



**Testimony of Don Ciosek
AARP Connecticut State President on S.B. 248
Public Health Committee
March 1, 2010**

Good Morning, Chairman Harris, Chairwoman Ritter, ranking members Debicella and Giegler, and members of the committee, my name is Don Ciosek and I am the AARP Connecticut State President. AARP is a nonprofit, non-partisan membership organization that serves people 50 and older. We have approximately 40 million members nationwide and over 600,000 in Connecticut.

AARP is proud to support S.B. 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities. This bill offers important changes that will enhance patient safety; it requires facility-specific adverse events reporting. These reports will also disclose the corrective action taken by the health care facility, a summary of the action taken by the Department of Public Health and results of random audits.

The Institute of Medicine estimates that 98,000 people die from preventable medical errors every year. According to Dr. Samantha Collier of Health Grades, "If the CDC's annual list of leading causes of death included medical errors, it would show up as number 6." This enormous number does not even reflect the additional number of people who don't die but have the added pain, additional surgeries, prolonged inpatient days and delayed recovery that result from a serious preventable error.

AARP believes that proper disclosure and facility-specific reporting would ensure greater accountability and oversight, ultimately allowing the Department of Public Health and medical facilities to address serious and preventable medical errors. The enhanced reporting requirement would increase the likelihood that hospitals focus on, analyze and implement procedural changes to reduce errors. Facility-specific information also alerts

consumers about a potential pattern of wrong site surgery, medication error or an outsized infection rate.

To ensure compliance the legislation requires mandatory audits and empowers hospital employees to participate in patient safety without fear of adverse employment action. Studies suggest that strong reporting requirements increase accountability and improve health outcomes. In a 2006 Rutgers University study of New York hospitals, 50% of hospital personnel interviewed believed that reporting increases accountability and therefore increases the level of awareness and attention to patient safety. A Quality Counts study of preventable medical events in 24 Madison, WI hospitals found that nine months after the release of a public performance report, hospitals included in the public report were significantly more likely to be engaged in quality improvement efforts than those given a confidential, private quality report, or no report at all.

AARP has been working hard in several states to advocate for better reporting systems. Most recently, AARP championed New Jersey's Patient Safety Act, which requires hospitals to publicly release the number and types of medical errors reported.

AARP believes that S.B. 248 is a common sense reform that will improve patient safety. The bill puts Connecticut on a path to greater transparency and accountability. On behalf of the more than 600,000 AARP members in Connecticut, thank you for hearing this bill and we ask members to support the proposal. Thank you.