Bill as Introduced

HB 1169 – AS INTRODUCED

2010 SESSION

10-2432
01/10

HOUSE BILL ***1169***

AN ACT deleting the repeal of the New Hampshire health care quality assurance commission.

SPONSORS: Rep. Craig, Hills 9

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill deletes the repeal of the New Hampshire health care quality assurance commission.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 1169 – AS INTRODUCED

10-2432
01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT deleting the repeal of the New Hampshire health care quality assurance commission.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Repeal. The following are repealed:

I. 2005, 157:3, relative to prospective repeal of the New Hampshire health care quality assurance commission.

II. 2005, 157:4, I, relative to the effective date of the prospective repeal.

2 Effective Date. This act shall take effect upon its passage.

Amendments

Rep. Donovan, Sull. 4
February 12, 2010
2010-0700h
06/04

Amendment to HB 1169

Amend the title of the bill by replacing it with the following:

AN ACT relative to the New Hampshire health care quality assurance commission.

Amend the bill by replacing all after the enacting clause with the following:

1 New Subparagraph; New Hampshire Health Care Quality Assurance Commission; Membership. Amend RSA 151-G:1, II by inserting after subparagraph (d) the following new subparagraph:

(e) One member-at-large appointed by the governor.

2 Reports. Amend RSA 151-G:7 to read as follows:

151-G:7 Reports. On or before June 1 of each year, the commission shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, [~~and~~] the governor, ***and the health and human services oversight committee established in RSA 126-A:13***. Such report shall describe the activities of the commission, indicate the extent of each institution's participation, state the aggregate relative frequency of the causes of the medical errors, unexpected adverse outcomes, and near misses reviewed and, to the extent possible, identify strategies for reducing preventable adverse events. Any information about processes or clinical outcomes provided pursuant to this section shall be aggregate data only and shall not reference individual incidents, patients, health care providers, or institutions.

3 Commission Extended. Amend 2005, 157:4, I to read as follows:

I. Section 3 of this act shall take effect July 1, [~~2010~~] ***2015***.

4 Effective Date. This act shall take effect upon its passage.

2010-0700h

AMENDED ANALYSIS

This bill makes changes to the New Hampshire health care quality assurance commission.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1169 Date 2/9/2010

Committee HHS

**** Please Print All Information ****

Name	Address	Phone	Representing	(check one) Pro	Con

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1169

BILL TITLE: deleting the repeal of the New Hampshire health care quality assurance commission.

DATE: February 9, 2010

LOB ROOM: 205 **Time Public Hearing Called to Order:** 10:00 AM

Time Adjourned: 11:10 AM

(please circle if present)

Committee Members: Reps. Rosenwald, Donovan, French, Schulze, Tilton, Butcher, Bridgham, E. Merrick, T. Russell, DiPentima, Miller, Batula, C. McMahon, Pilliod, Emerson, Case, Millham, Wells, Cebrowski and Kotowski.

Bill Sponsors: Rep. Craig, Hills 9

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Representative Robert Bridgham – introduced the bill.

Representative Jim Craig, prime sponsor – supports.

Representative Deborah Wheeler – opposes.

Dr. Jose Montero, DHHS – supports. The Department strongly supports this bill. He does attend the meetings and the aim is to improve the process and protect the care of the patient. This is process oriented and to improve the care of the patient.

Leslie Melby, New Hampshire Hospital Association – supports. She supports this bill to review and analyze patient care. There is always room for improvement and this is where this bill helps. Urges us to pass this bill. The purpose is to see what hospitals can do to improve public safety. Would support a public member added to the commission.

***Lori Nerbonne, NH Patient Voices – opposes.** See written testimony.

***Rachel Rowe, Foundtion for Healthy Communities – supports.** See written testimony and annual report. Adverse events form alert regarding problems. Hospitals need to look at procedures and adopt a patient safety check list as a way to protect patient harm. There is 88% compliance with hand washing in New Hampshire and the rest of the nation is at 50%. The confidential conversations between hospital Commission members is important.

Recommendations to be added to the bill:

1. Present in person to HHS Oversight.
2. Recommendation an objective public member.

The person is to look and listen and observe if the Commission is doing what they are supposed to. It is more important to keep the Commission, if a public member is to validate the work requested and make a stipulation to its continuance. Commission members are appointed by the Governor with the approval of the hospitals.

***Karen Bronson, Patient Voices – opposes.** See written testimony. She related a story of her father's premature death. We must ask more of hospitals and Quality Assurance Commission. The Commission needs a voice of the patient. A member of the public would be helpful.

Respectfully submitted,

Rep. Joan Schulze

Representative Joan Schulze, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1169

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Bill Sponsors: Rep. Craig, Hills 9

Donovan
rosenwald
mcmahon

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. P. Bridgham introduced the bill
Rep J. Craig spoke & supports
Rep. Deborah Wheeler - opposes the bill

Dr. Jose Montero - The Dept strongly supports this bill. Does attend the meetings aim is to improve the process & protect the care of the patient. This is process oriented and to improve the care of the patient.

Leslie Meeby NH. Hospital Assoc.
Supports this bill to review & analyze patient care - There is always room for improvement and this where this bill helps. Urge us to pass this bill.
The purpose is to see what hospitals can do to improve public safety. Would support a public member added to the commission

☆Lori Nerbonne. NH Patient Voices
See written testimony opposes the bill.

☆Rachel Laup supports the bill Submits testimony and the annual report
Foundation for Healthy Comm.
Adverse events form alert re: problems
Hospitals need to look at procedures & adopt a patient safety check list a way to protect patient harm.

88% compliance with hand washing in N.H. rest of nation at 50%

The confidential conversations between hospital Commission members is important

Recommendations to be added to bill.

1. present in person to H&S oversight
2- recommendations an objective public member

The person is to look & listen & observe if they are commission is doing what they are suppose to

More important to keep the commission, if a public member to validate the work is requested ~~is~~ and made a stipulations to its continuance.

Commission members are appointed by the Gov. with the approval of the hospitals.

☆Karen Branson - opposes the bill Patient Voices
Related a story of her fathers premature death.
We must ask more of Hospitals and Quality Assurance Commission.

Commission needs a voice of the patient. The public member would be helpful.

Sub-Committee Actions

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1169

BILL TITLE: deleting the repeal of the New Hampshire health care quality assurance commission.

DATE: February 11, 2010

Subcommittee Members: Reps. T. Donovan, E. Merick, C. McMahon

Comments and Recommendations: 1.) Extend for 5 years. 2.) Add an annual report to be presented in person at HHS Oversight Committee. 3.) Add "Citizens at Large" to committee. This person should not be affiliated with any healthcare system. Person should have the ability to objectively validate what the Commission is charged to be doing and be able to reflect the voice of the patient. The person is to be appointed by the Governor.

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. A. Millham

Seconded by Rep. E. Merrick

Vote: 3-0

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Tom Donovan
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1169

BILL TITLE: deleting the repeal of the New Hampshire health care quality assurance commission.

DATE: February 11, 2010

Subcommittee Members: Reps. T. Donovan, E. Merick, C. McMahon

Comments and Recommendations:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. Donovan OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, (OTP/A,) ITL, Retained (Please circle one.)

Moved by Rep. McMahon

Seconded by Rep. Merrick

Vote: 3-0

Respectfully submitted,

Rep. Tom Donovan
Subcommittee Chairman/Clerk

Recommendations
1) Extend for 5 years
2) Add an annual report to be presented in person at Health and Human Services Oversight Committee
3) Add "Citizen at large to committee. This person should be not affiliated with any healthcare system. Person should have ability to objectively validate what the Commission is charged to be doing and be able to reflect the voice of the Patient. Person to be appointed by Governor.

Public Present Rachael Rowe
Leslie Melby

Testimony

File
HB1669

Good morning. My name is Lori Nerbonne from NH Patient Voices. I represent consumers & patients from across the state who are committed to improving the quality and reducing the cost of healthcare in NH. Thank you for hearing my testimony today. I promise to only take 5 minutes of your time.

Last year, a young woman from Keene NH -- Erin Dallas-- a nationally ranked field hockey player developed a MRSA infection after knee surgery in a NH hospital. She was in and out of the hospital for 7 months, came close to dying, and incurred $250,000 in medical expenses. It took community fundraisers to pay off her medical bills.

My mother, Dorothy Etheridge, a 30 year NH state employee, developed a MRSA infection after surgery that led to an 8 month hospitalization, over 1 million dollars in costs and her eventual death from medication errors that were never disclosed to us and to this day continue to be kept behind a wall of secrecy. Sadly, these stories are a rather frequent occurrence in our state.

Preventable medical errors and infections are a leading cause of death in America and they cost billions; NH is no exception, and yet the only group our state has commissioned to deal with this problem is The NH Healthcare Quality Assurance Commission, which is made up of hospital administrators and association members who have repeatedly lobbied and testified against public reporting.

As you know, this Commission, under the administration of the NH Hospital Association, has met for five years. During this time, nationally published outcome data has revealed some poor results:

- Five NH Hospitals have "worse than national average" pneumonia mortality rates for senior citizen patients on Medicare
- Two of them made the list of the 100 highest mortality rates in the country; one for pneumonia, the other for heart failure. This means they performed worse than 94% of all US hospitals.
- If these hospitals had performed at just "average" , then **75 senior citizens** lives could have been saved
- If they performed in the top performing group of hospitals that were "better than average" , then 147 lives could have been saved.
- Several NH hospitals have higher than average surgical and medical mortality rates for Medicare patients (www.checkbook.org)

The Commissions annual report reveals that NH hospitals are not reporting two of the three infections as required by law (HB 1741). These include Ventilator Associated Pneumonia (VAP) which has a mortality rate of 46% & instead of reporting ALL surgical site infections, they are only reporting three types. Their reasoning behind this is that there is no national standard for reporting VAP. This same argument was used four years ago when members of the commission testified against the infection reporting bill and yet many, many hospitals across the country are successfully reporting infections and even getting their rates down to zero.

The CDC just last week announced that they fully endorse public reporting as a means to provide consumers with meaningful data about hospitals and to stimulate hospitals toward improvement.

At a recent patient safety conference, I had a chance to ask a national expert on infection prevention from Univ. of Pennsylvania about the lack of a standard definition for VAP. Dr. Rick Shannon' s response was: **"I would be very concerned if hospitals are not tracking & reporting VAP because of its high mortality rate. The CDC does provide a standard definition for VAP, but even if they didn' t , all that the hospitals in NH need to do is come up with a single definition that all the hospitals can agree on."**

NH DHHS was recently awarded $737,000 from the CDC through The American Recovery & Reinvestment Act to go directly toward tracking and reporting Healthcare Associated Infections. $50,000 of this money is being given to the NH Hospital Association for their handwashing program. This is taxpayer money. We hope that you agree that the residents of NH deserve a public report of **all** the infections required by law.

As a result of your support and your colleagues in the Legislature, NH now has two patient safety laws (the Hospital Infection Reporting and the Adverse Event Reporting laws) Three more bills are now working their way through the legislature this year: Maternal and Infant Mortality Review Panels & Ambulatory Surgical Center Infection Reporting. Together if passed, this data will bring meaningful information that can not only be reported to consumers but also provide important data that we feel the state should be analyzing for how it affects the cost of care & rising health insurance premiums.

We respect the work that The NH Healthcare Quality Assurance Commission is doing in sharing 'best practices' in order to improve care, but we feel that there is a large void in our current system that is not being addressed by the appropriate stakeholders.

We feel strongly that this group can only be effective if it is a sub-committee of a group of multiple statewide stakeholders who will roll up their sleeves and do the important and urgent work that needs to be done to improve hospital quality and gain control over the associated unnecessary costs that drive up our healthcare premiums.

I ask you to consider being a family member of Erin Dallas or my mother, where one life was close to ending and another one did end....over something that other states have found to be completely preventable. Now picture having to pay hundreds of thousands of dollars for this harmful care. Now consider that NH is at the bottom in hospital performance in some Medicare data during a time when this commission in its current format was in place.

To serve the needs of consumers and patient safety, we would ask that any group or commission going forward be accountable to the public through transparency, and be made up of consumers, employers, RNs, medical ethics, public health, mental health, financial & certified quality improvement professionals.

For these reasons we cannot support this bill in its current form of allowing the commission to operate secretly with no accountability to the public.

Thank you for the opportunity to come and offer our input today.

http://www.mainequalityforum.gov/

http://www.phc4.org/

http://web.doh.state.nj.us/apps2/hpr/index.aspx

CDC Statement: Public Reporting of Healthcare-Associated Infections

For Immediate Release: February 2, 2010
Contact: CDC Division of Media Relations, Phone: (404) 639-3286

Recently, several state health departments and Consumer Reports magazine released summaries of infection rates in healthcare facilities.

The Centers for Disease Control and Prevention (CDC) believes public reporting of healthcare-associated infections (HAIs) is an important component of national HAI elimination efforts. Research shows that when healthcare facilities are aware of their infection issues and implement concrete strategies to prevent them, rates of certain hospital infections can be decreased by more than 70 percent.

"Eliminating healthcare-associated infections is a top priority for CDC," said Dr. Denise Cardo, director of CDC's Division of Healthcare Quality Promotion. "The tracking and reporting of healthcare-associated infections is an important step toward healthcare transparency. Infection data can give healthcare facilities, patients and public health agencies the knowledge needed to design and implement prevention strategies that protect patients and save lives."

HAIs are not only a problem for individual healthcare facilities – they represent a public health issue that requires many people and organizations to work together in a comprehensive effort to attack these largely preventable infections. CDC is working with partners and states to implement infection prevention tools and increase their use of the agency's National Healthcare Safety Network (NHSN). This network is a surveillance system that allows HAI data to be tracked, analyzed and shared to maximize prevention efforts.

In 2003, CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) published guidance to states for implementation of HAI public reporting. Currently, 28 states have implemented public reporting laws, 21 of which utilize NHSN for their reporting requirements. CDC works to assist facilities and states working under a legislative mandate. CDC's collaborations with several states have demonstrated that implementing CDC's HAI prevention guidelines and using NHSN to monitor progress can achieve major decreases in HAIs. Recent investments through the American Reinvestment and Recovery Act are furthering this mission toward HAI elimination.

For HICPAC's guidance on public reporting of HAIs: http://www.cdc.gov/hicpac/pubReportGuide/publicReportingHAI.html

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File
HB1169

FOUNDATION FOR
HEALTHY COMMUNITIES

House Health and Human Services Committee
February 9, 2010

HB 1169
Deleting the repeal of the New Hampshire health care quality assurance commission

Testimony

Good morning Madam Chair and members of the Committee. My name is Rachel Rowe and I am the Associate Executive Director of the Foundation for Healthy Communities and the Administrator of the New Hampshire Health Care Quality Assurance Commission.

I am here to testify in support of HB 1169. For the past four years, representatives from every hospital and ambulatory surgery center in New Hampshire have met regularly to share information about medical errors and how to prevent them. We have had enormous success in implementing statewide patient safety programs at our facilities and achieving measurable improvement in adopting processes which are known to prevent harm to patients. For example, every hospital and ambulatory surgery center in the state has adopted a patient safety checklist for all areas where patients undergo a procedure and our statewide hand hygiene compliance rate is 88% compared to compliance rates across the country of below 50% according to the Centers for Disease Control.

There are two main reasons why the Commission has been so successful. The first is that the Commission was enacted by the Legislature and therefore creates a 'call to action' for New Hampshire providers which may not exist otherwise. The second is the provision in the statute which calls for the information communicated under the auspices of the Commission to be confidential and privileged. This has fostered the candor, self critical analysis, and trust necessary in creating the learning environment we now have to promote better and safer care for patients in our state. We are passionate about this work as evidenced by the overwhelming attendance at

every meeting and voluntary commitment by providers to the numerous patient safety initiatives we have undertaken.

Despite the great work accomplished in the past 4 years, there is more to be done to ensure that every patient receives the right care every time. The Commission members are steadfast in their commitment to provide better and safer care and understand that the Commission is continuing to evolve and mature as a learning organization. To that end, we recommend adding the Health and Human Services Oversight Committee to the list of those who should receive the Annual Report of the Commission. We also recognize that the Commission would benefit from the participation of an objective community member who would serve as the 'voice of the patient' and validate the important work that is being carried out by providers in the state.

I am providing you with a copy of our most recent Annual Report and look forward to continuing this meaningful work to provide better and safer care in all New Hampshire hospitals and ambulatory surgery centers.

I urge you to support HB 1169.

Thank you.

Rachel Rowe File
HB 1169

NH Health Care Quality
Assurance Commission

Annual Report of the New Hampshire Health Care Quality Assurance Commission

June 1, 2009
HB 514, Chapter 157:2, Laws of 2005

Chapter 157:2, of the Laws of 2005, established the New Hampshire Health Care Quality Assurance Commission. Its intent is *to enable health care providers to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission's deliberations.*

Members of the Commission include one representative from each acute care hospital and free standing ambulatory surgical center (ASC) and the designee of the Commissioner of the Department of Health and Human Services. Stephanie Wolf-Rosenblum, MD, MMM Chief Medical Officer, Southern New Hampshire Medical Center, serves as Chairperson; Ross Ramey, MD, Monadnock Community Hospital, Vice-Chair; Jean Corvinus, Director, Performance Improvement, Secretary; Sue Majewski, Chief Operating Officer, Bedford Ambulatory Surgery Center, Executive Committee member representing ASCs; and Rachel Rowe, Associate Executive Director of the Foundation for Healthy Communities serves as administrator of the Commission. The officers serve two year terms.

During its fourth year, the Commission met five times on the following dates: August 1, 2008, October 31, 2008, January 23, 2009, March 13, 2009, and May 8, 2009.

Executive Summary

The Commission continued its important work with hospitals and ambulatory surgery centers (ASCs) to voluntarily promote initiatives and share best practices which have been proven to enhance patient safety and decrease harm. In addition to ongoing statewide improvement initiatives, Commission members shared best practices, exchanged important information regarding their facilities' own stories of medical errors and prevention strategies, and continued to establish key networks and partnerships for ongoing individual and organizational improvement activities. Initiatives focused on error reduction by educating key stakeholders on the principles of High Reliability Organizations as developed in the aviation and other non-healthcare industries, and working together to disseminate and apply these techniques throughout the state.

The Commission members voluntarily expanded their collection and reporting of statewide central line bloodstream infection (CLBI) rates to include those infections which occur outside of the Intensive Care Unit. We also continued our strong commitment to increasing hand hygiene compliance across all disciplines and in all hospitals and ASCs by developing educational tools and establishing an ongoing statewide monitoring and reporting system.

The Ambulatory Surgery Centers reported surgical site infection rates for all surgeries in 2008. This is a major voluntary initiative and the first of its kind for the ambulatory surgery centers in the state.

The major accomplishment of the Commission this year was the establishment of a statewide campaign to promote 100% compliance with the use of a Surgical Safety Checklist, one of the primary mechanisms used around the globe to ensure patient safety during operative procedures. We were successful in achieving 100% commitment by the hospitals and the ASCs to pilot a checklist by May 1, 2009. Again, New Hampshire is leading the country in voluntarily participating in major patient safety initiatives where the evidence indicates that compliance would enhance the reliability of performance and the safety of patients.

Details regarding the establishment and activities of the Commission can be found on www.healthynh.com .

DETAILED ACTIVITIES OF THE COMMISSION

Infection Management and Prevention

The management and prevention of infections continued to be a high priority for the Commission this year. Hospitals and ambulatory surgery centers voluntarily collected data on specific infections to learn more about their progress with improvement strategies and to continue to refine their surveillance of these infections. Best practices were shared and members continued to work collaboratively and aggressively on the implementation of evidence based infection prevention strategies.

One of the most meaningful exercises the Commission members participated in this past year was analyzing the best practice steps in the care of a patient undergoing elective surgery. Members were divided into three groups representing the care of patients during the pre-op, surgical, and post-op phases. Each group discussed the important policies and practices that needed to be in place to prevent a surgical site infection SSI if someone such as Tom Brady was hospitalized for knee surgery at their institution.

A. VAP and CLBI Data Collection and Reporting

The Commission members agreed to collect and report Ventilator Associated Pneumonia (VAP) and Central Line Bloodstream Infection (CLBI) rates as one way to monitor progress over time and improve our data collection methodology. While our knowledge about these infections is increasing (how to detect them, how to prevent them, etc.), questions remain at the national level regarding the definitions and data collection methods which underlie the reliability of these infection rates. The Commission continued to engage in meaningful dialogue with the NH Infection Control Practitioners to interpret the results and determine if and how they could be used to identify high performers and stimulate improvement efforts.

The hospital members of the Commission collected and reported VAP and CLBI rates in the ICU for 2008. In addition, we piloted the collection of hospital-wide CLBI rates.

Results:

This is the Commission's fourth year of data collection. The most recent data is presented (2008) alongside data from the last 3 years for trending purposes. As in the past, members continued to work hard to improve the uniformity of data collection. Although this enhanced consistency of reporting does not ensure comparability, it increases the meaningfulness of the data within the given constraints of small numbers and case identification which is sometimes subjective.

All 26 acute care hospitals in New Hampshire reported information regarding the number of Ventilator-Associated Pneumonias (VAPs) and Central Line Bloodstream Infections (CLBIs) that occurred in their institutions. The definitions and methodology are drawn from the Centers for Disease Control and the evidence gathered by the Institute for Healthcare Improvement for their *5 Million Lives Campaign.* 2007 represents our first full year of data collection and reporting.

Ventilator Associated Pneumonia (VAP) statewide rate:

- 2008 (12 month period): 83 pneumonias for a statewide rate of 2.85 VAPs per 1000 ventilator days
- 2007 (12 month period): 96 pneumonias for a statewide rate of 4.75 VAPs per 1000 ventilator days
- 2006 (6 month period): 48 pneumonias for a statewide rate of 4.8 VAPs per 1000 ventilator days
- 2005 (3 month pilot period): 41 pneumonias for a statewide rate of 8.64 VAPs per 1000 ventilator days

Key considerations when interpreting these data:

- These statewide rates include data from 26 hospitals.
- These data were submitted by the hospitals to the Foundation for Healthy Communities and have not been validated by an external organization. As such, the results cannot be considered valid or comparable with other studies until there is consensus on definitions and the collection methodology at the state and national level.
- There continues to be a need to more clearly define what is classified as a pneumonia and who assigns that classification since controversy exists over the optimal method of VAP diagnosis (clinical and culture data).
- There continues to be no national consensus on how pneumonias are classified and what data collection methodology should be used to reduce unintended variation.
- Due to the low numbers and the evolving process of obtaining the data, it is difficult to draw conclusions about the trend.

Central Line Bloodstream Infection (CLBI) statewide rate:

- 2008 (12 month period): 55 CLBIs for a statewide rate of 1.93 CLBIs per 1000 central line days
- 2007 (12 month period): 69 CLBIs for a statewide rate of 2.36 CLBIs per 1000 central line days
- 2006 (6 month period): 28 CLBIs for a statewide rate of 2.3 CLBIs per 1000 central line days
- 2005 (3 month pilot period): 22 CLBIs for a statewide rate of 3.49 CLBIs per 1000 central line days

Key considerations when interpreting these data:

- These statewide rates include data from 26 hospitals;
- These data were submitted by the hospitals to the Foundation for Healthy Communities and have not been validated by an external organization. As such, the results cannot be compared with other studies until there is consensus on the data collection methodology at the state and national level.

- Hospitals continue to refine their processes for diagnosing CLBI and counting 'central line days' (i.e. concurrent vs. retrospective and electronic vs. manual);
- There continues to be some variation in definitional issues and collection methodologies continue to exist among hospitals across the state and country.
- Due to the low numbers and the evolving process of obtaining the data, it is difficult to draw conclusions about the trend.

The Commission members reviewed the results and engaged in a lengthy discussion about the continued challenges and opportunities associated with identifying and collecting this information. The most important challenges are those resulting from the small numbers associated with these infections and the methodological issues regarding data collection that remain despite the CDC definitions. It is clear to Commission members that the variation in reported rates between institutions is due primarily to differences in how "at risk" days (i.e. ventilator days and central line days) are counted and how pneumonias and infections are classified. However, they also recognize that there are best practices both within the state and on a national level from which to learn and opportunities to improve in all of their institutions.

The increasing attention being placed on decreasing these infections and greater transparency of these infection rates has been an important 'call to action' and is anticipated to continue to contribute to lowering infection rates.

Next Steps

As of January 1, 2009, hospitals are reporting their CLBI rates to the National Health Safety Network as required by Section 151:33 of the New Hampshire Statute. That information will be shared with the Commission in order to continue the important collaborative improvement work that has been fostered over the past four years.

Since meaningful gaps in the science related to reliable identification of Ventilator Associated Pneumonia remain at the national level, the Commission recommended that hospitals suspend the collection of VAPs after the June-December 2008 data collection period. There will be no collection of VAPs in 2009.

B. Additional Hospital Data Reporting

The hospital Commission members continued to collect and report measures related to the care a patient receives during surgery. These measures developed by CMS are based in science and validated by an external agency. They represent the percentage of time hospitals have provided the necessary processes of care which have been proven to reduce the incidence of infection from surgery and decrease the risk of venous thrombosis which can lead to prolonged hospitalization, added complications and even cardiovascular complications such as pulmonary embolism and stroke.

Results:

Antibiotic received within 1 hour of surgery:
4562 patients received an antibiotic within 1 hour of surgery of the 4789 patients who underwent the specified surgery or, **95%** of patients received an antibiotic within 1 hour of surgery for the specified procedures. This compares to a rate of 76% in Year 1, 85% in Year 2, and 93% in Year 3.

- This statewide rate includes data from all 26 hospitals;
- The national average for this measure is 93% compared to the NH average of 95%.

Antibiotic discontinued within 24 hours after surgery:
4303 patients had their antibiotics discontinued within 24 hours of surgery of the 4593 patients who underwent the specified surgery or, **94%** of patients had their antibiotic discontinued within 24 hours after surgery. This compares to a rate of 74% for Year 1, 83% for Year 2, and 91% for Year 3.

- This statewide rate includes data from all 26 hospitals;
- The national average for this measure is 89% compared to the NH average of 94%.

The meaningful increase in rates of compliance for these two evidence-based processes of care measures shows that hospitals are working hard to standardize the processes which have been proven to decrease infection rates. These measures are clearly defined, the collection of these data has been systematized within hospitals, and the results are validated by an external agency.

Prophylactic Antibiotic Selection:
4766 patients had the appropriate prophylactic antibiotic ordered for their designated surgery of the 4880 patients who underwent one of the specified surgeries or, **98%** of patients undergoing specific surgeries received the appropriate antibiotic before the procedure to prevent infection.

- This statewide rate includes data from all 26 hospitals;
- The national average for this measure is 96% compared to the NH average of 98%.

Recommended venous thrombosis prophylaxis (clot prevention) ordered:
4701 patients had the recommended prophylaxis ordered to prevent venous thrombosis following specific surgeries of the 4986 patients who were eligible to receive the prophylaxis or; **94%** of patients undergoing specific surgeries had an order for the recommended venous thrombosis prophylaxis.

- This statewide rate includes data from 26 hospitals;
- The national average for this measure is 92% compared to the NH average of 94%.

Recommended venous thrombosis prophylaxis received:
4616 patients received the recommended venous thrombosis prophylaxis following specific surgeries of the 4986 patients who were undergoing specific surgeries or, **93%** of patients received the recommended venous thrombosis prophylaxis for indicated surgeries.

- This statewide rate includes data from 26 hospitals;
- The national average for this measure is 89% compared to the NH average of 93%.

New Hampshire rates are higher for each of these 5 measures of quality and patient safety than the national average and continue to improve over time.

C. Ambulatory Surgery Reporting

For the first time, 17 ambulatory surgery centers voluntarily collected and reported surgical site infections (as defined by the Centers for Disease Control) on all surgeries performed at their centers during July-December 2008. Of over 15,000, there were only 38 infections for a SSI rate of 0.25%. This is a statistically insignificant rate. The ASCs are committed to continuing to monitor their surgical site infections and share their best practices with the Commission.

D. Hand Hygiene Reporting

Beginning in April 2008, hospitals and ambulatory surgical centers have voluntarily monitored hand hygiene compliance within their institutions using trained observers. It is well known that one of the primary ways to decrease infections is by using evidence based practices for cleaning hands before and after contact with patients and with their environment. During the 8 month period from April-December 2008, there were over 20,000 opportunities observed where a caregiver or employee who had contact with a patient should have cleaned their hands. Our statewide rate of compliance for that time period was about 83%. This compares to about 69% compliance in the statewide pilot conducted in November and December 2007. Although the improvement has been fairly dramatic, Commission members agreed that we need to continue our aggressive efforts to improve this rate. It is important to understand that these data are not validated by an external organization but rather, voluntarily reported by the individual institutions.

New Hampshire continues to be the only state in the country to have every hospital and participating ambulatory surgery center committed publicly and at the leadership level to establishing a goal of 100% compliance with hand hygiene. NH hospitals and ASCs will continue to monitor hand hygiene compliance on an ongoing basis and share successful strategies at Commission meetings.

New Initiative for the Commission

The Commission members unanimously agreed to engage in a statewide educational effort to learn what they could do to become more highly reliable organizations in order to increase patient safety across all hospitals and ASCs. Initiatives focused on error reduction by educating key stakeholders on the principles of High Reliability Organizations as developed in the aviation and other non-healthcare industries, and working together to disseminate and apply these techniques throughout the state. Spence Byrum from Convergent HRS, LLC provided a very engaging presentation on the topic to begin our group discussion leading to the development of a major new statewide patient safety initiative.

Scott Goodwin spearheaded a year long effort focused on promoting error reduction by applying high reliability concepts to the Universal Protocol. He based his proposal on a recent NEJM study where the WHO Surgical Safety Checklist was validated in eight pilot sites in diverse global settings with marked improvements in surgical outcomes. Use of the checklist involved both changes in processes and changes in the behavior of individual surgical teams at these hospitals. To implement the checklist, all sites had to introduce a formal pause in care prior to induction of anesthesia, prior to incision, and just before closure of the incision. It was also noted that the Institute for Health Care Improvement (IHI) has also recommended adoption of this Checklist as a national best practice priority for 2009.

In March, the Commission members agreed that an initiative to promote adoption of a surgical safety checklist in all New Hampshire hospitals and ASCs was an excellent fit both for the Commission's legislative charge to reduce medical errors and for a focal point to introduce the principles of high reliability process throughout all institutions. As such, a consensus was achieved that a letter be sent to all CEOs asking for an organizational commitment to create and display Universal Protocol procedure safety checklists in all procedure areas by May 1, 2009. We are the first state in the country to have signed commitments from every hospital and ASC in the state.

Summary

Year 4 has been another highly successful year for the New Hampshire Health Care Quality Assurance Commission. The members continued to share best practices and improvement strategies as well as agree to adopt several evidence-based practices that have been proven to improve care and decrease adverse events. The discussion related to how hospitals and ASCs should treat patients admitted for knee surgery to avoid the same type of infection suffered by Tom Brady, was robust and meaningful because of the confidentiality protections afforded the Commission allowing for frank and open dialogue. All public documents as well as educational materials related to the Commission and its improvement activities can be found as *www.healthynh.com* .

The members of the Commission will continue to collect central line blood stream infection rates and submit them to the National Health Safety Network as required by NH Statute. The Commission will review those data and continue to identify and share improvement strategies used by high performing hospitals. Although CLBI rates in NH

hospitals are stable and lower than the nationally available benchmarks, our goal is to continually work to decrease this rate by identifying and sharing best practices.

Great strides were made across hospitals and ASCs this past year in the frequency with which care providers comply with recommended hand hygiene practices. The members agreed to maintain an aggressive campaign to maintain our gains and improve our rates.

The rates for all 5 measures related to how often hospitals carry out the evidence based recommended processes to prevent surgical infections remain well above the national average on a scale where 100% is best practice.

The major accomplishment of the Commission in year 4 was the new focus on becoming more highly reliable organizations and the statewide initiative to promote adoption of a surgical safety checklist in all New Hampshire hospitals and ASCs. New Hampshire is the only state in the country to have every hospital and participating ambulatory surgery center committed publicly and at the leadership level to adopting a surgical safety checklist in all procedure areas.

The Commission will begin Year 5 in July 2008 focused on providing tools and support for every hospital and ASC to continue improving practices to reduce infections and to fully implement a surgical safety checklist in every procedure area.

Stephanie Wolf-Rosenblum, MD, MMM, will step down as Chair of the Commission after two years of outstanding leadership. The Commission members acknowledged her tremendous passion for quality and patient safety and the immense dedication with which she carried out her role.

The Commission voted to adopt this fourth year report of the New Hampshire Health Care Quality Assurance Commission.

For questions, please call: Stephanie Wolf-Rosenblum, Commission Chair: 577-3044 or Rachel Rowe, Administrator 225-0900.

Respectfully submitted,

Rachel Rowe

Rachel Rowe
Administrator, NH Health Care Quality Assurance Commission

File
HB1169

Good Morning

My name is Karen Bronson. Thank you for giving me the opportunity this morning to speak on behalf of my father, Stanley Bronson. My Dad died on May 6, 2008—he was only 67 years old. The death certificate said my Dad died of pneumonia—but the real truth of what happened isn't found on the death certificate; it isn't found in the sanitized hospital medical records; and it certainly isn't found in interviews with the doctors and nurses and social workers. Therefore—it isn't found in the State of New Hampshire's investigation or the Medicare investigation into family complaints of harm. The acceleration of my father's death and the intimate details—are all blamed—by the medical community on my father's Alzheimer's disease. The hospital says he wasn't harmed—so he wasn't harmed. The family is silenced.

So my questions for this Honorable Group—Does that mean my Dad didn't suffer a series of adverse events while in the hospital that led to his premature death? No, my Dad *was harmed* while in the hospital and those fragile details of harm led to his death. I was there.

So what is the reason for the huge *disconnect* from what family witnessed and *said* happened and what the hospital staff *reports* happened—and what the State and later the Medicare investigation found? The answer is found in the question—*Disconnect* supported by Isolation and Denial--and quite frankly, in the case of an elderly man with Alzheimer's, no fear of medical malpractice—none—as all new symptoms are blamed on age and Alzheimer's progression.

This isn't just about my father—it's about your father or mother or loved one too—and I believe we must demand more and better from our hospitals—and from the Quality Assurance Commission.

Groups and committees and subcommittees and task forces—many are looking at the big picture of one thing or another, all too frequently these groups have an agenda, or are isolated from the people they are supposed to be serving—*Disconnected.*

The House Bill 514 was an Act to establish the New Hampshire Quality Assurance Commission—that name sounds wonderful—*Quality Assurance Commission.* The purpose was to reduce the incidence of adverse outcomes from medical care, *that sounds great so far*, and the cost of insuring against medical malpractice. *Malpractice avoidance* and detailed change to prevent adverse outcomes are two different things. In fact, *malpractice avoidance* is many times counterproductive to patient safety—but more acutely in the elderly. For example, in my Dad's case—he was old, and he had Alzheimer's disease—a double whammy. Unless a doctor cut off my Dad's leg by mistake, he posed little malpractice risk. Still my Dad was harmed in a hospital setting—shouldn't the reasons why be understood, acted upon, and changed for the next elderly patient? Further, *malpractice avoidance* can be as simple as a clever lawyer and a cleverly worded discharge plan—or medical records that meet all professional standards but *still—still a patient dies.* Therefore, the root causes of adverse events and the goals of patient safety are not necessarily the same as malpractice avoidance.

If the group, as is the case of the Quality Care Commission, is closed, lacks transparency about data and outcome and specific findings, and made up of only one voice—in this case the hospital's perspective; the committee will not and cannot give voice to the intimate details of what went wrong—for your Dad or for mine. I am witness to that. If true, and immediate, and specific, life saving changes are going to be implemented at our state's hospitals and equally importantly—nursing homes—the family perspective must be listened to, and they must be part of the mechanism of oversight and change.

My Dad's good and rich life was reduced and disinfected to a handful of words: Alzheimer's progression and psychosis. No one asked why? The deadly details of my Dad's decline and death are found in that simple question: **Why?** And only the family was asking as the crisis was unfolding and only the family is asking presently. If the State of New Hampshire, Medicare, and our state's hospitals want to understand root causes of adverse events—they don't necessarily need expensive oversights, many times they need to look no further than a family member who witnessed what went wrong. To silence their input, to invalidate any claims they make, to not even give them a seat at the table—when the question of how do we improve health care in the state of New Hampshire is asked—infections, rates of pneumonia, harm caused from medications, hidden adverse events occurring with our elderly—to name a few examples—patients will continue to die in so called never events. It is dangerous and deadly not to seek and value and use patient and family input. A group composed of hospital specialists will only focus on one portion of adverse events—to the peril of patients and in the end to the peril of themselves. This shouldn't be a case of patients versus hospitals—if it is we all lose in terms of lives lost, and certainly in terms of many very expensive health care crises down the road.

In closing: How long do you think a family can continue the vigil for a loved one, meet investigators, write letters, take time off from work, take time away from their children, only to be told their voice—when weighted against doctors or nurses or a hospital administrators—is not important. I am here because I still believe the system will in the end do the right thing and make it better for the next patient.

I also believe in the quote: Silence in the face of injustice is a form of complicity. I will not be complicit in what happened to my Dad, or what may happen to yours, if I keep silent, and it doesn't matter how many experts tell me otherwise. I was the expert when it came to what was really happening with my Dad—and I am here this morning not because I'm paid to be—but because *I want—as many families and victims of medical adverse events want*—and keep repeating: *We want it better for the next Dad or Mom or family—maybe your family.*

Thank You.

Karen J. Bronson Addendum to my Testimony

Regarding Clear and Present Danger and Disconnection between hospitals, investigations, and the realities of harm caused to our loved ones.

My testimony today is very important to me and I want to *get it right.* My original testimony became too long, and too detailed about the specific harm my Dad suffered, and although relevant to reasons why hospital investigations and patient safety need to be more unified—I chose to rewrite my testimony. I have included portions of the original text here. It is my hope it will be read at a later time to further illustrate the disconnection.

The real and meaningful details of harm are dangerously absent in the physicians account and in the medical records. Meaning they will be repeated and may be repeated on your mother or father or sister or daughter. The *real* details of what went wrong—live only in the hearts and memories and documentation provided by the family—and no one wants to hear it. The family's voice, in the end, is deemed irrelevant and not worthy as the State and Medicare investigations will **only** investigate hospital medical records, **only** speak with the doctors and nurses involved in my Dad's care, and base the end result of harm or no harm **only** on the hospital perspective. In the end, there are two expensive investigations and no findings—because the hospitals said so. According to all the specialists there was no harm caused and therefore no adverse event. I know differently.

Does it mean his discharge plan was completely and safely executed? Does it mean my Dad wasn't discharged from the hospital in markedly worse condition than he was when he went in—without a diagnosis, without a plan, and without support to the family once my Dad returned home? Does it mean antipsychotic medications used to calm him, didn't have the effect of putting my Dad in a dangerous and delirious and life threatening condition—a condition that was ignored upon discharge and in fact ignored until it became too late to alter my father's horrible descent into medical hell—and then? The harm the hospital caused *was used as justification for more antipsychotics.*

We are told by the State and by Medicare that our specific details of harm are not good enough. *Not good enough?* Curious, one would naively believe the hospitals surely would want to know the intimate details about *what happened*? And what went wrong from the family's perspective—so it can, if possible, be corrected immediately. If the hospitals don't? want to know? Surely the State of New Hampshire and Medicare would want to act upon those details to improve the quality of care for the next elderly patient--*if they could.* One would be wrong—because according to the hospital and the doctors—no harm was caused.

There is no second look at the details of what led to my Dad's overnight decline; no analysis of why a man suddenly has a severe escalation of confusion, hallucinations, is drooling, cannot stand or walk without risk of falling, is confused and vacant and angry—and eventually is talking about wanting to die. These conditions were brought on by anti-psychotics, morphine, and Haldol. My Dad went to the hospital **for a fall** that occurred in his back yard while raking leaves. My Dad was sent home from the hospital in markedly worse condition than when he went in—**for a fall**—with the systemic and

lackluster diagnosis that this was escalation of Alzheimer's. My Dad was ultimately diagnosed as having psychosis--which now insured and justified aggressive treatment with antipsychotics—AGAIN—*as he was now a danger to himself and to others.* This medical approach should defy logic and common sense.

However, instead antipsychotics caused delirium and psychosis and now the very medicines that harmed my Dad were justified to treat him. This time, my now weakened Dad could not tolerate this assault upon his already fragile brain. At Laconia Geriatric Psychiatric Hospital—where we went to understand what was happening with my Dad's medications, and nearly overnight, those very medications were used repeatedly and my Dad was turned into a moaning, drooling, incoherent shell of a human being—and five months later he died—but not before losing 80 pounds and suffering humiliations too numerous and too painful to detail. After the "nothing inappropriate happened" treatment, my Dad never recognized me again.

According to the State investigation *nothing inappropriate happened* to Stanley Bronson, my father. According to the "Board Certified in Geriatric Psychiatry" physician consultant who oversaw the investigation for Medicare--*nothing inappropriate happened*, to Stanley Bronson my Mom's husband for fifty years.

The hospital and medical staff because of hubris, isolation from reality, lack of training about the fragile needs of a geriatric patient, systemic denial, lack of information, lack of necessity to listen to the family, no fear of malpractice because of my Dad's age and Alzheimer's diagnosis, lack of training about the dangers of delirium to an Alzheimer's patient, a combination of reasons too complex for me to understand—are disconnected, isolated, and in denial. My Dad died at 67 years old of what is generically described as pneumonia and complications stemming from Alzheimer's. Medical staff absolutely believe they did all they could and followed all protocols and the family just doesn't understand. I understand. I witnessed very specific harm to my Dad. No one appears to want to hear or listen to my perspective.

The investigations--both State and Medicare--yielded no findings of harm and stated: *The services that were the subject of your complaint did meet all applicable professionally recognized standards of health care at Littleton Hospital and Lakes Region General Hospital, based on medical records and information provided by the practitioners.* Case closed. Therefore, the practitioners who didn't return phone calls, didn't follow up on their own discharge plan, didn't diagnose a dangerous antipsychotic induced and fueled delirium, didn't notify the family of the use of Haldol and morphine and antipsychotics—and what the adverse outcome might be—and nearly overnight my Dad is catatonic and never recovers—and they are deemed as *meeting all professional standards* and the family is silenced.

Why?

Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1169

BILL TITLE: **deleting the repeal of the New Hampshire health care quality assurance commission.**

DATE: February 16, 2010

LOB ROOM: 205

Amendments:

Sponsor: Rep. T. Donovan — OLS Document #: 2010 0700h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP), OTP/A, ITL, Interim Study (Please circle one.) **AMENDMENT 0700 h**

Moved by Rep. T. Donovan

Seconded by Rep. J. Pilliod

Vote: 19-0 (Please attach record of roll call vote.) **MOTION ADOPTED**

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. T. Donovan

Seconded by Rep. E. Merrick

Vote: 19-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 19-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Joan H. Schulze, Clerk

Rep. Joan H. Schulze

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1169

BILL TITLE: **deleting the repeal of the New Hampshire health care quality assurance commission.**

DATE: 2/16/2010

LOB ROOM: 205

Amendments:

Sponsor: Rep. Donovan — OLS Document #: 0700h

Sponsor: Rep. Pillsbury — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP), OTP/A, ITL, Interim Study (Please circle one.)

(1) Moved by Rep. Donovan

Seconded by Rep. Pillsbury

Vote: 19-0 (Please attach record of roll call vote.)

Motions: OTP (OTP/A) ITL, Interim Study (Please circle one.)

Moved by Rep. Donovan

(2) Seconded by Rep. Merrick

Vote: 19-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 19-0 Consent

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Joan H. Schulze, Clerk

OFFICE OF THE HOUSE CLERK 2009 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

(1)

Bill #: HB 1169 Title: deleting the repeal of the NH health care quality assurance commission

PH Date: 2/9/2010 Exec Session Date: 2/16/2010

Motion: OTP Amendment #: 0700h

MEMBER	YEAS	NAYS
Rosenwald, Cindy, Chairman	19	
Donovan, Thomas E, V Chairman	1	
French, Barbara C	2	
Schulze, Joan H, Clerk	3	
Tilton, Joy K	4	
Butcher, Suzanne S	5	
Bridgham, Robert G	6	
Merrick, Evalyn S	7	
Russell, Trinka T	–	
DiPentima, Rich T	8	
Miller, Kate W	9	
Batula, Peter L	10	
McMahon, Charles E	11	
Pilliod, James P	12	
Emerson, Susan	13	
Case, Frank G	14	
Millham, Alida I	15	
Wells, Roger G	16	
Cebrowski, John W	17	
Kotowski, Frank R	18	
	19	0

TOTAL VOTE:

Printed: 1/12/2009

OFFICE OF THE HOUSE CLERK 2009 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

(2)

Bill #: HB1169 **Title:** Deleting the repeal of the NH health care quality assurance commission

PH Date: 2/9/2010 Exec Session Date: 2/16/2010

Motion: OTP/A Amendment #: 0700h

MEMBER	YEAS	NAYS
Rosenwald, Cindy, Chairman	19	
Donovan, Thomas E, V Chairman	1	
French, Barbara C	2	
Schulze, Joan H, Clerk	3	
Tilton, Joy K	4	
Butcher, Suzanne S	5	
Bridgham, Robert G	6	
Merrick, Evalyn S	7	
Russell, Trinka T	—	
DiPentima, Rich T	8	
Miller, Kate W	9	
Batula, Peter L	10	
McMahon, Charles E	11	
Pilliod, James P	12	
Emerson, Susan	13	
Case, Frank G	14	
Millham, Alida I	15	
Wells, Roger G	16	
Cebrowski, John W	17	
Kotowski, Frank R	18	
	19	0
TOTAL VOTE:		

Printed: 1/12/2009

Committee Report

CONSENT CALENDAR

March 3, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB1169,

AN ACT deleting the repeal of the New Hampshire health care quality assurance commission. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Thomas E Donovan

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB1169**
Title:	**deleting the repeal of the New Hampshire health care quality assurance commission.**
Date:	**February 16, 2010**
Consent Calendar:	**YES**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT**

STATEMENT OF INTENT

This bill as amended not only extends the commission but also adds a member of the public to the commission and mandates an annual report to be presented to the health and human services oversight committee. The commission is charged with looking at the frequency of medical errors and adverse events in hospitals and ambulatory surgical centers. The committee agreed with the testimony that adding a member of the public could only strengthen the work of this critical commission.

Vote 19-0.

Rep. Thomas E Donovan
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB1169, deleting the repeal of the New Hampshire health care quality assurance commission. **OUGHT TO PASS WITH AMENDMENT.**

Rep. Thomas E Donovan for HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. This bill as amended not only extends the commission but also adds a member of the public to the commission and mandates an annual report to be presented to the health and human services oversight committee. The commission is charged with looking at the frequency of medical errors and adverse events in hospitals and ambulatory surgical centers. The committee agreed with the testimony that adding a member of the public could only strengthen the work of this critical commission. **Vote 19-0.**

Original: House Clerk
Cc: Committee Bill File

HB 1169 T. Donovan OTP/A 19-0 CC

This bill as amended not only extends the commission but also adds a member of the public to the commission and mandates an annual report to be presented to the health and human services oversight committee. The commission is charged with looking at the frequency of medical errors and adverse events in hospitals and ambulatory surgical centers. The committee agreed with the testimony that adding a member of the public could only strengthen the work of this critical commission.

HB 1169, relative to New Hampshire Health care quality assurance commission. Ought to Pass with Amendment. Rep Thomas E Donovan Jr for Health, Human Services and Elderly Affairs: This bill as amended not only extends the commission but also adds a member of the public to the commission and mandates an annual report to be presented to the Health and Human Services Oversight Committee. This commission is charged with looking at the ~~frequency~~ frequency of medical errors and adverse events in hospitals and ambulatory surgical centers. The committee agreed with the testimony that adding a member of the public could only strengthen the work of this critical commission. VOTE 19-0

CR

Rep. Donovan

COMMITTEE REPORT

COMMITTEE: HHS+E

BILL NUMBER: HB 1169

TITLE: deleting the repeal of the NH health care quality assurance commission

DATE: 2-16-2010 **CONSENT CALENDAR:** YES ☑ NO ☐

☐ **OUGHT TO PASS**

☒ **OUGHT TO PASS W/ AMENDMENT**

Amendment No. 0700h

☐ **INEXPEDIENT TO LEGISLATE**

☐ **INTERIM STUDY** (Available only 2nd year of biennium)

STATEMENT OF INTENT:

COMMITTEE VOTE: 19-0

RESPECTFULLY SUBMITTED,

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rep. Thomas E. Donovan
For the Committee

Rev. 02/01/07 - Yellow