

**Department of Health and Senior Services**  
**Commissioner Heather Howard**  
**Testimony on S2471 – Public Reporting of Patient Safety Indicators**  
**Senate Health, Human Services and Senior Citizens Committee**  
**Monday, January 26, 2009**

Good Afternoon Chairman Vitale, Vice Chairwoman Weinberg and distinguished members of the Senate Health, Human Services and Senior Citizens Committee.

I am pleased to be here this afternoon to testify in support of Senate bill 2471, which takes an important step forward for patient safety, health care transparency and accountability. This legislation would give the public access to hospital specific reports of serious medical errors and indicators of patient safety endorsed by national experts.

The groundbreaking Institute of Medicine (IOM) report, “To Err is Human: Building A Safer Health System,” found that health care in the United States is not as safe as it should be, with at least 44,000 to as many as 98,000 preventable deaths occurring in US hospitals as a result of medical errors that could have been prevented. Since that report, patient safety and reducing medical errors have been a high priority for health care providers, the Department of Health and Senior Services and many in this room today.

In particular, the issue of patients having access to the rates of medical errors by hospital has been the focus of considerable concern among seniors and consumer groups. Under current law, the Patient Safety Act, which was established to encourage a culture of patient safety, provides for confidential reporting of medical errors by hospitals as a way of fostering more reporting and analysis of errors, with the emphasis on the prevention of errors. The Patient Safety Act continues to be a success and confidentiality is a major component of its success.

It has resulted in more hospitals reporting adverse events and a higher volume of reports. We have also seen qualitative improvement in the caliber of hospitals’ mandatory analyses of the root causes of medical errors. It is critical that we find and understand the causes of the events to assist and enable providers to make key process improvements.

But public disclosure is also a critical part of our quality improvement strategy. The more valid measures of medical error rates that are reported, analyzed and publicly disclosed, the more informed patients will be and the greater the chance that hospital administrators and health care professionals will make the systems improvements needed to prevent future mistakes.

Last fall, Governor Corzine directed the Department to create a Hospital Reporting Work Group to address this important health care and consumer issue. I want to publicly thank you, Senator Vitale, and the other members of the work group for your diligent work on this issue. The work group members included leadership from the Senate, Assembly, the New Jersey Hospital Association, AARP, HPAE, the Health Professionals and Allied Employees Union, and the Health Care Quality Institute.

The public reporting requirement in the legislation before you today is a result of that working group. It will enable errors to be made public using hospital billing data. It also uses a well-researched and validated framework for reporting errors to the public.

Under this bill, the medical error data that would be presented in our annual Hospital Performance Report will be based on Patient Safety Indicators (PSI). The Patient Safety Indicators, developed by the federal Agency for Health Care Research and Quality (AHRQ), are a set of measures of serious adverse events in hospitals. These events can almost always be prevented by changes at the system level.

The Indicators include medical errors that occur in hospitals, such as post op hip fractures, transfusion reactions, objects left inside bodies during surgeries, birth traumas, and accidental punctures.

AHRQ has been working on advising states and others in how to use the PSIs for hospital accountability. I want to stress that the PSIs included in this legislation have been carefully chosen by AHRQ to be the most accurate for public reporting.

I also want to note that we are not creating a new reporting requirement. But rather, we are simply extracting available billing data that we already have and putting it into a consumer-friendly format.

This new initiative will complement the Department's ongoing quality efforts. The Department currently publishes multiple reports about hospital quality and patient safety. The Department has previously publicly reported the AHRQ hospital-specific Inpatient Quality Indicators (IQIs) in 2007 and Prevention Quality Indicators (PQIs) this summer. Both of these reports are available on our web site.

In addition to the quality and safety reports published by the Department, New Jersey's hospitals are making great strides to improve patient care. The Department worked with NJHA to develop a collaborative workshop on falls prevention for hospitals that builds on the NJ experience with falls and the national perspective on fall reduction. NJHA also created a pressure ulcer collaborative. Due to the hard work of hospital administrators and health care practitioners, we actually saw a decrease in the number of reported pressure ulcers in the latest patient safety report.

To ensure this reporting system is adaptable over time and keeps up with best practices, the legislation requires that the Department's Quality Improvement Advisory Committee (QIAC) study and make recommendations on how to expand public reporting.

The public is clearly the winner under this legislation. Consumers will benefit from having information, and our hospitals will continue to make great strides in improving patient care. With this new initiative, coupled with the continued success of the Patient Safety Act, New Jersey will truly be a nationwide leader on improving patient safety.

Thank you again for this opportunity to testify. I would be happy to answer any questions you have on this new reporting system.