

7 The Commission is very pleased to
8 recommend -- or to welcome our 14th participant today,
9 Larry Horwitz.

10 MR. HORWITZ: Thank you very much. I'm Larry
11 Horwitz. I'm president of the Economic Alliance of
12 Michigan. Pursuant to your rules, I'm just going to
13 identify the organization. We're a 22-year-old
14 coalition of corporations and unions. As far as we
15 know, there is no -- any comparable organization in
16 the country. Half of our board are the CEOs of a
17 range of companies -- autos and banks and small
18 companies and retailers and so forth, but in an equal
19 number are the heads of the labor movement.

20 We clearly don't have every business but we
21 do have a good array of them, and we do have
22 representatives from all major segments of the private
23 sector labor movement.

24 The overriding concern of the organization is
25 very much focused on the business and jobs climate,

1 very much focused on the needed issues that these two
2 groups in society are contending with, having Michigan
3 still be a place where they can have jobs, profit
4 opportunities for business.

5 We've dealt with many other issues in our
6 history but for recent years healthcare has been our
7 overriding issue. And while cost is what we are most
8 familiarly identified with, the Alliance has always
9 said from the very beginning that our concern is with
10 the intertwined triumvirate of cost, quality, and
11 access.

12 You cannot talk about cost or quality or
13 access without considering the ramifications of them
14 all.

15 The Alliance clearly has a long-established
16 board position on publicly available data systems for
17 outcomes.

18 I want to emphasize that I'm here today

19 because though we do not have an established clear-cut
20 board position on patient safety issues, and we very
21 much recognize that the position of the organization
22 on outcomes of healthcare services is really in many
23 important ways different than patient safety
24 questions. Some overlap and some not.
25 But we're here today because of the urging of

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1 many of our members who serve on this Commission and
2 because we were the one purchaser group mentioned in
3 the statute that you are supposed to be hearing from.
4 So we felt an obligation as a result of this --
5 unknown why we were the only business entity in the
6 state listed in the statute -- to come forth and talk
7 to you.

8 So I'm going to be presenting really some
9 things that I've identified in talking to our members
10 in the last week since we got this focused request.
11 And I've listened here for the last hour and a half
12 about other people's comments, and I thought that from
13 that perspective I might give you what I believe to be
14 the concerns of our members.

15 Clearly the union people look upon this very
16 much as consumers of healthcare but also as
17 purchasers. The business people also look upon it as
18 purchasers.

19 I think it's valid to say that there's a
20 crisis in confidence in the consumer and purchaser
21 community about this question of patient error.

22 This was very much dramatized to the whole
23 country by the Institute of Medicine report. And one
24 way of looking at that, I checked this morning, if you
25 took the fact that -- if you took the lower number of

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1 the Institute of Medicine, 49,000, not the 98, and
2 said what percentage of that would be attributable to
3 Michigan, on my presumption that Michigan is not
4 particularly -- and there's no evidence that Michigan

5 is particularly better or worse than the national
6 average -- that would mean there were 1,600 people who
7 died in a given year in Michigan hospitals due to
8 preventable errors.

9 The U.S. Transportation Department reported
10 two months ago that the number of people who died from
11 traffic accidents in Michigan was 1,283. In other
12 words, more people die from preventable errors in
13 hospitals than die from car accidents.

14 I went on the Web and got what was most
15 recently said. Here's Modern Healthcare, the premiere
16 publication for the hospital industry in the United
17 States. Two weeks ago the lead story, cover story,
18 was about the very topic of this Commission.

19 The quotes in here from members of the
20 Commission -- of the Institute of Medicine group is a
21 rather troubling report because the nonhospital
22 participants quoted in this report all are indicating
23 that they're very concerned. Quote, "There's no
24 evidence we've come anywhere near the 50 percent
25 improvement at this stage, namely five years

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1 afterwards."

2 "While comments about getting bogged down,
3 the diversionary argument between mandatory and
4 voluntary, one Commission member said that there's no
5 evidence that the voluntary system works."

6 I'm not saying because I don't know whether
7 or not these various Commissioners on the Institute of
8 Medicine report are accurate or right, but here's the
9 group of people who have very dramatically brought
10 this to public attention.

11 I think it's fair to say that the general
12 concern among consumers and purchasers is a great deal
13 of concern about the overall quality of healthcare
14 that they're getting and with particular comment on
15 the patient safety question.

16 You can go to any cocktail party in America
17 and listen to people tell you about the horror stories

18 of what just happened to themselves or a beloved one
19 at some hospital, not necessarily death or anything
20 else but some untoward event.

21 So that as this Commission struggles with the
22 very difficult question -- and I listened to the
23 gentleman from Trinity, and there's a big article very
24 similar to that from a guy from VA who used to be an
25 astronaut and is now running the VA quality program,

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1 and someone from Ascension.

2 As you balance the fact that providers are
3 incredibly frightened, distressed and anxious about
4 reporting information about errors, near misses, full
5 misses or whatever, seeing, you know, Mr. Fieger
6 coming over the -- coming at them with all this data,
7 I think the Commission has to balance that against
8 what are you going to do to reassure the payers of
9 healthcare and the consumers of healthcare that this
10 problem is being meaningfully addressed.

11 And so thoughts that just have occurred to me
12 as I was sitting here listening to this, there really
13 is a difference between a mandatory system versus a
14 public system; all right?

15 You could have -- and what I just found
16 notable is the Institute of Medicine report, which I
17 read last night, calls for both a mandatory system in
18 some regards and a voluntary system in other regards.
19 And I think, therefore, it would be useful for this
20 Commission to not get sucked into the issue that it's
21 all one or all the other.

22 Let me just give you some examples that occur
23 to me. If you have the two-thirds of all the
24 hospitals in the state that are not classified
25 hospitals are participating with the Blue Cross

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1 system, we don't really know whether they're
2 participating in a meaningful and adequate fashion.
3 All we know is they've sent in some data; right?

4 There is no method in the Blue Cross system to say did
5 you turn in all the data that you should have, because
6 there's no way the Blues could know about all the data
7 they weren't told about.

8 So unless you have some kind of mandatory
9 system with standards, criteria, and some degree of
10 spot check auditing, you don't really know that you're
11 getting all the information.

12 That doesn't mean it's necessarily going to
13 be put on the Web the next morning after the entity
14 receives it. I think there's a distinction between
15 whether you initially make it mandatory and whether
16 you immediately put it out.

17 I would think that from the experience we've
18 had on the data collections, everyone -- garbage in
19 garbage out. The data that you might get from 138
20 hospitals in the state of Michigan, no matter how
21 careful you told them this is the data we want, you
22 probably are not going to get everybody to understand
23 the data request in exactly the same way. It's going
24 to take a while to understand it.

25 So that during that time and during that

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1 process, you can imagine it might be, you know, not
2 publicly reported; but that at some point I think
3 you're going to have to require some elements of this
4 process to be publicly available if you're going to
5 address the concern of the patients and the payers
6 and, yeah, even random sample juries.

7 If you want to know why juries sometimes
8 award these phenomenal awards is because there's a
9 general impression that people are doing bad things,
10 and if you have an opportunity to zap someone, you do
11 it, because it's just a general admission that
12 somebody is not taking care of this problem.

13 Well, if you're going to be able to properly
14 recognize that the bulk of hospitals, the bulk of
15 doctors, the bulk of healthcare practitioners are
16 absolutely responsible moral people with great

17 integrity and discipline, are trying to do the right
18 thing, you need something to buttress this image.
19 So that I think that this Commission should
20 clearly try to consider this, look at the Institute of
21 Medicine report, see what is the mix of required
22 mandatory versus voluntary.
23 The other distinction it would seem to me is
24 there's a tremendous difference between process
25 measures and outcome measures. In other words, to say

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1 that we're going to publicly report after the first
2 few years whether or not any given hospital or
3 ultimately other providers did provide us all the data
4 they were supposed to provide us, right, in a
5 standardized proper manner that's been audited and
6 verified, that's something that should be reported
7 publicly.
8 It's a different question than you're giving
9 someone a score of A plus versus D minus for their
10 incidence of errors; right? But still to see did
11 they, are people really reporting; otherwise, you've
12 created a terribly perverse incentive. A hospital
13 that for whatever reason has lots of actual misses and
14 near misses that chooses not to report them all to you
15 ends up looking better than one that is very
16 conscientiously reporting to you all the information.
17 So that the -- I think you need to have some
18 method of this ultimately being available to the
19 community.
20 And then, finally, the ultimate question is
21 going to be the Institute of Medicine said we're
22 supposed to have reduced the number of deaths by 50
23 percent in five years, and we clearly are nowhere
24 close to that.
25 Do we want to go now to another five years

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1 and still not have gotten to that? You need some
2 method of ultimately assuring that this has really

3 happened.

4 One of our key members is called the auto
5 industry. I remember the J.T. [sic] Power Report
6 starting 35 years ago, and it was the most widely
7 detested activity I ever came across in the auto
8 industry. I've been working in and around the auto
9 industry for 50 years, and, my God, did they hate
10 that. But you know something, it had the most
11 influential impact of anything I know of, crude as it
12 may have been or anything else, in changing actual
13 behavior within that major industry of ours, and it
14 caused them to get better and less errors and less,
15 you know, problems. You want to consider about doing
16 that.

17 I understand that there's a great deal of
18 concern about, my God, legal liability, but there also
19 was that in the auto industry; right?

20 So that -- and, finally, I would think that
21 you should recommend that State Government take an
22 active and proactive role in doing something on an
23 ongoing basis and not just have you submit the report,
24 like the Institute of Medicine, but that out of your
25 work come an ongoing instrumentality that will assist

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1 and set up some kind of structure for both the
2 voluntary reporting and the ultimate mandatory
3 reporting and publicly available information that I
4 think we're going to really need if we're going to
5 achieve the actual outcomes we want and deal with the
6 question of confidence. Thank you very much.

7 DR. SIMMER: Thank you. Do we have any
8 questions from the group?

9 MR. KELLY: Larry, is there any example of
10 reporting now that you or the Alliance has been able
11 to use or point to that's been effective or at least
12 directive or offered some of the change that you've
13 outlined?

14 MR. HORWITZ: On patient safety, none that I
15 know of.

16 MR. KELLY: Or any other aspect?

17 MR. HORWITZ: There certainly are some data
18 systems which I know is a bad term, but performance
19 measures in things such as the outcomes of -- the only
20 one I really know that much time has been spent on is
21 on open-heart surgery.

22 There's a -- the quality aspect of open-heart
23 surgery that people focus in on is are you still alive
24 30 days after they finish the surgery.

25 And there are some places in the country, New

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1 York is probably the most famous one, which does
2 severity adjusted assessments of that. It is far
3 better than we do. The Economic Alliance publishes a
4 brochure that just tells you the quantity of
5 open-heart surgeries done hospital by hospital.
6 Terribly crude measure, but we don't have any way of
7 assessing the severity adjusted outcome. We don't
8 know whether the patient had one bypass, had one
9 blockage or 15.

10 MR. KELLY: Sure.

11 MR. HORWITZ: And so that's something that
12 would be good. In New York, their experience there is
13 that the number or percentage of deaths that is
14 correlated with open-heart surgery drops significantly
15 when that reporting system came in.

16 Now, it's also true that it was dropping
17 everywhere else in the rest of the country anyhow, so
18 it's not the only factor, but there certainly seems to
19 be some evidence that it was.

20 I suppose the other thing I would want to
21 tell you, Kevin, there's a tremendous amount of
22 concern among providers about the fact that the
23 insurance industry and purchasers on their own are
24 going around and imposing data requirement, data
25 reporting systems on major providers, and you can't go

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1 to a meeting in which people don't complain to you

2 about the fact that, you know, they don't have a
3 standardized measure, standardized report. They all
4 have this. Why can't you have one standardized
5 method?

6 The reason that companies and unions and
7 other groups are asking for this data is they want to
8 be responsible purchasers of healthcare and be able to
9 have some weight assigned to quality.

10 If we don't have some organized process
11 within the provider community which allows for those
12 assessments to be made, which would be much better if
13 we had one standardized method that everybody could
14 relate to, then you're going to have all these
15 different people asking you for reports and drive
16 every doctor and hospital data -- hospital system nuts
17 having to fill out all these different reports.

18 So there is a benefit of having some kind of
19 governmentally sponsored -- not necessarily a State
20 agency, God forbid we don't want more, you know,
21 another bureaucracy someone will say, but some kind of
22 standardized method so that we could have a common
23 arrangement by which we look at these things. And
24 maybe patient safety factors is just a way to look at
25 this and begin, since we have had this Institute of

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1 Medicine report that got everybody very frightened.

2 MS. McDONALD: Larry, were you here when the
3 man from the nuclear power industry was here?

4 MR. HORWITZ: I didn't hear him. I walked in
5 as he was speaking.

6 MS. McDONALD: Because he maintains that
7 there are some things that are common across
8 industries, that healthcare is uncommon, and it isn't.
9 And I just wondered if you had heard that, because it
10 seems like we just sort of get drowned in all this
11 complexity of healthcare and it isn't exactly like
12 other things, but, anyway, I just -- and we will look
13 to that probably, because you raised in the auto
14 industry the issues that surfaced some years ago and

15 it was difficult for the auto industry but in the end
16 probably everybody was better for it. I don't know
17 about Ralph Nader, but, anyway, just my little --
18 anyway, that's -- I just wondered if you had heard
19 him. And it will be interesting to read his testimony
20 because he said it is different and it is the same as
21 other industries.

22 MR. HORWITZ: I can only tell you that my
23 general impression -- I didn't hear his testimony, but
24 if you -- I think it's certainly true that the
25 healthcare industry is very different and very much

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1 the same than many other industries, without knowing
2 anything about the nuclear -- without referring to
3 nuclear.

4 Sure that nothing in human endeavor is so
5 unique that there's nothing else like it, and there's
6 a lot of things about healthcare.

7 I mean, we've had people from corporate
8 management processes who have gone into hospitals and
9 worked with emergency room people and everything else
10 to improve the practices and flows of equipment and
11 supplies to the system.

12 DR. SIMMER: Okay. Thank you, again.

13 MR. HORWITZ: Thank you.