

**U.S. Senate Special Committee on Aging  
Congressional Field Hearing Testimony  
July 2, 2012**

Senator Blumenthal, thank you for the opportunity to provide testimony today about patient safety and for bringing attention to this serious public health issue. I am Jean Rexford and I am the Executive Director of the Connecticut Center for Patient Safety, a non-profit consumer advocacy organization.

According to the Inspector General November 2010 study, preventable adverse events contributed to the deaths of as many as 950 Medicare beneficiaries last year in Connecticut alone. These 950 deaths occurred in Connecticut hospitals -- this statistic does not include preventable deaths in our nursing homes or private homes, nor does it include the non-Medicare population. Another 22,000 patients acquired infections while they were treated in health care facilities and almost all of these were preventable.

Three separate recent reports in 2010 and 2011 found that at least 1 in 4 patients are harmed while hospitalized. And the financial costs are staggering. Nationally, hospital acquired infections cost our economy as much as \$45 billion dollars, while patient falls in hospitals and nursing homes in 2005 alone added another \$34 billion in costs.

Behind each statistic there is a name, a family, a story of sorrow; for some it's medical bankruptcy, for others, it is unemployment. But for all patients harmed by the healthcare system, there is physical and emotional pain, a profound broken trust, and disbelief that while being treated they had been harmed by preventable medical errors. The CT Center for Patient Safety was formed in 2005 to be the voice of consumer patients. We are determined not to be forgotten collateral damage in a terribly broken healthcare system. Today we are joined by other advocacy groups in a national patient safety movement. Loosely organized through Consumers Union Safe Patient Project, we work together to promote patient safety, improve quality, and protect patient rights. In CT we are working with another patient focused advocacy group – Code Jump Start. We are trying to shine a spotlight on the need to put the patient first and foremost in this vast medical industrial complex and the regulatory agencies that have in the past not always had patients' interests in mind.

We began our work with hospital infections. When I learned in 2005 that there were just two infections reported across 31 hospitals in Connecticut, I knew that it was a good issue to tackle. We were told by hospitals executives with whom we spoke that most infections were “expected”, which revealed to me a fundamental gap between consumer and medical facility perspectives. I can assure you that no healthcare

consumer “expects” to visit a licensed medical facility and acquire a deadly infection as a result of receiving care. It was not difficult to amass stories of patients and families and what had happened to them when they had acquired an infection. Keith lost his job, Mary’s infected hip replacement put her in a wheel chair for the rest of her life. We brought these stories to our legislature – and legislators added their own stories. Twenty-six states now have legislation requiring public reporting of hospital acquired infections and the Federal government paid attention. There is an impressive nationwide effort to begin to address infections and needless suffering and costs. But think of the individuals who have died and their families loss because medical facilities were slow to react without legislative intervention.

We have learned over the years that legislation has limitations – the healthcare consumers will never get all that we want or all that we deserve. There is absolutely no road map for the consumer patient safety movement and only meager funding for advocates. When funding is awarded for patient safety improvements in the clinical setting, there is seldom a requirement for consumer representation on medical facility commissions, panels, and workgroups studying patient safety innovation and quality improvement. Most funded endeavors exclude patient voices altogether.

While we have worked hard to collaborate with hospitals to get a seat at the table to solve the patient safety epidemic, we concurrently faced obstruction by the industry’s powerful and well-funded lobbyists serving profit motives first. We realized we had to think more creatively and decided that nurses make an enormous difference in the quality of care and keeping patients safe. We started an outreach program to nursing schools. Collaborating directly with providers, instead of institutions, seemed a far more positive way to work. Our nursing education program has been successful and continues to grow.

Some doors have now opened and we regularly participate in state and national efforts; however there is much work to be done to bring awareness to an issue that for too long has been accepted by the medical community, overlooked by regulators, unknown to the vast majority of the general public and unsuspecting patients, and out of the realm of consumer protection. Without transparency and accountability, patients will continue to be harmed by medical facilities that tolerate errors at a rate unheard of in other safety sensitive industries.

We are eager to work with medical facilities and the healthcare system, and have just recently begun collaborating with innovators that welcome our participation. Testimony provided later in this Hearing will provide an example of the islands of excellence that have begun to take shape and make progress. But why aren’t these islands the norm, instead of the exception?

Several years ago, the Federal Government launched *the Partnership for Patients*. This was an important initiative for healthcare providers but it took two years before patients and patient advocates were even invited to Washington to participate. But then we were told, not to come. There was no money – no money for the patients.

We were sadly an afterthought. Patients and patient safety must be a reflex. Only when we become an equal partner will we begin to see safe patient-centered care.

We thank you Senator Blumenthal for your never-ending commitment to ensure that patients' and consumers' voices are heard.

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Three recent studies

In 2010 and 2011, three much-anticipated new studies on medical harm appeared within six months of each other. All three studies used a system called the [Global Trigger Tool](#), developed by the Institute for Healthcare Improvement to mine medical records for signs (“triggers”) of potential adverse medical events. All found exponentially greater levels of harm than had been reported by the IOM.

- The [Inspector General reported](#) that more than 1 in 4 hospitalized Medicare beneficiaries suffered adverse medical events resulting in some degree of medical harm, and that an estimated 180,000 Medicare beneficiaries a year died from their medical care.
- [The Health Affairs study](#) found that one third of admitted patients in three large teaching hospitals suffered medical harm, with many experiencing multiple events. Most of these incidents were flying under the radar, the researchers found. The team from the University of Utah, the Institute for Healthcare Improvement, Missouri Baptist Medical Center, Brigham and Women’s Hospital, and Intermountain Healthcare wrote:
- In [the New England Journal of Medicine study](#), 18.1% of patients in ten North Carolina hospitals were found to have experienced one or more adverse medical events. The authors also found that there was no significant change in the rate of harm over the six years of the study from 2002 to