CONNECTICUT
HOSPITAL
ASSOCIATION

TESTIMONY OF
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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.