

8 DR. SIMMER: The Commission is pleased to
9 welcome participant number eight, Paul Conlon.

10 MR. CONLON: Good afternoon, Tom.

11 DR. SIMMER: Hello.

12 MR. CONLON: Hi, I'm Paul Conlon. I'm vice
13 president and senior vice president for clinical
14 quality and patient safety for Trinity Health, and the
15 humble recipient of the Michigan Health and Safety --
16 Michigan Hospital Association award for leadership and
17 quality.

18 Trinity Health is the third largest Catholic
19 healthcare system in the United States and a major
20 provider here in the state of Michigan. We believe
21 we're actually probably the largest single provider in
22 the state of Michigan healthcare services, both
23 inpatient, ambulatory, home health, and hospice types
24 of services.

25 As a national provider of healthcare

1 services, we have a firm commitment to improving
2 quality and safety in all of our organizations in the
3 communities of the people that we serve and have --
4 would love to comment on all of the categories that
5 are available in the request for testimony but will --
6 and we'll do so in our written documentation but for
7 today's purposes wanted to focus on error reporting.

8 And the reason we want to focus on error
9 reporting is that we've been able to implement an
10 online anonymous capable error and event-reporting
11 system that captures data on both near misses and
12 actual events across our system. It is resident in
13 four of our states, and we have hospitals from Silver
14 Spring, Maryland to Fresno, California.

15 To date it is available in 28 of our
16 facilities and partner facilities across Michigan,
17 Iowa, Idaho and other areas, Indiana.

18 In that system, we have received almost
19 70,000 reports, 68,500 reports as of this morning on

20 it. And the importance of that is that we are able to
21 take disparate organizations, create a common
22 nomenclature structure for gathering information on
23 events and near misses, and then start analyzing that
24 data to create information out of it.

25 This Commission is faced with a historic

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1 opportunity -- and I want to underline the opportunity
2 as being historic -- to do something unique,
3 different, provocative, and challenging. The time has
4 come for us to get out of the blaming and shaming game
5 and start understanding and identifying what are the
6 root causes of medical errors and adverse events.

7 We cannot do that if the environment is one
8 of shame and blame. We can only do that if we look at
9 the data in a standardized manner, identify the
10 opportunities for improvement, share information in a
11 de-identified way and focus on the improvement
12 opportunities that are there.

13 The Commission should be asking organizations
14 not what problems that they have had but what
15 solutions they have generated. What solutions are now
16 present?

17 As we look forward to discussions about
18 mandatory reporting of events and the like, we have
19 found that that isn't as productive as looking at what
20 type of solutions are being effective and utilized
21 across our organizations. A focus should be on that.
22 To do that, you must have information that clearly
23 describes what is taking place in the events.

24 So when we look at our events across our
25 systems, we know what time of day the events are

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1 taking place, we know who is the participant and the
2 categories of people, participants in the events, and
3 different events occur in different types of units.

4 Emergency departments see a different type of
5 event than behavioral health units. A one solution

6 doesn't fit all. And so it's critically important
7 that we understand that.

8 In order to do that, in our organization we
9 had to be leaders, and we had to make it safe for
10 people to tell us what was going wrong. If we have an
11 environment that creates a punitive milieu, people do
12 not share voluntarily.

13 In fact, one would argue, and Jim Bagian has
14 stated from the VA Center for Patient Safety, that all
15 reporting is voluntary. And you can look at the
16 sentinel event reporting that the Joint Commission has
17 across the country and see the sparse amount of
18 information that is actually present there, when if
19 you look at an environment where you can have
20 de-identified information, you can gather a heck of a
21 lot more.

22 Our data is now showing up, in the 30,000
23 reports that we had last year, in nearly a thousand
24 changes in policy process outcome facilities and the
25 like. That is real change. That is a story that is

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1 worth telling. And it's the type of information that
2 we are able to share within our own organization to
3 help drive process and practice changes. That is an
4 opportunity for the rest of the state to do.

5 Michigan also should not go off on its own
6 and establish its own unique taxonomy for how this
7 reporting is to be done. It should look towards
8 national reporting organizations -- and NQF is in the
9 process of starting such a taxonomy to validate a
10 taxonomy for reporting -- and piggyback upon that so
11 we can maximize the utilization of the data that we
12 collect. And that will give us an opportunity to
13 really focus on the improvement of practices that are
14 there.

15 We have found that people want to tell us
16 what is going on but they must have it safe. We
17 actually ask participants that participate in our
18 surveys, in our random process of a survey of their

19 intentions, whether anonymous reporting is important.
20 98 percent of them say yes, yet 64 percent of the
21 reports they identify themselves as the reporter. So
22 there is this opportunity to learn and to share and
23 grow.
24 But we also have to look to other industries.
25 And the person was speaking to the nuclear regulatory

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1 industry, the nuclear power industry, we would also
2 point out aviation.
3 In aviation, the aviation safety reporting
4 system allows for identification of the reporter for
5 48 hours only, after which the data is de-identified.
6 The data is not collected by the FAA. It's actually
7 collected by a division of NASA, and that's because
8 the FAA is the regulatory agency. They're the
9 policeman. You have to have an independent agency to
10 collect the information.
11 If you breach confidentiality of the
12 reporting, you dry up reporting. New Zealand's FAA
13 breached their confidentiality and they basically
14 destroyed their reporting system.
15 We have to learn from other agencies. We
16 have a great opportunity here. We're on a cutting
17 edge. We would echo Dr. Bagian's comments that all
18 reporting is voluntary, and we have to make it safe
19 for people to do that type of reporting, to tell the
20 stories. The Commission should be holding healthcare
21 organizations accountable to take action upon the
22 stories.
23 DR. SIMMER: Thank you very much. Do we have
24 any questions?
25 MR. WAGENKNECHT: Paul, regarding your error

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1 reporting system, in your report are you going to
2 include some of the experiences and challenges that
3 you've had in putting that in place, both from a cost
4 perspective as well as, you know, changing the

5 environment and identifying some of those challenges?
6 Can you touch on some of that?

7 MR. CONLON: We will touch on it but I will
8 just give you a brief snippet right now. It's more
9 about the culture than the economic cost. The
10 economic cost of us developing the system actually was
11 relatively small compared to the other information
12 technology. We're spending almost \$300 million on
13 electronic health records. That's a different story.

14 But on this one here it was actually very,
15 very relatively inexpensive. That isn't the issue.
16 It's the culture. It's how do you create an
17 environment where the people that work in it day in,
18 day out, are willing to say I think this went wrong.

19 Here's another interesting fact. Most of our
20 reports are self-identified reports. In other words,
21 it's Paul talking about what Paul's experience of what
22 he did or almost did in his role and participation in
23 an error.

24 What we are finding is that this whole system
25 that we have had in the past of human vigilance of

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1 watching for mistakes doesn't work and we have to
2 develop systems in place to make that obsolete, and
3 that's what we're talking about. We want to create an
4 environment where it's safer -- we want to create an
5 environment where people feel safe to report but they
6 also see the benefit of that reporting. Benefit is we
7 are implementing systems that make it safer for them
8 to do their job.

9 MR. WAGENKNECHT: Just a follow-up on that,
10 Paul. The reports that you generate, are they shared
11 with employees or those individuals who submitted the
12 report in the situation that they identified
13 themselves?

14 MR. CONLON: We share at a higher level.
15 We're very concerned about piercing our veil of
16 protection on peer-review protections associated with
17 that. And so even at a corporate level, I can't get

18 down to some nitty-gritty details to maintain that
19 confidentiality. It really doesn't affect me as I
20 analyze what's going on in the events. So we tend to
21 roll it up to a higher level so that so we can talk
22 about what seems to be the trends and the causes and
23 where events take place, where falls take place, what
24 are the situations around that so we can design our
25 systems in place so that those type of things don't

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1 take place in the future.

2 MR. WAGENKNECHT: And does your system
3 include near misses? Is that part of your reporting
4 as well?

5 MR. CONLON: Yeah. In fact, the cultural
6 piece, actually clinicians have a hard time talking
7 about near misses. They are much more readily -- they
8 much more readily talk and report on things that they
9 would have identified as an event.

10 DR. SIMMER: Yes, Marge.

11 MS. FREUNDL: Paul, I would think if there's
12 a high level of reporting in this anonymous reporting
13 that there are also some patterns in terms of what is
14 getting reported versus probably what has been
15 published, maybe, in the literature. Have you had any
16 learning from that?

17 You were mentioning different departments
18 have different types of errors. What about different
19 things that are getting reported?

20 MR. CONLON: Yeah, we are identifying -- and
21 what Marge is bringing up is very important because as
22 we have rolled this out, we used to see a lot of
23 reports about medication events. Almost 40 percent of
24 our original reports were medication events.

25 We look at a whole database today, it's less

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1 than 20 percent, right around 20 percent of our
2 reports are medication events. Why? Are we seeing
3 fewer of those? Well, we think we might be seeing

4 some, but it's really we're having more confidence in
5 gathering information about other types of events.

6 And here's the other important point: We are
7 celebrating the fact that our reports are going up.
8 That's a cultural issue and sometimes it's hard for
9 people to understand.

10 But if you don't celebrate that you've got an
11 open environment to hear more about the events, and
12 this what I'm deeply concerned about mandatory
13 reporting, if we're going to go out there and say look
14 at all these bad things that occurred at St. Elsewhere
15 Hospital, if we do that we're going to drive our
16 reporting underground.

17 And so that's why I say this is a historical
18 opportunity for us to do something unique, something
19 different, something that's progressive and something
20 that can change the face of healthcare in this state.

21 MS. McCOSKY: I just would be interested to
22 know that in your efforts I understand you want to go
23 towards mandatory -- I mean a voluntary approach to
24 rectifying this issue, but I would be interesting in
25 knowing if there's any legislative efforts or

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1 legislative desires that would be an asset to you or
2 would any legislation be a hinder and barrier? I'd
3 like to know what your thoughts are.

4 MR. CONLON: Well, the reason we support the
5 Federal Senate Bill 702, I think that's what it is,
6 which creates a reporting scheme, we are in support of
7 that. But I think there's a great opportunity to
8 create even at a state level by some state
9 organization that is not tied to the regulation an
10 opportunity to learn about these events.

11 We learn different things from small
12 organizations than we do from large teaching
13 organizations. The hospitals that participate in this
14 are 20-bed hospitals, others are 550, that are tied to
15 a facility, so we're seeing a big difference there.
16 And yet sometimes the events are very similar and

17 sometimes they are unique because of the unique
18 circumstances that care is provided.

19 So I think it's a great opportunity for us to
20 create a warehouse of data at a state level to learn
21 and from all -- how many hospitals are there, 148,
22 150, something like that.

23 MS. CIESZKOWSKI: 136.

24 MR. CONLON: 136 hospitals across the state.
25 What a great learning lab. But you have to make it a

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1 safe environment for people to report.

2 DR. SIMMER: Okay. Thank you very much,
3 Paul. We appreciate your testimony.