senate Bill 270. I've submitted testimony on a number of other measures but I'd like to concentrate on this bill, AN ACT CONCERNING THE -- I'm sorry the actual number of the bill is 248 -- I have submitted testimony on 270 -- AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL CENTERS.

I am accompanied today, with the permission of the committee, by Angel Morales, who has a personal experience that I think speaks more eloquently and powerfully than I could to need for this measure. But I am here today because there is a disgraceful legal loophole in our provisions on reporting medical errors and mistakes known as adverse events for "never" events. Unfortunately, these "never" events occur much too frequently. The number of deaths in Connecticut, alone, due to these medical errors or mistakes since 19 -- since 2004 is 116. There have been 116 deaths in Connecticut hospitals or surgical centers due to medical errors or mistakes since 2004.

And we're here to ask that the Legislature close this loophole in the present law. Perhaps unintended by the Legislature when it amended the law in 2004 but it permitted these adverse events to go undisclosed, unreported, uninvestigated. This bill would accomplish a number of central goals. It would require reporting to the Department of Public Health as well as investigation.

The Department of Public Health would conduct random audits of health care facilities to determine compliance with the reporting requirements and examine more closely the

closely -- the reported adverse events. The annual report, obviously made public, would include the results of such audits as well as the other information submitted to the Department of Public Health.

It would also provide, very importantly, protection for whistleblowers against retaliation. Anybody coming forward from the hospitals or surgical facilities giving information could be protected against any sort of adverse action or retaliation against them.

This bill has been modeled after the five states that have adopted similar measures; Colorado, Indiana, Massachusetts, Minnesota and Washington. Essentially, it is not only for benefit of patients, as people undergoing treatment, but also consumers who are making choices about where they want to go for surgery or send their loved ones. It gives them the kind of information that they need to make smart choices.

The sunlight of information is always the best disinfectant and these measures are a prescription for prevention. They deter medical mistakes as well as a cure for the mistakes themselves because the information provided may enable many hospitals to avoid litigation and to diminish overall the number of lawsuits resulting from these adverse events.

I would like to ask Mr. Morales to give you a brief description so that we have sort of a face and voice for the problem about his experience recently with his father, with the committee's permission.

REP. RITTER: Thank you. You may go ahead, perhaps briefly.

ANGEL MORALES: Good morning. Thank you, Attorney General. Thank you members of the committee.

Very briefly, my father suffered from a subdural hematoma back in 2008 at Hartford Hospital. I did file -- I questioned the hospital as to the event that occurred and I didn't had different stories; one from the physician, one from the nurse, the unit manager. And it was very conflicting.

When I filed a complaint to the Department of Public Health, two years ago, as of today, I have not heard anything. I think it is unfair to my father as a patient. I think it's unfair to my family to -- for us not to get these questions answered. And I am here to support Senate Bill 248 because I believe it is about time that health care providers are held accountable for their actions. And we will continue to fight, you know, with our -- whatever resources we have and with the help of the Attorney General and members of the House and the Senate -- actually the Senate, to make sure that this bill does pass.

You know, put yourself in a situation like we did, my family. How would you feel if a loved one of yours would fall, suffer from a subdural hematoma. My father lost short-term memory. Something that will not be recovered ever again. And it hurts me every single day. And I'm here, again, to support this bill. And I trust wholeheartedly that soon, you know, we get answers to our questions.

And my father is currently at Hartford Hospital. He suffered from a cardiac arrest on Sunday and -- a week from yesterday, and he's still in the intensive care and I hope by testifying here that this will not be in any

way shape or form retaliation against my father. So -- but again, you have to give credit when credit is due, when you do right or when you do wrong. I think that we need to be held accountable for -- for these actions.

Thank you.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Thank you.

REP. RITTER: Thank you, Attorney General and Mr. Morales. And thank you for sharing your story with us.

Are there questions from the committee?

Senator Prague.

SENATOR PRAGUE: Thank you, Madam Chair.

I feel badly, Mr. Morales, that this happened to your dad. I want to ask our attorney general a question.

How do you get around the fact that sometimes hospitals don't document their mistakes and don't document the adverse events? What do we do about that?

ATTORNEY GENERAL RICHARD BLUMENTHAL: Well, I think hospitals are doing a better a job. The general trend in the country is toward not only better documentation but also more disclosure. And, you know, I think I should emphasize that we're not here about a single hospital or about the vast majority of doctors, surgeons, other caregivers in those hospitals. These kinds of errors or mistakes, fortunately, are a very small proportion of the total.

But this measure will, in effect, require that kind of documentation. It will require better

record keeping. The hospitals have procedures to require it already but it will provide additional incentive for the hospitals to make sure that there are backup and check procedures.

SENATOR PRAGUE: Thank you for that answer.

And I'm wondering why Mr. Morales couldn't get the information as to what happened to his father.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Well, again, if I may respond -- I don't mean to respond for him, but since his case in litigation -- potential -- I shouldn't say litigation -- since, first of all, he is involved with his father's case, it may well be that Hartford Hospital has the records and would disclose them at some point. His father is still in treatment there and I think that's an issue that he will have to work out with them.

SENATOR PRAGUE: And if may, Madam Chair, if I may ask one more question, would his attorney have access to the records?

ATTORNEY GENERAL RICHARD BLUMENTHAL: Well, again, I can't -- I don't want to speak for him or his attorney. There have been instances, putting aside Hartford Hospital, we're not about --

SENATOR PRAGUE: No, we're not here about Hartford Hospital because I could tell you a horror story about another hospital. But I'm just wondering if attorneys have access to the records.

ATTORNEY GENERAL RICHARD BLUMENTHAL: And the answer is that sometimes there are difficulties in obtaining access and that is a reason why this kind of measure offers the prospect of less

litigations because once the truth is known, people can deal with it on both sides.

SENATOR PRAGUE: Thank you.

REP. RITTER: Thank you.

Representative Heinrich.

REP. HEINRICH: Thank you, Madam Chair.

Good morning or afternoon, I guess, now. Mr. Attorney General, one of -- we heard earlier today from the Department of Public Health, who opposes this legislation. And I was hoping to get a little clarification. Right now, they -- they report in aggregate and my understanding is we would like them to be reported individually in this bill. And I'm sure you've heard the argument that it -- there would be risk factors that need to be worked in size factors.

Do you see this as a hurdle to reporting individually and if so or if not, can you offer some suggestions that we might be able to build into this that would allow -- that would allow individual reporting with these risk factors taken into account?

ATTORNEY GENERAL RICHARD BLUMENTHAL: I think, Representative, that goal can be accomplished through the regulations. It's much easier to do so then through legislative thresholds and criteria and so forth. But there are clearly ways to deal with that issue and, you know, I've heard the argument again and again that there's -- there are disincentives to reporting for the professionals that they'll be less likely to report it. There is disclosure.

But, you know, in my view the -- the medical

profession has come a long way toward accepting the need for this kind transparency and most responsible members of it are ready for it. And I think there are ways to deal with those factors and others through the regulations and the safe guards that can be (inaudible.)

REP. HEINRICH: And -- and one final quick question: Many of these things are required to be reported already and so if they can report it in the aggregate they do have the information already. So it's just disaggregating that information wouldn't be an entirely large amount of work. Is that your understanding?

ATTORNEY GENERAL RICHARD BLUMENTHAL: The -- the information should be there.

REP. HEINRICH: Okay.

ATTORNEY GENERAL RICHARD BLUMENTHAL: It's just a question of how it's reported. And what is disclosed and how the investigations are done. This measure provides for, in effect, additional layers of reporting and disclosure of which the public really deserves.

REP. HEINRICH: Thank you very much.

Thank you, Madam Chair.

REP. RITTER: Any other questions from the committee?

I have one or two. And -- and I know, Attorney General Blumenthal, that you were not here earlier perhaps to hear the testimony from the Department of Public Health but we had several questions afterwards and I had a concern that much of that testimony dealt with the issues around the required reporting surrounding hospital acquired infections rather than this

issue, which is an adverse medical event. And if you look carefully at the bill, in Section 1 it's very clear that this bill is talking about the adverse medical events that are identified on the National Quality Forum's list, not hospital acquired infections.

And I didn't know if you wanted to speak to that distinction as well because I believe it has been -- well we haven't heard all the testimony -- but in the minds of many people in the discussion, perhaps, are sometimes cluttered with the lack of distinction between these events. And in that discussion, also, I was seeking an idea, if you have an estimate how many of these events this might involve in a given year.

ATTORNEY GENERAL RICHARD BLUMENTHAL: I'll try to provide it. I'm not sure that the information is even readily available. But the distinction that you mentioned is important. Obviously, hospital acquired infections may not be the consequence of these adverse events, medical errors and mistakes. Equally important hospital acquired infections are certainly adverse to the patients when they happen and there is a growing body of the medical community that believes stronger steps should be taken to prevent hospital acquired infections.

But this measure really deals with much more blatant, flagrant avoidable, I guess the term is really avoidable mistakes and errors going from, you know, the proverbial sponge left in the patient to the kind of programs that Mr. Morales has just described to operating on the wrong knee or -- which is a different class of error than hospital acquired infection. And the best hospitals, and I would wager the majority in Connecticut, have actually adopted

new procedures to prevent these kinds of errors.

And I suspect that Connecticut will rank high if this measure is adopted. Will rank high not only in the transparency gradation but also in the assessment of how well we're doing in preventing such errors because we have great hospitals here in Connecticut that are moving forward to try to prevent them -- to try to prevent adverse events. So I think there is an important distinction and I think this bill recognizes it.

REP. RITTER: Thank you.

Another question that we had in an earlier discussion concerns lines 69 and 70 of the proposed bill where it indicates that the Department of Public Health in a public forum shall select those hospitals or outpatient surgical facilities. And I believe Senator Harris asked the question as to, do you have a vision of what that public forum might be? We seemed to not be clear on that.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Well, certainly, you know, I could say at the very outset as to the details of the bill, we're happy to -- to talk about possible modifications to improve them. Our view is that the meeting -- there ought to be some meeting, not necessarily a legislative committee hearing, but some kind of meeting that is open and accessible to the public.

REP. RITTER: Thank you very much.

And cert -- there are several areas in the bill where that might happen but certainly this is one is sort of left out perhaps to us. And I had another question that has left me at this

moment so I will ask if anyone else on the committee has any further questions?

Representative Esty.

REP. ESTY: Thank you, Madam Chair.

Good afternoon. I guess I want to be clear because I've gotten questions in my district, which actually has quite a few nursing homes and other facilities and hospitals that have -- they believe are institutions, which would need risk adjustment to have proper reporting here. And I guess it gets to the question of, are we after, here, corrective, preventative efforts, or are we after punishment? Because how you structure this matters a great deal depending on what your objectives are.

Hugely important because I think some in the medical community are very concerned when they look at this and look at the structure and they say you may be mouthing the words of transparency and correction but this reads to us as punitive. And I -- and I'd like to be clear what we're going after here because I don't think we can optimize both. We can't. I know that we can't. You know, and we will not be able to able optimize both.

So I'm trying to get a feel from you not just what led to pushing this but you do see -- how should be balancing those because efforts we make in one will actually be counter to efforts in the other.

ATTORNEY GENERAL RICHARD BLUMENTHAL: This measure is very much about prevention not about punishment. The penalties in the bill would apply to failure to report or disclose. They're not punishment for the errors or the treatment or the judgments that are made. That

is an issue that the individuals and the institutions will have to address. And there are other forums to address it. This measure is about reporting.

And, as was indicated earlier, that information should be there. There should be no additional cost to compile it. Any good institution has this information and much more. So the thrust of the bill, the intent and purpose are about, I use the transparency, disclosure, reporting. It is not punitive. It should have no penalties against the doctor or against the hospitals.

REP. ESTY: As a follow-up though, the -- the question that was raised by -- by some constituents and was raised here earlier this morning, how do we ensure that we have appropriate comparisons? If we have very different population pools in different institutions, they are concerned that the public without making some adjustment for comparable population that transparency alone could be misinterpreted as an institution that is, in fact, exemplary but of the nature of the patient population it serves would appear to be doing a poor job.

And I think that is a legitimate concern. You know, how are we comparing apples to apples and oranges to oranges. And if you're willing to work with us and if we decide to forward with DPH on that significant issue because really you're covering a large number of institutions and what we don't want to do is then incentivize institutions to cherry pick patients.

ATTORNEY GENERAL RICHARD BLUMENTHAL: I think --

REP. ESTY: In the sense, that they will otherwise

be -- be tagged with actually having a high risk population as opposed to practicing medicine and not following best practices.

ATTORNEY GENERAL RICHARD BLUMENTHAL: I think that is a very legitimate concern and should be addressed but it is a concern that I hear repeatedly when it comes to consumer protection. In other words, you know, consumers won't know. In the little bit -- in some ways it would be a little bit like a car manufacturer saying well the defects in our automobile if they're reported may lead people to buy less of them and people who can't afford a higher price vehicle shouldn't be told about the defects because they can't afford the higher price vehicle.

And, you know, consumers -- I have a theory and maybe you don't agree, but I think consumers can make these choices. If they are informed by an institution or a hospital or a nursing home facility, you know, we have higher risk patients. You're going to see some numbers here or you can, you know, you can judge for yourselves, come around, visit. You know, we deal with a high risk population. Just as somebody going for surgery or exper -- or, you know, cancer treatment that is at the cutting edge has to make judgments about whether they are willing to undertake the risk.

But I think, generally, consumers can be told the truth and make sound judgments and those risk factors that you mentioned are a very legitimate concern and maybe there is a way of ranking or specifying to consumers or providing caveats or whatever that will enable better informed judgments. If Department of Public Health embraces the goal, it can play a very important function in educating consumers as can the institutions to prevent any

misconceptions.

REP. ESTY: Thank you.

REP. RITTER: Thank you.

Are there any other questions from the committee?

And I believe Senator Harris has some.

SENATOR HARRIS: Thank you, Madam Chair.

Mr. Attorney General, thank you for coming here, as always, and for your service to the citizens of Connecticut.

Mr. Morales, thank you for being here and your courage to relay your personal experience and we wish your father and your family the best.

I guess we -- sunlight always is the best disinfectant. I know that the intent here is -- is good but we always have to balance, and I think Representative Esty was kind of getting to this or did, how much information is actually given and being sure that the information that is given is sufficient or not too much information to allow consumers to make informed choices.

And I guess one of things that I'm looking right now at the adverse events reports from September 8, 2009 by frequency, and unfortunately, Mr. Morales, the most frequent one is falls, the frequency of 502; 41 percent of all adverse events reported. As you probably can imagine, there are different types of falls. There are falls that you can say because maybe the patient wasn't restrained appropriately given the condition of the patient. That there is -- that never should

happen. But there are also falls where somebody has to get up at night to go to the bathroom and they don't present as a risk of fall and an injury that way, and they trip because they are unfamiliar with the room, no fault to the hospital. And that's also I think reported.

Do you envision that there is some kind of description or context given to some of these reports so that it can be put into context?

ATTORNEY GENERAL RICHARD BLUMENTHAL: If there is reporting, Senator Harris, and again, I want to emphasize the legitimately -- the legitimacy of your concern as well as Representative Esty's about risk factors, about the potential context so that it is accurate and truthful about any report. And yes, I would envision that there should be actual context that balances a report. In fact, makes it more accurate and more explanatory than simply the aggregate numbers.

SENATOR HARRIS: That I think would be helpful. I'm looking at another one, which is only 20 occurrences; 1.6 percent of obstetrical events resulting in the death or serious disability to the neonate. I can imagine that there are some that are caused by inappropriate perhaps negligent behavior but there are also things that occur perhaps because of something physiological with the mother. How are we able to distinguish between those? Because I guess what I'm getting is that we hear the stories that we know, like your father Mr. Morales, things that shouldn't happen.

By the same token, our hospitals see, you know, thousands upon thousands of patients on a daily, monthly basis and overall they provide good care. How do we figure out if it's really

a problem or just something that occurs because we're human beings and we're fallible.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Well, you know, I don't mean to duck the question but all human beings are fallible, which is why we have checks and balances when human beings make very serious judgments. And hospitals have developed procedures to overcome the effects of fallibility as routine as checking the marks as to where the surgery is to be performed so that it is in the right place for the right reason. Computerization of medical records will eliminate many errors due to handwriting mistakes, misfiling, and so forth. So we're advancing through technology to -- to respond directly.

I think that a lot of these problems can be dealt -- can be addressed in regulations as has been done in those other states where these laws have been adopted, most prominently Massachusetts and Minnesota and Washington, I believe. We can provide some of that background to the committee if you wish. I think your concern is certainly legitimate one and the hospitals and other institutions are -- are rightfully concerned and we need to be mindful of that concern.

Where the -- where the problem is the result of physiological, inevitable failure, that fact should be known very clearly.

SENATOR HARRIS: And that's what I was getting at. I used the word fallible and --

ATTORNEY GENERAL RICHARD BLUMENTHAL: Right.

SENATOR HARRIS: But I appreciate you delving into that part of the answer. But I was really more thinking of not fallibility of the human being

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but the, I guess, the humanness of the human being.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Right.

SENATOR HARRIS: The fact that, you know, that life can be sometimes a very thin thread depending on our makeup, et cetera. Well, I appreciate you bringing this forward --

ATTORNEY GENERAL RICHARD BLUMENTHAL: Thank you.

SENATOR HARRIS: -- and addressing this issue. It obviously is important to strike that balance between appropriate information for consumers to make informed decisions. And also, on the other side avoiding, sort of a scare that is unnecessary. So that's what we have to start here and we look forward to working with you to -- to make sure that we do that.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Thank you. I appreciate that, Senator. And we also, on my behalf, want to listen to the hospitals and surgical centers and others who may be affected directly because they have -- and we have been listening to them because they have a set of concerns that are legitimate and bona fide and they deserve to be heard. So we're open to work with you on all of the details and provisions.

SENATOR HARRIS: Thank you.

REP. RITTER: Thank you.

Are there further questions from the committee?

Thank you very much. And Mr. Morales, in particular, thanks for -- for sharing your story and our heartfelt hopes for your father.

to hurt you. It's going to taste horrible, so you probably wouldn't finish it.

And the same thing goes with an acidified food product if left in the most undesirable conditions, let's say, you forget, you know, you open it and then you don't put it in the -- in your fridge or something. Because of that acid, it's as Anita mentioned, that it's a very, very good barrier against any kind of mold, yeast growth, bacterial growth and also botulism.

REP. RITTER: Thank you very much.

Are there any other questions from the committee? Thank you.

We'll next be hearing from Susan Davis and she will be followed by Bruce Lott.

SUSAN DAVIS: Representative Ritter, Senator Harris, members of the Public Health Committee. My name is Susan Davis and I urge your support of House Bill Number 5287.

SB 248

We are happy this bill will allow us to make salsa without the expense of a commercial kitchen. Value added products tend to add more to the bottom line than the products they are made of. The costs in logistics of producing products in a commercial kitchen keeps many people from creating food items that will bring in extra income to the farm.

As a former dairy inspector for the State of Connecticut, I like the provisions that will ensure the consumer buys a quality product. This will also help my marketing. I can use the certificates and a test results as further proof that my salsa is truly special.

Having participated in Lebanon's farmers markets the last two years, I know how fussy a buyer of produce can be. Now those surplus tomatoes will become a wonderful salsa, rather than ending up as a special treat for our flock of chickens.

In conclusion, as Attorney General Blumenthal stated in his earlier testimony on Senate Bill 248, about consumers being able to make informed decisions, I also believe the consumer understands product labeling and disclosures.

When I bring my salsa to market and someone is there to purchase it and I explain to them it was made in my kitchen and it has the correct pH and my water is tested properly, and I've taken the food preparation course; if that scares them, they can go -- there's a couple places in town where they can go buy the typical jarred stuff on a shelf.

And I'd also like to close with a little comment. When we talk about these homemade foods, I noticed earlier you guys were passing around cookies and, you know, where they in a prepared kitchen or was it one of your friends? And I noticed that that -- those comments didn't seem to be happening. So, with that --

REP. RITTER: For purposes of the record, I made those cookies myself last night. And to further introduce all kinds of concerns, my stove broke on Friday and I had to use the oven next door. So good luck untangling that one.

Are there any questions from the committee?

Senator Prague.

SENATOR PRAGUE: Thank you, Madam Chair.

The next bill that we're going to hear is Senate Bill Number 248, AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES.

Our first Speaker will be Jennifer Jackson and she will be followed by Dr. Louise Dembry.

JENNIFER JACKSON: Thank you, Representative Ritter and Senator Harris and members of the Public Health Committee. My name is Jennifer Jackson. I'm president of the Connecticut Hospital Association and I appreciate the opportunity to testify on Senate Bill 248, AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES.

CHA opposes this bill because it does not make changes to Connecticut's adverse event reporting system that improves patient safety. Specifically, we oppose the removal of confidentiality and the imposition of penalties, because we believe that an effective adverse event reporting system must be confidential and non punitive.

We also oppose the provisions regarding DPH audits and infection reporting because we think they are duplicative of efforts already underway.

Although we are opposed to this bill we are unequivocally supportive of adverse event reporting. I want to make sure that I'm very clear about that. We think adverse event reporting is an important part of building a culture of safety where adverse events are reported and examined and what is learned from those events is then used to prevent future events and to improve care.

All hospitals have internal adverse event

reporting systems on which they rely to improve care. You'll hear about that from the hospitals. It's part of what they do everyday, an important part of their focus of building a culture of safety. All hospitals also report in the statewide reporting system and are working collectively to learn together from what has been reported.

You heard in Wendy Furniss' testimony this morning about the two statewide collaboratives that we've done through CHA's patient safety organization, which -- where we have made remarkable progress on two of the most commonly reported events, patient falls and pressure ulcers.

As proud as we are of that work that we've done together and the progress that we've made on what we've learned from the system, we know that we have a lot more to do to work together from -- to learn from each other about how we can improve patient care and safety.

And we ask that you support those efforts by ensuring that Connecticut's system encourages reporting in a confidential non punitive environment.

CHA and its member hospitals are deeply committed to patient safety and being accountable for improving care. So we thank you for your very careful consideration of this important issue. Thank you.

REP. RITTER: Great timing. Thank you very much.

Are there questions or comments from the committee?

I want to just perhaps ask you to repeat a portion of your testimony. It's my

understanding from your testimony that specifically, that every hospital in the state currently has an adverse event reporting system in place. Am I correct?

JENNIFER JACKSON: Yeah. They have an internal one that they use and then those events are reported to the State. Very -- in all cases, their internal system is actually broader than the state system. They investigate near misses and they encourage employees to report anything actually that they think may create a problem with patient care so that it can be acted upon.

REP. RITTER: And once that information gets to the State, and I'm assuming you mean to the Department of Public Health, then it is your understanding that what happens?

JENNIFER JACKSON: The State assesses every event that comes into them. They investigate many of them.

REP. RITTER: Do you have an opinion about what percentage of them perhaps are actually investigated?

JENNIFER JACKSON: I think it is a very high percentage. As Wendy talked about this morning, the department is very active in the hospitals. They are out there frequently and it is an important part of what they examine when they're out. They look at how the hospitals have responded to any adverse events.

REP. RITTER: In the testimony this morning and at a couple of points there was some discussion made about the apparent confusion between hospital-acquired infections reporting and the annual report that is issued from the Department of Public Health on

hospital-acquired infections, versus what this bill seeks to look at.

And in some of the testimony from the Department of Public Health, we learned -- understood from them, that while they, in many cases, visited hospitals quite a bit, which I have no doubt that they do. I hear from my hospitals all the time, that they're there a lot investigating this, that and the next thing, which is laudatory.

My concern is that in some of the reporting of that, these things are, perhaps, being a bit confused and that not all of those investigations are for adverse events. Would you like to comment?

JENNIFER JACKSON: They -- it is -- they are not. They are for many different reasons that the health department talked about. I think that the distinction that you're making between an adverse event report and infection reporting is a very important one, because there are many ways in which we are -- hospitals are accountable for the results and processes that they have in place.

So for their performance, an infection reporting is in that category where we use scientifically valid measures. We are committed to public reporting on our outcomes of care as well as those processes that the experts know make a difference in care.

Adverse event reporting is very different. It is not performance reporting. It is designed as a system so that we can aggregate information and learn from it and improve systems and analyze the risk around events or processes that we know could harm patients. So they are two very different things. I think

it's an important distinction.

REP. RITTER: But am I correct in understanding from your testimony that although that's very important and valuable information, it's not your position that that is important or valuable information for the public to see?

JENNIFER JACKSON: Infection reporting?

REP. RITTER: No. Adverse event reporting.

JENNIFER JACKSON: Correct. We think for the reasons that we've articulated, its not about performance. The experts that -- and we've seen it in other industries; in the aviation industry, in the chemical manufacturing, the nuclear industry.

There are a lot of studies that show that you have the system so that there is this culture of reporting everything. That it is not about blame, but it is about making sure that everything is brought forward so it can be examined and acted on.

And then you have an outside third party to whom you report, is what they find in many effective systems. So that all that information can be aggregated and acted on. So what we think is important for the public to know is, what hospitals are doing in response to what we have learned from a reporting system, not the specifics of each event.

REP. RITTER: And I hope the committee will indulge me for a moment in commenting on that because you did mention the nuclear industry, and I come from the one district in Connecticut that is home to our nuclear power plant.

And I would like to just take some exception to

your comments, at least regarding that industry and the benefit of very specific and very public adverse event reporting.

For many years that was not the case. And certainly among the public there was a large perception -- we made the cover of Time and Newsweek over this down in my town. And it was not a good time, and justifiably so. However, there was a huge issue about the nature of that reporting, irregardless of the level of event. In other words, the severity of the adverse event.

And these events ranged from simple -- no, I would say simple, because I'm not a nuclear person, either -- from human error or errors in communication, and ran all the way through the gauntlet to the infamous missing fuel rods, which actually still have not been found. A fairly serious event.

And in that process, painful as though it was, lots of changes happened to the nuclear industry, but a big change that happened there was the very increased level of public scrutiny of every single event that occurred.

And I believe, and of course they're not here to comment, but as certainly I believe the power plant owners as well as the residents of the community have a very different opinion about how they feel about their power plant now, that we understand these events; what occurred, why, how, where.

And I wondered if you wanted to perhaps comment on that.

JENNIFER JACKSON: I appreciate that opportunity and you're far more of an expert on that industry

that I. We've actually patterned -- what we've learned from the most is the aviation industry. Lucian Leape, who's the father of this study, started with those industries.

And I just want to make sure that I'm clear that we do believe in public disclosure. Adverse event reporting is a very small part of what hospitals do to improve patient safety and all quality. And hospitals will tell you that very often when there is an event they do openly disclose them and they discuss it. They are required to discuss it with the patient, they often do with the family. But we're talking about a system that is a small piece of this very important culture that we're trying to build.

REP. RITTER: Thank you for your comments. And maybe we need to have some more conversations, but I'm not sure I quite understand the parallel.

It's my belief and certainly been my experience that everyone has benefited in more -- in many ways, I think, from the increased public knowledge of this type of reporting, at least in the instance I was talking about in my community. And I believe also the operators and the employees at the power plant have a very different view, too, and a very different level of pride in their work.

And I think that's something that is, perhaps is done pretty well with increased level of scrutiny.

JENNIFER JACKSON: And we would very much appreciate the opportunity to have more conversations. And I do think that we do need to do a much better job about talking about what we have learned. And we would like to work with the

department in terms of being accountable for how we have learned and implemented processes to learn from the reports to the adverse event reporting system. So we do need to talk about that more.

REP. RITTER: Thank you. And those are conversations that, yes, I believe certainly the State can benefit from.

Are there more questions or comments from the committee?

Senator Harris.

SENATOR HARRIS: Thank you, Madam Chair. Good afternoon -- almost evening.

Don't you think that the chilling effect of -- the potential chilling effect of being open and not having confidential would be overcome by a random audit, that there would be incentives for the hospitals to report, because if they don't they could get caught in a random audit?

JENNIFER JACKSON: Well, hospitals are very committed to reporting. I have to admit, I don't really understand the statements or what's behind them that hospitals aren't reporting, because the regulator, that very vigorously regulates hospitals, has talked about today and in other settings that they are very comfortable that hospitals are reporting.

So we are very committed to reporting and we don't feel that there is non reporting that would be uncovered.

SENATOR HARRIS: And I'm not making that statement for the record that there isn't reporting going on. One of your arguments in opposition to this bill is that a confidential system, I

think, would best ensure full reporting internally within hospitals, correct?

JENNIFER JACKSON: That it helps create a culture of safety where reporting is encouraged, that people feel very safe about coming forward and talking about adverse events as well as near misses.

SENATOR HARRIS: But wouldn't the -- again, there by an institutional incentive to make sure there's full reporting even in an open system if there are random audits that could actually catch a hospital, if you will, if they do not disclose?

And it would actually be worse, perhaps, if you aren't disclosing it and you get caught through one of these random audits of.

JENNIFER JACKSON: The hospitals already have an incentive to report in addition to the fact that it is consistent with the obligation that they have to their communities to actively improve care; the fact that it is the law that they must report.

And they are heavily regulated by DPH, by the joint commission, who also investigates adverse events and requires schools to have done was called a "root cause analysis," a very thorough examination of the event.

So hospitals already have an incentive to report and they do comply with the law. They do report.

SENATOR HARRIS: Thank you.

REP. RITTER: Are there further questions from the committee?

Thank you very much. And I gather we will be

talking about this.

Our next speaker will be Dr. Louise Dembry and she will be followed by Jeff Flaks.

LOUISE DEMBRY: Thank you. Good evening -- at least it seems like evening to me. It must seem like evening to you. My name is Dr. Louise Dembry and I'm a hospital epidemiologist and codirector of quality improvement support services at Yale New Haven Hospital.

And I appreciate the opportunity to testify for the Connecticut Hospital Association in opposition to Senate Bill 248, AN ACT CONCERNING ADVERSE EVENTS IN HOSPITALS AND OUTPATIENT SURGICAL FACILITIES, specifically on Section 4A, lines 254 to 257.

This is a section where there's a provision here on reporting hospital acquired infections that conflicts with the work that's already underway by the Department of Public Health's health care associated infections committee.

This committee was established in 2006 as required by AN ACT CONCERNING HOSPITAL ACQUIRED INFECTIONS that passed that year. One of the many charges to the committee is to make recommendations on the measurement and prevention of health care associated infections as well as the public reporting of these infections.

The collection of infection control data requires clear definitions and parameters that must be evidenced-based, risk-adjusted reflect thoughtful processes and ultimately add value by supporting the quality and patient safety mission of the organization's infection prevention program and improve care for patients.

The 2006 ACT CONCERNING HOSPITAL ACQUIRED INFECTIONS takes these considerations into account and requires that measurements that are recommended be capable of being validated, be based on nationally recognized and recommended standards, and also based on reliable scientific evidence.

The collection and analysis of infection control data is a critical component to our quality and patient safety work, and we do it diligently. Infection control data collection happens every day and surveillance occurs throughout the entire hospital using a variety of different measures and methodologies.

It is very resource intense. One of those reasons being that it must be collected by a trained infection control expert and thus, we're careful to only collect data on performance measures that are validated, meaning full use, both scientifically sound and can be used to improve care.

Time spent on surveillance is important, but must be balanced with time spent on prevention efforts, both of which are crucial to maintaining the highest level of safety for our patients. And our prevention efforts encompass not only our staff but also our patients, their families and their community.

The DPH's health care associated infections committee is multidisciplinary, has clinical, operational and patient advocate representation. The committee has experience working together and understands the challenges in infection control data collection surveillance reporting and the nuances of choosing valid performance measures.

We've been publicly reporting central line bloodstream infection data since 2008. The data is validated by the DPH annually and is reported on their website. The committee is currently exploring facility-specific reporting and doing that in the background of prevention efforts that Connecticut hospitals are taking on.

So the Connecticut Hospital Association urges you to let the Department of Public health care associated infections committee continue to work together on this complex issue, which requires choosing validated performance measures including the context and meaning of the data presented and the development of useful consumer information education that can be understood by the public.

And I thank you for consideration and your time.

REP. RITTER: Thank you for your testimony.

Are there questions from the committee? No.

Hearing none, thank you very much.

Our next speaker, for Jeff Flaks, will be Dr. Jamie Roche followed by Joel Faxon.

JAMIE ROCHE: Thank you. Yes. My name is Dr. Jamie Roche. I'm here on behalf of Jeffrey Flaks, who's the Executive Vice President and chief operating officer at Hartford Hospital. I'm here today in opposition to the amendments to Senate Bill 248 in that it fails, in our mind, to make improvements to the quality of care or safety of patients in the state of Connecticut.

Hartford Hospital is absolutely committed to

the prevention of adverse events. As a cornerstone of our aspirations, as a leader in clinical excellence, we're committed to reporting and investigating such events when they do occur, and most importantly, to learn from these events with a goal of enhancing patient care and safety.

We embrace the importance of holding hospitals and providers accountable for the safety and quality of the care that they deliver. We embrace the public reporting of adverse events. We see it as a critical tool in the effort to enhance quality and safety, but the changes proposed in this bill do not advance that objective.

Hartford Hospital has reported adverse events since 2002. We have a robust process for the identification and review of potential adverse events. There are significant resources dedicated to this. We involve all appropriate parties from the staff level through top leadership. Our safety culture is built on a nonpunitive foundation that encourages sharing, reporting and learning. It is through leadership that this occurs. And our efforts are resulting in material quality improvement with demonstrable drops in patient falls, hospital-acquired pressure ulcers and so on.

We place an unceasing focus on quality and safety within the institution. We begin each day with a huddle, a safety huddle of 30 staff from all levels of the organization spending time assessing the opportunities that we might have missed in the last 24 hours.

We value transparency, and for the last two years we have, on our website, published a patient safety and action newsletter highlighting to our staff our accomplishments

and the challenges that we faced and where we fall short. We are very open about this.

Bill Number 248 proposes eliminating the confidentiality of reporting, as you've heard earlier and fines that are in stark contrast to our progressive nonpunitive culture that we and other acute hospitals -- care hospitals around the state are creating.

Our improvement efforts are not based on the avoidance of penalties, but rather on identifying and sharing opportunities for improvements that are in our patient's best interests. Limiting confidentiality will not promote increased disclosure, nor will it enhance safety of our patients.

Please note we embrace the release of additional hospital-specific information on reported adverse events. We believe that we have unique opportunity at this moment in Connecticut to make a real difference by proceeding with creating a system that increases patient's awareness and leads them to an accurate understanding of these events.

We passionately advocate for transparency for empowering patients and for an environment in which institutions can rapidly disseminate practice, and we believe that this can be done and that our patients deserve no less.

We would welcome an opportunity to make this a reality in Connecticut, but not as proposed in this bill.

REP. RITTER: Thank you.

Are there questions from the committee.

I wanted to make one thing clear in my mind and

that is the use of the word "confidentiality."
It's my understanding of -- my understanding of
the terms of the bill that the word
"confidentiality" -- let me rephrase this.

Is that there's nothing in the bill that
contemplates patient confidentiality being
breached, or confidentiality on the part of,
say, someone who reported an adverse event, a
so-called, "whistleblower," or a person in that
respect.

And you can correct me if I'm wrong, however it
is my understanding that the bill, as opposed
to what happens now, simply seeks to identify
the hospitals where the events occur. Am I
correct?

JAMIE ROCHE: I would -- my understanding is similar
to yours relative to the provision of
information about who may have reported or
about whom that report was made. I suspect
that hospitals would be identified. That's a
piece of the confidentiality that I -- that may
be in discussion. We don't dispute that,
though, at Hartford Hospital. We feel that it
may not actually be an issue.

It's, I believe, the context that you provide
to patients in our community as they review a
litany of information that may be, one,
difficult to process and may not provide the
context for understanding rates and trends and
the abilities to compare one report or one
issue to another across the region. And I
think really that's the issue.

A system needs to be developed and this takes
time -- would require borrowing this from best
practice; looking at, for example, what's been
done, as pointed out earlier by Jennifer
Jackson in other states. And frankly,

following the ION's lead ten years ago when To Err is Human came out, we were challenged as a nation to come up with a standard approach across the United States that would address these issues. And today, this would be yet perhaps the 31st example of a different system of reporting. And that's what we have an issue with.

We think a thoughtful approach would be one that would include -- be inclusive of all hospitals in the state and the Department of Public Health to work together to create a platform that would take us to the next level.

REP. RITTER: So I'm going to --

JAMIE ROCHE: It's the contest.

REP. RITTER: -- restate something that I took from this and you may feel free to tell me if I'm incorrect or not. It's -- was my impression from that that it's perhaps -- might be the presentation of the information to the public that might be the problem, not the fact that hospitals so much would be identified as long as the presentation were clear, fairly reported, again from all hospitals. Am I correct, or am I not correct?

JAMIE ROCHE: As we've discussed it at Hartford Hospital, a system we believe could be developed where that would be acceptable. Absolutely, and perhaps add value and advance the quality agenda in the State.

But this bill doesn't address that, doesn't describe, indeed what this would mean and what would be presented to the public and how, and how rates and trends would be identified. That's an issue.

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REP. RITTER: Thank you very much.

And the reason I wanted to be clear about that is -- and I appreciate your being candid -- is that those are two very different statements. And so generally, when we're at the public hearing phase on bills, particularly ones like this that came, I mean, quite frankly there's been a lot of publicity about these recently, particularly that I think has been painful for many people involved.

And so when that happens, of course, it generates a proposed legislation that is far from perfect. So it would be perhaps my hope that we could move to a more perfect or a more positive or useful piece of legislation. And I think quite a few people have already indicated they would be pleased to work in that direction.

JAMIE ROCHE: Absolutely.

REP. RITTER: Thank you very much.

JAMIE ROCHE: Thank you.

REP. RITTER: And pardon me. And our next speaker will be Joel Faxon to be followed by Michael Ivy.

BILL SMITH: Joel Faxon is not here. He had to leave today. I'm Bill Smith and Joel is one of my attorneys.

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Thank you for giving me an opportunity to address the committee. I'm sorry I don't have any prepared remarks, but I'll certainly fill up two minutes.

My wife went in for an operation Tuesday before Thanksgiving in 2005, and -- to repair a broken

collarbone. The operation was successful. She was in recovery.

In about one hour in the recovery, my wife quit breathing. By the time folks were able to get to her bedside and resuscitate her, within less than one minute my wife was -- had irreparable damage done to her brain and she was in a coma and was put on life support. Consequently to that, on December 11th of 2005 my wife passed away.

With that being said, it appears that the current -- or the law that was modified in 2004, the current laws in place now, didn't afford my wife to have a safety net. I believe that one of the things that happened, if you look at the reporting requirements that were done in 2004 versus the requirements now, I think you'll see there's approximately about an 80 percent reduction in the number of adverse effects that are being reported by hospitals.

My feeling is, is that if the hospitals are able to report to everyone adverse effects that go on, that we could all benefit from the Monday morning quarterbacking and things of this nature to do best practices and figure out exactly why something went wrong.

It won't bring my wife back. I miss her terribly, but it might reduce the number of folks that might pass because of something like this that would happen in the future. Please change the law. Thank you.

REP. RITTER: Thank you very much for your testimony.

Like many, we were somewhat familiar with your story from the more recent articles in the paper and I appreciate your sharing it with us

personally.

Are there any questions or comments from the committee? No.

Thank you very much and thank you for sticking with us for what seemed like an interminable amount of time.

Next we will be hearing from Michael Ivy and he will be followed by Tom Balcezak.

MICHAEL IVY: Good afternoon. Thank you for giving me this opportunity. My name is Michael Ivy. I'm the vice president for performance management and risk management at Bridgeport Hospital. I think you have my statement, so I'll just try to summarize some of my thoughts.

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I trained as a trauma critical care surgeon. When I was training, any kind of adverse outcome that you had to present was treated as a personal failing. I mean, that was the feeling in surgeons. In general, you can talk to any surgeon who is my age or older, that's been the feeling for a long time.

It was a pretty punitive environment, actually and as a result of that, things were not really fixed. There was a lot of blame, a lot of finger pointing. To big conceptual progress that's been made over the last couple decades has really been about understanding that there are systems failures that underlie these mistakes and that you need to be able to fix the systems, and you can, actually. There's actually a way to do that. We've actually made a lot of progress. We're able to fix systems.

Now the bigger challenge is openness, getting our staff and our physicians to tell us about things, not just about the big things. We know

when someone dies as a result of an adverse event. That's not the big thing. The goal is to get them to tell us about that near misses, the opportunities that we miss because they go unreported and because they don't want to report them because they don't want to get in trouble.

And so what that requires is a just culture. And so we've actually worked pretty hard on developing a just culture -- and it's actually something that's made popular by a lawyer in New York, if you want to look it up. There's actually a number of very good articles and slideshows that he's put on the web. But that's helped.

I mean, we're really making progress on this and the concerns that I have, you know, about the bill as currently constituted, and you've heard this from, you know, other people, is that, you know, hospitals do get punished for this kind of thing. I mean, let's be clear. I mean, there are adverse consequences for the hospitals and for the people involved in caring for those patients.

And so is a result of that, you worry about the near misses and things like that not being reported and us missing out on opportunities to make the care better.

And that's really all I had to say. If you have any other questions --

REP. RITTER: Thank you very much for your testimony.

Are there questions from the committee?
Barring none, you can go home and have dinner
thank you.

The next person we'll be hearing from is Tom Balcezak followed by Chuck Bell.

THOMAS BALCEZAK: Thank you. My name is Tom Balcezak. I'm a physician, a practicing board-certified internist and I'm also the vice president for performance management and the associate Chief of Staff at Yale New Haven Hospital.

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So in my role at Yale New Haven Hospital, I have oversight over all clinical quality -- I assume that's not for me.

REP. RITTER: That's okay. You can keep going.

THOMAS BALCEZAK: But I have oversight and responsibility for all clinical quality performance improvement and patient safety initiatives at the organization. And adverse event reporting for me, at least at our organization, is vitally important for us to know where to direct our efforts.

You heard earlier in previous testimony that loss of confidentiality, or blame in the public around adverse event reporting creates a chilling effect on individuals who present adverse events or near misses within their organizations and therefore, driving down the opportunities and the opportunities for us to improve.

The primary goal behind adverse event reporting is for us to be able to aggregate those adverse events, understand the systems of care or root causes behind the cause of those adverse events and then fix those systems.

And I think there's a discussion here that needs to be had between the difference between disclosure and adverse event reporting. We

absolutely back disclosure. We want to disclose to our patients and families when things go wrong and it's very important for that to happen on an individual patient-to-clinician level and within organizations.

I don't know that the public needs to know the exact level of detail about that individual's case at the level of the institution. I don't think that does anything to improve the quality or improve the systems of care within the organizations.

I believe that aggregating that data, understanding why things happen and it's usually not the cause of individual failings. It's usually systems of care that goes wrong and then understanding how those systems of care can be improved. And that happens when you get large numbers of adverse events aggregated together and you're able to understand what has gone wrong.

If this bill goes forward, I can tell you with my organization, I'm concerned that there's going to be a chilling effect on adverse event reporting. And from my prospective, adverse event reporting is bigger than what we report to the State of Connecticut. It includes all adverse events, even those that are not legislatively required to report to the DPH.

And it also includes those events where something almost bad happens. And these are the hardest things to get at, when things almost go bad, but there is an individual who fixes a problem and prevents that thing from happening. Those are the kinds of things that I need to know about. So thank you very much.

REP. RITTER: Thank you for your testimony.

Are there questions from the committee? No.

Thank you very much.

Next, we will be hearing from Chuck Bell followed by Len Banko.

CHARLES BELL: Good afternoon, Representative Ritter, members of the committee, ladies and gentlemen. I'm Charles Bell. I'm the programs director for Consumers Union. We're the nonprofit publisher of Consumer Reports, based in Yonkers, New York.

I'm here to express support both for S.B. 248 and also S.B. 270, the drug marketing code and transparency bill. We think both of these measures are very strong, pro patient accountability and transparency bills that should be must-do on sort of a minimal legislation that should be passed for consumers in this session.

I'm going to focus my remarks mostly on the adverse event bill. Consumers are very concerned about medical errors and have very real fear about them. And according to a national survey by the National Patient Safety Foundation, 42 percent of respondents said that they had been affected by a medical error either personally or through a friend or relative.

We believe that Connecticut is at a crossroads and that you have a choice here. We believe the State has not been well served by a culture of excessive medical secrecy. We found the details of the events that were reported in the Hartford Courant last November to be very troubling. And particularly that the State has investigated dramatically fewer adverse events

cases.

We were concerned that the State is, in effect, shielding hospitals and surgical facilities from public pressure to investigate problems, implement corrective action plans and reduce adverse events. There are other states that are taking a different path, both in terms of the 27 states that have passed public hospital infection reporting laws, but also more importantly, states like Minnesota that have implemented public adverse event reporting that now is also accompanied by a 50 member multistakeholder collaborative to improve safety at hospitals.

It had not been the end of the world in Minnesota. It's actually helped to pry the lid off this issue and emphasize that we have to dramatically reduce the rate of medical errors that are taking place in these facilities. What gets measured gets done, and we're concerned that the confidential reporting system that you have in this state has bred a culture of complacency.

And we heard from family members here today, this is a urgent, high-priority issue particularly for patients and their families who have experienced permanent disabling injuries and deaths. And they have courageously and appropriately called for swift reform and they want your assurance that we're going to take away the secrecy and share this information with the public and create the incentives for health care facilities to clean up their act.

So thank you for that. I've submitted two written statements and would be happy to share more information from our organization to help with this legislation and other policymaking.

REP. RITTER: Thank you very much.

Are there questions from the committee? No.

Seeing none, then have a nice evening.

THOMAS BALCEZAK: Thank you.

REP. RITTER: We will next be hearing from Len Banko to be followed by Deborah Parker.

LEN BANKO: Thank you very much. I want to thank the Chair and the members of the committee for allowing me to speak today in opposition to the revisions to Senate Bill 248. I am the chief medical officer at Bristol Hospital and I'm responsible for hospitalwide quality improvement activities there. And I just want to make a couple of salient points which play off of a couple of things people have already said.

I am made aware of all the adverse events that occur at our hospital that had to be reported to the Department of Public Health. It's important that you understand, particularly in light of the previous testimony that the term "adverse event" does not mean medical error. They are confused repeatedly and confounded in the press and on the Internet, but, in fact, only a small percentage of the adverse events that occur and are reported are, in fact, medical errors.

What it does mean is an unexpected bad outcome, which can be due to a medical error, but most often it's not. We investigate every one of these events by use of many tools: our peer review system, morbidity and mortality conferences, and most important, through root cause analysis. Root cause analysis seeks to

identify specific reasons an adverse event occurs, and most importantly, to learn from the event in order to prevent it from happening again:

What you need to know, though, is that the root cause analysis that we do at our hospital are only a small percentage of those that need to be reported publicly. We do them, as people have mentioned previously, around near miss events. In fact, the majority that we do are around those kinds of events and not the ones that we report publicly. We have worked very, very hard to create a culture of safety where no one is afraid to make a report that can identify problems and improve care.

I want to make just a couple of other comments. There's no question that there's a sense underlying some of the material that's put into bills like this and some of the testimony that we've heard, that there is a conspiracy of silence that seems to be believed in this state.

I have to tell you that maybe 10 or 15 years ago that was the case. I can tell you that all of the hospitals, mine included, are working very, very hard to create a culture, a just culture, a transparent culture where people work on every one of these events to try to make sure they do not happen again. It's a complex system, but we're trying very, very hard. This is not a conspiracy to deceive the public.

And the last thing I want to say is that there has been a history of blame and punishment which is played out in the press and even quite honestly, through the Department of Public Health. If you look at Minnesota and you look at Minnesota's website, you will see that that

is part of a collaborative effort between the Department of Public Health, the equivalent of their hospital association and other organizations in the state to take an overall approach to the improvement of care and not to identify individual events and hold hospitals and individuals blame -- to blame for those events. And we need to get past that history and to one where we come out the other side where we work together to get a better outcome.

REP. RITTER: Thank you for your testimony.

Are there questions from the committee? No.

Thank you very much.

Next, we will be hearing from Deborah Parker to be followed by Doug Waite.

DEBORAH PARKER: (Inaudible) that includes both Manchester Memorial and Rockville General Hospital. I am pleased to be here today to have the opportunity to testify in opposition of S.B. 248.

We oppose the bill because the changes proposed to the advance -- adverse event reporting system do not improve quality of care or patient safety. Confidential reporting is imperative in promoting a culture of safety and encouraging open and honest communication among clinicians with the ultimate goal of proving every patient experience at every patient interaction.

We've worked deliberately and diligently to create an environment that fosters quality patient care and patient services. As one of its five strategic pillars, quality and safety is a priority of each and every one of our employees.

I must say that I am most proud of the work that our employees have done in doing proactive risk assessment, conducting failure mode and effects analysis and root cause analysis, and taking an active role in identifying the opportunities to improve safety and quality. This has been accomplished because of the nonpunitive approach to the promotion of improvement.

As an active member of the patient safety organization, we have participated in numerous collaborative initiatives to improve patient safety and quality. Those have already been spoken about: reduction in pressure ulcers, reduction in central line bacteremia prevention, reduction in falls and reduction in the health care acquired MRSA.

We know that a system that fosters patient safety by having confidential reporting actually increases reporting of both events and near misses. I am incredibly fearful that a change to a system that is not confidential and one that imposes penalties and other punitive measures will be counterproductive to continuing all of these positive initiatives.

ECHN along with other Connecticut hospitals work very hard every day to prevent errors from occurring, but when they do occur we investigate them promptly and thoroughly, search to identify the root cause and develop detailed action plans to prevent recurrence. We then monitor those plans and make additional corrections as necessary.

Simply said, taking away confidentiality and adverse event reporting will only undo the measures Connecticut hospitals have taken thus far to provide quality care and a safe

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environment for our patients. Thank you.

REP. RITTER: Thank you very much for your testimony.

Are there questions from the committee? No.

Seeing none, thank you very much.

Our next speaker will be Dr. Doug Waite and he will be followed by Dan Rissi.

DOUG WAITE: Thank you. My name is Dr. Douglas Waite. I am a board-certified infectious disease physician and the hospital's epidemiologist and the vice president for medical affairs and quality at Day Kimball Hospital in Putnam. I thank the committee for the opportunity to testify.

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At Day Kimball we are committed to patient care, quality and safety and to being accountable for improving care and safety. We really owe this to our patients and to our communities to do this. We supported adverse event reporting as an important tool in this effort. In fact, we have expensive policies in place to encourage the reporting of such events by staff, which include assurances to the staff for confidentiality in a nonpunitive approach.

The current statute initially passed in 2002 and then amended successfully in 2004 works quite well to improve quality in Connecticut hospitals. The proposed changes however would reduce the benefits to patients for several reasons.

First, confidentiality in adverse event reporting is essential to the process. Quality improvement experts consistently state that to encourage free reporting, the most ideal

systems should be confidential. Our policies at Day Kimball do, in fact, have a commitment to confidentiality. Experts also indicate that public disclosures of events do not necessarily drive improvements in safety. In fact, public disclosures may actually reduce reporting and thus, reduce our ability to actually implement change necessary.

Second, civil penalties and other punitive measures have a negative effect on adverse event reporting. The national trend in improving patient safety focuses on creating a culture of safety, whereby events are freely reported and not assigning blame or punishment for errors. Doing so has been proven to reduce the reporting of events.

Punishments, in fact, can drive disclosure and reporting underground. And this is a big concern of ours. The purpose of reporting is to identify problems, and to learn from them and to remedy that improves patient safety and quality of care.

If there is a disincentive to staff or hospitals to report such events, the quality improvement process does not work, in fact, cannot even get started. Penalties are such disincentives to reporting.

Finally, with regards to the infection reporting provision, being the hospital's epidemiologist and head of the infection control and prevention department, we oppose the provision on infection reporting as it conflicts with the work currently underway by the Department of Health's health care associated infections advisory committee.

This committee currently is working on exactly this: how to report health care associated

infections in appropriate way with a focus on explanatory consumer information and education with understandable definitions with a focus on -- with -- and scientifically based comparison data. Therefore, the infection reporting provision of S.B. 248 is, in fact, actually duplicative of this committee's efforts. Thank you.

REP. RITTER: Thank you for your testimony.

Are there questions or comments from the committee?

Thank you very much.

Next, we'll hear from Dan Rissi, and he will be followed by Ken Rosenquist.

DANIEL RISSI: Good evening, Representative Ritter and members of the committee. My name is Dan Rissi. I'm the chief medical officer at Lawrence & Memorial Hospital in New London. I appreciate the opportunity to testify in opposition to Senate Bill 248, AN ACT CONCERNING THE ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES.

Lawrence & Memorial Hospital opposes the bill because of proposed changes to the adverse event reporting system will not improve the quality of care or patient safety. We would be delighted however, to work with the committee to develop a system that fosters patient safety through confidential analysis of adverse events in a nonpunitive environment. I think you've heard this now several times.

The concept of analyzing and learning from adverse events is not new to hospitals. We focus every day on providing the very best care for our patients and I'd like to give you a

flavor for what that means in our hospital. We encourage and practice vigorous peer review, root cause analysis, monthly quality council sessions involving physicians, nurses and board members. Above all, we listen to our patients by actively engaging in in their care and through surveys to assure that we are constantly improving the care delivered to our communities.

L & M Hospital is proud to be one of 160 hospitals nationwide participating in the QUEST initiative. This three-year cooperative effort is focused on quality, efficiency, safety and transparency. The participants have set a goal of achieving 100 percent compliance with the publicly reported quality and safety measures.

We are also a leader in Connecticut in reducing the incidence of hospital acquired pressure ulcers and in reducing the incidence of patient falls. Indeed, specifically with regard to preventing the hospital acquired pressure ulcers, L & M's rate is now less than 1 percent, which is a national best practice.

As with our involvement in the national QUEST demonstration Project, we are collaborating with other Connecticut hospitals to reduce pressure ulcers and falls. We share our successes and our failures to learn from each other and to help each other improve care for our patients. We're able to share our successes and failures and to advance quality and patient safety because this work is carried out in a confidential, nonpunitive environment.

While we support the concept of public reporting and transparency is one of the cornerstones of our quality initiatives, we also know that numerous industries have demonstrated the importance of confidentiality.

A nonpunitive system best serves our patients and is best able to promote an environment of rigorous analysis and a thoughtful process for correction and improvement.

Punitive measures have a chilling effect on reporting of adverse events and are in direct conflict with our primary purpose of improving the quality of care and the safety of our patients.

Thank you for your consideration of our position and for your efforts to help us provide the very best care for our patients.

REP. RITTER: Thank you for your testimony.

Are there questions from the committee? No.

Hearing none, thank you for coming from my hospital. We very much appreciate hearing from you.

Next, we will be hearing from Ken Rosenquist and he will be followed by Jean Rexford.

KEN ROSENQUIST: Good evening, Representative Ritter and distinguished members of the Public Health Committee. I'm Ken Rosenquist and I'm president of the Connecticut Association of Ambulatory Surgical Centers and I'm an administrator of an ambulatory surgery center. I'm here to speak in opposition to Senate Bill 248, AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL CENTERS.

As you know, medicine is not an exact science and unfortunately, sometimes there can be bad outcomes with medical procedures. In the vast majority of cases, these unfortunate results are caused not by medical mistakes, but rather circumstances that are beyond the control of

the physician and the facility. This is important fact to consider when reviewing a bill like the one before you today.

The National Quality Forum's list of serious reportable adverse events, or "never events" and the reporting mechanisms that are currently in place today are good for patients and good for health care. At no time are any of these events acceptable. Of that, there can be no argument.

The reporting mechanisms in place today are comprehensive and make the information publicly available in a manner that permits full disclosure of the facts and circumstances of each event. This strength of the system as it exists is that it allows the health care community to disseminate all of the facts of each event in their entirety to allow those facts to be examined with all of the circumstances that lead to an adverse event, and in a way that creates true qualitative improvement.

The information outlets contemplated by this bill are potentially less thorough, less comprehensive and thereby, less fair to physicians attempting to practice medicine under often very trying circumstances. The practice of defensive medicine is a leading driver of cost in our delivery system. A bill which penalizes providers by making adverse events public in a way that may not present all the facts helps to fuel that problem.

As I mentioned, there are things completely out of the control of a health care provider that can lead to a bad outcome. Under this proposal, higher-risk patients with complicated medical problems may find it increasingly difficult to find physicians and facilities

willing to take care of them.

As an example, bowel perforations, or other complications; they are known risks of surgery. This bill would penalize providers skilled at caring for these individuals, these high-risk individuals by making public this kind of adverse event and penalizing them through monetary fines and through inappropriate disclosure.

Lastly, what I want to say is that the ambulatory surgery centers are all members of patient safety organizations. They have very low incidence of any of these adverse events, we're happy to report. And we want to -- nevertheless, we stand in opposition to the increased reporting mechanisms as contemplated by this bill.

I thank you for your time today and I'm happy to entertain any questions.

REP. RITTER: Thank you for your testimony.

Are there questions from the committee?

Seeing none, thank you very much.

KEN ROSENQUIST: Thanks.

REP. RITTER: Our next speaker will be Jean Rexford, and for the record, she will be allowed four minutes for testifying on more than one bill.

JEAN REXFORD: Thank you, Representative Ritter and distinguished members of the committee. First of all, I'd like to say how much we have enjoyed working with the hospital association and in the Department of Public Health on the hospital acquired infections. It has been a collaborative effort.

SB248
SB270

I have heard a lot about collaboration and yet we continue to forget to include the public, and yet we are all the public. I was also thinking about the culture of public safety. To be, the culture of public safety could be emblematic when I look at Cincinnati Children's Hospital's website, it slashes when the last adverse event took place. My feeling is that the hospitals resisted the hospital acquired infections reporting and yet, we've made enormous progress. They are resisting this, but I think working together we can make enormous progress.

The public is very confused. We are -- it is a fragmented industry. We don't really have a health care system. So increasingly, the public has to take greater and greater responsibility. By knowledge -- by knowing where the wrong-site surgeries are, the sponges left in; I believe it's a tool for the public. This is simple legislation that can address a complicated problem.

The other bill I want to talk about is the pharmaceutical bill. This is our third year in raising this as an issue and this is a gift disclosure bill as well as a gift limitation bill.

SB270

Three years ago we tried to codify the pharmaceutical industry's code of ethics and that didn't get very far. Last year it was -- it -- the bill came out of committee, but the reservations were that we would be perhaps hurting jobs in the state of Connecticut.

We listened. We have changed the bill. We believe that if you want to bring in lunch, if you want to bring in small tokens, that's a great thing, but we still need to have a

registration of conflicts of interest, of financial relationships. It's not a small deal. It can be a big deal.

Chuck Bell was looking through the record and seeing, you know, one physician in Connecticut getting 60,000, another, 13,000. I mean, there's a lot of money in this and that's why once again, we believe that the transparency is of critical importance for the benefit of the health care consumer.

I have bundled my pharmaceutical testimony. We wanted to spare you bringing everybody here, but I need to tell you about our growing coalition, that you will see testimony from Steve Smith, the National Physicians Alliance, the AFL-CIO, the American Medical Students Association, Community Catalyst, the Prescription Project, Consumers Union. It continues to grow as the belief that more information for the consumer is a better -- is a good deal.

REP. RITTER: Thank you very much, Jean.

Are there questions from the committee?

Hearing none, thank you very much.

Our next speaker will be Don Ciosek and he will be followed by Angel Morales.

DON CIOSEK: Good after -- late afternoon, almost evening. I try to be as positive as possible when dealing with legislative issues. And that's why, when preparing my testimony, it would have said, good morning.

SB248

But members of the committee and Chairwoman Ritter, my name is Don Ciosek. I'm the state president of AARP which, as you know, is a

nonprofit, nonpartisan organization that serves people 50 years and older. We have approximately 40 million members nationwide, over 600,000 of which are in Connecticut. And AARP is very happy to support Senate Bill 248, AN ACT CONCERNING ADVERSE EVENTS IN HOSPITALS AND OUTPATIENT SURGICAL FACILITIES.

This bill offers important changes that will enhance patients' safety. It requires facility-specific adverse event reporting. These reports will also disclose correction -- corrective action taken by these health care facilities, a summary of action taken by the Public Health Department, and the result of random audits.

Now, there is a distinction between adverse events and preventable medical errors, but preventable medical errors, as a subset, it's been reported that roughly 98 thousand to a hundred thousand people die every year, and if the CDC listed among its causes of death, on its list, this would rank sixth only behind major illnesses of heart disease and cancer and accidents and lower respiratory disease.

So we're talking about very serious issues. And many of the folks that are affected by adverse events or prevented -- medical errors do not die, but, in fact, do live, but have added pain, additional surgeries, prolonged inpatient days, delayed recovery, and more as significant as many other issues, increased cost to our medical system.

AARP believes the proper disclosure of facility-specific reporting would ensure greater accountability and oversight, ultimately allowing the Public Health Department and medical facilities to address serious problems. And it would enhance

consumer ability to make choices in how they receive their medical care.

So we -- we support this effort. We've worked on it in other states, including recently New Jersey's Patient Safety Act, and we hope this bill will pass this committee and onto the bodies of the Legislature. Thank you.

REP. RITTER: Thank you very much for your testimony.

Are there questions or comments from the committee? No.

Thank you very much.

And Mr. Morales spoke earlier. I don't believe he's still here. No. I don't see him.

Our next speaker will be Debbie Thompson and she will be followed by Dr. Michael Tarnoff.

BONNIE THOMPSON: Thank you. Good evening, ladies and gentlemen. It's actually Bonnie Thompson and I'm the director of organizational excellence at the William W. Backus Hospital in Norwich. I wanted to testify tonight in opposition to Senate Bill 248, but, first, I want to thank you for the opportunity to participate in this discussion about the things that we can do to keep our patients safe.

The issues we're discussing today are the same issues that are hospital faces on a daily basis as we interact with our patients and our staff in an effort to improve the care that we deliver. As health care workers, we are privileged to work with people who each day place their lives in our hands. This trust is something that those of us in this room strive to live up to each and every day in a million

ways. Nothing is worse than knowing you've betrayed that trust.

So whether we are planning improvement events or talking with you about proposed legislation, the most important thing we can do is to keep our focus on the patient and keep the conversation open on how to improve care.

Communication, it's the subject of numerous research studies related to patient safety. It's the topic of a joint commission sentinel event alert, and you can find hundreds of books written on the subject. But in the end, they all conclude the same thing: to keep patients safe, we need to keep communication open.

Our concern regarding the proposed legislation is that it closes the lines of communication. Not only will it limit communications between the hospitals and DPH, but it will also weaken the lines of communication between the hospitals and the community.

If the community is only hearing what they think are the bad things, they may actually be avoiding the very hospitals that are working the hardest to keep their patients safe. Patients may actually find themselves unknowingly going to a hospital that is hiding things and not reporting adverse events for fear of repercussions, rather than heading to a hospital with excellent outcomes that has reported adverse events as they attempt to improve the care we all deliver.

Health care is an amazingly complex combination of people and technology. This combination can create miracles. It can also be a recipe for disaster sometimes, no matter how hard we try to control the situation. We cannot create these miracles alone nor can we learn from the

mistakes of others if we are forced to work in isolation. By sharing our triumphs and successes, we developed gold practice standards and by sharing our mistakes and near misses, we save countless lives.

DPH needs to be a partner in patient safety as well as an enforcer. Sharing best practices, as well as adverse events, would encourage hospitals to work with DPH. The proposed legislation would instead discourage conversations regarding improvement and encourage hospitals to report events as infrequently as possible.

DPH has a unique role, much like that of a patient safety officer at any hospital. How do you encourage reporting, improve care and fix the problems? As we know, the saying goes that if you don't know that it's fixed, it can't be -- don't know if it's broken, it can't be fixed.

So I think that to kind of sum it up, I think by making communication a priority and saving the punishment for those who don't live up to their responsibility, DPH could become a catalyst for patient safety rather than a nemesis who must be appeased so we could get back to what we want to do, which is care for our patients as safely as possible.

The citizens of Connecticut do deserve the best health care we can offer them and this means groups of committed people working together to assure the safe delivery of care, not groups of people that are afraid to talk to each other for fear of being publicly chastised.

Thank you for listening to our thoughts and concerns.

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 2
326 – 648**

2010

REP. RITTER: Are there any other questions from the committee?

Thank you very much for your testimony.

We'll next hear from Ken Ferrucci who has successfully bargained for four minutes.

KENNETH FERRUCCI: It was a tough bargain, too. I had to give up quite a bit for that.

REP. RITTER: That would be four minutes.

KENNETH FERRUCCI: I understand and I'll talk very quickly. And I just want to point out -- and one of the reasons that I did make that bargain is we did present you with quite a hearty packet of testimony today on six different bills. So I won't go through them individually, yet I'll be more than happy to answer questions on any of them.

SB248 SB262
SB270

Just to briefly touch on them, they were the requirement for identification badges, which we would support. Want some -- would like a little clarification as to the setting because we think you capture offices in which that is not needed, such as physicians, podiatrists, chiropractors; which there isn't that confusion because of the limited disciplines.

SB265

The epileptic drug bill; in support of that again.

HB5307

The administration of vaccines by pharmacists; we did present testimony in opposition to the way it's drafted because of the various ways and manner in which vaccines are delivered, be it intramuscular, you know, be it different timing, this and that.

HB5290

And then also, we did hear testimony today to consider anyone over 12 an adult. That we would have a concern about also.

The adverse events; we did present testimony is similar to the Hospital Association on that also.

SB248

The collaborative drug therapy agreements; in opposition to that as drafted. It is not as simple a change as I think you've heard today. It does eliminate any setting, but what it also does is it eliminates the limited disease states that were in there originally.

SB262

Before we move forward, the results of the two-year pilot program that were due in 2008, the Commission on Pharmacy did respond that there was not enough information from that pilot program. So I think before we're expanding on the locations, diseases and settings, we really should take a look at what transpired there.

Now, on to the medical device and pharmaceutical gift bill. I just want to first state that, you know, while we believe that there are -- misconceptions exist regarding the magnitude of the impact of gifts on physicians, within the framework of what's before you today, we want to point out a few things.

SB270

You heard about the physician data restriction program that the AMA has that the medical society uses is also. We promote that through our website, through our publications at our meetings. That is available to members to opt out of that rather than reinventing the wheel. We think the language before you should clearly state that that compliance with the PDRP is compliance with the -- by the companies to allow physicians to opt out of having their data shared.

WRITTEN TESTIMONY OF
The Hospital of Central Connecticut
To
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010
Regarding
SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient
Surgical Facilities

My name is Kate Betancourt and I am the Director of Performance Improvement for the Hospital of Central Connecticut (HCC). I appreciate the opportunity to provide comment on behalf of HCC regarding SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

HCC appreciates the *intent* of the Attorney General in advocating for certain modifications to current legislation. We recognize that there is global concern regarding incidents of harm related to healthcare delivery. The problem has been well-defined in both professional and lay literature, and we share the concerns of the nation's leading patient safety experts, e.g. Robert Wachter, Lucian Leape and Donald Berwick. As the committee knows, there is a well-established body of research that demonstrates the need for a *just culture* in assuring that factors impacting safe healthcare delivery are brought to light, and other industries (aviation, nuclear safety) have provided guidance in how best to achieve such an end. It has long since been established that a non-punitive environment, one that balances an appreciation for the role of systems-failure with personal accountability, is the best environment for improving safety. Accordingly, any legislation that fosters a punitive approach would be a step backwards for Connecticut, and that assumption is well founded in evidence-based research.

HCC has been on the same journey as most hospitals in the nation to better understand how errors occur, and we recognize that transparency is paramount in establishing and maintaining the trust of our community. We have worked collaboratively with the Connecticut Department of Public Health since the inception of the 2002 Quality of Care program, and have reported events in accordance with regulatory requirements. We have learned from our colleagues around the state and indeed *around the nation* by sharing "lessons learned" in discussion of actual or near-miss events, and we have in turn shared our gained wisdom. HCC was among the first in the nation in 2002 to voluntarily report performance data for public scrutiny via the National Healthcare Quality Alliance. We have sought the input of nationally recognized patient safety experts in our efforts to improve the culture of our organization, including Dr. James Bagian and Dr. Brian Sexton. Our Department of Surgery spearheaded the introduction of Crew Resource Management (team training) to our organization, bringing safety expert Dr. Donald Moorman to our facility back in 2008. To date, over 200 physicians, nurses and technicians have participated in this important program to improve safety in the perioperative setting. We consistently work proactively to employ strategies to create an environment where risk is minimized, e.g. senior leadership rounds to regularly interact with front line staff and discuss their concerns regarding quality and safety, regular survey of staff to gauge perceptions of safety and hear suggestions for improvement, and significant resource commitment in maintaining a "league" of more than 40 patient safety liaisons throughout the organization. Our nursing staff was the recipient of the 2009 Excellence in Nursing award from the Connecticut Nurse's Association, in recognition of a grassroots project that reduced fall rates on one unit from well above the national average to among the lowest in the nation.

These improvement activities, just a few of the many that are ongoing at HCC, occur as a result of dedication and commitment to providing excellent care to our patients, not from external pressure to improve. Any legislation that increases administrative burden, diverts resources from patient care, and potentially demoralizes caregivers, will be counterproductive to any intended goal of making healthcare safer. Legislation that enhances open dialogue and supports learning would be most welcome.

Thank you for your consideration of our position



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Written Testimony of Matthew Miller, M.D.,

Chief Medical Officer, on behalf of Danbury Hospital

Respectfully Submitted to the Public Health Committee March 1, 2010

Regarding Senate Bill 248 "An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities"

Danbury Hospital appreciates the opportunity to submit comments on Senate Bill 248. At Danbury Hospital, our unwavering commitment to quality care and patient safety is driven by the Board and demonstrated daily by our dedicated team of doctors, nurses and staff. We deploy multiple teams of personnel throughout the organization to monitor and improve patient safety and quality outcomes. Beyond our continual internal efforts, Danbury Hospital has had a long history of comprehensive reporting on patient outcomes to the community. In fact the same outcomes data that are reported to our Board are available to the public on our website at www.DanburyHospital.org.

We are consistently among the first to implement national patient safety best practices. Some examples of these practices are things such as Hospitalist and Intensivist programs, computerized physician order entry, electronic medical records, web-based informed consent/patient education modules, full-time chairmen covering all clinical services, and rapid response teams. We have totally revamped our Peer Review programs to provide centralized oversight, expedited case review, and timely attention to interdepartmental issues. We participate in multiple national quality data comparison programs to compare and improve our outcomes, such as NDNQI (The National Database of Nursing Quality Indicators), NSQIP (National Surgical Quality Improvement Program), ACC-NCDR (American College of Cardiology- National Cardiovascular Data Registry), to name just a few. Additionally, each year we invite external parties to conduct thorough reviews of our complex clinical areas to identify any opportunities for improvement.

We have been committed to developing and maintaining a strong patient safety culture, with a focus on responsibility and accountability. To strengthen this culture, we engaged in comprehensive work to bring "**Just Culture**" into the organization a number of years ago. This model of safety is based on accountability related to behavioral choices and safe system design. All employees are responsible for maintaining safe environments for our patients, and are expected to identify any individual or system issues that might interfere with this. Managers

are expected to be open to safety improvement suggestions, coach or discipline employees on their behavior, and ensure safe system design in their areas of responsibility.

Last year, we implemented an electronic adverse event reporting system that allows for real time notification of actual or potential events. Any employee or medical staff member can report a safety concern or actual event in a very user friendly "click and send" manner. This automatically sends out notification to identified responsible parties, with an expectation for immediate attention and documented follow-up.

We've worked hard to promote an atmosphere of non-punitive reporting, and feel that our efforts have fostered an environment that has been recognized by national experts as promoting a strong patient safety culture. In this time when health care delivery is more complex than ever, it is imperative that our staff and medical staff willingly engage with us in these efforts, without fear of inappropriate punitive action or civil penalties. We have grave concern that the proposed amendments to the Adverse Event Reporting law will have a significant negative impact on these efforts.

Sincerely,

A handwritten signature in black ink, appearing to read "Miller", with a horizontal line extending to the right and a small arrowhead at the end.

Matthew Miller, MD



University of Connecticut Health Center
John Dempsey Hospital

TESTIMONY
PUBLIC HEALTH COMMITTEE

Monday, March 1, 2010

SB 248, an Act Concerning Adverse Events at Hospitals and Outpatient
 Surgical Facilities

My name is Mike H. Summerer, MD and I am the Director of John Dempsey Hospital. I appreciate the opportunity to provide written testimony in opposition to SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

John Dempsey Hospital (JDH) opposes the bill as the changes it proposes to the adverse event reporting system, we believe, would not improve quality of care or patient safety, and would likely have the opposite effect. As demonstrated in other industries, and widely accepted in healthcare, it is important to have a system that fosters safety by encouraging reporting of adverse events in a confidential, non-punitive environment so that trends can be detected and systems can be made safer and more reliable.

JDH has been committed to patient safety since its inception. With the passage of the first adverse event reporting legislation in 2002, JDH has worked closely with the state and CHA to promptly report adverse events and to seek preventive solutions. Over the past year a complete reorganization and restructuring of our quality programs with new medical and nursing executive leadership is in place and has enhanced our focus on safer, reliable patient care of the highest quality.

JDH has developed mechanisms to identify and act on patient safety concerns raised by our employees, providers, patients and family members. We participate in an on-line reporting system with other academic medical centers that allows anyone to report patient safety events without risk of retaliation. These reports allow our hospital to quickly find the root cause of an incident and implement a corrective action plan. This reporting system is just one cornerstone of our safety culture at JDH. A yearly patient safety culture survey of hospital employees is another tool used by our leadership to identify improvement opportunities. We highlight our performance improvement projects each year at an annual Patient Safety Fair.

JDH has been actively involved in several collaboratives sponsored by the Connecticut Hospital Association (CHA) to improve patient safety. Through our current state wide adverse event reporting system Connecticut hospitals have identified the need to improve skin care, take additional steps to prevent patient falls and decrease our infection rates. These collaboratives have been possible because of a non-punitive reporting structure within our state.

JDH is concerned SB248 duplicates improvement initiatives already in place, adds administrative burdens for DPH and Connecticut hospitals, and creates disincentives for reporting. The national safety improvement movement in hospitals, learning from other industries such as commercial aviation, promotes reporting of all incidents and "near misses" so that safety can be improved. A culture of blame will actually have the opposite effect of intent of the bill and will decrease transparency for the citizens of CT.

An Equal Opportunity Employer
 Thank you for your consideration.



**Testimony of Robert Englander, MD, MPH, Senior Vice President,
Quality and Patient Safety, Connecticut Children's Medical Center
To the Public Health Committee
Regarding Senate Bill 248, An Act Concerning Adverse Events
at Hospitals and Outpatient Surgical Facilities
March 1, 2010**

Senator Harris, Representative Ritter, members of the Public Health Committee, thank you for the opportunity to speak with you today. I am Dr. Robert Englander, Senior Vice President for Quality and Patient Safety at Connecticut Children's Medical Center and I am here to speak about Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

Like other hospitals in the state, Connecticut Children's is committed to reporting, investigating, and preventing adverse events. However, Senate Bill 248 does not improve upon the system currently in place, and in fact potentially works as a disincentive to reporting events and improving patient safety. The primary purpose of reporting is to learn from experience, not to impose sanctions and penalties. As we have learned from the well-documented experience of the aviation industry, public disclosure of events does not drive improvements in safety. Non-punitive reporting systems serve the best interest of the patient by encouraging reporting of adverse events as a first step in taking corrective action.

In health care, as in other industries, good people make mistakes for which they are very sorry. In addition, many adverse events as defined by this proposed legislation are unpreventable and yet can be the source of learning for both individual institutions and health care systems. Senate Bill 248, as written, could drive errors into secrecy and that does not benefit anyone. Punitive measures have a chilling effect on adverse event reporting. The national trend in improving patient safety focuses on creating a culture of safety where events are reported, rather than ascribing blame and punishment for errors. There are other, more appropriate mechanisms to ensure accountability of healthcare facilities and professionals. We cannot lose sight of the purpose of an adverse event reporting system: to identify trends of problems and remedy them, which improves patient safety and quality of care.

Connecticut Children's Medical Center is committed to transparency, accountability and creating a culture of safety for all of our patients and families. I urge your committee to reject Senate Bill 248 but also to recognize that a process that encourages reporting without the assignment of blame and punishment is the first step towards making changes that result in improvements. Creating and maintaining systems that encourage collaboration between and among hospitals, and allow our health care system to gain understanding of best practice and learn from mistakes will yield better patient safety outcomes more expeditiously than this bill as written.

Thank you for your time and consideration of this important matter.

TESTIMONY Submitted by
Mary Nolan, RN, MS, CNAA, & VP Nursing and Patient Care Services
And Claire Davis, VP Quality
Norwalk Hospital
To the Public Health Committee
Monday, March 1, 2010

SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient
Surgical Facilities

We appreciate the opportunity to submit testimony in opposition to SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

Norwalk Hospital opposes the bill as the changes it proposes to the adverse event reporting system do not improve the quality of care or patient safety. It's important to have a system that fosters patient safety by having confidential reporting of adverse events in a non-punitive environment.

Norwalk Hospital has worked hard to encourage reporting as a cornerstone of our strong culture of safety. Our commitment to quality and patient safety is proven through our achievements:

- Norwalk Hospital is ranked among top 5% of hospitals nationally in quality, patient safety and low mortality rate (Forbes Magazine, 2010).
- Norwalk Hospital's mortality rate declined to 1.5% in 2009 which is amongst the lowest in the state, region and nation.
- Norwalk Hospital is ranked among the best 3% of hospitals nationally in terms of medication error rates: A computerized physician order entry (CPOE) system to enable physicians to electronically enter patient medications and treatments, along with wireless voice communication for clinicians and bedside electronic patient identification with bar coding for drug administration have led to a decrease in medication errors from 12.8% in 2006 to 2.8% at the end of 2009.
- Pressure ulcers dropped from 6% in 2006 to 1.7% at the end of 2009, well below state and national standards.
- Norwalk Hospital's Intensive Care Unit received the prestigious Beacon Award for Critical Care Excellence recognizing the nation's top hospital critical care units last year – for the third time!
- Norwalk Hospital achieved near perfect scores for Medicare's "Alliance Measures," which gauge improvements in clinical outcomes.

We don't feel that the change in legislation will promote improvement in processes and outcomes. We support spending our valuable capital and human resources to collaborate on evidence-based methodologies that have been proven to reduce mortality, morbidity, and complications. Time and money spent on punitive actions takes away from those endeavors. A recent Forbes article notes that Connecticut is among the top 5% of states with high performing hospitals in terms of quality.

Norwalk Hospital welcomes the opportunity to work in collaboration with the State to set precedents to help hospitals improve, particularly if there has been an event.

Thank you for consideration of our position.



Hospital of Saint Raphael

A member of the Saint Raphael Healthcare System

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**WRITTEN TESTIMONY OF
ALAN KLIGER, M.D.
CHIEF MEDICAL OFFICER and CHIEF QUALITY OFFICER
HOSPITAL OF SAINT RAPHAEL
BEFORE THE
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010**

**RE: SB 248, AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS
AND OUTPATIENT SURGICAL FACILITIES**

The Hospital of Saint Raphael opposes Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

The Hospital of Saint Raphael embraces the value and importance of adverse reporting but must oppose Senate Bill 248 as the changes it proposes to the adverse event reporting system will not improve the quality of care delivered to our patients or improve patient safety. It is critically important that Connecticut have a system that fosters patient safety through the use of confidential reporting of adverse events in a non-punitive environment. We also do not agree with the proposed annual reporting of healthcare-associated infections, as it conflicts with valuable work already in progress by the Committee on Healthcare Associated Infections, which was established by statute in 2006.

The Hospital of Saint Raphael is committed to providing the highest quality care and utilizing "best practices" to improve patient outcomes. We constantly examine our processes to confirm things we do effectively, continually identify areas to improve, and implement the best methods to keep our patients safe. One of the cornerstones of this culture of patient safety is adverse event reporting by our staff and our community physicians. Every employee and physician is encouraged to report safety variances and quality of care issues. These reports can be anonymous, if the reported so chooses, to facilitate reporting that might otherwise be avoided by a reluctant staff member. We believe that mandated public reporting of such events will have the unintended consequence of "driving underground" such reports, impairing our ability to recognize and correct threats to our patients' safety. We take the current adverse event reporting system seriously -- be assured that in addition to changing hospital processes, we hold our employees and physicians accountable, we provide counseling and additional training to correct behavior and reprimand or terminate staff depending on the circumstances causing the adverse event.

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Adverse events reported over the last two years in the area of "patient falls with injury" have led to many initiatives designed to prevent falls and reduce injuries when falls occur including: the purchase of new equipment including specialty beds and commodes, improved training and nursing protocols to screen for risk of fall, intensive review of medication correlations leading to formulary changes, signage in patient bathrooms to remind them to request assistance, hourly rounding to see if help is needed with toileting, and raised toilet seats. The total number of patient falls at the Hospital of Saint Raphael has decreased by over 100 in fiscal year 2009 - the fall rate of 3.75% per 1000 patient days decreased to 3.07% (below the national average of 3.6%).

At the Hospital of Saint Raphael, we have made significant progress toward improving patient safety. In addition to double-checking the identification of a patient and verifying the planned test, procedure or treatment through "time outs," our Hospital has identified several opportunities to improve patient safety and has established quality improvement processes, in many areas, including those published as national patient safety goals. These goals have been accomplished here by forming interdisciplinary teams to examine barriers, implement best practices, and monitor evidence-based processes and patient outcomes to assure that we are achieving our goals. Following are just a few specific examples of patient safety initiatives and our progress to date:

- Goal to decrease central-line associated blood stream infections. We observed an infection rate of 2.0 infections/1,000 catheter days. After our first 3 months of implementing this quality initiative, our infection rate dropped to 1.04 per 1,000 catheter days.
- Patient Safety CUSP Model (Comprehensive Unit Based Safety Program). The Hospital of Saint Raphael has joined 14 other Connecticut hospitals in this national patient safety initiative. This goal includes eliminating central line-associated blood stream infections by standardizing processes, implementing "best practices," learning from past mistakes, and providing additional clinical staff training.
- Goal to decrease angioplasty wait time for patients who arrive with chest pain. Before starting this quality initiative, our mean time from the patient's arrival in the emergency department to correction of the cardiac arterial narrowing at catheterization was 132 minutes. Following initiation of our quality collaborative, our times are now consistently at or below 90 minutes. The mean time for patients treated in December 2009 and January 2010 was 78 minutes. This improvement was the result of substantial changes to processes and staff expectations.

Patient safety initiatives, quality measures and adverse event reporting improve patient outcomes, lower medical costs, and improve healthcare employees' morale and productivity. Patient safety initiatives can be cumbersome, utilize resources and staff

Page 3

time, and can be challenging when changing employee behavior, and yes, many patient safety initiatives, such as physician order entry, can be expensive, but patient safety is a priority and an investment we must all commit to. Hospitals have spent capital on patient safety initiatives at a time when access to capital is very limited. The imposition of fines, as proposed in SB 248, would only further reduce our ability to invest in additional safety measures.

We are confident that healthcare providers and legislators have the same goals - to decrease and prevent medical errors and to ensure that patients are safe and receiving the best quality care. Unfortunately, SB 248 is a disincentive to reporting events and improving patient safety. SB 248 proposes to eliminate confidentiality of reporting and impose fines. Connecticut's hospitals have worked hard to encourage reporting as a cornerstone of patient safety -- SB 248 is counterproductive to this goal. The primary purpose of reporting is to learn from the experience, not to impose sanctions and penalties. Confidential, non-punitive reporting systems serve the best interest of the patient by encouraging reporting of an adverse event which is the first step in taking corrective action. We ask that any changes contemplated to the current adverse event reporting system be carefully considered to ensure that they have the end result of improving patient care.

We urge the Public Health Committee to oppose Senate Bill 248. Thank you for your consideration.



SENATOR GARY D. LEBEAU
Third District

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State of Connecticut
SENATE

DEPUTY PRESIDENT PRO TEMPORE

Chair

Commerce Committee

Member

Finance, Revenue & Bonding Committee

Legislative Management Committee

Transportation Committee

March 1, 2010

Public Health Committee
 Connecticut General Assembly
 300 Capitol Avenue
 Hartford, CT 06108

Dear Members of the Public Health Committee:

Thank you for providing me time to testify before this important committee. Here are some cogent reasons I support Senate Bill 248, *An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities*:

- The Institute of Medicine reports 100,000 preventable deaths in US hospitals. This equals twenty preventable deaths per hospital. Of these deaths:
 - *7,000 from medication errors*
 - *100,000 from hospital acquired infections – some of these are not preventable*
- The health care consumer needs concrete and specific information about hospitals. By publishing, hospital specific information of reported adverse events, the consumer can know if there is a pattern of wrong site surgery, medication error or an outsized infection rate.
- Auditing of the hospitals gives incentives for everyone to report accurately.
- The reporting also gives a heads up to Boards of Directors who generally have not thought of quality and patient safety to be as critical to the running of hospitals as financial statements.
- Reliably delivering the basics of care – which our adverse event reports cover, improves outcomes and saves money. Oftentimes, a high-value care system embraces the appropriate use of scientific guidelines, standard practice, teamwork, checklists and accountability and transparency.

Senate Bill 248 is an important first step

Thank you again for the opportunity to speak before the Public Health Committee.

Sincerely,

A handwritten signature in black ink, appearing to read "G. D. LeBeau". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Gary LeBeau
State Senator, 3rd District



State of Connecticut
HOUSE REPUBLICAN OFFICE
STATE CAPITOL
HARTFORD, CONN. 06106

Chairs Harris, Ritter, Ranking Members DeBicella and Giegler and members of the Public Health committee, thank you for the opportunity to submit comments regarding Senate Bill 248, *AAC Adverse Events at Hospitals and Outpatient Surgical Facilities*.

The House Republican Caucus recognizes the importance of patients feeling confident that the hospitals in our state are of the highest quality. We believe expanding our current hospital errors reporting laws to provide greater transparency to patients is important, but we have concerns that the language contained in SB 248 goes beyond what is necessary.

It is our understanding that the Department of Public Health (DPH) currently inspects the hospitals in the state at least once a year. DPH conducts unannounced "routine" inspections. It also conducts on-site, unannounced inspections based on complaints filed. These are conducted for the vast majority of patient complaints about the care they received at the facility and hospital error (a.k.a. adverse events) reports filed by the hospitals. Since the hospitals are inspected by DPH approximately once a year, we do not feel it is necessary to require DPH to conduct additional annual, random audits of the hospitals.

If the audits are to become law, we believe it is unnecessary to require the Attorney General to be consulted when "developing and implementing" them. We believe DPH has the expertise and ability necessary to carry forward these requirements without the Attorney General's assistance.

We fully support providing whistleblower protections to any hospital employee who comes forward to make a hospital error report. Whistleblower protections are vital in ensuring that hospital error reports are filed whenever necessary. Protections like these guard against any chilling affect for those that come forward to make a report.

We also have concerns with the language of the bill that creates a new \$10,000 civil penalty to be assessed against hospitals. The current mechanism used by DPH to resolve hospital errors or misreporting is a Consent Order, which may already include fines on a hospital. . Currently, any fines assessed and collected are used to improve the quality of care in the fined hospital, as well as throughout the state to inform and teach other hospitals about the error that caused the Consent Order to be issued. Simply creating a

new fine that would go to the general fund does not assist patients in getting quality health care.

We would recommend DPH review its current process and implement best practices in formulating its hospital error reports with the goal of publishing reports that provide the public with relevant, comparable data and information, while at the same time protecting the privacy of patients and healthcare providers whenever appropriate. . In short, we believe it is important that the DPH take into account the public's right to know what is happening at the specific hospitals in the state and that our hospitals continue to report errors and adverse events without it having a chilling affect on patients or hospital workers. .

We hope the committee can work to come up with a compromise that will work for our hospital patients, hospitals and their staff, the DPH and the public at large. We would be happy to assist the committee in any work it does in this area. Thank you.



**TESTIMONY OF
JENNIFER JACKSON
PRESIDENT AND CEO
CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010**

**SB 248, An Act Concerning Adverse Events At Hospitals
And Outpatient Surgical Facilities**

My name is Jennifer Jackson, and I am CEO of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify on behalf of CHA concerning **SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities**. CHA opposes this bill, as it fails to make changes that improve the quality of care or safety for patients in Connecticut's hospitals.

I want to state unequivocally that CHA and its member hospitals are deeply committed to patient safety and to being accountable for improving care and safety. We support adverse event reporting as an important tool in the effort, but we do not support these changes.

SB 248 proposes to eliminate confidentiality of reporting, impose fines, require the Department of Public Health (DPH) to conduct annual random audits, and require hospitals to report annually on the rate of healthcare-associated infections. Hospitals have worked hard to encourage adverse event reporting as a cornerstone of a strong safety culture, and these proposals are either counterproductive to those efforts or duplicative of work that is already being done.

Every hospital in Connecticut has an adverse event reporting system in place. All hospitals are working aggressively on patient safety improvement and all are committed to reporting, investigating, and preventing adverse events. We have been reporting adverse events to DPH since 2002, and supported the unanimously enacted 2004 change in the law to replace the previous classification system with the National Quality Forum's list of 28 Serious Reportable Events, supplemented by Connecticut-specific events determined by DPH.

The number one priority of Connecticut's hospitals is building a culture of safety within which adverse events, errors, and near misses are voluntarily reported immediately and investigated quickly, and where what is learned is widely shared and used to prevent a similar incident. Our hospitals are working continually, individually and collectively, to identify opportunities to improve patient safety. We are especially proud of the work hospitals do together through the CHA Patient Safety Organization (PSO), where we focus on statewide efforts to improve the quality and safety of patient care.

Through the PSO, we have convened several clinical collaboratives—multi-hospital, multi-disciplinary initiatives—and over the past few years, these collaborative teams have made remarkable progress. Collaboratives addressing two of the most commonly reported adverse events, pressure ulcers and falls with injury, have resulted in significant improvements at hospitals throughout the state.

We ask that any changes contemplated to the current adverse events reporting system are carefully considered to ensure the end result of improving care. Evidence from healthcare and other industries where safety is a paramount concern show that confidential, nonpunitive reporting systems encourage voluntary reporting, which is essential in eliminating future adverse events.

Confidentiality in adverse event reporting is essential to the process, thus we oppose section 1(d) of SB 248. The primary purpose of reporting is to learn from experience, not to impose sanctions and penalties. As we have learned from the well-documented experience of the aviation industry, public disclosure of events does not drive improvements in safety. Confidential, nonpunitive reporting systems serve the best interest of the patient by encouraging reporting of adverse events as a first step in taking corrective action.

We oppose the imposition of civil penalties for adverse events as proposed in section 2(a)(8). Punitive measures have a chilling effect on adverse event reporting. The national trend in improving patient safety focuses on creating a culture of safety where events are reported, rather than ascribing blame and punishment for errors. There are other, more appropriate mechanisms to ensure accountability of healthcare facilities and professionals. We cannot lose sight of the purpose of an adverse event reporting system: to identify trends of problems and remedy them, which improves patient safety and quality of care.

CHA also objects to Section 1(g) of SB 248, which would impose random audits of hospitals to review adverse events reported during the one year period previous to the audit. These audits are duplicative of regular surveys of Connecticut hospitals and complaint investigations currently conducted by DPH, and an unnecessary expenditure of limited state funds.

We also oppose the proposal on annual reporting of healthcare-associated infections (HAI) contained in Section 4(a) of SB 248, as it conflicts with work already in progress by the Committee on Healthcare Associated Infections. This committee, established by statute in 2006, is advising DPH on the development and implementation of mandatory healthcare-associated infection reporting in Connecticut.

Thank you for your consideration of our position.



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
LOUISE DEMBRY, M.D., M.S., M.B.A.
HOSPITAL EPIDEMIOLOGIST
CO-DIRECTOR, QUALITY IMPROVEMENT SUPPORT SERVICES
YALE-NEW HAVEN HOSPITAL
ASSOCIATE PROFESSOR OF MEDICINE (INFECTIOUS DISEASES) AND
EPIDEMIOLOGY, YALE UNIVERSITY**

**BEFORE THE
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010**

**SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient
Surgical Facilities**

My name is Dr. Louise Dembry and I am a Hospital Epidemiologist and Co-Director of Quality Improvement Support Services of Yale-New Haven Hospital. I appreciate the opportunity to testify for the Connecticut Hospital Association in opposition to Section 4(a) of **SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities**.

The Connecticut Hospital Association opposes Section 4(a) of the bill. The provision on infection reporting conflicts with the work under way by the Department of Public Health's Healthcare Associated Infections Committee, which is currently considering the implementation of hospital-specific central line-associated blood stream infection (CLABSI) reporting with appropriate explanatory consumer information.

Since 2008, CLABSI data has been reported by Connecticut hospitals to the Centers for Disease Control's National Healthcare Safety Network as required in the 2006 DPH statute. This data is aggregated by the Department of Public Health annually and is publicly reported.

Collection of data, especially infection control performance data, requires clear definitions and parameters that must be evidence-based, reflect thoughtful processes, and must ultimately add value by supporting the quality and patient safety mission of the organization and its infection prevention program.

Collection and analysis of infection control data is a critical component of our quality and patient safety work and we do it diligently. Infection control data collection happens every day, and surveillance occurs throughout the entire hospital. It is resource intense because it must be collected by an infection control expert, and for this reason we are especially careful to only collect data on performance measures that are validated, meaningful, useful, and scientifically sound.

Time spent on surveillance is important but must be balanced carefully with time spent on prevention efforts, both of which are crucial to maintaining the highest level of patient safety. Our prevention efforts encompass our patients, their families, employees, and our community; they reach throughout the hospital environment, from the emergency department to the newborn nursery, and to our outpatient facilities.

The Department of Public Health's Healthcare Associated Infections Committee was established by law in 2006 (Section 19a-490n of the Connecticut General Statutes) to make recommendations on the measurement and prevention of healthcare associated infections.

The Committee is multidisciplinary – with clinical, operational, and patient advocate representation. The Committee has experience working together and understands the challenges in infection control data collection, surveillance, reporting, and the nuances of choosing the right performance measures to report.

The Connecticut Hospital Association urges you to let the Department of Public Health's Healthcare Associated Infections Committee continue to work together on this complex issue, which requires choosing validated performance measures, including the context and meaning of the data presented, and the development of useful consumer information and education that can be easily understood by the public.

Thank you for consideration of our position.



BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

**TESTIMONY OF
Michael Ivy, MD
Bridgeport Hospital
Before the Public Health Committee
March 1, 2010**

**SB 248, An Act Concerning Adverse Events
At Hospitals and Outpatient Surgical Facilities**

Good Afternoon. My name is Michael Ivy and I am the Vice President of Performance and Risk Management at Bridgeport Hospital. I am here today to express serious concern with Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

I am a trauma and critical care surgeon by training, and I have practiced at 4 hospitals in the State of Connecticut; Yale-New Haven, Bridgeport, the VA, and Hartford Hospital. I have been in my present role at Bridgeport Hospital for the past two years, and I chose to become involved in quality improvement and risk management because I know I can make a difference. I am skilled at getting people to collaborate and improve the systems they work in. I am passionate about my work, and I don't think there is anything I can do that is more important than this work.

Like most surgeons my age and older, I was trained to think that errors were the result of an individual failing to do his work competently. It is now clear that only rarely are the mistakes that harm people in healthcare truly individual errors, instead they are the result of a system that is flawed. The recurrence of a mistake can be minimized or prevented by fixing the system itself. It also turns out that if we can get enough openness in our hospitals, where our employees and physicians feel safe in reporting "errors" or "near misses," we can identify the "system" problem and fix it before someone is seriously harmed. That openness occurs when staff members believe we have a "just" culture and know that they will not be punished for mistakes that do not warrant punishment.

We work to improve safety and quality every day at Bridgeport Hospital – that is the most important thing we do. This year, we have worked hard to establish a "just" culture at the hospital, and we are starting to reap the benefits of that work. We want to keep this openness so we can learn from our mistakes and proactively prevent adverse events. Senate Bill 248 threatens to destroy that culture by setting back the culture of openness and inhibiting the progress we are making. This legislation will not make things better; it will only slow us down.

While I believe the proposal is well-intentioned, as written, it will not improve the State's current adverse event reporting system, and would likely work as a disincentive to reporting events and improving patient safety. Confidentiality in adverse event reporting is essential to the process. The primary purpose of reporting is to learn from experience, not to impose punitive sanctions and penalties. Adverse event reporting is a critical first

Page 2
Testimony of
Michael Ivy, M.D.
Bridgeport Hospital

step toward taking corrective action. It is proven that confidential systems encourage, rather than discourage, reporting of adverse events.

To conclude, at Bridgeport Hospital, our highly skilled patient care teams provide safe, high quality patient care to thousands of Connecticut residents. When errors occur, I can assure you that we promptly and thoroughly investigate them to identify the cause, learn from our findings, and most importantly, prevent recurrence.

I respectfully urge your opposition to SB 248 which would likely erode the safety culture we have worked diligently to foster as a means of improving patient care. Thank you for your consideration of our position.

**TESTIMONY OF
Thomas Balcezak, MD
Vice President, Performance Management
and Associate Chief of Staff
Yale-New Haven Hospital**

**Before the Public Health Committee
March 1, 2010**

**AAC, SB 248, An Act Concerning Adverse Events
At Hospitals and Outpatient Surgical Facilities**

Good Afternoon. My name is Dr. Thomas Balcezak and I am the vice president of performance management and associate chief of staff at Yale-New Haven Hospital. I appreciate the opportunity to testify for Yale-New Haven Hospital in opposition to **Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.**

In my role at Yale-New Haven Hospital, I am responsible for oversight of all clinical quality, patient safety and operations improvement efforts for the Hospital.

I believe the proposed Senate Bill is well-intentioned. However, it would not improve the State's current adverse event reporting system, and would likely work as a disincentive to reporting events and improving patient safety. Confidentiality in adverse event reporting is essential to the process. The primary purpose of reporting is to learn from experience, and to make improvements based learning, not to impose punitive sanctions and penalties. Adverse event reporting is a critical first step toward taking corrective action. It is proven that confidential systems encourage, rather than discourage, reporting of adverse events. It is also proven than punitive systems that use public blame and shame reduce reporting rates, thus reducing opportunities for improvement.

In medical care, as in the aviation industry, it is established that improvements in safety come from creating a non-punitive environment, learning from errors, and moving away from looking at errors as individual failures to realizing that they are caused by system failures.

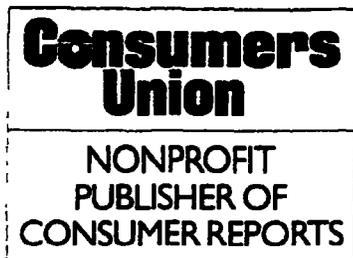
Confidential, non-punitive reporting systems increase reporting, while punitive systems discourage such transparency. Hospitals currently report adverse events and the annual DPH public report of aggregated data has helped hospitals identify problems and has led to improvements in the two most commonly reported events: falls with injury and pressure ulcers.

Removing confidentiality from this reporting process, and imposing fines will have a chilling effect on adverse event reporting. We want to encourage reporting, and the national trend in healthcare is to create a culture of safety where reporting is encouraged, not punished. Our goal is to increase reporting in order to learn from our experiences and, as experience with the aviation industry has demonstrated, individual public

disclosure of events does not drive improvements in safety. Improvements in safety are driven by careful evaluation of events and systems improvements based on findings.

To conclude, at Yale-New Haven Hospital, our highly skilled patient care teams provide safe, high quality patient care to thousands of Connecticut residents. When errors occur, I can assure you that we promptly and thoroughly investigate them to identify the cause, learn from our findings, and most importantly, prevent recurrence.

I respectfully urge your opposition to SB 248 which would likely erode the safety culture we have worked diligently to foster as a means of improving patient care. Thank you for your consideration of our position.



**Memorandum of Support for SB No. 248
An Act Concerning Adverse Events at Hospitals
and Outpatient Surgical Facilities**

Consumers Union, the nonprofit publisher of Consumer Reports and ConsumerReports.org, strongly supports Senate Bill 248. This legislation would require that the Department of Public Health's annual report to the General Assembly on adverse events identify the specific hospitals and outpatient surgical facilities where the adverse events occurred. It would also require the Department of Public Health to conduct annual random audits of hospitals and outpatient surgical facilities concerning adverse events, and include information on these audits in its annual adverse events report. The bill would also provide employment protections to certain individuals who take action in furtherance of the adverse event reporting objectives, provide the Commissioner of Public Health with authority to impose civil penalties against hospitals and outpatient surgical facilities, and require that hospitals report annually on the rate of health care associated infections

SB 248 would help propel health safety and quality improvement forward in Connecticut by establishing higher standards of public disclosure and accountability. SB 248 contains strong provisions to ensure regular public reporting of serious adverse events such as wrong-site surgeries, pressure ulcers and objects left behind after surgery. The bill would also require random audits, to ensure providers are reporting appropriately and accurately. In addition, the bill protects hospital and surgical center employees against disciplinary action or retaliation for ensuring that adverse events are reported to the state.

Public disclosure of adverse events in Connecticut hospitals and outpatient surgical facilities will improve patient safety, and provide valuable information to consumers, employers, and others concerned about improving health care safety and quality. Over ten years ago, in a report entitled "To Err is Human: Building a Safer Health System," the Institute of Medicine estimated that medical errors are the eighth leading cause of death in this country. The report estimated that as many as 44,000 to 89,000 people die in U.S. hospitals each year as the result of medical errors. This is higher than the number of deaths from motor vehicle accidents, breast cancer, or AIDS. About 7,000 people per year are estimated to die from medication errors alone—about 16 percent more deaths than the number attributable to work-related injuries.

Awareness of these problems has been growing. Consumers have a very real fear of medical errors. According to a survey by the National Patient Safety Foundation, forty-two percent of respondents said they had been affected by a medical error, either personally or through a friend or relative. Another national survey, conducted by the American Society of Health-System Pharmacists, found that Americans are "very concerned" about being given the wrong medicine (61 percent), being given two or more medicines that interact in a negative way (58 percent), and complications from a medical procedure (56 percent).

Health care professionals are human beings and like all of us, they sometimes make mistakes. But the problem of reducing medical errors and adverse events is largely a systems problem. And the fact is that some health care institutions are doing a significantly better job than others in improving their quality of care, and reducing errors. The public needs regular, reliable, trustworthy information on how well our health care facilities are doing in training their staff and implementing smart systems to reduce serious adverse events and safety problems. For a variety of reasons, the error rate will never be zero, but it can be sharply reduced from what it is today, by as much as 75% of more

[continued]

Senate Bill No. 248, page 2

By hiding adverse event data from the public, Connecticut is in effect shielding hospitals and surgical facilities from public pressure to investigate problems, implement corrective-action plans and reduce adverse events. In November, 2009, the Hartford Courant reported that public access to hospitals' adverse events has fallen 90 percent since the legislature redrafted the law five years ago

According to the Courant:

"... The state has investigated dramatically fewer adverse-event cases, with about three out of four reported events now closed without a formal inquiry — keeping them hidden from the public — including more than 50 cases in which patients died. Narrower reporting requirements have allowed hospitals to keep more medical mistakes secret even from state regulators, with reports to the state immediately dropping by more than half¹

The public has an absolute and fundamental right to know how well hospitals and other medical providers are doing in reducing the serious risks of adverse events. For too long, patients have been kept in the dark about the nature and existence of serious adverse events at Connecticut hospitals and outpatient surgical centers. Public disclosure of adverse events will give consumers much better information about the quality of care that is delivered at each hospital. It also gives the hospitals and surgical facilities the strong incentive they need to re-double their efforts to improve care and prevent errors

This is an urgent, high priority issue that deeply matters to patients and their families. As last November's Hartford Courant series made clear, many Connecticut consumers have experienced serious permanent, disabling injuries and deaths from medical errors. Their families courageously and appropriately call for swift system reforms as a matter of simple justice and basic medical safety. No one would want to experience what these families have been through. All of us have a stake in preventing such errors from reoccurring at the earliest possible date. Health care providers and government agencies need to get on the right side of history in addressing this serious problem, and addressing it comprehensively and assertively with all deliberate speed.

Connecticut can be a national leader in driving the rate of medical errors down, so that this state's hospitals and surgical facilities will be among the safest facilities in the nation. Consumers Union is pleased to join Attorney General Richard Blumenthal, the Connecticut Center for Patient Safety, and many other advocates in calling for facility-specific disclosure of adverse events. Consumers want more and better information about error rates at the medical facilities they may visit, and the state of Connecticut has an obligation to provide that information. Sunlight is truly the best disinfectant. Consumers Union, the nonprofit publisher of Consumer Reports magazine, enthusiastically endorses SB 248 to open the books on adverse events at Connecticut hospitals. We strongly urge Connecticut Senators and General Assembly Members to approve this bill.

For more information, contact:
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Consumers Union of United States, Inc., publisher of Consumer Reports and Consumer Reports Online, is a nonprofit membership organization chartered in 1936 to provide consumers with information, education, and counsel about goods, services, health and personal finance. Consumers Union's print and online publications have a combined paid circulation of approximately 8.5 million. These publications regularly carry articles on Consumers Union's own product testing, on health, product safety, financial products and services, and marketplace economics, and on legislative, judicial, and regulatory actions that affect consumer welfare. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and services, and noncommercial contributions, grants, and fees. Consumers Union's publications and services carry no outside advertising and receive no commercial support. Consumers Union's mission is "to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves."

¹ Kauffman, Matthew and Altimari, Dave. "Special Report: Hidden Mistakes in Hospitals," The Hartford Courant, 11/15/09 - 1



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**TESTIMONY OF
 Eastern Connecticut Health Network
 [Manchester Memorial & Rockville General Hospitals]
 Deborah A. Parker
 Senior Vice President for Patient Care Services
 BEFORE THE
 PUBLIC HEALTH COMMITTEE
 Monday, March 1, 2010**

SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities

My name is Deborah Parker and I am the Senior Vice President for Patient Care Services at the Eastern Connecticut Health Network (ECHN), which includes Manchester Memorial Hospital and Rockville General Hospital. I appreciate the opportunity to testify in opposition to **SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities**.

ECHN opposes the bill because the changes proposed to the adverse event reporting system do not improve the quality of care or patient safety. Confidential reporting is imperative in promoting a culture of safety and encouraging open and honest communication among clinicians with the ultimate goal of improving every patient interaction and every patient experience.

At ECHN, we have worked deliberately and diligently to create an environment that fosters quality patient care and patient safety. As one of its five strategic pillars, Quality and Safety is the priority of every ECHN employee. Through the practice of proactive risk assessments, failure mode and effects analyses and root cause analyses, ECHN employees are encouraged to take an active role in identifying opportunities for enhanced patient safety and quality. This has been accomplished because of the non-punitive approach to the promotion of improvement. As an active member of the Patient Safety Organization, ECHN has participated in numerous collaborative initiatives to improve patient quality and safety. These have included, but are not limited to pressure ulcer prevention, fall prevention, central line bacteremia prevention and the reduction of health care acquired MRSA. I know our success have come through the open sharing of experiences and best practices. Evidence has shown that a system that fosters patient safety by having confidential reporting of adverse events in a non-punitive environment encourages the reporting of these events. I am incredibly fearful that a change to a system that is not confidential and one that imposes civil penalties and other punitive measures will be counterproductive in continuing all of these positive initiatives. ECHN, along with the other Connecticut hospitals work very hard every day to prevent errors from occurring. But when they do occur, we investigate them promptly and thoroughly, search to identify the root cause, and develop detailed action plans to prevent recurrence. We then monitor those plans and make additional corrections as necessary. Simply said, taking away confidentiality in adverse event reporting will only undo the measures Connecticut hospitals have taken thus far to provide quality care and a safe environment for their patients.

ECHN respectfully asks that any and all changes that are contemplated to the adverse event reporting system be carefully considered to ensure that the end result is improved patient care.

Thank you for consideration of our position.
Better together.



TESTIMONY OF
Lawrence and Memorial Hospital
Daniel Rissi, MD
Chief Medical and Clinical Operations Officer
BEFORE THE
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010

**SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient
Surgical Facilities**

My name is Daniel Rissi and I am the Chief Medical Officer of Lawrence and Memorial Hospital in New London. I appreciate the opportunity to testify in opposition to **SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities**.

Lawrence and Memorial Hospital opposes the bill as the changes it proposes to the adverse event reporting system do not improve the quality of care or patient safety. We would be delighted to work with the Committee to develop a system that fosters patient safety through confidential analysis of adverse events in a non-punitive environment.

The concept of analyzing and learning from adverse events is not new to hospitals. We are focused every day on providing the best care for our patients. We encourage and practice vigorous peer review, root cause analyses, monthly Quality Council sessions involving physicians, nurses and Board members. Above all, we listen to our patients by actively engaging them in their care and through surveys to assure that we are constantly improving the care delivered to our communities. Lawrence and Memorial Hospital is proud to be one of 160 hospitals nation-wide participating in the QUEST initiative. This three year cooperative effort is focused on quality, efficiency, safety, and transparency. The participants have set themselves a goal of achieving 100% compliance with the publically reported quality and safety measures. We have also been a leader in Connecticut in reducing the incidence of hospital-acquired pressure ulcers and in reducing the incidence of patient falls. Indeed, specifically with regard to preventing hospital-acquired pressure ulcers, L&M's rate is now less than 1% -- a national best practice. As with our involvement in the national QUEST demonstration project, we have collaborated with other Connecticut hospitals to reduce pressure ulcers and falls. We share our successes and our failures, to learn from each other and to help each other improve care for our patients. We are able share our successes and failures -- and to advance quality and patient safety -- because this work is carried out in a confidential, non-punitive environment.

While we support the concept of public reporting, and transparency is one of the cornerstones of our quality initiatives, we also know that numerous industries have demonstrated the importance of confidentiality. A non-punitive system best serves our patients and is best able to promote an environment of rigorous analysis and a thoughtful process for correction and improvement. Punitive measures have a chilling effect on reporting of adverse events and are in direct conflict with our primary purpose of improving the quality of care and the safety of our patients.

Thank you for your consideration of our position and for your efforts to help us provide the very best care for our patients.

**Testimony of Ken Rosenquest, President of the
Connecticut Association of Ambulatory Surgery Centers
On SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient
Surgical Centers
Before the Public Health Committee
March 1, 2010**

Good morning, Senator Harris, Representative Ritter and distinguished members of the Public Health Committee, I am Ken Rosenquest, President of the CAASC and an administrator at a hospital affiliated surgery center.

I am here today to speak to SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Centers.

As you know, medicine is not an exact science and unfortunately, sometimes there can be bad outcomes with medical procedures. In the vast majority of cases, these unfortunate results are caused not by medical mistakes but rather circumstances that are beyond the control of the physician and the facility. This is an important fact to consider when reviewing a bill like the one before you today.

The National Quality Forum's list of Serious Reportable Adverse Events, or "never events", and its current reporting mechanisms are good for patients and good for healthcare. At no time are any of these events acceptable. The reporting mechanisms currently in place are comprehensive and make the information publically available in a manner that permits full disclosure of the facts and circumstances of each event. The strength of this system is that it allows the healthcare community to disseminate all of the facts of each event in their entirety, to examine all of the circumstances that lead to the adverse event, and in a way that creates true qualitative improvements. The information outlets contemplated by this bill are potentially less thorough, less comprehensive, and thereby less fair to physicians attempting to practice medicine under often trying circumstances. The practice of "defensive medicine" is a leading driver of cost in our delivery system, a bill which penalizes providers by making adverse events public in a way that may not present all the facts helps fuel that problem.

But, there are things completely out of a provider's control that can lead to a bad outcome. Under this proposal, patients with complicated medical problems may find it increasingly difficult to find physicians and facilities willing to take care of them. Perforations and other complications are known risks but this bill penalizes those providers skilled at caring for these individuals by making public this kind of adverse event.

Already, there are specific things that must be done when an adverse event occurs, from reporting and documentation to extensive review by the Department of Public Health. (I am pleased to report that the experience within the outpatient surgical setting in this area has been very limited.) Root cause analysis and corrective action plans are already required by the Department of Public Health.

Second, every surgery center in the State of Connecticut and hospital, for that matter, must belong to a Patient Safety Organization approved by the Department of Public Health. These organizations look at best practices and review the policies and procedures within the surgical setting to educate facilities and staff on approved guidelines. Our General Assembly has already raised the bar in outpatient surgery by requiring facilities to be licensed, follow extensive regulations and maintain membership in a PSO. Isn't that where our focus should be and not penalizing facilities as outlined in this bill.

Histories and physicals are done in advance of surgical procedures, but sometimes things don't show up until a patient's body is subjected to the stress of a surgery. By passing this bill, you will force every provider to think three times about agreeing to do a procedure.

Every informed consent document includes the potential risks associated with a surgical procedure, and death, which is one possibility, is one that no provider wants to experience.

Our system is already in crisis; do we really want to penalize the very providers that do everything possible to save the lives of their patients? Do we really want physicians not to be able to perform needed surgeries because of the possibility of a bad outcome? This is the kind of system we are creating under SB 248.

I hope you will look at the processes already in place- and effectively implemented by the Department of Public Health-and oppose SB 248. Thank you for your consideration.



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Connecticut State Medical Society Testimony on

Senate Bill 248 An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Centers

Public Health Committee

March 1, 2010

Senator Harris, Representative Ritter and Members of the Public Health Committee, my name is Ken Ferrucci, Vice President of Public Policy and Government Affairs for the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members thank you for the opportunity to present this testimony to you today on SB 248 An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Centers.

CSMS is proud to be part of efforts over the past years to ensure the delivery of the highest quality healthcare in the state balanced with appropriate transparency and disclosure. We have also advocated for the need to ensure that the all information we accompanied by the education and disclaimers necessary for it to be accurately interpreted b the public. Furthermore, our involvements in such activities is formally codified though our representation on the Quality of Care Advisory Committee.

The legislation before you today provides an opportunity to strengthen public trust in our healthcare delivery system by addressing any real or perceived shortcomings of the current reporting system. For that reason, we welcome the opportunity to be a part of this process. Moving forward, it is important that first and foremost it is understood that healthcare should not be punitive. Penalties and fines must be appropriate for the seriousness and willfulness of the act and not so punitive as to bankrupt providers and hinder access to care. In addition, the process for audits must be appropriate and clearly communicated. Due to the diversity of entities regulated under this legislation, it is imperative that input be provided by impacted groups prior to the establishment of a process and commencement of audits.

Finally, Section 4 adds as a component of the Commissioners report annually to the Public Health Committee the reporting of healthcare associated infections incurred. Once again we state the importance of a clear explanation of this information. Current Centers for Disease Control definitions for infections differ significantly. There is an extreme difference between

such infections as those "associated" versus those "acquired" and the ability of the facility to prevent. This must be clearly explained.

Thank you for the opportunity to present this testimony. We look forward to working with you as this legislation progresses.



**Testimony of Jeffrey Flaks, Executive Vice President and Chief Operating
Officer of Hartford Hospital
Before the Public Health Committee
Senate Bill No. 248
March 1, 2010**

An Act Concerning Adverse Events At Hospitals and Outpatient Surgical Facilities.

Good afternoon my name is Jeffrey Flaks, Executive Vice President and Chief Operating Officer of Hartford Hospital and I am here today in opposition to the amendments to Senate Bill 248 "*An Act Concerning Adverse Events At Hospitals and Outpatient Surgical Facilities*". This bill fails to make changes that improve the quality of care or safety for patients in Connecticut's hospitals.

The Hartford Hospital is absolutely committed to the prevention of adverse events as a cornerstone of our aspirations as a national leader in clinical excellence. We are committed as well to reporting and investigating such events when they do occur and, most importantly, to learning from these events with the goal of enhancing patient safety and preventing recurrences. Hartford Hospital embraces the importance of holding hospitals and providers accountable for the safety and quality of care that they deliver. We embrace the public reporting of adverse events as a critical tool in the effort to enhance quality and safety for our patients, but the changes proposed in this bill do not advance this objective.

Hartford Hospital has reported adverse events to DPH since 2002 and we have a robust process for the identification and review of potential adverse events. We involve all appropriate parties in these reviews from the staff level through top leadership.

Our safety culture is built within a non-punitive environment that encourages sharing, reporting, and learning. And our efforts are resulting in material quality improvement. We are, in fact, witnessing significant, demonstrable drops in patient falls with injury and hospital-acquired pressure ulcers. We place an unceasing focus on safety and quality within our institution. We begin each day with a quality and safety huddle of approximately 30 staff from all levels of the organization focused on assessing daily quality and safety performance and identifying opportunities for improving the care we deliver.



Hartford Hospital values transparency. For over two years every Thursday evening we have published on our website the Patient Safety and Quality Newsletter. Each week in this newsletter we highlight for our staff and for the public both our accomplishments supported by data and the ongoing challenges we face as we aspire to the highest levels of quality and safety. Our commitment is unquestioned and our progress is evident.

This bill proposes to eliminate confidentiality of reporting, impose fines, require the Department of Public Health (DPH) to conduct annual random audits, and require hospitals to report annually on the rate of healthcare-associated infections. Hartford Hospital identifies, reviews, and reports adverse events as a cornerstone of a strong safety culture, and these proposals are either counterproductive to those efforts or duplicative of work that is already being done.

Bill No. 248 proposes eliminating the confidentiality of reporting and imposing fines that are in stark contrast with the progressive non-punitive culture that Hartford Hospital and other acute care hospitals across the state are creating. Our improvement efforts are not based upon the desire to avoid penalties, but rather on identifying and sharing opportunities for improvement that are in our patients' best interest. Eliminating the confidentiality of reporting will not promote increased disclosure nor will it enhance the safety of our patients. In healthcare and other industries where safety is paramount there is a growing evidence base showing that confidential, non-punitive reporting systems do indeed encourage voluntary reporting and that this is essential in eliminating future adverse events.

Please note that Hartford Hospital embraces the release of additional hospital specific information on reported adverse events to the public. In fact, we believe that we have a unique opportunity at this moment in Connecticut to make a real difference in patient safety by proceeding with creating a system that increases our patients' awareness and leads them to an accurate understanding of these events. At the same time, by crafting a process where this event information and action plans are shared in a timely fashion, healthcare facilities could positively impact outcomes across the region. Senate Bill 248 is not designed to accomplish this.



Hartford Hospital passionately advocates for transparency, for empowering patients with accurate, actionable information, and for an environment in which institutions can rapidly disseminate best practice. We believe this can be done, that our patients deserve nothing less, and we would welcome the opportunity to make this a reality in Connecticut.

Thank you for your time and consideration.

**TESTIMONY OF BRISTOL HOSPITAL
LEONARD BANCO, MD
SR. VICE PRESIDENT & CHIEF MEDICAL OFFICER
BEFORE THE PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010**

**SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient
Surgical Facilities**

My name is Dr. Leonard Banco, and I am the Chief Medical Officer of Bristol Hospital. I am here today to speak in opposition to SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

Bristol Hospital opposes the bill because the changes it proposes to the adverse events reporting system do not improve the quality of care or increase safety for patients. It is important to have a healthcare system that promotes patient safety by encouraging confidential reporting of adverse events in a **non-punitive environment**.

As the Chief Medical Officer of Bristol Hospital, I am responsible for hospital-wide quality improvement activities. I am made aware of all adverse events that occur at our hospital which must be reported to the Department of Public Health. It is important that you understand that the term "adverse event" does not mean "medical error". What it **does** mean is "unexpected bad outcome", which may be due to a medical error, but more often, is not. We investigate every one of these events by use of many tools - Our Medical Peer Review system, morbidity and mortality conferences, and most important, through Root Cause Analysis. Root Cause Analysis seeks to identify the specific reasons an adverse event occurred and most important, to learn from the event in order to prevent it from happening in the future.

What you need to know, however, is that reportable adverse events are only a small part of our quality improvement efforts. We use Root Cause Analyses for many other events, and even "near miss" events that never affect the patient. In fact, the vast majority of Root Cause Analyses we perform are NOT related to reportable adverse events. We have revamped our internal occurrence reporting system, so that "near misses" and even just concerns about the way we provide certain elements of care can be reported by anyone who works at the hospital, including patients. We have worked very hard to create a culture of safety where **no one is afraid to make a report that can identify problems and improve care**.

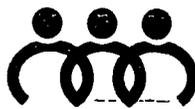
The bill you are considering today will do exactly the opposite. It will create fear, and discourage internal reporting of unexpected outcomes, near misses and concerns. It will try to improve care by publicly vilifying individuals, and by fining them and the organizations at which they work. Will this improve care? NO. What it will do will satisfy the need to place public blame under the mistaken belief that if we do that often enough, it will eliminate bad actors and hence, bad outcomes. However, this premise is wrong. Adverse events will continue to occur and the tools we have been trying to

develop to reduce them will be rendered worthless through fear of participation. The medical peer review process will grind to a halt. Hospitals will fear to collaborate with each other through CHA and DPH sponsored quality improvement activities, for concern about exposure and recrimination.

Since 1999, the national effort to adapt quality improvement efforts from the airline industry and industry in general is prospectively changing the way we work. There is much more work to do. Medical care is complicated; each patient is unique; the systems that support medical care are Byzantine. Yet dedicated people work long hours every day to provide the best care they can, patient by patient, one at a time while trying to build a "more perfect system".

You know all too well that we are in a time of scarce resources, and everyone, state government included, is struggling every day just to stay afloat. We need to be wiser about how we use our limited resources. Rather than pass this bill and devote more resources to retrospective public reporting, investigation and punishment, I would urge you to look at what some other states are doing to improve health care. Their Departments of Public Health are being directed to refocus their efforts and resources on prevention of adverse events and promotion of quality and safety by working with their hospitals to change the systems of care across the whole state.

Our mutual goal needs to be to improve the quality of the healthcare we provide to each resident of our state. SB 248 will not improve the quality of healthcare. I urge you to vote against this bill.



CONNECTICUT CENTER
FOR PATIENT SAFETY
QUALITY HEALTHCARE IS A RIGHT

TO: MEMBERS OF THE PUBLIC HEALTH COMMITTEE

FROM: CONNECTICUT CENTER FOR PATIENT SAFETY

DATE: MARCH 1, 2010

**PLEASE SUPPORT SENATE BILL 248—AAC ADVERSE EVENTS AT HOSPITALS
AND OUTPATIENT SURGICAL FACILITIES**

The members of the Connecticut Center for Patient Safety (CCPS) respectfully request you to **SUPPORT Senate Bill 248**.

Current Connecticut Law requires certain hospitals and outpatient surgical facilities to report to the CT Department of Public Health certain adverse events that occur to patients in the care of these facilities. Importantly, the *Hartford Courant* reported in November 2009 that some Connecticut hospitals are underreporting the adverse events that occur in those hospitals (please see the attached 11/22/09 *Courant* Editorial). This is a dangerous problem which is addressed by Senate Bill 248.

- **Section 1 of Senate Bill 248 improves Connecticut's current adverse event reporting law by adding a provision that requires the CT Department of Public Health to report to the Legislature's Public Health Committee the names of the hospitals where the adverse events occur. This will allow consumers to have more access to crucial public health information regarding certain patterns of problems (adverse events) that may be occurring in certain hospitals.**
- **Section 1 of the Senate Bill 248 also contains a provision to establish a "Random Audit" procedure, under which the DPH can randomly audit a hospital to investigate whether the hospital is complying with the adverse event reporting law. A Random Audit is generally a very successful and very cost-effective mechanism to ensure compliance with the law. For example, the Connecticut Office of State Ethics has a very successful random audit program in place. Every year, 40 lobbying entities, along with all of the entities' associated in-house and outside lobbyists, are randomly selected to have their business records audited by the Office of State Ethics. This process has encouraged and facilitated compliance with the State Ethics laws (in fact, the Connecticut Center for Patient Safety was audited last year). The audit process for lobbying entities and lobbyists is confidential, but the results of the audits are public and are subject to public review and inspection. We respectfully believe that it is a good idea for the CT DPH to similarly perform annual random audits on certain hospitals. This will encourage all hospitals to comply with the adverse event reporting law—just as the random audit process encourages compliance by lobbyists.**

THANK YOU FOR YOUR SUPPORT OF SENATE BILL 248

OPINION

OUR VIEW

IN THE DARK ABOUT DEATHS

Connecticut's hospitals invite public scorn when they refuse to disclose serious medical mistakes that kill or injure patients.

Courant writers Matthew Kaufman and Dave Altman reported last Sunday that hospitals are failing to inform the state health department about dangerous lapses—such as the deaths of two 81-year-old women from accidental cuts at Hartford Hospital in 2005.

Just as troubling, the state investigates only one in four reported cases, keeping the others secret, including more than 50 in which patients died in recent years.

HOSPITAL 'ADVERSE EVENTS'

>> Mistakes, injuries go unreported

The General Assembly amended the "adverse event" law in 2004 to limit the types of cases that must be reported to those that health experts say should never occur in a hospital (such as leaving a sponge

inside a patient after an operation). Legislative supporters hoped the change would result in more honest compliance with internal reviews to fix problems.

After the law took effect, filings of "adverse events" dropped by more than half. Hospitals are clearly keeping more of their mistakes to themselves. Even when they report medical errors, there is a good chance the state will do nothing. Shockingly, the state has failed to investigate sexual assaults in hospitals and egregious errors that resulted in deaths. Cases not investigated are automatically kept secret.

Attorney General Richard Blumenthal reacted to the disclosures with appropriate anger when he called the revised law "a deadly and disgraceful failure" shielding hospitals and medical professionals from scrutiny and accountability and leaving patients in the dark.

The state has not even tried to determine whether hospitals are following the amended law.

There is no excuse for this code of silence about patient outcomes. The state's hospitals, which usually provide outstanding medical care, damage their credibility when they cover up botched procedures, many of which become public only after a lawsuit is filed.

As noted by Jean Rexford, executive director of the nonprofit Connecticut Center for Patient Safety, hospitals would address lapses more quickly if the information was public. In her words, "Sunlight works and public shame also works."

The attorney general has vowed to seek legislation requiring greater disclosure and providing regulators with more resources and new authority to levy fines.

Fixing this broken reporting system must be a priority. The alternative is to keep the public in the dark, leading to cynicism about the state's hospitals and denying patients the right to see

RICHARD BLUMENTHAL
ATTORNEY GENERAL



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Office of The Attorney General
State of Connecticut

**TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL
BEFORE THE PUBLIC HEALTH COMMITTEE
MARCH 1, 2010**

I appreciate the opportunity to support Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Centers.

This proposal requires that the annual Department of Public Health report on adverse events in hospitals and surgical centers include identifying the individual hospitals where such adverse events occurred. The proposal also requires the Department of Public Health to conduct random audits of these health care facilities to determine compliance with the reporting requirements and to examine more closely reported adverse events. The annual report would include the conclusion of such audit.

The proposal also protects any employee, applicant for employment or health care provider from retaliation because such person disclosed a hospital or outpatient surgical facility's failure to comply with the reporting and other requirements of the adverse events statute. Finally, the proposal establishes civil penalties for serious violations of public health laws by hospitals and surgical centers, including failure to report these adverse events.

The current law is a deadly and disgraceful failure, shielding hospitals and surgical centers from scrutiny and accountability and leaving patients in the dark. Medical mistakes causing death and serious illness may go unreported, undisclosed and uninvestigated, undermining patient protection. Gaping loopholes keeping most hospital medical errors secret -- including 116 that resulted in death -- are unconscionable and unacceptable.

Senate Bill 248 provides greater disclosure of -- and accountability for -- medical errors at hospitals, protecting patients and improving quality of care. Public disclosure provides a tremendous incentive to hospitals and surgical centers to take the necessary, often simple and common-sense, steps to prevent these 'never' events which should never happen and other potentially deadly mistakes.

Currently, 5 states have passed laws requiring hospital specific disclosure of adverse events -- Colorado, Indiana, Massachusetts, Minnesota and Washington.

Random audits of hospitals and surgical centers by the Department together with civil penalties and whistleblower protections will ensure that these institutions comply with reporting requirements and fully and fairly follow-through with promised improvements.

I urge the committee's favorable consideration of Senate Bill 248.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TESTIMONY PRESENTED BEFORE THE PUBLIC HEALTH COMMITTEE
March 1, 2010

Barbara Cass, Section Chief, Facility Licensing and Investigations Section, 860-509-7407

Senate Bill 248 - An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities

The Department of Public Health opposes Senate Bill 248 as currently written.

Existing regulations governing hospitals and outpatient surgical facilities address the Adverse Event Reporting requirements. The Department of Public Health currently includes a review of compliance with these regulations as part of its evaluation during onsite inspections of these facilities. Staff may identify specific instances of underreporting by comparing hospital and outpatient surgical facility reports against complaints, referrals, and other sources of data collected through onsite reviews.

The agency's expectation is that the hospitals and outpatient surgical facilities comply with regulations that require that all events occurring in these facilities that meet the national quality forum list of serious reportable events—as well as Connecticut specific events—are reported to the Department. The bill's call for public disclosure of these reported incidents may not result in added benefits for consumers. This additional disclosure could lead to undermining patient privacy and may also discourage event reporting.

This bill also directs DPH to consult with the Attorney General's Office regarding the development and implementation of audits. It is unclear whether the Attorney General's Office has any expertise in regards to the proper execution of health care facility inspections.

Additionally, reporting requirements in section 4 are vague. It is unclear whether the reporting of all infection rates would be required, or only those infections recommended by the Healthcare Associated Infections Advisory Committee. Hospitals currently report the infections designated by this committee. A reporting of all infections would require extensive resources for both hospitals and the Department of Public Health. To fulfill a reporting mandate of this magnitude would require hospital staff to devote time and energy solely to data collection that would interfere with their ability to address issues of infection prevention and control. It is essential that data collection efforts be focused on areas that are linked to evidence-based research so that limited personnel resources can be devoted to infection prevention and control. The advisory committee, referenced in the underlying statute, continues to meet actively and make appropriate recommendations in this regard. The department feels that the collective expertise possessed by this committee makes it the most appropriate body to identify the relevant data for tracking these infections moving forward.

Although the DPH generally supports the issuance of monetary penalties to licensed health care facilities, the department is opposed to placing this remedy on a per diem basis, as this is not practicable from an administrative perspective. Additional staff would be necessary to toll the fine for a "continuing violation" which is undefined.

In order to meet the regulatory requirements of this bill, the Department would require additional staff resources that are not provided for in the Governor's budget.

Thank you for your consideration of the Department's views on this bill.

Phone



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**Testimony of Kevin P. Lembo
Healthcare Advocate**

**Before the Public Health Committee
In support of SB 270 and SB 248
March 1, 2010**

Good morning, Senator Harris, Representative Ritter, Senator Debicella, Representative Giegler, and members of the Public Health Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. The Office of the Healthcare Advocate (OHA) is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems. I submit this testimony for the record.

OHA supports SB 270, AN ACT CONCERNING THE ESTABLISHMENT OF A REGIONAL POLICY ON THE PROHIBITION OF CERTAIN GIFTS FROM PHARMACEUTICAL AND MEDICAL DEVICE MANUFACTURING COMPANIES TO HEALTH CARE PROVIDERS. This bill deserves passage. It reflects the tremendous amount of work put into this bill by Jean Rexford of the Center for Patient Safety and the Attorney General's office.

Prescription drug spending rose 500% between 2000 and 2005. Nearly one-third of the increase is attributed to marketing efforts. Gifts and incentives come along with the heavy sales pitch for the latest and "greatest" generation of medication, which are expensive and, sometimes, unnecessary. Studies reviewed in the *Journal of the American Medical Association* found that even small gifts influence prescribing decisions. Even token gifts including a company logo drive up name recognition. Regardless of their value, all gifts create demands for reciprocity. The research shows that the latest and "greatest" drug is often not the best, but always the most expensive – adding unnecessary cost the system. At the end of the day this is a case of a powerful commercial influence being wielded over prescribers and consumers. That influence needs to be reigned in.

SB 270 adopts the provisions of the successful Massachusetts law prohibiting almost all gifts from pharmaceutical and medical device companies to health care providers and their employees. Samples and payments for participating in clinical trials would still be

permitted under SB 270. This is especially important for those patients who do not have insurance and for ongoing medical research.

SB 270 also requires the pharmaceutical and medical device companies to disclose to the DPH the value, nature, purpose and particular recipient of any fee, payment, subsidy or other economic benefit with a value of fifty dollars or more, that the company provides, directly or through its agents, to any covered recipient in connection with the company's sales and marketing activities.

OHA supports the transparency sought in this bill. As healthcare costs continue to skyrocket, we must allow more scrutiny of all healthcare related expenses. I urge your support for the passage of this consumer protection bill.

OHA also supports SB 248, AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES. This bill provides a much needed incentive for clear and complete adverse event reporting by hospitals and outpatient surgical facilities. Right now, when adverse events are reported to DPH, they do not consistently include a summary of the hospital or outpatient surgical facility's corrective action and whether the department has reviewed the implementation of such corrective action.

The requirement that DPH perform random audits of the hospitals and outpatient surgical facilities for report compliance should promote detailed and complete reporting of adverse events, and improved patient care as facilities comprehensively address the causes of and solutions to adverse events.

This legislation, proposed by the Attorney General comes on the heels of his office's discovery of inadequate and incomplete adverse event reporting by hospitals and surgical facilities. The information in these reports is shielded from public view and allows complete disclosure on the part of the individuals involved with the adverse event. That protection and the possibility of a substantial fine for noncompliance should encourage accurate reporting. I urge passage of the bill.

Thank you for your consideration of OHA's testimony.