



General Assembly

February Session, 2008

Raised Bill No. 5695

LCO No. 2117

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Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING RESPONSIBILITY FOR HOSPITAL "NEVER" EVENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective January 1, 2009*) As used in section 2 of
2 this act:

3 (1) "Facility" means a hospital, as defined in subsection (b) of section
4 38a-493 of the general statutes or an outpatient surgical facility, as
5 defined in subsection (a) of section 19a-493b of the general statutes.

6 (2) "Serious disability" means (A) a physical or mental impairment
7 that substantially limits one or more of the major life activities of an
8 individual, such as seeing, hearing, speaking, walking or breathing, or
9 a loss of bodily function, if such impairment or loss lasts more than
10 seven days or is still present at the time of discharge from an inpatient
11 health care facility, or (B) loss of a body part.

12 Sec. 2. (NEW) (*Effective January 1, 2009*) (a) Notwithstanding any
13 other provisions in the general statutes or elsewhere to the contrary, no
14 insurer, health care center, hospital service corporation, medical

15 service corporation or fraternal benefit society shall pay a facility for
16 expenses incurred by the underlying procedure or service that gives
17 rise to the following events or for expenses incurred by the following
18 events themselves:

19 (1) Surgery performed on a wrong body part that is not consistent
20 with the documented informed consent for that patient. Such events
21 do not include situations requiring prompt action that occur in the
22 course of surgery or situations whose urgency precludes obtaining
23 informed consent;

24 (2) Surgery performed on the wrong patient;

25 (3) The wrong surgical procedure performed on a patient that is not
26 consistent with the documented informed consent for that patient.
27 Such events do not include situations requiring prompt action that
28 occur in the course of surgery or situations whose urgency precludes
29 obtaining informed consent;

30 (4) Retention of a foreign object in a patient after surgery or other
31 procedure, excluding objects intentionally implanted as part of a
32 planned intervention and objects present prior to surgery that are
33 intentionally retained;

34 (5) Death during or immediately after surgery of a normal, healthy
35 patient who has no organic, physiologic, biochemical or psychiatric
36 disturbance and for whom the pathologic processes for
37 which the operation is to be performed are localized and do not entail
38 a systemic disturbance;

39 (6) Patient death or serious disability associated with the use of
40 contaminated drugs, devices or biologics provided by the facility when
41 the contamination is the result of generally detectable contaminants in
42 drugs, devices or biologics regardless of the source of the
43 contamination or the product;

44 (7) Patient death or serious disability associated with the use or

45 function of a device in patient care in which the device is used or
46 functions other than as intended. "Device" includes, but is not
47 limited to, catheters, drains, and other specialized tubes, infusion
48 pumps and ventilators;

49 (8) Patient death or serious disability associated with intravascular
50 air embolism that occurs while being cared for in a facility, excluding
51 deaths associated with neurosurgical procedures known to present a
52 high risk of intravascular air embolism;

53 (9) An infant discharged to the wrong person;

54 (10) Patient death or serious disability associated with patient
55 disappearance, excluding events involving adults who have decision-
56 making capacity;

57 (11) Patient suicide or attempted suicide resulting in serious
58 disability while being cared for in a facility due to patient actions after
59 admission to the facility, excluding deaths resulting from self-inflicted
60 injuries that were the reason for admission to the facility;

61 (12) Patient death or serious disability associated with a medication
62 error, including, but not limited to, errors involving the wrong drug,
63 the wrong dose, the wrong patient, the wrong time, the wrong rate, the
64 wrong preparation, or the wrong route of administration, excluding
65 reasonable differences in clinical judgment on drug selection and dose;

66 (13) Patient death or serious disability associated with a hemolytic
67 reaction due to the administration of ABO or HLA-incompatible blood
68 or blood products;

69 (14) Maternal death or serious disability associated with labor or
70 delivery in a low-risk pregnancy while being cared for in a facility,
71 including events that occur not later than forty-two days from the date
72 of delivery and excluding deaths from pulmonary or amniotic fluid
73 embolism, acute fatty liver of pregnancy, or cardiomyopathy;

74 (15) Patient death or serious disability directly related to
75 hypoglycemia, the onset of which occurs while the patient is being
76 cared for in a facility;

77 (16) Death or serious disability, including kernicterus, associated
78 with failure to identify and treat hyperbilirubinemia in neonates
79 during the first twenty-eight days of life. For the purpose of this
80 subdivision, "hyperbilirubinemia" means bilirubin levels greater than
81 30 milligrams per deciliter;

82 (17) Stage 3 or 4 ulcers acquired after admission to a facility,
83 excluding progression from stage 2 to stage 3 if stage 2 was recognized
84 upon admission;

85 (18) Patient death or serious disability due to spinal manipulative
86 therapy;

87 (19) Artificial insemination with the wrong donor sperm or wrong
88 egg;

89 (20) Patient death or serious disability associated with an electric
90 shock while being cared for in a facility, excluding events involving
91 planned treatments such as electric countershock;

92 (21) Any incident in which a line designated for oxygen or other gas
93 to be delivered to a patient contains the wrong gas or is contaminated
94 by toxic substances;

95 (22) Patient death or serious disability associated with a burn
96 incurred from any source while being cared for in a facility;

97 (23) Patient death or serious disability associated with a fall while
98 being cared for in a facility;

99 (24) Patient death or serious disability associated with the use or
100 lack of restraints or bedrails while being cared for in a facility;

101 (25) Any instance of care ordered by or provided by someone

102 impersonating a physician, nurse, pharmacist, or other licensed health
103 care provider;

104 (26) Abduction of a patient of any age;

105 (27) Sexual assault on a patient within or on the grounds of a
106 facility; and

107 (28) Death or significant injury of a patient or staff member resulting
108 from a physical assault that occurs within or on the grounds of a
109 facility.

110 (b) No insured shall be required by a facility to pay for such
111 expenses that an insurer, health care center, hospital service
112 corporation, medical service corporation or fraternal benefit society
113 has refused to pay, pursuant to subsection (b) of this section.

114 Sec. 3. (NEW) (*Effective January 1, 2009*) (a) Following the occurrence
115 of any of the events specified in subdivision (1) to (28), inclusive, of
116 subsection (b) of section 2 of this act, the facility shall report such
117 occurrence to the Commissioner of Public Health, in accordance with
118 section 19a-127n of the general statutes. Such report shall not include
119 identifying information for any of the health care professionals, facility
120 employees or patients involved.

121 (b) A facility reporting such event shall conduct a root cause
122 analysis of the event and shall implement a corrective action plan, as
123 defined in subdivision (1) of subsection (a) of section 19a-127n of the
124 general statutes. If the root cause analysis and the implementation of a
125 corrective action plan are complete at the time an event must be
126 reported, the findings of the analysis and the corrective action plan
127 shall be included in the report of the event.

128 Sec. 4. Section 19a-127l of the general statutes is repealed and the
129 following is substituted in lieu thereof (*Effective January 1, 2009*):

130 (a) There is established a quality of care program within the

131 Department of Public Health. The department shall develop for the
132 purposes of said program (1) a standardized data set to measure the
133 clinical performance of health care facilities, as defined in section 19a-
134 630 of the 2008 supplement to the general statutes, and require such
135 data to be collected and reported periodically to the department,
136 including, but not limited to, data for the measurement of comparable
137 patient satisfaction and the occurrences of the adverse events specified
138 in section 2 of this act, and (2) methods to provide public
139 accountability for health care delivery systems by such facilities. The
140 department shall develop such set and methods for hospitals during
141 the fiscal year ending June 30, 2003, and the committee established
142 pursuant to subsection (c) of this section shall consider and may
143 recommend to the joint standing committee of the General Assembly
144 having cognizance of matters relating to public health the inclusion of
145 other health care facilities in each subsequent year.

146 (b) In carrying out its responsibilities under subsection (a) of this
147 section, the department shall develop the following for the quality of
148 care program:

149 (1) Comparable performance measures to be reported;

150 (2) Selection of patient satisfaction survey measures and
151 instruments;

152 (3) Methods and format of standardized data collection;

153 (4) Format for a public quality performance measurement report;

154 (5) Human resources and quality measurements;

155 (6) Medical error reduction methods;

156 (7) Systems for sharing and implementing universally accepted best
157 practices;

158 (8) Systems for reporting outcome data;

159 (9) Systems for continuum of care;

160 (10) Recommendations concerning the use of an ISO 9000 quality
161 auditing program;

162 (11) Recommendations concerning the types of statutory protection
163 needed prior to collecting any data or information under this section
164 and sections 19a-127m and 19a-127n; and

165 (12) Any other issues that the department deems appropriate.

166 (c) (1) There is established a Quality of Care Advisory Committee
167 which shall advise the Department of Public Health on the issues set
168 forth in subdivisions (1) to (12), inclusive, of subsection (b) of this
169 section. The advisory committee shall meet at least quarterly.

170 (2) Said committee shall create a standing subcommittee on best
171 practices. The subcommittee shall (A) advise the department on
172 effective methods for sharing with providers the quality improvement
173 information learned from the department's review of reports and
174 corrective action plans, including quality improvement practices,
175 patient safety issues and preventative strategies, (B) not later than
176 January 1, 2006, review and make recommendations concerning best
177 practices with respect to when breast cancer screening should be
178 conducted using comprehensive ultrasound screening or mammogram
179 examinations, and (C) not later than January 1, 2008, study and make
180 recommendations to the department concerning best practices with
181 respect to communications between a patient's primary care provider
182 and other providers involved in a patient's care, including hospitalists
183 and specialists. The department shall, at least quarterly, disseminate
184 information regarding quality improvement practices, patient safety
185 issues and preventative strategies to the subcommittee and hospitals.

186 (d) The advisory committee shall consist of (1) four members who
187 represent and shall be appointed by the Connecticut Hospital
188 Association, including three members who represent three separate

189 hospitals that are not affiliated of which one such hospital is an
190 academic medical center; (2) one member who represents and shall be
191 appointed by the Connecticut Nursing Association; (3) two members
192 who represent and shall be appointed by the Connecticut Medical
193 Society, including one member who is an active medical care provider;
194 (4) two members who represent and shall be appointed by the
195 Connecticut Business and Industry Association, including one member
196 who represents a large business and one member who represents a
197 small business; (5) one member who represents and shall be appointed
198 by the Home Health Care Association; (6) one member who represents
199 and shall be appointed by the Connecticut Association of Health Care
200 Facilities; (7) one member who represents and shall be appointed by
201 the Connecticut Association of Not-For-Profit Providers for the Aging;
202 (8) two members who represent and shall be appointed by the AFL-
203 CIO; (9) one member who represents consumers of health care services
204 and who shall be appointed by the Commissioner of Public Health;
205 (10) one member who represents a school of public health and who
206 shall be appointed by the Commissioner of Public Health; (11) one
207 member who represents and shall be appointed by the Office of Health
208 Care Access; (12) the Commissioner of Public Health or said
209 commissioner's designee; (13) the Commissioner of Social Services or
210 said commissioner's designee; (14) the Secretary of the Office of Policy
211 and Management or said secretary's designee; (15) two members who
212 represent licensed health plans and shall be appointed by the
213 Connecticut Association of Health Care Plans; (16) one member who
214 represents and shall be appointed by the federally designated state
215 peer review organization; and (17) one member who represents and
216 shall be appointed by the Connecticut Pharmaceutical Association. The
217 chairperson of the advisory committee shall be the Commissioner of
218 Public Health or said commissioner's designee. The chairperson of the
219 committee, with a vote of the majority of the members present, may
220 appoint ex-officio nonvoting members in specialties not represented
221 among voting members. Vacancies shall be filled by the person who
222 makes the appointment under this subsection.

223 (e) The chairperson of the advisory committee may designate one or
224 more working groups to address specific issues and shall appoint the
225 members of each working group. Each working group shall report its
226 findings and recommendations to the full advisory committee.

227 (f) The Commissioner of Public Health shall report on the quality of
228 care program on or before June 30, 2003, and annually thereafter, in
229 accordance with section 11-4a, to the joint standing committee of the
230 General Assembly having cognizance of matters relating to public
231 health and to the Governor. Each report on said program shall include
232 activities of the program during the prior year and a plan of activities
233 for the following year.

234 (g) On or before April 1, 2004, the Commissioner of Public Health
235 shall prepare a report, available to the public, that compares all
236 licensed hospitals in the state based on the quality performance
237 measures developed under the quality of care program.

238 (h) (1) The advisory committee shall examine and evaluate (A)
239 possible approaches that would aid in the utilization of an existing
240 data collection system for cardiac outcomes, and (B) the potential for
241 state-wide use of a data collection system for cardiac outcomes, for the
242 purpose of continuing the delivery of quality cardiac care services in
243 the state.

244 (2) On or before December 1, 2007, the advisory committee shall
245 submit, in accordance with the provisions of section 11-4a, the results
246 of the examination authorized by this subsection, along with any
247 recommendations, to the Governor and the joint standing committee of
248 the General Assembly having cognizance of matters relating to public
249 health.

250 (i) The Department of Public Health may seek out funding for the
251 purpose of implementing the provisions of this section. Said
252 provisions shall be implemented upon receipt of said funding.

253 Sec. 4. Section 19a-127n of the general statutes is repealed and the
254 following is substituted in lieu thereof (*Effective January 1, 2009*):

255 (a)(1) For purposes of this section, an "adverse event" means any
256 event that is identified on the National Quality Forum's List of Serious
257 Reportable Events, any event specified in subdivisions (1) to (28),
258 inclusive, of subsection (a) of section 2 of this act or on a list compiled
259 by the Commissioner of Public Health and adopted as regulations
260 pursuant to subsection (d) of this section; and "corrective action plan"
261 means a plan that implements strategies that reduce the risk of similar
262 adverse events occurring in the future, and measures the effectiveness
263 of such strategies by addressing the implementation, oversight and
264 time lines of such strategies.

265 (2) The commissioner shall review the list of adverse events
266 periodically, but not less than annually, to ascertain whether any
267 additions, deletions or modifications to the list are necessary.

268 (b) On and after October 1, 2002, a hospital or outpatient surgical
269 facility shall report adverse events to the Department of Public Health
270 on a form prescribed by the Commissioner of Public Health as follows:
271 (1) A written report and the status of any corrective steps shall be
272 submitted not later than seven days after the adverse event occurred;
273 and (2) a corrective action plan shall be filed not later than thirty days
274 after the adverse event occurred. Emergent reports, as defined in the
275 regulations adopted pursuant to subsection (c) of this section, shall be
276 made to the department immediately. Failure to implement a
277 corrective action plan may result in disciplinary action by the
278 commissioner, pursuant to section 19a-494.

279 (c) The Commissioner of Public Health shall adopt regulations, in
280 accordance with chapter 54, to carry out the provisions of this section.
281 Such regulations shall include, but shall not be limited to, a list of
282 adverse events that are in addition to those contained in the National
283 Quality Forum's List of Serious Reportable Events.

284 (d) On or before October first annually, the commissioner shall
285 report, in accordance with the provisions of section 11-4a, on adverse
286 event reporting, to the joint standing committee of the General
287 Assembly having cognizance of matters relating to public health.

288 (e) Information collected pursuant to this section shall not be
289 disclosed pursuant to subsection (a) of section 1-210 of the 2008
290 supplement to the general statutes at any time, and information
291 collected pursuant to this section shall not be subject to subpoena or
292 discovery or introduced into evidence in any judicial or administrative
293 proceeding except as otherwise specifically provided by law. Nothing
294 in this section shall be construed to limit access to or disclosure of
295 investigative files, including any adverse event report contained in
296 such files, maintained by the department as otherwise provided in
297 section 19a-499.

298 (f) If the department determines that it will initiate an investigation
299 of an adverse event that has been reported, such investigation may
300 include review by one or more practitioners with clinical expertise of
301 the type involved in the reported adverse event.

302 (g) The Quality of Care Advisory Committee established pursuant
303 to section 19a-127l shall establish methods for informing the public
304 regarding access to the department's consumer and regulatory
305 services.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2009</i>	New section
Sec. 2	<i>January 1, 2009</i>	New section
Sec. 3	<i>January 1, 2009</i>	New section
Sec. 4	<i>January 1, 2009</i>	19a-127l
Sec. 4	<i>January 1, 2009</i>	19a-127n

Statement of Purpose:

To prohibit hospitals and outpatient surgical facilities from collecting reimbursement from insurance companies and insureds for "never" events.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]