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Union**

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CONSUMER REPORTS

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% or more.

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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 half.¹

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.

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¹ Kauffman, Matthew and Altamari, Dave. "Special Report: Hidden Mistakes in Hospitals," The Hartford Courant, 11/15/2009 - 1