PRESS ROOM

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**"STATEMENT BY TREASURY SECRETARY PAUL H. O'NEILL
SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS"**

Mr. Chairman, Senator Kennedy, Members of the Committee, thank you for inviting me to testify today on the subject of patient safety.

I am pleased to join Secretary Thompson here today. Obviously, his role at HHS is to lead the Federal government's contribution to address this critical issue. I am appearing today not so much in my capacity as Treasury Secretary, but as someone who has seen firsthand what is possible when all of those involved in paying for and delivering health care in a region come together to seek systematic and far-reaching improvements in quality. I want to share with you what I learned from this experience working to reform the local health care delivery system on the ground level out in Pittsburgh when I was at Alcoa.

The Tip of the Iceberg of Systemic Problems

I believe that through local efforts to systematically improve the way health care is practiced, we can substantially enhance the value of health and medical care in this country. If we could capture the potential that exists to do it right the first time, I believe we can simultaneously increase quality and reduce cost in health and medical care potentially as much as 30 to 50 percent.

The scope of the problem has been documented well in the last two reports that have been issued by the Institute of Medicine. In particular, their first report called attention to the fact that as many as 100,000 people a year are dying as a result of medical mistakes, and highlighted the level of mistake-making that takes place in the daily delivery of care - not because doctors and nurses are being sloppy or careless, but because they are not working within systems designed for quality care and patient safety.

I believe that this is just the tip of an iceberg of the systemic problems that have accumulated over the years. These problems have been further exacerbated by changes to tort laws, administered prices, and other regulations that are often driven by the notion that health care providers are less than honorable people. As a result, doctors often feel that they are considered the enemy. The system of malpractice liability makes it very difficult for medical professionals to tell each other when they've made a mistake - and therefore to learn from it - because if they do so, they risk losing their right to provide medical care.

I believe we need to look at the things we can do in Washington to create an environment in which locally led initiatives to improve health care quality can succeed. And hearings like this one and other efforts to use the "bully pulpit" can help these local efforts spread from one area to another.

We should remove barriers to quality in the current reimbursement systems. Ideally, payment systems in government-run health care programs, such as Medicare, should reward quality and productivity improvements. At a minimum, they should not reward complications. But I'm also convinced that, no matter how hard we may

try, continuing to focus on well-intentioned but ever more complex modifications to reimbursement formulas, coupled with more and more complex regulations, will not fundamentally reorient the system toward creating value and quality health care for the patients. If we're going to see substantial and lasting improvement, the real work is going to be done on the ground in places ranging from Deaconess Hospital in Boston to the Intermountain Health Care System in Salt Lake City, where they're working on these important ideas. Indeed, a recent study at Intermountain found they had reduced costs in an intensive care unit by at least 30 percent while increasing care quality as a result of adopting a systems-based approach. That's why I am so optimistic about even broader approaches to systemic reform like the one I helped start in Pittsburgh.

The Pittsburgh Regional Healthcare Initiative

Three years ago, I became involved with a community effort called the Pittsburgh Regional Healthcare Initiative (PRHI). Created in 1997 and supported by local business and medical communities, as well as more recently by the Department of Health and Human Services, PRHI has launched a process aimed at radically improving regional health system performance.

PRHI consists of hundreds of clinicians, 36 hospitals, 4 health plans, the region's major healthcare purchasers and other key healthcare stakeholders. Health care purchasers and providers have agreed that faulty systems are responsible for producing the wrong outcomes at unacceptably high levels, and imposing unnecessary costs. To address this problem, PRHI has employed quality management principles pioneered at Toyota and refined at Alcoa.

They have adopted the central goal of achieving "perfect patient care" by identifying and solving problems at the point of patient care using a systems approach. PRHI is pursuing this through several strategies. One is to improve safety by eliminating medication errors and hospital acquired infections. Another is to undertake pilot efforts to measure and eliminate complications and re-admissions in five major areas of clinical practice (cardiac procedures, hip knee replacement, repeat c-sections, depression, and diabetes). These projects are now at various stages of maturity.

Early Findings

Based on the early experience at PRHI, I would urge the Committee to consider how public policies can support - or at least not impede - efforts like those at PRHI to improve patient safety and health care quality. PRHI's early findings include the following points.

Solutions are found in proven strategies for improving complex systems. The world's leading example of highest quality/lowest cost manufacturing - Toyota - has demonstrated the power of these principles for years. I adopted them myself at Alcoa. Properly applied, these tools drive a fundamental reordering and simplification of work processes, rather than transitory improvements. These ideas have potentially powerful application in health care - particularly because they let doctors and nurses do something about the frustrating things that are keeping them away from their patients, and let them get back to delivering the kind of quality care to people that made them want to enter the profession. This approach is distinctly different from top-down or "magic bullet" approaches to quality improvement that have so disillusioned many in health care and other industries. And when you see what can happen when you let the people in the hospital pharmacy design and implement the solutions to prevent medication errors before they occur, you realize the power of this approach.

Focus on the patient. Great organizations are entirely focused on delivering what their customers need. But, healthcare delivery systems are not yet managed according to patient need and quality outcome. That's why we need to focus on patient care at the point of delivery.

Goals should be placed at the theoretical limit of performance - perfect patient care.

In the case of patient safety problems, the goal should be *perfect* patient care-zero adverse incidents resulting from medical errors. Progress comes in increments, but to set incremental goals - even seemingly ambitious goals (such as reducing medication errors 50%) risks complacency with improvements that may be merely transitory and not sustainable. Setting zero errors as a goal encourages breakthrough thinking, orients work cultures towards continuous improvement, and keeps people pushing toward the goal.

Collaboration not coercion. Patient safety is not something that can be "done" by any one group or institution to another. Only by a commitment to learning and working together at the point of patient care delivery is fundamental progress possible. This involves changes in the environment of medical practice to support and reward systemic initiatives like PRHI.

It's the people who do the work who make change. Raising the performance of healthcare systems requires the people "on the ground" who perform care to make and sustain change. The national debate about financing mechanisms, "patients' rights" and patient satisfaction obscures the basic imperative: seeing that every patient gets what he or she needs at the right time, the first time. The creation of systems capable of producing superior results every time cannot be ordered from Washington or the hospital CEO's office. It requires an alignment of incentives, values, goals and skills among workers "on the ground" - from the receptionist to the physician - which is not commonly taught or supported in health systems. It includes giving people tools to do it right the first time. For example, one PHRI hospital is experimenting with a voice recognition prescription system to eliminate medication errors right at the front end.

Measurement and reporting systems must be in place to facilitate learning. If you can't measure it, you can't improve it. If you don't measure it, you're not serious about improving it. Yet, when it comes to patient safety and health care quality, the necessary data often don't exist. That's why PRHI has started by gathering baseline data on medication errors, complications, infection rates, and death rates. Only then could PRHI begin to learn from mistakes and make real changes.

It must be safe to learn from errors. This is a fundamental requirement for improvement. Punishment, ridicule and legal exposure drive reporting underground so learning does not occur. Properly constructed quality and safety initiatives should be protected from liability. They are not now.

The real cost of waste and errors first has to be captured in order to be eliminated. It's impossible to quantify and correct the waste in the healthcare delivery system until accounting systems can link measures of resource use to clinical processes and patient outcomes. Activity-Based Cost (ABC) accounting is an emerging standard among the highest-performing American industrial producers and has proven its ability to dramatically improve the performance of complex organizations. By contrast, healthcare cost accounting today continues to merely aggregate resource flows, to focus primarily on maximizing overall reimbursement for the hospital, and to link to few if any, measures of clinical outcomes. The goal PRHI has is to give managers the data they need to direct resources to improve patient care. PRHI is now working to develop ABC demonstrations.

While many of these reforms are still in their infancy, PRHI believes it can generate a 33% to 50% improvement in the value of health care delivered in Southwestern Pennsylvania within three years in a working model that should offer insights to the rest of the country.
Thank you again for inviting me to appear this morning.