McLaren Health Care Corporation
Written testimony for the State Commission on Patient Safety

November 24, 2004

Topic: Incentives for Patient Safety improvement from public/private purchasers

Since the inception and release of the IOM reports related to patient safety there has been an outpouring of activity from the private/public sector, government agencies, and healthcare industries. This is activity that is often disjointed and lacking coordination. The purchasers of care and third party payers feel that they would not be fulfilling their obligations to employees or patients unless strategies are developed related to improving patient safety. The primary target for many of these activities is the acute care hospital setting. The hospital often feels overwhelmed as we attempt to respond to the multitude of payers and purchasers who do business with us on a daily basis.

The requests from the various entities vary in content and substance. These requests may or may not be evidenced based, may or may not include aggregate patient outcome information, and may or may not reflect the capabilities of the current monitoring systems in place. The result is an ongoing "scramble" to gather information and provide this information in the specific formats requested by the external entities. Unfortunately, in this era of rising healthcare costs, the hospitals have minimal human resources to respond to these requests. Often times, our resources are the same individuals who can best coordinate actual improvement efforts within the hospital. There are times when we have had to choose between launching another improvement effort based upon the external "request of the day" or utilize the resource to gather the information for reporting purposes on an ongoing basis. Due to this, improvement efforts can become stalled and progress is slowed as individuals attempt to balance their time.

Patient safety improvements rely upon a coordinated effort between hospitals and their respective medical staff. The hospitals focus much time and energy on streamlining processes, providing a more consistent approach, and reducing the barriers to care. These efforts could potentially have minimal results if we cannot hold the attention of the physician over time. We often see the "halo effect" in improvement efforts as systems naturally attempt to degradate over time. This degradation occurs even if there are strong physician champions and attempts are made to hard-wire processes. Attention must be focused on methods to hold physicians accountable for the care of their patients as well as the hospitals.

McLaren Healthcare Corporation has incorporated patient safety goals within our strategic plans and maintained a Board level Patient Safety Measurement Dashboard since the year 2000. We are proud of our continued involvement within MHA patient safety efforts, the Keystone ICU projects, and BCBS Incentive programs.

Unfortunately, we currently feel that we have been placed in an extremely vulnerable position with the most recent Leapfrog/MHSC joint survey process. These requests were not for measurements of patient outcomes but specific to internal hospital processes of care. In our litigious world, medical errors lead to malpractice suits. We asked our legal services to evaluate the survey for discoverability and peer protection. Due to the fact Leapfrog could not give assurances related to confidentiality of responses and the questions were very specific to high-risk hospital processes, the survey placed us in a

vulnerable position. We strongly encourage and believe in the promotion of a non-punitive culture. The private sector can assist with this by promoting methods to peer protect disclosure of information that may be necessary for their use.

We would very much like to feel confident and comfortable in participating with group efforts to improve patient safety. The Joint Commission has proactively helped hospitals protect their information and yet promote a learning environment. We anticipate others will learn from this and assist to promote non-punitive efforts.

Hospital margins have significantly diminished over time. Many hospitals are increasing their direct care human resources and reducing administrative overhead to help meet minimal margins necessary for reinvestment into capital expenditures. There are several improvement goals the purchasers of care could focus on to assist the hospitals:

1. Do not self create measurements of patient safety in an isolated fashion.
2. Rely on validated evidenced based patient outcome measures that have been proven through research to improve the safety of patients.
3. Provide a peer protection environment and process for disclosure requests of internal processes related to patient outcomes. (Much like the JCAHO process for sentinel events.)
4. Coordinate efforts within the public/private sectors to move towards a more consistent approach and process for the hospitals to respond to.
5. Allow the hospitals to define the process and procedures within their organization (the "how") and hold the hospital accountable to measurable patient outcomes. Avoid mandating the "how" since many of these solutions are often no cost effective and/or cannot be implemented in a "cookie-cutter" fashion.
6. Provide incentives to the **physicians** for achievement of the patient outcomes.
7. Help to subsidize the hospital data gathering efforts through reimbursement or subsidies.
8. Provide physician and resident training regarding human factors theory and communication techniques.
9. Provide research grants and funding to continue to explore the impact of human factors theory on medical errors.
10. Assist to bring other commercial industry techniques to healthcare processes for benchmarking purposes.

Topic: Role of professional society and groups in patient safety

Professional societies and groups can help to reduce patient medical errors by assisting as advocates for healthcare patient safety efforts. These advocacy efforts include ongoing research to continue and provide correlations of acute care processes to patient outcomes, education and dissemination of best practices within hospitals as well as other industry applications and lobby efforts to continue and promote a culture of safety. In addition, public reporting should be emphasized to reduce industries that use marketing techniques with public data as symbols of quality (i.e. Healthgrades.com).

Research and evidence-based approaches are the hallmark for consistent high quality outcomes. Currently, research in patient safety is relatively new with little historical comparisons. Minimal research exists in nursing models of care, the impact of human factors, and the impact of existing process on patient errors and patient outcomes. Continued funding and resource assistance are necessary to expand research efforts. In addition, healthcare organizations need assistance in identifying the strength of existing research and implementing techniques within daily operations.

Professional groups provide a noncompetitive setting for organizations to discuss their challenges and opportunities within a learning environment. Continued efforts to help healthcare organizations to engage with each other will lessen the steep learning curve and the ability to build on each other's experiences. An excellent example of this type of sharing technique is the MHA Keystone ICU project. We believe this type of massive hospital approach is unprecedented in its scope and patient results that are being achieved. The MHA process should be investigated closely and used as a benchmark for other focused techniques. Its methods prove the ability to change patient outcomes and cultural improvement via collaboration and support versus simply public accountability that causes the hospitals to "spin" as they attempt to respond to their environment.

Professional groups need to play a strong role in tort reform and the application of peer protection for hospital participation within the current environment. It is the role of healthcare organizations to acknowledge efforts necessary for improving safety and participate fully with others in changing the lives of our patients. Hospital's reluctance to participate is historically steeped within our cultures due to previous punitive approaches that have been taken with physicians and hospitals for identified quality concerns or problems. A historical culture of judgment and blame will take efforts both internally by the healthcare organizations and by external agencies and groups to reverse. Trust is built through good faith efforts over time.

Currently, profit motives have spawned organizations who use public patient information to judge and grade hospitals. These organizations often use "black box" approaches for calculations of quality and patient safety outcomes. It has been our experience that to receive their "5 star rating" requires payment of significant dollars for the marketing opportunity. Hospitals may actually have ratings better than designated hospitals but will not receive the coveted rating due to a refusal to contract for these types of marketing

techniques. A continued focus on public reporting and a comprehensive government web site should slowly help the industry to move away from this type of activity.

Professional society improvement goals that will enhance healthcare organizations include:

1. Advance research resources, opportunities, and funds related to care models, nurse patient ratios, and human factors theory.
2. Assist hospitals to identify current relevant research and applicability to healthcare operations.
3. Provide a learning environment and coordinated project techniques similar to the MHA Keystone ICU project for advancement of additional operational implementations.
4. Provide lobby efforts and advocacy for tort reform and liability protection within the healthcare industry to participate with the private/public sector in patient safety efforts.
5. Continue focus on public patient outcome reporting and de-emphasize commercial marketing use of data that victimizes hospitals or rewards only those that pay.

In summary, healthcare organization hold significant accountability for improving patient outcomes and eliminate medical errors. The scope of the job ahead is enormous with cultural and historical barriers within the systems themselves. We would ask all of the parties who are watching and monitoring us closely to help remove as many barriers as possible to promote success. The outcome desired is to eliminate errors and provide a safe environment for our patients.

We thank you for the opportunity to contribute to the dialogue for advancement of patient safety in Michigan.