TESTIMONY
OF
CAROLYN BRADY
VICE PRESIDENT, PATIENT CARE AND REGULATORY SERVICES
CONNECTICUT HOSPITAL ASSOCIATION
PUBLIC HEALTH COMMITTEE

Thursday, March 14, 2002

HB 5715, An Act Creating A Program For Quality In Health Care

SB 550, An Act Concerning Prescriptions

Good morning Senator Harp, Representative Eberle and members of the Public Health Committee. My name is Carrie Brady and I am Vice President of Patient Care and Regulatory Services of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify this morning on two bills before the Committee.

CHA supports **HB 5715, An Act Creating A Program For Quality In Health Care**, which would create a quality of care program within the Department of Public Health (DPH). This bill is a product of the Quality of Care Issues Work Group of the Commission on the Future of Hospital Care in Connecticut. CHA and some of our members actively participated in the Work Group and we support this Committee's efforts to implement the Work Group's recommendations.

Our members continuously strive to provide excellent care to all patients. The quality of care program, if used appropriately, is another opportunity for providers and others to collectively develop methods to improve care for Connecticut patients.

The bill requires DPH to initially develop a standardized set of data for collection and public reporting by hospitals. In developing the data and collection methods, we urge DPH to consider the additional resources hospitals will need to expend to obtain the data. Hospitals already collect and report clinical performance data to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and others and we encourage DPH to incorporate existing data into its data collection requirements.

The bill also requires DPH to publicly release a report comparing all licensed hospitals in Connecticut based on quality performance measures by April 1, 2004. In designing the

reports, we encourage DPH to include national benchmarks to demonstrate how Connecticut hospitals as a whole compare with other states. A wide range of national data will be available at that time because the federal Agency for Healthcare Research and Quality (AHRQ) will have published its first annual national healthcare quality report in 2003. When the Connecticut report is released, it will be extremely important for DPH to clearly explain how the indicators are defined and analyzed and what the information means to consumers. It also will be important for DPH to explain the limitations inherent in any system of risk adjusting for the severity of illness of patients in different hospitals. We look forward to working with DPH in designing appropriate, meaningful reports and creating the concurrent public education materials.

The way in which DPH manages the program will be a critical factor in its success. As designed, the quality of care program is a collaborative method for DPH, providers, and other interested parties to work together to improve patient care. This collaborative, systemic focus must be maintained. We look forward to actively working with DPH and other members of the quality of care advisory committee to improve all aspects of the healthcare system.

Even in the absence of this proposed legislation, DPH has indicated its desire to take a leadership role in continuously improving the quality of patient care. We are currently working with DPH and look forward to continuing to work with the agency on its initiatives as well as the proposed quality of care program.

CHA opposes **SB 550, An Act Concerning Prescriptions**, which would require the Department of Public Health to develop regulations "for the purpose of developing a system for checking errors made in dispensing medication to a patient by prescribing practitioners or pharmacists." Although it is not clearly described in the bill, we presume that the system for checking errors is likely to include mandatory reporting of errors to DPH.

Mandatory reporting of errors is a subject that requires detailed analysis and the system contemplated by the bill needs careful design. An effective reporting system must be crafted to produce reliable information that can actually be utilized to reduce errors. It is essential for all reporters to have a common understanding of what is an "error" and detailed rules must be established regarding the use of the reported information. The system must be non-punitive and include appropriate confidentiality protections to ensure that it does not have the effect of discouraging disclosure of errors. These details are not addressed in SB 550.

The concept of mandatory reporting is currently being studied in detail on the national level. The CHA Board of Trustees also convened a Committee on Medical Errors last year that is charged with developing strategies for assisting hospitals and other healthcare providers in their efforts to reduce errors. CHA looks forward to working with the Legislature and appropriate state agencies to develop concrete strategies to address medical errors and improve quality, but we believe that SB 550 is premature and will not achieve its intended goals.

Thank you for your consideration of our positions.

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