



**TESTIMONY OF  
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VICE PRESIDENT, QUALITY AND PATIENT SAFETY  
CONNECTICUT HOSPITAL ASSOCIATION  
BEFORE THE  
INSURANCE AND REAL ESTATE COMMITTEE  
Thursday, March 6, 2008**

**HB 5695, An Act Concerning Responsibility For Hospital  
"Never" Events**

Good evening Senator Crisco, Representative O'Connor, and members of the Committee. My name is Brian Fillipo and I am the Vice President, Quality and Patient Safety, of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify on behalf of CHA and its members on **HB 5695, An Act Concerning Responsibility For Hospital "Never" Events**.

HB 5695 focuses on the National Quality Forum ("NQF") list of serious reportable events, so called "never" events, and seeks to accomplish two things. The bill would exempt insurers from their obligations to pay for any event on the NQF list, essentially making all "never" events no-pay events for insurers, without regard to the cause or preventability of the event. The bill would also require each instance of a "never" event to be reported to the Department of Public Health (DPH), and mandate a DPH oversight process, including oversight through the Quality of Care Program.

While we do not support the approach of the bill to make all "never" events no-pay events without further analysis of the preventability of the event, CHA understands and supports the goal of 5695 to prevent payment to facilities responsible for preventable adverse outcomes that are within their control. To this end, hospitals have been diligently working to find a way to review all adverse events, including those on the NQF list, to determine whether adverse patient outcomes were within a hospital's control, preventable and the result of a hospital mistake.

Connecticut's hospitals are dedicated to making healthcare as safe and free from harm as possible. For the past several months, Connecticut hospitals have been working hard to develop strategies to assist an injured patient and his or her family, which includes not charging the patient for the costs of care related to an incident. CHA created a multi-disciplinary committee of healthcare professionals who have developed a policy on this issue. This policy is modeled after the Minnesota Hospital Association's voluntary reporting system for NQF events, which is the system upon which HB 5695 is based. The policy incorporates the reasoning used by the National Quality Forum when it explained that not all serious reportable events are the fault of the provider. CHA's Board of Trustees will be voting in the next several weeks on adopting this policy state-wide. Under the policy, when an error resulting in significant harm to a patient occurs, information about the error will be quickly and openly communicated to patients and

their families, and hospitals will not expect payment for care if the error satisfies the following criteria:

- The error or event is reasonably preventable by the hospital.  
Hospitals should be held accountable for serious events that could and should have been prevented by the hospital.
- The error or event is within the control of the hospital.  
Hospitals should not be held accountable for errors that occurred, for example, in the manufacture of drugs, devices, or equipment, well before the materials reached the hospital's doors.
- The error or event is the result of a mistake made in the hospital.  
The event must clearly and unambiguously be the result of a mistake made by the hospital.

The NQF list is a consensus document, created with the input of hospitals and numerous experts, to identify areas where quality improvement resources might be better directed within a facility. The list is not an assignment of guilt or fault or liability. The list does not determine whether an event was preventable or within the facility's control. The list is a tool for improving quality and for focusing attention on areas of care. Hospitals helped develop this list, and it has been extremely useful in moving quality and patient safety forward. To now use it as a punishment against hospitals takes a step backward in the pursuit of quality and patient safety.

We urge you to take a more careful look at the purpose behind the NQF list, specifically that it is not a "no-pay" list as the bill assumes, and consider instead that the best way to move forward is through case-by-case analysis to determine preventability and control of the situation before a "no-pay" label is given, as is contemplated by the CHA policy.

With respect to mandatory reporting and oversight by DPH, the bill seems to overlook that Connecticut's hospitals and outpatient surgical facilities have, since 2004, been required to report these events to DPH. DPH reviews every single report and event, working with each hospital to ensure that care is improved in the future, and a publicly available report is made by the DPH Quality of Care Program at DPH. Sections 3, 4 and 5 of the bill are unnecessary as they are duplicative of existing law. This duplication will create conflicting legal standards and substantial confusion in the adverse event reporting system. We are not aware from DPH, or any other source, that the current system is not working or needs revision.

We strongly believe that HB 5695 is not needed at this time because a comprehensive adverse event reporting system is already in place and functioning properly, and because Connecticut hospitals are in the process of implementing a nonpayment policy for patients and insurers consistent with the National Quality Forum's framework for use of the list of serious reportable events.

Thank you for consideration of our position. I am happy to answer any questions.