



Statement for the Record

of the

**MEDICAL ASSOCIATION OF GEORGIA**

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to the

Subcommittee on Health

Committee on Energy & Commerce

U.S. House of Representatives

**RE: PATIENT SAFETY AND QUALITY INITIATIVES**

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On behalf of the physician members of the Medical Association of Georgia (MAG), I want to thank Chairman Deal for his initiative in calling this hearing today to discuss the important issues of "Patient Safety and Quality Initiatives." I am particularly grateful to have the opportunity to present testimony on the innovative work in this area by physicians on the state level.

1999 represents a tipping point for patient safety and quality in the U.S. That was the year the IOM published its seminal report "To Err is Human." Interestingly, although the IOM report had a galvanizing effect on the health care provider community, the bulk of the data it contained were really quite old. I would argue that the powerful influence of the IOM report was partly a result of its clear and incisive message but equally a result of superb timing. After several decades of extraordinary advances in therapeutic and diagnostic technology including remarkable imaging and image guided interventional technology, pharmaceuticals, fiberoptics, genomics and proteomics, health care providers were in 1999 developing a growing sense that improvements in the quality and safety of the delivery of care were lagging behind. Thus, the powerful message of the IOM report fell on receptive ears. The evidence for this is that when the IOM report was released, despite some debate about the numbers, there was remarkably little disagreement about the message itself.

Not coincidentally, 1999 is also the year I became Chief Quality Officer, a new role, for Emory Crawford Long Hospital in Atlanta. In the six years since then, my responsibility has grown to encompass the Emory Healthcare system. Emory Healthcare is the clinical arm of the Woodruff Health Sciences Center and provides patient care to millions of Georgians each year. As the largest, most comprehensive health care system in Georgia, Emory Healthcare includes The Emory Clinic, Emory Children's Center, Emory University Hospital, Emory Crawford Long

Hospital, Wesley Woods Center of Emory University, the jointly owned Emory-Adventist Hospital, and EHCA, LLC, a limited liability company created in collaboration with HCA-The Healthcare Company. Emory Healthcare has 9,000 employees, \$1.2 billion in net patient service revenue, and 1,184 licensed patient beds. In addition to Emory's own primary and multispecialty health care centers located throughout metro Atlanta, the Emory Healthcare Affiliate Network comprises 45 hospitals representing 65 communities and more than 6,000 physicians throughout Georgia, Alabama, North Carolina, and South Carolina. Emory Healthcare also is an owner of 1st Medical Network, Georgia's largest PPO network of physicians and hospitals, serving more than 700,000 lives. It is designed to serve as a delivery system for HMOs, PPOs, insurers, and others with a managed care network of hospitals and physicians in the state. The Woodruff Health Sciences Center is a top-ranked research institution with an annual budget is \$1.85 billion. We have over 1,752 full time faculty, plus 1,391 adjunct or volunteer faculty and collaborative scientists, and close to 3,500 students and medical residents in training.

In the six years since the IOM report the physicians of Georgia have accomplished a lot to improve the quality and safety of the care we deliver to our patients. I would like to share with you today some of those accomplishments. I would also like to share my thoughts about challenges and threats to progress.

In 2001, the Medical Association of Georgia, Georgia's largest physician organization, formed a separate 501 (c) 3 organization, the MAG Institute for Excellence in Medicine. I have the privilege of serving on the Board of Directors of the MAG Institute. The mission of the MAG Institute is to improve patient safety and improve clinical outcomes for the patients of Georgia physicians. The MAG Institute is focusing on educational activities as well as sponsoring applied studies to assess the effectiveness of practices and processes in the outpatient

setting, primarily in physician's offices. For example, we are working in areas such improving the detection and treatment of diseases such as colorectal cancer, asthma and kidney disease. Perhaps the most exciting aspect of the work that is being done by the MAG Institute is the application of information technology to patient safety and improved clinical care. The MAG Institute is currently partnering with Blue Cross Blue Shield of Georgia in a study to determine whether the use of handheld computers to access important clinical data at the bedside will improve patient outcomes. We are also very excited about the variety of projects that are designed to help Georgia physicians adopt and use health information technology to provide safe and more effective care. We are pleased to be working with the Georgia Medical Care Foundation (GMCF), the Medicare Quality Improvement Organization (QIO) on a series of initiatives sponsored by the Centers for Medicare and Medicaid Services. MAG and GMCF together will work with physicians to promote the adoption of health information technology (HIT) to improve the quality and efficiency of care—with a focus on e-prescribing, registries and deployment of full electronic health record systems. This project will help physicians select HIT products, reorganize their workflow and care processes to effectively use HIT, and undertake quality improvement projects to realize the benefits of HIT.

MAG also participated with the Georgia Hospital Association and other statewide organizations to form the Partnership for Health and Accountability (PHA) in 2000. Whereas, the MAG Institute has focused on patient safety in the outpatient setting, the PHA has focused its efforts on the hospital or inpatient setting, which was the primary focus of the IOM report. Through the PHA, hospitals confidentially and with peer review protection share lessons learned from adverse events, outcome and process data and best practices.

At Emory Healthcare, we have been taking a multi-pronged approach to improving quality and safety. A major focus has been on enhancing our “culture of safety.” Fundamentally, this means a culture that emphasizes a systemic rather than an individual approach to quality and safety. This represents a major paradigm shift in health care. Traditionally, most of us were trained that quality in health care resulted from individuals striving for solo perfection. When errors occurred, they were viewed as individual failures, resulting in a culture of “blame and shame.” Health care workers were felt to be a special breed that could and should aspire to error-free performance, even under adverse circumstances such as sleep deprivation. We thought ourselves exempt from the “laws” of human performance. This may have been a reasonable approach decades ago when the complexity of health care was orders or magnitude less. However, it has not been reasonable for at least the past 20 years. One of the major accomplishments of the IOM report “To Err is Human” was to send that message loud and clear.

A critical aspect of a culture of safety is the encouragement and indeed, rewarding of reports of errors and near misses. The blame and shame approach had the inevitable effect of discouraging such reporting. A corollary of this insight is that reported error rates are an extreme underestimation of true error rates. Benchmarking on error rates therefore has the unintended consequence of reducing reporting. Therefore, virtually all patient safety experts, including myself, oppose such benchmarking whether it is between units within a hospital or between hospitals. This in no way disputes the public’s right to know. Rather it is a statement that outside of research settings, reported error rates do not convey meaningful comparative information, that public reporting of such rates has negative impacts on safety, and that for now, we need to focus on increasing internal reporting of each occurrence so that we can analyze and learn from each such event. When we are successful at creating such a culture of safety, one of

the signs of success is a paradoxical increase in error rates due to an increase in self-reporting. I should emphasize that I am talking here about error rates. I do favor reporting of individual occurrences under a protected and non-punitive umbrella so that lessons learned can be shared. This has worked well for aviation. In Georgia, the Partnership for Health and Accountability has created a peer review protected mechanism for reporting and mutual learning throughout the state. I also support the reporting of quality process measures such as the Joint Commission National Quality Measures.

There are many ways we are working on creating a culture of safety at Emory. We have begun surveying our employees on culture of safety issues and in fact helped develop the culture of safety survey tool that AHRQ is now promulgating. PHA is facilitating such surveying for all hospitals in the state. We and others have started weekly senior executive patient safety rounds to ask our staff about what we can do to improve the safety for our patients and to enhance the culture of safety. We have made a total commitment to disclosing errors to our patients and apologizing for their occurrence. It should be noted that the new tort reform law recently enacted in Georgia prohibits such apologies from being introduced as evidence in a medical malpractice case; this is extremely important. At Emory we have a national expert on medical error disclosure, Dr. John Banja. Dr. Banja is working with both the MAG Institute for Excellence in Medicine and PHA to teach physicians and other health care providers in Georgia how to improve their skills in such empathic communications.

As we are succeeding at creating a culture in which our staff reports more errors and near misses, we are committed to analyzing each error, learning from each error and sharing what we learn through peer protected channels both internally and with other providers in Georgia. These activities are critically dependent upon the continuation of peer protected reporting options.

We also learn through these activities where to focus our quality and safety improvement efforts. Over the past several years, Emory Healthcare has won patient safety and quality awards from PHA for our “Medication Error Prevention Initiative,” our “Correct Site Surgery Initiative,” and our “Skinsational Program” to reduce pressure ulcers.

Let me turn to what we believe to be the absolutely critical role of information technology. The extraordinary increase in the complexity of clinical care over the past two decades reflects the remarkable advances that I have previously cited. This is a good thing but managing that complexity has created challenges. The dramatic increase in clinical complexity has been compounded by a parallel increase in administrative complexity. I am referring here to such things as complex billing codes, various documentation requirements, and managed care formularies that vary from plan to plan and moment to moment based on best available deal on a particular drug. Administrative errors at best create the need for rework and at worst elicit a visit from the OIG. It is no wonder that physicians often seem preoccupied during patient visits as their heads spin trying to manage this complexity. The simple truth is that this level of complexity cannot be managed without supporting information technology any more than flights in and out of Atlanta’s airport could be. Like any therapy, this technology will have some adverse effects, much as looking at instruments rather than out the window may have occasional undesired effects in aviation. Recent reports, like the one from the University of Pennsylvania which appeared earlier this year and highlighted new errors caused by such systems, raise appropriate cautions. However, it is very clear that done right, these systems will improve safety and quality. These systems are becoming the most important tools in our quality and safety improvement toolboxes. They are, however, just that—tools. We must learn from one another as we go along about how to start right and how to continuously refine these tools to

continuously improve quality and safety. These systems must also be able to share information between one another. To both these ends, I applaud the goals and early progress of the National Healthcare IT initiative under Dr. Brailer's able leadership and the announcement this week by Secretary Leavitt of the creation of the American Health Information Community, which he will personally chair.

These systems are extremely complex and expensive. At Emory we are spending around 50 million dollars over 10 years on our system and have made it one of our top organizational priorities. We have project leaders who are highly sophisticated and dedicated to this project. We are doing this to improve the quality and safety of the care we deliver. However, most care in the state of Georgia, and throughout the United States, is delivered by physicians in solo or small group practices. How are they going to make this transition and how are they going to do so safely? Clearly, funding support is crucial. Even at an organization of Emory's size, our 50 million dollar investment in this technology is a severe strain and competes with other crucial capital investments in the latest diagnostic and therapeutic equipment. Expertise is also a critical success factor. As mentioned earlier the MAG Institute has recognized this need and has several innovative projects under way to help Georgia physicians incorporate information technology into their practices. These initiatives enable folks like us at Emory who have the resources to be a little ahead of the curve to work with our colleagues in the state to help them work through these hurdles.

When I look back to when I was in medical school and residency 30 or so years ago, I am amazed at how much better we can care for our patients now than then. We health care providers should be ecstatic about the progress, yet by and large we are a stressed out and often unhappy bunch. I think that's because we are keeping our patients safe through heroic individual

efforts that can't be sustained. We desperately need these systemic approaches such as electronic medical records and others including those I've mentioned in order to be able to truly appreciate and deliver on what could be viewed as the beginning of a golden age of health care. As part of the "tipping point" phenomenon that is underway, that realization is bubbling to the surface of consciousness for the great majority of providers.

The other thing I realize looking back to when I started my medical training is that I thought then that knowledge was both necessary and sufficient to deliver outstanding patient care. I thought that if I could just learn everything about what needs to be done, it would get done. What we have learned from the IOM reports and the other emerging literature on these topics is that knowledge is, in fact, not enough; we have to learn how to more reliably apply this knowledge. Indeed, each IOM report now has on its frontispiece a quote from Goethe that begins, "Knowledge is not enough; we must apply." Through efforts like those I've described, we are intensely focusing on increasing the reliability and safety of the application of our knowledge. I believe that with such efforts and with your help and support, we can achieve what will truly be a golden age of health care in this country.

However, as with any great opportunity, there are challenges and risks that must be overcome. As I have mentioned these efforts are expensive and labor intensive. We need to find ways to fund and incentivize them and we must do so quickly. Meaningful measurement of quality and especially safety is challenging and still fairly primitive. Electronic medical record systems will help us collect and report better data. In the meantime, we need to be able to report individual errors in a protected non-punitive environment so that we can share lessons learned. Benchmarking of error rates must be avoided. The latter would undermine our efforts to enhance reporting and the culture of safety and would not help anyone identify which health care

providers are safer. Finally, we must strive for a more rational approach to health care financing that deals with coverage for all Americans and that rewards health rather than disease.

Again, I want to thank Chairman Deal and the members of the committee for the opportunity to share these thoughts with you and I will be happy to answer any questions you may have.