



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.