Statement of Karen Wolk Feinstein, Ph.D., President, Jewish Healthcare Foundation of Pittsburgh, Pennsylvania,
and Chair, Pittsburgh Regional Healthcare Initiative, Pittsburgh, Pennsylvania

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of the House Committee on Ways and Means

Hearing on Health Quality and Medical Errors

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Chairman Johnson, Congressman Stark and distinguished Members of the Committee:

I am Karen Wolk Feinstein, Chair of the Pittsburgh Regional Healthcare Initiative (PRHI) – a community-wide effort to establish Southwest Pennsylvania as the world leader in patient outcomes – including perfect patient safety.

On behalf of the more than 30 hospitals, 20 corporations, four health plans, small business purchasing coalitions, unions, government officials, and hundreds of physicians, nurses pharmacists and other clinicians that constitute PRHI, it is an honor to be asked to testify today.

Two days ago, in downtown Pittsburgh, CEOs from the region's competing hospitals met to openly review patient safety incidents in their institutions and to discuss powerful leadership approaches to address those errors. Today, I'd like to tell you why this is happening in our community, describe help we have already received from federal partners, and note how federal policy can help efforts like ours, if the intention is to fix healthcare systems "from the bottom up."

For us, addressing safety issues is not adding another layer of activities for hospitals and other healthcare providers. Achieving safe practices is integrally connected to the entire process of restoring each patient to health as quickly as possible.

To err may be human, but failure to share those errors, learn from them, and prevent them from happening again is unforgivable. Cloaked in darkness, secrecy and fear of reprisal, medical mistakes are not used for learning, so they are repeated. Like Sisyphus, we err and err again because we do not fix our systems after each error to prevent future ones.

That is why, in American health care today, a hospital patient has a 7% chance of contracting a preventable hospital-acquired infection during their care, and a 2.3%-4.6% chance of being damaged by a medication error.

The scale of damage is stunning. Recent anthrax attacks took five innocent lives. Healthcare-acquired infections are associated with 88,000 deaths each and every year, and afflict more than two million Americans a year. The direct financial cost of caring for these infections in our region alone exceeds $110 million per year. In fact, our first data sharing efforts show that just one type of infection (blood stream infections) in intensive care units costs our region $15 million a year. As this Subcommittee knows, the story isn't any better for medication errors. They wound or kill approximately 770,000 Americans annually. But these aren't the only costs associated with errors.

The reason errors occur at shocking rates is also the reason why the American healthcare system is staggering on so many fronts, including escalating costs and rising dissatisfaction among all healthcare workers. What is that reason? We have lost our collective focus on helping care teams deliver the right care, every time, for every patient. Imprecision, waste, and errors are inevitable.

To regain our focus on the patient and to learn how to create a better performing healthcare system in our region, more than 30 hospitals and PRHI's other coalition members have formally committed to working together to eliminate medication errors and healthcare-acquired infections. (PRHI hospitals are also working to perfect patient care in six areas of clinical medicine).

In setting this framework for change, we drew our inspiration from Alcoa, which is based in Pittsburgh, and PRHI's founding Chair, now-Treasury Secretary Paul O'Neill. In 1987, when Secretary O'Neill became its CEO, Alcoa publicly committed to eliminating workplace injuries. Over the next 13 years, all of its employees worked together to learn how to do so, from the maintenance worker in Brazil to the CEO in Pittsburgh. Alcoa is now the safest workplace in the world. In 2002, Alcoa – a heavy manufacturing company with 140,000 employees in 37 countries -- is 18 times safer to work in than the average hospital.

It is no coincidence that over the same period, Alcoa experienced dramatic overall gains in its business, becoming by far the world's largest, most efficient and most profitable aluminum producer.

To move decisively toward those kinds of results in our community's healthcare delivery system, we have become the first region in the country where competing hospitals have begun efforts to count every medication error and infection, count them in the same way, and share that information openly for the purposes of learning.

We have had extraordinary help from federal agencies and national resources. The Centers for Disease Control in Atlanta has been a generous strategic partner in attacking healthcare-acquired infections. Recognized as a world authority in infection control and public health, the CDC has been collecting hospital-acquired infection rates through the National Nosocomial Infection Surveillance System (NNIS) for 30 years. NNIS has, however, historically been available only to hospitals that meeting rigid criteria, due to funding and other constraints. CDC generously made a variant of its NNIS system available to each PRHI hospital. CDC also provides extensive on-site instruction and support for our efforts. Our first shared target for surveillance and improvement, initiated April 1, 2001 has been a catastrophic type of blood stream infection occurring in intensive care units. We are moving on to other critical infection types this year.

To report and learn from medication errors, PRHI's partner hospitals have all agreed to use U.S. Pharmacopoeia's MedMARx system, a web-based error reporting tool that allows healthcare workers to describe errors and their contributing causes according to the most credible national standards, and to learn from the experiences of other hospitals in the system. PRHI hospitals share their information regionally as well as nationally. Pittsburgh area hospitals constitute less than 5% of the hospitals contributing error reports to MedMARx, but have provided approximately 15% of the errors reported to MedMARx to date. This does not mean that Pittsburgh hospitals have more medication errors. On the contrary, just that they are more committed to error reporting – the first critical step in error prevention.

In September, our patient safety efforts were given a critical dose of support from the Agency for Healthcare Policy and Research (AHRQ). Under a generous AHRQ grant for studying the implementation and use of patient safety reporting systems to the University of Pittsburgh, PRHI, and a number of local and national research partners, including Carnegie Mellon University, RAND and Purdue University, we will accelerate the pace of our patient safety programs by refining how to translate the information contained in patient safety reports into knowledge in front-line healthcare workers that actually protects patients. With AHRQ support, we can also generate insights to share with the rest of the country regarding effective and less effective strategies. AHRQ has constructed a national learning network for grantees that will be an important resource for us.

The direct support of these federal agencies, together with a generous grant from the Robert Wood Johnson Foundation and a strong base of funding support from local corporations and foundations, has been indispensable.

We believe that federal health care policy can further aid efforts like ours, if it addresses the root cause of under performing health delivery systems and supports strategies for reducing error and improving performance at the point at which patients are cared for.

Enlightened federal policy can succeed where previous "quick fixes" have failed if it relies less on mandates, regulation and punishment, and more on helping health care teams get care right by creating learning networks. Here are some key steps:

- **Increasing confidentiality protections for reporting and learning from medical errors** without lessening a patient's right to information about their own medical care. We cannot stress how important an expanded zone of protection beyond today's loophole-filled state peer review statutes for discussion about medical errors will be to future progress. When punishment, ridicule and legal exposure drive reporting underground, learning does not occur. Like aviation, nuclear energy and other high-risk industries, the government must act decisively to protect the reporting, analysis and sharing of information about errors and near misses. Extending the confidentiality protections of Medicare's Peer Review Organizations (now called QIOs) to reporting on all of an institution's patients would be welcome, but healthcare institutions will respond most powerfully if protection is extended to other major error reporting systems, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and MedMARx, particularly if the hospital is required to participate.

- **Increasing support for the quality improvement efforts of clinicians and institutions.** The federal government, together with allied organizations such as JCAHO and the National Committee on Quality Assurance (NCQA), can and should expand technical assistance efforts to support quality improvement efforts within institutions and communities. Government can also provide financial incentives for healthcare institutions to install and use error reporting and prevention systems, as well as clinical data systems that link processes of care with patient outcomes. Helping to set universal standards and definitions for these measurement systems would also be a critical government contribution. The CDC and other federal agencies are poised to help more institutions and communities establish these kinds of critical learning infrastructures, if resources can be made available.

- **Expanding federal partnership with local communities and rewarding local initiative.** Just as government can increase its investment in quality improvement efforts within individual institutions, it can add enormous energy to community-wide efforts like PRHI by participating in learning partnerships with coalitions like ours. The problems in health care are too complex to untangle from Washington. Only by getting out to where care is delivered, and observing how we can help care teams learn to deliver the best care precisely, will the path to addressing America's continuing health care crisis become clear. We are working with other like-minded health systems improvement efforts around the country to establish just such a grassroots learning network, and would welcome participation by federal agencies.

We also recommend the following federal policy steps:

- Invest in demonstrations applying successful industrial models, such as the Toyota Production System, to health care. (We have such experiments underway at five local hospitals).

- Make training in safety and systems improvement a core component of medical education.

- Increase medical research funding dedicated to encouraging academic physicians and institutions to become more deeply involved in measuring and improving quality of care.

- Accelerate experiments in methods of payment that might better reward "the right care at the right time." And provide relief for federal/community partnerships where it becomes clear that specific regulations impair patient outcomes or efficient care delivery.

In exchange, individual healthcare institutions and communities like ours are obligated to create the kind of learning network I have described, to create regional healthcare delivery systems fundamentally committed to and capable of performing at the highest levels.

The partners of PRHI are committed to this framework for change. We are honored by your interest in our work. I look forward to your questions and comments.