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ON HEALTH

Improving Patient Safety in New York: Understanding and Improving The Current System

Assembly Hearing Room

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A P P E A R A N C E S:

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Chair, Committee on
Health

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Chair, Committee on Health

RICHARD CONTI
(Staff Member of Richard Gottfried)

LIST OF SPEAKERS

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SENATOR DUANE: Good morning, everyone. Welcome to our joint hearing of the Assembly and the Senate on Health Committees, improving patient safety in New York, understanding and improving the

current system. Even without flipping a coin, the assembly member suggested that I should go first just to tell you a little bit about why we're here. And then Assembly Member Gottfried, as Chair of the Assembly Health Committee, will do similarly, and probably with as much and probably greater eloquence. Thank you.

As chair of the Senate Health Committee, patient safety has been a primary concern of mine. 10 years ago, the Institute of Medicine came out with a report that highlighted really a very large problem in America's hospitals. The report spoke about the large number of medical errors, many of which were and are preventable and, unfortunately, we do know that errors occur today, every day really, in hospitals.

I say that not to be overly

critical. I do strongly believe that people who work in healthcare are called to that work and actually want to help people, make people feel better, help to save lives, but, all that said, there are errors which occur in hospitals.

One of the recommendations coming

out of the Institute of Medicine was to create a mandatory reporting system, really systems, where medical errors could be identified and studied with the goal of preventing errors, and the New York patient error reporting system is really based on and is just such a system, and it is NYPORTS.

But we haven't solved the problem of medical errors here in New York hospitals, yet. And news reports this past summer in the New York Daily News remind us that the problems of medical errors in hospitals, again, they have not gone away.

The report found what appear to be significant lapses in the safety of patients and lapses in the reporting

systems. Their findings echoed recent findings by New York City Comptroller William Thompson, pointing to inadequate oversight of hospital's compliance with the New York Patient Occurrence and Tracking System, i.e., NYPORTS.

So the movement toward improving quality in healthcare will only be successful if the institution who is

providing care honestly report their activities, both good and bad. It's critical that the Department of Health, the State Department of Health, uses its oversight capabilities to ensure that the system works the way that it is designed, that is, to improve the quality of care at our hospitals, and to protect patients obtaining needed healthcare services.

Now, when I first became Chair of the Health Committee, this is an issue which I discussed with the commissioner on what data is collected, and how much data is put out there, and what the data is used for. And I actually think that -- so the

Department of Health is well aware, and I believe we'll hear -- would agree that we need go even further and ask even whether even the best patient reporting system is all that we should or could be doing to prevent medical errors in our healthcare facilities.

So, the purpose of this hearing is to learn how New York can improve patient safety in hospitals across the state. To find out what is the role of NYPORTS, how

well is it working, how can it be strengthened and made more effective to protect the public, and what other measures should New York State take to reduce medical errors and to improve patient safety.

So I appreciate everyone coming today. I'm looking forward to hearing the testimony today. I believe we'll get some excellent insights and I think that this hearing will be very helpful towards improving the system that we use to make patients as safe as possible in our healthcare facilities.

Thank you.

CHAIRMAN GOTTFRIED: Thank you. You know, as Tom said, we've had in the last, I don't know, several months, a series of reports, newspaper series, some very focused on New York State, one on the Health and Hospitals Corporation here in New York City, one national newspaper series focusing on issues of patient safety in hospitals.

I think this is probably an issue on which any legislative body in the country at any given point, you know, in the last couple of centuries, could hold a very

productive hearing. In New York, we have a couple of -- we have several systems designed to advance patient safety within the Public Health Law, and two, in particular, are the NYPORTS system for reporting of adverse events, with the follow-up mechanism of the Health Department's inspection systems both before incidents are reported, and following up when an incident is reported in addition within the Public Health Law. In hospitals

and some other facilities we have internal peer review, morbidity mortality review processes. All of these processes in current New York Law are protected to a certain extent with confidentiality. There are also some provisions for public disclosure, particularly of the aggregate information in certain circumstances.

There are those who advocate that the system would work better and result in more disclosure and analysis of things going wrong if there were stronger confidentiality. There are -- and I'm sure we will hear some discussion of that today.

There are also those who argue

precisely the opposite, that we would learn more and have better outcomes, et cetera, if we eliminated the existing protections of confidentiality on these processes and if everything were available to the public. And I know there will be -- I'm pretty certain there will be people here testifying in support of that position.

So we will be trying to sort out

those arguments and others so that we can hopefully move New York forward.

Unfortunately, I am going to have to leave for the first part of this hearing when Senator Duane gets back in a moment. A couple days ago, as I'm sure everyone here knows, Governor Paterson announced a proposal of an extraordinary package of cuts in the state budget.

The Assembly Majority Conference is holding majority conferences to discuss the state budget, one here in Manhattan, one in Albany, and I think there's a third scheduled. The New York one we were told on Friday, I guess, is alas being held right now four floors up in this building.

And considering that the Medicaid

program, which is one of the major areas of the Health Committee's jurisdiction, is about a third of the state tax levy budget or more, and as Willie Sutton said when I asked why he robs banks, that's where the money is. Healthcare, Medicaid, the health department budget on the one hand, and

school aid on the other, are the two largest targets of opportunity in any Governor's budget-cutting, and so my presence upstairs is kind of required. But I will get back down here as soon as I can.

The written statements of witnesses that are delivered while I'm away, I will certainly read. Rather than have our first witness, Dr. John Morley, begin right away, we're going to pause and stand down for a moment until Senator Duane returns.

I guess one procedural point I can mention. Since this hearing was initiated by the Senate Health Committee, and they invited the Assembly Health Committee to participate, we are not following the ordinary Health Committee, Assembly Health Committee hearing rules which would be swearing in all witnesses.

So those of you who are worried that would be imposed on you, you can heath a sigh of relief. That's not an invitation to just make things up, of course. I say that just for those of you who are wondering how come

we won't be swearing in witnesses at this hearing, that's why.

Also, another, I guess, procedural announcement, at some point, probably around 12:30 or 1:00, we will take a short break for what we, in the healthcare world, call ambulation and toileting. Although some may also use it as a nutritional break as well.

So we will recess for the moment.

(A break was taken.)

SENATOR DUANE: Excuse me for the interruption and the delay. There's nothing more to say about it. So, I'm sorry, and please pardon the delay.

Our first witness, if you will, although that sounds like an awfully harsh term for it, is Dr. John Morley, who is the medical director of the Office of Health Systems Management with the Department of Health.

Welcome.

DR. MORLEY: Thank you. Good morning, Mr. Chairman. I would like to

start by thanking you for this opportunity to address you this morning on an issue that's been a major focus of my career for the last several years.

This morning, I would like to provide you with a more abbreviated presentation than my written testimony that has been provided.

Along with me this morning is Ruth Leslie, who has been working with the department for approximately ten years and working with the NYPORT system.

My name is John Morley, as mentioned, the medical director for the Office of Health Systems Management. I've been with the department for the last four years. I started August the 1st. Prior to that, I was the medical director for Tertiary Care Academic Medical Center from July '01 through July '05.

My clinical background includes residency training in anesthesia and internal medicine, and fellowship training

in infectious disease, pulmonary and

critical care medicine.

I was associate professor of anesthesia internal medicine and surgery, and currently enrolled in a university Master's in medical management program.

I became acquainted with NYPORTS and involved in patient safety when I was in clinical practice approximately 10 years ago or 12 years ago, and the associate medical director of the institution in the late 1990s. By the time the Institute of Medicine Report "To Err is Human" was published, I was heavily involved in quality and safety in my own institution.

I'd like to provide with you some background on NYPORTS. It was created under a different name in the mid to late '80s. It was developed in response to an awareness that many adverse events were occurring in the hospitals, and the Department of Health would only become aware of those events through the press.

According to the National Academy for State Health Policy, there are

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currently, approximately, 26 states and the District of Columbia, that have a reporting system for adverse events. All but one state's system are mandatory reporting systems. NYPORTS began as a paper reporting system and has gone through several iterations in the last 20 years.

In 1998, the department announced the first web-based reporting system. In '99, when the IOM report, "To Err Is Human" caught the attention of the nation and affirmed the goals and efforts of the department to make healthcare systems safer, NYPORTS was attracting national attention as a model for adverse event reporting systems.

Currently, NYPORTS has 31 codes identifying 31 reportable adverse events. While the collection of adverse events is seen as a critical first step, and the events collected are only of any value when the event is studied to understand what went wrong and/or what led to the adverse event.

Without this analysis, there can be no change and no improvement in safety.

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As was mentioned earlier in the introductions, NYPORTS is only one of many tools that the department uses for data collection and for improvements in safety.

In addition, we have the cardiac database, the trauma registry, healthcare associated infection reporting, office-based surgery adverse events system, and our stroke designation program.

These systems and more are used to understand and improve safety in New York. The various offices within the department including laboratory and epidemiology collect information from hospitals through over 30 different reporting systems.

The department receives approximately 12,000 NYPORTS reports on an annual basis. A report is periodically issued providing aggregate data and outcomes and events for New York State hospitals as well as trends over time.

While we have not done as much analysis of the events as we would have

liked, we have reviewed and continue to review specific issues, such as, wrong-sided surgery, medication errors, and maternal deaths.

When it was identified in 2005 that wrong-sided surgery was an ongoing issue, we convened a panel of clinical experts to review the cases. The panel developed a protocol which addressed each step in the process for a patient's surgery, as a result, we created and defined a standard of care with the New York State Surgical and Interventional Procedure Protocol, also known as NYSIPP.

Shortly after we published NYSIPP, the Joint Commission asked us to participate in their wrong-side surgery summit.

NYPORTS is a reporting system. Information comes into the department and is reviewed. Most often the events are collected by the department and nothing further is necessary. This is because of the expectation that in the case of serious

events, the hospital has conducted a review

of the event and taken appropriate action. And that is part of the NYPORTS report that comes back to the department.

Often, however, the event can trigger a department investigation to gather additional information. Selected cases are occasionally referred to epidemiology or the Office of Professional Medical Conduct for further review and action.

NYPORTS is a tool that's been used for both process improvement and regulation, with occasional enforcement and penalty assessment. I believe both uses are appropriate, but I believe clarification of the parameters for referral and refinement of that process is necessary. We have and will continue to identify these events in which it was clear that reckless behavior played a significant role in the event.

These cases require an unambiguous response from a regulatory agency. Most events, however, are not the result of reckless behavior but are the

result of human error to which each and every one of us is susceptible.

It's only when we know what

happened and we can respond appropriately, and we must also remind ourselves that the goal is to improve and optimize patient outcomes, not, actually, to eliminate errors. Humans will always make errors. The goal is to prevent those complications that are preventable and obtain the best possible outcome for the patient.

To design a system that allows for the fact that humans will create errors and catch those errors before they reach the patient, that's what NASA has done, that's what the FAA has done, that's what high reliability organizations has done, such as the nuclear regulatory agency.

When a motor vehicle accident occurs, the outcome is reviewed. Was it a scratch, a fender bender, or a collision with a great deal of damage and death? Was alcohol or other substances involved? Was someone shaving or applying make-up while

looking in the mirror, not paying attention? Was speeding a relevant issue? That could be five miles above the speed limit on a rainy, snowy, icy day, or 50 miles above the speed limit. Sometimes it's a bolt of

lighting that strikes the tree that falls on the car.

Sometimes people make mistakes because we're human, sometimes we demonstrate at-risk behavior with relatively minor actions, and sometimes we are reckless. When addressing or responding to any type of motor vehicle accident, it's critical to understand what went wrong, what contributed to the accident before response is taken.

A just culture recognizes that individuals should not be held accountable for systems failures over which they have no control, however, it does not tolerate conscious disregard of standards, policies and procedures that promote risky or reckless behavior affecting the health of patients.

The airline industry learned a long time ago that firing the professional in an event without changing the systems results in eliminating the only person who now has the experience to know how and why not to make the same mistake a second time.

But even after the data is

gathered, analyzed, and policy and protocols created, there is still much to be done to bring about a safer environment.

The veterans administration has an internationally acclaimed patient safety center. In their spring 2000 publication, Ambulatory Outreach, Dr. Jim Bagian and Dr. John Gosbee point out "without facility culture change, no policy, procedure, rule or regulation will make caregivers comply with a system's approach to patient safety."

The department has received criticism for its monitoring and completeness of reporting to NYPORTS. Dr. Charles Billings, the architect of the NASA Aviation Reporting System states, "in the final analysis, all reporting is voluntary."

Dr. Jim Bagian, a physician, an astronaut and the Chief Patient Safety Officer of the Veteran's Administration has made that same statement to Congress in testimony. Both of these physicians are acutely aware of the complexity of the clinical condition and the requirement for interpretation of both the condition and the event definitions.

Underreporting of events occurs

for several reasons. It's critical to acknowledge that underreporting can be the result of a poor system design for collecting adverse events in the facility. Large complex hospitals have a great deal going on and every person has a lengthy list of responsibilities.

The first concern of every provider is the direct care of the patient. Once the patient is cared for, a decision has to be made about whether a particular case meets the definition of a reportable event. That's not always as straightforward and simple as it may seem.

Then we must acknowledge that

there are very real and significant disincentives to reporting, including shame, liability, and concerns about retaliation, both personal and institutional.

Add to this the challenge that an institution must face when it is very aggressive about reporting every possible adverse event. The risk related to the public interpretation of a large number of events as bad care is significant. The institution with the lower number of adverse

events reported, can be perceived by the public as excellence performance, but it can also be identified as poor reporting.

The institution with a high number of reported events may be very aggressive about reporting all possible events, or they may be a very poor performing hospital. Either is possible and we don't have the data to identify which is which at this time.

The department's Bureau for Certification of Surveillance is aware of facilities with lower reporting rates. We

work with them to educate staff on the codes and the definitions for those codes, to improve their reporting responsibilities. Periodically, reportable adverse events are identified by means other than the hospital self-reporting. Chart reviews are done for other purposes and the review of these cases of a reportable event may be identified.

Over 2000 complaints are received from patients and family in an investigation of a complaint can turn up a reportable event. When an event is identified that we believe met criteria for reporting, it's

brought to the attention of the institution. This will frequently result in the issuance of a statement of deficiency and perhaps a fine. The department has issued almost 1,300 NYPORTS-related citations from 2005 to the present.

A great deal of time and effort has gone into collecting information on adverse events, and many changes, many improvements, have been made. But it is clear that we can and must do much more. We

would like to see this reporting system be clearly identified as a tool for patient safety as the Institute of Medicine recommended in its 2004 report "Crossing the Quality Chasm." We must also, however, provide greater clarity for the industry as to what information is to be utilized for process and systems improvements, and when information is to be referred to other areas of the department for evaluation and response.

This has been a major issue that's been addressed by the agency for healthcare research and quality, or AHRQ, in their requirements for the creation of

federally designated patient safety organizations.

I am well aware, as are you, of the level of frustration of the public in the area of patient safety. We have not accomplished nearly enough, nor nearly as much as we had hoped in the 10 years since the Institute of Medicine report, "To Err Is Human." But we have made measurable

progress and we are building a foundation on which a great deal more can and will be accomplished. This is a very large boat to be turned, but we are overcoming inertial forces and change is taking place.

Cardiac care has better outcomes in the last 10 years, trauma care is improved, transplant surgical outcomes are better, healthcare associated infections are dropping, and more improvements are taking place. But there is far more yet to be accomplished and I am absolutely confident we've only seen a small fraction of the improvements that we'll be seeing in the next 10 years.

We will continue to work with national healthcare experts and the New York

State healthcare industry to improve New York State and to assure that we have the best patient safety systems, strengthening the confidence of patients and stakeholders alike.

Thank you very much and I'd be very happy to take any and all questions you

have on NYPORTS or the efforts that the Department of Health has in making towards improving quality and safety of healthcare. Thank you.

SENATOR DUANE: Thank you for your testimony. I do have some questions.

Why are the cardiac database, the trauma registry, the stroke center designation program, why are they not all integrated into a more exhaustive and comprehensive NYPORT system?

DR. MORLEY: I think each of those have come about for different reasons and they have been evolving separately and at different speeds. I think that's something that could be done and could be looked at. But the historical facts are that they've arisen from different areas of the department.

But putting those into a patient safety structure along with NYPORTS -- now even NYPORTS is actually part of the certification and surveillance end of the department, so it's seen in the regulatory

end of the department, but each of those has their own strengths, their own resources, their own history going forward. I think it would be a very reasonable thing for us to look into putting them all under a single umbrella for patient safety.

SENATOR DUANE: It does occur to me or seem to me that some of the reporting involved in those procedures, or --

DR. MORLEY: Treatments?

SENATOR DUANE: -- treatments may not be specific to that procedure, that health issue, and that there would be overlap which would be appropriate to have as part of a larger, more integrated reporting system.

What is the impediment to that?

DR. MORLEY: I think that when the patient safety center -- now let me see if I understand correctly what you're talking about, would be incorporating them

into a patient safety center or that type of a structure?

SENATOR DUANE: That NYPORTS

might be the umbrella for all of the data collection for the purposes of patient safety.

I don't want to get specific about, well, this could happen during, you know, a cardiac procedure, but that same possible accident could not be only specific to cardiac procedures, but, in fact, could be a general issue of which it would be helpful to have it be part of the NYPORT system.

DR. MORLEY: I think that there is another answer to this and that is that there is some specific, you know, as you say, clearly there is some crossover of some events. There is also some crossover, the resources, one of those points in terms of working with the Trauma Advisory Committee, the Emergency Medical Advisory Committee, the cardiac -- all of those things, but the first step is generally to understand what happened in this particular environment and the expertise for cardiac exists with the

Cardiac Advisory Committee and for trauma

with them.

So while there is some crossover, I think the bigger pieces, the bigger pieces of the puzzle as to what happened and understanding it, generally is owned by the cardiac experts, cardiac surgeons, and cardiologists, the trauma surgeons, and once the lessons are identified, once it's been peeled apart and you understand where the flaw was, then that lesson can be taken out and moved over to other areas of the department. That is something that we have tried to do.

SENATOR DUANE: With success, or is there -- I mean, is it something you're trying to do, or is it --

DR. MORLEY: It is something that we're trying to do and trying to do more of. That was one of the things that I came into the department to attempt to do. There wasn't in my role before, but I do cross over all of those different areas. I think that we hope to do that much more in the future.

But NYPORTS, again, I go back to what I said before about the history of some of the things that we've been talking about. They were started and seen as particular pet projects that had a specific, very specific and narrow focus at the time.

In 1985, the legislation and the statute that supports NYPORTS is basically a reporting system that started because the department just wanted to know what happened. Well, we have evolved that ourselves and added a few events that we would like to see reported into the system, but it started out as an isolated system, as did the cardiac advisory committee, as did trauma.

So the histories, they can be combined, there isn't any major reason why not going forward, but how they were started was as individual projects.

SENATOR DUANE: And if I acknowledge that NYPORTS is always a work in progress, is now, will probably be, probably forever, as we learn more and more, and I

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understand that the other reporting systems are also works in progress, and I did hear you say that it is something that you would do, but we would have to, or if I acknowledge that they're all always going to be works in progress, and there will be more probably as time goes on, why can they not -- I mean, what is the impediment to integrating all of them, and is there any down side to that at all?

DR. MORLEY: Only a minor one in my view, and that would be we would continue to need the expertise of the specialists in their areas for the primary level of understanding of the event, whatever happened.

SENATOR DUANE: I would always, and I don't want to speak for you, but I would always believe it's important to have, as we say, the stakeholders and those who -- the specialists, the people who know the most about it at the table, as that is -- as we're doing that. I want to say that goes without saying. Maybe it doesn't, and I

don't want to speak for you, but in my mind it would go without saying that, of course, we would always have them involved and at the table and --

DR. MORLEY: I agree.

SENATOR DUANE: So, again, is there a down side to doing that?

DR. MORLEY: No.

SENATOR DUANE: So what's the impediment?

DR. MORLEY: You know, it's just making the decision to do that. To bring those resources together. We actually have recently in large part because of the same reasons that Senator -- excuse me, Assemblyman Gottfried isn't here, looking at the budget, we're looking at how we're structured, and we're looking at how we can become more efficient. So this may be the ideal time. That's something I'll be bringing back to the commissioner and to the deputy commissioners to discuss. And there may be, in addition to some of the things you talked about, additional deficiencies to

be gained by something like that.

SENATOR DUANE: Of course we're

in an incredibly difficult and horrible budget period. However, I would even think -- I think maybe even short term improving patient safety and doing everything we can is an excellent investment with a short and a long-term savings.

So I think it would be helpful if we, in the legislature, and something that we could discuss with the department and the Department of Budget, if we knew what kind of resources it would take short term to do this because a lack of safety is a very expensive proposition, and, of course, that goes without saying, patients not being saved is a terrible -- there's a lot of things, you know, we just have to -- that I keep saying goes without saying. Okay. So, primary thing, patient should be as safe as possible. We have to do everything we can. We have to help institutions to make it as safe as possible for patients.

So I may not -- well, maybe I

will keep repeating it, but that should be the bottom line throughout this hearing. And, if we're looking to improve the system so that happens, and because it's cheaper,

it's better, it's more efficient, what would the department need for that to happen?

That's a question I'm going to have to bring back that I'm just not able to answer. I don't know.

SENATOR DUANE: I mean, I think it would be incredibly worthwhile for us -- well, I don't know this, if I assume that you're doing the best that you can, and you're working as hard as you can, and you were brought in to do this, I think it would be very helpful for us to know what it is that you need because, now I'm going to say it again, I'm not doing it without saying it, because if we're doing everything we can to improve patient safety, if we're doing everything we can to have as much data, integrated data to make that happen, it would be helpful to see what that is.

I don't consider the Department

of Health to be in any way adversarial at all on it, and I would like to see how we could work with you to make that happen and with the stakeholders as well.

DR. MORLEY: I think that there has been some integration that has taken

place already in terms of the data. The information that comes in to NYPORTS is not restricted out of any trauma event or trauma patient or any healthcare acquired infection or out of any wrong-side procedure.

So when NYPORTS gets an event, it can come from the cardiac surgery folks. It can come from trauma or from anybody within the institution. And those lessons then from NYPORTS do end up being passed on. So there is a level of integration. That's not to suggest that there isn't room for further integration. I think that there is certainly room for further integration.

SENATOR DUANE: Okay. I think that's something we would like to look at. I mean, I'm going to put you in a difficult position, it may -- this may be a way to

find out whether or not what you do is adequately funded and what are the resources we can bring to it. Again, patient safety and efficiencies, short term and long term. And, again, because I'm not -- I mean, I can't say that it won't turn adversarial, but so far I hope you'd agree that generally my relationship with the Department of

Health is not adversarial, I mean, we've had our dust-ups but, generally, I think it's been very good.

So tell us how the department -- how we could help the department to do the things that, I want to say, in a perfect world never get there, but in a better world we can work with you on.

DR. MORLEY: I think it's important, we certainly appreciate what you're doing today. This hearing is a major step in that direction. Quite frankly, even if we don't get anything else, I think just the attention that this type of an issue brings. I think we frequently, all of us, identify that this is important and that's

important and the other thing is important.

But after you've decided that something is a good thing, the next thing that goes on in your mind and mine is, okay, how important, let's quantitate this, and when you have a hearing from the Assembly and from the Senate, that certifies that we're going to bring together the group of experts, that's clearly an indication of just how important this issue is to you.

I think when you -- over the course of the year you're involved in many good important things, but you've got to quantitate that to some degree.

In my presentation, I commented about the VA recognition of the fact that policies and protocols alone will not do this. This is about culture change. What is culture? Well, it's a group of unsaid, assumed values, and there are some assumptions that are made for sure, but when you identify whether something is important or not, it goes -- there are certain things that go along with that. You put teeth into

the legislation of something that's really important.

There are multiple different ways by which you can identify out of the 10 things you've been working on or thinking about, how do you quantitate which is the most important? And this type of a presentation and a discussion, a hearing today, certainly indicates the importance that you put towards safety and quality and it's greatly appreciated by us.

SENATOR DUANE: Thank you. And,

as you know, Assembly Member Gottfried, the chair of the Assembly Health Committee and I are really strong partners on this. So thank you also for that last comment.

If you can just address -- we may have to take a break from your testimony, and someone else may testify in the meantime, but I did want to ask one question before we do that, or if you think it's too complicated and you want to think about it.

Patient confidentiality. I'm assuming this is an issue that comes up time

and time again, and I'm wondering if you could tell us what the legal parameters are, what the philosophy is of the department as it applies to the various reporting systems.

DR. MORLEY: The issue of patient confidentiality overlaps a bit with this concept of transparency. So the patient confidentiality piece, in part because of HIPAA, but in part because of just our value system, is utmost in our minds at all times.

So we cannot and would not, and would not want to even think about disclosing patient level identifiers, and we make efforts at just about every turn, every

discussion, to assure that patient confidentiality is maintained at all times.

When you talk about transparency, I'm a significant proponent of transparency. That said, I'm also a believer in the need for balance in life. I don't know that it's possible to do surgery without a scalpel, and I don't know that it's going to be possible for us to make improvements in the system in quality and safety without a level

of transparency. But when you put the scalpel in the hand, you're careful at what you cut, and I think as we go forward with transparency, which, again, I believe in, I think we need to be careful what it is we're transparent about.

I think the easy part of transparency is to recognize that confidentiality of patient level information must be maintained. But beyond that, I think that we then have to ensure that information is accurate and understandable. Once we do that, when it's accurate and understandable, then, you know, my leaning is more -- transparency tends to be better. I think that that's going to evolve over

time. I think it would be a disaster if we overnight decided that we're going to take the covers off of everything.

Let's move forward with it like a surgeon moves with a scalpel, carefully, knowing what we're dissecting, knowing what you're showing, but then it continues. It's not something that's going to happen over

six months or a year. This will evolve and there will be more and more transparency over time.

SENATOR DUANE: I think that you make an excellent point in your testimony regarding the -- starting from the reporting is voluntary, and the range that could be included within hospital -- institutions that are aggressive about reporting, and those who are less aggressive about reportings, and how in a transparent system that may make them appear to the public.

So I actually wanted to ask you a little bit more about that. And now I'm just going to say, I know he's on a very tight time frame, I'm going to ask you if we can just take a break from your testimony for a moment as someone who has had a busy

schedule because of the time of year that it is, I'm just going to ask if you would indulge me in allowing the comptroller just to provide his testimony, and then I'm going to ask you to come up for a few more questions. And I apologize to everybody who

is waiting to testify and wants to be heard, but I actually think he has something of value to discuss and I know that we can't keep him here for a very long time because he's a very busy person on the go.

So I apologize and thank you for your cooperation. And don't go away. If I could ask Comptroller Thompson, if he's here, to come and testify. And, of course, now he's not here.

We'll acknowledge he is here. Thank you, Comptroller Thompson. Thank you and welcome. I know you're on a very tight timeframe, which I totally and completely and utterly appreciate. So welcome, if you need to take a breath, I'm happy to allow you to take even several breaths.

COMPTROLLER THOMPSON: Thank you, Senator. It's a pleasure. Good seeing you, Tom.

Mr. Chairman, members of the committee, let me thank you for the opportunity to speak today. A decade ago, a groundbreaking report by the Institute of

Medicine of the National Academies concluded that hospital medical errors were responsible for as many as 98,000 deaths in the United States annually. These errors were associated with $29 billion in extra costs.

In New York, NYPORTS, the New York State Patient Occurrence Reporting and Tracking System, is the most important tool government has for reducing the number of hospital medical errors and other adverse occurrences.

Through NYPORTS, hospitals are required by law to report specified categories of medical adverse occurrences to the State Department of Health. The department would analyze this data and use it to identify patient safety and quality issues at individual hospitals, which could lead to department intervention, and to prepare studies with risk reduction strategies for distribution to hospitals.

The Health Department has emphasized that accurate and complete

reporting of adverse occurrences is essential if NYPORTS is to accomplish its goal of improving quality of care and avoiding needless costs.

Without full reporting, hospitals lose a very important tool for identifying areas where systemic improvement may be needed and for comparing their performance against their peers.

However, a study released this March by my office, the high costs of weak compliance with the New York State hospital Adverse Event Reporting and Tracking System, found that underreporting is widespread.

We analyzed the numbers of reports hospitals submitted to the Health Department for adverse occurrences that occurred in 2004, 2005, 2006, and 2007. The reporting data was broken out by hospital and reporting category. We found enormous reporting disparities that can only be explained by systemic underreporting of adverse occurrences.

First, we found that the New York

City hospitals reported adverse occurrences at a rate approximately 40 percent lower than hospitals elsewhere in the state. This finding echoed the Health Department's own finding in 2001 that there were large regional disparities in occurrence reporting rates, with New York City hospitals reporting adverse occurrences at a lower rate than elsewhere.

The department concluded that this was due primarily to underreporting. Second, we discovered enormous inexplicable reporting rate disparities among individual hospitals. For example, measured in occurrences per 10,000 discharges, one of the smaller New York City hospitals reported occurrences at a rate 18 times higher than another similarly-sized hospital in the same borough.

One academic medical center located outside of the city reported occurrences at a rate eight times higher than a similarly sized New York City academic medical center. Some hospitals

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reported hundreds of adverse occurrences, while other similar-sized hospitals, only several dozen.

Third, we observed enormous disparities among hospitals in many of the individual reporting categories. For example, some hospitals reported acute pulmonary embolism at rates 30 times of other comparable hospitals.

When we asked Health Department staff why there was such large disparities among comparable hospital, we were told some hospitals are better reporters than others. We were assured that a hospital with a high reporting rate was not necessarily a bad hospital, it was just a good reporter.

Indeed, we identified one particular New York City academic medical center that had high reporting rates in multiple reporting categories. This hospital has been regularly listed among the nation's best in the annual U.S. News and World Report hospital rankings.

We also discover that medication

errors were virtually never reported. Hospitals are required to report medication errors that result in death, a near death event, or permanent patient harm. A major study by the Institute of Medicine concluded that 7,000 hospitals patients die from medication errors in the U.S. every year, and many times as many are injured.

Yet from 2004 to 2007, there were only 37 medication error reports by all New York City hospitals. 22 New York City hospitals did not report any medication errors during this period. I find that number incredible.

Our study concluded that underreporting is tacitly sanctioned by weak enforcement of the reporting law. The department is exhibited little appetite for enforcing reporting requirements despite the former commissioner's warning in 2001 to underreporting hospitals. His quote "we will identify you, single you out, and sanction you in a public forum."

According to a Health Department

response to our query, in 2008, only a handful of citations resulted from identification by the department of unreported occurrences. And a citation merely leads to a requirement for a hospital to submit a plan of correction.

Only if the plan of correction is inadequate, might a fine be imposed, and the actual fines are low. An absence of commitment by the department to NYPORTS was evidenced in 2005 when the department discontinued 22 of the then 54 reporting categories. And it is telling that the department has not issued a NYPORTS annual report since the report covering 2002 to 2004.

In mid 2008, we were told that the department was working on an update, but it still has not been issued. NYPORTS reporting compliance is important, not only because adverse occurrences harm patients, they also result in higher costs through longer hospital stays and additional medical treatment.

The excess cost when a patient develops a new deep vein thrombosis, for

example, has been estimated at more than $10,000. New York City taxpayers pick up some of these excess costs through Medicaid and government employee health plans.

There are also higher medical hospital malpractice insurance premiums and lawsuit payouts. The high reporting rates by some hospitals, they range from several small community hospitals to a few of the State's major academic medical centers, demonstrate that full reporting is indeed feasible.

In our discussions with executives of several these hospitals, we've learned that they have created a culture of full reporting and their staffs were extensively trained in NYPORTS reporting.

These hospitals understand that even a small reduction in adverse occurrences can avoid substantial excess costs. I urge the department to take NYPORTS seriously. The Health Department

should have a separate NYPORTS unit with its own staff. Medical audits and retrospective chart reviews to check for non-reporting should be implemented, focusing on hospitals

that have abnormally low reporting rates and on the most problematic reporting categories. There should be timely feedback to hospitals of comparative occurrence data. Penalties for non-reporting should be increased.

In 2001, the department said it would ask the state legislature to increase the fine for an initial violation from 2,000 to $6,000, and for a top fine of $60,000.

Fines were recently increased but still standard at only $2,000 for an initial violation, and a maximum of only $10,000 if serious physical harm resulted. Full reporting is essential for NYPORTS to work as intended and to be of practical benefit.

I understand that the state fiscal crisis severely constrains any new spending, but it has been well documented that reducing adverse occurrences in

hospitals saves money.

In the first few years after NYPORTS was established, the department did take the system more seriously. It analyzed reporting data and published the periodic NYPORTS alert focusing on selected reporting

categories and providing useful risk reduction strategies.

Hospitals reported that through NYPORTS they had discovered and remedied deficiencies. The initial promise of NYPORTS must be redeemed again.

SENATOR DUANE: Thank you very much, Comptroller Thompson, and thank you to you and your staff for your very thorough and thoughtful report.

COMPTROLLER THOMPSON: Senator, I would like to acknowledge Glenn Lenostidge (phonetic) from my office who was a great assistance in overseeing the preparation of our report.

SENATOR DUANE: I believe he used to work for the New York State Senate at one time, actually. Obviously much of what you

examined, the questions you raised, the criticisms you've made, the critiquing is -- all of which is being used for questions and what we're going to be exploring during this hearing, frankly, it's the basis for numerous questions.

Rather than keep you here and ask you the questions that you've already

raised, I'm sure that you'll have people here that'll hear the answers to the questions and they may lead to other questions, and we are -- would be very interested in continuing to work with your office on this, because I think we all share the goal of the best possible patient safety.

So thank you very much for your good work on this issue and we consider you a partner as we try to improve patient safety absolutely across the state and, of course, with you here in New York City.

COMPTROLLER THOMPSON: Mr. Chairman, let me thank you for your comments. Let me thank you for this hearing

also, and I'm sure that the people of this city and the people of this state thank you for the hearing also. It is in their best interests that you're investigating this. So, again, thank you so much, Senator.

SENATOR DUANE: You're welcome. And I think I'm -- I hope and I believe I'm also speaking for the Chair of the Health Committee, Assembly Member Gottfried. Thank you very much.

SENATOR DUANE: Thank you very much. If I could ask Dr. John Morley to come back. I hope he was willing to stay.

Thank you very much.

DR. MORLEY: I actually feel like I should know the answer to my next question. I forgot what we were talking about before. Oh, my goodness, I'm 54. So even if I was 24, that would be all right. What was I talking about? What was I asking you about? What was I asking him about? Oh, transparency, yes, okay. Patient confidentiality. I don't know that you were finished with your --

DR. MORLEY: Yes.

SENATOR DUANE: You were. I feel like I should know the answer to this and I don't. Tell me, is there, for lack of a better term, whistle-blower protection for non-sanctioned institutional reports made? Can they be made anonymously by staff members? Are they protected if they do so? Is it only through official channels, if you will, that reports are made and, if not, is there protection for the people that are maybe trying to do the right thing? And I

don't mean to imply -- well, I'll just leave it that way.

DR. MORLEY: There's two separate answers for that and the first and most important is, not being an attorney, I'm not sure what's in statute. I did recently discuss -- read about that very issue and, to the best of my knowledge, I don't know anything, but that's the question for the attorneys.

I can comment, though, that there are many institutions that certainly allow

anonymous reporting. There are -- but it's all at an institutional level. There were some events involving reporting in the state of Texas recently that has brought up the whole whistle blower protection issue related to adverse events and related to all sorts of things, but it's strictly at an institutional level, to the best of my knowledge, and it varies a bit across the state.

There are some employees that are told up front that anything that's going to go to the state is going to go through us. That said, if they go home and pick up the

phone, we answer the phone and they're quite free to talk to us, and we accept anonymous reporting on a daily basis. I mean, we frequently get anonymous reports coming in.

SENATOR DUANE: And not just from patient's families, but from employees of institutions?

DR. MORLEY: From staff, yes. Absolutely.

SENATOR DUANE: Well, I think

this is actually an area for us in the legislature to explore more in depth and we'll probably hear more about it. I'm sure we're going to hear more about it, but I just wanted to -- so that said, we'll, of course, be working with the department and the other stakeholders just to look a little bit more closely at that. And I have just a couple more questions.

Is one of the reporting areas the procedures that may not be necessary that it performed? I know that one of the things, wrong-side surgery, but is unnecessary surgery or unnecessary procedures part of the NYPORTS system?

DR. MORLEY: I regret that the

answer is not a clear yes/no. That's one of those things that's a definitional issue. There are cases that clearly do fall under that when the wrong patient has the surgery.

So if it's at that level of, it was inappropriate, very definitely if, you know, two patients are named Jones and they get mixed up in the operating room, one has

their gallbladder out and the other one has something else, that is a code 911, wrong patient having surgery.

There are other cases that I know make it into the news where the question comes up about this being inappropriate surgery. Then the question becomes more one of medical decision-making and you could find a team of surgeons that would disagree as to whether or not it was necessary. There are operations if somebody has appendicitis where it's pretty clear. All surgeons that agree that this is appendicitis, the appendix must come out. No discussion.

But there are patients who have other conditions that are less clear, for example, low back pain. There are surgeons

that believe that the more aggressive they are in terms of treating back pain, the better off patients are, and there are other surgeons that are much more conservative.

So, if the patient gets the aggressive surgeon, someone else may come

back to them later and say, you know, that really wasn't necessary, and that's debatable and there is no category for anything like that. If they agreed to back surgery and that's what they got, that's not something that's reported to NYPORTS.

SENATOR DUANE: And I just want to go to back to transparency for this next question.

How is it decided what is put in the public realm, and are the limitations to that -- and what informs what is and isn't -- what the limitations are for that, what can we do better in terms of informing the public and providing an opportunity to improve patient safety through the public disclosure?

DR. MORLEY: The first answer to that is the first level of answer and that is what's written in statute. So when

somebody created the Healthcare Acquired Infection Reporting System through statute in there, it's identified specifically that there'll be an anonymous report the first

year, and that's what happened a year and a half ago. A report was generated. Hospital X had A results, hospital Y had B results, hospital C, and the following year --

SENATOR DUANE: But what is reported and what is made public as a floor? So help me to understand what is in statute would be the floor, yes?

DR. MORLEY: Yes.

SENATOR DUANE: The next --

DR. MORLEY: The next level up, we do have debates on a surprisingly regular basis.

SENATOR DUANE: I am not surprised at all.

DR. MORLEY: About what we can put in, not just about what we should put in, but what we can put in. There are issues that come up fairly frequently about, is this a data set that will allow identification.

You know, there was an event that

occurred in New York City Hospital about seven years ago where someone had cardiac

surgery. There was a very prominent individual who had, you know, cardiac surgery in a New York City Hospital. It's possible that somebody would get all sorts of information about that individual if there was one thing that made him stand out in the data set. So if we released information about patients that were 48 years of age and/or included their birth date or those kinds of things, so we're looking at every level of detail that we provide including things like zip code and other information as to what we can provide so that patients aren't identified.

So that HIPAA piece is probably the next thing that comes up. Are we able to do this? And is there anything in statute that would prevent us from doing this? And the third level and final level of discussion is, is this something that's going to benefit the public? There's large amounts of information we could release that would serve to confuse further than what the situation is that currently exists.

So we discuss, is this going to be information that'll be helpful to the public? Information on reporting I think the public has been confused on related to NYPORTS. You know, the issues I discussed before, is this a hospital that's just very aggressive about reporting everything? Now, our cardiac database is verified six ways from Sunday. It is the gold standard in the world in terms of verification of accuracy of data. It's still not perfect, but we go through additional verification processes with that database above and beyond any other.

So we have a high confidence level in this clinical database reporting. Without that kind of verification, you know, we are concerned about the accuracy of information that's provided to the public and whether or not it will help them with their decision making.

SENATOR DUANE: And, so, if some hospitals are high reporters of adverse events and others are low reporters, which

is -- we want as much data, you know, as possible to improve patient safety, what do you think accounts for that and why is there such a wide range and what can we do to improve low reporting?

DR. MORLEY: How much time have you got? That's a good question, a very good question, but with a very lengthy answer that I'll try to keep short.

So I think, going back to what I said before about culture, culture is changing. There isn't any doubt in my mind that it's changing, but it's changing around the state and around the country at different levels. I think that there's a few institutions in the state that have put up much more information on their own individual websites than anybody has required them to do. I think that's fantastic. Those are the leading -- I don't know that I would identify a leading institution in 2009 the way it was identified in 1960 or '70 or '80.

The leaders in this are the ones

that are making those kinds of changes and we see those around. We also see the followers that are struggling, and I think the leading institutions have some of the brightest minds. And I don't mean just the brightest mind that they got the understanding of anatomy and physiology and pharmacology and they're doing the research. They appreciate what the needs of society are and they make the changes so that, you know, they're at the forefront of, here's what society needs, here's what society wants, and we're going to give it to them.

Not everyone is able to do that. There's still people who believe that quality and safety -- and I hate to say this, but I do honestly believe there are people that believe it's a fad. That, oh, I can't wait until this goes away. It's not going away, it's only going to get, from their perspective, worse. We're going to get more transparent. We're going to have more data sets. We're going to have better information as we evolve. And I do think

that ultimately everyone will end up having

to do more of this, but right now we're just seeing early adopters or leading institutions that are doing it.

And finances -- let me be honest and blunt about this. Finances play a significant role in this, because the institutions that have the resources to be able to dedicate towards quality improvement are doing it, and they're doing a great job.

I do honestly -- something that concerns me is that not every institution has those resources, so where some are improving, others less so. They're a little slower to adapt. I think there's a number of great collaboratives that have worked in this state. Those collaboratives have made a significant difference, very significant in terms of reducing things like ventilator associated pneumonia, central line infections, obstetric care, prenatal care. There's a number of those different types of projects that hospitals are cooperating with, and when they cooperate, great things

are happening. But many of those things are also voluntary, and so the ones that are doing a decent job and have the resources to

commit, are doing better.

SENATOR DUANE: I think that we would look forward to the members of my committee and the members of the Assembly Committee, both sides of the aisle, both houses, on collaboration between institutions and the Department of Health and also for lack of a better term, carrots and sticks, to try and improve that as well.

And I do consider the Department of Health a partner in that and, of course, we'll work with the other institutions because it's in everyone's best interests obviously.

And I was going to ask you earlier on if you thought that the NYPORTS system was worth saving, and I'm assuming now that the answer would be yes, you wouldn't throw it out and start a new system, correct?

DR. MORLEY: Absolutely correct.

Unequivocal, yes. I think it does need to evolve and to change, but there's no way I would even consider throwing it out and starting over.

SENATOR DUANE: And I want to

make sure that you strongly believe that we are in a better place now then we have been, and that we --

DR. MORLEY: We're making slow advances, and I share as I said in my comments, I share the frustration of the public, and you share the frustration with anyone and everyone in this state that actually is involved in quality improvement and safety.

You know, the collaboratives that are being run by the folks at Greater New York and HANYS and Northern Metropolitan and Iroquois, those are doing some great things, but all of the folks in quality are really the ones that are pushing to have this happen. And they've got some great organizations to work with, but cooperation is not 100 percent. Not everybody is

jumping on board on this for a number of different reasons.

SENATOR DUANE: All right. I just want to make sure, do you think -- I know he's going to come back in a little bit, but I want to make sure that the assembly member's questions have been

adequately -- and, if not, that they would be or that we would look forward to doing it in other venues.

MR. CONTI: I think we got a lot of answers and I do have one quick question, the status of your annual report.

DR. MORLEY: Unfortunately, the answer is, as has been said for several months, we are continuing to work on it. We're made revisions, very significant revisions. I would fully hope that we would have this published before the end of 2009. That's our goal. That's our plan. That's what we're working on. I believe that the significant revisions that have had to be done are all done. So we should then have it out --

MS. LESLIE: Very shortly. And then the next one on its heels.

SENATOR DUANE: We would look forward to that and we -- I don't want to say we would more or less demand that with love and affection, but --

DR. MORLEY: Appreciate that, yes.

MR. CONTI: Is there a problem

even with putting it out as a work in progress if there is a delay beyond very shortly --

DR. MORLEY: I don't know the answer to that, but we're going to first work towards getting it out without any disqualifiers but, if we can't, I will ask the commissioner, we'll see what we can do about that.

SENATOR DUANE: A big asterisk that says "work in progress" or we would, I think -- we would like to see it, I think the public would like to see it. So, if we could make that an option first, of course, very soon, that would be great but, if not,

at least very soon, the work in progress.

DR. MORLEY: Okay, yes.

SENATOR DUANE: Thank you very much. Thank you. Art Levin, the Director of the Center for Medical Consumers.

I just want to make sure, from the Senate side, Denise Soffel, who I know you know, who is the executive director, Brian O'Malley, who has come all the way from Albany to be here with us and he's got a new baby and everything. So give him a

medal. You know Mr. Conti, of course.

MR. LEVIN: So thank you for having this hearing and inviting me today. I have not submitted written remarks and I just want to tell you why. I think in the next month or so, working with my colleagues, particularly Blaire Horner (phonetic) at New York Public Interest Research Group, Chuck Bell at Consumers Union, and hopefully Bill Ferris at AARP, we'll be working on yet another one of our reports that we'll try to outline what we think needs to happen in detail in New York

State to deal with these issues.

So we've heard a lot about the IOM report. I had the distinct privilege and pleasure to be a member of the committee on the Quality of Healthcare in America that wrote that report, and about a year and a half later published "Crossing the Quality Chasm," which described what a 24th Century safe high quality healthcare system should look like.

These reports were followed by a number of others in what became known as the IOM quality chasm series, all of which made

a wide range of recommendations about what is need to address this arguably worrisome crisis of confidence in the safety and quality of healthcare in the U.S.

"To Err is Human" admonished all of us about the need to act urgently to address patient safety. And we have to remember these words were written a decade ago. And "the status quo is not acceptable and cannot be tolerated any longer." Despite the cost pressures, liability

constraints, resistance to change, and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same healthcare system that is supposed to offer healing and comfort. First Do No Harm is an often quoted term from Hippocrates. Everyone working in healthcare is familiar with the term. At a very minimum, the health system needs to offer that assurance and security to the public.

I'm here to suggest that unfortunately it appears to me, in my experience, as if the status quo has too often been tolerated over the past decade.

In the wake of the IOM report at a meeting, I believe, convened by the Greater New York Hospital Association, discussed the report's implications for New York Hospital. The then Commissioner of Health pledged that New York would meet the IOM's challenge goal of cutting medical errors in half by the year 2005.

So we're here today five years

after that pledge due date has passed, 10 years after the IOM report was first released, and I believe we're unable to reassure New Yorkers that they are any safer today when they go into a hospital than they were in years passed.

We're unable to provide that assurance and security despite the fact that there's lot of energy and resources and good work being invested by healthcare providers and professionals in trying to make patients safer. Why is that? Why do we find ourselves unable to even estimate how safe or unsafe healthcare is in our state? And I'd suggest it's because we have, over the years, shortchanged patient safety surveillance, and error, and infection

prevention. And by short changed, I don't mean just in dollars. But also, in how we, as a community, appear to value or, I would submit, not to value, the deaths and injuries caused by preventable mistakes, whether the result of system failures or incompetence that occur too often in our

healthcare system.

And I think here I'm pointing fingers at all of us and I'm talking about a culture which seems to, you know, to cry what goes on in terms of the cost in human terms and monetary terms in error and other failures in the healthcare system, but I would suggest just simply doesn't react with enough strength to deal with the problem.

So, again, a reminder that the IOM said that it's simply not acceptable for patients to be harmed by the same healthcare that is supposed to offer healing and comfort.

We respond differently to other epidemics. Look what's going to H1N1. We respond differently to other diseases. The war on cancer, tens of billions of dollars invested. And we respond differently even

in the case of disease and conditions that exact a far smaller toll on members of our community than errors and infections, preventable infections.

So I think we have a crisis of

culture here. We spend billions of dollars to find the cure for a wide range of diseases and conditions, but pennies on preventing the iatrogenic harm.

And frankly I think we're all to blame. I've yet to see a 10K run dedicated to raising money so we can stamp out medical errors or healthcare associated infections.

So I think all of us who gather here today need to think about the following question; has the state, our healthcare system, providers, professionals, even public advocates like myself, patients, families, and caregivers, despite IOM's admonition, been too accepting of the inevitability of preventable harm, and have we been bowed to the seemingly insurmountable obstacles to improving patient safety?

While failing to prioritize a prevention of harm to those using the

healthcare system, we've also failed to build a functioning, reliable system to track such events, let alone stop them.

We can't track medical mistakes. We cannot know what exactly they are and what their cause may be. We cannot know if any progress is being made in reducing their frequency or severity. If we cannot track our progress, we cannot know with certainty which safety inventions work best -- excuse me, which safety interventions work best to make patients safer, and which, despite all good hypotheses and intentions, don't work.

In other words, we're unable, because we lack the necessary evidence to assure patients in New York's healthcare system that they are safer than they were 10 years ago.

Now, New York State's Medicaid expenditures are currently about 46, 47 billion dollars. It's easy to imagine that state employee related healthcare benefits add another few billion.

So the state's direct purchase of healthcare services approaches the $50 billion mark annually. It's the biggest

buyer purchaser of healthcare in the state.

I would submit that the state has a fiduciary responsibility to spend the taxpayer's billions prudently. It cannot be a prudent act to purchase unsafe, poor quality healthcare, and we know from the literature that poor quality and unsafe care is costly, both in economic terms, in New York State that would be hundreds of millions of dollars, and in human terms, in New York State, that would be thousands of lives.

When economic times are hard we historically attack healthcare costs and inflation with a blunt instrument. For example, by reducing reimbursements of payments across the board. All are punished equally whether or not they're providing services of high value, or services that have no value because they're unsafe or of substandard quality.

It is short-sided on the failure of the state's fiduciary responsibility to not differentiate based on safety, quality, and efficiency of a provider's performance.

In times of economic stress like the present, it would seem to me to be even more important for the state to be the prudent purchasers, the accountable fiduciary, and not waste scarce resources on sub par, unsafe healthcare. So what's it worth to the state to invest in safety and quality? One percent? 10th of a percent? 200th of a percent of their total purchase dollars? Even the latter would produce almost $10 million in new funds for patient safety, which is more than double of what I calculate we're investing now. A 200 percent plus increase in resources might demonstrate a renewed commitment to reducing preventable harm for medical mistakes and poor infection control practices.

There are over 2,600,000 hospital discharges each year in New York State. A small per discharge assessment could provide a considerable new investment in patient safety.

As an example, Pennsylvania's patient safety authority is permitted to

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assess up to $6,000,000 per year to fund its activities. Those funds are collected by the Department of Health and transferred into a patient safety trust fund. The funding is based on a per hospital bed levy which has been capped at six million and then gets adjusted for inflation.

Now I'm not alone in arguing that the keystone to successful programs is funding. Consider this from a private communication with an authority, Pennsylvania authority manager, "My own opinion is that funding is critical with most programs suffering from being unfunded or underfunded. Even large sums of money are justified by just a few lives saved."

So I respectfully suggest that New York's lack of attention to patient safety is not only a violation of its fiduciary responsibility, but an ethical failure as well.

There's something distasteful about knowing bad things are happening to patients, knowing that many of those things

are preventable, having the knowledge to prevent them, and yet not doing so.

If I have time, I'll very quickly switch to my experience with NYPORTS and spend a little time on that subject.

So in terms of this funding issue, it's my understanding that over the years, NYPORTS has received less than $700,000 in annual funds at least in the recent past.

For a number of years, a substantial amount of those funds were used to contract with the SUNY School of Public Health for data analysis because the program had no internal capacity to do its own data analysis. Part of that analysis included periodic efforts to validate the accuracy of reporting in the NYPORTS by using SPARCS data as an audit trail.

That analysis found over and over again unexplainable divergence in the number of reported events for selected codes between NYPORTS and the comparable fields in the SPARCS database. Attempts to reconcile

these two data sets were never very

productive. In recent years, it's my understanding that almost all the funds were used to upgrade a web-based reporting system to replace a sort of old, antiquated non-web-based reporting system.

So we're not talking about a lot of money and most of it is going to outside contractors. Now I'm not certain whether in this economic climate the NYPORTS budget is the same or it's been reduced. In my years working on the statewide work group, my observation was that senior management staff was assigned their NYPORT responsibilities as an extra curricula activity. Most of them had other important responsibilities which were their full-time job titles and they worked on NYPORTS sort of out of their hip pocket without full time the ability to be full time. I'd suggest that that sent a message to everyone that NYPORTS was not a very valued program. It had really no senior staff its own and it had this very low level of funding.

However, I will say that in working on the NYPORTS iteration from its beginning, that I think it evolved actually

into a very thoughtfully work-through and potentially useful way of having standardized reporting. I think the value it may have had and it had, as people have pointed out, more value perhaps in its first years when it was more proactive, has dissipated as a result of dwindling support. The program, as I said, never had in house analytic capacity until the arrival of Dr. Morley, no clinical experience to rely on either, except as provided by the professional and clinical members of the statewide work group.

I think we know that the state and city controllers and news reports have raised questions about the integrity of the NYPORTS program. Within NYPORTS and the DOH, there were concerns always about the accuracy and completeness that NYPORTS received, the reports received from hospitals.

We've heard about the effort in 2001 to sort of use a tracer element unexpected death within 48 hours. Not a very subjective issue. You know, people are either dead or alive. I guess sort of the

unexpected is the subjective part of that as a tracer element to try to see how accurate reporting was and, frankly, what came up was the reporting was highly inaccurate and highly variable. It is true as the comptroller's report mentions that when the commissioner reminded hospitals throughout the state of their obligations to report that particular code, the reporting increased dramatically. So that we know it can be done if people want to do it.

As has also been said, it's unclear when you are not confident in the accuracy and completeness of reporting, what the numbers mean. Is it good reporter, good hospital; good reporter, bad hospital; bad hospital, bad reporter; bad hospital, good reporter. We just don't know what it means. And that's unfair to everybody. So even if

we make that data public, what does it mean to anybody? It doesn't mean anything. I think we have an obligation to the hospital and other providers in New York State.

One of the things that may made very clear and they participated with great energy in this process of developing the

NYPORTS iteration is that they wanted to get meaningful data back from this system that would help them to compare themselves to peers and to make improvements internally.

I think the accuracy and completeness is very much an issue for them. So I think we owe it to hospitals in the state to have a level playing field, to be able to say that whatever we take into NYPORTS, and whatever we perform analytics on in NYPORTS, represents the true picture of what's going on in the hospital.

The playing field has to be level for everyone so that the hospitals that do invest in being good reporters and that means they are serious about their own quality improvement, are not harmed by

looking like they're outliers on the bad side because they have high numbers, and the hospitals that don't invest shouldn't sort of get a free pass, because they look like they're good hospitals, because their numbers are low.

The data that goes into the system has to be complete because it's the only way we're going to be able to use that

data to make improvements. If you ask me, should NYPORTS be scrapped or saved, I would say it shouldn't be scrapped. There's a lot of good work that's gone into it.

I think it needs to be refocused. I think probably the greatest value that we can get from NYPORTS is to -- we already know from NYPORTS and other literature that what the sort of big ticket items are in terms of where we can make improvement where the frequency, the severity or the cost of not doing the right thing, is significant.

I think we could use NYPORTS to target one or two important things a year or every two years that we're going to really

have an all out effort to make better in New York State, to have patient outcomes better, to have their care safer. To be able to track that on a regular, almost real-time basis, and to continue to sort of push in that direction so at the end of a period of time, we can really say, have we or have we not made this better for patients in New York? Have we made the system safer?

I think we need to collect a wide array of data, but I think the focus needs

to be much more granular in picking and choosing things carefully that are the utmost importance for improvement. Working on those. Hopefully makes those improvements and moving on to the next step. So I think NYPORTS is a good basis. I think we have a system that suffers greatly from the lack of commitment on the part of all of us to funding and re-sourcing it adequately to do its job.

If we value this program then we have to put our money and our resources where are mouths are. I'll stop there.

SENATOR DUANE: Thank you, Mr. Levin. I would have to say, the questions that I had had for you you answered. I would be remiss if I didn't tell you that in our office, you are a rock star. So, you know, I know you'll continue to be available to us as we try to improve patient safety, improve reform, NYPORTS, and I also very much appreciate your comments about the level playing field and, really, I could go on and on, but in our office, you are a rock star.

MR. LEVIN: I only wish I had the

salary that's commensurate with that.

SENATOR DUANE: So do I. For you, for you.

MR. CONTI: I don't have any questions for Mr. Levin.

MR. LEVIN: As I said, we will hopefully be working with you to work on specific recommendations with the legislative agenda in mind. Thank you.

SENATOR DUANE: Absolutely. Thank you very very much.

We have slightly out of order, our next testifiers, the former Lieutenant Governor, and now the Chair of the Committee to Reduce Infectious Deaths, Betsy McCaughey.

MS. McCAUGHEY: Thank you. I'm very glad to be here today. Thank you for your interest in this very important topic. I'm going to focus my comments on one specific bacterium, Clostridium difficile and, the reason is, I would like to urge the members of the assembly and the State Health Department to add Clostridium difficile to the reportable infections in what will now be our annual hospital infection reporting.

And also to improve efforts to educate healthcare workers on how to prevent patients from contracting Clostridium difficile.

Let me tell you a few things about it. It's not so much of a household name as MRSA or VRE. This is one of the newer bugs. It's been around for a long time but it's suddenly posing a much graver

threat to patients throughout the United states and Canada.

This hyper virulent strain that has entered North America in the last 10 years and is now growing rapidly, really raging through hospitals here, it's the same hyper virulent strain that killed more people in England last year than MRSA.

Last year about 300,000 Americans contracted C.diff or Clostridium difficile. We don't have numbers for New York State. What is this? Well, it's a gram positive infection and this bacterium has a hard shell so it's in a spore. That's going to be important to know in just a second.

About five percent of people carry C.diff in their gastrointestinal

systems normally. But it doesn't cause a problem because the other bacteria in you GI tract keep the C.diff under control.

But the story changes when you're in a hospital. Because in a hospital, many patients are taking antibiotics, and the antibiotics kill the good germs, or good

flora and allows the C.diff to rage out of control. When that happens, C.diff causes deadly deadly diarrhea. It the out of control nature of the diarrhea that makes C.diff so hard to control in a hospital because it gets on virtually every surface; nurses' uniforms, bed rails, wheelchairs, IV poles, over-the-bed tables, literally everything. And then here's what happens. A patient whose in his or her own room, reaches over and just touches the bed table or the bed rail, not seeing these very small C.diff spores and then the C.diff spores get on their hands, and then a few minutes later they may touch their lips and ingest the spores. Or their meal tray is delivered and, without cleaning their hands, they pick up the roll or their sandwich and they eat it and swallow these spores along with their

food.

That's why cleaning is the essential feature, essential strategy to protect patients from C.diff. Because the invisible spores are virtually on everything

in a hospital once C.diff becomes present there. Just to give you a few examples, I was doing gram rounds at Thomas Jefferson Hospital in Philadelphia recently and the infection control officer put up a slide of one patient room. Three consecutive patients were admitted to that room. All three contracted C.diff, one died. Out at Intermountain Health Center in Provo, Utah, eight infants in the neonatal intensive care unit contracted C.diff. It was traced back to three bassinets in one corner of the NICU that had been inadequately cleaned.

When I say "cleaning is essential," it requires a more rigorous strategy than has been used in the past. For example, researcher at Case Western Reserve in the Cleveland VA found that after rooms are terminally cleaned, that is deemed ready for the next patient to be admitted to that room, 78 percent of the surfaces still

had C.diff on them. But when the researchers worked with the cleaning staff to use bleach and to drench and wait, rather

than the quick spray and wipe, they were able to reduce that contamination level to one percent. So rigorous cleaning is one of the most important things that can be done to prevent patients from ingesting those spores.

It's also really important to educate hospital personnel about C.diff because, believe it or not, doctors and nurses and other healthcare workers who have been in the field for a decade or more, know very little about Clostridium difficile, since it's one of the newer villains on the scene.

The result is that recent studies have shown that at about a third or more of healthcare professionals don't know that cleaning with alcohol based hand sanitizers won't remove C.diff spores from your hands. You have to literally use soap and water and wash them down the drain.

They also were unaware of how patients are contracting C.diff. Most

healthcare workers will tell you,

antibiotics cause C.diff. Well, they really don't. They make a patient vulnerable to it, but if the patient doesn't ingest those spores, they're not going to get C.diff.

In 95 percent of cases, patients are giving it to themselves by touching the contaminated surfaces in the hospital and then allowing the spore to reach their mouths. That's why the cleaning is so important.

One study shows, for example, that a third of the blood pressure cuffs that are moved from room to room and wrapped around one patients bare room after another have C.diff spores on the inside of them.

It's a quick trip from the patient's arm to the patient's fingertips and then into the patient's mouth. So, as I said before, I'm here to urge you to consider three things. One is, because of the importance of C.diff as a threat to patient safety, adding it to the list of reportable infections. It's particularly important to do so because the correlation

between adequate hygiene and rigorous environmental cleaning, and the rate of C.diff, the incidence of C.diff in a hospital is compelling. There is study after study now to show that when hospitals undertake very rigorous cleaning of patients's rooms, they can bring the C.diff rate way down.

For example, Carlene Mutow, at the University of Pittsburgh Presbyterian reduced C.diff associated diarrhea 89 percent through a strategy that featured rigorous cleaning of patient's rooms with bleach.

Secondly, we need to educate doctors and nurses and healthcare workers in New York State. I know that every two years healthcare workers and physicians are required to undergo a course provided by New York State and pass the test. But it doesn't feature the knowledge we know about C.diff. And, as a result, if you stand in a hospital for even one evening, you'll see that there is total lack of awareness of how

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patients are getting C.diff. Nurses aren't warning patients, don't put that cookie on the over-the-bed table and eat it because you'll be eating the C.diff spores along with the cookie.

So we need to improve education and testing of healthcare workers in New York State to reflect this new knowledge. I'm going to show you just two tools, three tools here. One is a card that we've had printed for hospitals and distributed free of charge. It's a little tent card. It's in English on one side and, in this case, Spanish on the other side, but we can print it in any language, and it says, "please clean your hands before enjoying this meal and avoid placing your food or utensils on any surface except your plate." We need to help patients understand that they're giving C.diff to themselves in 95 percent of cases because they're unaware of how they get it, that's it's on the surfaces all around their bed.

Secondly, we have a cleaning card

here that we've created that digests and translates into simple language the steps that are necessary to adequately clean a hospital room. It's, again, in English on one side, in this case Spanish on the other. But we have them in Korean and other languages too.

And, thirdly, we have a 15 step brochure that patients -- that explains to patients, educates patients on how to protect themselves from hospital infection and one of the most critical steps in there is alerting patients, clean your hands before eating, and avoid putting your food on any surface except your plate.

So I hope this is a helpful reminder to everyone in New York State in the Health Department and in the New York State Assembly that with some simple additional steps, we can protect patients in the hospital in New York from this growing threat, Clostridium difficile. Thank you.

SENATOR DUANE: Thank you very much. It's very nice to see you. Your

dedication and good work and your missionary-like zeal on this issue is very

much appreciated. So thank you for making the time and coming here, and you've given us -- I don't want to say food for thought, but you've given us some good information so when we work with the institutions, we can improve patient safety. So thank you very much for that.

DR. McCAUGHEY: You're welcome. Especially the reporting issue.

SENATOR DUANE: Our next speaker is Kathleen Ciccone, the executive director, Quality Institute, Healthcare Association of New York State. Welcome.

MS. CICCONE: Thank you very much. We appreciate the opportunity to be here, Chairman Duane and staff members.

My name is Kathy Ciccone. I am the executive director for the Quality Institute at the Healthcare Association of New York State. And with me is Dr. Robert Panzer. Dr. Panzer serves in many roles. He'schief quality officer, associate vice

President of Patient Care Quality and Safety, and Professor of Medicine of Community and Preventative Medicine at University of Rochester.

Also, in pertinent to these discussions today, Dr. Panzer was the chairperson of the NYPORTS Advisory Committee for the Department of Health and served in that role for many years.

I have submitted written testimony on behalf the association and our members. But my comments are more abbreviated and I'd be glad to respond to any questions that you may have during that discussion. But I'd also like to point out that what you'll hear in terms of our written -- of our comments, many of them overlap with those made by previous speakers, in particular, I would say Dr. John Morley and Mr. Art Levin, two individuals that we've worked very closely with on many of our efforts to improve quality and patient safety.

My comments really fall into two

major categories. First and foremost, I do want to underline the commitment of New York State healthcare organizations to quality improvement and meeting the expectations for the reporting of quality data. Most importantly, for using that information to

improve care for patients.

And, second, I'd also like to share a series of recommendations that we believe will enhance NYPORTS as a system for quality and patient safety and lead to improved patient care. These recommendations fall into three areas, one is alignment and integration of various quality reporting databases, similar to what Senator Duane referenced earlier, and in your comments with Dr. Morley.

Second of all, focusing on some of the reporting efforts and that is consistent with what Art Levin was talking about, and then also improving the capabilities of NYPORTS to better disseminate its best practice learnings to healthcare organizations throughout the

state.

You know, I would like to start off by saying, there have been tremendous advancements in New York State healthcare organizations with regard to quality and patient safety since the IOM report.

Hospitals have significantly improved their culture and really focused on

improving quality and patient safety from the board level on down. Hospitals in New York State have undertaken very important steps to implement practices that support clinical improvement in patient safety.

Every hospital has a rigorous program in place that supports organization-wide quality and patient-safety programs. The process begins with the board of trustees and it cascades across the organization, but despite these efforts, adverse events, although rare, they do occur. And these events are tragic for patients, for family and for caregivers.

When they do occur, New York Hospitals undertake a variety of strategies

to begin -- that begin with taking care of the patient and supporting the patient and his or her family rectifying harm that was caused whenever that's possible.

Organizations also undertake a rigorous investigation to identify the cause if there's an error or accident and implement strategies to prevent that reoccurrence. This is called a root cause analysis in many cases, which is really a

very in-depth complex process of review and evaluation that involves multiple caregivers, experts both within and outside an organization.

In addition to conducting a root cause analysis, hospitals also report to the State Department of Health via NYPORTS. But NYPORTS is really only one piece of what is a much broader performance improvement program in which hospitals are engaged.

SENATOR DUANE: This is a question we were going to ask you, so --

MS. CICCONE: Which is?

SENATOR DUANE: What are the

others?

MS. CICCONE: We'd be happy to talk about that. In fact, in addition to our written testimony, in one of the handouts there's actually something that's called the "Pinnacle Award" for quality and patient safety. That's just one publication that the association put out every year and begins to highlight a number of the excellent strategies and programs that hospitals have in place right now for quality improvement.

At the association level, we've been involved in a number of collaboratives and partnerships with the Department of Health, with CMS, with experts across the country such as the Institute For Healthcare Improvement, with the American Hospital Association, and, locally, with experts in each area.

And I think that Dr. Morley talked about the Ventilator-Associated Pneumonia Program which was supported by the Department of Health and we conducted, we

saw significant improvements in that. HANYS has also served as a statewide node for the Institute for Healthcare Improvement both in the 500 Lives Campaign and the Five Million Lives Campaign.

Nearly every hospital in the state agreed to participate in that initiative and to adopt the strategies for improving care that were part of the menu of different options that were available.

So hospitals -- and at the regional level, I know that Lorraine Ryan from Greater New York is going to talk about their many initiatives and collaboratives,

and every other region also can talk about that because hospitals are engaged in a whole series of collaboratives.

Also attached to the written testimony you might see a document that shows a number of different reporting programs. That document really is intended just to illustrate the many many public reporting and hospital reporting initiatives that occur in New York State.

Hospitals really need to report information to a whole variety of organizations and, sometimes that information is inconsistent, there aren't uniform standard definitions, there's not consistent reporting requirements and that leads to some confusion, frankly, in some of the work that's being done.

But I'd also like to talk a little bit about NYPORTS and how well it's working and without really wanting to date myself, I will say that I've been at the association for quite a while, and was there when NYPORTS was first initiated. So the association has worked well with the support of our board of trustees with the Department

of Health to really work on developing, implementing and refining NYPORTS across many years.

But when it was first instituted, NYPORTS was really considered to be a very innovative improvement effort and, unfortunately, and over time, as the system became more robust, hospitals really were

able to look to NYPORTS to obtain information about how they might be able to better improve their care and to have comparative data with respect to their peers. And the program served a dual role, and the dual role is one informing the Department of Health when adverse events occur.

And, secondly, it served the role of supporting quality improvement efforts. But the environment has changed. A whole host of other reporting programs are in place right now and there's been a proliferation of those at both the state and federal level that includes the CMS, Hospital Quality Reporting Program, also known as Core Measures, it includes the New York State Department of Health Infection

Reporting Program, HANYS, Greater New York, Medical Consumers, and other groups, worked with the Department of Health and the legislature to craft that legislation. There's a hospital acquired condition program which is in place through CMS and

also through the Department of Health. There's the AHRQ quality indicators, and there are any number of registries that hospitals use for reporting and obtaining information about best practices.

Since that time, when NYPORTS first initiated, there's also been a number of significant advancements in electronic registries and information that is available via that.

For example, we have hospital information technology, we have electronic medical records in many organizations, and there is the ability to draw from some of the administrative databases some information.

For example, the hospital acquired conditions are identified by CMS through administrative data reviews. And unfortunately, although there are many

requirements at the state and the federal level, as I said before, they're fragmented. Lacking some uniform and standardized framework, the efforts provide inconsistent

definitions in reporting methods, and the inconsistencies and the silo approaches really serve to undermine many of the quality improvement work that is being done in organizations. It causes a lot of rework because we're diverting scarce resources towards additional reporting, the inconsistency results in confusion, not just for the healthcare organizations but also for the public who obtain or are given much of this information for the Department of Health because it's unable to really take advantage of other databases that are available with respect to integrating that information and to share in the learning and the analysis that had been conducted even through other state registry or databases as well as across the country.

Frankly, you know, it is our opinion that the department has not had sufficient resources to analyze the data that is obtained through NYPORTS and then to

develop best practices to improve care across the state. And, unfortunately, what

has happened over time is NYPORTS has transitioned from its role with respect to a dual role of reporting and improvement to one really around simply reporting.

And from our view, we think it's really important to point out that reporting is only valuable when it leads to improvement. And NYPORTS is most powerful when we can use it to improve the systems of care because reporting itself doesn't have any intrinsic value.

New York State hospitals support reporting adverse events but they are frustrated by the lack of meaningful information that has been able to be coming back from NYPORTS and that can be used to improve care and promote patient safety.

We believe that NYPORTS needs to be redesigned. So to answer your question do we think that NYPORTS should be scrapped or improved, we think that NYPORTS needs to be improved so that it can become an efficient reporting system for improving quality of care.

Our recommendations primarily fall into the following areas:

First and foremost, New York State hospitals really do support event reporting and understand that enhancing patient safety must be a shared responsibility of healthcare organizations, providers, and the state.

We need to develop the next generation of NYPORTS programs to achieve the goal of efficient reporting. NYPORTS needs to be a tool for patient safety and, to this end, HANY 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 system must be able to document the impact of serious adverse events, monitor trends, evaluate the effectiveness of prevention efforts. HANYS recommends that a formal and regular feedback mechanism be put in place to communicate lessons learned in the field.

These goals will only be met if the state is able to make a commitment to adequately fund the program.

Measures reportable to NYPORTS should be aligned with other national reporting definitions and methodologies. The growing demands for data place an enormous strain on this entire healthcare system. Standardized definitions in reporting will not only reduce duplicative and misaligned reporting obligations, but they'll also result in more accurate and consistent reporting whenever possible.

The Department of Health could streamline the NYPORTS program to focus its efforts on a more defined set of quality measures thereby enabling it to use the data collected to reduce errors and improve quality. When possible, the NYPORTS reporting category should be defined using such currently reporting requirements as the CMS hospital associated conditions.

Standardized definitions will reduce the duplicative and misaligned

reporting, and the information will result in more accurate and complete reporting as well as well as increased opportunities to improve patient care.

With that, I'd like to turn it over to Dr. Panzer to talk a little bit about his role at the hospital and in terms of being patient safety officer, but also his role and experience with the Department of Health as the Chairman of the Committee for NYPORTS.

SENATOR DUANE: Welcome. And we actually had you down as a separate testifier witness, but I'm happy you're part of this panel. I'm sorry I didn't identify you in advance, but welcome and thank you.

DR. PANZER: Thank you. It's a pleasure to be here in both the roles Kathy mentioned as chief quality officer of the medical center and hospital, chair of the NYPORTS Council for I think about a decade.

And recently I was a patient in my own hospital, so all the things you've talked about, about infection prevention and

things like that are very real.

I thought I'd comment a bit about the history and evolution of the system, to not duplicate what others have talked about, and I go back to 1994 when we had an event reporting system. It was called PETS, Patient Event Tracking System, it was in its second iteration, and a lot of hospitals were reporting, writing what I'd like to call essays about events that occurred very often about events that were neither preventable nor in a category where one could have an effort to improve the care.

A number of us were contacted by the then deputy commissioner of the department, Dr. Sue, in late 1994 and asked to work on a re-design of the system, and I still recall the conversation because it basically went like this, why are you asking me, I don't believe in incident reporting as an important part or experience with the PET systems is that it's not all that useful. We know we need to do it, but it's not all that useful, and our staff don't find it

useful, and he said, that's the point. We want to make it better. And so I said, be

happy to participate, and I think the other hospital representatives did, if we could turn it into something that was more useful in improving patient care, and, to that end, we agreed. The commissioners changed over in '94 into '95, and the new commissioner's office called us in early '95 with a request to do the same, but to add another component which was to reduce the burden of reporting and other required activities on the hospitals in New York because, as you may recall, there was a major medicaid budget crisis that year, and the hospitals were struggling.

So our group was convened in the spring of 1995. We had a retreat. I think a number of people in this room were at that retreat, Kathy and myself, along with DOH staff, and the vision of that group was to take an existing event reporting system, and turn it into something that would improve the health of the population of New York,

not to make it the best event reporting system, but to make it something that was useful to improve care.

And, to that end, the group came

up with a number of things, first is that the categories were then needed to be reported needed to be focused. They needed to be clear. They needed to be important. We needed to get away from paper that was mailed to Albany and went into, we hear boxes that may have been closed and never opened, but I don't know that for a fact, into a computer database system which soon after turned into a web-based system. The group designed the system, tested it in the nine hospitals represented on the work group.

And the next year, 1996, then expanded the test later that year to 28 hospitals, and then as a sign of the fact that the system was perceived to be more useful, there was a voluntary third test for which 130 New York Hospitals volunteered before the system fully went live because it

did reduce burden and it was more useful.

So NYPORTS, as we know it, roughly went live in 1998 with, I believe, the web-based reporting then, or close to it, and the so called trackable events, which are the lesser events with short

reports and the more detailed reports on the more serious events.

In 2000, the Joint Commission on Accreditation of Hospitals was pushing on the safety front in a very good way by saying we needed to do a credible analysis of those events that occurred using root-cause analysis.

The NYPORTS then Council I think took that idea and said we can take the joint commission format and apply it to the detailed events in New York. It would be a more useful system. So the format was created and was rolled out to all the hospitals in 2000. And has become a part of the way we do quality work in our hospitals.

In 2001, you heard there was the analysis of the administrative data on

reporting of the subcategory of death within 48 hours, I think of surgery, but I think I may -- is that right or wrong? And it was the one that was quoted as showing a 16 percent reporting rate which led to the commission's letter that you've heard about.

So a focus on completeness, but there was a very good period in NYPORTS from

2002 to 2004, and that was the period when the department had a grant from the agency of healthcare research and quality through its event reporting subcategory that three-year grant enabled the department to staff NYPORTS to improve the system. It gave additional resources to the school of public health in Albany to analyze the data. It funded three pilot projects on improving postoperative heart attacks, postoperative blood clots and surgical site infections.

And it was the one time in the history of the NYPORTS it was adequately staffed, and it was only in hindsight that we can see this. During the previous years, we heard things were tight, as I think a

number of people mentioned, the department staff working on it had other jobs and we often heard about some of the funding coming from discretionary budgets as opposed to hardcore funding.

So when that grant went away at the end of, I believe 2004 into 2005, there was a period of transition that takes us forward to now, there was an effort to further focus NYPORTS, based on the analysis

that was done, and the cross tabulation of NYPORTS events with the administrative data, and that lead to the reduction of the numbers of so-called trackable events from 25 down to five or six, which was a wise thing to do because the other 20 events were of uncertain value, of lower frequency, and the five or six that were kept, were those that were most important to patient outcomes.

And that takes us forward to today, at least in my experience in the system. The root cause analysis, part of NYPORTS is a robust part of the system.

It's a core activity in our hospital quality and safety program. While I was here this morning listening to you, there were several e-mails from my home institution about root-cause analyses that were either in process or to start; should they be included; how do we determine standard of care? And other things that we do in our routine work. That keep works well and keeps us focused on a number of key events.

The trackable events with short forms have passed their time as a number of

people, including Kathy, mentioned the federal work to track through administrate data hospital-acquired conditions, or the agency research and quality, patient safety and quality indicators, really capture various similar concepts in administrative data coded by our own medical records department, and meets the needs we have in those areas.

That was not always true in that we didn't always have the so-called present-on-admission indicator to determine

the difference between events that occurred in the hospital from those that the patients came in with.

So, with that, I support virtually every speaker's comments and the need to improve the system to keep the system, to focus the system, to staff it adequately, and to make it part of an overall patient safety system in New York.

SENATOR DUANE: Thank you both very much. I'm aware that I may have sounded -- because of a couple of lines of questioning that bigger is better, I understand that, while you're not

disagreeing with that, it depends on how that would be done and maybe less big in some areas would be better, and more bigger in other areas. I'm not very articulate, but I think you know what I'm saying.

So is it possible and likely and how can we align reporting with other reporting? Is that achievable, and if we use -- before I even -- so let me hold that thought for a moment.

I do find and I am aware, you know, I know of all of the reporting, but there is nothing like a visual to drive home the point.

But if we agree in what we do and what we're required to report, or even if we don't agree, but imagine that we did all agree that that would be a floor, and if that was a base, is it possible to align that with what is asked, for instance, by federal statute and regulation and not lose data that we're getting, and can we still -- I know this is several questions in a row, but use that as a way to improve patient safety? That's sort of -- that's to both of you.

MS. CICCONE: I'll be glad to start, and, Bob, I hope you'll chime in. So, Senator, I think your questions were, is it possible to align some of the various databases and definitions across national and state efforts?

SENATOR DUANE: Yes.

MS. CICCONE: I just want to make

sure that I understand your questions. And, secondly, if we do that, do we improve or reduce the usefulness of the information that we're already collecting in NYPORTS?

SENATOR DUANE: And the potentially usefulness even if it's not being used in a useful manner now.

MS. CICCONE: Sure. Sure. I think that in many areas, it is possible to align the national definitions and national reporting requirements with state requirements, and we've done that to a certain extent.

For example, HANYS board had worked to develop a policy, a billing policy around adverse events. And we were trying to create one statewide policy, to put one statewide practice, and then we worked with

the Office of Medicaid to develop its policy as it moved forward on that, but many of the definitions that we used were actually incorporated from the national definitions. So there is some precedence, in fact, where the state has looked to federal efforts to

inform its own practices.

With respect, for example, to something like infection reporting, you know, the Department of Health has an infection reporting program which we support and helped to design. That program is something that took over actually some of the infection reporting around surgical site infections that used to occur through NYPORTS.

The area where we think there may be an opportunity for improvement, is the data is now reported to the national database that is run by CDC, the Centers For Disease Control. And there's also another database at the national level, the CMS Quality Reporting Databases Core Measures, the infection information that's reported to that database is a little bit different than what's reported at the CDC database.

We think it's possible to integrate those two efforts and have one reporting system that would give us a very robust set of information about infections

and improve, not only the information that we have, but also the usefulness of it because we would be able to draw from the national experiences and apply it to our own state setting.

We think that's true in many of the reporting categories. But we can use the agency for healthcare, quality and research, their definitions to be able to draw from administrative databases and develop some comparative reports, but it won't be possible in every instance. We understand that and, you know, certainly we believe where it's possible and where it's appropriate that the state should make every effort to integrate its own databases and some of the line of questioning that you raised earlier this morning about, is it possible to integrate some of the various databases at the state level, we believe that would be an improvement, as well as to align the definitions at the national

database, the national level.

Bob, would you add to that?

DR. PANZER: Sure. I think one thing that would be important both for efficiency and having the right focus areas is to align what's done in New York with the national standards that have been set by the national quality forum. CMS and joint commissions and others have committed to use that forum to set its definitions on one of the technical advisory panels on one of the categories on blood clots.

So if we go for the same definitions, then when people look at issues from different directions, they're going to be looking at the same thing. I think we should keep, as Dr. Morley talked about, the good special focused areas of improvement that have grown up over the years which have some depth, which are much more clinically detailed than the routine systems that we have, and add selective priorities, driven by the data about what happens to patients in New York. C.difficile is not a bad concept to add because in our hospital, it is a top priority right now, very hard to

fight, and it's a real problem for our patients.

So I think standardization will reduce the redundancy in waste. We're now reporting, if not scores, a hundred or 200 measures to different entities and I think the discord between the different definitions for the approaches is a problem.

SENATOR DUANE: I'm going to turn the mike over, and I'm sure you're all saying, thank heavens, but after I ask this next question, to Assembly Member Gottfried, but is there value in focusing all of the, you know, stakeholders, that's the new, you know, all the stakeholders on maybe a few or even a couple of events to do a very thorough analysis of those without regard to where they may be with the goal of improvement across all systems?

DR. PANZER: I think so. They're kind of universal. In our hospital, we have an internal weekly report, it's actually called "The Report of Harm," which is internally controversial because people feel

it sounds negative, but our point is to get attention. But what we report there every week are the previous weeks and tracking back from there, central line infections, surgical site infections, C.difficle infections, pressure ulcers, and falls, and we track, in other ways, unexpected deaths.

So there are a number of focus areas that are of universal interest to hospitals that I think could lead to improvement and, in fact, the mandated reporting through the NHSN, the CSC system for central line infections, and surgical line infections that we do today in New York is an example of doing exactly that.

SENATOR DUANE: So maybe that is something we can look at with the department to start it off with a couple and then we'll see the value and either expand or whatever from there, or not expand, see if that's what we should continue to do.

I'm just going to step out for a brief moment.

MS. CICCONE: If I can just add

to Bob's comments, earlier Bob mentioned that we think -- one of the times when the department was most successful, when the NYPORTS program was most effective was -- went ahead and focused attention on a couple of specific areas and that was through the HRQ grants that it had, and it was very very helpful.

I can remember going to NYPORTS meetings that were held at the school of public health, and I had to get there early because, if I didn't, there wouldn't be a seat in the room. And that was when NYPORTS was absolutely the most useful, the most meaningful. There were as many people in the audience as there were at the table because everybody saw that as a very viable and strategic and great learning opportunity. And that really was a result of the focus initiatives and efforts by the department.

CHAIRMAN GOTTFRIED: And when was that period?

MS. CICCONE: It was a few --

DR. PANZER: The grant was I

believe 2002 through 2004, roughly those calendar years.

CHAIRMAN GOTTFRIED: I'm back and I'm sorry I had to miss the first couple of hours of the hearing. I wish I had good news to bring you, but I don't.

A couple of questions just from the portion of your testimony that I've been hearing so far.

On the question of, I guess, revising what gets reported under NYPORTS or how things are categorized, and you may have spoken to this in your written testimony or in your oral testimony, are these revisions things that the department can do administratively or is statutory change needed?

DR. PANZER: I'm sure we would defer to the department on that. I believe that the hard core of the statute relates to what we would call the detailed event -- the detailed reviews and the root cause analysis component of NYPORTS. I believe the

department could further reduce or eliminate the trackable events.

CHAIRMAN GOTTFRIED: And have you

raised this question with the department and, if so, what has been their response?

MS. CICCONE: I can respond to that if you like. Actually, HANYS has talked with the department and worked with the department along with the Allied Regional Associations and the hospitals across the state to really look at what events are being reported in NYPORTS right now and where can we scale back and focus our attention to be most effective?

I think that there is some common understanding about areas that are most important to address, and we certainly, the changes that we recommended in our written testimony were that we perhaps focus on the statutorial required events so it wouldn't require any sort of the changes in statute and then add to that, perhaps some common focused areas that are important to look at.

CHAIRMAN GOTTFRIED: Well, that's

what you said to them. Have you gotten feedback from the department?

MS. CICCONE: The conversations that we've had with the department is that we certainly -- and I don't really want to

speak for the Department of Health or Dr. Morley, but, yes, I can tell you that there was an understanding that we would be most effective if we focused in on certain efforts, and the department was actually supportive of streamlining some of the reporting requirements so that it could do that.

CHAIRMAN GOTTFRIED: The other thing I'd like to ask about, and, again, I don't know whether it was touched on in your testimony, is the hospital internal peer review processes. Are those processes working as well as they possibly could?

Or are there -- well, I don't know if any human activity meets that standard, but are there changes that should be made legislatively or otherwise that would improve the functioning of those

processes?

MS. CICCONE: Well, I would agree that probably it would be hard to identify any process that works as best as it possibly can, but the peer review programs in hospitals are a very rigorous program for quality improvement, assessment of quality

improvement and performance enhancement. So that it's very important as hospitals investigate different events.

They really are able to have candid and very open conversations to explore potential issues and then to develop remedies to improve situations and avoid them from happening in the future. We believe the peer review protections are absolutely imperative to maintain as they really are the under-structure for a lot of the quality improvement activities that occur in organizations.

CHAIRMAN GOTTFRIED: I've been told over the years that the fact that the confidentiality provisions in the law relating to the peer review process does not

cover everyone, but excludes from its protection, basically any party that could get sued as a result of the topic under discussion, that as a result of that exclusion of some party from confidentiality protections, that some parties are reluctant or refuse to participate fully in peer review discussions. Is that what happens?

DR. PANZER: I'm not a lawyer,

and I didn't stay in a Holiday Express last night, so I'm still not a lawyer, but our chief risk manager would probably say that it's more the reverse, that because of the quality assurance protections and peer review protections in New York, there is a certain way we can't involve or shouldn't involve the clinicians involved in an event in the review.

We can't put them on the team, for example, and have their wide open comments on what happens, so we need to understand the system with them as people we can talk to, but are not an active member of that team.

The system works reasonably well. I think one of the biggest challenges to all of us is that while we can talk to ourselves internally or to the department about events, we can't talk easily to other hospitals without theoretically risking the waiving of that quality assurance protection, and that would be helped if some entities in New York became patient safety organizations, then we'd have the federal protections for that. But I don't think

that's a big obstacle inside a hospital on case review. It's an issue, but not a big obstacle.

CHAIRMAN GOTTFRIED: I'm sorry, it's not clear to me, did you say the fact that the clinician involved is not covered by confidentiality does inhibit a clinician's participation in peer review discussions?

DR. PANZER: Yes, it does. But none of them have refused to participate based of that. We can't and don't directly involve them in review teams.

CHAIRMAN GOTTFRIED: So they're -- are you saying that their testimony or their remarks do not come forward in the peer review process, but not because they refuse, but the mechanism is that the hospital says, doctor so and so, you stay out of the room, is that --

DR. PANZER: For the peer review discussions, correct. We still validate the events that occurred and the decision-making that occurred in other fashions.

CHAIRMAN GOTTFRIED: Okay. Would the hospital learn more about what happened

and how to improve things in the future if the clinician involved had the confidentiality protections that others have and, therefore, was brought into the room?

DR. PANZER: Yes.

CHAIRMAN GOTTFRIED: Okay. And your other point was that if you were -- if two hospitals were to have, let's say, periodic meetings in which they discussed one another's -- what each one had learned in their respective peer reviews, that

sharing process would break the confidentiality protection?

DR. PANZER: I understand that it theoretically could. That's correct.

CHAIRMAN GOTTFRIED: And the suggestion then is that there be some mechanism to extend the confidentiality process to -- or the confidentiality protection to cover multi-hospital discussions of incidents in a peer review process?

DR. PANZER: Correct. And that's the National Patient Safety Organization Legislation that's in place today which has voluntary participation of groups of

hospitals.

CHAIRMAN GOTTFRIED: But is there a need for comparable state legislation, do you think?

DR. PANZER: There's been --

CHAIRMAN GOTTFRIED: I mean, I've heard people discussing the need for multi-hospital discussions and the legal obstacles to that happening, so far no one

has come to me and said, here's an amendment to the law that we think we need in order to make that happen.

DR. PANZER: Personal opinion, again, I'm not a lawyer still, so that if New York State or the hospital association is together and became the Patient Safety Organization, I believe we'd have a lot of those protections under that umbrella.

CHAIRMAN GOTTFRIED: So there is a federal kind of organization that hospitals could form?

DR. PANZER: Correct. And Patient Safety Organization Legislation was I think five years ago and the regulations deploying it occurred within the past year or so, and it requires that organizations

come together and agree to do that sharing in the interest of patient safety, and that they also submit data to the federal agency of healthcare research and quality on some of the aspects of safety patient.

My understanding is that that information today is not standardized but

moving forward within a couple of years, those organizations would need to submit some standardized information in a standard format to the national database.

But the intent of it is to do both, the creation of a central database and also to improve the ability of any entity, not just hospitals, to talk to each other about safety issues.

CHAIRMAN GOTTFRIED: And is it your understanding that that federal legislation, if you are part of one of those patient safety organizations, then what you share is then by the federal government granted confidentiality protection that would be effective in state proceedings?

DR. PANZER: Correct.

CHAIRMAN GOTTFRIED: Okay. Art Levin is in the back looking anxious, no,

Art, hang on. We'll do one at a time. We'll talk later.

DR. PANZER: Art's probably right on this one.

MS. CICCONE: Well, if I may, the

Patient Safety Organizations were created by the agency for healthcare quality and research, that was why the regulations only came out within the past year or so, and there is some work trying to develop a standardized uniform approach for the way that the various agencies or the organizations conduct themselves to collect information.

But legislation does provide for confidentiality protections as part of that for information that is submitted to the patient safety organizations but, what it doesn't do, is the Patient Safety Organizations in no way take away from what is already required as part of state regulatory processes.

So, for example, hospitals who report information to NYPORTS and New York State would still have to report information to NYPORTS. If they were to report an

incident to the patient safety organization that was also reported to NYPORTS, then it gets a little bit confusing because the

hospitals cannot use any of its work or its activities that was led to reporting to the state in its work to report to the Patient Safety Organizations.

So there is a bit of confusion about how that works in states that have mandated reporting programs. But, for those types of adverse events or near misses, which this is really very much about a near-miss program, in terms of patient safety portion organizations that are not reportable to NYPORTS, or where there is another way to get information, those organizations can very helpful in terms of identifying trends and patterns, conducting the types of analysis that we've been talking about, and then sharing that information throughout the state, or in patient safety organizations can be in multiple states. They can focus in on a specific area. There's a lot of latitude and flexibility with respect to how they'll work in different areas.

CHAIRMAN GOTTFRIED: Okay. Well,

that's something we're going to have to look into.

Thank you very much.

MS. CICCONE: Thank you.

CHAIRMAN GOTTFRIED: Okay. Our next witness is Dr. Ragu, on behalf of the New York City Health and Hospitals Corporation.

DR. RAGU: Good afternoon. My name is Dr. Ramanathan Raju, and I'm the Executive Vice-President and the Corporate Chief Medical Officer for the New York City Health and Hospitals Corporation.

Thank you for the opportunity to describe the work that our corporation has done to institute some of the most advanced patient safety programs and rigorous quality assurance oversight activities of any healthcare system in the nation.

HHC is committed to providing high quality care to our patients and to minimizing and, where possible, eliminating risks to their safety. Our corporation set a goal in 2005 to become one of the safest

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healthcare systems in the country by 2010 through implementation of evidence-based clinical practices, aggressive cultural change efforts, intensive training program, system-wide collaboration, development of advanced clinical information technology systems, and dedication of resources and staff at all levels to create the appropriate patient safety infrastructure.

When we embarked on our system-wide patient safety campaign, no models existed to guide a large, multi-facility system through the steps of engineering and organization wide patient safety transformation.

We began to build on a long-standing robust quality improvement program, closely overseen by our board of directors. Our quality improvement agenda proceeded methodically from the initial emphasis on compliance with the Joint Commission National Patient Safety Goals and specific federal quality reporting requirements, to our current relentless

focus on patient safety as a core value and critical programmatic pillar of our strategic direction.

I am happy to report that we are all well on our way to achieving our goal of becoming one of the safest healthcare systems in the nation. We are succeeding in embedding a quality in the patient safety culture throughout our organization and workforce. Staff at every level, from the board room to the operating room, are engaged in this effort.

Patient safety is an integral component of our quality assurance performance improvement program and, medical mistakes, when they do occur, are subjected to a formal, rigorous analysis to help us prevent further recurrences of similar adverse events.

A cornerstone of this program is reducing opportunities for human error. Our goal is to hardwire our systems and processes so that nearly all the medical errors can be prevented from happening.

It's a challenging goal, but it reflects our commitment to every one of the 1.3 million patients we serve each and every year.

To successfully address our patient safety challenges, we devise our own safety protocols and processes when necessary. However, we are also integrating into our routine work nationally recognized clinical best practice approaches such as ventilator associated pneumonia and central line infection bundles, deploying rapid response teams, and using innovative technologies like electronic medication and administration. The concept of using bundles in healthcare has been promoted by Institute of Healthcare Improvement and other agencies that influence patient safety and quality.

A bundle is a structured way of improving care processes by implementing three to five evidence based practices that have been proven to improve patient outcomes when performed collectively and reliably.

For example, dramatic

improvements in the rate of ventilator

associated pneumonia has been achieved at HHC as well as across the nation by healthcare providers consistently following several specific processes for patients who are on a ventilator; like elevating the head of the patient's bed, periodically reducing the sedation, and providing patients with prophylaxis for peptic ulcers and deep vein thrombosis, otherwise known as blood clots.

The building blocks of a patient-safety agenda have been put in place systematically. We have emphasized and supported intensive leadership and frontline staff development; awareness building and empowerment activities; collaboration and implementation of clinical best practices, and a broad transparency initiative that I will talk about in a few moments.

Through extensive and clear communication, we have strategically engaged our clinical and non-clinical staff, our patients, and our community advisory boards to deepen awareness of patient-safety

issues, and also involve those groups in the patients as partners in our collective work, while giving the tools and the techniques to

recognize and prevent medical error.

Today, all of our constituencies are emerged in improving patient safety. Motivated by the patient safety, motivated by the patient safety progress we have demonstrated, and driven by the ambitious goals we have set.

Each of our facilities have in place an array of proactive patient safety initiatives. These initiatives have been responsive to the patient safety goals of external review agencies such as the Joint Commission of the New York State Department of Health, Federal Center for Medicare and Medicaid services, as well as other nationally-recognized organizations, such as the Agency for Healthcare Research and Quality, AHRQ, the National Patient Safety Foundation, and Institute of Healthcare improvement.

For example, we regularly measure

our performance on AHRQ's patient safety indicators, this is a set of indicators designed to help hospitals identify potential adverse events that occur during inpatient stay. Additionally, each HHC

facility has a designated patient safety officer who has received training from the Institute of Healthcare Improvement on specific tools and techniques essential for the robust patient safety program.

All of HHC's hospitals and long-term care facilities are in full compliance with the Joint Commission's numerous national patient safety goals as evidenced by the positive results of their on-site accreditation surveys of facilities.

Last year the Joint Commission conducted accreditation surveys of five HHC, Bellevue, Harlem, North Central Bronx, Queens Hospital and Woodhull. And our long-term care facility at Coler-Goldwater. All achieved successful survey results and full accreditation.

This year, three of our

hospitals, Coney Island Hospital, Kings County Hospital Center, Lincoln Medical and Mental Health Center, and one long-term care facility, Sea View Hospital Rehabilitation Center and Home were surveyed.

Again, all facilities received full accreditation. The Joint Commission's

very experienced survey leader in providing a summation of the surveys to our board said, and, I quote, "I have not seen, as a group, facilities so committed to improving quality as this system. This was apparent from the executive level down the organizational line to include all staff."

The survey leader pointed out that the recent survey results for HHC Hospitals as a group outperformed the majority of the surveyed hospitals in the nation by a significant margin.

The Joint Commission also noted some of the leading practices evidenced at the HHC facilities it reviewed. At Coney Island Hospital, they highlighted a comprehensive multi-step form developed by

the hospital known as a universal protocol verbal certification checklist that must be completed prior to taking an invasive procedure.

In a related development earlier this year, our corporation fully implemented the surgical safety checklist recommended by the World Health Organization in all of our operating rooms to foster better surgical

team communication and reduce risks of complications in surgery. We were the first hospital system in New York City and among the first in the nation to do so.

At Lincoln Medical and Mental Health Center, surveyors noted the use of unique hand-off communication system called S-BAR used by all departments to ensure clear and accurate communication during the staff shift changes at the hospital. Kings County received accolades this year from the Joint Commission for their systemic efforts to reduce medication errors by incorporating innovative electronic system edits, labeling techniques, and safety warnings for

medications that sound or spelled similar to each other, otherwise known as, look alike, sound-alike medications.

However, despite the accolades from Joint Commission and the many gains we have made, we are not just resting on our laurels. HHC has consistently sought to exceed the external agency requirements around patient safety. In 2007, we began our transparency initiative which includes publically reporting hospital quality and

safety data on our website. We are the first healthcare system in the state to publically post this information.

The HHC In Focus section of our website displays safety and quality data of each of our hospitals and long-term care facilities across nine categories. These CAT are:

Mortality rate, heart attack care, heart failure care, pneumonia care, preventing infections, nursing home and long-term care indicators, disease prevention, chronic disease management, and

maternity and infant care.

Very few hospitals can match the scope and detail of our public reporting efforts. This special section on our website was created so the public can see many of the quality measurements that HHC is using to assess our progress, as well as how we fair against established state and national benchmarks.

All national, state, and other comparative data on our website are from CMS and/or from AHRQ, both federal agencies. By posting this information in a way that is

clear, understandable, and timely, we are showing our willingness to be held publically accountable for doing all that we can to do to offer excellent care and to keep our patients safe.

Our commitment to patient safety is also evident in our decision to invest heavily in the development of a clinical information system, despite daunting financial challenges we face. We have implemented a comprehensive electronic

medical record, including a computerized physician order entry system, as well as integrated digital radiology, and other diagnostic imaging in all eleven of our acute care hospitals. This technology has demonstrated to reduce common medical errors, particularly those related to illegible and confusing physician orders and prescriptions.

Our computerized order entry system also contains functionality that alerts clinicians to potential medical errors including the flagging of any potential adverse reactions among patients multiple medications.

Last year, we also began to implement the Colors of Safety program in our hospitals and our long-term care facilities, which uses standardized color-coded wristbands to quickly communicate patients' high alert medical conditions and to help prevent medication errors, allergic reactions, and falls.

We continue our system-wide

efforts to aggressively reduce hospital-acquired infections, achieving reductions in central line bloodstream infections and ventilator-associated pneumonia for the third straight year. From 2005 to 2008, we achieved a 65 percent reduction in the rate of central line bloodstream infections and a 90 percent reduction in the rate of ventilator-associated pneumonia among adult patients in our intensive care units.

Notably, in 2008 and 2009, three HHC hospitals did not have a single central line infection in one or more intensive care units for 18 consecutive months. Of course, we continue to strive to achieve our goal of zero infection, a radical goal that we

believe is possible.

In addition to progress in preventing hospital acquired infection, the 2007 data posted on HHC's website also shows that our system wide mortality rate continued to stay below the relevant national benchmarks. Overall, the system

wide mortality rate for HHC hospitals has decreased by 11 percent from 2003 to 2007, resulting in roughly 1,350 fewer patient deaths over that period of time. Our data in 2008 shows a further decrease in system-wide mortality compared to 2007.

Earlier this year, the corporation received the prestigious John M. Eisenberg Patient Safety and Quality Award from the National Quality Forum and Joint Commission for efforts in promoting unprecedented transparency around quality and patient safety.

Also, the Commonwealth Fund, the national private foundation that advocates for changes in health policy, financing and practices, that support a high performance healthcare system, published a comprehensive case today about our corporation last year.

In this report, the Commonwealth Fund praised the improvement initiatives that we have undertaken in recent years. The report noted that we are becoming a provider of choice in achieving a higher

level of performance through our advanced use of clinical information systems, our work to improve chronic disease management, our collaborative team approach to identify and implement clinical best practices, our efforts to bolster our financial health, and our continued commitment to expand access and create a patient-centered healthcare system.

All four of our long-term care facilities were rated at or above the national average by the Federal Center of Medicare and Medicaid under ask its recently launched rating system for nursing homes. Two of our facilities, Gouverneur Healthcare Services and Sea View Hospital Rehabilitation Center and Home received the highest rating possible, five stars, which was received by only 12 percent of 1,580 nursing homes rated nationally.

While there are many many other

patient safety initiatives I could discuss, given my limited time, I would like to briefly describe the Quality Assurance

processes at our corporation. Each facility within HHC has got its own quality assurance committee, and a medical board which actively monitors compliance with quality of care requirements and continuous quality improvement efforts.

This activity at the facility level is subject to oversight by me as the Chief Medical Officer, as well as by the Executive Directors and Medical Directors of that facility.

At the corporate level, my staff and I provide daily oversight and support to HHC Board of Directors who embrace quality assurance as a critical aspect of the governance role. The Quality Assurance Committee of HHC's Board meets for several hours nearly every week to review in detail with senior administrative and clinical leadership the performance of all of the facilities.

This committee then provides a report to the full board on a quarterly

basis. The Quality Assurance Committee of

HHC Board of Directors takes very seriously its responsibility for discharging a governing body's obligation to oversee quality of care at every HHC facility. The Committee's membership includes the chairman of the Board, the President of HHC, and board members with clinical backgrounds. The duties of the Quality Assurance Committee include:

Assuring that each facility is fulfilling mandates in the areas of quality assurance, performance improvement, credentialing of physicians and dentists, and overall compliance with federal, state, and other regulatory requirements;

It reviews efforts to improve the quality of care to patients and monitoring the outcomes of risk reduction programs;

Ensuring that information gathered pursuant to the quality assurance and performance improvement program is used to revise policies and procedures appropriately;

Assuring that there is a systemic

and effective approach to reviewing quality of care that includes analysis of data on specific clinical performance; infection control activities, preventative and public health measures, patient complaints and satisfaction surveys, external agency reviews, credentialing activities, and sentinel events.

Each HHC facility must present its data to the Quality Assurance Committee for every three months and its leadership is questioned on steps undertaken to address any quality of care issue. Where necessary, the Quality Assurance Committee recommends that action be taken to address specific issues of concern.

As a part of their quarterly data submission to the Quality Assurance Committee, all our facilities report on more than 100 quality and performance indicators. These indicators enable the Committee to gauge a facility's performance on the individual level and on a comparative basis with other facilities.

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In conclusion, I would like to invite you to visit any one of HHC's facilities, and encourage your colleagues, who are not here this afternoon, to do so as well. We would very much like you to talk to a dedicated staff about the efforts I have briefly described to see firsthand the initiatives at work and learn more about our facility deep commitment to providing high quality healthcare services to all New Yorkers.

This concludes my testimony. I'll be happy to answer any questions. And to my right is Carolyn Jacobs, she is a Senior Vice President for Patient Safety, so we would be more than happy to take the questions from you. Thank you.

CHAIRMAN GOTTFRIED: Thank you and I apologize for misspelling your name on the witness list. I think we have to explore the following with you. A few weeks ago, maybe a couple of months ago, there was a series of newspaper articles in one of the daily papers about a number of patient

incidents in HHC facilities which, you know, if you focused on those articles, you would come away with a very different sense of HHC from your testimony.

And I know President Aviles at the time put out a statement in response, but I would appreciate it if you would tell us, reiterate to us, the corporation's response to those stories.

SENATOR DUANE: I mean, that is one of the reasons we're having this hearing. It was a wake-up call, if you will, for me and for the state that we need to focus on this, but it was the dramatic reporting that was an additional and a very large impetus for us holding this hearing, and I think we -- so we do need to hear your response.

DR. RAJU: First, in my testimony, I stated, I recognized the adverse event -- or unfortunate events that occurs in all hospitals, and our hospitals are not an exception.

However, I just want to assure

the committee that we have a very very robust process which I described to you of

identifying, disclosing, and revealing all those incidents at -- and understand mistakes that are made, and we are very very -- we practice just culture, and we really take very seriously and we do a root cause analysis, and fix the system issues where they're necessary, and holding people accountable where it is necessary.

Having said that, I just have to say that that series was really, in our opinion, is a misleading portrayal of HHC practices on reporting it.

The report was really filled with broad color claims that are not really supported by the facts, and failed to to decline that we are -- they were clearly aware of and mischaracterize the nature of many of the events.

I just want to give even every one of those incidents is a bad incident and take it very seriously and personally I hold myself responsible for it. But having said,

during the five-year period they looked at it, we discharged 1.2 million inpatient were discharged. Even if you perform a 99.99 percent, it will still leave us with about

120 unfortunate adverse events in a corporation of our size and they picked on about 12 cases over a period of time and they kind of concentrated on that.

That did not really give a complete picture of our system as a system which is committed to quality, committed to patient safety, and committed to making improvements to our patient care in our system.

CHAIRMAN GOTTFRIED: Apart from Dr. Aviles' statement, has the corporation put out a more extensive analysis or response to the cases mentioned in the newspaper reports; do you know?

DR. RAJU: We sent -- Mr. Aviles sent a letter and also we sent a letter to our employees to identify those issues, and we'll be happy to give the letters to the members if they need to.

MS. JACOBS: We also sent a letter to our key constituencies, those key stakeholders across the city, whom we serve, so those community-based organizations and the like, we also sent a letter to them as well.

SENATOR DUANE: Even so, based on those occurrences, has there been, within the system, a concerted attempt by using analysis and calling in the stakeholders and specialists based on -- earlier I asked the hospital association if they thought there was value and merit in taking a couple of incidents and really doing a thorough analysis of them.

It does seem that there are ready-made incidents for that kind of analysis within HHC. I am not saying or implying that it is not necessary or needed or valuable or appropriate in other hospitals or other systems.

However, in that -- whether those incidents as reported were in the public eye or not, have they risen to the level of that

kind of analysis within the system? If no, why not? If yes, where are you? And if yes and they're completed, what is the -- what did you learn?

DR. RAJU: Thank you, Senator. Every one of those incidents -- actually, I should say most of the incidents, are being already investigated by us by a root cost

analysis which identified both system issues, in which system issues are fixed, where there was individual culpability, we took action on those culpability including in one of instances where we have terminated people or really did not provide, in our opinion, proper care.

So every one of the incidents has been thoroughly discussed over a period of time. We have extensive discussions by various levels. We brought in outside and inside expertise to give us advice on those cases when you do root cause analysis.

So every one of those cases have been completely looked at and thoroughly investigated and any improvements we need to

put in, the improvements are put in, whether we need to hold people, we hold people accountable for that.

SENATOR DUANE: Are there documents that you could share with us on the actions taken and the procedures, policies put in place going forward?

Because I hear what you did and some people were terminated and things were examined and you brought in specialists, and

-- can we see that? And whether it's fair or not that HHC and the system was the subject of this reporting, I think that it would be important for us to see that and, frankly, I think it would be of value to other institutions generally anyway.

DR. RAJU: To the extent possible, I need to talk to my president and find out, but some of the cases are still under litigation, and some of the expert opinions we brought in to look at those cases are still -- it's still in litigation, so I don't know how much we can share of that kind of opinions with you.

But if we -- with the root cause analysis, I don't know whether we could ever share with an outside -- an agency, we can take a look at that, and I will definitely get back to you on that.

SENATOR DUANE: You know, the point of this hearing is not, from our point of view, to do any more shedding of public light or -- well it is, but I mean to say to pile on -- I'm not quite sure how to say it, HHC, that that's not our goal here.

However, we do have a goal of how

to improve the system generally across New York State. And for unfortunately or unfortunately, serendipitously or tragically, you are in a position to provide us with how to fight to work, to reform so that this doesn't happen again, to the best of our ability, not just at HHC, but systemwide. And that is why that would be of such great value for us.

We are doing this, again, not to punish or point out or scapegoat or stigmatize HHC. It really is, how can we do

better. And that's why it is important for us to see that, and I think we take you at your word, but I think the public also I think would like to see that as well. And the public would like to know, not just those that use HHC facilities, which we are very supportive of, I would say in Albany, we are very protective of HHC, to the best our ability.

But it is about making sure that the public for the people who use HHC facilities, and need HHC facilities, and we want to make sure that you are there to provide that. You're a critically important

part of healthcare in our city, our state, and nation, frankly, and we need to make sure that the public has as much confidence as they possibly can in HHC.

And I'm coming from a place of being very supportive of HHC, and we need you to -- because you're a public institution, we need you -- I don't even want to say to be at a higher standard, but because of the circumstances, because of the

reporting that's been done, your standard is one that we have to see how it is that you are working to achieve that standard.

So I very much would like -- I don't want to speak for everybody, and the assembly member I think will probably speak to this but, I implore you, I almost demand of you that you provide us as much information as you possibly can on what actions were taken within the system. It would be incredibly helpful for us to see that and for the public, and, frankly, just for our state's healthcare system, not just HHC, but our healthcare system statewide.

DR. RAJU: Okay. Thank you, Senator.

SENATOR DUANE: We expect going forward to work with you, talk with you about improving, reforming, adding, subtracting, aligning the NYPORTS system, and I think because of the uniqueness of the HHC system, the data that's collected both as part of the NYPORTS and the other state systems, plus any other information that is

gathered by HHC that is unique to HHC would be of great value. We would like to work with you to disseminate that in our efforts here on improving the system.

DR. RAJU: Sure. We would definitely like to part of that. And, again, I cannot thank you enough, both Senator Duane and Assemblyman Gottfried for the support and what you've given over this period of time, and continue to do for our system. I appreciate that.

SENATOR DUANE: Thank you.

DR. RAJU: I appreciate that.

MS. JACOBS: Thank you.

CHAIRMAN GOTTFRIED: So our next witness will be Richard Binko, New York State Trial Lawyers Association.

Senator Duane and I have agreed

that in the interest of moving the hearing forward, we will sacrifice our dignity and eat during the testimony.

SENATOR DUANE: We'll try to do it in a tasteful manner.

MR. BINKO: First, I would like

to thank the members of the Senate Committee on Health and the Assembly Committee on Health.

My name is Richard Binko, and I am the President of the New York State Trial Lawyers Association.

I appear here today to testify about the vital need to improve patient safety in New York, and how important it is that we have a working, effective incident reporting system. I appear on behalf of NYSTLA Board of Directors and our 4,000 lawyer members who practice in the trial and appellate courts throughout this state.

We thank Chairpersons Duane and Gottfried for convening this hearing on this critically important issue. Thank you for inviting NYSTLA to participate.

Patient safety must be improved. It's time to improve patient safety. For

more than a decade we've been aware of this severe problem, yet far too little has been done to improve it.

In 1999, the Institute of

Medicine estimated that up to 98,000 deaths per year are due to medical occurs at a cost $29 billion per year.

In New York State, between 18 -- I'm sorry, between eight and 18 people will die today because of preventable medical errors in hospitals. Sadly, since this committee hearing convened at 10 o'clock, between one and four people have already died on this very issue that we're seeking to try to stem.

In January 2000, then New York State Health Commissioner Novello pledged to make and meet the Institute of Medicine's goal of a 50 percent reduction in hospital medical errors by 2005. But in a 2006 follow-up report, Preventing Medical Errors, the Institute of Medicine concluded that 1.5 million preventable medical errors cost hospitals over $3.5 billion annually.

A recent report found that if the Centers for Disease Control included

Preventable Medical Errors as a category, it would be the sixth leading cause of death in

America.

The Institute of Healthcare Improvement estimates that there are 15 million incidents of medical harm each year. Nine years after Commissioner Novello's pledge to make New Yorker's safer against medical errors, where are we now? Are New Yorkers safer when they visit the hospitals? Sadly, the answer is a clear and resounding no, and this is unacceptable.

Reducing medical errors is the most effective way to reduce healthcare costs and save taxpayer money. When medical mistakes are made, the cost must be absorbed not only by hospitals, but by insurers, patients, and taxpayers particularly through the Medicaid and Medicare programs.

For example, Comptroller Thompson's report found that the cost of post-operative deep vein thrombosis and acute pulmonary embolism, both of which are required to be reported by the NYPORTS, is almost $11,000. This means that for the $6,461 reported cases of these adverse

effects, the cost was more than $70 million in 2006 alone.

The severe underreporting of adverse incidents by hospitals is a significant problem that prevents the true scope of medical errors from being known.

As early as 2001, the New York State Department of Health found widespread NYPORTS ranging disparities among regions across New York State. Despite pledges to fix the program, underreporting has not changed and appears to be worse than ever.

A recent report by Public Citizen analyzed the incidents of easily preventable errors recorded in both the National Practitioner's databank and NYPORTS. Public Citizen found that New York is failing to make significant headway in reducing avoidable errors, and may in fact be seeing an increase in such errors. So where are we now after those 10 years, we're back-sliding.

Comptroller Thompson's March 2009 report found that extremely wide variations

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among hospital reporting and occurrence rates persist with some hospitals recording incidents at rates 20 times greater than the rates of comparable hospitals.

The report found that the New York City hospitals reported at a much lower overall rate than did hospitals elsewhere in the State of New York. In fact, reporter Kyla Calvert recently reported that 22 New York State hospitals -- New York City hospitals, including four large hospitals, reported no serious medication errors at all from 2004 and 2007. Despite the fact that medication errors are the most common adverse effect. This type of fiction borders on ridiculous and I think incredible.

A recent New York Daily News series chronicled severe underreporting of medical errors at the 11 New York City Health and Hospitals Corporation hospitals. Out of the 11, the Daily News found all 11 to have covered up and/or underreported serious medical errors. The Daily News

series, in that series, even HHC officials acknowledge that underreporting was a problem and said, "All hospitals in New York City, not just HHC, have been challenged by the issue of underreporting."

But hospitals have the capacity to report accurately. We know this because there are a few hospitals that actually choose to make relatively accurate NYPORTS reports. Too few hospitals feel currently compelled to do so despite the mandatory nature of the NYPORT system. Underreporting hospitals must change the hospital culture that frames accurate adverse incident reporting as a bad thing. Accurate reporting benefits patients, doctors, hospitals, and taxpayers alike.

There were some earlier testimony about, we need to reduce the reporting codes. The Comptroller's report on page 22 and 23 talks about some of the 22 reporting codes that were cut. These -- code, for instance, 303, pneumothorax, a collapsed lung which can occur as a medical procedure,

such as a catheter insertion, there were 529 reports of that alone in 2004, yet that category is cut. Code 501, all unplanned conversions to an open procedure because of an injury and/or bleeding during a laparoscopic procedure. There were 242 reports in 2004. Now we've cut that.

Well, you're saying it's probably only a couple of hundred. Well, code 803, post-operative hemorrhage or hematoma, 4,501 reports in 2004. Yet, sadly, we've cut this code also. Of course, we probably don't care about 804, leakage of gastric or intestinal fluid along the suture line requiring repair, there were 308 of those in 2004. Code 805, wound de-hissing, rupture or splitting open requiring repair, 645 reports in 2004, and code 806, a displacement, migration, or breakage of an implant, device, graph, or drain whether repaired or intentionally left in place or removed. There were 682 reports.

So the testimony to the extent that we want to make a weak New York report

system weaker, we've already cut significant things and I argue that we need to include

those back.

Hospitals and doctor groups argue that stricter enforcement of reporting requirements will result in more doctors being subjected to malpractice actions. But this is patently untrue. The truth is that most doctors never have and never will make a malpractice payout. Only a small minority of doctors ever make a medical malpractice payout. And those tend to be the repeat offenders.

In New York State, between 1992 and 2008, only 6.6 percent of the doctors have made three or more insurance medical malpractice payouts, but they account for 49.9 percent of all the payments. Is it the repeat offenders that doctors should blame? These repeat offenders are responsible for the bulk of malpractice payouts and make malpractice insurance coverage more difficult for all the other doctors whoever commit malpractice.

The awful truth is that the small minority of doctors who commit malpractice are rarely disciplined for their actions in New York State, even when they are repeat

offenders.

NYPIRG's June 2009 report, contraindication, federally government data demonstrates that New York's medical malpractice insurance rates are contrary to payment trends, shows that only 7.8 percent of New York City doctors who have made two or more medical malpractice payments were ever disciplined by the New York State Board of Professional Medical Conduct. This is unacceptable.

Similarly, a public citizen report analyzed figures from the national practitioner databank and showed that only 33 percent of doctors who made 10 or more malpractice payments received any discipline by their state medical boards.

Even more disturbing that national practitioner databank data show that physicians with up to 31 medical

malpractice payments totalling millions of dollars in damage never received any disciplinary action. What's worse is that the handful of doctors in New York State -- that New York State does choose to punish, a 2007 NYPIRG report found that over 59

percent of those disciplinary actions by BPMC were based on disciplinary actions already taken by a federal or state agency. And, to boot, New York is only a handful of states that won't permit the public release of the doctors' names that are formally charged with misconduct. This must be changed and we must have sunshine replace the secrecy.

The NYPORTS system is broken. Our current NYPIRG report system is broken. Hospitals are not accurately reporting adverse interests, adverse incidents, and the DOH is not sufficiently holding hospitals accountable for committing medical errors or underreporting these incidents.

In fact, the Daily News found that the HHC hospitals have received very

few citations. Between 2004 and September 2008, HHC was issued 517 citations. The Daily News found that the enforcement was virtually nonexistent between June 2002 and June 2009, with only 12 enforcement actions being initiated despite hundreds of citations by DOH. How can we expect hospital to comply with a mandatory system

that is not enforced? Clearly, the lax enforcement has not encouraged accurate reporting by hospitals.

The Department of Health claims that in addition to NYPORTS, it has other tools for protection of patient safety like investigation of doctor misconduct. But as I've described above, the abysmal disciplinary record against doctors who commit serious and multiple serious malpractice shows that the state is not using doctor discipline as a tool to protect patients.

Doctors and hospitals often like to blame medical malpractice lawsuits for underreporting adverse medical incidents,

and for causing healthcare costs to skyrocket. Studies have shown that by limiting the legal rights of injured people, it does not lower healthcare costs more than two percent, but safety does.

For example, the September 2009 Northwest Kellogg School of Management concluded that comprehensive nationwide tort reforms would lower overall healthcare costs by 2.3 percent at most.

Similarly, a recent report by the Congressional Budget Office showed that medical malpractice amounted to less than two percent of the overall healthcare spending, that is not malpractice actions that is unfairly burdening the healthcare system. In fact, in that 2.3 percent, it was also included the cost of the hospitals -- or the insurance companies administration and profits were included in there.

Moreover, the number of medical malpractice cases filed in New York State has steadily decreased. This is a national trend. According to the National Center for

State Courts, only six percent of the civil caseload is comprised of tort cases. Of that, just three percent is comprised of medical negligence cases. And even that tiny number has decreased by eight percent over the last 10 years. Data from the national practitioner database to which all physicians and medical malpractice payments must be reported confirms the same downward trend. Moreover, only about four percent of injured patients or their families sue according to a Harvard study.

Finally, only one in five lawsuits results in an award to the patient. The amazing thing is that more patients don't sue, said Paul Keckley, the director of Deloitte's Center for Health Solutions.

In October 2009, 81 year old Noreen Zasara entered the Saint Joe's hospital in Syracuse for a routine procedure for heart patients getting a shot of diuretic to treat her swollen legs. She had Type II diabetes and dementia and a pacemaker, but was otherwise in perfect

health. She was admitted, treated, and released on the same day but her rehab facility could not admit her and that extended her hospital stay. Three days later she had respiratory distress with 104 degree fever. She was tested and found to have MRSA, and that, of course, is we know is an antibiotic resistant bacteria. She fell into a coma and was placed on a ventilator.

On December 2008, she passed away when her family decided to remove the ventilator. Adding more pain to the situation was when Betsy Zasara received her

mother's death certificate, the cause of death was listed as pneumonia, not MRSA. MRSA was not even mentioned on the death certificate. This is just one classic example hospital underreporting. When Betsy complained, the doctor said, well, does it really matter what's on the death certificate? And she replied, yes, it does. One of these days we may start counting the people who died from MRSA, and I want my

mother to be counted. The death certificate was ultimately changed to reflect MRSA. We can only question as to how many cases the death certificate wasn't changed.

Now, another case on September 2007, 32 year old Diane Rissick McCabe went to the Albany Medical Center to give birth to her second child. After 12 hours of labor, her obstetrician order a cesarian section. However, during the surgery, she began bleeding internally after her uterine arteries were cut or torn. Her obstetrician and attending physician at Albany's Medical Intensive Care Unit disagreed over how to treat her and she would ultimately bleed to death.

She was moved from the operating room to the post anesthesia care unit to a surgical intensive care unit as her condition worsened. An affidavit submitted by Joseph McCabe's attorney recounts testimony regarding what happened. A portable ultrasound machine was used to scan the insider of her uterus for signs of

bleeding. But her obstetrician testified that, "his skills with the machine were not great when evaluating bleeding."

A year or so ago, the Governor in a program bill number 54 advanced sweeping pro-patient legislation, and some of these measures included requiring the State Department of Health to review medical malpractice payments by physicians to identify potential problems.

The state Health Department collects data on medical malpractice payments of physicians from insurance carriers, and recently pledged to use the data to identify those problem doctors, 6.6 percent.

The review of the so-called close claims could uncover patterns of misconduct

deserving of investigation. A law should be passed to make those close claims review a requirement. In addition, the state should take steps to ensure that reporting of close claims by insurance companies is accurate and complete and their books should be open.

Requirement number two. Requirement that the Health Department release the names of doctors who have formally been charged with misconduct. The Governor's proposal follows the practice of virtually every state in the nation.

Number three, requirements that every healthcare facility and physician's office post a notice advising the public how to access the physician profile's website and the website of OPMC. The general public deserves to know the availability of these programs. Currently, they essentially do not.

The Health Department must require that all licensed facilities and professionals post conspicuous signs in their office alerting the public to these programs.

Four, the bill ask for the

requirement that the Health Department ensure the accuracy of the information provided by doctors that they maintain in their patient profiles -- or physician profiles. Physician profiles are supposed to be updated. It is clear that there is currently no system in place to enforce this requirement.

Five, the requirement that healthcare plans and managed care organizations report the termination of a doctor's contract premised on impairment or misconduct, and it would require courts to report sentences imposed against physicians for criminal activities.

Six, requirement that doctors who have lost their New York license to practice medicine take steps to safeguard and make assessable the medical records of their former patients.

Seven, allow OPMC in certain circumstance more easily obtain a doctor's own personal medical records if there's reason to believe that he or she is impaired by alcohol, drugs or a disability.

And, lastly, a requirement that

OPMC begin an objective, impartial
evaluation of a physician's competency when

it is called in to question, specifically by
multiple payments of medical malpractice.
In conclusion, on behalf of
NYSTLA and its 4,000 members, I'd like to
thank the members of the Senate Committee on
Health and the Assembly Committee on Health.
Assembly Member Gottfried and
Senator Duane, again, thank you for the
opportunity to testify here today. I'm
grateful to this committee for holding this
hearing to examine the critical need for
improving patient safety and incident
reporting in New York.
NYSTLA is willing to offer
whatever assistance and support it can to
help the legislature tackle this very
important issue. I am happy to take any
questions.
SENATOR DUANE: Thank you very
much. I was wondering if you could speak to
the confidential reporting, how you think
that impacts NYPORTS, just tell me what your
thoughts are on that?
MR. BINKO: Let's just take a

simple basic case, all right? During the delivery of a baby, the baby is dropped by the doctor and sustains skull fractures and ultimately brain injury.

Right now, if there is a peer review held by the hospital, the doctor we just heard from, the doctor from Rochester, that they don't even invite him to testify. They're concerned. They don't -- their peer review system is essentially flawed because they're not making the person whose responsible come in and talk about what happened.

The problem with proving a case like from that the attorney's perspective or the family's perspective is that the proof of what happened is something that they control 100 percent of. First of all, they write all the medical records, they write all the care records, they write the operative reports. The people that are in that emergency -- operating theatre or in that room are all employees of the hospital or are of the doctor and his staff. So

essentially they have all the cards.

By allowing the disclosure of the testimony or the statements that the offending doctor made at a peer review, it allows us to have some sunshine as to what happened. It allows us, meaning the patient's family and the lawyers, because if there is complete secrecy there, the doctor can say what he's wants, and during the time of the examination before trial, at deposition, can simply say "I don't know." "I don't know how the baby fell," and there's no way to effectively challenge it.

I think if the interest of this committee was to safeguard the liability coverage of the insurance companies, then the answer should be that there should be total secrecy. But I think if the focus of this committee is to actually protect the patients and the public, I think there should be less secrecy. Not only should they be not allowed to skirt -- the doctors skirting this situation, they should be required and mandated to come in and tell

what happened. If you dropped the baby, it's terrible, but lying about it and covering it up is another thing.

And most of the time, when there's these errors at the hospital, there's so few people that actually sue because they never know what happened. They don't know why grandpa died. They have no idea about the infectious disease that we learned today can come from just placing a cookie on a counter that's supposedly clean. They never know and they never have a chance. So by keeping everything in the dark and allowing an opportunity where you'll never know, I think the focus, since this focus is on patient safety, there should be no secrecy and they should be compelled to have to testify at peer review and testify honestly.

SENATOR DUANE: Now if I can just follow up. You know, when I taught high school civics class which I did until fairly recently, and which I would like to do again very much, I often would have to discuss

with the students how when you pass a law,

when you promulgate regulations, you can't make -- it's difficult to make exceptions when you're doing that.

And so the examples that you used in answering that question, of course, you know, I see and, generally, of course, sunshine sounds, and is generally the best policy. However, there are conceivably times when because of a patient's, a family's needs, or a compelling reason for other reasons that confidentiality would be requested, required. I'm not sure how -- you know, when you -- when we craft regulations and law regarding sunshine, how would you craft exceptions to that and how would you protect the confidentiality when that is necessary and appropriate?

MR. BINKO: Well, I guess, Senator, I think the first thing we'd have to try to do is identify when this complete sunshine would be at detriment. Certainly, it wouldn't a detriment to the hospital itself if it's assessing why a particular

fatality or injury occurred. I can't imagine why they would not want to know the full story.

Certainly, with respect to the patient's family, in order to get the type of disclosure I'm talking about, I mean they have to -- they've usually retained a lawyer and a lawsuit started and as part of the discovery process, that's when those statements come forward, after the case is sued.

So there's a step of family having to do something affirmative. I think it would be kind of silly to make it -- that you have to sue a lawsuit in order to get that kind of disclosure, when, in fact, if you got that disclosure early, people may see that there may not be a basis for a lawsuit -- and mainly the people that come to me, and we reject a lot of cases, it's just because they never know, they don't know. That's the thing that bothers people. They loved their grandfather. He was 85 years old. They accept the fact that he may

not live much longer, but the fact that he went into the hospital and then died of some infection which was nothing compared to why he went in in the first place, that just frustrates people.

And to the extent that there would have to be exceptions, I guess if we can figure out from a policy reason why, certainly I think that the NYPORTS system would work tremendously well if we had to have doctors give testimony at a peer review, honest testimony, and then that got reported back.

As far as specific names or assigning numbers to the system, I mean we have that in the National Practitioner Database. At least we have the data. We don't get to find out who the names are. But to the extent that the families should know, they should; and to the extent that the doctors and the hospitals and NYPORTS, we're looking for incidents of, for instance, MRSA. We're looking for incidents of what our former lieutenant governor

wishes to include as a code.

If that really is such a hot and emerging disease, we should be proactive and that's something that's entirely preventable. That's the tragedy of all of this, that these are preventable. And to the extent that there is disclosure, you

know, it's one thing if it's a wrong-side surgery, or some of the never events described, with the dropping of the baby, but there is still a defense if they -- if the doctor's testimony is compelled and it's disclosed, there's still a defensive. There's an error in judgement, there's still all the courts that they can go through.

If it's something that's clear, then surely that would encourage companies like HHC to settle those cases quicker before they incur the unnecessary expenses of trial expenses, expert expense, defense lawyer expenses, and it would just move the whole system.

I know with respect to the courts, these medical malpractice cases,

they're complicated. They take a long time to try. If they could eliminate even 10 percent of them quickly, I mean, the court system would love that. So it's really win-win all the way around.

SENATOR DUANE: You know, I certainly appreciate what you're saying and there are times though when an attorney might ask a judge to have a gag order or

youthful offenders, you know, their record is sealed. I mean, there are times when an attorney might ask to have a gag order or sealing of something, and so even from that -- I mean, even if I am having some trouble, you know, right here, right now, thinking of times when you would want to have exceptions, it is possible that there would be, and how would you make that fair? How would you -- you can't say, you know, they have to be all sunshine, but then the other side -- you know what I mean?

MR. BINKO: Sure. Senator, we have some provisions right now where we ask a public agency for public record, we foil

them, freedom of information, and then they have so many days to reply and, if they want to take an exception and not disclose them, they have to provide an answer saying why and we can go and ask intervention of a judge.

Certainly, there's a similar system like this that already works so well with foil. If there's a reason why that doctor who dropped the baby in the hospital are trying to stop the disclosure of those

records, then perhaps the burden should be on them that they make the application in front of a supreme court judge, and, you know, you get another filing fee for an index number, $170, and another $45 for judicial -- an RJI, request for judicial intervention, another $45 for a motion cost. So all the generating fee things that New York State's put in place to generate revenue would certainly be enhanced and we would have more money in the system.

And for those types of costs, though, I mean, the standard of care is that

there would have to be some kind of a real good reason for secrecy other than to prevent responsibility from being affixed to the negligent actor.

I suppose if it had something to do with -- but then again, if it was somebody famous, I was going to say Michael Jackson's death or something, but doesn't the public have a right to know that he had pretty much the same doctor that Elvis Presley did, and it's just a different generation. A pop icon that sort of came to some bad medical advice and drugs.

SENATOR DUANE: You know, I don't really mean, you know --

MR. BINKO: But I think if you put the burden on the person resisting the discovery, I think that would certainly be fair. I wouldn't object to some type of a mechanism where they have so many days to go and apply in front of a Supreme Court Judge, and the judge en camera can review it. And if there's some particular reason that maybe there's -- I mean, I can't even imagine, but

if it's something to do with federal, men from Mars, some radiation, I don't know.

SENATOR DUANE: You know, I smiled really because foil is such a contentious issue in Albany.

However, if our goal is to improve NYPORTS, to improve the reporting, to streamline, to align, and to put a focus on -- two, three, four particular instructive incidents, or however it is when we move forward, and it's a little unfair to ask you and not to have asked some of the previous people who testified, but is it possible and how is it possible if we did work on that -- because it's being

contentious, relationships, that you would be at the table which you've had an adversarial -- is it possible, and how is it possible that we could work with you and the other stakeholders in a -- and I believe it can be done in the spirit that you would want it to be done, in a spirit of trust, and with the goal of improving patient safety.

MR. BINKO: You know, we come into this advocating patient safety. Even though it's economically against our best interests, but just from -- the biggest thing that any of our clients tell us is, they don't really care about the money, they just want their grandfather back, they want their arm back.

I have a case where I just signed up last week where I have a 15 year old child that was playing varsity football and he went and he made a tackle and he broke his wrist. He went to the hospital, the local hospital and they saw it was displaced, they called in an orthopedic surgeon and he manipulated it and put it in a cast.

The next day the family was back because the pain was so severe and he was given more narcotics and told to tough it out. Three days later he came back. They finally cut the cast a little bit and his arm blew up. Two and a half weeks later, they amputated his arm because of the cast

being on too tight and the advanced gan green and complete tissue lost.

Now, I'm representing that child. But that's a completely preventable and negligent thing. And because I represent him, that's terrible that I have to have a case like that in today's day and time.

We have medical error cases where the pharmacist can't read the prescription, and the person sitting out here in New York City that's writing a ticket has better equipment.

So all of those things are reasons why we would be effective partners. We think that it's time for medicine to move forward because every one of those patients we have would rather have their arm back or have the tragedy not happen to them. That's why we're here.

SENATOR DUANE: Okay. Thank you.

CHAIRMAN GOTTFRIED: A couple of questions. Towards the end of your testimony. I don't know if you were reading from a written statement or just from notes

about legislative recommendations.

MR. BINKO: Yes. The site for that is strengthening New York State's Oversight of Doctors, a case for reforms, May 2008. It was written by Blair Horner of the New York Public Interest Research Group.

CHAIRMAN GOTTFRIED: Okay. One of the things we did in '08, I mean, we enacted, not every word, but a large part of the Governor's program bill and we added some additional material to it.

In terms of the disclosure of malpractice allegations, they are now legally disclosed once a three member investigative committee of the board of professional medical conduct reviews the allegation and recommends that the case go forward, and so what is not disclosed to the public is allegations that have not yet gone into that process or were rejected from that process.

How does that revised reporting system, so that allegations, once they are cleared to go forward in the system become

public, at what point in the lawyer professional misconduct process do allegations get disclosed, and should be two systems be comparable?

MR. BINKO: Well, the lawyer system is -- it works tremendously well to the extent that it -- we're regulated specifically by the Appellate Divisions in which we practice and the discipline comes directly from the higher court that we're a part of, and the courts -- if any time that the decisions of the fourth department, third or second come out and are published, there's a large number of people who -- there's names and everything, gets disclosed, and it's fully disclosed to the public what they did, and what the recommendations are.

A lot of times going through that, they're very severe. For instance, simply commingling money in a client's account, your trust account with your business account, basically using your

client's money to pay your bills, the courts

are very -- they'll look at it for two factors; one, if you've never had a problem; and, two, if you cooperated fully with the process. If you tried to hide what you did, the courts usually will disbar you or suspend you for a long period of time. Whereas, if you came forward and admitted what you did freely to that disciplinary process, that they will give you a suspended sentence or a lesser term of a suspension or a public censure.

What's lacking with the medical society is there's no incentive in the very few percentage cases that they actually do something about for these doctors to come forward and truthfully say what they did.

It's also contingent upon them hiding behind the theory that they would be responsible. The lawyer who tries to hide behind that is still going to end up being -- he will have a license. That's the difference.

So if you did marry the two of them up, there's tremendous enforcement on

our side of the issue for the lawyers, because if you don't cooperate and admit to it, you will no longer be a lawyer and you're going to end up finding some other kind of employment.

Whereas, the doctors -- and we may be scared too by liability concerns like let's assume that it's because of malpractice and we didn't sue the case in time. There might be some incentive for -- our ethics and our system requires us to meet with the patient or, in this case, the client and say, Assembly Member Gottfried, you than matter you entrusted me with, that car accident, well, that was three years ago and I blew your statute of limitations. I'm sorry. You can sue me, of course, and we have to disclose that publically. We don't have any "I'm sorry rules." We don't have anything to say, well, if you sign this, I'll tell you what happened, why your case didn't -- we have nowhere to hide behind.

And if we don't do that to you and you go report me, and I didn't have that

full and frank discussion with you, it kind of -- I probably would be suspended I would hazard a guess, but it would be longer than had it been very honest with you and said a mistake happened, and, by the way, I have malpractice insurance and there's, you know, that type of thing.

So I think if you're going to marry these two together, pick the system that we have because it invites responsibility and it takes licenses and it suspends people.

CHAIRMAN GOTTFRIED: Does public disclosure of a legal discipline proceeding happen before the proceeding is terminated against the accused lawyer?

MR. BINKO: Generally, it occurs after, but there are examples of where things have happened if they felt that the public was at risk for the lawyer's conduct, and what the lawyer was doing.

Generally -- and I can see why there's a difference. I mean, if somebody's doing horrible surgery out of the back of

their office without proper utensils, there's more harm for injury rather than the lawyer who is commingling Senator Duane's money and Assemblyman Gottfried's money. That's going to cause harm, but that's not going to result in death.

What happens in those situations is the courts have authority to take over that trust account, so they can just freeze that and they can stop it. So they can cause -- so to that extent, the fact that we're not killing or maiming people, at worse, we're committing legal malpractice on the reaction or commingling money and the Appellate Divisions and stuff have authority to take over that account. That might be the reasons.

CHAIRMAN GOTTFRIED: Lawyers don't really have an entity that would be really analogous to a hospital other than to a certain extent maybe a large firm may be similar.

Do law firms have organized quality assurance peer review processes and

what is the legal status if there is a law

firm that has such an internal process, what, if any, disclosure potential is there for what is said among the lawyers of a firm when they are discussing, if they do discuss in a formal way, what happened, you know, what went wrong on case X?

MR. BINKO: Well, actually, there is -- I'm going to tell you -- I'm from Buffalo. I'm a member of the Erie County Bar Association out there and Erie County Bar Association has its own discipline program. It's completely different from the Appellate Division and, let's assume, assembly member, I was representing you and you were unhappy for whatever reason, and you wanted to write a letter to "blow me into the bar" or to do somebody like that.

You would write that letter. It would go to the bar association of Erie County and their lawyers, their people would review it, and they would send it to me, and they would tell me that I have X amount of days to respond to it.

They would also tell me that anything that I say in that letter will be given to you. So I now have to write the

letter back explaining or going through what I did or didn't do or accepting responsibility in the case of a breakdown, and then that letter gets sent to you, and you may send a reply, and then, at that point, the Erie County Bar Association's will review the matter and they'll come up with some kind of a recommended action.

They may recommend that the matter get turned over to the Appellate Division for their licensure. It's a serious matter. Or they may try to just come up with a way to resolve it between a member of the public, you, whose not satisfied with services that I have if I represent you.

A lot of times, what we found, it's mostly a communication error. You may have had a lot of unreturned phone calls. You might have been frustrated by something that I did or didn't do on your behalf, and

the bar kind of tries to get in there, I don't know if that's what you'd call peer review, but we do have people in the Erie County Bar who do that job to try and get in the middle of the public and the offending

lawyer.

A lot of times it gets worked out and a lot of times they may end up saying, you know, the two of you have irreparable differences. There's nothing that's he's done that's unethical. There's nothing that he's done that's malpractice. Maybe it's just that you need a different attorney because of personality issues. And that helps the public in large, and it's also in a sense a peer review that, for whatever reason, I failed representing you as a client. I didn't do anything wrong, but I failed.

So, to that extent, there is a check and that's something available that the public can -- now, obviously, it's a greater issue or something that merits -- than the Erie County Bar Association

lawyers, they themselves, they decide. It isn't that I have a choice anymore.

Then everything that I've written and that you've written, and their recommendations then get sent to the fourth judicial department which is where I practice out of and where I was admitted and

then they have their own formal process that goes forward.

So, essentially, while it isn't a large firm peer review, I think it works better because it applies even to a lawyer like Richard Binko who has three lawyers in his office. So I am held accountable by that bar association.

CHAIRMAN GOTTFRIED: Okay. Thank you.

SENATOR DUANE: Thank you very much.

CHAIRMAN GOTTFRIED: Our next witness is Lorraine Ryan from the Greater New York Hospital Association.

MS. RYAN: Good afternoon, Senator Duane and Assemblyman Gottfried,

your staff and interested parties. All of us here are committed to patient safety.

Thank you for the opportunity to provide testimony about improving patient safety and, more specifically, NYPORTS. In my role at Greater New York, I work directly with our member hospitals on a daily basis to help support there improvement efforts with regard to quality and safety, as well

as efficiency, and help to implement these quality initiatives focused ultimately on improving clinical outcomes.

I also serve as a resource and spend a lot of time with the hospitals with regard to the state's incident reporting program.

As a former hospital administrator, nurse and attorney, I've been involved with the state incident reporting program since its inception in 1985. I've also participated in the development and implementation of NYPORTS over the last decade as a member of the statewide NYPORTS council in my role as an advisory to

hospitals at Greater New York.

I appreciate and agree with your comments, Senator Duane, with regard to the need in our state for a more comprehensive agency, if you will, with regard to overseeing all of our patient safety activities, and I think Dr. Morley also supported that in his comments.

I also acknowledge and support Comptroller Thompson's call for greater resources being devoted to NYPORTS and

you'll hear in my comments today that I think that is a call to action that we must heed and heed swiftly.

I also agree with Comptroller Thompson's remarks that an effective incident reporting system can, in the long run, decrease cost to our healthcare system.

I echo Senator Duane's comments that Art Levin is a rock star. I think that all of us who have known him and worked with him over the years and, believe me, he has been a tireless advocate for the public and patients at the Statewide NYPORTS Council

meetings, and he's offered a great degree of candor and credibility to that program, and I'm proud to have sat at the table with him and hope to continue to do so soon, another thing I will call for in my remarks as we go through the testimony.

I'd also like to just acknowledge Mr. Binko's statements, and the cases that he chronicled today I think unequivocally all of us in the room would agree should never happen. They're tragic, they're horrific, and they should not be taking place in the year 2009 and beyond in our

hospitals in New York State.

Now the downside of testifying at this point in the hearing is you've basically heard everything that I'm going to say, but the good news is that I think the platform has been set for maybe me to put a little window dressing on that, if you will, or a little more meat on the bones.

I also would just like to make one further comment that I totally applaud the efforts at the Hospital Association of

New York State with regard to quality and patient safety, as well as those at Health and Hospitals Corporation. Every word that you heard from Dr. Raju, those actions are taking place, those programs are implemented across their 11 hospital systems and they're to be applauded as a leader in this area.

I, too, however, would like to take just a minute at Greater New York because I think, in the context of what you've heard today, you need to know a little bit about what's going on in the area of patient safety and there's a lot going on.

Greater New York has in the past

and will continue to devote considerable resources assisting our over 250 members, hospitals and long-term care facilities with improving quality, patient safety and efficiencies through innovation, education and collaboration among members as well as with regulatory accrediting and professional bodies, and I'm very proud of that collaboration with the Department of Health

and others.

Over the last several years, our hospitals have been able to implement a number of successful and sustainable patient safety initiatives in the area of infection prevention and, specifically, C.difficile, is currently very much on our radar and we have an existing ongoing collaboration to that end.

We've taken the C.diff collaborative further than just infection prevention, which is obviously pivotal in our ultimate goal, and are really looking at issues with regard to appropriate antibiotic use and the cleaning issues that were raised by Ms. McCoy this morning.

Other areas of quality and

patient safety include our perinatal safety initiatives and our strong focus on critical care including rapid response systems. These initiatives, along with involving a tremendous focus on creating a culture of safety and really reshaping that culture in our organizations by actually asking

hospital staff, what do you think about this hospital? Would you want your daughter to deliver her baby in this hospital? Would you want to be operated on in this hospital, so on and so forth. And then bringing these results to the attention of leadership in a very meaningful way.

These initiatives also involve reengineering existing delivery systems in developing strong partnerships with frontline staff. They are pivotal to the war on medical errors. And, as you heard again, in the infection prevention area, they are the essential ingredient to success.

We also have undertaken and will continue to undertake an extensive team training so that we can create a more standardized approach to clinical care.

Together, all these activities have led to safer care and improved outcomes for the hospitals that are participating in these initiatives.

A number of our quality

improvement initiatives focus on the collaborative methodology and, in my written remarks, I go into greater detail about what that is, but, suffice it to say, that we truly believe that a group of hospitals working toward a common goal can achieve much more than any one individual institution can achieve on its own. And this collaboration has truly been very rewarding and worthwhile, and has been demonstrating excellent results.

In this model, hospital leadership commit to creating and promoting this culture of safety which I just mentioned which includes complete and full reporting at adverse events.

Hospitals have to commit the resources needed to support staff participation in the initiative, adopt a bundle of evidence-based practices which Dr. Raju also mentioned this morning as a key

ingredient, and arrange for
multi-disciplinary team participation in
both training and ongoing educational

programs. These collaboratives collect and
act upon data to drive improvement and then
share these successes so that others within
the state can benefit from these improvement
opportunities.

There are a number of areas that
we are focusing on that, again, are in my
prepared written remarks which I will not go
into at this point.

I also want to mention another
area of focus for Greater New York for the
last, actually, decade. In the early 2000s,
we were granted funding from the health
workforce retraining initiative to focus on
the root cause analysis process. This is
pivotal to changing behaviors and to
identifying constructive strategies for
improvement.

Through this grant funding,
Greater New York has trained over 1,500
hospital staff, primarily quality
improvement specialists, nurses and
physicians. This intensive focus on root

cause analysis and the fundamentals of

what's required to do a meaningful root cause analysis is paying off. And effective risk reduction strategies designed to prevention of recurrence of adverse events is taking place.

We are currently in the process of seeking additional funding to renew this training and to continue the quest and we'll also be adding a component for case identification. And I think, as I go through my remarks, and address some of the challenges to the NYPORTS program, you'll better understand some of the obstacles and barriers hospitals currently face with regard to case identification.

But suffice it to say, that we believe that all of these initiatives collectively have and will continue to lead to improved outcomes and inpatient safety and clinical care.

In almost all of our initiatives, we have included the Department of Health as a partner. We brought them to the table in many of our collaboratives, and we strongly

encourage the department to utilize the lessons learned from these initiatives with all hospitals and caregivers across the state whether or not the hospitals themselves are involved in these collaboratives. So we're very interested in chairing the wealth, if you will, and having others benefit from our experience.

Now I'd like to turn my attention to NYPORTS. Several of the speakers before me have reiterated my feelings that reporting is only valuable when you do something with the data that is reported, and that it is disseminated in a meaningful way across the state.

And I will try to sort of shortcut through some of these comments, but I may have to turn to my prepared remarks to a certain extent to really make that point.

We all know that incident reporting in New York State came before the IOM sentinel report, To Err Is Human, but that report underscored the importance of a mandatory incident reporting system as a

quality improvement tool. The initial focus on incident reporting in New York State was purely on accountability, and I don't think there's any argument with that, but as the system evolved into the NYPORTS system in the later 1990s, we saw that much -- there was a much greater focus on quality improvement as well as accountability as the state tried to fulfill -- attempted to fulfill its mission.

The objective of NYPORTS is to make sure that hospitals identify and report adverse incidents promptly, and they undertake a thorough root cause analysis so that they can effectuate corrective action plans in a meaningful way.

The overall goal of NYPORTS is, of course, to improve the degree of healthcare for all New Yorkers. We know that. To achieve this goal, it is intended that DOH through NYPORTS provides information back to the public as well as to hospitals, meaningful information to hospitals so that they can use this

information to benchmark data and ultimately improve what they do.

Accountability still underscores part of the department's mission, however, but we're all in this to improve patient care. Greater New York supports the department's goals and agrees that meaningful analysis of NYPORTS can have a significant positive impact on patient safety. However, NYPORTS faces serious challenges in meeting its goals and objections.

Greater New York believes that NYPORTS is not appropriately funded to achieve objectives outlined above. In a paper entitled, Lessons Learned from the Evaluation of Mandatory Adverse Event Reporting Systems, which was published in the Agency For Healthcare Research and Quality Journal in April of 2005, and which, by the way, was authored by the Department of Health and others involved in the development of NYPORTS, the following elements were noted as critical to the

success of a mandatory incident reporting program. A collaborative system design, a

system based in statute with clear definitions and objective reporting criteria, meaningful data that can be analyzed and disseminated for improving patient safety and adequate resources to maintain the system.

I would like to quickly address each one of these goals with the aim of helping the State Senate and Health Committees more clearly understand the challenges that NYPORTS faces today, and how it can be improved.

The first essential element, collaborative system design, I don't think has been a problem. From day one, the department has welcomed hospital input into the development of NYPORTS, and through the effective work of the Statewide Council, consensus has been reached on many elements of the NYPORTS program.

In fact, there has been study and consistent stewardship of the program from

the many voluntary engaged representatives from the hospital community, active consumer advocates, as well as representatives from the Department of Health.

However, I will say that this momentum has ground to a halt, if you will, over the last couple of years, and the Statewide Council has not met in over two years. So although, initially, the collaborative work, it was full of energy and rigor, it has come to a halt to a certain extent. And I call for the department to reconvene the Statewide Council as soon as possible and have been calling for that for a number of months and they have supported my calling for that and welcomed it to a certain extent.

The second essential element is a system based in statute with clear definitions and objective reporting criteria. I won't go through how NYPORTS evolved to where it is today, but suffice it to say, we're in a much better place than we were in 1985 when incident reporting first

came to us in statute and regulation.

NYPORTS' progression from its original incident reporting program to NYPORTS has been very positive in that it is now based on a list of identifiable, reportable, and trackable codes, and this

migration occurred because of the difficulty, the great difficulty hospitals had in identifying what they were required to report based on the statute and regulations alone.

NYPORTS was developed to standardize reporting across the state with not only the use of these inclusion exclusion criteria, but also a NYPORTS definition manual that again was put together by the Statewide Council to actually further standardize and help hospitals understand and interpret what needs to be reported.

As you've heard from other speakers, we initially had approximately 54 codes in the system. That has now been reduced to, I think, the codes list is in

the 30s, and the whole idea there was to focus more on what the priority areas were so that hospitals, as they undertook these intense root cause analyses, were really focusing on where they could get the biggest bang for the time they spent.

Reporting and analyzing cases is a huge undertaking. There was a great

degree on the part of the hospitals as NYPORTS was involved because they anticipated and expected and hoped that this would be a very meaningful system and one that could help drive their quality improvement efforts. And notwithstanding this effort to clearly articulate what was considered reportable under NYPORTS, because of the complexity of healthcare and the unique characteristics of each patient, a certain degree of subjectivity still remains to this day in the system.

There is no automatic system or framework for effectively identifying and reporting a case. Rather intricate processes must be developed in each hospital

to concurrently identify reportable cases. Then, each and every case that is identified as potentially reportable, goes through a rigorous review process whether this case meets the ultimate criterion, that being whether the occurrence or event occurred as a result of an error or judgement or technique or as a result of systems failure versus whether it was a result of the patient's natural cause of illness.

Compounding the difficulty of assuring that each and every case is 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 is reported.

However, notwithstanding the difficulties, hospitals have invested substantial resources to meet the reporting requirements, and notwithstanding the

challenges described and those that have been heralded in various reports, they actually do a pretty good job of case identification and reporting. More than a pretty good job, I'd say they do a very good job.

Getting to the third essential element, providing meaningful data that can be analyzed and disseminated for improving patient safety. Although 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 occurrence, it's not nearly enough.

Many hospitals have been able to use the aggregate NYPORTS data that department makes available to facilitate this hospital level evaluation and analysis. However, a hospital's ability to do this is often dependent on the level of IT system's knowledge and sophistication within that

hospital because the department, to date, has not been able to, or does not have the capacity to give very much support, technical support.

We believe that the department could play a greater role in quality improvement if they were to devote more resources to data aggregation analysis and feedback to the hospitals. In this vain, more code specific tracking and trending by type of hospital, type of patient, as well as more widespread sharing of the findings of the root cause analyses and lessons learned are needed.

Currently, the data available to hospitals are either not retrievable or not available in a form that is useful, and that can contribute in a meaningful way to performance improvements efforts. More timely and useful feedback that providers and senior leadership receive about the quality improvement facets of NYPORTS will offer greater motivation to report into the system.

The fourth essential element is adequate resources. And although I've already mentioned this, I have some more specifics with regard to the lack of resources.

We believe there is a fundamental conflict between the goals of NYPORTS and the adequacy of the resources available to the department to effectuate these goals, and I think you've heard that from other speakers today.

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 the available funding, influence the performance and capabilities of that 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 the hospitals.

To that end, insufficient training resources are also the current state of affairs. Ongoing NYPORTS training is invaluable to system users striving for consistency and quality in reporting, there are things that they NYPORTS system has been criticized by most recently in the comproller's report.

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 ongoing education and training on NYPORTS has been provided through Greater New York's root cause analysis training program which includes a discussion of

NYPORTS reporting requirements.

Additionally, several years ago, Greater New York formulated a NYPORTS users group in supporting hospitals in meeting the challenges of full and complete reporting, to keep them abreast of the activities of the NYPORTS Statewide Council, and to provide a forum for hospitals to provide input on issues the council was considering. Although Greater New York has continued these efforts since the NYPORTS Statewide Council stopped meeting more than two years ago, there has been limited information to share with the user's group.

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. 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, the data analysis component is just not working. 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.

Further along that line, there's been insufficient dissemination of the lessons learned. In addition to the focus on training and education, communication and the dissemination of information had been an important area of focus for the department and the NYPORTS Statewide Council.

In 1999, the department began issuing a periodic newsletter, NYPORTS News and Alert. This newsletter provided timely information about analysis, interpretations, and the use of NYPORTS data, and made information about NYPORTS more generally

available to the hospitals, community, and beyond. The last time this newsletter was

published was in 2006.

We've heard about the annual report a little bit this morning and there was a commitment for the department to get the annual report for the last couple of years worth of NYPORTS data out before the end of the year, but, suffice it to say, the last annual report was issued in 2006 and prior to that, I believe there had been two other annual reports over the last, I guess it's about 11 years.

The lack of the ability to really provide this data analysis and to disseminate these lessons learned severely undermines the NYPORTS program and is one I think the department will have heard by the end of the day clearly on something that needs to be addressed.

Very briefly, some of the other challenges to NYPORTS and recommendations for improvement. The annual reports demonstrate that there's been improvement with regard to increasing the reporting rates and, for that, we applaud the

hospitals. The numbers you have to play with a little bit because the actual numbers of reportable and trackable codes has come down, but reporting is at a steady level and we applaud the hospitals for that.

There are two principal reasons for a program like NYPORTS; to support regulatory surveillance for serious adverse events, and to help the department serve as the protector and watchdog for the public and to serve as a repository for carefully investigated serious adverse events, and, in turn, support aggregated analysis research sharing and learning.

We believe that these two principal reasons for the existence of NYPORTS may be in conflict. 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

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which is one that supports responsibility and accountability and that is blame free.

There is support from the experience of other incident reporting programs, such as that in Pennsylvania and the one within 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 and system design and research.

And I think you've heard from others this morning in their support for both the Department of Veteran Affairs program as well as that in the Pennsylvania patient safety authority.

Greater New York recommends that these models be reviewed and examined by the State of New York for NYPORTS to regain its prominence as a leading incident reporting program that can drive and sustain

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 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, Greater New York 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.

We've had a lot of discussion today, this afternoon, and this morning about confidentiality privileges. As we all know, we enjoy a limited confidentiality with regard to the NYPORTS data. Although the reports themselves are protected from disclosure, confidentiality protections does not extend to the related surveillance

activities and findings of the Department. Often these findings, which are publically available, are published word for word in the department's statement of deficiency, an act that diminishes the value of the quality assurance privilege and that operates with the chilling effect on the quality improvement process.

Greater New York strongly supports transparency when it comes to aggregate data, but we believe that confidentiality protections on these individual case reports are essential to drive improvements in the healthcare institutions in this state.

Our recommendation is that 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 privileges.

The issue of multiple reporting systems definitions was covered this morning

in the remarks by Kathy Ciccone, and I won't reiterate what she said, but basically

understand that there are multiple and redundant, in many cases, incident reporting requirements that our hospitals must abide by in this state.

We recommend that the NYPORTS reportable codes themselves be refined and limited to the most important areas for review, and those from which the healthcare community can derive the greatest benefit from reporting and analysis.

NYPORTS definitions should be aligned with national reporting measures such as those found in the Agency For Healthcare Research and Quality Serious Adverse Event Policy, a policy that many others around the country are relying for with regard to their payment policies for serious adverse events, and for mandatory incident reporting. This would create standardization of what is reported as well as consistency in definitions, which is very much needed. This should decrease

variability in reporting and allow for national benchmarking, a process that would, in and of itself, drive improvement.

In conclusion, I hope I have

conveyed that Greater New York is devoted to improving healthcare quality, patient safety and efficiencies. Greater New York 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 thank you for this opportunity to appear before you today and to work with both the Department of Health and other agencies in the state to improve the system.

Thank you.

SENATOR DUANE: Thank you. The section on the challenges, your recommendations was very thoughtful, very well done, very -- it's now hugely in the

mix in my head which is dangerous but could also be good.

MS. RYAN: Thank you.

SENATOR DUANE: You know, you said despite the progress, the subjectivity, the hospitals are actually doing a good job

with reporting. So now I'm asking you a question which, you know, I'm unfairly asking you, and I should ask everybody, and hopefully everybody will help us out with this. So then, why the disparity then in reporting? If you're saying they're doing a good job, but there is a disparity in reporting -- well, I'm going to leave that.

MS. RYAN: Yeah. Again, like others who have came before me today, we can do better, but I don't want the impression to be left that hospitals intentionally under-report. I tried to convey in my remarks the difficulty in both identifying cases and then having cases that go through this very rigorous process. It's very time consuming and, clearly, it's time well spent because our ultimate goal here is to improve

care and prevent any patient from being harmed during their hospitalization. It's a very resource intensive process.

I haven't studied this, but I'm sure hospitals have been cutting these type of administrative positions which are merely overhead costs in many people's minds as they try to balance their budgets, if you

will, which is impossible.

So I just can't underscore the fact that despite all efforts, there's a certain degree of subjectivity and review that we owe each patient as well as each provider as we go through these cases. It's not, you know, you can't just stamp it out, it's not cookie cutter. You have to, you know, take seriously each and every one of these cases.

I think the better way to go, and you've heard it from others today, is to prioritize our areas of focus, and whether that's the revolving priority list that, if we haven't achieved our goals of actually improving outcomes through measurable

evidence, then we add to the list.

But I think we have to focus at this point on a smaller list of occurrences that have, you know, the biggest impact on patient safety. I think we're beginning to do that voluntarily with our -- you know, we have our reporting requirements, but the things that we truly are focusing on in a more in-depth and broader way, like infection prevention, and the surgical case

identification that has gone on in the state, Dr. Morley, I think he did mention the New York State Invasive Procedure Protocol which is New York's version of the universal protocol, which is New York's version of the universal protocol which is to get at wrong surgeries, wrong site surgery, wrong procedures, wrong patient.

There's been an enormous effort to have that very focused approach and, hopefully, hopefully, we are making improvements. But to cover everything that could potentially happen to a patient during a hospitalization and say that you have to

drill down and make this your priority is nearly impossible. Healthcare is just far too complex and so underfunded at this point for us to cover every conceivable potential adverse event. I think we need to prioritize and focus.

SENATOR DUANE: And I guess, finally, you know, HANYS, Greater New York, others, you know, I, you know, have staked out and feel strongly about not cutting during the DRO, you know, we live to fight another day next year, but, traditionally,

increasing funding for NYPORTS -- I mean, traditionally it hasn't been on -- actually, I should know, maybe it has been, but I don't think it's been on increased funding lists, and dare we --

MS. RYAN: I believe it's on the list to cut.

SENATOR DUANE: So, you know -- but, I mean is it on -- you know, if we have the courage of our convictions, dare you and I ask to increase funding while at the same time we're asking not to cut? Do you see

what I mean? I think absolutely in my general philosophy and ideology would be absolutely, and it's such an incredibly difficult time, so I'm more saying that just as a, you know, we have a tough battle on our hands as we also make this a priority.

MS. RYAN: My call for additional resources, Greater New York's call for additional resources is very much focused on the system as it exists today. But I think we need to be much more efficient with the Department's resources and how it approaches patient safety overall. And I think the discussion you had with Dr. Morley this

morning was sort of moving in that direction of taking all of these systems that hospitals are required to comply with, how can we make them all more efficient?

Because the burden is now on the hospitals. There is no support for doing what is required. They want to do what's right for the most part. 99.9 percent of the time hospitals are trying to do the right thing. I would like to say 100

percent, but I'm sure I would lose my credibility.

SENATOR DUANE: And even elected officials shockingly.

MS. RYAN: But as the program exists today, it's both underfunded on the agency side and there's clearly little to no funds on the hospital side. The hospitals get very little back from the NYPORTS program at this time in terms of meaningful, useful information.

What's happening in New York today with regard to a sentinel event can be happening in Syracuse because we didn't share the lessons learned from that root cause analysis on a statewide basis. There

was a time in the mid 2000s when there was a lot of energy in the system, much of it funded through the AHRC grant program that allowed that sharing to take place. The newsletter that the state put out, they're not perfect, but it was some vehicle to say, we know what's going on in the state. Let me tell you what happened downstate so that

we can inform you upstate, or even on the east side versus the west side. Because we are limited and we had a little bit of that conversation was had this morning about sharing from one licensed entity to another, what those quality improvement strategies are based on your experience.

There was discussion about the Patient Safety Organization, and I won't get back into that. It's not necessarily the answer because it's very costly and it's cumbersome, and nobody in the state at this point, aside from a few, are very interested in getting into the PSO business.

So we're looking to the department to serve as a vehicle to share these very important lessons and best practices and create standardization with

regard to the level of care that we are providing.

We have a perinatal safety collaborative out of Greater New York. We have 44 hospitals participating trying to standardize OB care across the system, and

it's working. We bring it to the department and they're very receptive, but they don't have the resources to take it to any other part of the state. We need to acknowledge that because there a lot of good work that's going on, but as Art Levin said this morning and some others said, if we really think this is important, we'll put the resources behind it. We will have that patient safety walk-a-thon to prove that we really believe that this is a priority, this is important, and there, but for the grace of God, go any one of us if we don't improve the system.

A lot of, you know, our efforts I think at Greater New York, HANYS, and other regions of the state, they're working but we need to embrace them on a statewide basis. And whether that's through the department or some kind of a voluntary system, I'm not quite sure. I think the effectiveness can

come at a great -- in a greater sense from the department in a more concerted way.

SENATOR DUANE: Thank you.

CHAIRMAN GOTTFRIED: On the

question of underreporting, granted some hospitals may regard the reporting process as an expense that can be easily foregone.

On the other hand, when you see at least allegations that there are some hospitals that report a reasonably expectable number of medication errors or this error or that error, and others that report zero, when you -- and when you consider that not reporting something bad that happened in your operating room or on your watch, isn't there a -- shouldn't there be a serious concern that what's going on is intentional non-reporting?

I mean, it seems to me if two doctors are chatting and one says, gee, this bad thing happened, I guess I better write it up and send it in, and the other one says, you know, don't be a jerk. You could lose your license over that. Nobody's ever going to know if you don't report it.

Is the friend who says, don't

report it, don't worry, nobody's ever going to know, is there some truth in what that

fellow doctor is saying to his or her colleague? And will there really be adequate reporting until or unless a day arrives when personnel do have to fear, realistically, that if they don't report, they'll get found out and get in even bigger trouble, and does that fear exist today?

MS. RYAN: Let me begin by saying that zero reporting is not defensible, and I don't defend intentional obfuscation of the system in any way. That's not what Greater New York is all about nor I think any of us in the room today.

Unfortunately, there is no, as I said, push of a button. There aren't decision support systems in place in all of our institutions to inform them that every single case has been identified.

Those hospitals that do have such systems, however, you will find are the better reporters. You'll also find in many cases hospitals that narrow the focus in terms of the type of patients that they care for often have a better track record because

they have a greater control over the database with regard to the procedures that are being performed. I don't know what the percentage is at this point, but a large percent of the NYPORTS codes are procedure related, more than diagnostically related or -- actually there's an event that takes place as opposed to an omission where something that should have occurred didn't occur.

Much of reporting also depends upon the sophistication of the IT systems, as I mentioned, decision support system, and the level of education and training that hospitals have to continuously do as they have turnover in staff, as they have new residents come into their program every year, and maybe the more informed ones leaving their hospitals and their programs.

NYPORTS is a hospital responsibility, not necessarily a physician responsibility. However, most hospitals throughout through their relationships, their policies and procedures, their bylaws,

they make it the physician's business and the clinician's business to become part of the system.

However, ultimately it falls to the hospitals. It depends on a communication system, an elaborate communication system, one that's built on trust, and one that, to a large extent, can be blame free so that these occurrences are brought to light.

Intentional non-reporting I cannot support. I think that's about all I can say about zero reporting levels and just the intent to hide, if you will. I'm not sure that that's what's happening. I think it's more that people are not necessarily always informed at all levels of what is required to be reported.

CHAIRMAN GOTTFRIED: I'd like to ask you a little about the Pennsylvania and VA systems, if there was more discussion of earlier in the day that I missed, I apologize but, in your testimony, the way you seemed to say that what makes the

Pennsylvania and VA systems different is that they are run by really talented people who care about their work.

I hope that is not meant to suggest that the New York system is not run by talented people who care about their work. Although, I guess if that's true, I ought to hear it.

What is it that is different about the Pennsylvania and VA systems that we should try to emulate?

MS. RYAN: I just want to first say that, yes, you're correct, that my comments were not in any way meant to disparage or criticize our colleagues at the department who we work very closely with.

Both of those systems are the central core and mission of those systems is patient safety. It's not surveillance and patient safety or any other regulatory requirement. They're embedded within their systems in a center devoted to patient safety and quality improvement. I think that's what makes it different.

The department staff will be the

first I think to admit that they have sort of a dual role that they play with regard to incident reporting, the role of sort of gatekeepers if you will, and protectors of the public and assigned to a certain level of regulatory compliance and surveillance activity, and then there's the quality improvement piece, but the two don't necessarily -- what takes priority over one versus another, it isn't clear to me, how time and resources are allocated isn't clear, but what my remarks were intended to convey is that there needs to be a much more concerted effort on the part of the state to focus very meaningfully on our patient safety needs. Whether that's in a particular center -- we have a patient safety center but NYPORTS does not reside within the patient safety center at the Department of Health. It resides in the Office of Health Systems Management, which say more of a regulatory driven agency, or part of the department.

So I was calling for more of a focus and a coming together on patient safety in a more concerted way and in a more

quality oriented only way, if you will, with the regulatory surveillance, part of the department's function being taken out of NYPORTS.

It's a rather -- I don't think it's controversial maybe for some, but I think it's something that we bantered about at the NYPORTS Council for years, even with the department present, they would admit that they had the dual responsibilities in an ideal world.

When we talk about things in an ideal world, patient safety would exist unto itself, but it doesn't at this point in time.

CHAIRMAN GOTTFRIED: So in Pennsylvania and the VA, one way to characterize it would be that their reporting system is part of a system that deals in carrots and not sticks, and somebody else in Pennsylvania deals with

sticks but not carrots?

MS. RYAN: Yes, because it's a consortium and it's not purely Department of Health in terms of stakeholders within the Pennsylvania system, and a clear yes to the

Department of Veterans Affairs program.

CHAIRMAN GOTTFRIED: And in those systems, if they discover something that ought to lead to discipline of some sort, are they supposed to report it to the discipline people? Are they not to report it because that would stain their quality assurance work, or how does that operate?

MS. RYAN: As I understand it and I'm probably not as conversant as I need to be to answer some of your questions, yes, there's a reporting line out of each of those systems where there's clearly been intentional or reckless behavior, but not meeting a particular standard of care in a single case, as it's supposed to be in New York, would not arise to that level of reporting outside the system.

Unfortunately, the way the system

works in New York right now, there is this sort of need for the department to share with its colleagues in the Office of Professional Medical Conduct, certain types of cases, and they're very open about that.

But it has a chilling effect, if you will, on the providers who feel that

their case will not be fairly adjudicated and that one person's view of not meeting the standard of care may not be the same for others.

It gets complicated but it absolutely has a chilling effect when the department has this dual role to play. The department -- also, by the way, it hasn't been mentioned in any of the remarks today, is engaged with a small demonstration, near-miss registry project in the state with the goal being that you can also learn from near misses and that there should be more less fear of reporting into a near-miss system because there's been no patient injury. It's in its infant stages at this point but it is something again to explore

and that is coming out of the patient safety center.

So there is some precedent for the patient safety looking at adverse event, but, again, we have a fragmented approach to patient safety in New York, and I think that's something -- if anything results from these hearings today it would be very useful to look at eliminating some of that

fragmentation and putting together a more comprehensive approach to patient safety overall.

Clearly, those other reporting obligations exist, they exist in statute and regulation, and the department has to fulfill those in some way, but I'm not sure that the way the current system is set up is really benefiting us all as best it could.

CHAIRMAN GOTTFRIED: There would certainly be criticism that if we put the reports to the department, into a more walled off quality assurance process, with less or no tattling, if you will, to the enforcement folks. There are those who

would view that as being essentially a covering-up mechanism of the state.

I mean, that would be, I think, pretty quickly characterized as the state working with the doctors and the hospitals to make sure that nobody ever learns on the outside about who did what to who. How would you respond to that criticism?

MS. RYAN: I'm not calling for eliminating, you know, requisite peer review and reporting to state agencies as

appropriate based on the findings of the peer review. What we are calling for, however, is a separation of an incident reporting program designed to look at system and process issues and how we can improve our systems and processes across the board and separating that out from a surveillance system.

But, clearly, inappropriate behavior and performance that is less than proficient and substandard care would still be reviewed and reported in the ways that our state currently calls for. But I'm

talking about, NYPORTS have evolved, to a large extent, in its mission, as a program designed to help healthcare providers improve upon the systems within which they work, and I think we could get, you know, a greater degree of improvement and a greater degree of standardization, if we could do that in a more blame free, protected environment.

It's not to say that we are covering up in any way. I believe in public reporting of aggregate NYPORTS data. There's no reason that how we're doing and

the trend lines should not be publically reported. Again, now that's available under the Freedom of Information Law, but it's out there already. There are hospitals that are already posting these type of benchmark data on their websites, we can't be afraid of it, but the actual mission of the agencies that oversees this process, I believe would be more meaningful and could achieve a lot more if its primary goal and mission was patient safety, and not patient safety and

surveillance.

CHAIRMAN GOTTFRIED: Okay. Thank you. We are now going to take a five or 10-minute break and then come back.

(A break was taken.)

CHAIRMAN GOTTFRIED: We are now going to reconvene. Charles Bell is our next witness.

MR. BELL: Good afternoon, Chairman Duane, Chairman Gottfried.

My name is Charles Bell. I am the programs director of Consumers Union, and we are the nonprofit publisher of Consumer Reports magazine based in Yonkers New York. I think I can save some time by

acknowledging that Art Levin covered a number of points that pertain to my written remarks as well.

I think all of the consumer organizations that I'm familiar with are quite concerned about the material that's in Comptroller Thompson's report about NYPORTS. We're -- we think it would be hard for the public to have confidence in the system of

mandatory reporting where there's very weak validation measures and weak enforcement provisions, such that the reporting for institutions is widely inconsistent and there's underreporting of medical errors and other things as was noted in Commissioner Thompson's testimony.

So we are very interested in the recommendations that were made in that report. We look forward to working with Comptroller Thompson's office and others to try to make sense of this. We operate as part of our advocacy program a thing called the safe patient project in which we seek to eliminate medical harm in our healthcare system through public disclosure of healthcare outcomes, such as hospital

acquired infection rates and incidence of medical errors, and information about healthcare providers such as complaints against licensed violations of physicians and hospitals.

We've been working in states around the country help pass public

disclosure laws for hospital-acquired infections and for medical errors.

As part of our activities, we've been working with the center for medical consumers and other patient safety groups to develop a paper which is attached to my testimony. It's called To Err is Deadly -- I'm sorry To Err Is Human, To Delay is Deadly. This is a paper we developed around the 10th Anniversary of the Institute of Medicine Report, To Err is Human.

And we basically give the United States a failing grade on select recommendations that we believe are necessary to creat a healthcare system that's free of preventable medical harm.

I wanted to call to your attention a section in the report that's on page seven, create accountabilities through

transparency which sort of lays out the case for a couple of the suggestions I'm going to make here. We think that -- you know, the IOM report recommended basically two types of natural reporting systems; a mandatory

and public reporting designed to encourage accountability of healthcare institutions and create pressure for change; and a voluntary and confidential system designed to facilitate learning about errors.

When I talked to the project director for the safe patient project, Lisa McGifford, who is based in Texas. She expressed concern about NYPORTS because, even though it's a mandatory system, it's essentially of the variety that it's really intended to promote learning and does not provide facility specific reports about medical errors. We believe sunlight is the best disinfectant and then consumers are being hurt by excessive secrecy in the medical system.

From our perspective, having a confidential or secret reporting system and having only aggregate data is a big problem. We would rather see or we would like to see

in addition to whatever is done on the learning side to have New York State also mandate that reports about medical errors

are made public by individual facility.

And Lisa said to me, we have years of experience in the states that with programs similar to NYPORTS that shows that reporting medical harm confidentially often does not advance efforts to reduce medical harm or lead to improvements.

We need complete consistent reporting and we need a timely spotlight on safety problems and institutions that are chronic offenders, we want consumers to have the opportunity to make wise decisions about which facilities to visit and which to avoid based on their safety record.

So we're concerned that confidential systems that report an aggregate have not been effective tools for harnessing financial acceptance to encourage safe care.

We support public reporting of medical harm based on the National Quality Forum list of never-events or adverse-events and the AHRQ patient safety indicators. We

believe that facility specific reports must

be broadly made available to the public or they have no use to the public or to motivate the hospitals to improve their patient safety efforts.

We do believe that the new public hospital infection reporting system adopted in Newark is a very encouraging development that was actually enacted with consensus between advocates and the industry and that highlights the need for greater openness about other types of adverse events.

The states of Indiana, Massachusetts, and Minnesota, currently report facility specific medical harm and adverse events beyond infections, and in its current legislative session, New Jersey has just enacted a new state law requiring hospital specific data reporting on medical errors for 14 patient safety indictors, and they also empowered the Commissioner of Health and Human Services to add additional public reporting categories by regulation.

92 percent of the public believes that adverse patient safety events should be

made public -- I'm sorry, they believe that hospitals should be required to report serious medical errors, 92 percent of the public, and 63 percent believe that those reports should be made public.

And in the State of Minnesota which adopted a medical error public reporting system in 2003, they found that 72 percent of the Minnesota hospitals and ambulatory care centers surveyed in 2008 felt that their Error Reporting Law had made them safer than they were when reporting began in 2003. One respondent said, our focus is always on patient safety, however, now safety efforts are better understood by more of our staff and we prioritize this work ahead of other work. Data is helping us to create more sense of urgency for this work.

So we believe that a public reporting system for other types of medical errors such as medication errors here in New York State would help to give greater visibility and also to ensure the integrity

of the data collection and validation process itself.

We're troubled by a situation in which it takes, you know, State Comptroller Hevessey or Comptroller Thompson to kind of come in and say, hey, things are not going well. These systems are really not working out. We think consumers can have more confidence in a system that is transparent and fully available to the public.

We agree with many of the points that were made by other speakers here today about the need for adequate funding for patient safety initiatives in New York State including NYPORTS, and so we look forward as consumer organizations in working with other stakeholders to increase the amount of resources that are available, but also we really want to make sure that the data that's collected is a robust data set that's validated through audits and other means and it's something that both policy makers and consumers can rely on.

So thank you very much for the

opportunity to testify. We would be happy to answer any questions or also to work with you as you go forward on these issues.

CHAIRMAN GOTTFRIED: It's interesting to hear you say that NYPORTS was criticized for being essentially intended only to promote learning and not to be part of, essentially a disciplined surveillance system when Greater New York Hospital Association's testimony was just about 180 degrees the opposite. Can you expand on that?

MR. BELL: Well, I think, as I mentioned in the IOM report, they discussed two different types of reporting systems that you can have. One is generally the voluntary confidential types of system like the patient safety organization approach that has been mentioned by some of the other speakers.

I think NYPORTS started out with a great -- maybe a more ambitious mission and scope, so I don't want to be unfair to the people who have worked very hard on this

system, but I think we have sort of a

different vision about the importance of patient safety and the importance that we have accountable healthcare for consumers.

If we look at the number of people that are hurt by patient safety adverse events, as was mentioned earlier, if it's between 3,500 to 7,000 deaths following the IOM estimates here in New York State, that's the equivalent of six to 12 jumbo jets a year crashing in New York State, people losing their lives, and then another, as many as 20,000 patients injured, a billion to two billion in additional costs for treating people who have been hurt by medical errors and hospital infections.

So I think the point for us is that we need to put this on a higher footing, and I think there's a danger with the system that we have for NYPORTS that this has become -- just as war is too important to leave to generals, patient safety improvement is too important to leave to healthcare insiders.

And the fact that you have this entity that can't even put out an annual report or its last newsletter came out two

or three years ago, is really troubling from the consumer and patient perspective.

So I'm not trying to say that they don't have a lot of -- a much more ambitious mission, and I'm sure people sincerely believe this is a great way to pursue safety improvements. I think what we're saying for our side is we want consumers to have the information that they need in real time to make intelligent decisions and if there's a hospital, whether it's a private hospital or public health hospital that is consistently getting it wrong, and not able to improve, we need effective real-time action against those facilities, and the types of reports that we've been seeing from the comptroller really undermine the confidence that patients will have in New York State and in our regulatory system if we don't take actions to fix these problems.

CHAIRMAN GOTTFRIED: Since it is already mandatory that hospitals report these incidents, what do we need to do if that reporting is not happening?

MR. BELL: We would agree with

the recommendations in the comptroller's report that we need to tighten our enforcement actions, perhaps raise fines to ensure that there is broad compliance. We also will need more financial resources to run this agency and make sure that there's somebody who is an effective watchdog on these issues. We also would need, you know, stronger efforts to validate and calibrate the data because, as was mentioned during the testimony today, it appears that there are some institutions that are very diligent reporters, they may question why they should be a diligent reporter if there are other institutions that are reporting zero medication errors and so forth.

So clearly there needs to be more public education and more efforts to try to calibrate and ensure uniform data reporting

across the entire marketplace. Because we have some idea of what the denominator is in terms of how many patients we have in New York State, but we don't know what the numerator of the adverse events is, and that's a really troubling thing. So we can't tell if we're making progress in

reducing serious medical errors in our state.

CHAIRMAN GOTTFRIED: I personally think we don't have a clue about how many hospital based patient injuries or deaths there are in a given year, and whether that number has gone up or down in the last quarter century.

As I understand it, the IOM 98,000 number was based on research that a team at Harvard did looking at a sample of hospital records in New York in the mid '80s and they estimated a certain number of hospital error generated deaths a year for New York in the mid '80s and 10 or 12 years later, the IOM multiplied that by, you know, New York's percentage of the national

population and came up with a 98,000 number which was something of a guesstimate 11 years ago and people are still citing that same number today, even though it's an extrapolation from something that was an estimate in the mid '80s.

So today there might be 200,000 such deaths. It may be there are only 50,000 such deaths, neither of which would

be a comforting number, but is there a source of a number that is that has a different history than this 98,000 number,

MR. BELL: Well, I think this is actually an issue that was addressed in the IOM report itself in that it said we needed to create a measurement system that's widely trusted and widely used across the country.

In fairness, we can say New York State's job might be easier if that had come to pass at the national level. We do address this in our paper To Err Is Human, To Delay is Deadly, in saying we need to establish a national program to track progress in patient safety.

So I think there is some question, we can't be confident that we've accomplished, for example, the former Health Commissioner Antonio Novello's statement will try to reduce medical errors in New York State by 50 percent in five years. I don't think anyone could really establish that we've been able to be successful to have that level of reduction because we don't have a trusted system for measuring how many are out there. We do have evidence

of --
CHAIRMAN GOTTFRIED: Or although if the number were either half of what it was when Dr. Novello spoke or twice, we would really today have no way of knowing?
MR. BELL: Right. I think that undermines the seriousness of the issue and we do believe that it's important to have a wide range of stakeholders involved in this discussion including those institutions that are payers of healthcare bills like employers and, of course, the State of New York with its multi-billion Medicaid and

Family Health Plus programs, we think that you have a fiduciary stake in making sure that you're buying safe healthcare and withdrawing your money from dangerous healthcare if you can do that.
Thank you.
SENATOR DUANE: Can you help us with one of the open questions that we've been dealing with about the concerns of healthcare personnel who may be reluctant to report patient errors, you know, their concerns are on blame and retribution and how do you create a culture of openness,

and, you know, if our goal is not punishment, but improving -- how do we best address that and how can we craft something or create a policy that would encourage that kind of openness to help us?

MR. BELL: Well, I think that based on the lessons that we've seen in other states, we feel that the publically accountable reporting systems do help in that regard because in a sense they hold all institutions equally accountable. I think

most experts recognize that the errors we're talking about, whether it's infections or medication errors, are often not the fault of particular individuals but it's because of incomplete or dysfunctional systems.

So there is a sense that if we understand the patient safety challenge, it's a systems challenge and, in that sense, we want to hold people accountable for their part in those systems, but also recognize that the systems that we have may not be designed in appropriate ways. If we have medications that have similar names or common similar color packages for different conditions, things like that need to be

addressed at sort of a structural or a design level.

So our concern is that, when we carve out large areas of the healthcare system for confidentiality and secrecy, that that could be a damper on momentum for change. So, from our point of view, transparency is something that helps propel change, and confidentiality and secrecy

needs to be used very judiciously because we see that as something that can serve a break on change and quality improvement.

SENATOR DUANE: Well, if you got push back on that position, how would you respond? Because, you know -- I mean, yes, of course, and there's another side and how do you respond to that?

MR. BELL: Well, I think actually there is a sense in which the healthcare system considers itself exempt from rules that we see in other parts of the economy. I mean, we work on product safety and food safety issues across the board in many different sectors of the economy, and, you know, many different types of institutions don't like regulation, they prefer

confidentiality and secrecy.

I believe in passenger rights as well as patient rights, and if you look at something like the federal aviation administration, you know, we need systems that assure that our planes fly safely and, if it's not safe, that they're grounded and

they don't fly. So I tend to look at the healthcare system through that lens too.

I'm troubled by some of the points that were raised earlier about healthcare systems failure to report examples of medical errors and abuse, and I think it needs to be accounted for that. I'm not sure that we can address all those issues in the context of NYPORTS, but I think that those are important issues and it's a real issue.

SENATOR DUANE: Thank you very much.

MR. BELL: Thank you.

CHAIRMAN GOTTFRIED: Our next witness is Leigh Briscoe-Dwyer.

MS. BRISCO-DWYER: Good afternoon. I am pleased to represent the New York State Council of Health-Systems

Pharmacists at this hearing today, and I'm pleased that I can give a bit of a focus on when we talk about medication safety and patient safety, and that being the role of the pharmacists in this process.

The New York State Council represents pharmacists and pharmacy personnel who practice in a variety of healthcare settings including inpatient, outpatient, homecare, and long-term care settings.

Pharmacists are experts in medication use who serve on interdisciplinary patient care teams to ensure that medications are used safety, effectively, and in a cost-conscious manner.

We believe that pharmacists offer vital and unique assistance in efforts to improve the quality of patient care. While many would associate pharmacists with a distribution activity, pharmacists clinical activities are well aligned with priority areas defined by quality organizations such as patient centered care, medication therapy management, preventive services including immunization, and medication teaching and

the provision of medication records and medication reconciliation.

Pharmacists' education and

training prepares these healthcare professionals to lead efforts to ensure safe and evidence-based medication use. Scientific literature has demonstrated improved clinical outcomes, fewer adverse events, and more cost-effective medication use when pharmacists are involved in patient care.

The benefits of pharmacist leadership in antimicrobial stewardship programs, management of chronic disease, and involvement in care of sepsis, pneumonia, and heart failure patients are significant and have demonstrated effectiveness in decreasing mortality and hospitalization.

Pharmacists have also applied their knowledge to information systems and automation to reduce risk in the medication use process. Transformational practices in the profession of pharmacy throughout the country have demonstrated pharmacists impact on decreasing fall-related injuries, decreasing the development of antimicrobial

resistance, increased utilization of

medications to prevent the development of blood clots in medical and surgical patients, optimizing antimicrobial surgical prophylaxis, decreasing adverse drug events in ICU patients, and decreasing hospitalization rates of patients with congestive heart failure. And I have attached a list of references to my testimony.

As Ms. Ryan mentioned earlier, adverse medication events and medication errors are reported in hospitals across the state. Several hospitals also track what we call these near-miss events, and these are events that could have resulted in harm should they have reached the patient but they are caught before they in fact do so.

Examples would include a pharmacist adjusting the dose of a medication based on age or renal function, or a nurse realizing that an incorrect medication has been dispensed and contacting the pharmacy to correct the error before administering it to the patient.

These are really wonderful teaching moments and are shared in interdisciplinary meetings -- committees throughout the hospital, but could actually have a greater impact if they are shared throughout the state. This information can be used to identify trends, benchmark a hospital's performance, and as an educational tool.

Pharmacists are critical yet under-used personnel in healthcare systems. Maximizing the use of pharmacists and support personnel will become more important as we continue to improve upon the safe and effective use of medications.

Allowing healthcare personnel to continue to be confined in outmoded turf-protected silos that jeopardize patient safety should no longer be tolerated. Just as it was important to allow pharmacists to assist in immunization, which the legislature recent authorized, it is essential to allow appropriately qualified pharmacists to play their full role in

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helping to manage medication therapies for patients.

The New York State Council encourages the Assembly to join the Senate in passing of a bill which would authorize pharmacists to enter into voluntary collaborative drug therapy management protocols with physicians and nurse practitioners. Assembly Bill 6848 remains pending before the Higher Education Committee. The companion Senate Bill 3892 was unanimously passed for the third consecutive year earlier this fall.

Collaborative drug therapy management has a demonstrated track record in the 46 states that have already authorized the practice. Not only has it saved lives, reduced medical errors and complications, and enhanced professional collaboration, it has saved significant dollars in a healthcare system that is desperately seeking intelligent means to reduce cost.

Even as we implement CDTM, the

appropriate utilization of highly trained support personnel, will be crucial to move pharmacists away from distributive functions toward more clinical and cognitive services.

Establishing requirements for registration and certification of pharmacy technicians will be fundamental to the role of pharmacists in patient safety efforts and we would urge the legislature to turn its attention to this issue as well.

The New York State Council and the increasingly highly-trained pharmacists that are its members, welcome the opportunity to work with the Legislature on other ways that we can improve patient safety and make our state a leader once again in the innovative approaches to high quality healthcare.

I thank you again for the opportunity to present this testimony.

CHAIRMAN GOTTFRIED: Do you know, is there a bill in the Legislature dealing with pharmacy technicians?

MS. BRISCOE-DWYER: There is a

bill on the Assembly side -- I'm sorry, on the Senate side. Yes. And there have been

bills in the last several years, but none have really made it out of committee.

CHAIRMAN GOTTFRIED: Okay.

SENATOR DUANE: Not as instead of, but just for -- it must be late for you as it is for me. Even, you know, in lieu of the voluntary collaboration drug treatment therapy, as you understand it, has there been a lessening anyway, a trending down of medication errors, or is it -- or can you not tell because of NYPORTS, I'm just wondering if that's a --

MS. BRISCOE-DWYER: Well, medication errors that are reported within a hospital system are different obviously than those that are reported through NYPORTS, so the actual number that we see that are reported through pharmacy committees and hospitals is probably higher. Just like everything though, should that number be higher than it is and what we're actually seeing, yes. So we have significant

underreporting there as well.

What we do see sometimes with medication error reporting is that there are certain high alert medications that we

target, things like Heparin and insulin where, if you make a medication error, either in dispensing or administration, the results can be catastrophic.

So we actually can say that, through some of our efforts, nationwide, that medication errors pertaining to some of those high-risk medications have gone down. But overall, what you see, even with computerized order entry and computerized physician prescription prescribing, what you tend to see sometimes is a shift in the type of medication error, but you still will see a certain percentage of medication errors.

SENATOR DUANE: And then does the sort of response follows the increasing incidents of that medication as it becomes known is that it's chasing it rather than getting ahead of it, is that --

MS. BRISCOE-DWYER: Correct. And

that's where near-miss data becomes so important is because it actually sometimes let's you get ahead because while you report it early, and you say this is what happened at some other institutions, so let's keep an eye open for it, let's stop it before it

happens.

SENATOR DUANE: Okay. Thank you.

CHAIRMAN GOTTFRIED: The collaborative drug therapy management bill, what would that change that would help improve patient safety?

MS. BRISCOE-DWYER: Probably one of the first things that it would do, if you look at the treatment of chronic disease, it's been shown that with chronic disease such as diabetes, hyper lipidemia, asthma, you actually have better control, so patients not in the hospital. If patients are not in the hospital, you'll have less hospital errors.

So that's one of the things we're trying to do, we're trying to keep people out of the hospital. It would actually

decrease ER rates, ER admission rates for asthma, decrease the progression of some of those chronic disease states. It would ensure the appropriate utilization of medications in general. Somewhere around 25 percent of hospital admissions, it has been estimated, are due to medication mismanagement. Patients either don't take

it, they don't take it correctly. They stop getting refills.

We know that in patients with chronic disease states that after six to eight months, they stop paying attention to that chronic disease state and their adherence really tapers off. And if you're looking at a disease state that is managed by medication, if you're not taking your medication, it can be significant.

CHAIRMAN GOTTFRIED: Well, are you saying that the main impact of the legislation would be on what a pharmacist would do for a patient who is not in the hospital?

MS. BRISCOE-DWYER: It's in all

settings. It wold help patients in the outpatient settings, but it would also allow pharmacists to actually be more timely in our response to medication issues that we see in the hospital.

Right now, very often if we see a patient who is not getting an order for something for blood clots, or if an order for post-operative antibiotics hasn't been written, we have to stop, try to find the

prescriber. If they're not available, try to find the covering prescriber to get someone to write an order for the drug that's missing.

If we had a protocol in place, we would be able to implement the protocol and dispense the drug as soon as we found that there was an error or an omission.

CHAIRMAN GOTTFRIED: Okay. Thank you.

SENATOR DUANE: Are there studies about adherence? This is slightly off topic but really not off topic, you know, with hypertension, diabetes, HIV, asthma, and so

by disease and by insurance and race and class and geography, I -- actually, I'm not surprised about the adherence, but on the other hand, I'm not -- how large a problem is it, and how can we fix it? I guess that is --

MS. BRISCOE-DWYER: I'm looking at a report from the New England Healthcare Institute that talked about a study that they released in 2007 called Waste and Inefficiency in the Healthcare System; Clinical Care, a Comprehensive Analysis in

Support of Systemwide Improvements, and they talked about adherence, and their statement is, non-adherence has been shown to result in $100 billion dollars each year in excess hospitalizations alone.

SENATOR DUANE: Because, you know for instance, in the HIV and TB, non-adherence leads to -- they just turned the air back on, so I might start to be able to think more clearly again -- it's not immunity, but --

MS. BRISCOE-DWYER: Decrease in

infections and resistance, correct.

SENATOR DUANE: Right. So then that obviously is the cause side.

MS. BRISCOE-DWYER: I mean, if an asthmatic patient, for example, doesn't take their maintenance medication, they'll use a lot more of their rescue medication, or they'll more events that will cause them to be -- their rescue medication won't be enough, that's going to land them in the ER.

SENATOR DUANE: And I do know that there are -- there are pharmacies in place to help to track adherence and different -- people lose their insurance, I

mean, it's a very, it's a thorny problem, and another -- okay.

MS. BRISCOE-DWYER: I mean, there are patient assistance programs, but it takes, you know, time and effort to be able to --

SENATOR DUANE: Even people coming out of prisons, for instance, don't necessarily get their -- hooked up to their -- for their benefits quickly enough. It's

just a whole other area, a topic for another day, although actually something though that could be integrated into the NYPORTS system, too, to help us, you know, just generally I would think, too, but I would have to -- I would say offhand, yes, absolutely, and is that -- should that be the top priority or just in and of itself, is that the top priority? You know what I mean?

So thank you for coming and confusing me at an even higher level than I already was.

MS. BRISCOE-DWYER: Then my work here is done. Thank you.

CHAIRMAN GOTTFRIED: Sometimes advancing our -- at least awareness of our

confusion is important.

SENATOR DUANE: I took a whole course on that one time. It was very confusingly helpful.

CHAIRMAN GOTTFRIED: Next is Ilene Corina.

MS. CORINA: Thank you so much for allowing me to speak today. Sometimes

it's best being last so I can fix what everybody else screwed up.

SENATOR DUANE: Oh, please.

MS. CORINA: My name is Ilene Corina, and, again, thank you very much for allowing me to speak here today. I'm going to talk a little bit about including the patient in patient safety.

Some of the things we might hear is ask your doctor to wash their hands before touching you, bring a list of medications with you to the doctor, have an advocate ask questions for you if you can't ask for yourself. These are the things that we are told to do to be a good or empowered patient and stay safe in our healthcare system. But if we do these things, will we truly be safe?

Learning how to be an active patient is more than asking a doctor how many times he or she has performed a procedure. The agency for Healthcare Research and Quality or AHRQ, a branch U.S. Health and Human Services says, the single

most important way you can help prevent medical errors is to be an active member of your healthcare team.

Being part of this team means understanding that hospitals are dangerous places, that medical professionals don't wash their hands, and that medication errors are dangerously common. Being an active patient means being an informed patient and, the first thing we need is knowledge about a system that fails us more than the public is aware.

More than 20 percent of adults read at or below a fifth grade level. 90 million Americans have difficulty comprehending and complying with health and medical advice. And, yet, we are continually handed information to read at our most vulnerable time. When we are being to a hospital with symptoms of a heart

attack, when we're in labor, or just suffered the trauma of a serious accident, are we supposed to be reading and comprehending material that medical

professionals still don't follow the basic safety practices such as hand washing so we must remind them?

Safe patient care can begin at home with family, friends and even volunteers functioning as patient safety advocates, and this would directly address the adherence question that you asked before. Training family appropriately to help with communication, care, and treatment won't replace competent care, but a loved one who understands what a bed sore looks like or what an infection is can potentially save a life.

Nonprofit organizations that focus on diseases and health must include safety in their community educational programs. Surgery safety educational programs such as the Surgical Care Improvement Project or SCIP for cancer patients can mean the difference between positive outcomes and disastrous ones. The

U.S. Department of Health and Human Services spent money on rolling out SCIP program for

patients, but does anyone even know about it?

As a patient safety advocate working with patients and families attempting to receive safe, quality care, I've had opportunities to witness some of the most wonderful treatment of patients. I've also had opportunities to witness some horrific acts that are not only dangerous but direct disregard of policies and standards that are set for safe, quality care.

With firsthand knowledge, I watched as my son bled to death following a tonsillectomy. Three years later, I had a child who was born severely premature. Both incidents took place in New York Hospitals. I, myself, have had the chance to see the worst in healthcare and the best in healthcare.

I've since founded the organization PULSE of New York that teaches patient safety and family centered patient advocacy. We work closely with the medical

community but with no formal commitment in patient safety.

Our work has brought national attention because the leaders in patient safety almost all are from outside of New York. There is a weaving of the patients and families' voices in how patient safety should be addressed throughout the country, but not in New York.

This year, as a fellow of the American Hospital Association Patient Safety Leadership Training, I'm being trained by the American Hospital Association by nationally recognized leaders in patient safety. Even they are including me, the patient, in this extensive training.

There needs to be a place to turn when the care is below standard. Reporting bad outcomes must be made easy for the patient, the family and even frontline staff. A place is needed to report unexpected events that can be responded to immediately and give the person reporting the event some piece of mind that he or she

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is doing the right thing.

Many hospitals have rapid response teams that can be triggered by family members but no training for the family members on how to use it. There's measurements for outcomes, but no one advertising their existence and there's hospital report cards that just on a website with no one actively acknowledging their existence to the public.

There should be an immediate response from the hospital within 24 hours when someone reports a possible deviation from standards;

There should be a patient safety advocate independent of the hospital of every county in the state to address family and patient's concerns;

Reporting of sexual misconduct should come with counseling to the patient or the reporter;

The untimely death of a loved one should come with a support hotline to address the unexpected death even before the

final report is complete;

Patients and families need to be involved with root cause analysis. Without the patient or family's participation, you will only get half the story, with important facts being overlooked, missed or misinterpreted;

Patient safety committees in hospitals throughout the country often have patients involved in their work. Hospitals in New York should be required to have patient safety committees that involve their patients;

Finally, patient safety needs to be included in school curriculums. Children as young as sixth grade can learn about look-alike-sound-a-like medications and communication with their healthcare providers.

Patient safety should be taught the same way seatbelt safety is taught, the same way that young women are taught about examining themselves for breast cancer, and the same way young people are taught about

HIV AIDS.

It was only after the public was involved in prevention of these diseases that the death rate started to drop. The public also needs to be involved in patient safety to bring down the death toll from preventable medical errors. Statistics show that it is only a matter of time until we all feel the impact directly.

I just want to comment on some of the things we heard today, that the hospital workers that come to the table and talk about patient safety, when you're alone with them, and when they are talking directly to the community about patient safety or their colleagues, they're talking about the problems in their facilities.

It saddens me that nobody that I heard came here today and said, yes, we have a problem, and we want to address it. Instead, they all talked about how wonderful their facilities are, and it seems like everybody else has it wrong.

So I think we all need to start

addressing that there is a problem. Patient safety is a serious problem and we all need

to start working together and there needs to be transparency for everyone to get through the issue of patient safety.

So thank you very much for allowing me to speak today.

SENATOR DUANE: I'm sorry for your loss and the difficult times that you've had. I also want to let you know that, this is my first time hearing you, but I know you met with Denise and you have a very big fan in her, and now you have a very compelled hearer in me. So thank you.

MS. CORINA: Thank you.

CHAIRMAN GOTTFRIED: And having been in the chair role for a long time, of course, I've had the good fortune to be involved with your work and to have seen your advocacy for a long long time, and you're a very important force for patient safety in New York.

MS. CORINA: Thank you. No questions?

SENATOR DUANE: We know where to find you.

MS. CORINA: That's great.

CHAIRMAN GOTTFRIED: Okay. Thank

you. I think the way we officially close it is we just say this hearing is adjourned.

SENATOR DUANE: And thank you everybody, with the exception of a slight warm situation, which I know you weren't in charge of, thank you for your help and service today.

CHAIRMAN GOTTFRIED: And thanks, as always, to our faithful and long-suffering stenographer. We are done. Thank you.

(Whereupon,the Committees on Health adjourned at 4:07 p.m.)

C E R T I F I C A T E

I, EDWARD LETO, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby stated:

THAT I attended at the time and place above mentioned and took stenographic record of the proceedings in the above-entitled matter;

THAT the foregoing transcript is a true and accurate transcript of the same and the whole thereof, according to the best of my ability and belief.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2009.

_____

EDWARD LETO