



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.