



Testimony of the

Healthcare Association of New York State

before the

Senate Standing Committee on Health
Assembly Standing Committee on Health

Joint Public Hearing

on

**Improving Patient Safety in New York:
Understanding and Improving the Current System**

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Senator Thomas Duane
Chairman
Committee on Health

Richard N. Gottfried
Member of Assembly
Chairman
Committee on Health

Introduction

Chairpersons Duane and Gottfried, and honorable members of the Assembly and Senate Health Committees, thank you for this opportunity to testify on behalf of the more than 550 hospitals, nursing homes, and home health care organizations that comprise the Healthcare Association of New York State (HANYS) membership. I am Kathleen Ciccone, Executive Director of the HANYS Quality Institute.

Today, I will discuss our members' commitment to quality improvement and reporting of quality data, and I will offer recommendations to improve the New York Patient Occurrence and Tracking System (NYPORTS) to enhance quality improvement.

HANYS' testimony can be summarized by a few key points, which I will discuss in more detail:

- New York's hospitals are committed to quality improvement and reporting of quality data.
- HANYS helped develop NYPORTS and New York's hospitals support its goals.
- NYPORTS is only one piece of a broader performance improvement program with which hospitals are engaged.
- NYPORTS has become outdated and cumbersome.
- Where hospitals have dual federal and state quality reporting responsibilities, NYPORTS should seek concordance with national measure definitions and reporting methodologies.
- Reporting systems like NYPORTS are powerful tools only when the reports are used to educate providers on emerging patterns and on methods for improving care delivery.
- NYPORTS needs sufficient support to enable it to conduct a comprehensive analysis of hospital data and identify trends and factors that contribute to adverse events. Shared with hospitals across the state, this information could be a vital resource to hospitals and help to prevent future adverse events.

Hospitals' Commitment to Patient Safety

New York State is home to more than 200 acute care hospitals, each committed to continually improving the quality of care provided to patients. The foundation of every not-for-profit hospital and health care organization's mission is advancing the health of its patients and community by delivering safe, high-quality health care. Devoted health care professionals work every day to implement new evidence-based practices and sophisticated technology and information systems; and to assimilate new drugs, devices, and equipment to provide patients with the best care possible in an ever-changing medical environment. We are proud of the highly trained health care professionals staffing our hospitals, who save lives every day and provide patients with critical relief from illness and injury.

Every hospital in New York State is taking important steps to implement practices that support clinical improvement and patient safety. Despite these efforts, serious adverse events, although rare, can and do occur. These events are tragic for the patients, families, and caregivers involved. When they do occur, hospitals undertake a variety of strategies to support the injured patient and his or her family. Hospitals work to rectify any harm caused to the patient and undertake a rigorous investigation and analysis to identify the cause of the event and develop strategies to prevent it from recurring. In addition to conducting a root-cause analysis to determine what went wrong and how care can be improved to prevent a recurrence, hospitals also report the event and share their root-cause analysis findings with NYPORTS.

A root-cause analysis is an iterative complex review process that involves the participation of multiple individuals and draws on expert research and advice, often from outside the organization. Hospitals also conduct a similar examination and review process in response to occurrences that are important opportunities for performance improvement, but may not meet the requirements for reporting to NYPORTS (Appendix A).

HANYS has been involved with the development of NYPORTS since its inception and we continue our support for the program. We are currently a member of the NYPORTS Advisory Committee.

Participating in NYPORTS, however, is only one piece of a broader performance improvement program with which hospitals are engaged.

Every hospital has a rigorous organization-wide quality program, overseen by the Board of Trustees that is designed to continually and consistently identify and act on opportunities to improve patient care and safety. In examining various quality indicators, it is clear that New York hospitals have made tremendous improvements in recent years and, in fact, do better than the nation on several measures.

For example, as Commissioner of Health Richard Daines, M.D., recently emphasized in a press conference regarding hospital infection rates, hospitals in New York average better than the national average in all of the five Surgical Care Improvement Project measures—measures designed to reduce surgical complications and infections. In addition, an October 2009 study by The Commonwealth Fund showed that New York was one of the top five states to make the most gains in quality improvement in recent years.

Accreditation agencies have recognized hospitals across New York for the excellence of the quality of care they deliver. For example, many of our hospitals have “Magnet” distinction, a recognition given to health care organizations that have achieved nursing excellence. The American Heart Association has given New York hospitals Gold and Silver Performance Awards for their success in improving the quality of care for patients with heart disease and stroke. Members are also accredited by The Joint Commission, a symbol of quality that reflects an organization’s commitment to meeting hospital performance standards.

New York hospitals have made significant achievements in improving the quality of health care delivery for the patients they serve. HANYS’ Pinnacle Award for Quality and Patient Safety recognizes their efforts to achieve excellence in patient care. For your reference, I have enclosed our 2008 compendium, *Leading the Quest for Quality: 2008 Profiles in Quality and Patient Safety*. The examples in this publication underscore the significant achievements being made in quality improvement and patient safety by hospitals in New York State.

As evidenced by *Leading the Quest for Quality*, our hospitals are engaged in a wide-range of activities designed to improve quality care and reduce errors. HANYS and New York's six regional health care associations are pleased to be a part of and to facilitate member participation in important quality improvement initiatives. We have taken a leadership role in helping hospitals and health systems identify and prioritize which quality improvement initiatives best meet the needs of their institutions and patients.

Nearly every hospital in New York, for example, implemented best practices as part of the Institute for Healthcare Improvement (IHI) 100,000 Lives and 5 Million Lives Campaigns. These nationwide initiatives helped hospitals save lives through the dissemination of education, tools, and successful practices. IHI estimates that 6,318 lives were saved in New York State as a result of the first Campaign—15% above the goal. HANYS served as the statewide coordinator for both campaigns and partnered with a noteworthy group of organizations (Appendix B). We continue to serve in that role for IHI's *Improvement Map*, which is designed to help hospitals make sense of complex and competing demands and effectively implement quality improvement initiatives.

We continue to look to IHI as a thoughtful leader in evidence-based practices and are proud to be partnering with IHI. We appreciate the support received from the New York State Assembly for these important initiatives.

Below are just a few of the recent quality improvement initiatives in which HANYS and our members have participated in recent years, many of which were made possible by collaboration with state government and other leaders. In addition, hospitals conduct a wide array of other quality and patient safety initiatives, some of which are internally-driven and others in which hospitals partner with other regional, state, and national entities.

- **Preventing Ventilator-associated Pneumonia.** HANYS' Ventilator-associated Pneumonia (VAP) Prevention Project started in October 2007 and achieved tremendous success, with participating hospitals reducing their ventilator days by 36%. This project was generously funded by the Department of Health (DOH).

- **Preventing Bloodstream Infections.** Members are engaged in an initiative to enhance infection control in areas such as central-line associated bloodstream infections (CLABSIs). New York hospitals are partnering with Johns Hopkins University Quality and Safety Group and implementing evidence-based interventions that have shown to dramatically reduce CLABSIs.
- **Enhancing Obstetric Safety.** More than 80 obstetric hospitals throughout the state participate in New York State's Obstetric Safety Initiative: Providing Excellence in Electronic Fetal Monitoring. Conducted in partnership with the American College of Obstetricians and Gynecologists, District II and DOH, and funded by the New York State Health Foundation, this initiative provides hospital obstetric teams vital training on how to interpret, communicate, and effectively respond to fetal heart rate tracings, thereby improving perinatal outcomes.
- **Emergency Department Quality Improvement.** Hospitals are working to address emergency department (ED) quality improvement, overcrowding, demand capacity management, and patient flow through the Emergency Care and Hospital Operations (ECHO) Collaborative. We appreciate the support from the New York State Assembly for this important quality improvement work.
- **Improving Diabetes Care.** This collaboration with the New York State Health Foundation, HANYS, and physician specialty groups on the Statewide Diabetes Campaign, focuses on increasing the skills and capacity of health care organizations and providers to meet standards of care for treating patients with diabetes.
- **Comparing Performance.** HANYS' annual *Comparative Hospital Report* enables hospitals to compare their performance for a multitude of services with the average performance of all other New York hospitals. The report is based on Agency for Healthcare Research and Quality (AHRQ) quality indicators.

HANYS' Commitment to Transparency and Quality Reporting

HANYS' Board of Trustees has a long-standing history of supporting the development of quality measurement and reporting initiatives designed to improve care and inform consumer decision-making. In fact, with the full endorsement of our Board, New York was one of three states to initially pilot the Centers for Medicare and Medicaid Services (CMS) Hospital Quality Initiative to publicly report quality data. An expanded version of these indicators is now included in a national public reporting system.

Under the direction of our Board, HANYS worked closely with Greater New York Hospital Association, our members, and various consumer groups to develop and enact legislation authorizing DOH to implement a statewide hospital infection reporting system. The legislation, which went into effect in 2005, requires all hospitals to report to DOH certain infections—these data are now publicly available on the DOH Web site to help inform consumer decision-making. HANYS serves on the committee that advises the implementation of this legislation.

Similarly, and consistent with New York State hospitals' commitment to transparency and accountability, HANYS' Board developed and adopted voluntary, statewide billing guidelines for serious adverse events in 2008. While New York hospitals have followed their own billing practices for serious adverse events for years, this guidance was an effort to formalize and standardize current practices regarding when a hospital should forego payment from patients and insurers for the costs associated with a serious adverse event. The HANYS Board took affirmative steps to address this important issue before New York State moved to require identification and non-payment for serious adverse events. DOH subsequently released its own Medicaid policy for serious adverse events and we have worked closely with DOH to implement the policy.

HANYS remains committed to working with hospitals and the state to support quality measurement and reporting – with the ultimate goal of enhancing quality of care and patient safety.

NYPORTS Has Become Outdated

When New York hospitals began reporting adverse events to DOH in 1985, the purpose was not only to report the occurrence of sentinel events, but to identify the causes of such events and work to prevent them in the future. New York was one of the first states to require hospitals to report adverse events and complete a root-cause analysis after an event occurred. At the time, it was considered to be one of the most innovative quality improvement efforts in the country.

Since that time, there have been significant advances in quality reporting. With sophisticated systems, information technology, electronic medical records, and the expanded use of administrative claims data for quality reporting, hospitals can now systematically and more efficiently report quality measures, such as hospital-acquired conditions, to government entities.

Not only do claims data provide clear and nationally recognized event specifications, but they can be easily validated, enabling hospitals to improve reporting compliance. When NYPORTS was created, claims data were not widely used for quality reporting and lacked sophistication. Hospitals reported events via a time-consuming, error-prone manual process. Although claims data have evolved into an efficient, refined quality reporting tool, NYPORTS does not take advantage of claims data.

The NYPORTS reporting process, which was once considered a cutting-edge approach, is now outdated and cumbersome.

NYPORTS Must Focus on Quality Improvement

Throughout its history, NYPORTS has struggled to balance program expectations with resource constraints. Consequently, DOH has not consistently been able to fulfill its mission to use the information reported to develop and share best practices, and improve quality care across the state. NYPORTS has gradually transitioned from a robust quality improvement program to a focused reporting system.

There is a flawed notion that quality reporting itself has an intrinsic value—it does not. New York State hospitals support and are committed to reporting adverse events, but their data should be used to make meaningful quality improvements. NYPORTS must be more than a reporting system. It must also be a response system that works to analyze the data and share lessons learned to protect the public through the provision of high quality care.

Through the NYPORTS reporting and review process, DOH has access to valuable data regarding the causes of serious adverse events. Given adequate support, NYPORTS could conduct a comprehensive analysis of the data and identify trends and factors that contribute to adverse events. Shared with hospitals across the state, this information could be a vital resource to hospitals and help to prevent future adverse events.

NYPORTS functioned most effectively when it was provided with both the resources and direction necessary to focus its activities. For example, between 2002 and 2004, DOH received a grant from AHRQ to study and improve the NYPORTS system. This included central analysis of all of the different types of reports in the system, working with the State University of New York at Albany School of Public Health to compare NYPORTS to administrative data in the Statewide Planning and Research Cooperative System (SPARCS), and conducting demonstration projects to show how groups of hospitals could work to implement best practices to reduce high frequency events. NYPORTS focused on acute myocardial infarction, deep vein thrombosis (DVT), DVT and pulmonary embolism, and post-surgical wound infection. DOH staff worked closely with hospitals and subject matter experts to design, implement, and test improvement programs for the care of patients with these conditions. NYPORTS staff closely examined associated events and root-cause analyses, and shared its conclusions broadly with the field.

The quarterly NYPORTS committee meetings were heavily attended by hospitals throughout the state to the point of creating logistical problems for meeting planning due to overcrowded meeting rooms. Hospitals were excited and eager to participate in such meetings because they believed that the meetings were valuable opportunities for learning about ways to improve care.

The conclusion of the grant funding was a significant factor contributing to the reduction in the quality improvement work conducted by DOH related to NYPORTS.

It is regrettable that providers take the time and effort to provide data to DOH, yet rarely share in the lessons or best practices that could be derived from such a wealth of information. HANYS strongly recommends that the NYPORTS program be redesigned in a manner that allows it to fulfill its original mission—improving patient safety.

Streamline NYPORTS

The quality reporting environment has changed dramatically since the inception of NYPORTS, with the introduction of hospital-acquired conditions, Centers for Medicare and Medicaid Services (CMS) core measures, AHRQ Quality and Patient Safety Indicators, and various quality registries. To improve NYPORTS and enhance hospital reporting compliance, HANYS recommends that the program be streamlined and aligned with other state and national hospital reporting requirements.

HANYS has long advocated for a uniform quality reporting environment that enables hospitals to leverage evidence-based knowledge, maximize the use of limited workforce and resources, and continually improve quality and safety in health care. Over the years there has been a proliferation of quality reporting requirements for hospitals at the state and national level (Appendix C). Many of these requirements are duplicative and have inconsistent definitions and reporting methods. Inconsistent approaches to quality reporting result in duplication of effort and can undermine efforts to enhance quality improvement.

Hospitals also must report the same or similar data to New York State that they report to various federal agencies, such as CMS and the Centers for Disease Control and Prevention. Not only is this effort duplicative, but reporting methodologies are separate and distinct, and often have slightly different quality measure definitions. This makes it cumbersome for hospitals to meet oversight expectations. The fragmentation also obfuscates the Department's ability to take advantage of information in other state and federal databases that could further contribute to knowledge about patient safety.

For example, if a patient suffers an injury in the hospital as a result of a medical error, the information on the medical chart is used to notify CMS of the occurrence via administrative claims data. However, NYPORTS does not use claims data, so a hospital must also complete a NYPORTS reporting form, identifying the date and distinct NYPORTS code for the event.

In New York State alone, hospitals are required to report to numerous DOH databases. Often, the same data elements are being reported to separate reporting systems in New York State. Rather than the duplicate reporting of these elements, state databases should be integrated and use the same data definitions so that elements are reported once and shared among systems.

HANYS recommends that in instances where hospitals have dual federal and state quality reporting responsibilities, the state should seek concordance with national measure definitions and reporting methodologies.

Quality reporting is a dynamic process that needs to be responsive to new knowledge and best practices. Reporting programs such as NYPORTS must continually reflect changes in evidence-based science. When NYPORTS was first created, it required reporting of sentinel events. Since that time, reporting requirements have been expanded well beyond statutorily required reporting. Some of the measures that were introduced are no longer relevant, as the science has changed. For example, several of the NYPORTS events overlap with the AHRQ Patient Safety Indicators, such as hospital-acquired DVT or pulmonary embolism.

The NYPORTS program has an obligation to require reporting of only those measures that we have the highest confidence directly impact health outcomes. To streamline the reporting requirements and make the best use of hospital and state resources, HANYS recommends the elimination of any reporting category not clearly required by statute. This will enable both DOH and hospitals to focus their attention and actions on priority areas rather than deploy very scarce resources across multiple areas.

HANYS' Recommendations

Enhancing patient safety must be a shared responsibility of health care organizations, providers, and the state. We need to develop the next generation of the NYPORTS program to achieve the goal of efficient reporting and improving quality of care.

- HANYS urges the state to develop an up-to-date, efficient, and effective program for reporting, investigating, and learning how to prevent serious adverse events.
- The NYPORTS reporting system must be able to document the impact of serious adverse events, monitor trends, and evaluate the effectiveness of prevention efforts. HANYS recommends that a formal and regular feedback mechanism be put in place to communicate lessons learned to the hospital field. These goals will only be met if the state makes a commitment to adequately fund the program.
- Reduce the burden of reporting by focusing reporting requirements and developing efficient, user-friendly data collection systems. Measures reportable to NYPORTS should be aligned with other national reporting definitions and methodologies. The growing demands for data place an enormous strain on hospital resources. Standardized definitions and reporting methodologies will not only reduce duplicative misaligned reporting obligations, they will result in more accurate and consistent reporting. Additionally, this alignment would enable the Department to draw lessons and comparisons with national patient safety and reporting programs.

Especially given the current financial constraints of the state, DOH could streamline the NYPORTS program to enable DOH to focus its efforts on sentinel events and a valuable set of quality measures, thereby enabling it to use the data collected to reduce errors and improve quality.

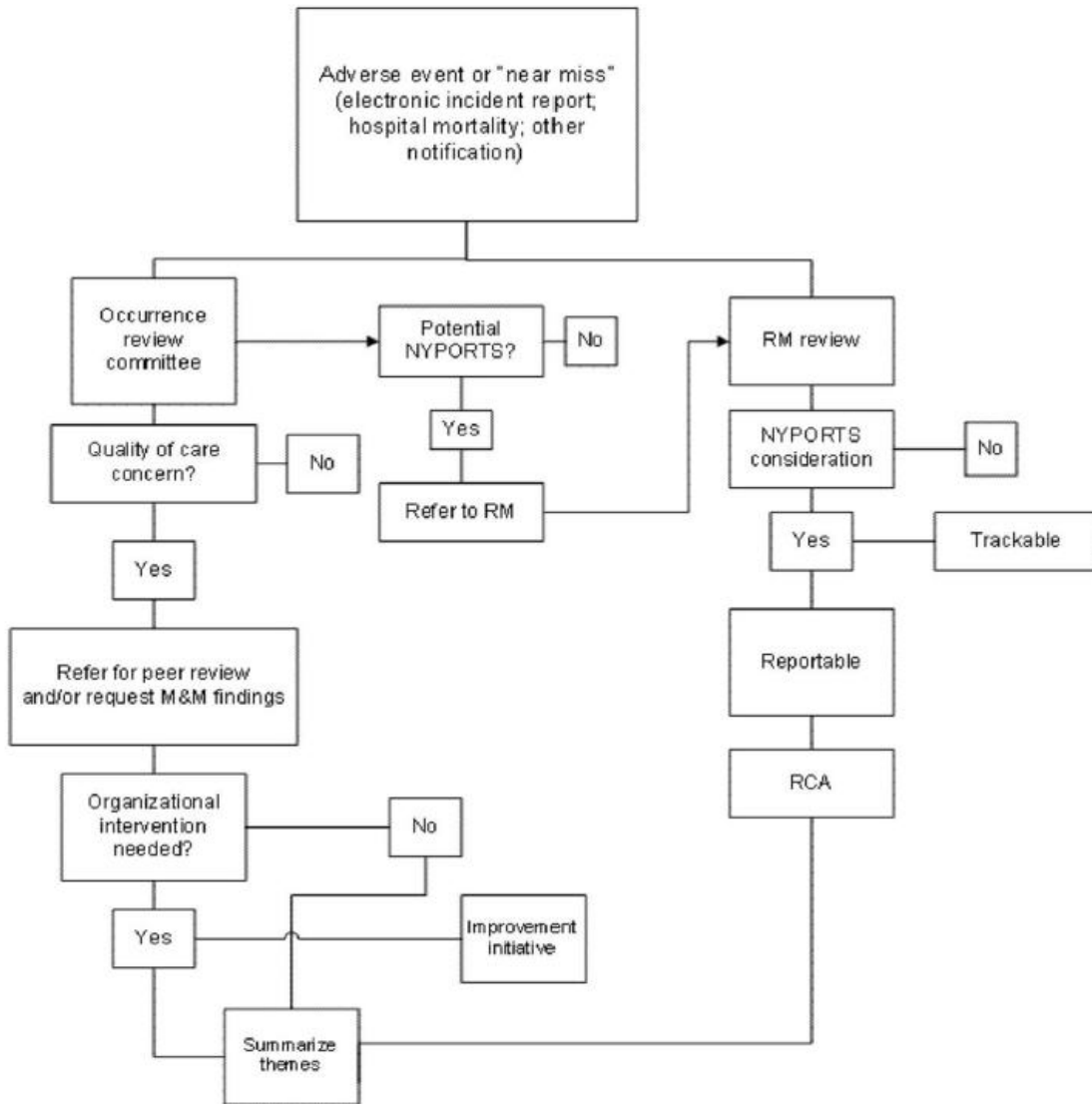
Conclusion

We want to emphasize New York hospitals' commitment to quality improvement and reporting of quality data. We stand ready to work with state government to improve quality reporting to broaden knowledge, enhance patient care, and foster efficiency in the health care system.

Thank you again for your inquiry and your attention to such an important patient safety priority.
Please contact me if you require any additional information.

Appendix A

Sample Occurrence Review Process



Appendix B

IHI 100,000 Lives and 5 Million Lives **Campaign Partners**

New York State Node:

Healthcare Association of New York State (HANYS)

Partners:

Business Council of New York State
Center for Medical Consumers
Excellus BlueCross-Blue Shield and Univera Healthcare
Greater New York Hospital Association
Healthcare Trustees of New York State
IPRO (QIO)
Iroquois Healthcare Alliance
Medical Society of New York State
Nassau-Suffolk Hospital Council
New York State Department of Health
New York Health Plan Association
New York State Nurses' Association
New York State Nursing Executives Organization
Northern Metropolitan Hospital Association
Rochester Regional Healthcare Association
United Hospital Fund
VHA – Regional Offices
Western New York Healthcare Association

