CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
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BEFORE THE PUBLIC HEALTH COMMITTEE
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SB 566, An Act Concerning The Quality In Health Care

Good morning Senator Murphy, Representative Feltman, and members of the Public Health Committee. My name is Jennifer Jackson and I am President and Chief Executive Officer of the Connecticut Hospital Association (CHA). On behalf of Connecticut's not-for-profit hospitals, I appreciate the opportunity to testify this morning in support of **SB 566, An Act Concerning The Quality In Health Care**, which contains essential improvements to Connecticut's adverse event reporting system.

Connecticut hospitals are committed to providing the highest quality care to each and every patient, 24 hours a day, seven days a week. This commitment to quality is not new; it has always been the cornerstone of every not-for-profit hospital's mission.

What is new is Connecticut hospitals' ability to integrate their commitment to healthcare quality with their commitment to public accountability. Although hospitals have participated in standardized reporting for years, hospitals traditionally have measured their quality internally using a variety of measurement techniques. Only recently, as ways of measuring hospital quality have been standardized nationally, have hospitals gained the ability to effectively compare their performance against national goals and to provide useful comparative quality information to consumers.

In part due to the General Assembly's enactment of *Public Act 02-125, An Act Creating A Program For Quality In Health Care*, Connecticut has become a national leader in hospital quality performance reporting. Connecticut hospitals actively participated in developing the comparative report on hospital quality that will be released by the Connecticut Department of Public Health (DPH) next month and have worked closely with DPH on other initiatives created by the Act.

Connecticut's hospitals also have taken a leadership role in seeking other opportunities to provide hospital quality information to the public. Connecticut is one of four states working with the federal Centers for Medicare and Medicaid Services (CMS) to develop a national voluntary hospital report card. As part of this initiative, CMS asked all hospitals nationwide to voluntarily submit quality performance information for posting on its website. Connecticut was the first state to achieve 100% participation and is still one of only 5 states in which all hospitals are participating in making hospital quality information available to the public on the CMS website.

The CMS and DPH reports, which measure hospital performance in treating three common conditions, heart failure, heart attack and pneumonia, are just the beginning of making comparative hospital quality information available to consumers. Connecticut hospitals already have committed to releasing patient satisfaction information to consumers when standardized information is available, and have been working with CMS to develop a standardized patient satisfaction survey.

Connecticut's hospital quality performance reporting system successfully promotes the dual goals of quality improvement and public accountability. Although the adverse event reporting system is designed to achieve the same two goals, the current system is not able to achieve either one, because it lacks the necessary foundation of standardized, accurate, and useful information.

SB 566 would provide the necessary foundation to enable the adverse event reporting system to effectively promote both these goals by adopting the National Quality Forum's (NQF) list of serious reportable events as the events to be reported to the Department of Public Health. The current A, B, C and D adverse event classifications are not specific enough to facilitate comparative analysis of reported events and, although hospitals have been reporting events for almost 18 months, no information that could be used to improve patient safety has been provided to hospitals. Adoption of the NQF list will allow for evaluation of reported events, identification of trends, and development of concrete strategies to improve patient safety in Connecticut. Use of the NQF list also will allow Connecticut to compare results and share strategies with several other states who have adopted or are evaluating adoption of the NQF list.

The use of the NQF list also will facilitate holding Connecticut hospitals publicly accountable. The NQF list is focused on events that are usually preventable, as opposed to the current adverse event reporting system, which requires hospitals to report events that may have no relationship to the quality of care provided by that hospital. The current system's combination of errors and unpreventable adverse events makes public disclosure of the number of reported events misleading and unreliable as a basis for consumer information.

In addition to adopting the NQF list, SB 566 will facilitate accurate public reporting by making available to the public the DPH's regulatory findings after investigation of adverse events but maintaining the confidentiality of adverse events as they are filed. Hospitals should be held accountable for proactively implementing systems to improve patient safety and taking action to prevent similar future errors when an error occurs and under SB 566, if DPH determines that a hospital is not taking appropriate actions to protect patient safety, that information will be made available to the public. This approach to disclosure is consistent with the conclusions of national experts, including the Institute of Medicine and the National Academy for State Health Policy, and also was recommended by the Department of Public Health's Quality in Health Care Advisory Committee.

Connecticut is missing important opportunities to use the adverse event reporting system to improve patient safety. By enacting SB 566, the General Assembly would transform the system into an effective tool for improving the safety of healthcare in Connecticut by aligning the reporting requirements with national standards, creating a repository of information that hospitals

can learn from to improve safety, holding healthcare providers accountable for implementing patient safety improvements, and ensuring that meaningful and accurate information is provided to the public.

It is appropriate that the Committee is considering SB 566 during national Patient Safety Awareness Week, especially given this year's theme of "Patient Safety: The Power of Partnership". Working together, we can substantially reduce medical errors and make Connecticut a national leader in patient safety, as it already is in hospital quality performance reporting.

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Attachment

Additional Detailed Comments in Support of SB 566

Section 1(a) of the bill adopts the National Quality Forum's list of Serious Reportable Events as the adverse events that must be reported to the Department of Public Health (DPH). NQF is the recognized national leader in development of standards for adverse event reporting and was designated by expert national patient safety organizations, including the Institute of Medicine (IOM) and the federal Quality Interagency Task Force, as the entity that should develop national standards for adverse event reporting. Upon request of the federal government, NQF developed a list of serious reportable events for states to use in developing mandatory adverse event reporting systems. Other states have already adopted or are considering adoption of the list.

Use of the standardized NQF list as the events to be reported to DPH will facilitate analysis of reported events and the development of patient safety recommendations because it provides a level of standardization and sophistication that will make the reported data more useful as a quality measurement tool. It also will allow comparisons with other states and establish Connecticut as a national leader in developing effective adverse reporting systems, as it already is in hospital quality performance reporting. In addition, the Department of Public Health Quality in Health Care Advisory Committee charged by the General Assembly with advising DPH on methods to reduce medical errors has specifically recommended adoption of the NQF list as the basis for Connecticut's adverse event reporting system.

Section 1(b) modifies the timelines for reporting by eliminating the verbal report and giving providers 7 days to file a written report. The Quality in Health Care Advisory Committee specifically recommended that the timelines for reporting be extended. The adverse event reporting system is not designed to trigger immediate medical or regulatory intervention for patients involved in the reported adverse event. Instead, the purpose of the adverse event reporting system is to collect data on events in order to identify trends, develop recommendations to improve patient safety practices, and hold providers accountable for taking actions to keep patient safe.

By extending the timelines, the bill would allow hospitals to consult with necessary personnel and prepare a written report based on reliable and complete data that can effectively be used to evaluate events and develop patient safety recommendations. Recognizing that the reports concern outcomes or occurrences that have already happened and cannot be changed, the requirement of a verbal report within 24 hours is unreasonable and unnecessary except in highly unusual situations. In those situations, currently defined by DPH as "emergent reports", hospitals would still make an immediate report.

In addition to eliminating the verbal reports and extending the timeline for written reports, CHA recommends that the bill be amended to also extend the timeline for corrective action plans to up to 30 days in order to allow hospitals to develop comprehensive plans that address all of the issues that contributed to an event. Hospitals will still begin to take corrective action immediately after an event occurs, but the 30-day time period will allow the hospital to submit

the most comprehensive plan to DPH. National experts, including the Joint Commission on Accreditation of Healthcare Organizations, recognize the time involved in conducting a thorough "root cause analysis" of an event and allow even longer than 30 days for such analyses.

Section 1(d) allows DPH to adopt regulations expanding the National Quality Forum list of adverse events. This provision gives DPH the flexibility to revise the list periodically to reflect emerging issues of concern nationally or specific Connecticut issues of interest, and ensures that on an ongoing basis, the adverse event reporting system will be focused on tracking the right data. This flexibility was specifically recommended by the Quality in Health Care Advisory Committee.

Section 1(f) modifies the public disclosure provisions to allow disclosure of DPH's investigation findings related to adverse events, but to keep the individual adverse events reports and corrective action plans confidential. This approach to disclosure will facilitate the provision of accurate patient safety information to the public and is consistent with the Institute of Medicine's recommendations in *To Err is Human* and the recommendations of the National Academy for State Health Policy (NASHP), as well as the recommendation of the Quality in Health Care Advisory Committee.

Section 1(g) requires that whenever DPH investigates an adverse event, the investigation should involve review by a practitioner with clinical expertise of the type involved in the event. The use of experts to review adverse events is necessary in order for DPH to be able to accurately assess the event and the sufficiency of the corrective action, as well as to evaluate whether the event is the basis for statewide patient safety recommendations.

Section 2 allows patient safety organizations to be established with which providers could confidentially share a broad range of information about patient safety. The bill does not designate a specific organization as the patient safety organization; instead, the bill would allow DPH to designate organizations after evaluating their patient safety mission, qualifications to review events, and lack of any conflict of interest. The creation of non-regulatory patient safety organizations is recommended by national experts as an important way for providers to learn from each others' experiences as providers candidly share detailed information about not only their errors, but their "near misses." Development of Connecticut legislation to establish patient safety organizations was also specifically recommended by the Quality in Health Care Advisory Committee.

Section 3 would create a committee on cardiac care improvement reporting that would be responsible for identifying an appropriate data collection system for assessing cardiac care outcomes. CHA supports the development of this committee and respectfully requests that Section 3 be amended to state that the committee will include a representative from CHA, as well as the two hospital representatives currently identified, in order to ensure that the perspectives of a wide variety of hospitals are represented.