HAWAII MEDICAL ASSOCIATION
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Friday February 4, 2011; 4:00 p.m. Conference Room 229

To: COMMITTEE ON HEALTH
Senator Josh Green, M.D., Chair
Senator Clarence K. Nishihara, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, MD, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 705 RELATING TO HEALTH

In Opposition.

Chairs & Committee Members:

First, "medical harm events" are quite common and most often minor, and if the law is vague about what constitutes a reportable event, that will put providers in a "Catch 22." Reporting everything would be intolerably burdensome, but not reporting everything could trigger severe penalties. The judgment about what should have been reported could be made by non-clinical bureaucrats intent on rooting out "deficient" health care, with very severe adverse consequences for quality health care. The bill would need to very clearly define a required level of severity to trigger the reporting requirement.

Second, and more generally, **reporting requirements with penalties attached have been shown to inhibit, not enhance, error prevention programs**. Everyone becomes so concerned about avoiding the penalties that they look for ways to avoid reporting (covering their tracks to avoid non-reporting penalties), don't communicate or collaborate, and get into blaming and finger-pointing that inhibit effective error reduction. **As has been demonstrated extensively in the airline industry, and also in health care, error reduction requires a trusting atmosphere in which everyone sees errors as systems problems, and not a matter of individual blame.** That way, reporting leads to **improvements in policies and procedures** within an institution to prevent future errors, not punishment of whoever is stuck with the blame.

Hawaii already has a well functioning error reduction program for Medicare run by Mountain Pacific Quality Health - Hawaii. HMA encourages the legislature to look into expanding this to Medicaid and other programs.

HAH
Healthcare Association
of Hawaii

SENATE COMMITTEE ON HEALTH
Senator Josh Green, M.D. Chair

Conference Room 229
Feb. 4, 2011 at 4:00 p.m.

Opposing SB 705.

The Healthcare Association of Hawaii (HAH) advocates for its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. The Healthcare Association opposes SB 705, which requires hospitals to report events resulting in medical harm to the Department of Health (DOH). In turn, DOH is required to submit a report annually to the Legislature and make outcomes of inspections and investigations readily accessible to the public.

Hospitals are some of the most scrutinized organizations in Hawaii and the nation, as they are monitored by State government through licensing, by the federal government through the Centers for Medicare and Medicaid Services (CMS), and by a national accrediting agency, the Joint Commission.

Hospitals are complex organizations utilizing complex medical processes that involve many people who perform different functions. Although some medical errors may be attributed to individuals, the greater proportion of errors result from shortcomings in processes or structures.

Hospitals have committees that discuss the root causes of medical errors and adverse events for the purpose of developing solutions. Fears over organizational censure, malpractice litigation, and even licensure sanction can have a chilling effect on communication. Discussions that take place in these committees must be kept confidential so that members are willing to disclose all pertinent information.

Hawaii law recognizes the importance of creating a blameless and non-punitive setting to discuss medical errors and adverse events. Hospitals are authorized to create quality assurance committees and other similar committees in which information considered by the committee is prohibited from being used in medical malpractice lawsuits.

Hospitals and other health care providers are also collaborating to target medical errors and adverse events. The HAH Patient Safety and Quality Committee was established in 2010 to formulate and implement strategies for member organizations to collaborate in improving healthcare safety and quality. Committee members are composed of quality professionals representing acute care hospitals, home care, and long term care facilities.

Presently, the committee is actively working with Hawaii's acute care hospitals on specific campaigns such as hand hygiene, healthcare associated infections in collaboration with DOH, and national efforts with the Agency for Healthcare Research and Quality (AHRQ), American Hospital Association (AHA) and Johns Hopkins University Quality and Safety Research Group. Improving safety at the point of care using evidence based protocols provides a culture of safety.

For the foregoing reasons, the Healthcare Association opposes SB 705.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 4, 2011

The Honorable Josh Green M.D., Chair
The Honorable Clarence K. Nishihara., Vice Chair

Senate Committee on Health

Re: SB 705 – Relating to Health

Dear Chair Green, Vice Chair Nishihara and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 705 which would increase transparency within the health care system. HMSA supports this measure.

In the U.S., medical errors are estimated to result in 44,000 to 98,000 unnecessary deaths, in hospital settings, and 1,000,000 excess injuries each year. A conservative average of both the Institute of Medicine and HealthGrades reports indicates that there have been between 400,000-1.2 million error-induced deaths during 1996–2006 in the United States. Research has documented significant underuse, overuse, and misuse of medical treatments, as well as unexplained variations in treatment patterns in certain demographic groups and across the country.

HMSA has taken great strides towards encouraging providers and facilities to increase the quality of care provided. One of the ways which we are doing this is by pursuing a new methodology of provider reimbursement that rewards health care providers for quality rather than volume. We believe that transitioning to this new payment model and away from simply paying for services based on volume is a vital part of creating an economically sustainable health care delivery system.

We appreciate the intent of this measure as it attempts to work towards providing potentially useful information specifically related to the reporting of medical errors in an attempt to improve the overall quality of our health care system. We also support the creation of an advisory board to provide guidance to the Department of Health.

Thank you for the opportunity to testify today in support of SB 705.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Feleai Tau

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 02, 2011 10:33 AM
To: HTHTestimony
Cc: joyamarshall2003@yahoo.com
Subject: Testimony for SB705 on 2/4/2011 4:00:00 PM

Testimony for HTH 2/4/2011 4:00:00 PM SB705

Conference room: 229
Testifier position: support
Testifier will be present: No
Submitted by: Joy A Marshall,Rn
Organization: Individual
Address: 95-013 Kuahelani Avenue Mililani Town,HI
Phone: 808-623-8734
E-mail: joyamarshall2003@yahoo.com
Submitted on: 2/2/2011

Comments:
As a health care professional I support transpariency for patients seeking information related to the stated errors in this bill

THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 538-9011 • Fax: (808) 547-4646

Senator Josh Green M.D., Chair
Senator Clarence K. Nishihara, Vice Chair
COMMITTEE ON HEALTH

Friday, February 4, 2011 – 4:00 p.m.
State Capitol, Conference Room 229

RE: SB 705 Relating to Health

Chair Green, Vice Chair Nishihara and Members of the Committee:

My name is Robin Fried, Director of Risk Management for The Queen's Medical Center **testifying in opposition to SB 705** which establishes medical error reporting and disclosure requirements. Queen's is committed to ensuring the safety and quality of care for its patients and has a robust process improvement program in place. While we support open communication and appropriate disclosure to patients and their personal representatives, we find this bill to be unnecessary and duplicative of existing law and accreditation standards, as well as ambiguous in key aspects.

Specifically, the proposed language is duplicative of existing law and accreditation standards as follows:

HRS § 671-3(5) and longstanding case law holds that the treating physician has the duty to obtain informed consent. It follows that the physician, not the hospital, has the duty of disclosure of any actual complications and is in the best position to address the medical issues. In addition, certain requirements in the bill would inappropriately interject hospital staff into the physician-patient relationship.

Queen's is accredited by The Joint Commission which currently requires accredited hospitals to:

- Ensure that the patient or surrogate decision-maker is notified about unanticipated outcomes related to major adverse events,
- Perform in-depth analyses of events resulting in significant injury or death and implement corrective action plans to prevent future, similar events,
- Have an organized performance improvement program and peer review processes that continuously improve the quality and safety of patient care.

The proposed language is ambiguous with regard to the following:

- The definition of "medical harm event" categories is overbroad and could include almost any unavoidable complication that may occur.

- The respective roles of the hospital and physicians, most of whom are independent practitioners, not hospital employees.
- The bill imposes civil penalties for failure to report ambiguously defined "medical harm events" and provides no clear standards for compliance, raising issues of due process.

The bill would present an extraordinary administrative burden. The requirement that hospitals engage in a formal notification process for almost every complication, no matter how minor, and no matter how much the complication is out of their control, presents an extraordinary administrative burden that would ultimately increase healthcare costs with no known appreciable benefit to patient care.

Thank you for the opportunity to testify.

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LORETTA J. FUDDY, A.C.S.W., M.P.H.
ACTING DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

Senate Committee on Health

SB0705, Relating to Health (Medical Error Reporting)

Testimony of Loretta J. Fuddy, A.C.S.W., M.P.H.
Acting Director of Health

February 4, 2011

Department's Position: The department appreciates the intent of this bill but respectfully OPPOSES it as currently drafted.

Fiscal Implications: The department estimates the cost of these requirements at approximately $120,000 per year for a data analyst and other administrative support and expenses. While this bill allows for penalties and fines to be levied against hospitals, those monies cannot be expected to be a guaranteed, robust or consistent method of funding and current resources could not absorb these additional duties. As a result, general funds would be required.

Purpose and Justification: The state legislature has worked with the Healthcare Association of Hawaii (HAH) on identifying a way to create a voluntary reporting system for medical errors. More work needs to be done in this area but recent efforts to work with the hospital community to develop a voluntary way of sharing infection rates on healthcare acquired infections (HAI) is proving fruitful. We should apply this same work effort on medical error reporting rather than through legislation.

Notwithstanding the above efforts, this bill would essentially duplicate other current practices aimed at ensuring a safe, quality of care environment at acute care hospitals, with the exception of the advisory committee and public disclosure requirements. For example, currently, Medicare requires hospitals to "develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality

assessment and performance improvement program … (that) involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its (Quality Assessment and Performance Improvement) program for review by CMS." (42 CFR 482.21)

Hospitals and other healthcare facilities currently report sentinel and other events to the department's Office of Health Care Assurance (OHCA). These are called "incident reports" and they report on events such as deaths, elopements, inappropriate restraints, patient falls, and other events. Incident reports and complaints are investigated by OHCA to determine their scope and severity, i.e., was the event isolated or widespread, was there actual patient harm or potential harm, and has the facility taken corrective action to prevent future events. If no action was taken, OHCA will require the hospital to take action and report on its results. If hospitals are slow to act, refuse to take action, or take inappropriate action they could be fined or they could jeopardize their Medicare certification or state license.

Hospitals must remain compliant with federal certification or state licensure requirements in order to continue to be certified or licensed, and hospitals must be licensed to stay in business and they must be Medicare certified in order to receive Medicare or Medicaid payments. Failure to comply could lead to Medicare decertification or loss of state license and could force a facility to close. This motivates hospitals to maintain their certification and licensure. As a result, it appears there are sufficient safeguards currently in place to protect the health and safety of patients at Hawaii's acute care hospitals. Nevertheless, improvements can be made and the department believes the best way to accomplish this is in partnership with the hospital community in the same collaborative way as was achieved with the healthcare acquired infection reporting system.

Thank you for the opportunity to testify.