10 DR. SIMMER: The Commission is pleased to
11 welcome it's 11th participant, Dr. Tammy Lundstrom.
12 DR. LUNDSTROM: Good afternoon. I'm
13 Dr. Tammy Lundstrom. I'm the Vice President and Chief
14 Quality and Safety Officer at the Detroit Medical
15 Center, and I'm here testifying on behalf of the
16 Detroit Medical Center.
17 I'd like to thank the members of the
18 Commission for this opportunity to discuss
19 interventions to improved patient safety in Michigan.
20 Detroit Medical Center is Detroit's
21 largest -- one of the largest private employers with
22 13,000 employees and nearly 3,000 private and faculty
23 positions. Our organization is made up of ten
24 hospitals currently, including the state's first level
25 one designated trauma center, Detroit Receiving

1 Hospital; Michigan's largest pediatric facility,
2 Children's Hospital of Michigan; and a National
3 Institutes of Health perinatal research site, which is
4 Hutzel Women's Hospital.
5 The DMC serves many aspects of the Michigan
6 health system. Together with our academic partner, we
7 offer the largest teaching establishments in the state
8 with more than a thousand residents, and also
9 participate in pharmacy training and also nurse
10 training through many of the nursing programs in the
11 state.
12 In partnership with multiple agencies
13 throughout the state, which I'll detail in a minute,
14 as I think models that the Commission should consider
15 in developing its patient safety efforts, the DMC has
16 been involved in patient safety activities for many,
17 many years.
18 Since the late '80s, the DMC has participated
19 in the National Nosocomial Infection Surveillance
20 System, a voluntary confidential reporting system
21 coordinated by the Center for Disease Control and

22 Prevention, which is used to systematically define and
23 collect data on healthcare associated infections and
24 then to use this data in performance improvement
25 efforts, implementing evidence-based recommendations

1 and demonstrating the effectiveness of the same.
2 Some of these include hand hygiene, aseptic
3 surgical technique, and full barriers for the
4 insertion of central venous catheters, among others,
5 as means to improve patient safety.
6 Recent studies demonstrate that these
7 interventions have been successful in preventing
8 healthcare associated infections. Notably, the CDC
9 has demonstrated that life-threatening bloodstream
10 infection rates have been reduced by as much as 44
11 percent in some intensive care units through feedback
12 of surveillance data by infection control
13 professionals in collaboration with direct care
14 providers. Proof I think that voluntary confidential
15 reporting systems can have a great impact on patient
16 safety.
17 Currently NNIS is evolving the system into a
18 broader national healthcare safety network to capture
19 a broader range of adverse events, including employee
20 safety initiatives, something that is near and dear to
21 my heart as an AIDS doctor who handles sharps every
22 day.
23 Despite the fact that not all hospitals
24 participate in the NNIS system, the evidence-based
25 practice is that result really becomes the standard of

1 care very quickly in the community and are adopted to
2 hospitals, and the benchmark data that comes out of
3 the CDC is used for hospitals in their improvement
4 efforts.
5 Shooting for a goal of zero nosocomial
6 infections, again, the National Healthcare Safety
7 Network is soon to open up participation to all

8 hospitals through a Web-based product. The expansion
9 again will include employee as well as patient safety,
10 and patient safety initiatives include device
11 associated infection reduction, surgical infection and
12 postoperative pneumonia reduction, and antimicrobial
13 use and resistance. And plans are to expand beyond
14 outcomes reporting to process reporting in the near
15 future as well as to focus beyond infections to
16 device-related complications, for example.
17 DMC physicians will be among the presenters
18 at a national consensus meeting, already described to
19 you, on mandatory public reporting of healthcare
20 associated infections in early February.
21 And DMC also participates in a statewide
22 group that's been working for over five years to
23 improve antimicrobial usage in Michigan, the Michigan
24 Antibiotic Resistance Reduction Coalition, which is
25 really a true coalition of providers, consumers, and

1 payers all working to improve the use of antibiotics
2 in the state, which is and can be a patient safety
3 issue.
4 Finally, the Keystone ICU project coordinated
5 through MHA in which the DMC participates is showing
6 remarkable results in terms of patient outcomes.
7 Like Trinity, we have implemented a Web-based
8 voluntary confidential reporting system for errors in
9 our facility in 2000, and we are getting over 14,000
10 reports now annually from our providers regarding near
11 misses, many, many near misses, something that we
12 didn't have data collection on previously, and we're
13 using those very vigorously with failure mode and
14 effects analysis to really improve care of our
15 patients.
16 Just wrapping up, I'd like to recommend that
17 the Commission strongly considers a confidential
18 voluntary de-identified patient safety reporting
19 system modeled after the CDC NNIS system that promotes
20 adoption of evidence-based practice and feeds back

21 comparison data to participating hospitals, strongly
22 considers disseminating successful strategies for
23 building patient safety teams within facilities.
24 And, lastly, I would urge the Commission to
25 further engage consumer groups as well as providers in

1 its mission as patients should be first and foremost
2 in patient safety efforts in Michigan.
3 We'll be outlining these recommendations in
4 much greater detail in the written testimony, and I
5 really thank you for the opportunity to present today.
6 DR. SIMMER: Thank you, Dr. Lundstrom. Do we
7 have any questions?
8 MS. FREUNDL: Dr. Lundstrom, you were talking
9 about the NNIS system and then mentioned the Keystone
10 ICU Initiative, which is a similar model to that
11 implemented in the VHA project and the IHI project on
12 critical care, where they have driven nosocomial
13 infections down to zero in some areas.
14 What would be the difference between what's
15 gone on with NNIS for the last 20 years versus this,
16 both of them I would consider voluntary reporting, but
17 there must be something different?
18 DR. LUNDSTROM: Well, I think one of the
19 things is that when you look at the history of NNIS,
20 taking 30 years to get to the point where we are with
21 Keystone, the data definitions, the training required
22 to really reliably record and report and investigate
23 and find and do surveillance for nosocomial
24 infections, all that background work was done through
25 the CDC.

1 So Keystone ICU was able to adopt data that
2 came out of NNIS voluntary reporting system and
3 evidence-based practices that were developed as a
4 result to really push for further reductions.
5 And, you know, there are some hospitals in
6 the initial data that are showing no nosocomial

7 infections, and I can tell you that many of us who are
8 close to that utilizing the NNIS system really I think
9 gave more impetus to effects to use evidence-based
10 practices from CDC to really demonstrate that you
11 can -- you can in some cases get to zero or close to
12 zero, and that should be our goal.
13 And I think that effort with Keystone would
14 not have been possible had it not been for all the
15 background information that's been done and researched
16 and data standardization and development and training
17 that came out of the NNIS system, and that hopefully
18 will be utilized in the new NHNS system that will be
19 coming out and rolled out from CDC in 2005.
20 DR. SIMMER: Okay. Thank you again. I'd
21 like to announce that after our next two speakers who
22 are at the on-deck table, we will be taking a brief
23 break.