

TESTIMONY OF

GREATER NEW YORK HOSPITAL ASSOCIATION

BEFORE THE

NEW YORK STATE SENATE AND ASSEMBLY COMMITTEES ON HEALTH

REGARDING IMPROVING PATIENT SAFETY IN NEW YORK:

UNDERSTANDING AND IMPROVING THE CURRENT SYSTEM

OCTOBER 19, 2009

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Good afternoon. My name is Lorraine Ryan, I am Vice President, Legal, Regulatory, and Professional Affairs, at the Greater New York Hospital Association (GNYHA), which represents more than 250 hospitals and continuing care facilities in the New York metropolitan area, as well as throughout New York State, New Jersey, Connecticut, Rhode Island, and Pennsylvania. All of GNYHA's members are either not-for-profit, charitable organizations or publicly sponsored institutions. Together, our members provide services that range from state-of-the art, tertiary care to the most basic primary care, given their roles as safety net providers for many of the communities they serve.

I thank you for the opportunity to provide testimony about improving patient safety in New York and the current status of the New York Patient Occurrence Reporting and Tracking System (NYPORTS). In my role at GNYHA, I work directly with our member hospitals on a daily basis to help support them in their efforts to provide high quality, safe, and efficient patient care through the implementation of quality initiatives focused on improving clinical outcomes and hospital performance. I also serve as a resource for the hospitals with regard to the State's mandatory incident reporting requirements. As a former hospital administrator, nurse, and attorney, I have been involved with the State incident reporting program since its inception in 1985. I have also participated in both the development and implementation of NYPORTS over the last decade as both a member of the NYPORTS Statewide Council and in my role as an advisor to hospitals at GNYHA.

I. PATIENT SAFETY INITIATIVES

GNYHA is a membership-driven organization, and in this regard, GNYHA has devoted and will continue to devote considerable resources to assisting our members with improving quality, patient safety, and efficiency through innovation, education, and collaboration among members as well as with regulatory, accrediting, and professional bodies. Over the last several years, our hospitals have been able to implement a number of successful and sustainable patient safety initiatives in the areas of infection prevention, perinatal safety, and critical care. These initiatives involve assessing and then re-engineering existing delivery systems, developing strong partnerships with front line staff, and undertaking team training to create a more standardized approach to clinical care. Together, the foregoing activities have led to safer care, improved outcomes, and a reduced incidence of adverse events and medical errors.

Additionally, through grant-funding provided by New York State’s Health Workforce Retraining Initiative over the last decade, GNYHA has provided more than 1,500 hospital staff—primarily quality improvement specialists, nurses, and physicians—with intensive root causes analysis (RCA) training focused on the fundamentals needed to perform meaningful RCAs, including how to develop effective correction action plans and risk reduction strategies designed to prevent recurrence of adverse events. GNYHA is currently in the process of seeking funding to help support future training in this area, which will include a component on case identification to help our hospitals comply more effectively with incident reporting requirements.

A number of GNYHA’s quality and patient safety initiatives have been implemented through a “collaborative” model, undertaken in many cases in coordination with the United Hospital Fund (UHF). This model is a structured process within which a number of hospitals work together toward a common patient safety or quality goal. In this model, hospital leadership must commit to creating and promoting a culture of safety, which includes full and complete reporting of adverse events; provide the resources needed to support staff participation in the initiative; adopt a “bundle” of evidence-based best practice strategies to effect and sustain change; arrange for multi-disciplinary team participation in team-training and other educational programs; collect and act upon data to drive improvement; and share successes and strategies for improvement.

The GNYHA collaborative model also provides members with access to clinical experts who are available to offer guidance and solutions to overcoming clinical and administrative barriers. GNYHA's successful initiatives include:

- Focusing on team-training to ensure effective communication and “hand-offs” in care
- Reducing health care-associated infections (HAIs) through the following approaches:
 - *CLABS Collaborative*
 - *Infection Prevention Coach Training Program*
 - *Minimizing Transmission of MRSA and C. difficile*
 - *Supporting Public Reporting of Infection Rates*
- Saving lives through the use of rapid response systems (RRS) in hospitals
- Improving Critical Care
 - *The GNYHA/UHF Critical Care Leadership Network brings together physician and nursing leaders from across the region to share expertise in specialty critical care areas, to implement evidence-based practices, and to standardize clinical training, all in an effort to improve outcomes in intensive care units (ICUs).*
- Improving Perinatal Safety
 - *The Perinatal Safety Collaborative goals are to identify best practices and standardize protocols in the area of obstetrical and perinatal care; educate staff on these protocols; promote teamwork and communication skills training; empower frontline staff to initiate early interventions; reduce variations in practice; and engage senior leadership to ensure that changes effected are sustainable.*
- Developing physician leaders in quality and patient safety
- Using information technology (IT) to improve patient care
- Responding to adverse events by developing staff communication skills to achieve full and effective disclosure, and apology when warranted

GNYHA believes that all of these initiatives have led to, and will continue to lead to improved outcomes and more efficient, safer patient care. GNYHA has included the New York State Department of Health (DOH) in many of these initiatives and has strongly encouraged DOH to utilize the lessons learned from these initiatives with all hospitals and caregivers across the State.

II. NYPORTS

Goals and Objectives

Incident reporting in New York State predated the sentinel Institute of Medicine report, *To Err is Human: Building a Safer Health System*, which highlighted the importance of creating mandatory incident reporting as a quality improvement mechanism. The initial focus of mandatory incident reporting in New York State was on accountability. However, over the years, the focus has expanded, and as the State's reporting system evolved to the New York Patient Occurrence Reporting and Tracking System (NYPORTS), the program became focused on both accountability and quality improvement. The objective of NYPORTS is to make certain that hospitals identify and report adverse incidents promptly and that they undertake a thorough root cause analysis of the incident so that effective corrective actions can be taken to prevent a reoccurrence. The overall goal of NYPORTS is of course to improve the delivery of health care for all New Yorkers. To achieve this goal, it is intended that DOH, through NYPORTS, provides pertinent information to the public; provide useful information to hospitals to promote improvement through the use of benchmark data; improve accountability; and ultimately to positively affect outcomes for patients. GNYHA supports DOH's goals and agrees that meaningful analyses of NYPORTS data can have a significant positive impact on patient safety by informing the development of strategic quality and patient safety initiatives across the State.

Challenges NYPORTS Faces in Achieving its Goals

However, NYPORTS faces serious challenges in meeting its goal and objectives. GNYHA believes that NYPORTS is not appropriately funded to achieve the objectives outlined above. In a paper entitled *Lessons Learned from the Evaluation of Mandatory Adverse Event Reporting Systems*, published in "Agency for Healthcare Research and Quality, (April 2005) and authored by DOH and others involved in the development of NYPORTS, the following elements were noted as critical to the success of a mandatory incident reporting system:

- a) collaborative system design;
- b) a system based in statute with clear definitions and objective reporting criteria;

- c) meaningful data that can be analyzed and disseminated for improving patient safety; and
- d) adequate resources to maintain the system.

I would like to address each one of these goals with the aim of helping the State's Senate and Assembly Health Committees more clearly understand the challenges facing NYPORTS and how it can be improved.

a) *Collaborative system design*

From day one, DOH has welcomed hospital input into the development of NYPORTS, and through the effective work of DOH's Statewide Council, consensus has been reached on many elements of NYPORTS. In fact, there has been steady and consistent stewardship of the program from the many voluntary, engaged representatives from the hospital community, active consumer advocates, as well as representatives from DOH.

b) *System based in statute with clear definitions and objective reporting criteria*

Mandatory incident reporting in New York State came into being in 1985 as part of the State's statutory Medical Malpractice Prevention Program. Since that time, the incident reporting program has evolved, and in 1998, as a result of the deliberations of the Statewide Council comprising DOH leadership, hospital staff, hospital association representatives, and consumer advocates, NYPORTS was developed and implemented. NYPORTS' progression from its original iteration as merely an incident reporting program (known then as the "Hospital Incident Reporting System") to NYPORTS, which is based on a list of identifiable, reportable, and trackable codes, occurred because of the difficulty hospitals had in identifying what they were required to report based on the statute and related regulations alone. NYPORTS was developed in order to standardize reporting across the State, and "inclusion" and "exclusion" criteria, each within a particular category of adverse events, were developed and defined to help hospitals identify more specifically the occurrences they are required to report and track. The Statewide Council went even further to assist hospitals with standardizing what was required to be reported by creating a NYPORTS definitions manual.

When NYPORTS was first implemented, there were more than 54 different codes that hospitals were required to identify, track, trend, and in many cases, report to DOH and with respect to which conduct an RCA. Although this was a huge undertaking, there was a great degree of cooperation on the part of hospitals to make NYPORTS a more meaningful and user-friendly system for reporting adverse events. However, notwithstanding this effort to clearly articulate what was considered ‘reportable’ for NYPORTS, and because of the complexity of health care and the unique characteristics of each patient, a certain degree of subjectivity remains with regard to whether a particular case meets the NYPORTS reporting requirements. The reality is that there is no ‘automatic’ system or framework for effectively identifying and reporting a case. Rather, intricate processes must be developed to concurrently identify reportable cases. Then each and every case that is identified as potentially reportable must go through a rigorous review process to assess whether that case meets the ultimate criterion: whether the occurrence/event occurred as a result of an error in judgment or technique or as a result of a systems failure versus whether it was a result of the patient’s natural course of illness. Compounding the difficulty of assuring that each and every case is correctly identified and reported is the fact that there is no administrative data set in New York State that completely aligns with NYPORTS codes, making it impossible at this time for a hospital to completely determine “short of 100 percent retrospective chart review” whether every single event that should be reported to NYPORTS is reported. Hospitals have invested substantial resources to meet the reporting requirements, and notwithstanding the challenges described, actually do a very good job of case identification and reporting.

c) Provide meaningful data that can be analyzed and disseminated for improving patient safety

DOH provides hospitals with NYPORTS data for statewide benchmarking with regard to the frequency of events reported by the institution and the data provided allow for some degree of identification of institutional trends or patterns of occurrences. Many hospitals have been able to use the aggregate NYPORTS data that DOH makes available to facilitate hospital-level data evaluation and analysis. However, a hospital’s ability to make use of these data is very dependent on the hospital’s level of IT systems knowledge and sophistication. GNYHA believes that DOH could play an even greater role in quality improvement if DOH was to devote more resources to data aggregation, analysis, and feedback to hospitals. In this regard, more code

specific tracking and trending by type of hospital and type of patient as well as more widespread sharing of the findings of root cause analyses and lessons learned are needed. Currently, the data available to hospitals are either not retrievable or are not available in a form that is useful and that can contribute, in a meaningful way, to performance improvement efforts. The more timely and useful the feedback that providers and senior leadership receive about the quality improvement facets of NYPORTS, the greater the motivation they have to report into the NYPORTS system.

d) Adequate resources to maintain the system

There is a fundamental conflict between the goals of NYPORTS and the adequacy of the resources available to DOH to effectuate these goals. Undoubtedly, reporting systems like NYPORTS are critical to improving patient safety. However, many factors, including a state's unique environment in which its reporting system operates as well as its available funding, influence the performance and capabilities of the system. Although New York strives for quality improvement in its implementation of the NYPORTS program, the lack of resources committed to the monitoring and evaluation of NYPORTS has limited its ability to provide better oversight and more useful feedback to hospitals.

Insufficient training resources - Ongoing NYPORTS training is invaluable to system users striving for consistency and quality in reporting. In fact, in the early 2000s, a training and education subcommittee of the NYPORTS Statewide Council was developed to coordinate regional and statewide trainings to promote standardization and consistency in reporting. With the limited resources allotted to the NYPORTS program over the last several years, the education and training needs of hospitals have not been sufficiently met. Currently, in this region, much of the on-going education and training on NYPORTS has been provided through GNYHA's RCA training program, which includes a discussion of NYPORTS reporting requirements. Additionally, several years ago, GNYHA formulated a NYPORTS Users Group to support hospitals in meeting the challenges of full and complete reporting, to keep hospitals abreast of the activities of the NYPORTS Statewide Council, and to provide a forum for hospitals to provide input on issues the Council should consider. Although GNYHA has continued these efforts—since the NYPORTS Statewide Council stopped meeting more than two years ago—there has been little information to share with the User's Group. GNYHA does, however, on a

daily basis address member's issues and concerns and consistently brings them to the attention of DOH.

Insufficient data analysis - Strengthening NYPORTS will aid in capturing the underlying root causes that lead to adverse events as well as the development of initiatives to reduce and avoid such occurrences. Securing adequate resources to maintain the system and to provide meaningful data for improving patient safety is essential to improving NYPORTS. Hospitals across the State have expended significant resources to support the data collection and analysis requirements of NYPORTS. However, because of a lack of resources and personnel within DOH, the data analysis component of NYPORTS is not able to provide system users with proficient and meaningful ways to obtain and use aggregate NYPORTS data. The lack of consistent and timely feedback and data analysis from DOH has been an impediment to NYPORTS' achieving its goal of becoming a meaningful tool for quality improvement purposes across the State.

Insufficient dissemination of lessons learned from NYPORTS data and RCA analyses - In addition to a focus on training and education, communication and the dissemination of information have been important areas of focus for both DOH and the NYPORTS Statewide Council. In fact, in 1999, DOH began issuing a periodic newsletter (*NYPORTS News and Alerts*). This newsletter provided timely information about analysis, interpretations, and use of NYPORTS data and made information about NYPORTS more generally available to the hospital community and beyond. The last time this newsletter was published was in 2006.

Another opportunity for dissemination of NYPORTS data and lessons learned is the NYPORTS Annual Report. These reports have included aggregate data analysis and key findings as well as findings on the completeness of reporting, analysis of select NYPORTS codes, patient safety initiatives, and enhancements to the system. DOH has issued three annual reports since the implementation of NYPORTS in 1998. The last annual report was issued in 2006.

III. CHALLENGES TO NYPORTS AND RECOMMENDATIONS FOR IMPROVEMENT

New York has clearly seen improvements in reporting with regard to its incident reporting program since its inception in 1985. For example, the number of reports submitted to NYPORTS

has continually increased from 16,939 cases in 1999, to 24,368 in 2000, to 28,689 in 2001, to 30,416 cases in 2002, to 31,029 in 2003, and to 31,154 in 2004¹ (the last year of published annual reporting statistics). However, to achieve optimal patient safety in New York, more support is needed to further develop the NYPORTS system.

There are two principal reasons for a program like NYPORTS:

1. To support regulatory surveillance for serious adverse events in furtherance of DOH's role as a "protector" of and watchdog for the public.
2. To serve as a repository for carefully investigated serious adverse events to in turn support aggregated analysis, research, sharing, and learning.

Conflicting program functions

However, the question must be asked whether these two functions are essentially incompatible, particularly when surveillance is often accompanied by sanctions for failure to meet a determined standard of care. Meaningful quality improvement can only take place in an environment that fosters a culture of safety, which is one that supports responsibility and accountability but that is blame-free. There is support from the experience of other incident reporting programs, such as the Pennsylvania Patient Safety Authority and the Department of Veteran Affairs, that greater progress in furthering the mission of a government-driven quality and patient safety program can be made if the program falls under the jurisdiction of an agency devoted to patient safety and equipped with the design and technology expertise that can undertake cutting-edge process/system design and research.

Recommendation:

GNYHA recommends that models such as those in Pennsylvania and the Department of Veteran Affairs be examined and considered for implementation in New York. For NYPORTS to regain its prominence as a leading incident reporting program that drives quality improvement, it needs to be part of a fully-funded, dedicated patient safety center run by quality and patient safety experts whose primary mission and responsibility are to improve the quality of care for all New Yorkers. These experts must also have the capability to provide hospitals with data analysis and feedback, technical support, and education and training on how to use the system and derive the

greatest benefit from the data in the system. Additionally, GNYHA recommends that the Statewide Council be reconvened as soon as possible to help in this assessment and to ensure the relevance and viability of NYPORTS moving forward.

Limited Confidentiality

Although NYPORTS reports are protected from disclosure, confidentiality protection does not extend to the related surveillance activities and findings of the DOH. Often these findings, which are publicly available, are published word-for-word in a DOH statement of deficiency, an act that diminishes the value of the quality assurance privilege and that operates as chilling effect on the quality improvement process.

Recommendation:

The data and documents generated as a result of the NYPORTS process as well as the valuable lessons learned from the RCAs conducted should be organized and disseminated widely to all providers across the State with full confidentiality protections.

Multiple reporting systems and definitions

There are currently multiple, and in some cases redundant, incident reporting requirements with which hospitals must comply. All of these systems have different definitions for what is required to be reported.

Recommendation:

NYPORTS reportable codes should be refined and limited to the most important areas for review and those from which the health care community can derive the greatest benefit from reporting and analysis. NYPORTS definitions should also be aligned with national reporting measures such as those found in the Agency for Healthcare Research and Quality's Serious Adverse Event Policy. This would create standardization of what is reported as well as consistency in definitions, which should decrease variability in reporting and allow for national benchmarking, a process that would in and of itself drive improvement.

CONCLUSION

GNYHA is devoted to improving health care quality, patient safety, and efficiency. GNYHA believes that NYPORTS can be an important tool to further the progress we have made to date in the area of quality and safety and urges the State to provide the administrative structure and resources needed to make it a state-of-the-art, effective system that will benefit and protect the citizens of New York.

I would like to thank you for the opportunity to appear today on the very important issue of improving patient safety in New York. Working together, hospitals, the State, consumers, and others can improve patient safety and enhance the quality of the health care we provide to our patients.

ⁱ State of New York Department of Health, Office of Health Systems Management Division of Primary and Acute Care Services. (2002-2004). *New York Patient Occurrence Reporting and Tracking System Report* by Antonia C. Novello, Commissioner of Health and Hon. George E. Pataki, Governor, State of New York.